Southwest Michigan Behavioral Health Board Meeting
January 12, 2024
Air Zoo Aerospace & Science Museum
6151 Portage Rd, Portage, MI 49002
9:30 am to 11:30 am
(d) means document provided
Draft: 1/3/24

1. **Welcome Guests/Public Comment**

2. **Agenda Review and Adoption (d) pg.1**

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

   - None Scheduled

4. **Consent Agenda (5 minutes)**

   a. December 8, 2023 SWMBH Board Meeting Minutes (d) pg.3
   b. November 29, 2023 Operations Committee Meeting Minutes (d) pg.6

5. **Required Approvals (5 minutes)**

   a. Financial Risk Management Plan (G. Guidry) (d) pg.7
   b. Financial Management Plan (G. Guidry) (d) pg.10
   c. Cost Allocation Plan (G. Guidry) (d) pg.13
   d. Fiscal Year 2024 Quality Assurance and Performance Improvement Plan (A. Lacey) (d) pg.23

6. **Ends Metrics Updates *(*Requires motion) (15 minutes)***
   Proposed Motion: The Board accepts the interpretation of Ends Metrics as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.

   - None

7. **Board Actions to be Considered (10 minutes)**

   a. Board Policy replacement set (d) pg.77
   b. Calendar Year 2024 Board Policy Review Calendar (d) pg.93
   c. Board as Board Compliance Committee (M. Todd) (d) pg.94
   d. February Board meeting confirmation

8. **Board Policy Review (5 minutes)**
   Proposed Motion: The Board accepts the interpretation of Policy _____ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.

   - BG-004 Board Ends and Accomplishments (d) pg.97

9. Executive Limitations Review (0 minutes)

Proposed Motion: The Board accepts the interpretation of Policy _____ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.

- None Scheduled

10. Board Education (20 minutes)

a. Fiscal Year 2024 Year to Date Financial Statements (G. Guidry) (to be displayed)
b. Consultant Costs (G. Guidry) (to be displayed)
c. Fiscal Year 2023 Program Integrity Compliance Evaluation (M. Todd) (d) pg.98
d. Fiscal Year 2023 Customer Services Report (S. Ameter) (d) pg.103

11. Communication and Counsel to the Board (10 minutes)

a. Fiscal Year 2023 Medicaid Services Verification Report (M. Todd) (d) pg.114
b. 2023 Board Member Attendance to Community Mental Health Service Providers (d) pg.120
c. February Board Policy Direct Inspection – None scheduled

12. Public Comment

13. Adjournment

SWMBH adheres to all applicable laws, rules, and regulations in the operation of its public meetings, including the Michigan Open Meetings Act, MCL 15.261 – 15.275.

SWMBH does not limit or restrict the rights of the press or other news media.

Discussions and deliberations at an open meeting must be able to be heard by the general public participating in the meeting. Board members must avoid using email, texting, instant messaging, and other forms of electronic communication to make a decision or deliberate toward a decision and must avoid "round-the-horn" decision-making in a manner not accessible to the public at an open meeting.

Next Board Meeting
February 9, 2024
9:30 am - 11:30 am

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting Minutes
December 8, 2023
Four Points Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
9:30 am-11:30 am

Members Present: Edward Meny, Tom Schmelzer, Louie Csokasy, Susan Barnes, Erik Krogh, Carol Naccarato

Members Absent: Mark Doster, Sherii Sherban

Guests Present: Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Ella Philander, Strategic Imperatives Project Manager; SWMBH; Cameron Bullock, Pivotal; Jon Houtz, Pines Board Alternate; Jeff Patton, ISK; Sue Germann, Pines BH, Richard Thiemkey, Barry CMH, Cathi Abbs, Pivotal Board Alternate, Debbie Hess, VanBuren CMH, Tina Leary, Jeannie Goodrich, Summit Pointe, Karen Longanecker, ISK Board Alternate

Welcome Guests
Edward Meny called the meeting to order at 9:33 am and introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to approve the agenda as presented.
Second	Louie Csokasy
Motion Carried	

Financial Interest Disclosure (FID) Handling
Mila Todd noted the following individuals submitted their 2024 FID forms, which require no Board action: Mark Doster, Nancy Johnson, Ed Meny, Jon Houtz, Tom Schmelzer, Sherii Sherban, Louis Csokasy, Erik Krogh, Cathi Abbs, Carol Naccarato, and Susan Barnes.

Consent Agenda

Motion	Louie Csokasy moved to approve the November 10, 2023 Board minutes as presented.
Second	Susan Barnes
Motion Carried	

October 25, 2023 Operations Committee Meeting minutes were included in the packet for the Board's information. No questions from the Board.

Required Approvals

None scheduled

Ends Metrics

None

Board Actions to be Considered

BEL-006 Investments

Garyl Guidry noted that he and Brad had met with bankers and have begun executing plans for revolving CDs which will yield a 4.6% interest rate at no cost or risk to SWMBH. Bankers had additional recommendations which SWMBH is considering.

Louie Csokasy stated that a revised Investment Policy would be ready at the January meeting. Discussion followed.

Board Governance Process Policy Replacement Set

Mila Todd noted that SWMBH Board Policies have been reviewed by SWMBH's consultant Susan Radwan and Brad is in the process of reviewing those policies. A replacement set will be offered to the Board at the January meeting for their review/approval, including Board consideration of an Ad Hoc Board Policy Review Committee.

Calendar Year 2024 Board Meeting Calendar

Edward Meny noted the 2024 Board meeting dates as documented.

Mila Todd noted that Ella Philander and Michelle Jacobs toured the Air Zoo of Kalamazoo as a new meeting location stating that this new location would alleviate current heating, lighting and audio visuals issues.

Motion Louie Csokasy moved to approve the meeting dates and location as presented and asked the Board to consider cancelling the December 2024 meeting at a later date.

Second Tom Schmelzer

Motion Carried

Board Policy Review

BG-005 Chairperson's Role

Edward Meny reported as documented.

Motion Susan Barnes moved that the Board accepts the interpretation of Policy BG-005 Chairperson's Role as meeting the test of any reasonable interpretation and the data shows compliance with the interpretation.

Second Louie Csokasy

Motion Carried

Executive Limitations Review

BEL-002 Asset Protection

Erik Krogh reported as documented. Discussion followed regarding changes and possible, if any changes, to the Asset Protection policy due to new investment strategies.

Motion Erick Krogh moved that the Executive Officer is in compliance with Policy BEL-003 Asset Protection and the policy does not need revision.

Second Carol Naccarato
Motion Carried

Board Education

Fiscal Year 2024 Year to Date Financial Statements

Garyl Guidry reported as documented noting that there is a deficit in Healthy Michigan Plan due to rate and enrollee decreases. 6 of the 8 CMHSPs submitted estimated financials. Actual financial data is needed from the CMHSPs in order to monitor deficits and provide feedback to Milliman. SWMBH has reiterated the need for routine, timely, actual data from CMHSPs and is working with CMH CFOs. Discussion followed.

Fiscal Year 2023 Contract Vendor Summary

Garyl Guidry reported as documented. Louie Csokasy inquired about conflict of interest processes for vendors. Mila Todd reviewed current financial interest disclosure procedures for SWMBH staff. Tom Schmelzer asked for the costs of SWMBH's consultant Susan Radwan. Board agreed and SWMBH will provide at January's meeting.

Fiscal Year 2023 Program Integrity Compliance Report

Mila Todd reported as documented. Discussion followed.

Communication and Counsel to the Board

January Board Policy Direct Inspection

None

February 2024 Meeting confirmation

Board agreed to determine a February meeting at the January Board meeting.

Public Comment

None

CMHSP Board Visits

Michelle Jacobs reviewed the current CMHSP Board visits matrix. Discussion followed.

May 10, 2024 SWMBH Board Planning Session

Mila Todd noted to keep planned process of SWMBH Board review and available inputs in March and April. A reminder of the May 10, 2024 day long Board Planning session at Bay Pointe Inn with dinner Thursday night (max 25) and Thursday overnight rooms available to Board members. Michelle Jacobs is handling logistics and Board requests and will email a Bay Pointe link to Board members.

Adjournment

Motion Erik Krogh moved to adjourn.
Second Louie Csokasy
Motion Carried
Meeting adjourned 10:35am

11.29.2023 Operations Committee Mtg Minutes – MT Notes

Present: Jeff Patton, Rich Thiemkey, Cameron Bullock, Jean Goodrich, Sue Germann, Ric Compton, John Ruddell, Deb Hess (via MS Teams), Mila Todd (SWMBH)

a) FY 23 PBIP payout and FY 24 PBIP distribution and beyond (Brad and all) (d) pg.5
    1. CMHs received and reviewed SWMBH's FY24 PBIP distribution proposal. MT offered context for development based on % of metric activities performed by involved entities.
    2. CMHs decline SWMBH's proposal with no counter proposal.
    3. CMHs request:
        i. How other multi-county PIHPs are distributing their PBIP funds and assert other PIHPs either pass the entire amount on to their CMHs or retain a smaller portion that what SWMBH retains.
        ii. Historical Jeff Wieferich memo(s) or other information about MDHHS's intent with PBIP funds.
        iii. Discussion about distribution to non-CMH SUD network providers.
        iv. Further discussion with Brad on this item.
b)) MDHHS Fiscal Year PIHP Delegation Agreement Reporting Request and form (Mila and all)
    1. Briefly reviewed/referenced MDHHS Establishing Administrative Costs document on MDHHS Reporting Requirements website - https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder60/Establishing_Administrative_Costs_PIHP_System.pdf?rev=42d238f4f6624d9d8b45eeb3966b98e7
    2. Discussion related to holistic approach to this MOU review. Goals include:
        a. Update Delegation MOU in line with Managed Care Rules
        b. Discuss cost centers and administrative cost allocations in light of SCA.
    3. OC to devote most of 12/20/23 meeting to reviewing and editing the Delegation MOU and request MT is present.
c) Veterans Navigator (A. Wickham) (d) pg.10
    1. OC explicitly declines to complete a separate Veteran Navigator report form. Discussion regarding SWMBH's grant funded position and extending administrative requirements to CMHs.
    2. OC declined to discuss further with SWMBH SMEs.
d) PCP Improvement Process (M. Tood; A. Lacey) (d) pg.18
    1. MT reviewed Memo. OC indicated Memo was too vague to identify the areas that need improvement. Discussion of issues in general related to medically necessary services not being included in Treatment Plans due to lack of provider availability, member due process rights, wait lists, etc.
    2. MT to bring explicit list of identified issues/sources of identification to 12/20/23 OC.
    3. OC prefers to address/problem solve at OC first before further addressing of this issue at Regional Committees.
e) BTRC Reporting (A. Lacey)
    1. Discussion regarding HSAG findings and requirements.
    2. PCE form is acceptable and, as implemented by Riverwood Center, contains all the data SWMBH needs to analyze the data.
    3. CMHs agree to either utilize the PCE module in the same format as Riverwood Center (Riverwood Center gave permission for PCE to replicate/ensure consistency for other CMHs) OR submit required data using the SWMBH-provided template.
    4. All parties agree SWMBH does not want duplicate efforts to submit the data.
f) FY '23 Financial Results (G. Guidry) (d) pg.19
    1. Garyl reviewed financials. Discussion ensued.
g) January 24, and March 27, 2024 OC Meetings (Directors Forum conflict)
    1. Beginning in January 2024, OC will meet the 2nd and 4th Wednesdays of each month, through March 2024, the duration of the meetings will be 2 hours, 9a-11a.
    2. January 10th – entire meeting will be CEO Only. Remainder of the meetings will be split, CEO only and open.
    3. January 24th meeting will be moved to Zoom from 2p-4p in light of Director's Forum conflict.
    4. OC will determine the March 27th meeting at a later date.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

SWMBH January 2024

1115 Demonstration waiver, 1915 (c)/(i), and Autism Program

SWMBH is solely responsible for Medicaid and Healthy Michigan Plan supports and services and any cost overruns at participating CMHSPs or in the aggregate. SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) or purchase risk reinsurance, at levels appropriate for this purpose. SWMBH will maintain a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on state maximums and allowed risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10) or method deemed appropriate as described in the MDHHS contract.

Beyond this and in further protection of SWMBH, participating CMHSPs will submit timely, complete, and accurate financial information, results of operations and apportioned regional contract cost compared to sub-contract revenues which balance to actual confirmed claims and encounters. This shall be in a form and format determined by SWMBH.

This reporting will be inclusive of the activities of the CMHSP. While SWMBH has responsibility for only the regional contract activities and cost, SWMBH has to assure that it is being charged for only those costs that are ordinary and necessary, properly assigned, allocated and apportioned, for appropriate, medically necessary, covered services provided or arranged for contracted eligible beneficiaries. It is also in SWMBH's best interest to assure itself of the financial stability and viability of participating CMHSPs. Should a participating CMHSP exceed, or project to exceed, its sub-contract revenue amount, that CMHSP will be provided additional technical support and oversight from SWMBH and/or its agents. This could include:

- Enhanced management and financial review by SWMBH Chief Executive Officer, Chief Financial Officer, or their designees.
- Provision of special technical assistance off-site and on-site to the CMHSP
- Development and implementation of a Corrective Action Plan for excessive cost that could have been prevented or avoided.

SWMBH, if imposed with any contractual remedies, sanctions or penalties by a regulatory body or contractual payor that is a direct result of participating CMHSP failure to perform or rectify the participating CMHSP shall hold SWMBH harmless and make whole SWMBH for cost incurred or revenues lost as a result, with non-Medicaid funds.

Healthy Michigan Plan

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

SWMBH is solely responsible for Healthy Michigan supports and services and any cost overruns at participating CMHSPs or in the aggregate. To this end, SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) and/or to purchase risk reinsurance, at levels appropriate for this purpose. SWMBH maintains a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on actuarially determined risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10) or method deemed appropriate as described in the MDHHS contract.

~~MI Health Link- Medicare Medicaid Dual Eligible (MME)~~

~~MI Health Link- Medicare Medicaid Dual Eligible (MME) Demonstration Participating CMHSPs are paid Fee for Service (FFS) for MI Health Link participants, CMHSP's are funded by the caption for cost above the FFS level. There are no risk sharing arrangements with the CMHSP's. SWMBH PIHP and Integrated Care Organizations (ICO) have specific risk sharing arrangements according to their respective contracts.~~

Substance Abuse Prevention and Treatment Block Grant/PA2

Allocation of substance use prevention and treatment Block Grant and PA2 revenues among participating CMHSPs are determined by eligible within the region, allocations based on the 2010 Census and regional county board request. PA2 funds and budgets are reserved to the sole authority of the Substance Use Disorder Oversight Policy Board. These are not entitled services and these services maybe reduced/suspended or terminated by SWMBH for lack of funding.

Other Revenues

SWMBH management and/or Board considers recommendations for other contracts and thus revenues and expense allocation on a case-by-case basis. SWMBH Board may allocate other contracts and revenues among participating CMHSPs and SWMBH based on several beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

Investment Management

It is the business practice of SWMBH to invest remaining funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds. Further information is provided on investment management in the Region Entity Investment Policy

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

Supervision of External Audits, Internal Audits, and Internal Controls

Independent Annual Audit - SWMBH and each participating CMHSP shall ensure the completion of an annual financial audit performed by an independent certified public accountant. A copy of the audit report, audited financial statements, footnotes and supplementary schedules, along with the management letter and management's response to the management letter, shall be submitted to SWMBH after the presentation to the CMHSP Board.

Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH within 10 days of its completion by the audit firm unless received by current SWMBH auditors.

Internal Audits– SWMBH will perform internal audits on as needed basis.

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Internal Controls - SWMBH shall maintain appropriate written policies and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

SWMBH January 2024

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Beyond this and in further protection of SWMBH, participating CMHSPs will submit timely, complete, and accurate financial information, results of operations and apportioned regional contract cost compared to sub-contract revenues which balance to actual confirmed claims and encounters. This shall be in a form and format determined by SWMBH.

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Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH within 10 days of its completion by the audit firm unless received by current SWMBH auditors.

Internal Audits– SWMBH will perform internal audits on as needed basis.

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Internal Controls - SWMBH shall maintain appropriate written policies and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

SWMBH Board January 2024

Southwest Michigan Behavioral Health (SWMBH) Cost Allocation Plan for Community Mental Health Service Providers (CMHSP's)

POLICY

SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSP's for those funds received by the PIHP under the contract with Michigan Department Health and Human Services (MDHHS). It shall be the policy of SWMBH, that SWMBH and each of the participating CMHSPs prepare a Cost Allocation Plan as an integral part of their annual budget process. For fiscal year 24' the Cost Allocation Plan methodology changed for the CMHSP's with the development of the Standard Cost Allocation (SCA) from MDHHS. All SWMBH CMHSP's will have switched over to the SCA model report for yearend FY2024 and have specific instructions and requirements outlined by the MDHHS on the methodology

The Cost Allocation Plan shall, at a minimum:

1. Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the organization.
2. Conform to the accounting principles and standards prescribed in pertinent contractual agreements, regulations, and other authoritative literature (i.e., GAAP, GASB, OMB Super Circular), 2 CFR 200.
3. Contain sufficient information, in such detail, to permit making an informed judgment on the correctness and fairness of the procedures for identifying, measuring, and allocating all costs to each of the programs operated by the organization.

The cost allocation plan shall contain the following information:

1. An organizational chart showing the placement of each unit or program within the organization.
2. A listing of revenue and costs for all programs performed, administered, or serviced by these organizational units.
3. A description of the activities performed by each organizational unit and, where not self-explanatory an explanation of the benefits provided to other programs performed, administered, or serviced by the organization.
4. The procedures used to identify, measure, and allocate all costs to each benefiting program and activity.
5. The estimated cost impact resulting from changes to a previously approved plan.

TABLE OF CONTENTS

AUTHORITATIVE GUIDANCE

Authoritative guidance for this policy can be found in the following:

1. The MD HHS contract and other state and federal law, regulation, and promulgation.
2. Office of Management and Budget, Super Circular, (formally OMB A-87, Cost Principles for State, Local, and Indian Tribal Governments, with reference to Attachment D and the referenced 45 CFR Part 95, 2 CFR 200 Subpart E.

Generally Accepted Accounting Principles (GAAP), with reference to Governmental Accounting Standards Board (GASB) Statement #34, Basic Financial Statements and Management's Discussion and Analysis for State and Local Governments (June 1999), and GASB Statement #10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues (November 1989).

ADEQUACY OF COST INFORMATION

Cost information must be current, accurate, and in sufficient detail to support payments made for services rendered. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor timecards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made.

ADEQUATE COST DATA AND COST FINDING

<u>PRINCIPLE</u>

Organizations receiving payment based on reimbursable cost must provide adequate cost data based on financial and statistical records, which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

<u>DEFINITIONS</u>

Accrual Basis of Accounting

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Allocable Costs

An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable

measure of application or consumption.

Directly Allocable Costs

Directly allocable costs are chargeable based on actual usage (e.g., metered electricity) rather than a statistical surrogate.

Indirectly Allocable Costs

Indirectly allocable costs are not chargeable based on actual usage, and thus, must be allocated based on a prospectively documented statistical surrogate (e.g., square feet).

Applicable Credits

Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs *(i.e., COBRA receipts)*.

Charges

The regular rates established by the provider for services rendered eligible individuals and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients. *(i.e., Gross Standard Charge Rate.)*

Cost Finding

Cost Finding is a determination of the cost of services using informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the assignment of direct costs and the allocation of indirect costs.

Cost Center

An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications may be accumulated in separate cost centers created to accumulate these indirectly allocable costs such as depreciation, facilities, and fringe benefits. These cost centers also fall under this definition to facilitate cost finding and cost allocation.

General Service Costs Centers (Nonrevenue Producing)

General Service (or Nonrevenue Producing) Costs Centers are those organizational units that are operated for the benefit of the organization. Each of these may render services to other general service areas as well as to Revenue Producing Cost Centers.

For the CMHSP and PIHP environment, General Service Cost Centers can be further differentiated and grouped by function into:

- General and Board Administrative functions

- Managed Care Administrative functions
- Program Administrative functions

Revenue Producing Cost Centers

Revenue Producing Cost Centers are those that usually provide direct identifiable services to individual consumers.

For the CMHSP and PIHP environment, Revenue Producing Cost Centers can be further differentiated and grouped by similar business activity into:

- Managed Care Risk Contracts (Medicaid, Healthy Michigan, MI Health Link)
- Service and Support Programs (direct-operated programs)
- Grants and Other Earned Contracts

Each CMHSP will incorporate unit costs into Encounter Quality Initiative (EQI) reports:

1. Each CMHSP will submit EQI reports to the PIHP based on the schedule identified in the Michigan Department of Health and Human Services (MDHHS) contract; and 2. The PIHP will compile data into one PIHP report for submission to MDHHS.

DETERMINATION OF COST OF SERVICES

PRINCIPLE OF COST APPORTIONMENT

Total allowable costs of an organization are apportioned between contract eligible individuals and other individuals so that the share borne by the contract is based upon actual services received by contract eligible individuals.

Departmental Method

This method of apportionment is the ratio of covered services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals, applied to the cost of the department.

COST APPORTIONMENT FOR COST-BASED CMHSP'S

The term apportionment, as used here, refers to the process of distributing allowable costs among various groups of cost-based eligible individuals and other non-eligible individuals.

The total allowable cost of supports and services furnished to contract eligible individuals shall be apportioned to the contract on the basis of the ratio of covered supports and services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals. For purposes of this apportionment, the preferred methods are based on RUUAC as defined above.

The PIHP must use a method for reporting costs and statistics that results in an accurate and

equitable allocation of allowable costs and is justifiable from an administrative and cost efficiency standpoint.

OBJECTIVES OF APPORTIONMENT

The objectives of the apportionment process are to assure that:

- Costs of covered supports and services provided to eligible individuals under contract will not be borne by other contracts or other individuals.
- Costs of supports and services to non-contract and other non-eligible individuals will not be borne by the contract.

PROVIDER SERVICES FURNISHED UNDER ARRANGEMENTS

Costs of covered services furnished to contract eligible individuals through arrangements with non-plan providers will, in most cases, are the amount the CMHSP/PIHP pays the provider under its financial arrangement, to the extent it is found reasonable.

APPORTIONMENT OF ADMINISTRATIVE AND GENERAL COSTS NOT DIRECTLY ASSOCIATED WITH PROVIDING SUPPORTS AND SERVICES

Enrollment and membership costs, as well as other administrative and general costs of the CMHSP that benefit the total eligible population of the CMHSP which are not directly associated with providing supports and services, are apportioned on the basis of a ratio of contract eligible population to total PIHP eligible population. These costs are classified as Plan Administration costs. *(i.e., Managed Care Administrative Costs.)*

ALLOCATION AND DISTRIBUTION OF OTHER ADMINISTRATIVE AND GENERAL COSTS

Administrative and General (A&G) costs, other than those described immediately above, which bear a significant relationship to the services rendered are not apportioned to risk contracts directly. Instead, these costs are allocated or distributed to the components of the CMHSP, which, in turn, are then apportioned to risk contracts.

COST CENTER FUNCTIONAL DEFINITION

The cost allocation plan process recognizes that the organization of cost centers for internal accounting and management responsibility in the formal accounting system may not adequately segregate costs by functional activity for the purpose of reimbursable cost computation. This is particularly critical within non-revenue producing administrative and general service cost centers.

For cost allocation plan purposes, segregation of costs by functional area is required if the costs are material, the effect of not segregating the costs is significant and if an appropriate basis for cost allocation is available. The functional areas are described below.

For example, if the above conditions are met, the cost of Billing and Accounts Receivable, and Claims and Financial Risk Management would be segregated from General Financial

Management and Accounting. However, if not material, not significant or not appropriate, these would not be segregated but allocated together with General and Board Administrative Functions.

The same would apply to such functions as Quality Improvement and Recipient Rights, as similar examples.

GENERAL AND BOARD ADMINISTRATIVE FUNCTIONS

General and Board Administrative functions are those that support the entire organization and are typically allocated to all other revenue and non-revenue producing cost centers typically based on accumulated cost. These costs will be allocated first.

General and Board Administrative functions typically include:

- Board and Executive Administration
- Financial Management and Accounting
- Human Resources and Employee Benefit Management
- Information Systems and Data Processing
- Other functions that benefit the entire organization as a whole

General and Board Administrative costs may also include costs that would otherwise be costs of other functional areas but where the cost of these other functions is immaterial, the effect of segregation is insignificant or an appropriate basis for separate cost finding is not available. Costs associated with other functional areas must be segregated and reclassified prior to allocation, if they are material, their effect is significant, and an appropriate basis exists.

PROGRAM ADMINISTRATIVE FUNCTIONS

Program Administrative functions are those that support the direct-operated Service and Support Programs of the organization. These are typically allocated to all Service Program revenue and non-revenue producing cost centers based on accumulated cost. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Program Administrative functions typically include:

- Program Management and Supervision
- Reception and Appointment Scheduling
- Records Maintenance
- Billing and Accounts Receivable
- Quality Improvement of direct-operated programs
- Recipient Rights, as a direct-operated program

- Other functions that benefit only direct-operated programs

MANAGED CARE ADMINISTRATIVE FUNCTIONS

Managed Care Administrative functions are those that support the Pre-paid Inpatient Health Plan responsibilities under risk contracts for eligible individuals and are typically apportioned to risk contracts based on eligible lives. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Managed Care Administrative functions typically include the following:

- General Managed Care Administration and Governance
- Member Services, including information and referral, and eligibility maintenance, recipient rights advocacy, grievance, and appeal management
- Utilization Management, including access to supports and services, provider referral and authorization, and utilization review
- Provider Network Management, including network development and provider contracting
- Claims
- Financial Risk Management
- Quality Improvement of the PIHP
- Regulatory Compliance
- Other functions that benefit the eligible population under contract

COST ALLOCATION PLAN

The Cost Allocation Plan is to be developed and review by SWMBH and the participating CMHSPs as part of the annual budget process. This planning process, in general, involves the following steps:

COST FINDING

Matching of related revenue and costs, identification of functional activities and associated costs, and, if necessary (and allowable), cost reclassifications to segregate:

- Capital-Related Cost, if not already properly assigned
- Employee Benefit Cost, if not already properly assigned
- General and Board Administrative Cost
- Program Administrative Cost
- Service Program direct and assigned indirect costs
- Grants and Earned Contract direct and assigned indirect costs

- Managed Care Administrative Cost
- Contract Provider and CMHSP Subcontract Program cost for supports and services provided to eligible individuals and segregated by risk contract responsibility.

COST ALLOCATION

Allocation of functional indirect costs to revenue/cost centers based on a priority of allocation and statistical allocation proxies.

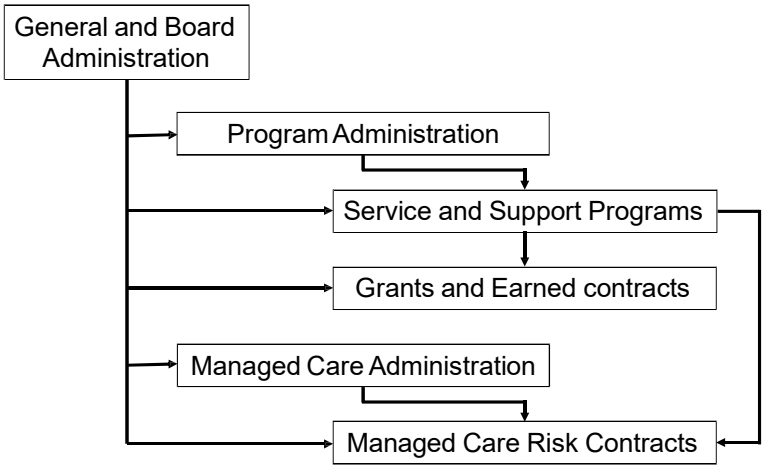
- Capital-Related Cost (depreciation and amortization, etc.) and Building Occupancy Costs, based on square feet operated for building and occupancy costs and actual depreciation for equipment and furnishings in use.
- Employee Benefit Costs based on the dollar value of Salaries and Wages.
- General and Board Administrative Cost to all revenue / cost centers based on accumulated cost.
- Program Administrative Cost to all applicable Service Programs based on accumulated cost.

COST APPORTIONMENT to Payors

- Managed Care Administrative Costs, including previously allocated costs, apportioned to Managed Care Risk Contracts or Subcontracts based on accumulated cost.

A schematic of cost allocation process is as follows:

Cost Allocation Plan Schema



CONTRACT AND SUBCONTRACT COST SETTLEMENT

Contract and Subcontract Cost Settlement including identification of sufficient local matching fund revenues to meet matching fund requirements takes place annually.

Quality Assurance and Performance Improvement Program (QAPIP) FY 2024 Plan

All SWMBH Medicaid Business Lines

October 1, 2023 - September 30, 2024

Reviewed and Approved by:
SWMBH Operations Committee on 11/29/2023
SWMBH Board of Directors on 01/12/2024
SWMBH Quality Management Committee on 02/08/2024

Submitted for MDHHS for Review by 02/29/2024

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Descriptions and Work Plan

Attachments

I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assurance and Performance Improvement Program (QAPIP) that meets the required federal regulations: the Medicaid Managed Care rules, 42 CFR § 438, and requirements outlined in the PIHP contract.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP Plan to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the eight Community Mental Health Service Partners (CMHSPs) in the region. The QAPIP Plan 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's QAPIP Plan is approved annually by the SWMBH Board of Directors. The Board shall act as the designated authority for governance oversight of the QAPIP. More information related to the QAPIP standards can be found in SWMBH policies and procedures, the Quality Management Committee (QMC) Charter, and other departmental plans.

II. Purpose

The QAPIP Plan delineates the features of the SWMBH Quality Management program. The QAPIP serves to promote quality health care services and outcomes for members through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical and non-clinical service delivery within the network as well as the 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 SWMBH and the CMHSPs within the region include individuals and their families who experience mental illnesses, 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 the region.
- Provide oversight and data integrity functions.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, integration of care, and member satisfaction.
- Improve the quality and safety of clinical care and services provided to members.
- Promote and support best practice operations and systems that promote optimal benefits in service areas of 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 drive process improvement throughout the system.
- Promote timely identification and resolution of quality-of-care issues.
- Conduct performance monitoring and improvement activities that result in meeting or exceeding all external performance requirements.

- Meet the needs of internal and external stakeholders and provide performance improvement leadership to other departments and throughout the region.

III. Guiding Principles

The Mega Ends serve as the guiding principles for the development of annual Board Ends, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. (*See Attachment A – Value Framework, and Attachment B – SWMBH Board Roster.*)

Board Ends

- ***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.
- ***Exceptional Care***. Persons and families served are highly satisfied with the care they receive.
- ***Mission and Value-Driven***. CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
- ***Quality and Efficiency***. The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

IV. Core Values of Quality Assurance and Improvement

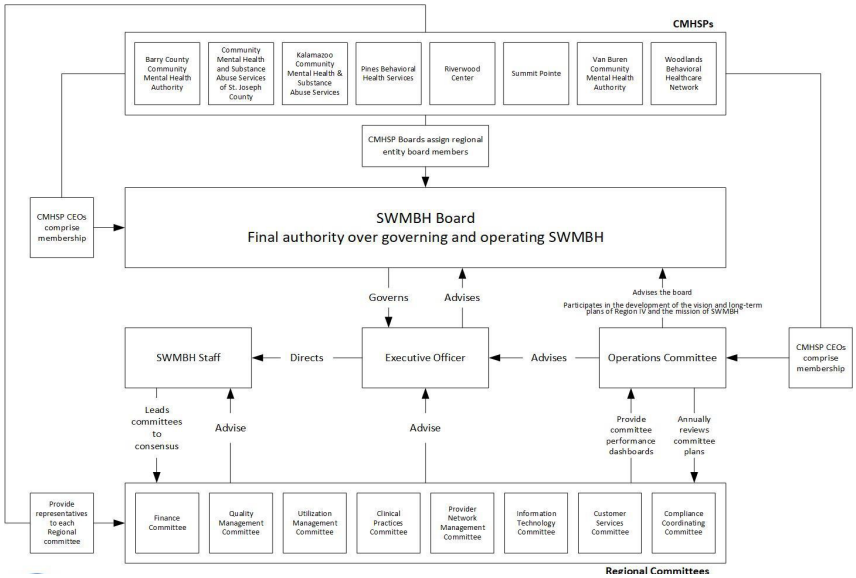
1. Quality healthcare results from a benefit management system embracing input from all stakeholders.
    - Education of all SWMBH stakeholders on continuous improvement methodologies, including providing guidance and support to other SWMBH departments, CMHSPs, and other providers as needed or requested. The involvement and inclusion of members, families, providers, and other internal and external stakeholders in the performance improvement design promotes optimal results.
    - Promoting a person-centered philosophy promotes member satisfaction with services as well as optimal treatment outcomes.
2. Poor performance is costly.
    - Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risks and benefits.
    - Quality Improvement projects are best approached systemically. The best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.
    - 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.
3. Data is valuable when the collection, analysis, and presentation are done with integrity.
    - Data that is consistently complete, accurate, and timely leads to consistent measurement and over time ensures data integrity.
    - Valid, accurate, complete, and timely data is vital to organizational decision-making. Making data accessible impacts value and reduces risk to SWMBH and the region.
    - Providers submitting data to SWMBH shall certify data integrity and have, available for

review, the process used to collect the data for verification purposes.

V. Authority and Structure

The SWMBH Board of Directors 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 Plan, receives periodic QAPIP reports and updates (including the selection of performance improvement projects and updates/results from the implementation of those), and reviews the annual evaluation of the QAPIP. The SWMBH Board ensures the annual QAPIP plan is submitted to MDHHS by the required deadline and that the plan includes a list of current Board members. In addition to the review by the SWMBH Board and SWMBH EO, the QAPIP Plan and Evaluation are taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement initiatives throughout the Region. The SWMBH Operations Committee consists of the CEO, or their designee, for each of the eight CMHSPs in the region and advises the SWMBH Board.

Regional committee members are expected to attend all meetings virtually, by phone, or in person. If members cannot participate in meetings, they should notify the committee Chairperson as soon as possible and send an alternative in their place. The committee representatives are required to communicate any relevant information discussed during the meetings (and included in meeting minutes) back to the appropriate individuals and departments within their organization. Committee members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting minutes and other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meetings. SWMBH additionally hosts a Customer Advisory Committee (CAC) where information is shared with customers actively receiving services, with representation from all CMHSPs. CAC members are also members of various regional committees which affords SWMBH the opportunity to involve customers in quality improvement efforts. cannot participate in meetings, they should notify the committee Chairperson as soon as possible and send an alternative in their place. The committee representatives are required to communicate any relevant information discussed during the meetings (and included in meeting minutes) back to the appropriate individuals and departments within their organization. Committee members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting minutes and other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meetings. SWMBH additionally hosts a Customer Advisory Committee (CAC) where information is shared with customers actively receiving services, with representation from all CMHSPs. CAC members are also members of various regional committees which affords SWMBH the opportunity to involve customers in quality improvement efforts.



SWMBH Quality Management and Clinical Outcomes Department

The general oversight of the development and implementation of the QAPIP is given to SWMBH's Quality Management (QM) Department. The Director of Quality Management and Clinical Outcomes is the designated senior official responsible for overseeing the department and QAPIP implementation. The QM Department is staffed two Quality Assurance Specialists, three Clinical Quality Specialists, two Clinical Data Analysts, a Clinical Projects Specialist, and a Strategic Initiatives Project Manager. The QM Department may also utilize an outside contracted consultant for special projects as needed. The Director of Quality Management and Clinical Outcomes collaborates on many of the QAPIP goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the Quality Management Committee (QMC), Regional Clinical Practices (RCP) Committee, Regional Information Technology (RIT) Committee, and Regional Utilization Management (RUM) Committee.

The QM Department staff work closely with the SWMBH IT Department. The IT Department assists with providing internal and external data analysis and management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations including developing and maintaining databases, consultation, and technical assistance. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, conducting factor analyses to determine causes or contributing factors for outcomes or performance outliers, and correlates the analysis to assess relationships between variables. In addition, the IT Department assists with the development of reports, summaries, and visual representations of the data.

SWMBH staff includes a designated behavioral health care practitioner to support and advise the QM

Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner provides 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 also provides clinical expertise and programmatic consultation with Quality Management and Clinical Outcomes Director to ensure complete, accurate, and timely submission of clinical quality program data.

Adequacy of SWMBH Quality Management Resources

The QM Department works collaboratively with many different functional areas. SWMBH will have appropriate staff to complete QAPIP functions as defined in this plan. In addition to having adequate staff, the QM 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, SUD Block Grant, PA 2 funds, and other grant funding. To complete these functions, additional resources are utilized including access to regional data from the CMHSPs as well as software and tools to analyze the data to determine statistical relationships.

The QM 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 the QAPIP is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QM 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), and maintains and manages the Quality Management Committee (QMC).

The QM Department works with other functional areas within the organization and external organizations/vendors such as TBD Solutions and Health Management Associates (HMA) to review processes and data collection procedures. These relationships are communicated to the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state per contractual requirements.
- Creating and maintaining QAPI policies, plans, evaluations, and other reports.
- Implementing regional projects and monitoring of reporting requirements.
- Assisting in the development of Strategic Plans and Tactical Objectives.
- Leading the development of the Agency Metrics and other Key Performance Indicators.
- Analyzing reports and data to determine trends and making recommendations for process improvements.
- Functioning as the liaison between different functional areas in the communication of audit requirements and timelines.
- Communicating, organizing, and submitting the annual Performance Bonus Improvement Program (PBIP) reports to MDHHS. (See Attachment C – PBIP Metrics.)

VI. Regional Quality Management Committee (QMC)

SWMBH has established the regional QMC to provide oversight and management of quality management functions and to provide 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 gathering participant communication and advice. QMC facilitates regional and

member input regarding the development and management of processes and policies related to quality management and the QAPIP. QMC is responsible for developing committee goals, maintaining contact with other committees to relay relevant information, and identifying people, organizations, or departments that can further the aims of both the QM Department and the QMC.

CMHSPs are responsible for the development and maintenance of a Quality and 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 and communication through the QMC. To assure a responsive system, the needs of those that use or oversee the resources (e.g., active participation of members, families, 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.

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 QM staff. All other ad hoc members shall be identified and attend as needed, which may include provider representatives, IT support staff, Coordinating Agency staff, the SWMBH designated behavioral health care practitioner, SWMBH clinical representation, etc. Additional individuals may attend QMC meetings throughout the year to present information and/or provide insight on relevant discussions. The QMC will make efforts to maintain member representation, assist with review of reports/data, and provide suggestions for regional process improvement opportunities. Alternates are named in the charter and will have all the same responsibilities of members when participating in committee work.

QMC Roles and Responsibilities

The QMC will meet regularly (at a minimum quarterly) to inform regional quality activities, to demonstrate follow-up on all findings, and to approve required actions. Committee oversight is defined as reviewing data and identifying performance improvement projects. Committee members represent the regional needs related to quality. QMC members should be engaged in the discussion of performance improvement issues and bring challenges from their site to the SWMBH committee's attention for deliberation and discussion.

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 and guidance. Additionally, the QMC is responsible for:

- Maintaining connectivity to other internal and external structures, including SWMBHs Board of Directors and Leadership Team, other regional committees, and MDHHS.
- Providing guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Providing data review and recommendations related to efficiency, improvement, and effectiveness.
- Reviewing and providing feedback related to policy and tool development.
- Ensuring each CMHSP has developed and is maintaining a performance improvement program within their respective organizations.
- Ensuring coordination is achieved through standardization of indicator measurement and performance indicators.

QMC Decision Making Process

The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. When consensus cannot be reached a formal voting process will be used and a super majority will carry the motion. This voting structure may be used to determine the direction of projects or with other various topics requiring decision making actions. If a participant fails to send a representative to a meeting, they will forgo the right to participate in any votes that occur. All regional committees are advisory with the final determinations being made by SWMBH.

VII. 2024 Regional Strategic Imperatives

Each year the SWMBH Board of Directors reviews annual priorities based on current environmental factors and strategic growth of SWMBH. Each Department and Regional Committee will work together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors meeting on September 9, 2022. The following represent a list of those Strategic Imperatives: (See Attachment D for more details on completion of Strategic Imperatives.)

Goal 1: Strengthen Equity and Quality in Behavioral Health Care.
Goal 2: Improve access to substance use disorders prevention, treatment, and recovery services.
Goal 3: Ensure effective pain treatment and management.
Goal 4: Improve access and quality of mental health care and services.
Goal 5: Utilize data for effective actions and impact on behavioral health.

As SWMBH enters 2024, its eleventh year of operations a reconsideration of strategic objectives and tactical actions for the period 2022-2025 based on past, present, and future federal and state policy changes is necessary. These plans are based on the presumption of stability in Board Ends and their definitions which the Board is free to modify. This 2022-2025 Strategic Plan is intended primarily for the Board and will drive downstream operational actions at SWMBH. As is displayed above a long-standing construct for all healthcare efforts is The Quadruple Aim.

VIII. 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. SWMBH measures performance using standardized indicators (where applicable) based on the systematic, ongoing collection, and analysis of valid and reliable data. It is important for SWMBH to review the system for errors and ensure that the data is correct, accurate, and timely. Monitoring occurs in the following ways:

- System Reviews- the QM Department along with IT is responsible for ensuring that there are:
  - Data reviews completed before information is submitted to the state.
  - Random checks to ensure data is complete, accurate, and that it meets the related standards.
  - Source information reviews to make sure data is valid and reliable.
  - The QMC and QM Department address any issues identified in the system review.
- Ensuring processes are clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Remeasurements happen as often as determined necessary for the identified project(s).
- 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.
- Maintaining and organization of the SWMBH portal and reports.
- Maintaining and organization of reports in the Tableau Data Visualization system.
- Validation checks are applied to incoming data from our participant CMHs and the SWMBH SmartCare system. Files that do not pass certain checks will not be put into SWMBH reporting databases or sent to the State until errors are corrected. Tableau reports are used to monitor data completeness and integrity (examples include LOCUS inter-rater reliability (IRR) reports, BH TEDS and assessment tool completeness reports, and encounter volume monitoring reports). There is a monthly data exchange workgroup with the CMHs where validation errors are reviewed, and reports are monitored to ensure data integrity. Assessment completeness and IRR reports are monitored in our regional clinical practices committee.

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IX. Communication

The QM 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 QAPIP. The QM Department works to provide guidance on project management, technical assistance, and supports data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through our Regional Committees is key. At least annually, the QM department shares information related to the QAPIP, survey results, and other relevant information in newsletter articles and on the SWMBH website for all stakeholders to review.

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

- Providers inside the provider network
- Members and their families (when appropriate)
- The SWMBH Board of Directors
- CMHSP staff

- SWMBH staff
- State representatives
- Others when appropriate

Information is provided through a variety of methods including but not limited to:

- Member and Provider newsletters
- The SWMBH website
- The SWMBH SharePoint site
- Tableau Dashboards
- SWMBH QM reports
- Meetings
- Other external reports

X. Definitions/Acronyms

BTRC	Behavior Treatment Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.
Behavioral Health	Referring to an individual diagnosed with a mental illness, intellectual developmental disability, and/or substance use disorder, or children diagnosed with serious emotional disturbance.
CMHSP	Community Mental Health Services Program is a program operating under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended. Refers to one of the eight Community Mental Health Services Programs (CMHSPs) in Region 4.
Contractual Provider	Refers to an individual or organization under contract with the SWMBH Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.
EQR	External Quality Review is an audit conducted annually by HSAG on behalf of CMS and MDHHS.
HCBS	Home and Community Based Services provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
HSAG	Health Service Advisory Group is a vendor contracted by MDHHS to audit the PIHPs and CMHSPs for compliance with CMS regulations and MDHHS contractual requirements.
LTSS	Long Term Supports and Services which are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identifies the Home and Community Based Services (HCBS) Waiver. MI-Choice as recipients of LTSS.
Member	For SWMBH purposes "member" includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive

	covered services and supports. The following terms may be used interchangeably within this definition: clients, customers, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.
MMBPIS	Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).
MDHHS	Michigan Department of Health and Human Services, along with 46 regional CMHSPs and 10 PIHPs, contacts public funds for mental health, substance abuse prevention and treatment, and developmental disabilities services.
OIG	The Office of Inspector General is the oversight division of a federal or state agency aimed at preventing inefficient or unlawful operations. They are charged with identifying, auditing, and investigating fraud, waste, abuse, embezzlement, and mismanagement of any kind within the executive department.
PBIP	The Performance Bonus Incentive Program is a platform for PIHPs to earn additional funding for achieving specific goals or hitting predetermined benchmarks established by MDHHS.
PIP	Performance Improvement Projects are projects that are conducted to address clinical and non-clinical services, that can be expected to have a beneficial effect on health outcomes.
PIHP	A Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities, and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.
Provider Network	Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the SWMBH PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.
QAPI	Regional efforts made toward Quality Assurance and Performance Improvement.
QAPIP	Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.
Research	(As defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.
RCA	A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998).
Sentinel Event	An “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury

	specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.
Stakeholder	A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
Subcontractor	Refers to an individual or organization that is directly under contract with a CMHSP to provide services and/or supports.
SUD Provider	Refers to substance use disorder (SUD) providers directly contracted with SWMBH to provide SUD treatment and prevention services.
SWMBH	Southwest Michigan Behavioral Health. The PIHP for Region 4.
Veteran Navigator	The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.
Vulnerable Person	A person in need of special care, support, or protection because of age, disability, or risk of abuse or neglect.

FY 2024 Quality Assurance and Performance Improvement Program Descriptions & Work Plan

A. Michigan Mission Based Performance Indicator System (MMBPIS)

Description

SWMBH utilizes performance measures established by MDHHS in the areas of access, efficiency, and outcome measures. SWMBH is responsible for ensuring that its CMHSPs and Substance Use Disorder (SUD) Providers are measuring performance through the Michigan Mission-Based Performance Indicator System (MMBPIS) per its contract with MDHHS. SWMBH maintains a dashboard tracking system to monitor individual CMHSP and Regional progress on each indicator throughout the year.

Each CMHSP is responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH via SWMBH Commons by the 25th of every month for analysis. SWMBH promotes data integrity by using electronic controls within the spreadsheets used for reporting MMBPIS data. SWMBH has a QAPI Specialist dedicated to reviewing the data to ensure it is complete and accurate, based on the MMBPIS PIHP and CMHSP Code Book, prior to submission to MDHHS. SWMBH submits the data to MDHHS quarterly as established in the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH requests the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). SWMBH SMEs also review indicators compliance and are incorporated in approval of MMBPIS-related CAPs. The PIHP ensures the action plans are achieved and improvements are recognized. Status updates are given, and regional trends are identified and discussed at relevant committees such as QMC, RUM, RCP and Operations Committee for further

planning and coordination. SWMBH also participates in MDHHS Performance Indicator workgroups and communicates any changes with indicator measurement or reporting to internal and external stakeholders.

SWMBH utilizes the QAPIP to assure it achieves minimum performance levels on performance indicators as established by MDHHS as defined in the contract and analyzes the causes of statistical outliers when they occur. Oversight and monitoring are conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. The Provider Network monitoring desk audit and site reviews occur at least annually. The SWMBH Quality Department completes a review of MMBPIS Performance Indicator data, primary source verification documentation and protocols during this annual site audit, and CAPs are requested from any CMHSPs that a site review score less than two for each indicator item.

FY24 Goals

SWMBH will meet or exceed the MDHHS-indicated benchmark for each of the access and follow-up MMBPIS performance measures (Indicators 1, 4 and 10). Additionally, SWMBH will meet or exceed newly established State benchmarks for Indicators 2a, 2e and 3 as indicated in the current MDHHS MMBPIS Codebook version October 2023. New benchmarks for Indicators 2 and 3 are calculated by taking the total cumulative percentage (total numerator/total denominator) for each indicator for each region and are based entirely on FY22 data. Each region falls under one of the percentile columns (Below 50th percentile, 50th-75th percentile and above 75th percentile). Based on final FY22 outcomes, PIHPs are required to increase to the next column or maintain above the 75th percentile.

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Indicators	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	Quality	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	Quality	QMC	Monthly
Indicator 2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (>=62%)	Quality	QMC	Monthly
Indicator 2e - Percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorders (>=68.2%).	Quality/SUD	QMC, SUD Directors Workgroup	Monthly
Indicator 3 - Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-	Quality	QMC	Monthly

emergent biopsychosocial assessment by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (>=72.9%)			
Indicator 4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	Quality/SUD	QMC	Monthly
Indicator 4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	Quality	QMC	Monthly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	Quality	QMC, SUD Directors Workgroup	Monthly
Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%).	Quality	QMC	Monthly
Indicator 10b - e-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%).	Quality	QMC	Monthly

B. Performance Improvement Projects

Description

MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Medicaid Managed Care rules, 42 CFR Part 438. According to the managed care rules, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. SWMBH's QAPIP includes affiliation-wide performance improvement projects that achieve thorough ongoing measurement and intervention, and demonstratable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that SWMBH serves.

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Each year, one PIP is reviewed by HSAG. The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

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The following are steps used to identify, implement, and evaluate the progress of a PIP.

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

There are currently two primary Performance Improvement Projects that SWMBH has targeted for FY2024.

1. Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). This is a high-risk service area, where improved continuity and coordination of care is needed; this project serves as our clinical PIP.
2. Increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment.

The details of each of the two identified PIPs can be found below:

FY24 PIPs

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Performance Improvement Project #1 (clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Goal: "To eliminate the statistically significant disparity between African American/Black and White rates of follow up after Emergency Department (ED) visits for alcohol and other drug use, from baseline (2021) to remeasurement 1 (2023) and 2 (2024), without a corresponding decrease in White follow up rates." Monitoring: Remeasurement 1 (2023) results will be available in June 2024. We will assess our performance on the following measures to determine whether we have met the PIP goal for 2023. 1. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 2. The percentage of White beneficiaries with a 30-day	Quality	Regional Clinical Practices Committee and Regional Quality Management Committee	Bi-Annual

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follow-up after an ED visit for alcohol or other drug abuse or dependence.			
Performance Improvement Project #2 (non-clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children. Goal: In FY24, SWMBH and its provider network will increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. Monitoring: By the end of FY24 Q1, we will complete a causal barrier analysis to evaluate factors contributing to the 2023 baseline of 56.78%. By FY24 Q2, we will develop and implement interventions to address the barriers in access and timeliness of services. The interventions will be utilized to increase the 2024 percentage to 73%. Remeasurement will occur in 2025.	Quality	Regional Clinical Practices Committee and Regional Quality Management Committee	Annually and Quarterly

C. Critical Incidents – Event Reporting

Description

SWMBH's process for identifying, reporting, and following up on incidents and events that put individuals at risk of harm is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents for members are defined by MDHHS as suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrest. Hospitalization or EMT due to an injury is further classified to include whether the injury resulted from physical management. Residential treatment providers prepare and file incident reports to the contracted CMHSP when incidents occur. The CMHSPs are responsible for reviewing and classifying the incident reports and submitting the reportable incidents to SWMBH as outlined in policy. SWMBH is then responsible for reporting qualifying incidents to MDHHS in a timely manner, as defined in the contract language, via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). SWMBH is also responsible for ensuring that MDHHS requests for further information, details related to the remediation of an incident, or any other requests are responded to timely.

SWMBH delegates the responsibility of the process for the identification, review, and follow-up of immediate events, sentinel events, critical incidents, and risk events to its eight contracted CMHSPs and SUD Providers (SWMBH contracts with four SUD residential treatment providers – Gilmore Community Healing Center (CHC),

Freedom Recovery Center (FRC), Kalamazoo Probation Enhancement Program (KPEP), and Sacred Heart Center). The CMHSPs and SUD providers have 3 business days after an incident occurs to determine if it is a sentinel event, and two subsequent business days to commence a root cause analysis of the event if it determined to be a sentinel event. The CMHSPs work with the residential treatment provider, when applicable, to complete a root cause analysis. All unexpected deaths are classified as sentinel events and are defined as deaths resulting from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect, for members who at the time of their deaths were receiving specialty supports and services. SWMBH ensures that the CMHSPs and SUD Providers review all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, are reviewed and the review includes:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews. SWMBH ensures that individuals involved in the review of sentinel events have the appropriate credentials to review the scope of care (e.g. deaths or serious medical conditions involve a review by a physician or nurse).
- Documentation of the mortality review process, findings, and recommendations.
- Following completion of a root cause analysis, or investigation, the CMHSP or SUD Provider is required to develop and implement either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or to document the rationale of why corrective actions are not needed.
- Use of mortality information to address quality of care.

A random sample is reviewed annually during each CMHSP Delegated Function Site Review to ensure the CMHSP is following the process as intended and is meeting all the requirements related to the review.

SWMBH requires that all CMHSPs and SUD Providers notify SWMBH within 36 hours of an immediate event that is subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). Following an immediate event notification, SWMBH will additionally submit to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within 1 year of the individual's discharge from a State-operated service.

SWMBH analyzes critical incidents, sentinel events, and risk events at least quarterly during the regional QMC meetings. The risk events reviewed minimally include those that put individuals at risk of harm including actions taken by individuals who receive services that cause harm to themselves, actions taken by individuals who receive services that cause harm to others, and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or patterns of events are reviewed and discussed to remediate the problem or situation and prevent the occurrence of similar additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes which are saved on the SWMBH Commons and available to all QMC members. It is the expectation that members that cannot attend the meetings will review the PowerPoint presentation and the minutes, and that all members communicate information from the meetings to the appropriate people within their organizations.

SWMBH Incident and Event Flowchart

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	Quality	Through submission to MDHHS in the new CRM	As SEs Occur

The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who were hospitalized due to an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who received emergency medical treatment (EMT) for an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who caused harm to themselves (risk event codes B9, B10, and B11) will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly
The rate for the region, per 1000 persons served, of individuals who caused harm to others (risk event codes B3, B4, B5, and B6) will demonstrate a decrease from the previous year.	Quality	QMC	Quarterly

D. Behavior Treatment Monitoring

Description

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement (QAPI) Program Technical Requirement, attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Each CMHSP is responsible for having a Behavior Treatment Review Committee (BTRC) for the collection and evaluation of data. The purpose of the BTRC is to review, approve, or disapprove any plans that propose to use restrictive or intrusive interventions. Only the techniques that have been approved during person-centered planning by the member or his/her guardian and have been approved by the BTRC may be used with members. The CMHSP BTRCs are required to submit their BTRC data to SWMBH on a quarterly basis where intrusive and restrictive techniques have been approved for use with individuals. Data being reviewed for analysis is where physical management, 911 calls to law enforcement have been used in an emergency behavioral situation, and any intrusive/restrictive interventions are used. The analysis includes the numbers of interventions and length of time the interventions were used per person. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. Tracking this data provides important oversight to the protection and safeguard of vulnerable individuals, including those receiving long term supports and services (LTSS). The data is available to MDHHS upon request. Based on the analysis, SWMBH requests the behavior plans for individuals as needed to review further. The criteria for further review may include, but is not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, and other critical incidents. A review and recommendation of the modification or development, if needed, of the individual's behavior treatment plan is included. SWMBH also utilizes the data

during the administrative and delegated site reviews to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete a quality review of at least 6 behavior treatment plans per CMH for FY24.	Quality	RCP and QMC	Quarterly
The region will achieve 90% or higher on the *Behavior Treatment Plan* section of the annual CMHSP audit.	Quality	RCP and QMC	Annually
SWMBH will implement a regional strategy to evaluate the BTRC's effectiveness by Q4 of FY24.	Quality	RCP and QMC	Annually

E. Member Experience - Customer Satisfaction Surveys

Description

The QM Department will administer an annual Member Experience Satisfaction Survey. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement at the CMHSP and PIHP levels. SWMBH will ensure the incorporation of individuals receiving long-term supports or services (LTSS), case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY24, SWMBH will utilize a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS) and the Experience of Care and Health Outcomes Survey (ECHO). All adopted survey methods and categories are certified as best practice survey tools to gauge member experience of care. The survey tools will be evaluated to ensure required data is collected from consumers and During FY24, the SWMBH Quality Department plans to collect consumer survey responses throughout the year with the goal of achieving 2100 completed surveys. Surveys can be accessed electronically by consumers via QR codes in waiting/lobby areas, tablets in the waiting/lobby areas, through the SWMBH website, by text message, by email, by mobile device or by paper copy.

SWMBH will also conduct focus groups with individuals who completed the survey and identified that they would be willing to participate. The focus groups will be aimed at gathering further information related to sources of dissatisfaction as well as strengths. The information gathered will be used to create more specific corrective actions to address areas of concern. The Consumer Advisory Committee and Quality Management Committees serve in an advisory capacity to ensure the accuracy and validity of the focus group questions, process and format. The two Committees also closely review the results/analysis of the focus groups to promote improved outcomes through enhancing programs and services.

At the conclusion of the survey project, a full analysis report will be produced, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The results and survey analysis will be shared with internal/external stakeholders. This includes the SWMBH Consumer Advisory Committee, Clinical Practices Committee, Utilization Management Committee, the Regional Operations Committee, Quality Workgroups, and Board of Directors. SWMBH informs practitioners, providers, members, internal/external stakeholders and the SWMBH Board of survey analysis results. The results will be shared via the SWMBH website and newsletters, Annual QAPI Evaluation and other SWMBH annual publications. The results will also be presented to the SWMBH Consumer Advisory Committee for feedback on survey process,

questions, content and distribution plan.

The Evaluation Report will outline the results of the survey project, identify any barriers, and provide recommendations for improvement for the following years survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, will be evaluated and discussed during the Regional QMC meeting. The survey analysis will address issues of quality and availability of care. Sources of member dissatisfaction will be investigated and identified and each CMHSP will be required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps will be outlined to follow up on the findings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1500 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Quarterly
Achieve at least 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Quarterly
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QAPI	QMC, RCP, and CAC Committees	Annually
Ensure CMHSPs develop improvement plans specific to their survey findings/results/analysis.	QAPI	QMC and CAC Committees	Annually
Present and receive feedback from the SWMBH Consumer Advisory Committee on survey process, questions, content, and distribution plan.	QAPI	QMC and CAC Committees	Annually

F. Member Experience – RSA-r Survey

Description

The QM Department, in conjunction with the SUD Department, will administer the Recovery Self-Assessment Survey, Person in Recovery version (RSA-r) to Medicaid and SUD Block Grant consumers within the region. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement in SWMBH's recovery-oriented care. At the conclusion of the survey project, a full analysis report will be produced, providing qualitative and quantitative analysis for each of the five subcategories measured (Life Goals, Involvement, Diversity of Treatment, Choice, and Individually Tailored Services). The results and survey analysis will be shared with internal/external stakeholders, SWMBH Consumer Advisory Committee, SWMBH Clinical Practices Committee, SWMBH Utilization Management Committee, the Regional Operations Committee, Quality Workgroups and the SUD Board of Directors, and feedback strategies will be implemented. The results will be shared via SWMBH website, newsletters, Annual QAPI Evaluation and other SWMBH annual publications.

The Evaluation Report will outline the results of the survey project, identify any barriers, and provide recommendations for improvement for the following year's survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, will be evaluated and discussed during the Regional QMC and the SUD Directors Subgroup meetings. The survey analysis will address issues of quality and

availability of care. Sources of member dissatisfaction will be investigated and identified and each SUD and CMHSP participant will be required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps will be outlined to follow up on the findings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase survey participation compared to the previous year as evidenced by more participating providers and/or more completed surveys.	QAPI	QMC, SUD Directors Subgroup	Annually
Achieve 90% consumer satisfaction with SUD services as indicated by survey results.	QAPI	QMC, SUD Directors Subgroup	Annually
Ensure participating CMHSPs and SUD Providers develop improvement plans specific to their survey findings/results/analysis.	QAPI	QMC, SUD Directors Subgroup	Annually

G. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance department performs the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to members by its Participant CMHSPs, providers, and subcontractors. This review is performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performs this review immediately after the end of each Fiscal Year Quarter to have real time results and an opportunity to effectuate change quickly. SWMBH submits its findings from this process to MDHHS annually and provides follow up actions that were taken because of the findings. SWMBH also presents the findings to the Board of Directors.

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For completing the fiscal year verification of sampled Medicaid claims, SWMBH uses the random number function of the Office of Inspector General's (OIG) statistical software package, RAT-STAS, and conducts quarterly audits of service encounters for each CMHSP and reviews claims from contracted substance use disorder (SUD) providers and non-SUD providers subcontracted with Participant CMHSPs. SWMBH utilizes a standardized verification tool, which includes the following elements against which all selected encounters and claims are evaluated:

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1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?
5. Is there documentation on file to support that the service was provided to the consumer?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
	~~Compliance~~	SWMBH Compliance Committee and	~~Monthly~~

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The overall Medicaid claims verification of services compliance rate for SWMBH will be above 90%.		SWMBH Regional Compliance Committee	

H. Provider Network Adequacy

Description

SWMBH completes an evaluation of the adequacy of its current fiscal year's provider network ~~annual report~~ during the first quarter of the applicable fiscal year, assessing provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The areas that are assessed include enrollee-to-provider ratios, crisis residential beds-to-enrollee ratios, time and distance standards, SUD services based on ASAM LOC, timely appointments, languages spoken, cultural competence, and physical accessibility. Each section contains a regional analysis and identifies opportunities for improvement that will be addressed throughout ~~during~~ the fiscal year. The report is submitted to MDHHS for review and feedback.

FY24 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current ~~2020~~ MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	Provider Network	SWMBH Assessment of Medicaid Network Adequacy Report	Annually

I. Administrative and Delegated Function Site Reviews

Description

SWMBH either directly performs or ensures that its Participant CMHSPs perform annual monitoring of all providers in its network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality.

Participant CMHSP Site Reviews

SWMBH performs annual Site Reviews of its Participant CMHSPs. These reviews consist of a review of each CMHSP's administrative processes and procedures in the following functional areas: Access and Utilization Management, Claims, Compliance, Credentialing, Customer Services, Grievances & Appeals, Provider Network, Quality, Staff Training, SUD EBP Fidelity and Administration, and Clinical Administration.

In addition to reviewing administrative processes, the annual site review process also includes file reviews for the following administrative functions:

- Denial File Review (performed quarterly)
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review (performed quarterly)
- Appeals File Review (performed quarterly)

~~XI.~~ MMBPIS and Critical Incident File Review

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XII. Staff Training File Review

To monitor clinical service quality, SWMBH performs a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that is focused on a specific population or service (consistent across all Participant CMHSPs). The population or service focus is determined annually by SWMBH's Quality Management and Clinical Outcomes Department based on several factors which may include State or PIHP-audit results, member complaints, or other identified concerns. SWMBH also performs an SUD Clinical Quality clinical record review of CMH SUD services.

SUD Providers

SWMBH does not allow for subcontracting of SUD services, and therefore directly holds each contract with its network SUD Providers. SWMBH directly performs annual site reviews for each of its contracted SUD providers. These reviews consist of a review of each SUD Provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor SUD Provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered.

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To monitor clinical service quality, SWMBH performs a clinical file review as part of the annual site review process.

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Subcontracted Providers

For non-SUD ~~subcontracted~~ network providers that are contracted with one or more of SWMBH's Participant CMHSPs, SWMBH ensures that monitoring is performed annually either directly by SWMBH or by a Participant CMHSP. SWMBH directly performs the annual site reviews for the following provider types:

- Autism Service Providers
- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)

SWMBH's Participant CMHSPs perform annual monitoring of the remaining ~~subcontracted~~ provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviews standardized subcontracted provider review tools which are used for completion of subcontracted provider site reviews to ensure consistency and foster reciprocity. The RPNMC also maintains a spreadsheet of all "shared providers", subcontracted providers that are contracted with more than one Participant CMHSP and assigns a responsible Participant CMHSP to perform the annual site review each year, to reduce the burden on shared providers. Completed reviews are uploaded to SWMBH's Portal so they are accessible to all Participant CMHSPs.

Network ~~Subcontracted~~ provider site reviews consist of a review of each provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY24 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring

SWMBH will complete or ensure completion of site reviews for the region (for Participant CMHSPs, SUD Providers, and Network ~~Subcontracted~~ Providers), and areas of non-compliance will require a corrective action plan.	~~All~~ SWMBH Departments; Participant CMHSPs	Site Review Tools and CAP Documents	Annually

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J. Credentialing and Re-Credentialing

Description

SWMBH either directly performs or ensures that its Participant CMHSPs and network providers perform credentialing and re-credentialing in compliance with SWMBH's Credentialing and Re-credentialing Policies, which are annually approved by the SWMBH Board of Directors. The credentialing process (inclusive of re-credentialing) ensures that organizations, physicians, and other licensed health care professionals are qualified to perform their services. SWMBH utilizes standardized credentialing and re-credentialing applications throughout its Region to ensure consistent application of required standards. These applications are periodically reviewed by the Regional Provider Network Management Committee. SWMBH utilizes a checklist to assist in processing credentialing applications. The checklist includes, among other things, the following components for re-credentialing files:

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- QI Data Check
  - Compliance F/W/A or other billing issues
  - Customer Services issues (other than formal Grievances/Appeals)
  - Utilization Management issues/concerns

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SWMBH directly performs credentialing for the following in its network:

- Applicable SWMBH employees/contractors (individual credentialing)
- Participant CMHSPs (organizational credentialing)
- SUD Providers (organizational credentialing)
- Autism Service Providers (organizational credentialing on behalf of the Region)
- Financial Management Service Providers (organizational credentialing on behalf of the Region)
- Crisis Residential Providers (organizational credentialing on behalf of the Region)
- Inpatient Psychiatric Service Providers (organizational credentialing on behalf of the Region)
- Large Specialized Residential Providers – Beacon, ROI, Turning Leaf, and Hope Network
  - SWMBH performs organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegates, under Delegation MOUs, credentialing activities to its Participant CMHSPs for the following:

- CMHSP network providers, other than those listed above.

SWMBH includes credentialing requirements consistent with its policies in its subcontracts with its Participant CMHSPs, SUD providers, and network providers via the CMH-provider subcontract boilerplate, for the following:

- Compliance with SWMBH or CMH organizational re-credentialing activities, including provider timely submission of credentialing applications and proofs; and
- Provider completion of i~~I~~ndividual practitioner credentialing of directly employed/contracted staff.

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and its Participant CMHSPs monitor compliance with credentialing requirements through the annual

site review process. Each site review includes a file review of a sample of the provider's credentialing files. See "Provider Network Monitoring" for additional information on the annual site review process. Additionally, SWMBH and its Participant CMHSPs require clinician information for any clinician to be listed as a "rendering provider" in the applicable agency's billing system. This is another way SWMBH and its Participant CMHSPs monitor to ensure licensed professionals are qualified to perform their services. While it is not "credentialing", when SWMBH receives a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performs basic screening checks including exclusions screening and licensure verification to ensure that the clinician is only assigned billing rights to service codes they are qualified to deliver.

Monitoring Activities – Non-licensed Providers

SWMBH and its Participant CMHSPs monitor non-licensed provider staff qualifications through the annual site review process. Standardized site review tools for all provider types include a Staff Training file review, which evaluates whether a sample of the provider's staff completed all required trainings within required timeframes. Standardized site review tools that are specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) include review elements that evaluate the provider's process for ensuring non-licensed direct care staff meet the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

Through the annual site review process SWMBH ensures, regardless of funding mechanism:

- Staff (licensed or non-licensed) possess the appropriate qualification as outlined in their job descriptions, including the qualifications for all of the following:
  - Education background
  - Relevant work experience
  - Cultural competence
  - Certification, registration, and licensure as required by law (where applicable)

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network	Provider Network Team Meeting Minutes	Annually
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated site reviews.	Provider Network	Site Review Tools	Annually
SWMBH will develop and implement a quality performance improvement project designed to improve adherence to SWMBH and MDHHS credentialing requirements.	Provider Network & QAPI	Site Review Tools, RPNMC	Annually

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K. Clinical Practice Guidelines

Description

Southwest Michigan Behavioral Health (SWMBH) reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its

Medicaid subcontracted provider network have adopted these guidelines. SWMBH assures that information related to the guidelines is made available to members and providers.

It is policy that the employees of SWMBH, the CMHSPs, and the provider network must assure that decisions with respect to utilization management, member education, coverage of services, and other areas are consistent with the guidelines found here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

SWMBH's Clinical Protocols and Practice Guidelines meet the following requirements:

- Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
- Consider the needs of the SWMBH members.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or Director of Quality Management and Clinical Outcomes.
- Guidelines are disseminated to all applicable providers through provider orientation/the provider manual and to members upon request.
- Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks.
- Implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
- Any decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

All practice guidelines adopted for use are available on the SWMBH website. SWMBH's adopted practice guidelines include:

- Inclusion Practice Guideline
- Person-Centered planning Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- Employment Works! Policy

Practices Guidelines are adopted, developed, and implemented by the SWMBH Regional Clinical Practices Committee (RCP), which consists of representatives from SWMBH and the eight CMHSPs in Region 4. This group works together to decide which guidelines are most relevantly matched to the individuals in this region by eliciting responses from CMHSP representatives who are close to the issues. They ensure that the essence and intention of these guidelines are filtered through the behavioral health system via meaningful discussion, policy, procedure, training, and auditing/monitoring. Practice guidelines are monitored and evaluated through SWMBH's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to

appropriate providers through relevant committees/councils/workgroups.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline and develop improvement strategies to address any deficiencies in FY24.	Quality	QMC, RCP, Site Review Tools	Quarterly

L. Long-Term Services and Supports (LTSS)

Description

"Long term services and supports (LTSS)" means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).

Long Term Services and Supports (LTSS) are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; or
- Physical, cognitive, developmental, or chronic health conditions; or
- other functional limitations that restrict their abilities to care for themselves; and
- Receive care in home and community-based settings or facilities such as nursing homes.

MDHHS identifies Medicare and Medicaid participants in its HCBS Waivers as recipients of Long-Term Services and Supports (LTSS). SWMBH manages funding for Michigan's specialty behavioral health Medicaid population through delegation and contracting with the eight CMHSPs and their provider networks in Region 4. SWMBH and its network serves members receiving LTSS through the following HCBS Waivers:

- Children's Waiver Program
- Waiver for Children with Serious Emotional Disturbances (SED)
- Habilitative Supports Waiver
- 1915(i)SPA
    - 1115 Behavioral Health Demonstration

SWMBH is dedicated to ensuring the quality and appropriateness of care to all its members. However, persons receiving LTSS are some of our most vulnerable citizens; therefore, additional analyses, both quantitative and qualitative, of the quality and appropriateness of care for the LTSS populations in Michigan are warranted. The quality, availability, and accessibility of care furnished to members receiving LTSS will be quantitatively assessed using an analysis of LTSS sections annual Member Experience Satisfaction Survey. SWMBH has incorporated survey questions that will identify individuals who are receiving LTSS. This will allow for a separate analysis of the LTSS population. Quality and availability of care are assessed in the MHSIP and YSS. Additional questions will be developed to assess accessibility.

The annual CMHSP site review tool that is utilized in Region 4 includes items to monitor the quality and appropriateness of care for members receiving LTSS. For reference, some of the items from the SWMBH annual

CMHSP site review tool are:

- In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the PCP.
- Needs, priorities, and a professional analysis of service needs and recommendations are documented.
    - All identified needs are included and addressed in the IPOS.
- Level of Care (LOC) is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment is completed annually and when there is significant change in individual's status.
- The IPOS is individualized based upon assessment of the customer's needs and preferences. The plan (or assessment) describes his/her strengths, abilities, plans, hopes, interests, preferences and natural supports.
    - health/safety risks are identified.
    - member choice is documented.
    - natural supports that will be used to assist the customer in being able to accomplish goals and objectives are identified.
    - the plan contains clear, concise, and measurable statements of the objectives the customer will be attempting to achieve.
- Individuals are provided with ongoing opportunities to provide feedback on supports and services they are receiving, perceived barriers or strengths during treatment, and their progress towards goal attainment.
    - may be documented in Progress notes and/or Periodic Reviews.
- Services and interventions identified in the IPOS are provided as specified –
    - goals/objectives are measurable.
    - the plan specifies the type, amount, scope, duration, frequency, and timeframe for implementing services.
    - individual has received all services authorized in plan.
    - if services are not being utilized as planned, and an appropriate reason for the lack of service provision is not present in the documentation, the IPOS has been amended. (Lack of provider is not an acceptable reason for not providing a medically necessary service.)

Aggregated annual audit outcomes are regularly monitored and analyzed by the Quality Management and Clinical Outcomes Department at both the CMHSP and PIHP levels. Results are used to inform annual provider training that is offered to the LTSS provider network. Additional quality improvement training is provided at the CMHSP-level as needed or required. Future training topics will include developing a regional approach to assess care between settings.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will use the Member Experience Satisfaction Survey results and the information from the Waiver Audit Interviews to assess the quality, availability, and accessibility of care of members receiving LTSS. Improvement areas	Quality	QMC, RCP	Annually

will be identified based on the analysis of the results in Q3 of FY24.			

M. Utilization Management

Description

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 PIHP must ensure services identified in 42 CFR §438.210(a)(1) must be furnished in an amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441.

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.

Utilization Management Activities

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 some 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 board-certified in addiction medicine, meet 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. For the purposes of utilization control, SWMBH ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. 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. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the member.

2. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, and/or long-term services and supports needs.
3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate.
4. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
5. 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.
6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
7. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
8. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

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 the 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.

Access Standards

- The percentage of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (MMBPIS #1) (Standard = 95%)
- The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (MMBPIS #2) (*Standard = >62%)
- The percentage of new persons receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD). (MMBPIS #2e) (*Standard = 68.2%)
- The percentage of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MMBPIS #3) (*Standard = 72.9%)
- The percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (MMBPIS #4a) (Standard = 95%)
- The percentage of discharges from a substance abuse withdrawal management (detox) unit who are seen for follow-up care within seven days. (MMBPIS #4b) (Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less.

* Effective FY24, Standards are based on the FY22 final percentages. PIHPs that fell below the 50th percentile will be expected to reach or exceed the FY22 50th percentile. PIHPs that fell in the 50th -75th percentile the benchmark will be expected to reach or exceed the FY22 75th Percentile. The PIHPs that are above the FY22 75th percentile would be expected to maintain their level of performance.

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 are 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 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, and the ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the SIS (Supports Intensity Scale) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. 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. Management of identified high cost, high risk service outliers or those with under- utilized 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 underutilization 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.

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

1. 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.
2. 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 ensure understanding of the utilization trends or patterns.
3. 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.

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 people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It is a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring

SWMBH will create a Utilization management Plan per MDHHS guidelines.	UM	RUM	Annually
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques.	UM, Clinical Quality, SUD	RUM, RCP	Monthly
SWMBH will identify the levels of care and subsequent reports to manage utilization and uniform benefit.	UM, Clinical Quality	RCP	Quarterly
SWMBH will ensure regional inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	UM	RUM	Annually
SWMBH will meet or exceed the standard for compliance with Adverse Benefit Determination notices completed in accordance with the 42 CFR 438.404 and verify compliance during Delegated Managed Care Reviews.	UM and Customer Services	RUM, Regional Customer Service Committee	Quarterly, Annually
Emergent and non-emergent access to treatment will be periodically monitored to ensure compliance with timeliness standards.	UM, Customer Service	RUM, Regional Customer Service Committee	Quarterly
SWMBH will achieve a call abandonment rate of 5% or less.	UM	Data submission to MDHHS	Quarterly
SWMBH will achieve an average call answer time 30 seconds or less	UM	Data submission to MDHHS	Quarterly
SWMBH will ensure a call center monitoring plan is in place and provide routine quality assurance audits.	UM	QMC	Monthly
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	UM	Site Review Tools	Annually

N. Customer Services

Description

Customer Service provides a welcoming environment and orientation to services. Customer Service provides

information about benefits and available provider network. Customer Service provides information about how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Service assists members with obtaining information about how to access Due Processes when benefits are denied, reduced, suspended, or terminated. Customer Service oversees grievances and appeal process and tracks/reports patterns of problems for each organization and regionally including over/under service utilization.

SWMBH delegates some Customer Service functions, Due Processes, and Grievances and Appeals to the CMHSPs. As such, a Memorandum of Understanding (MOU) between SMWBH and each CMHSP is implemented to specify the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all members have access to customer services that meet federal and state requirements, and to ensure the services are provided in a uniform manner throughout the SWMBH Region to ensure continuity of care for members.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Committee will review current Memorandum of Understanding (MOU) between SWMBH and CMHSPs and the application of the MOU delegated functions to the areas listed below by the end of FY24. (CCBHC, iSPA, CFAP, Managed Care Regulations/Contract, New MOU).	Customer Services	Regional Customer Service Committee	Annually
SWMBH will provide quarterly monitoring and feedback regarding Grievance and Appeal files to ensure contractual and delegated functions are met at each CMHSP at least 3 quarters by the end of FY24.	Customer Services	Regional Customer Service Committee	Quarterly
Committee will review Grievance and Appeal data for trends, ongoing.	Customer Services	Regional Customer Service Committee	Quarterly

O. Certified Community Behavioral Health Clinics (CCBHC)

Description

CCBHC Demonstration was created under Section 223 of the federal Protecting Access to Medicare Act. On June 25, 2022, the Bipartisan Safer Communities Act approved expansion of the CCBHC Demonstration extending the duration of the demonstration to six years. The act also allowed current Demonstration agencies to expand with new locations, and additional agencies to be brought into the demonstration. October 2023 Michigan expanded the demonstration agencies bringing on additional CMHSPs.

In October 2020, SWMBH had two participating CCBHCs (Pivotal, previously knowns as Community Mental Health and Substance Abuse Services of St. Joseph County, and Integrated Services of Kalamazoo). In October 2023 four additional CMHSPs joined from SWMBH's region: Barry County Community Mental Health Authority; Berrien County Mental Health Authority, DBA Riverwood Center; Branch County Mental Health Authority, DBA Pines Behavioral Health; and Calhoun County Mental Health Authority, DBA Summit Pointe. While Van Buren County Mental Health has a CCBHC Expansion Grants, SWMBH is not responsible for monitoring these requirements.

The CMS CCBHC Demonstration requires certified sites to provide nine core services and Michigan CCBHCs have twelve required and seven recommended evidence-based practices they must use.

Core Services: Screening, assessment, and diagnosis, including risk assessment; Patient-centered treatment planning or similar processes, including risk assessment and crisis planning; Outpatient mental health and substance use services; Outpatient clinic primary care screening and monitoring of key health indicators and health risk; Targeted case management; Psychiatric rehabilitation services; Peer support and counselor services and family supports; and Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

CCBHC General Requirements

PIHPs must adhere to the CCBHC contractual and policy requirements with MDHHS. CCBHCs must meet the requirements indicated in CCBHC certification. PIHPs and CCBHCs must adhere to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

PIHP Requirements

PIHPs share responsibility with MDHHS for ensuring continued access to CCBHC services. PIHPs are responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring and reporting on CCBHC measures, and coordinating care for eligible CCBHC recipients. Below is a sampling of the specific requirements:

PIHPs must have the capacity to evaluate, select, and support providers who meet the certification standards for CCBHC, including:
Identifying providers and DCOs who meet the CCBHC standards,
Establishing an infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services,
Collecting and sharing member-level information regarding health care utilization and medications with CCBHCs,
Providing implementation and outcome protocols to assess CCBHC effectiveness,
Developing training and technical assistance activities that will support CCBHCs in effective delivery of CCBHC services.
PIHPs must use CareConnect360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.
PIHPs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC.

SWMBH has a regional implementation governance structure for CCBHC with a steering committee of senior executives from SWMBH and CMHSPs. SWMBH restructured the sub-committees in 2023 from three (clinical/client flow, data/reporting, and finance) to two, finance/ IT and clinical/data quality. Each is led by a SWMBH director and CCBHC/CMHA representative, populated by current Medicaid CCBHC Demonstration CMHSPs with an open door to SAMSHA CCBHC CMHSPs.

CCBHC Monitoring & Evaluation Requirements

CMS has defined reporting requirements and guidance for the CCBHC Demonstration. There are two broad sets of requirements – CCBHC Reported Measures and State Reported Measures. A state-lead measure is calculated by the state for each CCBHC, usually relying on administrative data. A CCBHC-lead measure is calculated by the

CCBHC and sent to the state. The measures are not aggregated by the state. To the extent necessary to fulfill these requirements, providers must agree to share all CCBHC clinical and cost data with MDHHS. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers. The data will be reported annually by MDHHS to CMS within 12 months of the end of the Demonstration Year. CCBHCs must report measures to MDHHS within 6 months of the end of the Demonstration Year.

The specific Core Measures and other federal requirements are laid out below:

Metric Name	Benchmark	State or CCBHC Reported Measure
Time to Initial Evaluation (I-EVAL)	n/a	CCBHC
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	n/a	CCBHC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	n/a	CCBHC
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	n/a	CCBHC
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	n/a	CCBHC
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) **	**23.90%**	**CCBHC**
Major Depressive Disorder: Suicide Risk Assessment (SRA-A) **	**12.50%**	**CCBHC**
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	n/a	CCBHC
Depression Remission at Twelve Months (DEP-REM-12)	n/a	CCBHC
Housing Status (HOU)	n/a	State
Patient Experience of Care Survey (PEC)	n/a	State
Youth Family Experience Survey (Y/FEC)	n/a	State
Follow up after ED Visit for MI (FUM)	n/a	State
Follow up after ED Visit for Alcohol and Drugs (FUA)	n/a	State
Plan All-Cause Readmission Rates (PCR-BH)	n/a	State
Diabetes Screening Schizophrenia/Bipolar using antipsychotics (SSD)	n/a	State
Adherence to Antipsychotic Meds with Schizophrenia (SAA-BH) **	**58.50%**	**State**
Follow up after Hosp for Mental Illness, ages 21+ (FUH) **	**58%**	**State**
Follow up after Hosp for Mental Illness, ages 6-21 (FUH) **	**70%**	**State**

Follow-up care for children prescribed ADHD meds (ADD)	n/a	State
Antidepressant Medication Management (AMM-BHH)	n/a	State
**Initiation and Engagement of Alcohol and other Drug Treatment (IET-BH) **	**14 day- 42.5%; 34 day- n/a**	**State**

**DY3 Quality Bonus Payment (QBP) Metric

MDHHS affords a QBP for CCBHCs meeting CMS-defined quality benchmarks. To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. If performance benchmarks are met, MDHHS will provide the QBP payment to the PIHP for distribution to the awarded CCBHC(s). CCBHCs are eligible to receive 5% of the clinic's annual Medicaid costs (defined as the reported Medicaid daily visits x demonstration year PPS rate). If a CCBHC does not meet all benchmarks for QBP measures, the potential distribution amount will be added to a QBP Redistribution pool for CCBHCs who either hit or exceeded benchmarks.

Reporting Requirements

During the DY, CCBHCs should complete their SAMHSA 2016 Data Reporting Template quarterly. PIHPs should assist with validation and review of measures. Templates should be sent to PIHPs by the end of the month following the measurement period. PIHPs will also make the quarterly templates available to MDHHS or external evaluators throughout the DY for purposes of monitoring and evaluation planning.

FY24 Goals

Goal	Responsible Department/Person	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will track QBP measures and CCBHC-Reported Measures monthly and report to Clinical/Data Quality subgroup and Steering Committee each time they meet.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Bi-monthly, at minimum
Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBP measures.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
PIHPS will collect, validate clinic-reported data and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly Annually by 3/31/2024 (DY2) 3/31/2025 (DY3)
Develop written guidelines and process maps to support new regional CCBHC sites.	CCBHC Coordinator	All CCBHC Subgroup Meetings	Annually

P. External Monitoring and Audits

Description

The SWMBH Quality Management (QM) Department is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from Michigan Department of Health and Human Services (MDHHS), Health Service Advisory Group (HSAG), Centers for Medicaid Services (CMS), and other organizations as identified by the SWMBH Board. Audit results are reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board. Regional and internal corrective action plans are established for reviews/audits that do not achieve specified benchmarks or established targets. The QM Department is responsible for working with all SWMBH functional areas to ensure corrective action plans are developed, reviewed, submitted and followed up on in a complete and timely manner.

FY24 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH achieve an overall compliance score of >90% or top 2 scoring PIHPs during the 2024 HSAG External Quality Review (EQR).	Quality	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >95% on the annual HSAG Performance Measure Validation Review (PMV).	Quality	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
During FY24, SWMBH will follow up on all recommendations from the FY23 Waiver Audit in preparation for improved scores in FY25. Systemic issues from the FY23 MDHHS Waiver Audit will be addressed during regional committees for systemic remediation and to prevent the likelihood of a repeat citation.	Quality	QMC, CPC and other Regional Committees as necessary	Annually
SWMBH will achieve an overall compliance score of >95% on the MDHHS Substance Use Disorder Administrative Protocols/Review.	Quality /SUD	QMC, SUD workgroup and Board	Annually

Q. Cultural Competency

Description

SWMBH is dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all Members. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment to cultural competence and demonstrate compliance with the MDHHS/PIHP contract, SWMBH has the following five components in place:

1. community assessment
2. policy and procedure
3. service assessment and monitoring
4. ongoing training
5. culturally contextual services/supports.

Community Assessment:
SWMBH uses the annual regional Network Adequacy Assessment and a variety of consumer satisfaction surveys to assess for a culturally competent provider network and consumer involvement throughout the region. Languages spoken throughout the provider network are gathered through the Region's credentialing process.

At the county level, Michigan DHHS requires each CMHSP to conduct a nominal Needs Assessment at least every two years. Michigan also launched as a CCBHC Demonstration state in 2021, and Michigan DHHS will require all local CCBHC sites to have a Needs Assessment. These community health needs assessments provide current demographic data and involve extensive stakeholder surveys spanning both provider agencies and persons served. The CMHSPs analyze stakeholder survey responses alongside data points for a combined qualitative and quantitative view of cultural competence and needs in each county. These data points are discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments are used to create a foundational equity framework that is specific to the county level, complete with root cause analysis and subsequent strategic planning.

Policy and Procedure:
SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network.

Service Assessment and Monitoring:
SWMBH is fully dedicated to improving health equity within Region 4, as evidence by adding the Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. This is a grant funded position that will continue to plan and develop region wide programming to increase the access and participation of minority populations in behavioral health services. From this position, a Regional Health Equity Focus Group was formed, consisting of representation from all 8 counties in region 4. The workgroup helped to identify regional and county barriers, frontline partners for further coordination and support, provide feedback to training and campaign efforts.

Cultural competency is further assessed and monitored according to current PBIP, CCBHC, MMBPIS and other metrics geared toward ensuring cultural competence and fairness in service delivery. Metrics that center around underserved populations are reviewed by SWMBH's internal Health Equity Performance Improvement Project (PIP) work group monthly, to ensure up to date monitoring. This group will continue to expand on its work in FY23, which included creating a pathway for encounter data to reflect interventions for the FUA metric, hosting education opportunities for hospitals, and quarterly meetings with Medicaid Health Plans (MHPs) to collaboratively monitor fluctuations in performance measures and identify interventions pertaining to disparities.

Training:
SWMBH requires ongoing training to assure that staff are aware of, and able to effectively implement cultural

competency policies and procedures. SWMBH requires all provider's staff that are in-network to have cultural competency training and reviews this item as part of the Staff Training File Review in the annual site review process. SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan are trained annually during a Quality Management Committee meeting. Through the SWMBH Health Disparities Grant, representatives from each CMH in the region attended Advancing Health Equity in Public Health Training hosted by Michigan Public Health Institute (MPHI). SWMBH has likewise begun offering the following trainings free of charge to all provider agencies in Region 4: Ableism 101 and 102, Disability and Healthcare Equity Training, Disability and Intersectionality Training, Implicit Bias Training. In 2024, a health equity lecture series and symposium will be offered.

Culturally Contextual services/supports:
SWMBH strives to ensure that supports and services are provided within the cultural contexts of our recipients. SWMBH's community-sponsored events are selected by the Community Outreach Committee, which is dedicated to finding opportunities to better reach underserved and minority populations. Van Buren Project Connect.

FY24 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Further develop trainings in 2024 by adding a health equity lecture series and symposium will be offered.	Quality		
Promote continued education throughout the organization and 8-county region by participating in or contributing to local organizations and public events. Continue to seek culturally relevant, visible opportunities that attract minorities and their allies.	Customer Services	Customer Services, Provider Network and Clinical Practices Committees	Annually
SWMBH will evaluate language spoken by network providers vs. enrollees for FY24. SWMBH believes capturing more Provider data regarding languages spoken, cultural competency and physical accessibility of office space will assist the Provider Network Departments at each CMHSP in ensuring the Region's Member's needs are being met in this capacity.	Provider Network	Customer Services, Provider Network and Clinical Practices Committees	Annually

ATTACHMENT A – 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 B – SWMBH BOARD ROSTER

2024 Board of Directors Roster

Barry County

- Mark Doster
- Robert Becker (Alternate)

Berrien County (Riverwood)

- Edward Meny - Chair
- Nancy Johnson (Alternate)

Branch County (Pines)

- Tom Schmelzer – Vice-Chair
- Jon Houtz (Alternate)

Calhoun County (Summit Pointe)

- Sherii Sherban
- Kathy-Sue Vette (Alternate)

Cass County (Woodlands)

- Louie Csokasy
- Jeanne Jourdan (Alternate)

Kalamazoo County (ISK)

- Erik Krogh
- Karen Longanecker (Alternate)

St. Joseph County (Pivotal)

- Carole Naccarato - Secretary
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes
- Angie Dickerson (Alternate)

ATTACHMENT C – 2024 Performance Bonus Incentive Program (PBIP) Measures

FY24 PIHP Performance Bonus Incentive Program

1. Contractor-only Pay for Performance (P4P) Measures (45% of total withhold)

Measure	Description	Deliverables
P.1. Implement data driven outcomes measurement to address social determinants of health (40 points)	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record. MDHHS specifications published at Reporting Requirements (michigan.gov)	Contractor will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31. Narrative (based on guidance provided by MDHHS during FY24) must address beneficiary changes in employment and housing and actions taken to improve housing and employment outcomes. 20 points awarded for Employment and 20 points awarded for Housing.
P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) (10 points)	Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period	The Contractor must participate in DHHS-planned and DHHS provided data validation activities and mtgs. PIHPs will be provided SAA-AD data and validation template by January 31, and within 120 calendar days, return the data validation templated, completed, to DHHS.
P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (50 points)	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.	Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with Calendar year 2023. The points will be awarded based on Contractor performance measure rates. Points will be divided evenly between Initiation and Engagement measures.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (25% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

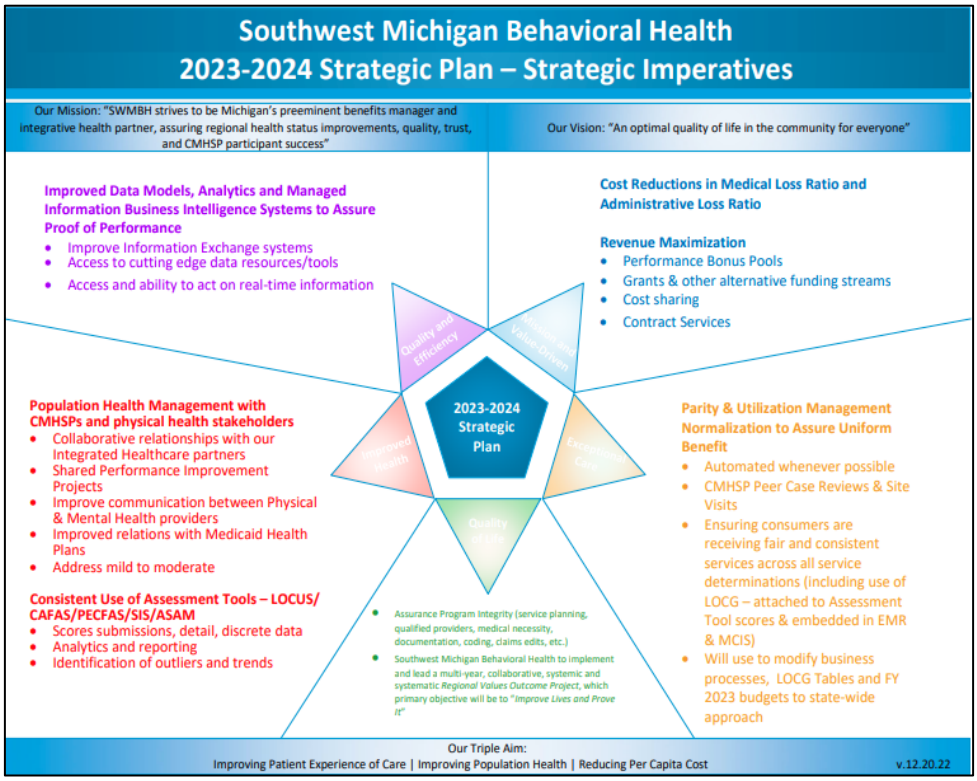
2. MHP/Contractor Joint Metrics (30% of total withhold)

Joint Metrics for the Integration of Behavioral Health and Physical Health Services
To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Contractor, the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

For J.2.2 and J.3.2 listed below, the PIHP metric scoring will be aggregate of/for all their MHPs combined, not each individual MHP-PIHP dyad.

Category	Description	Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the PIHP/MHP Collaboration Work Group in consultation with the State. Plans will submit an unscored narrative (no more than three pages) describing the process in place for identifying minors with appropriate severity/risk and providing care coordination of the population. Due August 1, 2024.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be calendar year 2023. The points will be awarded based on MHP/Contractor combination performance measure rates. (20 points) 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023. The points will be awarded based on Contractor performance measure rates. (20 points) The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given PIHP. See MDHHS reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at MDHHS - Reporting Requirements (michigan.gov)
J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with Calendar year 2023. The points will be awarded based on Contractor performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given PIHP. See MDHHS reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at MDHHS - Reporting Requirements (michigan.gov)

ATTACHMENT D – 2023-2024 STRATEGIC IMPERATIVES



ATTACHMENT E – 2023 REGIONAL STRATEGIC IMPERATIVE DECISION/PRIORITY MAP

SWMBH Board Policy Manual

Table of Contents

SWMBH Policy Manual *Uninterrupted*

Ends (Proposed to align with PG Philosophy)

1.0 Global End

SWMBH is a fiduciary for state and federal funds that exists to assure that member agencies create environments where persons with intellectual & developmental disabilities, serious emotional disturbance, autism spectrum disorders, serious mental illness, and substance use disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery, and family preservation, *at the cost of efficient stewardship of resources available.*

1. Quality of Life
   - Persons with intellectual & developmental disabilities, serious emotional disturbance, autism spectrum disorders, serious mental illness, and substance use disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery, and family preservation
2. Exceptional Care
   - Persons and families served are highly satisfied with the services they receive
3. Improved Health
   - Individual mental health, physical health and functionality are measured and improved •
4. Mission and Value Driven
   - CMHSPs and SWMBH fulfill their agencies' missions and support the value of the public behavioral health system
5. Quality and Efficiency
   - The SWMBH region is a learning agency where quality and cost are measured, improved, and reported

Commented [SR1]: Under construction, expected completion date May 2024

Section 2: Executive Limitations

(reordered with recommended changes)

2.0 POLICY: Global Executive Constraint (formerly BEL009)
The Executive Officer (EO) shall not cause or allow any practice, activity, decision, or organizational circumstance which is either ~~illegal~~ *unlawful*, imprudent, in violation of commonly accepted business and professional ethics or in violation of contractual obligations.

2.1 POLICY: Treatment of Plan Members (formerly BEL005)
With respect to interactions with Plan members, the SWMBH EO shall not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy.

Further, including but not limited to, the Executive Officer may not:

2.1.1. Use forms or procedures that elicit information for which there is no clear necessity.
2.1.2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.
2.1.3. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.
2.1.4. Fail to establish with Plan members a clear contract of what may be expected from SWMBH including but not limited to their rights and protections.

2.1.5. Fail to inform Plan members of this policy or to provide a grievance process to those plan members who believe that they have not been accorded a reasonable interpretation of their rights under this policy.

2.2 POLICY: Treatment of Staff (formerly BEL004)
With respect to the treatment of paid and volunteer staff, the EO shall not cause or allow conditions that are unfair, undignified, disorganized, or unclear.

Further, including but not limited to, the Executive Officer may not:

2.2.1. Operate without written personnel rules that:
- a. Clarify rules for staff
- b. Provide effective handling of grievances, and
- c. Protect against wrongful conditions such as nepotism and grossly preferential treatment for personal reasons.

2.2 2. Retaliate against any staff member for expression of dissent.
2.2.3. Fail to acquaint staff with the EO interpretation of their protections under this policy.
2.2.4. Allow staff to be unprepared to deal with emergency situations.

2.3 POLICY: Financial Planning and Budgeting (formerly BEL001)
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.

Further, including but not limited to, the Executive Officer may not allow budgeting which:

2.3.1. 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.
2.3.2. Plans the expenditures in any fiscal year of more funds than are conservatively projected to be available for that period.
2.3.3. Provides less than is sufficient for board prerogatives, such as costs of fiscal audit, Board development, Board and Committee meetings, and Board legal fees.
2.3.4. Endangers the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends.

2.4 POLICY: Financial Conditions and Activities (formerly BEL002)
With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material negative deviation of actual expenditures from board priorities established in policies and inclusive of annual budget.

Further, including but not limited to, the Executive Officer may not:

2.4.1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year).
2.4.2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.
2.4.3. Use any designated reserves other than for established purposes.
2.4.4. Conduct interfund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.
2.4.5. Fail to settle payroll and debts in a timely manner.

2.4.6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.
2.4.7. Make a single purchase or commitment of greater than $100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.
2.4.8. Purchase or sell real estate in any amount.
2.4.9. Fail to aggressively pursue receivables after a reasonable grace period.
2.4.10 Assure that total direct fiscal year annual costs payable to MCHE shall not exceed $5,000.
2.4.10.1 Exception: Group purchases which in the EO's judgment are required and have more favorable terms than an independent purchase by SWMBH. In the event of an urgent payment required, EO shall contact SWMBH Board Chair for guidance.

2.5 POLICY: Asset Protection (formerly BEL003)
The Executive Officer shall not cause or allow corporate assets to be unprotected, inadequately maintained, or unnecessarily risked.

Further, including but not limited to, the Executive Officer may not:
2.5.1. Subject facilities and equipment to improper wear and tear or insufficient maintenance.
2.5.2. Leave intellectual property, information and files unprotected from loss or significant damage.
2.5.3 Allow physical assets to be uninsured against theft and property losses at an appropriate level and against liability losses to board members, staff and the organization itself in an amount greater than the average for comparable organizations.
2.5.4. Compromise the independence of the Board's audit or other external monitoring or advice, such as by engaging parties already chosen by the Board as consultants or advisers.
2.5.5. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission.
2.5. 6. Change the organization's name or substantially alter its identity in the community.
2.5.7. Allow unbonded personnel access to material amounts of funds.
2.5.8. Unnecessarily expose the organization, its Board, or Staff to claims of liability.
2.5.9. Make any purchases:
i. Wherein normally prudent protection has not been given against conflict of interest
ii. Inconsistent with federal and state regulations related to procurement using SWMBH funds
iii. Of more than $100,000 without having obtained comparative prices and quality
iv. Of more than $100,000 without a stringent method of assuring the balance of long-term quality and cost.
2.5.10. Receive, process, or disburse under controls that are insufficient to meet the Board-appointed auditor's standards.
2.5.11. Invest or hold operating capital and risk reserve funds in instruments *at the expense of safety and liquidity.*

2.6 POLICY: Investments

The Executive Officer will not cause or allow investment strategies or decisions that pursue a high rate of return at the expense of safety and liquidity.

Further, including but not limited to, the Executive Officer may not:

2.6.1 Make investment decisions without consultation and guidance of an independent qualified investment advisor.

2.6.2 Ignore these priority values in investment decisions

- Preservation of principal.
- Income generation.
- Long term growth of principal.
- Protected from bank failures.

2.6.3 invest or hold capital in insecure instruments except where necessary to facilitate ease in operational transactions

2.6.4 invest without establishing a comparative benchmark to demonstrate investment performance.

2.7 POLICY: Compensation and Benefits

With respect to employment, compensation and benefits to employees, consultants, contract workers, Interns and volunteers, the Executive Officer (EO) shall not cause or allow jeopardy to financial integrity or to public image.

Further, including but not limited to, the Executive Officer may not:

2.7.1. Change the EO's own compensation and benefits.

2.7.2. Promise permanent or guaranteed employment.

2.7.2.1 Exception: Time-limited Executive Employment and Professional Services Agreements with termination clauses are permissible.

2.7.3. Establish current compensation and benefits which:

2.7.3.1 Deviate materially from the geographic and professional market for the skills employed.

2.7.3.2 Create obligations over a longer term than revenues can be safely projected, in no event longer than one year and in all events subject to losses in revenue.

2.7.3.3 Fail to solicit or fail to consider staff preferences.

2.7.4. Establish or change retirement benefits so the retirement provisions:

2.7.4.1. Cause unfunded liabilities to occur or in any way commit the organization to benefits that incur unpredictable future costs.

2.7.4.2. Provide less than some basic level of benefits to all full-time employees. Differential benefits which recognize and encourage longevity are not prohibited.

2.7.4.3 Make revisions to Retirement Plan documents.

2.7.4.4 Implement employer discretionary contributions to staff.

2.8 POLICY: Emergency Executive Officer Succession (formerly EO-003)

In order to protect the Board from sudden loss of the Executive Officer services, the Executive Officer will have no less than two executives identified to the Board sufficiently familiar with Board and Executive Officer issues and processes to enable them to take over with reasonable proficiency as an interim Executive Officer if called upon by the Board.

2.9 POLICY: Communication and Support to the Board (formerly BEL-008)
The Executive Officer shall not cause or allow the Board to be uninformed or unsupported in its work.

Further, including but not limited to, the Executive Officer may not:

2.9.1. Neglect to submit monitoring data required by the Board *on the schedule established by the Board* in a timely, accurate, and understandable fashion, directly addressing provisions of Board policies being monitored, and including Executive Officer interpretations as well as relevant data.
2.9.2. Allow the Board to be unaware of any actual or anticipated noncompliance with any Ends or Executive Limitations policy of the Board regardless of the Board's monitoring schedule.
2.9.3. Allow the Board to be without decision information required periodically by the Board or let the Board be unaware of relevant trends.
2.9.4. Let the Board be unaware of any significant incidental information it requires including anticipated media coverage, threatened or pending lawsuits, and material internal and external changes, including:
  a. the status of uniform benefits across the region (from 2.1.3)
  b. timely and accurate investment reports
  c. information related to MCHE, including
    i. semi-annual written MCHE status reports to the SWMBH Board in April and October
    ii. verbal reports to the SWMBH Board if there are MCHE related items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy, or finances;
    iii. MCHE Articles of Incorporation revisions and bylaws to the Board prior to voting on them and after adoption by MCHE.
2.9.5. Allow the Board to be unaware that, in the Executive Officer's opinion, the Board is not in compliance with its own policies, particularly in the case of Board behavior that is detrimental to the work relationship between the Board and the Executive Officer.
2.9.6. Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation, and other.
2.9.7. Allow the Board to be without a workable mechanism for official Board, Officer, or Committee communications.
2.9.8. Deal with the Board in a way that favors or privileges certain Board Members over others, except when fulfilling individual requests for information or responding to Officers or Committees duly charged by the Board.
2.9.9. Fail to submit to the Board a consent agenda containing items delegated to the Executive Officer yet required by law, regulation, or contract to be Board-approved, along with applicable monitoring information.

Section 3: Governance Process Policies

3.0 Global Governance Commitment
The purpose of the Board who serve as the stewards of funding available for mental health services in the Southwest Region of Michigan, on behalf of the State of Michigan and the founding Plan Members, is to see to it that SWMBH achieves appropriate impacts through its Plan Members at an appropriate value and to assure that the organization avoids unacceptable situations and risks.

3.1 Governing Style and Commitment (formerly BG-011)

The Board will govern lawfully and in compliance with the agency's bylaws, observing the principles of the Policy Governance model, with an emphasis on (a) outward vision rather than an internal preoccupation, (b) encouragement of diversity in viewpoints, (c) strategic leadership more than administrative detail, (d) clear distinction of Board and Chief Executive roles, (e) collective rather than individual decisions, (f) future rather than past or present focus, and (g) proactivity rather than reactivity.

Accordingly, the SWMBH Board shall:

3.1.1 Cultivate a sense of group responsibility. The Board, not the staff, will be responsible for excellence in governing. The Board will be the initiator of policy, not merely a reactor to staff initiatives. The Board will not use the expertise of individual member to substitute for the judgment of the Board, although the expertise of individual members may be used to enhance the understanding of the Board as a body.

3.1.2 Direct, control, and inspire the organization through the careful establishment of broad written policies reflecting the Board's values and perspectives. The Board's major policy focus will be on the intended long-term impacts, not on administrative or programmatic means of attaining those effects.

3.1.3 Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policy-making principles, respect of roles, and ensuring the continuance of governance capability. Although the Board can change its governance process policies at any time, it will observe those currently in force.

3.1.4 Conduct continual Board development, including orientation of new Board members in the Board's governance process and periodic Board discussion of process improvement.

3.1.4.1 New Board Members shall be required to complete an initial orientation for purposes of enhancing their knowledge of the roles and responsibilities of SWMBH as an agency, and their understanding to assist in governance decision-making. Specifically, they shall be provided the following information:

- Governance Documents (Hierarchical)
  - SWMBH Board Bylaws
  - SWMBH Operating Agreement

- Michigan Consortium of Healthcare Excellence Bylaws (MCHE)
- Ends, Proofs and Strategy
  - Previous and Current Years' SWMBH Board Ends and Proofs
- Context
  - SWMBH General PowerPoint
  - Current SWMBH Board Meeting Calendar and Roster
- New Board Members will be offered a live/remote briefing for each functional area leader.

3.1.5 Allow no officer, individual, or committee of the Board to hinder or be an excuse for not fulfilling group obligations.

3.1.6 The Board will monitor and discuss the Board's process and performance periodically. Self-monitoring will include comparison of Board activity and discipline to policies in the Governance Process and Board-Management Delegation categories.

3.2 POLICY: Board Member Job Description (formerly BG-008)

Specific job outputs of the Board, as informed agents of ownership, are those that ensure appropriate organizational performance.

Accordingly, to distinguish the Board's own unique job from the jobs of its staff, the Board will concentrate its efforts on the following job "products" or outputs:

3.2.1 The link between Southwest Michigan Behavioral Health and CMH Boards of the Plan Members.

3.2.2 Written governing policies which, at the broadest levels, address:
a. Ends: Organizational products, impacts, benefits, outcomes, recipients, and their relative worth (what good for which needs at what worth to the organization).
b. Executive Limitations: Constraints on executive authority which establish the prudence and ethics boundaries within which all executive activity and decisions must take place.
c. Governance Process: Specification of how the Board conceives carries out and monitors its own task.
d. Board-EO Delegation: How Board expectations are assigned and properly monitored; the EO role, authority and accountability.

3.2.3 The assurance of organizational and EO performance.

3.3 POLICY: Board Code of Conduct (formerly BG-007)

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

Accordingly:

3.3.1 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. As a result, Board members will follow the SWMBH Conflict of Interest Policy (contained in Appendix ____.)

3.3.1.1 Conflict of Interest is defined as 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.

3.3.1.2 When a Member either must recuse themselves or chooses to recuse themselves from voting on a Board decision their prior potential vote count will be removed from the vote tally denominator; however, when a Member abstains from voting on a Board decision their potential vote count will not be removed from the vote tally denominator.

3.3.2 Members will respect the confidentiality appropriate to issues of a sensitive nature including, but not limited to, those related to client privacy laws, substance abuse services, or SWMBH business or strategy.

3.3.3 Members will be properly prepared for Board deliberation as well as educate themselves on the SWMBH Compliance Plan and Code of Conduct.

3.3.4 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.

3.3.5 Persons who have been excluded from participation in Federal Health Care Programs may not serve as Board Members.

3.3.5.1 If a Board Member believes they will become an excluded individual, that member is responsible for notifying the SWMBH Compliance Department. The Board Member is responsible for providing information necessary to monitor possible exclusions.

3.3.5.1.1 SWMBH shall periodically review Board Member names against the excluded list per regulatory and contractual obligations.

3.3.6 SWMBH Board members will establish, 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.

3.3.6.1 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.

3.3.6.2 SWMBH Board Members shall cooperate fully in any internal or external Medicaid or other SWMBH funding stream compliance investigation.

3.3.6.3 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.

3.3.6.4 Members will participate in Board compliance trainings and educational programs as required.

3.3.6.5 Members will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, who have a propensity to engage in illegal activities.

3.3.7 Board Members may not attempt to exercise individual authority over the organization except as explicitly set forth in Board policies.

3.3.7.1 Members' interaction with the Executive Officer or with staff must recognize the lack of authority vested in individuals except when explicitly Board-authorized.

3.3.7.2 Members' commenting on the agency and Executive Officer performance must be done collectively and in regard to explicit Board policies.

3.3.8 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, *or specifically authorized by the board through an officially passed motion of the Board*.

3.4 POLICY Annual Board Planning Cycle

To accomplish its job products with a governance style consistent with board policies, the board will follow an annual agenda cycle which (a) drives exploration of Ends concerns, (b) continually improves board performance through board education and enriched input and deliberation, and (c) re-examines the relevance of the underlying values that support existing policy.

3.4.1 The board calendar shall generally follow this sequence:

Jan-March Ownership Linkage Activity
April-May: Environmental Scan and Strategic Imperatives Review with Board.
May- Board Retreat
June – Develop Board's Cost of Governance, per Policy 3.8
July – 24 month strategic plan draft review of Mission, Capital, Market, Growth, Products, Alliances
September- Budget Board review and approval.
November – Annual Evaluation of the EO
December – Approval of the annual plan of Board work.

3.5 POLICY: Board Chair Role (formerly BG-005)
The Chair shall be a specially empowered member of the Board who shall be responsible for ensuring the integrity of the Board's process and occasionally represents the Board to outside parties.

Accordingly:

3.5.1. The result of the Chair's job is that the Board acts consistently with its own rules and those legitimately imposed upon it from outside the organization.

1. Meeting discussion content will consist of issues that clearly belong to the Board to decide or to monitor according to Board policy.
2. Information that is neither for monitoring Board or enterprise performance nor for Board decisions will be avoided or minimized.
3. Deliberation will be fair, open, and thorough, but also timely and orderly.
4. Every effort will be made to assure a psychologically safe environment for all engaging during any board meeting.

3.5.2 The authority of the Chair consists in making decisions that fall within topics covered by Board policies on Governance Process and Board-Management Delegation, with the exception of (i) employment or termination of the EO and (ii) areas where the Board specifically delegates portions of this authority to others. The Chair is authorized to use any reasonable interpretation of the provision in these policies.

3.5.3 The Chair is empowered to preside over all SWMBH Board meetings with all the commonly accepted power of that position, such as agenda review, ruling, and recognizing.

3.5.4 The Chair has no authority to make decisions about policies created by the Board within *Ends* and *Executive Limitations* policy areas. Therefore, the Chair has no authority to supervise or direct the EO.

3.5.5 The Chair may represent the Board to outside parties in announcing Board-stated positions and in stating Chair decisions and interpretations within the area delegated to that role. The Chair may delegate this authority but remains accountable for its use.

3.6 POLICY: Board Committee Principles (formerly BG-010)

Board committees, when used, will be assigned so as to reinforce the wholeness of the Board's job and to not interfere with delegation from the Board to the EO. This policy applies to any group that is formed by Board action, whether or not it is called a committee and regardless of whether the group includes Board members. It does not apply to committees formed under the authority of the EO.

Accordingly, the Committees shall:

3.6.1 Assist the Board by preparing policy alternatives and implications for Board deliberation. In keeping with the Board's broader focus, Board committees will normally not have direct dealings with current staff operations.

3.6.2 Refrain from speaking or acting on behalf of the Board except when formally given such authority for specific and time-limited purposes.

3.6.3 Refrain from exercising authority over staff.

3.6.4 Be used sparingly and ordinarily in an ad hoc capacity.

3.7 POLICY: Board Committees (formerly BG-001)
A committee is a Board Committee only if *its* existence and charge come from the Board, *and it helps the board do its own work* regardless whether Board Members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

3.8 POLICY: Cost of Governance

Because poor governance costs more than learning to govern well, the board will invest in its governance capacity.

Accordingly:

3.8.1 Board skills, methods, and supports will be sufficient to assure governing with excellence.

3.8.1.1 Training and retraining will be used liberally to orient new members and candidates for membership, as well as to maintain and increase existing member skills and understandings.

3.8.1.2 Outside monitoring assistance will be arranged so that the board can exercise confident control over organizational performance. This includes, but is not limited to, fiscal audit.

3.8.1.3 Outreach mechanisms will be used as needed to ensure the board's ability to listen to owner viewpoints and values.

3.8.2 Costs will be prudently incurred, though not at the expense of endangering the development and maintenance of superior capability. The Board will develop its budget by March each year to assure its inclusion in the overall budget and will include allowances for:

A training, including attendance at conferences and workshops.
B audit and other third-party monitoring of organizational performance.
C. surveys, focus groups, opinion analyses, and meeting costs.

Section 4: Board-Management Delegation

4.0 POLICY: Global Board-Management Delegation (formerly BG-002)
The Board's official connection to the operational organization, its achievements and conduct will be through its chief executive officer, titled Executive Officer, however, the Fiscal Officer and Chief Compliance Officer shall have direct access to the Board on matters of internal audited compliance with Board policy.

4.1 POLICY: Unity of Control (formerly BG-003)
Only officially passed motions of the Board are binding on the EO.
Accordingly:

4.1.1 Decisions or instructions of individual Board Members, Officers, or Committees are not binding on the Executive Officer (EO) except in instances when the Board has specifically authorized such exercise of authority.

4.1.2 In the case of Board Members or Committees requesting information or assistance without Board authorization, the EO can refuse such requests that require, in the EO's opinion, a material amount of staff time or funds, or are disruptive.

4.2 POLICY: Accountability of the Executive Officer (formerly EO-001)
The EO is accountable to the board acting as a body. The Board will instruct the EO through written policies or directives consistent with Board policies, delegating to the EO the interpretation and implementation of those policies and Ends.
Accordingly:

4.2.1 The Board will not give instructions to persons who report directly or indirectly to the EO.

4.2.2 The Board will not evaluate, either formally or informally, any staff other than the EO.

4.2.3 The board will view EO performance as identical to organizational performance, so that organizational accomplishment of board stated Ends and avoidance of board proscribed means will be viewed as successful EO performance.

4.3 POLICY: Delegation to the Executive Officer
The board will instruct the EO through written policies which prescribe the organizational Ends to be achieved, and describe organizational situations and actions to be avoided, allowing the EO to use any reasonable interpretation of these policies.
Accordingly:

4.3.1 The board will develop policies instructing the EO to achieve certain results, for certain recipients at a specified cost. These policies will be developed systematically from the broadest, most general level to more defined levels, and will be called Ends policies.

4.3.2 The board will develop policies which limit the latitude the EO may exercise in choosing the organizational means. These policies will be developed systematically from the broadest, most general level to more defined levels, and they will be called Executive Limitations policies.

4.3.3 As long as the EO uses any reasonable interpretation of the board's Ends and Executive Limitations policies, the EO is authorized to establish all further policies, make all decisions, take all actions, establish all practices and develop all activities.

4.3.4 The board may change its Ends and Executive Limitations policies, thereby shifting the boundary between board and EO domains. By doing so, the board changes the latitude of choice given to the EO. But as long as any particular delegation is in place, the board will respect and support the EO's choices.

4.4 POLICY: Monitoring EO Performance (formerly EO-002)
Monitoring Executive Officer performance is synonymous with monitoring organizational performance against Board policies on Ends and on Executive Limitations. Any evaluation of EO performance, formal or informal, may be derived from these monitoring data.
Accordingly,

4.4.1 The purpose of monitoring is to determine the degree to which Board policies are being fulfilled. Information that does not do this will not be considered to be monitoring.

4.4.2 A given policy may be monitored in one or more of three methods with a balance of using all of the three types of monitoring:

- Internal report: Disclosure of compliance information to the Board from the Executive Officer.
- External report: Discovery of compliance information by a disinterested, external auditor, inspector or judge who is selected by and reports directly to the Board. Such reports must assess Executive Officer performance only against policies of the Board, not those of the external party unless the Board has previously indicated that party's opinion to be the standard.
- Direct Board inspection: Discovery of compliance information by a Board Member, a Committee, or the Board as a whole. This is a Board inspection of documents, activities or circumstances directed by the Board which allows a "prudent person" test of policy compliance.

4.4.3 Upon the choice of the Board, any policy can be monitored by any method at any time. For regular monitoring, however, each Ends and Executive Limitations policy will be classified by the Board according to frequency and method.

4.4.4 Each November the Board will have a formal evaluation of the EO. This evaluation will consider monitoring data as defined here and as it has appeared over the calendar year.

4.4.4.1 The Executive Committee, (Chair, Vice Chair, and Secretary), will take data and information from the bulleted documents below upon which the annual performance of the EO will be evaluated. The overall evaluation consists of compliance with Executive Limitations Policies, Ends Interpretation and Ends Monitoring reports and supporting documentation, (as per the Board developed schedule), and follow through on Board requests, (what we ask for in subsequent meetings and what we want to see on the agendas).

For the performance review, the following should be documents given the Executive Committee at least one month prior (October)

- Minutes of all meetings
- Ends Monitoring reports for the past year along with the Ends Interpretation for each Ends Monitoring report
- Any supporting Ends documentation
- Ends Monitoring Calendar
- Other policies monitoring calendar

Appendix A: Southwest Michigan Behavioral Health Board Policy Review Calendar Year 2024

Policy Number	Policy Name	Board Review	Reviewer	
Board Governance (Policy Review)				
1.0 et al	Board Ends and Accomplishments	January	Board	
3.4	Annual Board Planning	April	Board	
3.3	Code of Conduct	February	Board	
3.7	Committee Structure	March	Board	
3.6	Board Committee Principles	April	Board	
3.1	Governing Style & Commitment	May	Board	
	Open Meetings Act and Freedom of Information Act	June	Board	
3.2	Board Member Job Description	September	Board	
3.8	Cost of Governance	?	Board	
3.5	Board Chair Role	December	Board	
Direct Inspection (Reports)				
2.3	Budgeting	March	Naccarato	GG
2.7	Compensation and Benefits	August	Barnes	AW
2.4	Financial Conditions	October	Csokasy	GG
2.6	Investments	August	Sherban	GG
2.2	Treatment of Staff	August	Perino	AW
2.1	Treatment of Plan Members	September	Csokasy	AW/SA
2	Global Executive Constraints	July	Meny	BC
2.9	Communication and Counsel	September	Schmelzer	BC
	RE 501 (c) (3) Representation	November	Sherban	BC
2.5	Asset Protection	December	Krogh	
2.8	EO Emergency Succession	October	?	GG

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Board-Staff Relationship (Policy Review)			
4.4	Monitoring Executive Performance	November	Board
4.2.	Executive Role & Job Description	September	Board
4.1	Unity of Control	August	Board
4.3	Delegation to the EO	July	Board
V 8.14.23			
Board Approved			

Southwest Michigan Behavioral Health Board Policy Review Calendar Year 2024

Policy Number	Policy Name	Board Review	Reviewer
Board Governance (Policy Review)			
BG001	Committee Structure	March	Board
BG002	Management Delegation	July	Board
BG003	Unity of Control	August	Board
BG004	Board Ends and Accomplishments	January	Board
BG005	Chairperson's Role	December	Board
BG006	Annual Board Planning	April	Board
BG007	Code of Conduct	February	Board
BG008	Board Member Job Description	September	Board
BG010	Board Committee Principles	April	Board
BG011	Governing Style	May	Board
Direct Inspection (Reports)			
BEL001	Budgeting	April	Naccarato
BEL002	Financial Conditions	October	Csokasy
BEL003	Asset Protection	December	Krogh
BEL004	Treatment of Staff	August	Perino
BEL005	Treatment of Plan Members	September	Csokasy
BEL006	Investments	August	Sherban
BEL007	Compensation and Benefits	August	Barnes
BEL008	Communication and Counsel	September	Schmelzer
BEL009	Global Executive Constraints	July	Meny
BEL010	RE 501 (c) (3) Representation	November	Sherban
Board-Staff Relationship (Policy Review)			
EO001	Executive Role & Job Description	September	Board
EO002	Monitoring Executive Performance	November	Board
EO003	Emergency Executive Officer Succession	October	Board

V 12.6.23

Board Approved

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter C —Medical Assistance Programs
Part 438 —Managed Care
Subpart H —Additional Program Integrity Safeguards

Source: 81 FR 27853, May 6, 2016, unless otherwise noted.
Authority: 42 U.S.C. 1302.
Source: 67 FR 41095, June 14, 2002, unless otherwise noted.

§ 438.608 Program integrity requirements under the contract.

(a) ***Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse.*** The State, through its contract with the MCO, PIHP or PAHP, must require that the MCO, PIHP, or PAHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract between the State and the MCO, PIHP, or PAHP, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

(1) A compliance program that includes, at a minimum, all of the following elements:

(i) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

(ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.

(iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

(iv) A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.

(v) Effective lines of communication between the compliance officer and the organization's employees.

(vi) Enforcement of standards through well-publicized disciplinary guidelines.

(vii) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

(2) Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

(3) Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:

(i) Changes in the enrollee's residence;

(ii) The death of an enrollee.

(4) Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

(6) In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

(7) Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

(8) Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23 of this chapter.

(b) ***Provider screening and enrollment requirements.*** The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

(c) ***Disclosures.*** The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors:

(1) Provides written disclosure of any prohibited affiliation under § 438.610.

(2) Provides written disclosures of information on ownership and control required under § 455.104 of this chapter.

(3) Reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

(d) ***Treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers.***

(1) Contracts with a MCO, PIHP, or PAHP must specify:

(i) The retention policies for the treatment of recoveries of all overpayments from the MCO, PIHP, or PAHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

(ii) The process, timeframes, and documentation required for reporting the recovery of all overpayments.

(iii) The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MCO, PIHP, or PAHP is not permitted to retain some or all of the recoveries of overpayments.

(iv) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

(2) Each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment.

(3) Each MCO, PIHP, or P AHP must report annually to the State on their recoveries of overpayments.

(4) The State must use the results of the information and documentation collected in paragraph (d)(1) of this section and the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for each MCO, PIHP, or PAHP consistent with the requirements in § 438.4.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Accomplishment	Policy Number: BG-004	Pages: 1
Subject: Board Ends and Accomplishment	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
04.11.2014	1/13/23	12.12.14, 1/8/16, 1/13/17, 1/12/18,1/11/19, 1/10/20, 1/8/21, 1/14/22

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.

FY23 Program Integrity & Compliance Program Evaluation

October 1, 2022 – September 30, 2023

01/12/2024

FY23 ROUTINE AUDIT ACTIVITIES

Audit	# Claims reviewed	# Invalid claims	Recoupments	Compliance Rate	Funding Stream
Medicaid Verification	1,833	146	$47,729.71	92.03%	Medicaid claims & encounters (Medicaid, HMP, MI Child)
MI Health Link (Duals) Audit	533	7	$1,005.20	98.7%	Claims paid by SWMBH with MI Health Link funds
SUD Coordination of Benefits Audit	90*	4	$383.01	95.6%	Medicaid as secondary payor for SUD services
SUD Block Grant – Ability to Pay Audit	180*	12	$498.64	93.3%	Community Block Grant funds

*Results for FY23 Q1-Q3. Q4 is in process.

FY23 Investigations

- Sixteen (16) investigations opened by SWMBH PI/C
- Ten (10) investigations resulted in substantiation of the allegations.
- Three (3) referrals made to the MI Office of Inspector General (OIG).
- Four (4) referrals received from the MI OIG for investigation.
- One (1) investigation resulted in a report to MDHHS.

Process Improvements Implemented in FY23

- Enhanced Data Mining
  - Monthly reports
    - Overlapping Services Report
      - Any service code that overlaps (same Medicaid ID and Date of Service) with a per diem code.
    - Day of Discharge Report
      - SUD services only. Review BH Teds Date of discharge date against SUD Residential or Detox code billed.
    - Duplicate Services Report
      - Any duplication of Medicaid ID, Date of Service, Code/Modifier, and Service Units
- Smart Suite Program Software
    - Procurement and implementation.
- Enhanced internal training content
- Internal department cross-training

Enhanced Regulator Relations

- MDHHS BHDDA
  - Involvement with MDHHS-PIHP contract negotiations on a monthly basis, including negotiating MI OIG Program Oversight related language
- MI OIG
  - Bi-annual meetings with the MI OIG and PIHP Compliance Officers
  - Open lines of communication between PIHP Compliance Officers and OIG
  - MI OIG proposals for PIHP Contract language are increasingly intrusive into and prescriptive of PIHP daily operations
- MI Attorney General's Office
  - Case presentations for all fraud referrals

Southwest Michigan
BEHAVIORAL HEALTH

FY 23 Customer Service Annual Report

January 12, 2024

Customer Service

A majority of the Managed Care federal requirements and contractual state obligations are delegated to our Community Mental Health (CMH) Partners.

SWMBH Customer Service department covers:

- Development and distribution of all written member materials and communications
- Member rights and responsibilities
- Processing grievance, appeals, and second opinions
- Member community resources and education
- Community events
- Auditing and monitoring of delegated functions

CMH Customer Service covers:

- All requirements and obligations identified above except for:
  - Updating and maintaining the member handbook
  - State Fair hearing processing and handling

SWMBH Customer Services Activities

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

- Updated Medicaid Member Handbook
- 4 Member Newsletters
- Reviewed and updated 6 of our 7 brochures
  - Updated taglines and general information

Customer Advisory Committee (CAC) convened 11 times in FY 23

Current representation from Barry (0),Branch(2), Cass(1), Calhoun(1), Kalamazoo(2), St. Joseph(0), Van Buren(1)

- Each county can have up to 2 representatives

SWMBH Customer Services Activities

Customer Services fielded 1288 phone calls on designated lines

- Call volumes have continued to decrease over the last few years on average of about 398 total calls per year since 2020
  - *Call data for 2020, 2021, and 2022 includes MHL data making the decrease in call volume more substantial in 2023*

Completed follow up calls for members discharged from Substance Use Disorder residential settings = 796

- CS participation in follow up calls has been greatly impacted by the addition of the LOC Transition Navigators as they now complete follow up with customers

Opioid Health Home outreach completed quarterly

- Each member receives 3 calls, and 2 letters total for attempts to engage
- A total of 115 members have had outreach in the last year

Community and Advocacy Engagement

SWMBH participated in 17 community events in FY 202

- SWMBH's Facebook page reached 1,850 individuals.
- SWMBH expanded its online presence by launching a new Instagram account

Veteran Navigator Activities

- Interacted with approximately 140 new Veterans or Veteran Family Members (VFM).
- Worked with a total of 62 Veterans/VFM's.
- Participated in 20 Veteran community events such as Stand Downs
- Coordinated 550 Holiday food baskets in 4 counties for veterans and their family's

SWMBH Customer Services Activities

SWMBH and 8 affiliate CMH providers managed and/or provided oversite of 279 Medicaid Grievances and Appeals

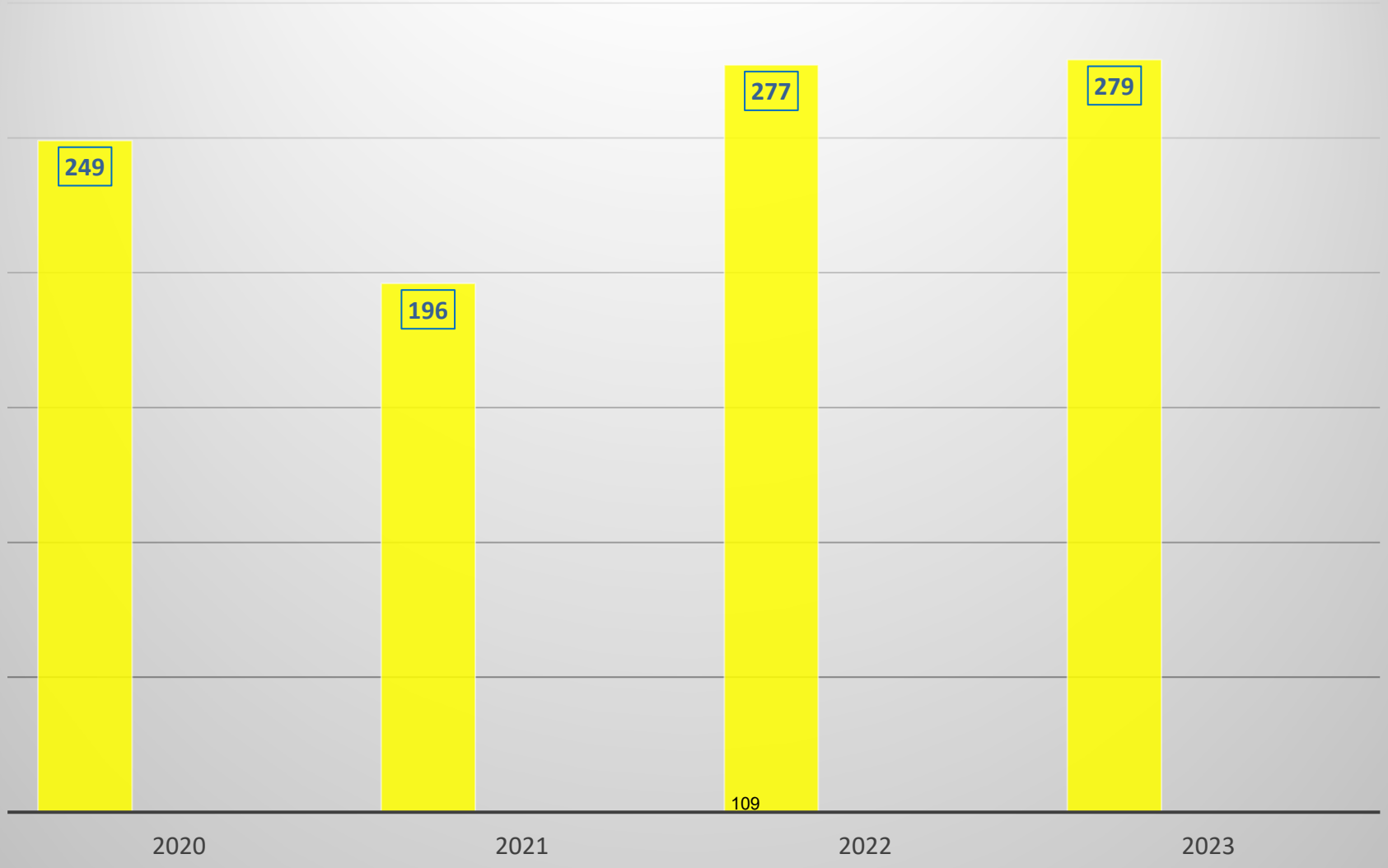
- MA/HMP Grievances reported: 180
- MA/HMP Local Appeals reported: 99
- MA Fair Hearings reported: 0

Even with removing the MHL data, we had an increase in grievances and appeals filed in the region

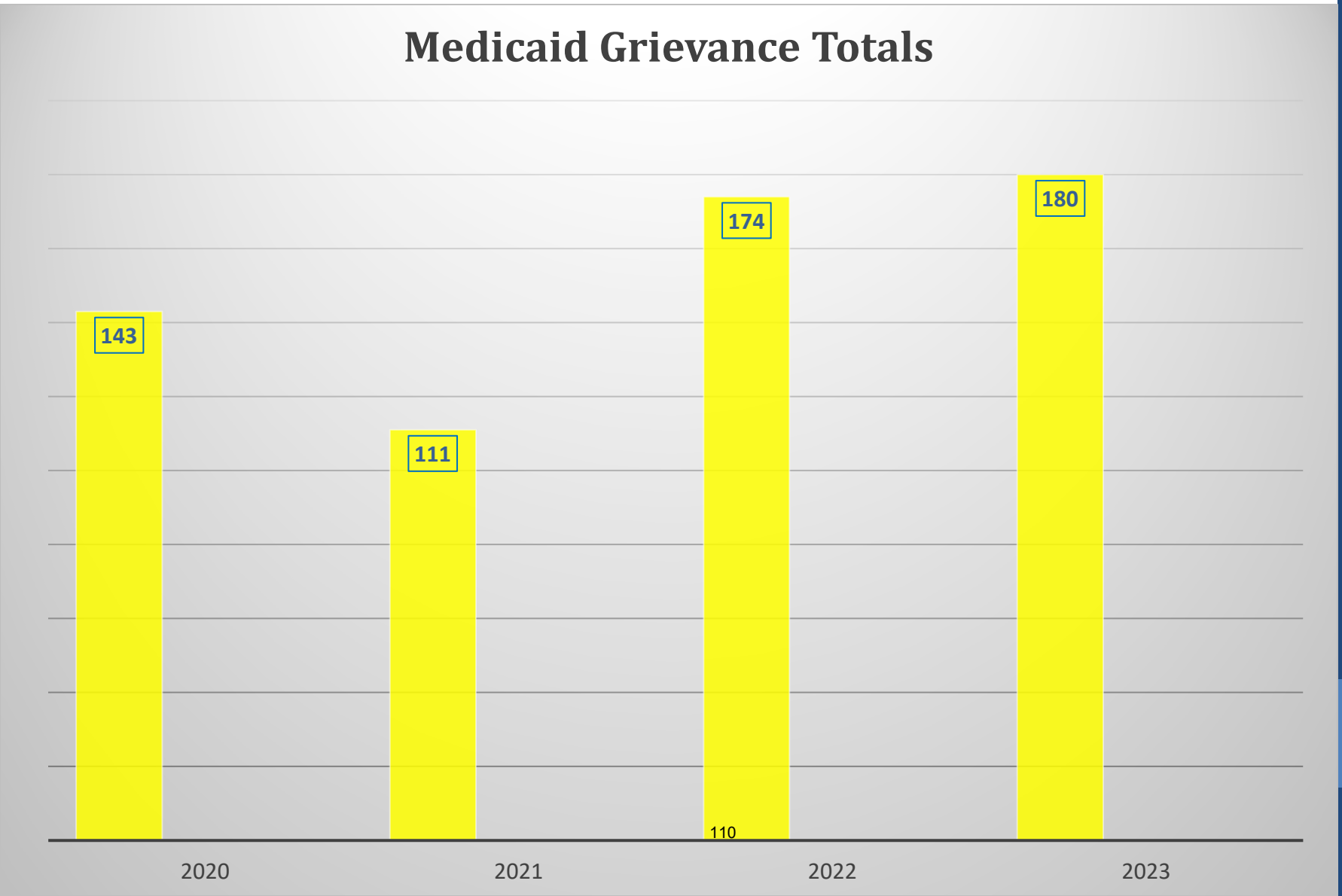
There has been a steady decrease in fair hearings filed over the last 3 years

* comparison data includes MiHealth Link data

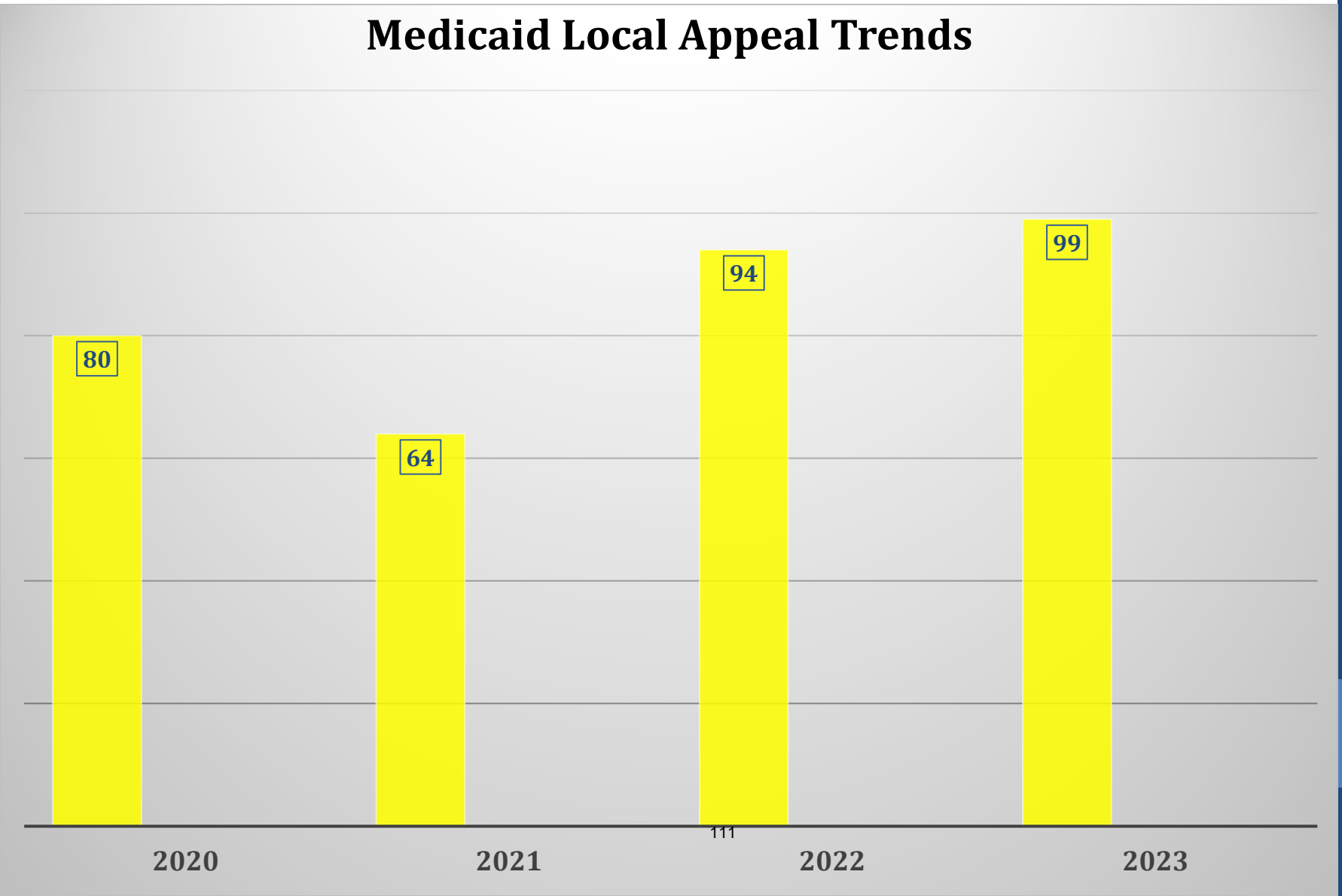
Grievance and Appeal Total Comparisons
Fiscal Years 2020, 2021, 2022 and 2023



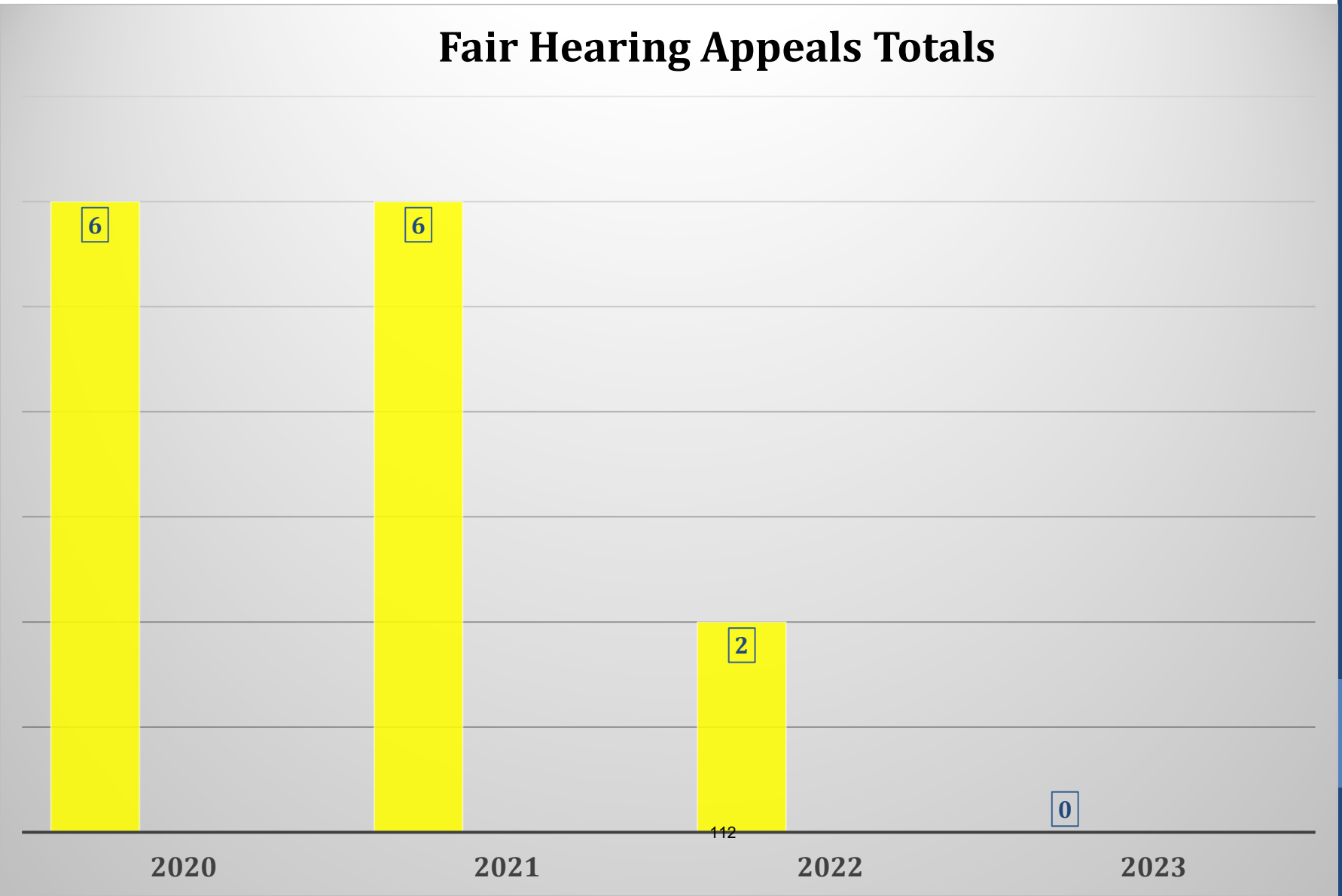
Grievance Trends
Fiscal Years 2020, 2021, 2022 and 2023



Local Level Appeal Trends
Fiscal Years 2020, 2021, 2022, and 2023



Fair Hearing Appeal Trends
Fiscal Years 2020, 2021, 2022 and 2023



Southwest Michigan
BEHAVIORAL HEALTH

Questions?

Medicaid Claims/Service Encounter Verification Report
Southwest Michigan Behavioral Health

Prepaid Inpatient Health Plan/Regional Entity

For the time period 10/01/2022 – 09/30/2023
Submitted December 19, 2023

Pursuant to MDHHS-SWMBH FY23 Contract
Schedule A Section 1.C.4 Medicaid Services Verification

Submitted by:
Mila C. Todd, Esq., CHC, CHPC, Chief Compliance Officer

Introduction:

Southwest Michigan Behavioral Health (SWMBH) is the Regional Entity and Medicaid Prepaid Inpatient Health Plan (PIHP) for eight counties and Community Mental Health Service Programs (CMHSP) in southwest Michigan. These eight CMHSPs are: Barry County Community Mental Health Authority, Riverwood Center (Berrien Mental Health Authority), Pines Behavioral Health Services (Branch County Community Mental Health Authority), Summit Pointe (Calhoun County Community Mental Health Authority), Woodlands Behavioral Healthcare Network (Cass County Community Mental Health Authority), Integrated Services of Kalamazoo (Kalamazoo County Community Mental Health Authority), Pivotal (St. Joseph County Community Mental Health Authority), and Van Buren Community Mental Health Authority. The FY2023 MDHHS-SWMBH contract Schedule A. Section 1.R. Program Integrity contains provisions for internal monitoring and auditing. To that end, SWMBH has conducted verification of Medicaid claims as detailed by the methodology outlined below, in conformity with contract Schedule A Section 1.C.4 Medicaid Services Verification Process.

In performing the verification of sampled Medicaid claims, SWMBH conducted quarterly audits of service encounters for each CMHSP and reviewed claims from contracted substance use disorder providers and Participant CMHSPs' network providers. The following is SWMBH's Medicaid Verification report with audit activities and results.

Summary of Findings:

SWMBH's reviewed clinical and claims records of participant CMHSPs, CMHSP network providers, and substance use disorder providers. Out of a total sample of 1,833 claims/encounters reviewed, 1,687 were verified to be a valid service reimbursable by Medicaid. This results in an overall compliance rate of 92.03%.

Fiscal Year	Region 4 MSV Compliance Rate
FY20	97.11%
FY21	95.27%
FY22	94.64%
FY23 (current report)	92.03%

Data Collection Methodology:

The Medicaid Verification auditing process consisted of a quarterly review of Medicaid claims approved for payment by SWMBH between the dates of October 1, 2022 and September 30, 2023. The Random Number function of the OIG's statistical software package, RAT-STATS, was used to select the random samples of claims for review from the total universes.

The Medicaid Verification testing sample size was a total of one thousand eight hundred thirty-three (1,833) claims/encounters, representing twenty-two thousand one hundred sixty-five (22,165) units and $1,880,781.06. These claims/encounters were reviewed based on Fiscal Year Quarters, divided as follows:

- Thirty (30) unique dates of service from each of the eight participant CMHSPs, stratified to include fifteen (15) encounters (CMHSP-provided services) and fifteen (15) network provider claims, per quarter.
    - Nine hundred sixty (960) unique dates of service reviewed in total for FY23;
    - Represented nine thousand five hundred fifty-two (9,552) units and $223,172.75.
- Thirty (30) claims/encounters from the total universe of substance use disorder providers, stratified to review ten (10) methadone dosing (H0020) claims, and remove claims from providers already reviewed in the CMHSP or Region-Wide samples for the remaining twenty (20) non-methadone dosing claims, per quarter.
    - One hundred twenty (120) claims/encounters reviewed in total for FY23;
    - Represented two hundred fifteen (215) units and $11,229.11.
- Fifteen (15) claims/encounters for each of the top three hospital providers (by dollar volume), stratified to remove the top three hospitals from FY22, per quarter.*
    - One hundred fifty-three (153) claims reviewed in total for FY23;
    - Represented one thousand one hundred and seventy-seven (1,177) units and $1,218,779.36.
    - *For quarter one, due to low claim volume, only seven (7) claims were reviewed for one of the top hospitals. For quarters three and four, only eleven (11) claims were reviewed for the same top hospital, as the last patient was discharged in May 2023.
- Thirty (30) claims for each of the top three CMHSP network providers (by dollar volume), stratified to remove the top three service providers from FY22, per quarter.
    - Three hundred sixty (360) claims reviewed in total for FY23;
    - Represented eight thousand one hundred and seventy-seven (8,177) units and $360,913.97.
- Sixty (60) claims/encounters from a region-wide universe, stratified to remove claims for services provided by any of the top three hospitals, any of the top three network providers, and any providers already pulled into the CMHSP samples, per quarter.
    - Two-hundred forty (240) claims/encounters reviewed in total for FY23;
    - Represented three thousand and forty-four (3,044) units and $66,685.87.

Identified Deficiencies. Out of a total sample of one thousand eight hundred thirty-three (1,833) claims/encounters reviewed, one thousand six hundred eighty-seven (1,687) were verified to be a valid service reimbursable by Medicaid. The following is a summary of the deficiencies noted among the seven questions addressed in the review tool for the one hundred forty-six (146) invalid claims:

- Was the person eligible for Medicaid coverage on the date of service reviewed? **0 deficiencies**
- Is the provided service eligible for payment under Medicaid?

8 deficiencies (These are claims for which Medicaid was secondary payor and the primary insurance was not billed prior to Medicaid.)

- Is there a current treatment plan on file which covers the date of service? **8 deficiencies** (This includes Treatment Plans deemed invalid due to no clinician signature at the time of the service.)
- Does the treatment plan contain a goal/objective/intervention for the service billed? **4 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer? **119 deficiencies** (This includes documentation that was completed/signed after the submission of the claim, which is a violation of SWMBH policy.)
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **2 deficiencies** (This includes claims for which there was an incorrect provider-qualifications modifier and/or there was no documentation provided to support the use of a particular provider-qualifications modifier.)
- Was the appropriate amount paid (contract rate or less)? **1 deficiency** (Billing a group service without the appropriate group-size modifier/rate.)
- Other deficiencies noted:
    - Service documentation insufficient to support the claim/documentation does not address the Treatment Plan goals/objectives/interventions.
    - Claim was for CLS overnight health and safety but did not use the appropriate modifier/code.
    - No start/stop times documented for per unit services.
    - Duplicative service documentation.
    - Service documentation not signed by the rendering provider or signed after the submission of the claim (in violation of SWMBH policy).
    - Billed in error/customer LOA for part of service claimed.
    - Service unbundled.
    - Billing for non-face-to-face time.

Verification Process:

Medicaid Verification was facilitated through a remote desk audit for each sampled claim/encounter, consisting of a review of relevant documents maintained within the electronic medical record used by all participant CMHSPs as well as service documentation sent electronically (if not maintained in the customer electronic medical record). The remote desk audits were scheduled between January 2023 and December 2023. A standardized verification tool was developed and used by all reviewers for both claims and encounters. The questions on the review tool included the following:

1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?

5. Is there documentation on file to support that the service was provided to the consumer?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

The Medicaid Verification reviews were conducted by SWMBH's Chief Compliance Officer (or designee, and under the direction of SWMBH's Chief Compliance Officer).

Medicaid Eligibility Assurance:

In addition to the Medicaid verification methodology used above, SWMBH has developed an automated verification process and management exception reports for use in daily verification that all encounters reported to Medicaid capitated plans are checked against the monthly Medicaid Enrollment eligibility files received from MDHHS. SWMBH has a centralized data warehouse where all information is stored. These reports are available to each CMHSP for use. The reports verify each transaction against the eligibility file and return to the user a report which identifies those individuals that have services charged to Medicaid that either do not exist in the eligibility file or do not show current eligibility. These reports are then verified by the agency utilizing the report using the CHAMPS eligibility lookup to determine true eligibility or non-eligibility on the given date of service and corrected accordingly.

Description of Follow-up Activities and Improvements:

Over the course of Fiscal Year 2023, SWMBH reviewed the service documentation and claims processing procedures of each participant CMHSP to ensure that both the applicable delegated and non-delegated functions follow Medicaid regulations and SWMBH policies.

With regard to the deficiencies noted pertaining to a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the service billed, the majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with a clinician signature prior to the provision of service and within 15 business days of the effective date of the plan. SWMBH will continue to work with our CMHSPs and network providers to address the timeliness of treatment planning and the signatures of the clinician validating the treatment plan. Additionally, SWMBH will continue to educate providers on the importance of specific and individualized goals/objectives/interventions for services contained within the treatment plan.

Regarding deficiencies noted for documentation on file to support that the service was provided, some providers continued to struggle with the MDHHS required documentation and the inclusion of actual begin and end times of face-to-face per unit services. Additionally, the required modifier/code for Community Living Services Overnight Health and Safety was identified as an area of improvement and education. SWMBH has been working and will continue to work with CMHSPs and network providers to ensure adherence to all MDHHS clinical records policies and requirements.

In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative and administrative review process, designed to provide ongoing feedback to both participant CMHSPs and network providers.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in Medicaid fraud and abuse prevention. In Fiscal Year 2024, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan timeliness, proper recording of face-to-face service start and stop times, accurate use of provider qualifications modifiers, and service documentation standards. Additionally, SWMBH will continue closely monitoring the reporting of in-home Community Living Support claims for the proper use of modifiers, start and stop times, and only billing face-to-face services.

Corrective Action and Follow-Up Process

Performance standards have been set based on the percentage of deficiencies identified which dictates the frequency of follow-up:

- Verification reviews with a score of greater than or equal to 90% – No corrective action plan is needed, and reviews will be performed annually. No follow-up is necessary.
- Verification reviews less than or equal to 89.9% – SWMBH will require the applicable agency to create a written corrective action plan within 30 days, which must be approved by the SWMBH Compliance Committee.

Given this year's findings, ongoing education and training will be provided with an emphasis on documentation standards, proper reporting of face-to-face service start and stop times, treatment planning timeliness, and required modifiers (U-modifiers and provider-qualification modifiers specifically). As a result of the anticipated staff training, efforts to continuously improve in this area will be ongoing. The Medicaid Verification findings are reported to the SWMBH Board of Directors and the Member Advisory Committee. The SWMBH Executive Officer, the Chief Compliance Officer, the SWMBH Corporate Compliance Oversight Committee and the SWMBH Leadership Team will also review the findings and identify any additional strategies needed to improve the findings. Given the overall compliance rate of 92.03% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP is not required and will not be submitted; however, SWMBH will continue the efforts described above in order to improve service claim processes congruous with Medicaid requirements.

The 146 claims/encounters identified as invalid represent a total of 2,763 units and resulted in payment adjustments totaling $47,729.71. Payment adjustments were communicated to the applicable agency via a recoupment ticket contained in the final audit report. Applicable agencies were advised of their appeal rights, and that once the appeal period had passed (30 days) the invalid claims would be reverted, and the funds recouped. When the claims are reverted and denied, the encounter that was previously submitted to MDHHS is voided.

2023 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Ruth Perino (Barry)												
Mark Doster (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Sherii Sherban (Calhoun)												
Louie Csokasy (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarato (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Jeanne Jourdan (Cass)												
Karen Longanecker (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 12/8/23

Green = present
Red = absent
Black = not a member
Gray = meeting cancelled