



**Southwest Michigan Behavioral Health Board Meeting**  
**Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001**  
**January 13, 2023**  
**9:30 am to 11:30 am**  
**Holiday Luncheon Following**  
(d) means document provided  
**Draft: 1/4/23**

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**
  - December 9, 2022 SWMBH Board Meeting Minutes (d) pg.3
5. **Operations Committee**
  - Operations Committee Quarterly Report (D. Hess) (d) pg.7
6. **Ends Metrics Updates (\*Requires motion)**

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

  - \*Fiscal Year 2022 Michigan Mission Based Performance Indicator System Results (J. Gardner) (d) pg.8
7. **Board Actions to be Considered**
  - a. Financial Risk Management Plan (G. Guidry) (d) pg.12
  - b. Financial Management Plan (G. Guidry) (d) pg.15
  - c. Cost Allocation Plan (G. Guidry) (d) pg.21
  - d. 2023 Quality Assurance and Performance Improvement Plan (J. Gardner) (d) pg.33
  - e. Fiscal Year 2022 Board Audit Committee Appointments (G. Guidry)
  - f. Draft May 12, 2023 Board Retreat Agenda (d) pg.119
8. **Board Policy Review**

*Is the Board in Compliance? Does the Policy Need Revision?*

  - BG-004 Board Ends and Accomplishments (d) pg.120
9. **Executive Limitations Review**

*Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?*

  - None

#### **10. Board Education**

- a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d) pg.121
- b. Fiscal Year 2022 Program Integrity Compliance Report (M. Todd) (d) pg.127
- c. Opioid Advisory Commission (B. Casemore)

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

- a. 2022 SWMBH Board Attendance Letters
- b. CMHAM Did You Know (d) pg.132
- c. February 10, 2023 Draft Board Agenda (d) pg.134
- d. Board Member Attendance Roster (d) pg.136
- e. February Board Policy Direct Inspection – None

#### **12. Public Comment**

#### **13. Adjournment**

#### **14. Holiday Celebration**

*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**

**Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001**  
**February 10, 2023**  
**9:30 am - 11:30 am**

# Southwest Michigan

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## BEHAVIORAL HEALTH

### Board Meeting Minutes

December 9, 2022

Four Points Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001

9:30 am-11:30 am

Draft: 12/12/22

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**Members Present:** Edward Meny, Tom Schmelzer, Susan Barnes, Carol Naccarato, Ruth Perino, Louie Csokasy, Erik Krogh, Sherii Sherban

**Members Absent:** None

**Guests Present:** Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH; Ella Philander, Strategic Initiatives Project Manager, SWMBH; Moira Kean, Senior Clinical Data Analyst, SWMBH; Tim Smith, Woodlands; Jon Houtz, Board Alternate for Pines Behavioral Health; Ric Compton, Riverwood Center; Nancy Johnson, Board Alternate for Riverwood Center; Cameron Bullock, St. Joseph County CMH, Jeanne Jourdan, Board Alternate for Woodlands BHN, Debbie Hess, Van Buren CMH; Alan Bolter, Associate Director, Community Mental Health Association of Michigan

### Welcome Guests

Edward Meny called the meeting to order at 9:30 am and introductions were made.

### Public Comment

None

### Agenda Review and Adoption

Motion	Erik Krogh moved to approve the agenda with one addition of Opioid Advisory Committee.
Second	Carol Naccarato
Motion Carried	

### Financial Interest Disclosure (FID) Handling

Mila Todd noted Tom Schmelzer and Edward Meny's Financial Interest Disclosure Statement with no new disclosures. No Board action necessary.

### Consent Agenda

Motion	Louie Csokasy moved to approve the November 11, 2022 Board meeting minutes as presented.
Second	Carol Naccarato
Motion Carried	

## Operations Committee

### Operations Committee Meeting Minutes

None

## Ends Metrics

### Fiscal Year 2022 Health Services Advisory Group External Quality Review

Jonathan Gardner reported as documented. Discussion followed.

Motion Carol Naccarato moved that the data is relevant and compelling, the Executive Officer was not in compliance and the Ends Metric language was revised in the new 2023-2024 Board Ends Metrics; which were approved by the Board during the November 11, 2022 Board Meeting.

Second Susan Barnes

Motion Carried

### Certified Community Behavioral Health Clinics Demonstration Year Report

Ella Philander reported as documented. Discussion followed.

### 2022 Health Services Advisory Group Performance Improvement Project

Moira Kean reported as documented.

Motion Erik Krogh moved that the data is relevant and compelling, the Executive Officer is in compliance and Ends Metrics does not need revision.

Second Carol Naccarato

Motion Carried

## Board Actions to be Considered

### Executive Officer Merit Award

Edward Meny reported as documented.

Motion Susan Barnes moved to approve the Board Resolution regarding the Executive Officer's Merit Award as presented.

Second Erik Krogh

Motion Carried Unanimously

### Executive Officer Paid Time Off

Anne Wickham summarized current paid time off accrument and paid holidays for SWMBH staff. Discussion followed.

Motion Louie Csokasy moved to approve the Board Resolution regarding the Executive Officer's paid time off as presented.

Second Erik Krogh

Roll Call Vote

Ruth Perino yes

Erik Krogh yes

Susan Barnes yes

Edward Meny yes

Tom Schmelzer	yes
Louie Csokasy	yes
Carol Naccarato	yes
Sherii Sherban	yes

Motion Carried

### **February SWMBH Board Meeting and Quorum Count**

Edward Meny discussed the scheduled February 10, 2023 Board meeting.

Motion Edward Meny moved the February 10, 2023 SWMBH Board meeting be cancelled.

Second Susan Barnes

Roll Call Vote

Ruth Perino yes

Erik Krogh no

Susan Barnes yes

Edward Meny yes

Tom Schmelzer no

Louie Csokasy no

Carol Naccarato yes

Sherii Sherban no

Motion Failed

### **2023 Board Calendars**

Brad Casemore reported as documented.

Motion Sherii Sherban moved to approve the 2023 Board Calendars as presented.

Second Ruth Perino

Motion Carried

### **Board Policy Review**

#### **BG-005 Chairperson's Role**

Edward Meny reported as documented.

Motion Edward Meny moved that the Board is in compliance with Policy BG-005 Chairperson's Role and the policy does not need revision.

Second Tom Schmelzer

Motion Carried

### **Executive Limitations Review**

#### **BEL-003 Asset Protection**

Sherii Sherban reported as documented.

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

Second Tom Schmelzer

Motion Carried

## **Board Education**

### **Cass Woodlands Delegated Managed Care Functions Status**

Mila Todd reported that Woodlands Behavioral Health Network is progressing well with corrective action plans and SWMBH is pleased with progression. Discussion followed.

### **Fiscal Year 2023 Year to Date Financial Statements**

Tracy Dawson reported as documented.

### **Fiscal Year 2022 Contract Vendor Summary**

Tracy Dawson reported as documented.

### **Fiscal Year 2022 Customer Services Report**

Sarah Ameter reported as documented.

### **November Election Results**

Alan Bolter reported as documented.

### **System Transformation**

Alan Bolter reported as documented.

### **Revised SWMBH Policy BEL-002 Financial Conditions**

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

### **Revised SWMBH Policy BEL-010 RE 501 (c) (3) Representation**

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

## **Communication and Counsel to the Board**

### **System Transformation**

Alan Bolter

### **January 13, 2023 SWMBH Draft Board Agenda**

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

### **Board Member Attendance Roster**

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

## **Public Comment**

None

## **Adjournment**

Motion Erik Krogh moved to adjourn at 12:00 pm

Second Susan Barnes

Motion Carried



**Operations Committee Board Report  
Quarterly Report for October, December 2022  
Board Date 1/13/23**

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**Action items:**

- Endorsed 2023-2024 Board Ends Metrics
- Approved Building Better Lives Project Workplan revisions
- Endorsed 2022-2025 SWMBH Strategic Plans

**Discussion items:**

- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some recommendations are to SWMBH management, and some go to SWMBH Board. Much information and recommendations are taken by Operations members take back to their own CMH's. Some of the topics from this quarter included:
  - Reviewed year to date financial reports, actions being taken to decrease expenditures, and reviewed state level actions which impact financials
  - Reviewed Fiscal Year 2023 Contract Status/Updates
  - Reviewed Fiscal Year 2022 Performance Bonus Incentive Program developments
  - Opioid Health Homes (OHH) status
  - Reviewed Grant Updates/Status (Block Grant, Opioid Health Homes)
  - Reviewed and discussed various State and Milliman rate setting documents, Cost Allocation Workgroup updates including Standard Cost Allocation, new administrative rules, tiered rates and managed care delegation
  - Reviewed Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and External Quality Review
  - Reviewed CMH Site Review results
  - Reviewed Building Better Lives Project
  - Discussed Direct Care Wage
  - Reviewed and discussed beginning Health Disparities Data
  - Reviewed MDHHS code changes
  - Discussion of Behavioral Health System Transformation proposals
  - Discussion of CCBHC (Certified Community Behavioral Health Clinics) implementation and status
  - Discussion of Integrated Healthcare strategies
  - Discussion of Conflict Free Access and Planning and LOCUS MIFAST
  - Discussion of Adverse Benefit Determination Letters
  - Discussion of MiCAL implementation
  - Discussion of MHL extraction
  - Discussion of 2022-2025 Strategic Plan and 2023-2024 Board Ends Metrics
  - Discussion of Opioid Settlement dollars and Opioid Advisory Commission

## 2022 MMBPIS Performance Indicator Board Ends Metric (Motion Required)

PERFORMANCE METRIC DESCRIPTION	STATUS										
<p><b>85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 22.</b></p> <p>a. 24/28 indicators meet the State Benchmark, throughout all FY22. 1pt. b. Indicator 3a,b,c &amp; d achieve a 3% combined improvement (<i>through FY 22 all 4 Quarters</i>) over 2021 baseline (1/2 pt. each) 2pts.</p> <p>Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: January 13, 2023</p> <p><b>Measurement:</b> Results are verified and certified through the quarterly consultative draft report produced by MDHHS. Currently (7/16) indicators have established benchmarks.</p> <p><u>Total number of indicators that met State Benchmark (total achieved)</u> Total number of indicators measured (28)</p>	<p><b>Completed Successfully</b></p> <p>26/28 or <b>92.8%</b> of Indicators met the MDHHS indicated benchmarks.</p> <p><b>Q1: 7/7</b> <b>Q2: 6/7</b> <b>Q3: 6/7</b> <b>Q4: 7/7</b></p> <p>Indicator 3 FY21 Baseline Values: (%) value represents metric goal.</p> <table> <tr> <th>SWMBH</th><th>PIHP Ave.</th></tr> <tr> <td>A. 65% (56%)</td><td>74%</td></tr> <tr> <td>B. 66% (61%)</td><td>73%</td></tr> <tr> <td>C. 74% (69%)</td><td>82%</td></tr> <tr> <td>D. 75% (68%)</td><td>79%</td></tr> </table> <p><b>+6.5%</b> improvement from FY21 baseline to current FY22 results.</p>	SWMBH	PIHP Ave.	A. 65% (56%)	74%	B. 66% (61%)	73%	C. 74% (69%)	82%	D. 75% (68%)	79%
SWMBH	PIHP Ave.										
A. 65% (56%)	74%										
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C. 74% (69%)	82%										
D. 75% (68%)	79%										

MMBPIS Indicator #	MMBPIS Performance Indicator	State Standard	Q1 2022	Q2 2022	Q3 2022	Q4 2022
1a	Pre-Admission Screening Children	95%	99.36%	99.64%	98.77%	100.00%
1b	Pre-Admission Screening Adults	95%	99.32%	99.42%	99.42%	98.89%
2a(a)	Request to Intake MI Adults	n/a	71.97%	75.08%	75.47%	70.99%
2a(b)	Request to Intake MI Children	n/a	70.75%	69.27%	75.63%	70.36%
2a(c)	Request to Intake IDD Adults	n/a	83.50%	80.17%	85.60%	85.19%
2a(d)	Request to Intake IDD Children	n/a	82.35%	79.07%	72.22%	74.29%
2e	Request to Service SA	n/a	401	351	420	430
3a	First Service MI Adults	n/a	64.99%	65.41%	55.64%	66.00%
3b	First Service MI Children	n/a	67.04%	65.68%	62.06%	66.75%
3c	First Service IDD Adults	n/a	52.94%	57.55%	50.39%	73.08%
3d	First Service IDD Children	n/a	80.00%	80.00%	60.78%	84.85%
4a(a)	IP Follow Up Children	95%	98.11%	100.00%	100.00%	97.14%
4a(b)	IP Follow Up Adults	95%	96.21%	97.60%	94.47%	95.27%
4b	Detox Follow Up	95%	97.93%	94.65%	99.03%	99.57%
10a	IP Recidivism Children	15%	7.69%	5.36%	3.23%	1.67%
10b	IP Recidivism Adults	15%	12.27%	9.61%	10.79%	10.76%
	<b>Overall Results</b>		<b>7/7</b>	<b>6/7</b>	<b>6/7</b>	<b>7/7</b>

\*Indicators 2a, 2b, 2c, 2d, 2e, 3a, 3b, 3c & 3d currently do not allow for exceptions and exclusions (*i.e., no shows, reschedules, cancellations or refusals*) to be deducted from the numerator and denominator, therefore providing lower values than the other indicators.

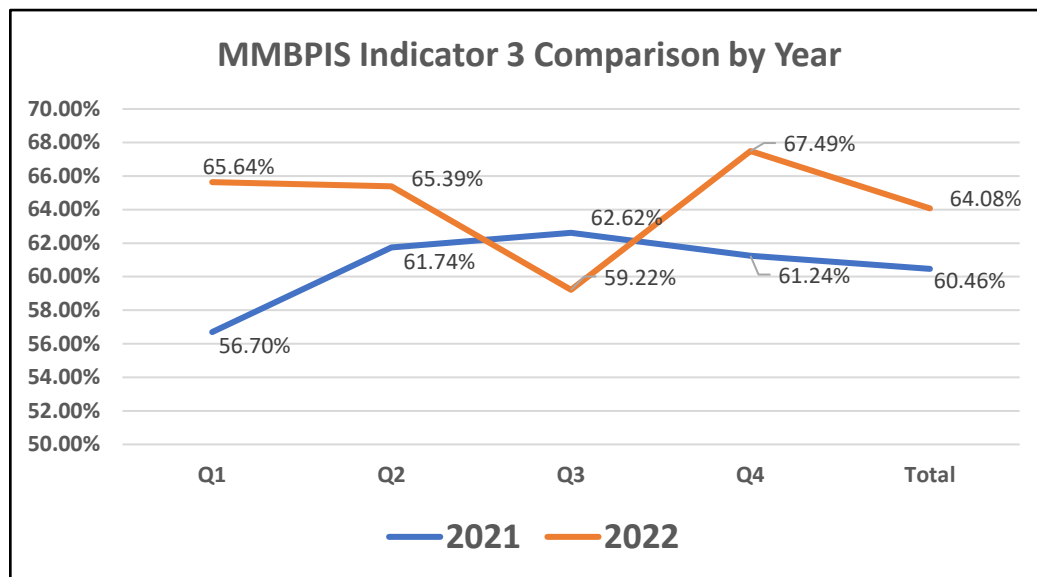
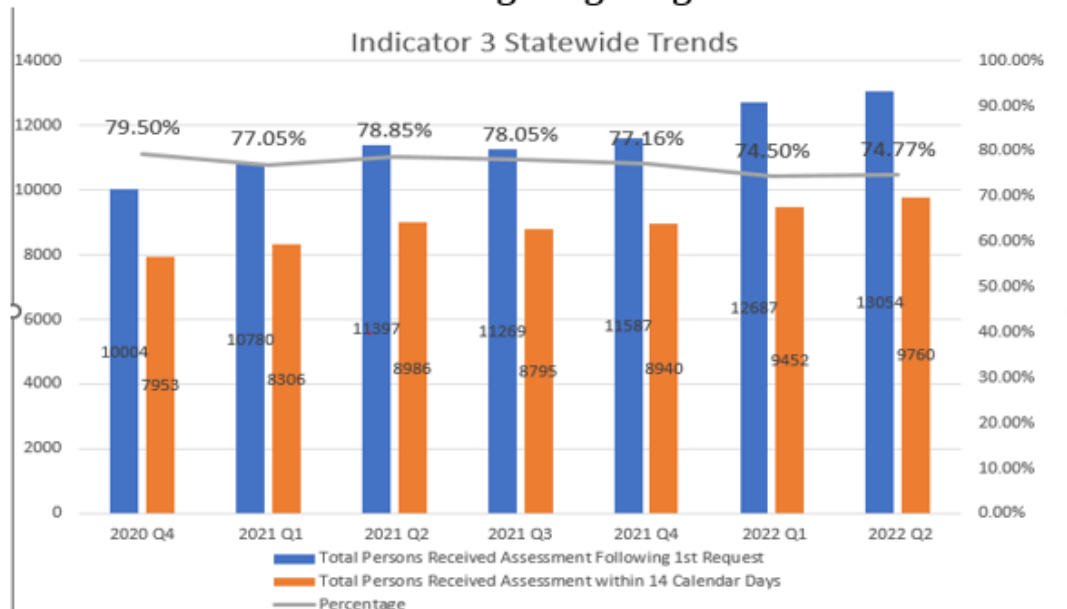


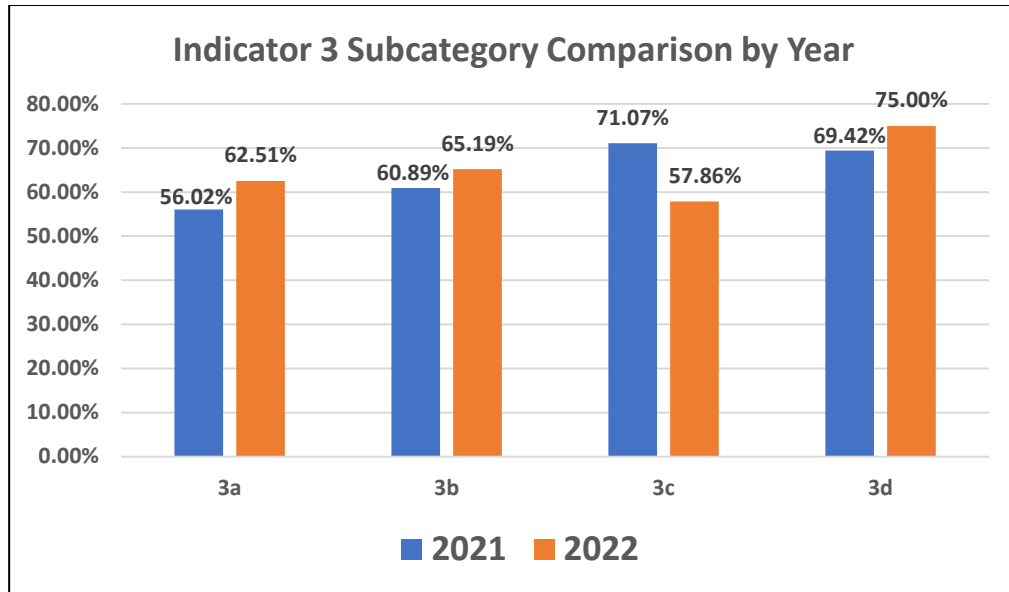
# MMBPIS Analysis-Indicator 3

Percentage=

*Total Starting Ongoing Service within 14 Calendar Days*

*Total Starting Ongoing Service*





## MMBPIS Indicator Descriptions

<b>MMBPIS Indicator #</b>	<b>MMBPIS Performance Indicator</b>	<b>MMBPIS Indicator Description</b>	<b>State Standard</b>
<b>1a</b>	<b>Pre-Admission Screening Children</b>	% of Medicaid adults receiving pre-admission screen for psychiatric inpatient care within 3 hrs. of disposition	95%
<b>1b</b>	<b>Pre-Admission Screening Adults</b>	% of Medicaid children receiving pre-admission screen for psychiatric inpatient care within 3 hrs. of disposition	95%
<b>2a</b>	<b>Request to Intake MI Children</b>	% of new persons (MI Children) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
<b>2b</b>	<b>Request to Intake MI Adults</b>	% of new persons (MI Adults) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
<b>2c</b>	<b>Request to Intake DD Children</b>	% of new persons (DD Children) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
<b>2d</b>	<b>Request to Intake DD Adults</b>	% of new persons (DD Adults) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
<b>2e</b>	<b>Request to Intake SA</b>	% of new persons during the quarter 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.	*

<b>3a</b>	<b>First Service MI Children</b>	<b>% of new persons (MI Children) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment</b>	<b>*</b>
<b>3b</b>	<b>First Service MI Adults</b>	<b>% of new persons (MI Adults) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment</b>	<b>*</b>
<b>3c</b>	<b>First Service DD Children</b>	<b>% of new persons (DD Children) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment</b>	<b>*</b>
<b>3d</b>	<b>First Service DD Adults</b>	<b>% of new persons (DD Adults) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment</b>	<b>*</b>
<b>3e</b>	<b>First Service SA</b>	<b>% of new substance abuse individuals starting service within 14 calendar days after a non-emergency assessment</b>	<b>*</b>
<b>4a(a)</b>	<b>IP Follow Up Children</b>	<b>% of children who discharge from a psychiatric inpatient unit and are seen for follow-up within seven days</b>	<b>95%</b>
<b>4a(b)</b>	<b>IP Follow Up Adults</b>	<b>% of individuals who discharge from a substance abuse detox unit and are seen for follow-up within seven days</b>	<b>95%</b>
<b>4b</b>	<b>Detox Follow Up</b>	<b>% of adults who discharge from a psychiatric inpatient unit and are seen for follow-up within seven days</b>	<b>95%</b>
<b>10a</b>	<b>IP Recidivism Children</b>	<b>% of adults readmitted to a psychiatric inpatient unit within 30 days of discharge</b>	<b>Below 15%</b>
<b>10b</b>	<b>IP Recidivism Adults</b>	<b>% of children readmitted to a psychiatric inpatient unit within 30 days of discharge</b>	<b>Below 15%</b>

**Proposed Motion:**

The Data is relevant and Compelling, the Executive Officer is in compliance and the Ends Metric needs no further revisions.

# Southwest Michigan Behavioral Health (SWMBH) Financial Risk Management Plan

SWMBH ~~January~~February 2023

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## 1115 Demonstration waiver, 1915 (c)/(i), ~~Healthy Michigan Plan~~ and Autism Program

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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 and the Medicaid Contract.

Beyond this and in further protection of SWMBH, participating CMHSPs will submit timely, ~~complete~~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 ~~all 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.**

Presentation to SWMBH Board for approval of the need for a sub-contract budget adjustment and funding increase. Remove we cost settle with the CMH'S so isn't needed, monthly financials detail monthly on-going. Ok

SWMBH, ~~if be 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

# Southwest Michigan Behavioral Health (SWMBH)

## Financial Risk Management Plan

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

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.](#)

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### 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 capitation 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.

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### 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 ~~eligibles~~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 may be 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

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## Southwest Michigan Behavioral Health (SWMBH) Financial Risk Management Plan

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 ~~and ISF policy it is just called the Investment policy.~~

### 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 ~~within five (5) business days of the~~ 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 Management Plan

This Financial Management Plan is prepared as an integral part of the annual operational and fiscal budget planning process. The Financial Management Plan shall be approved by SWMBH Board on an annual basis. Material revisions not directly a result of change in federal or state statute or regulation or SWMBH – Michigan Department of Health and Human Services MDHHS Contract terms shall also be approved by SWMBH Board before implementation. The Bylaws of SWMBH refer to the annual Financial Management Plan approved by SWMBH Board as the means to satisfy the legal requirements of the Michigan Mental Health Code, MCL 330.1204b.

SWMBH Financial Management Plan on a consolidated basis shall include:

- A Consolidated Executive Summary of the most significant operational proposals, changes or initiatives of SWMBH or a participating CMHSP, including the financial impacts thereof.
- A Consolidated Summary of Key Statistical Information, Projections and Assumptions.
- A Consolidated Summary Statement of Budgeted Income and Expense by payor and business segment.
- A description and *pro forma* computation of the manner for equitably providing for, obtaining, and allocating revenues between SWMBH and participating CMHSPs in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(i).
- A description and *pro forma* computation of the method or formula for equitably allocating and financing SWMBH's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(ii).
- A description and *pro forma* computation of the method for allocating any of SWMBH's other assets if applicable and in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iii).
- A description and *pro forma* computation of the manner in which, after the completion of its purpose as specified in SWMBH's bylaws, any surplus funds shall be returned to the DHHS in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iv).
- A description of the process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all SWMBH's receipts and disbursements, shall be prepared and presented. This will be in sufficient detail to satisfy

the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(e).

- A *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH Consolidated Financial Management Plan will be reviewed annually by participating CMHSPs. At the participating CMHSP level, the CMH proposed budget shall constitute a request for funding by SWMBH for its applicable allocated and apportioned cost. Each participating CMHSP submits to SWMBH a *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH and participating CMHSPs will comply with The Mental Health Code, the MDHHS Rules, the MDHHS/PIHP Master Contracts, and applicable State and federal laws, regulations, rules, policies and procedures, including but not limited to Balanced Budget Act (BBA) of 1997 as amended and OMB Super Circular.

## Financial Management Functions

SWMBH will be responsible for its own financial management functions. Financial management functions for SWMBH include at least the following:

- 1) Budgeting
- 2) General accounting
- 3) Financial reporting, analysis, and monitoring,
- 4) Financial risk management
- 5) Investments management
- 6) Supervision of external audits, internal audits, and internal controls
- 7) Payments for SUD, Financial Status Reports (FSR's) and invoices.
- 8) Cost allocation process

These functions will be performed by SWMBH finance staff under the management direction of SWMBH Chief Financial Officer.

Similar functions will continue to be performed at the participating CMHSPs because they are independent legal entities and have local responsibilities and independent contractual obligations outside of the business relationships with SWMBH.

### 1. Budgeting – Annual Projections of Revenues and Expenditures

The primary purpose of SWMBH is to contract with the State of Michigan and other payers for services and supports to be delivered to or arranged for covered eligible populations in the region. These services and supports for the regional service area will be provided or arranged for by SWMBH, its participating CMHSPs or others as agreed upon in writing.

### Medicaid 1915 (b) / (c) Waiver

The annual budget shall be prepared and presented as an integral part of the annual financial



management plan to be reviewed and approved by SWMBH Board.

SWMBH CFO will provide revenue projections for each participating CMHSP. Assuming the Medicaid contract continues as a per eligible per month (PEPM) regional rate capitation for eligible populations (from MDHHS to SWMBH), the allocation of SWMBH capitation revenue to the CMHSP of financial responsibility will continue to use the same funding allocation methodology as its starting point for interim payments and annual net cost budget limitations.

This methodology would follow the demographic, coverage levels, rate cells and regional PEPM rates inherent in the regional capitation determination and would fluctuate from month to month based on actual and confirmed eligibility fluctuations. Since the contractual relationship would not be a risk-sharing capitation between SWMBH and CMHSP's, the need for actuarial determinations or findings of "actuarial soundness" of CMH sub-capitation style payments is not required. This funding methodology is best referred to as a sub-capitation style interim payment with an annual net cost budget limitation and net cost settlement.

Recognizing that a regional rate may not be equivalent to the true, appropriate and medically necessary cost of services and supports for the entire eligible population in a specific participating CMHSP's service area, "needs based" funding adjustments for benefit stabilization could be made in the annual prospective funding allocation developed by SWMBH and as approved by SWMBH Board.

SWMBH is the sole party at-risk with the MDHHS. SWMBH will cost settle with the MDHHS. SWMBH would retain any year end contract savings (Medicaid savings), risk reserves and other funds consistent with MDHHS/PIHP contract. For participating CMHSPs the annual net cost budget limitation will be established in the budget and financial management planning process and adjust for changes in eligible covered lives. SWMBH Board may approve prospective performance incentives and sanctions for participating CMHSPs upon SWMBH management request.

Participating CMHSPs shall provide to PIHP on a quarterly basis, the obligation for local funds as a bona fide source of match for Medicaid. The payments shall be submitted to SWMBH in accordance with the schedule established by the MDHHS. SWMBH and participating CMHSPs shall establish mechanisms to assure that the local match of each participating CMHSP is funded at the adequate level. Any participating CMHSP that projects a problem or issue with local match funding shall immediately notify SWMBH. A plan of correction must be completed and sent to SWMBH within ten (10) business days of the identification of the problem.

Capitation revenues by participating CMHSP will be used as the basis of allocation of regional cost and other regional financial considerations applicable to SWMBH expense. This percentage will be established annually during the budget setting process.

The net result would constitute the sub-contract annual net cost budget limitation amount for each participating CMHSP. This initial sub-contract amount would be a "costs not to exceed" and would be subject to cost settlement to be described in the subcontract between SWMBH and the participating CMHSP. Participating CMHSPs are required to provide all medically necessary services to Medicaid beneficiaries, subject to SWMBH utilization management, evidence-based practice guidelines and other relevant policy.

## Healthy Michigan Plan

Allocation of Healthy Michigan Plan revenues to SWMBH is determined by the State based on participants in the plan in our region.

Autism is now included as part of the regions capitated funding. The PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual.

## MI Health Link Duals Demonstration

Demonstration Participating CMHSPs are paid FFS for MI HealthLink participants. SWMBH and Integrated Care Organizations (ICO) according to their specific agreements pay a PEPM rate for participants enrolled in the demonstration project in our region.

## MiChild

A health insurance program for uninsured children of Michigan's working families. MiChild services are provided by many HMOs and other health care plans throughout Michigan, the payment for the program is now included in the Medicaid Capitation payment amount.

## 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 eligibles 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.

## Other Revenues

SWMBH 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 a number of beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

### 1. Budget Preparation

SWMBH CFO will prepare annual budget for centralized operations that include:

- An Executive Summary of significant operational proposals, changes or initiatives including the financial impacts thereof.
- A Summary of Key Statistical Information, Projections and Assumptions.
- A Summary Statement of Budgeted Income and Expense by payor and segment.

- A detail Operating Budget including revenue and expense at the account and cost center level, with a staffing table at the position and cost center level.
- A Capital Budget showing anticipated replacement or new investment in capital assets.

Annual budget for SWMBH centralized operations will be approved by SWMBH Board.

## 2. General Accounting

SWMBH maintains accounting and financial reporting system in accordance with Generally Accepted Accounting Principles (GAAP). The accounting procedures and internal financial controls of SWMBH shall conform to Generally Accepted Accounting Principles (GAAP) for governmental units. SWMBH shall maintain accounts and source records in which any and all revenues received and expenses incurred are ascertainable and verifiable and include date of receipt / payment and sources of funds. SWMBH shall have a certified public accounting firm perform an annual independent audit of it in substantial conformance with the American Institute of Certified Public Accountants Guide to assess compliance with the appropriate standard accounting practices and procedures and MDHHS contract requirements.

## 3. Financial Reporting, Analysis, and Monitoring

SWMBH shall review its Financial Management Plan not less than annually and revise the plan as necessary to maintain an adequate and acceptable level of financial management. To ensure the financial stability of SWMBH, financial activities shall be performed in accordance with applicable federal and state guidelines, rules and regulations as may apply.

Financial management reports for SWMBH and each participating CMHSP shall be prepared monthly and presented to the respective boards of directors and administrative management. SWMBH shall establish the timing and content for required submission of financial management reports and other data from participating CMHSPs.

## 4. Financial Risk Management: See 8.2 Financial Risk Management Plan 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 Public Act 20 of 1943 as amended. Further information is provided on investment management in the Region Entity Investment Policy and ISF policy.

## 5. 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 within 5 business days of CMH Board receipt of the audit.

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 at the close of the audit, received from the PIHP commissioned auditors within 10 business days of its completion by the audit firm.

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

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.

## 6. Claims Adjudication and Payment

For consistency of policy, process and reporting, SWMBH will utilize a regional claims processing system/process for adjudication of all provider claims and service encounters for which it is the contract holder. Participating CMHSPs may utilize this system/process to adjudicate its external provider claims as needed or the CMHSP will adopt uniform claims adjudication and payment policies that adhere to those utilized at SWMBH or prior approved by SWMBH. This process is managed and monitored by the Operations and Compliance programs of SWMBH.

## 7. Cost Allocation Process

With respect to the MDHHS capitated funding SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSPs. It shall be the policy of SWMBH that SWMBH will prepare a Cost Allocation Plan as an integral part of their annual budget process and is suggested that each participating CMHSP prepare the same but must adhere to GAAP and the OMB Super Circular.

SWMBH Board ~~December~~ January 202022

## 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 232' the Cost Allocation Plan methodology ~~has~~ changed for the CMHSP's with the development of the Standard Cost Allocation (SCA) from MDHHS. ~~This initial year while the cost associated with the agency are relatively the same how the cost is allocated will have some differences for SCA adopted agencies and those that have not yet changed.— All SWMBH CMHSP's will that have switched over to the SCA model report for yearend FY2023 and have specific instructions and requirements outlined by the MDHHS state on the methodology. CMH'S that have not changed over may have developed their cost using the state instructions and a crosswalk will be used to determine actual allowable cost subject to cost settlement between SWMBH and participating CMHSPs~~

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.

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### *AUTHORITATIVE GUIDANCE*

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

1. The ~~Michigan Department of Community Health~~ HS 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 particular reference to Attachment D and the referenced 45 CFR Part 95, 2 CFR 200 Subpart E.
3. Generally Accepted Accounting Principles (GAAP), with particular 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*

##### PRINCIPLE

Organizations receiving payment on the basis of 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.

##### DEFINITIONS

###### 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 on the basis of 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 by the use of 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 so as 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 as a whole. 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.

Ratio of Units to total Units of Service Applied to Cost (RUUAC) ~~Is this still a thing? No can be removed or replaced with EQI~~

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A ratio that may be expressed as follows:

- The ratio of total beneficiary units of service to total units of service applied to total costs on a departmental basis; or
- The ratio of total cost to total units of service applied to total beneficiary units of service on a departmental basis.

## 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.

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#### 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.

**COST APPORTIONMENT FOR COST BASED CMHSP's** DOES THIS NEED CHANGING. This could be EQI language

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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.

#### PROVIDER SERVICES FURNISHED UNDER ARRANGEMENTS

Costs of covered services furnished to contract eligible individuals through arrangements with non-plan providers will, in most cases, be 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 on the basis of 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 on the basis of 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 on the basis of 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~~[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.

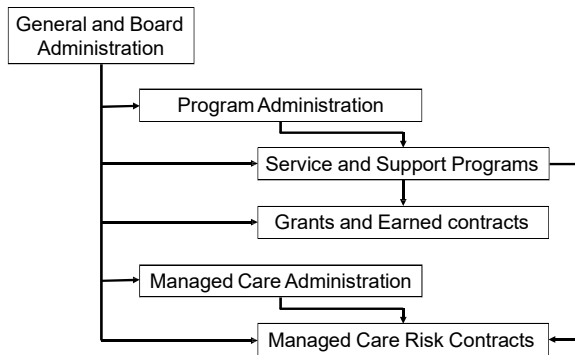
- Capital-Related Cost (depreciation and amortization, etc.) and Building Occupancy Costs, based on square feet operated for building and occupancy costs and actual depreciation for equipment and furnishings in use.
- ~~Employee Benefit Costs~~, [Employee Benefit Costs](#) based on the dollar value of 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



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### 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.



# 2023 Quality Assurance and Performance Improvement Dept. Overview (QAPIP)

January 13, 2023



*Southwest Michigan*  
BEHAVIORAL HEALTH

# Introduction

---

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

42 CFR section 438-210 indicates that;

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

42CFR section 438-230 indicates that;

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

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

# Authority and Structure

---

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

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

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

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

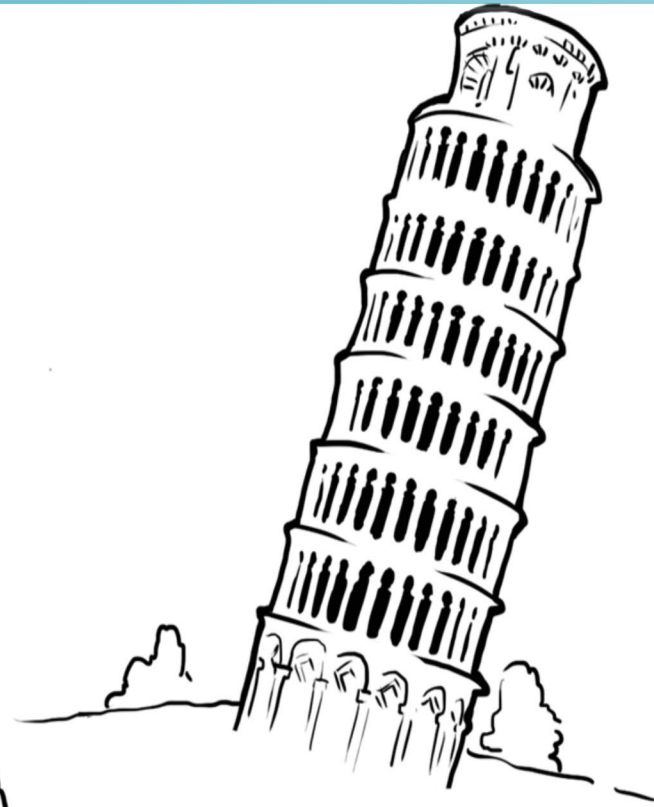
# Purpose

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

## **Additional purposes of the QAPIP are to:**

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

THAT'S GOOD ENOUGH.



QUALITY <sup>37</sup> CONTROL

# Regional 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 2023, its tenth 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.



# 2023 QAPI Goals

1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By 6/30/23)
2. Review current survey tool for the 2023 Consumer Satisfaction Survey Project, to ensure that it meets CCBHC and Best Practice Methodology for Measurement and Analysis (By 3/30/23)
3. Redesign structure/format of the annual QAPI-UM Plan and Evaluation report. (By 6/30/2023)
4. Create a flow chart for each quality related MDHHS contractually obligated reporting requirement. (By 12/30/2023)
5. Work with the Quality Management Committee and other Regional Committees to improve Health Service Advisory Group (HSAG) External Quality Review (EQR) results and corrective action plans. (By 10/30/2023)



# Data Management

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

1. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
    - ✓ *Data Reviews before information is submitted to the state*
    - ✓ *Random checks of data for completeness, accuracy and that it meets the related standards.*
    - ✓ *Source information reviews to make sure data is valid and reliable.*
  2. The QMC and QM Department will address any issues identified in the system review.
  3. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).
  4. The Quality Department is also responsible for establishing/scheduling outside audits/monitoring reviews of SWMBH internal data systems, validations and accuracy.
- SWMBH is contractually obligated to adhere to all MDHHS sponsored audits/reviews, including; the annual Health Service Advisory Group (HSAG) Performance Measure Validation Audit. (*review of data accuracy, quality and validations*)



# Communication



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

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

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

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

## Types of Information Shared:

- Consumer Satisfaction Survey Results
- RSA-r Survey Results
- Provider Communication Survey Results
- Annual SWMBH Successes and Accomplishments Report
- Audit and Accreditation Results
- Annual Performance Bonus Incentive Program (PBIP) Metric Results/Outcomes
- Board Ends Metric Results
- Critical Incident Results
- 41 • CCBHC Metric Results

# Evaluation

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- ❖ The SWMBH QM department will complete an evaluation of the accomplishments and any potential gaps identified during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation. (*The Evaluation Report will be available for Board review in March 2023*).
- ❖ A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timeliness and interventions) to correct the performance deficiency. The QM department may approve, deny or increase level of scrutiny on Corrective Action Plans; contingent on the level of compliance demonstrated during the monitoring period.

# QAPI 2023 Work Plan Key Performance Metrics

Activities/Programs Covered in 2023 Work Plan Include <i>(18 categories)</i>	
Annual Department and Regional Committee Goals and Objectives	Consumer, Provider Experience Surveys and other annual survey analysis
Oversight of External Audits/Reviews (MDHHS, HSAG, NCQA, ICOs)	MI Health Link and other Business Lines (Quality Withhold Measures and Reporting)
Michigan Mission Based Performance Indicators (MMBPIS)	Customer Grievances and Appeals Tracking and Monitoring
Critical Incident, Sentinel Event and Risk Event Tracking/Reporting	Access to Care Timeliness Tracking/Monitoring -Urgent – Preservice – Routine – Nonurgent – Retro/Postservice
Utilization Management and Customer Services	Certified Community Behavioral Health Clinic Quality Bonus Payment Measures and Reporting
Behavior Treatment Review Data Monitoring	Performance Improvement Projects (PIPs)
2022 Board Ends Metrics and Key Performance Metric Analysis and Reporting	Communication of Data and Outcomes to Internal and External Stakeholders
Verification of Medicaid Services Analysis	Provider Network/Administrative and Delegated Function Site Reviews
Credentialing and Re-Credentialing	Clinical Practice Guidelines

# Questions?

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*Thank you!*



# **Quality Assurance and Performance Improvement Program (QAPIP) FY 2023 Plan**

**All SWMBH Medicaid Business Lines**

**SWMBH Policy 3.1**

**October 1, 2022 - September 30, 2023**

**Reviewed and Approved by:**  
SWMBH Board of Directors on  
SWMBH Quality Management Committee on  
Submitted for MDHHS for Review on

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## ***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 specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, and requirements outlined in the PIHP contract(s), specifically attachment P.6.7.1.1. and schedule 'E' of the PIHP reporting requirements.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the 8 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. SWMBH's Executive Officer (EO) and the Board of Directors grant the authority of the Quality Management (QM) department and the QM Committee. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, SWMBH Strategic Guidance Document, QMC Committee Charter, and other departmental plans.

## ***II. Purpose***

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

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

### **Additional purposes of the QAPIP are to:**

- Continually evaluate and enhance regional quality improvement processes and outcomes.
- Monitor, evaluate, and improve systems and processes for SWMBH.
- Provide oversight and data integrity functions.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, integration of care, and member satisfaction.
- Improve the quality and safety of clinical care and services it provides to members.
- Promote and support best practice operations and systems that promote optimal benefits in service areas of service accessibility, acceptability, value, impact, and risk-management for all members.
- Conduct and report the results of ongoing performance monitoring and structure accountabilities for meeting performance standards and requirements.
- Promote best practice evaluation design and methodology in performance monitoring and outcomes research and push process improvement techniques throughout the system.
- Promote timely identification and resolution of quality-of-care issues.



- Conduct performance monitoring and improvement activities that will result in meeting or exceeding all external performance requirements.
- Meet the needs of internal and external stakeholders and provide performance improvement leadership to other departments.

### ***III. Guiding Principles***

During the November 11, 2022 Board Meeting, the SWMBH Board approved the 2023-2024 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for the development of annual Board Ends Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. (*See Attachment A – Value Framework, Attachment B – 2023 Board Ends Metrics, and Attachment C – SWMBH Board Roster.*)

#### **Mega 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 will result 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 will promote optimal results.
  - Promoting a person-centered philosophy will promote member satisfaction 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 risk.
  - 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.

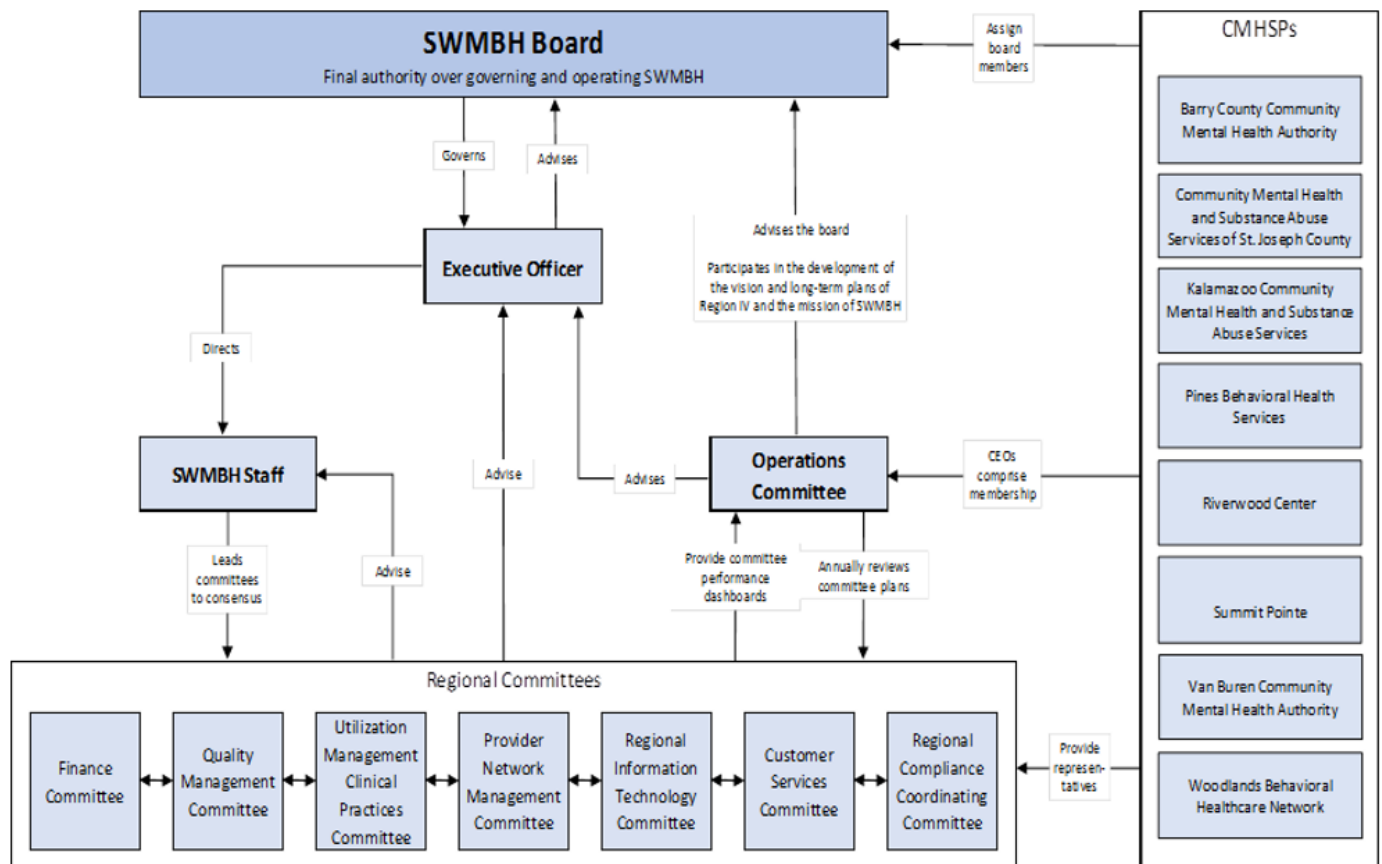
3. Data is valuable when the collection and analysis are done with integrity.
  - Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
  - Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making. Making data accessible will impact value and reduce risk to SWMBH.
  - Providers submitting data to SWMBH shall certify data integrity and have, available for review, the process used to collect the data.

## V. *Authority and Structure*

The SWMBH Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPIP Plan, receives periodic QAPIP reports and updates, and reviews the QAPIP Evaluation.

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 throughout the Region. The SWMBH Operations Committee consists of the CEO, or their designee, for each of the 8 CMHSPs in the region. The program plan outlines the current relationships and structures that exist to promote performance improvement goals and objectives.

### SWMBH Committee Structure



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 information discussed during meetings, or included in meeting minutes, back to the appropriate parties within SWMBH and/or their CMHSP. Members who cannot attend committees/meetings are made aware of process and outcome improvements discussed by meeting minutes that are shared with the full committee after the meeting.

#### **SWMBH QAPI Department**

The general oversight of the development and implementation of the QAPI is given to SWMBH's QAPI Department. The QAPI Department is staffed with a QAPI Director who oversees the QAPI Department, two full time Quality Assurance Specialists, and a Strategic Initiatives Project Manager. (*See Attachment D – SWMBH Organizational Chart for more details.*) The QAPI Department may also utilize an outside contract consultant for special projects as needed. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the Quality Management Committee (QMC), Regional Information Technology (RIT) Committee, Regional Utilization Management (RUM) Committee, and the Regional Clinical Practices (RCP) Committee. (See Attachment E – Organization and Committee Structure.)

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

#### **Adequacy of SWMBH Quality Management Resources**

The QAPI Department works collaboratively with many different functional areas. The following table outlines the positions within the QAPI Department and other departments that have quality related tasks, listed with the percentage of their time that is allocated to quality management (QM) activities.

Position Title	Department	Percent of Time Per Week Devoted to QM
Quality Assurance and Performance Improvement Director	QAPI	100%
Quality Assurance Specialists (2)	QAPI	100%
Strategic Initiatives Project Manager	QAPI	75%
Director of Clinical Quality	CQ	40%
Behavior Health & Integrated Care Manager	CQ	20%
Clinical Quality Specialists (3)	CQ	20%
Clinical Data Analyst	CQ	20%
Manager of Utilization Management and Call Center	UM	20%
Customer Service Manager	UM	20%
Chief Information Officer	IT	20%
Senior Systems Architect	IT	20%
Applications & Systems Analyst	IT	20%
Business Data Analysts (2)	IT	20%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PNM	20%
Chief Compliance Officer & Director of Provider Network Management	Compliance/PNM	15%
Chief Administrative Officer	Operations	15%

CQ = Clinical Quality

UM = Utilization Management

IT = Information Technology

PNM = Provider Network Management

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, 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 QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPI, assesses its outcomes, provides periodic reporting on the program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC).

The QAPI Department works with other functional areas within the organization and external organizations/ vendors such as Streamline Solutions and the Health Service Advisory Group (HSAG) 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 Boards Ends 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 F – PBIP Metrics.)

## **VI. Regional Quality Management Committee**

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 participant communication, alignment, and advice to SWMBH. QMC allows regional and member input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC Program is required of all SWMBH staff, participants, customers, and providers.

CMHSPs are responsible for the development and maintenance of a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC. To assure a responsive system, the needs of those that use or oversee the resources (e.g., active participation of 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 QAPI Departmental staff. All other ad hoc members shall be identified as needed, which may include provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. The QMC will make efforts to maintain member representation, assist with review of reports/data, and provide suggestions for regional process improvement opportunities. All QMC members are required to participate, however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

### **QMC Commitments**

1. Everyone participates.
2. Be passionate about the purpose.
3. All perspectives are professionally expressed and heard.
4. Support Committee and Agency decisions.
5. Members share relevant information with their colleagues.
6. Celebrate success.

### **QMC Roles and Responsibilities**

The QMC will meet regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., QAPIP, QAPIP Evaluation, and PIPs). Committee oversight is defined as reviewing data and approving 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 (see Attachment G – QMC Charter for more details).

### **FY 2023 Quality Management Committee Goals (Measurement Period: Oct 1, 2022 – Sept 30, 2023)**

1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By 6/30/23)
  - Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project.
  - Identify common denominators and classify into strategic categories.
  - Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category).
  - Develop and target interventions to improve identify problem areas.
  - Determine tracking mechanisms and targets goals for each identified area.
  - Share results with Operations Committee and other relevant committees.
  - Identify alternative electronic methods of gathering consumer responses, other than telephonic.
  - Establish and maintain 'new' process to keep the survey open for consumer participation all year, opposed to isolated dates.

- Identify tools/resources, which determine how many surveys have been completed and current scores (real time).
  - Each CMHSP should review their individual survey results and submit to the PIHP, a plan of action for improving identified areas of improvement. This should be well documented within CMHSP internal quality review, or other CMHSP workgroup meeting minutes/notes.
  - Review individual Performance improvement projects for each CMHSP, during the Regional Quality Management Committee meetings.
2. Review current survey tool for the 2023 Consumer Satisfaction Survey Project, to ensure that it meets CCBHC and Best Practice Methodology for Measurement and Analysis (By 3/30/23)
    - Identify NCQA approved consumer satisfaction survey tools, to ensure we are using the best option.
    - Review tools, questions and scoring methodology with relevant regional committees for feedback.
    - Identify survey distribution methods and possible process changes.
    - Communicate project logistics to CMHSP survey point persons and regional committees.
    - Complete analysis of results and distribute to internal and external stakeholders.
    - Evaluate selected tools effectiveness and make modifications, as necessary.
  3. Redesign structure/format of the annual QAPI-UM Plan and Evaluation report. (By 6/30/2023)
    - Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.
    - Utilize the MDHHS suggested template.
    - Identify program weaknesses and strengths for each category evaluated.
    - Identify detailed plans/timeline to remediate identified weaknesses.
    - Ensure all elements/standards/MDHHS recommendations are included in the redesigned report.
  4. Create a flow chart for each quality related MDHHS contractually obligated reporting requirement. (By 12/30/2023)
    - Each chart should provide processes and steps for collecting data, reporting data, timelines, project point persons and additional resources available.
    - Identified areas to include such as MMBPIS, Grievance and Appeals, etc.
  5. Work with the Quality Management Committee and other Regional Committees to improve Health Service Advisory Group (HSAG) External Quality Review (EQR) results and corrective action plans. (By 10/30/2023)
    - Establish a schedule of review for each section not receiving a score of “Met” within the relevant Regional Committees.
    - Identify action plans for improvement and assign functional area leaders.
    - Ensure CMHSP’s and SWMBH are compliant with any standards/elements indicated as ‘*Not Met*’ within the 3-year audit cycle.
    - Ensure that all sections identified during each of the 3-year audit cycle meet compliance at a minimum of 90% or SWMBH is one of the top 2 performing PIHPs in Michigan.

See the 2023-2024 SWMBH Board Ends Metrics for additional Key Performance Metrics assigned to QMC.



## VII. 2023 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 now 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 H 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 2023, its tenth 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. 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 QAPI 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 QAPI Department address any issues identified in the system review.

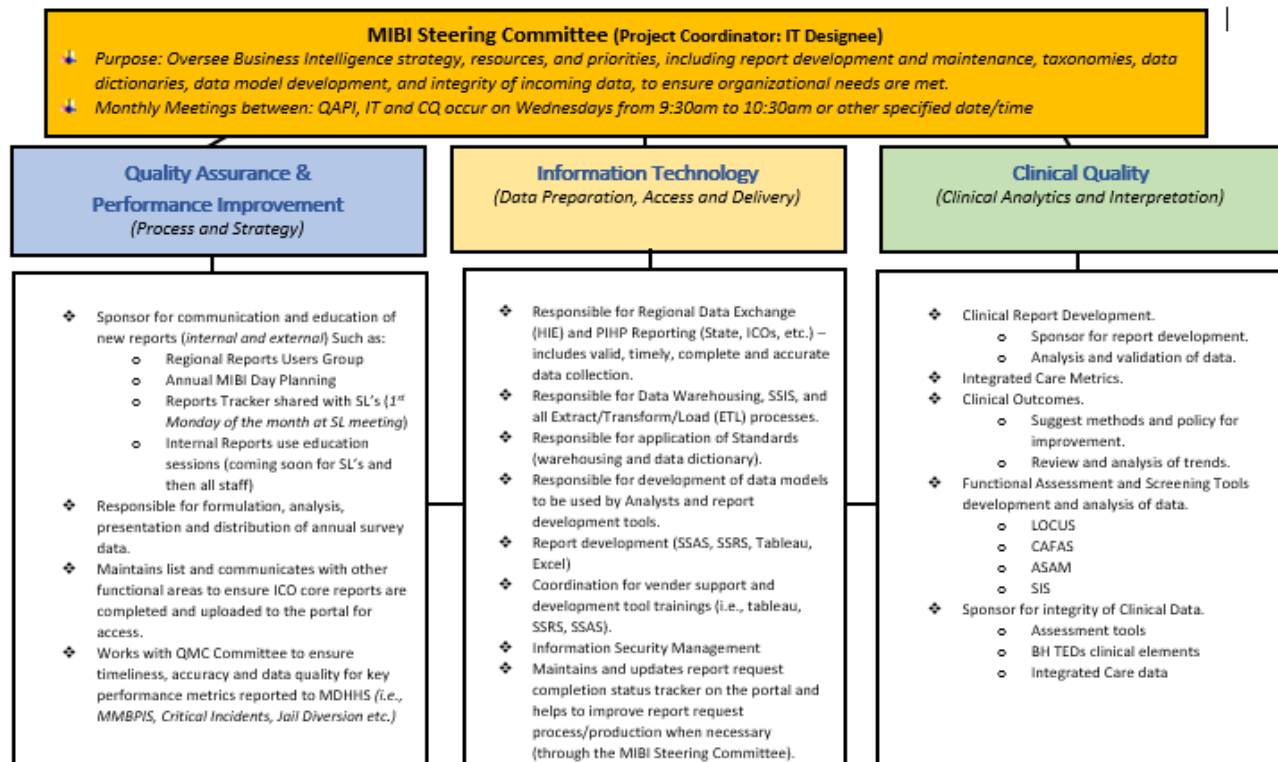


- Ensuring processes are clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Remeasurements happen as often as determined necessary for the identified project(s).
- The Health Service Advisory Group (HSAG) and Michigan Department of 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.

## IX. Managed Information Business Intelligence (MIBI) Steering Committee

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

### SWMBH MANAGED INFORMATION BUSINESS INTELLIGENCE DEPARTMENT ROLES



## X. Communication

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

## XI. 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, contracts 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 2023 Quality Assurance and Performance Improvement Program Descriptions & Work Plan**

## A. Michigan Mission Based Performance Indicator System (MMBPIS)

### **Description**

Access, efficiency, and outcome measures are established by the Michigan Department of Health and Human Services (MDHHS). 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 FTP by the 25<sup>th</sup> 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 according to the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH may request the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). 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 communicate any changes with indicator measurement or reporting to internal and external stakeholders.

Oversight and monitoring will be conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. 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 are out of compliance against the pre-established benchmarks.

### **FY22 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). SWMBH's Board Ends Metrics target that 85% of MMBPIS Indicators will achieve the State-indicated benchmark for four consecutive quarters for FY 2023. An additional target is set for Indicator 3a, b, c, and d to achieve a 3% combined improvement (though FY23, all four quarters) over the 2022 baseline.

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 ( $\geq 95\%$ ).	Quality	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request ( $\geq 95\%$ ).	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).	Quality	QMC	Monthly
Indicator 2b - Percentage of new persons during the quarter 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.	Quality/SUD	QMC, Clinical Quality	Monthly
Indicator 3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).	Quality	QMC	Monthly
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	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 Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

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.

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

The State of Michigan requests that each PIHP select a project topic to address healthcare disparities. This specific topic was selected through an evaluation of SWMBH performance and utilization data, which assessed for the presence of racial and ethnic disparities. The evaluation included racial and ethnic stratifications of: utilization rates of behavioral health services, access to medication-assisted opioid treatment, timely access to behavioral health services (measured by Michigan-specific performance metrics), and CMS Core Set/HEDIS quality metrics (including Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)), Follow Up After Psychiatric Hospitalization (FUH), and Initiation and Engagement of Alcohol and Other Drug Treatment (IET)).

There are currently (3) primary Performance Improvement Projects that SWMBH has targeted for progress in 2023. Those PIPs include:

1. "A decrease in the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates." (HSAG)
2. The percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following:
  - Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.
  - Engagement of AOD Treatment, the percentage of beneficiaries who initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit.
3. SWMBH will select a Performance Improvement Metric related to our Annual Customer Satisfaction Survey Scores in the *'Improved Outcomes'* category for adults and the *'Improved Functioning'* category for Youth. The identified categories have been our 2 lowest scoring categories over the past 5 years.



The details of each of the 3 identified PIPs can be found below:

**FY23-24 PIPs**

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
<b>Performance Improvement Project #1</b> <p>To reduce racial disparities in follow-up after Emergency Department (ED) visits for alcohol and other drug abuse or dependence.</p> <p>Monitoring:</p> <ol style="list-style-type: none"> <li>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.</li> <li>2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.</li> </ol>	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual
<b>Performance Improvement Project #2</b> <p>The percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following:</p> <ol style="list-style-type: none"> <li>1. Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.</li> <li>2. Engagement of AOD Treatment, the percentage of beneficiaries who initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit.</li> <li>3. SWMBH will participate in DHHS planned data validation activities and meetings. SWMBH will be provided IET data files by 1/31/23 and have 120 calendar days to return the completed validation template to DHHS.</li> </ol>	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual
<b>Performance Improvement Project #3</b> <p>SWMBH will select a Performance Improvement Metric related to our Annual Customer Satisfaction Survey Scores in the <i>'Improved Outcomes'</i> category for adults and the <i>'Improved Functioning'</i> category for Youth. The identified categories have been our 2 lowest scoring categories over the past 5 years.</p> <p>The target categories that have been targeted for improvement during the 2023 survey period are:</p> <ol style="list-style-type: none"> <li>1. Access and Timeliness to Care</li> <li>2. Expanding Treatment, Program and Group Therapy options.</li> </ol>	Quality	Regional Quality Management Committee	Bi-Annual

## C. Event Reporting – Critical Incidents

### **Description**

SWMBH's process for identifying, reporting, and following up on incidents and events is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents are defined by MDHHS as suicide, non-suicide deaths, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrests. Hospitalization or EMT due to an injury will be further classified to include whether the injury resulted from physical management. SWMBH is 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 delegates the responsibility of the process for the identification, review, and follow-up of sentinel events, critical incidents, and risk events to its contracted CMHSPs and SUD Providers. All unexpected deaths (UDs) 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 CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been identified and addressed, including the proper identification of a sentinel event and the commencement of a root cause analysis. 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. A random sample is reviewed annually during the CMHSP Delegated Function Site Reviews to ensure each CMHSP is following the process as intended.

SWMBH analyzes critical incidents, sentinel events, and risk events at least quarterly during the regional QMC meetings. The risk events reviewed minimally include 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 (unrelated to a planned surgery or natural course of a chronic illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or events are reviewed and discussed to remediate the problems and prevent similar occurrences of additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes.

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 process for SUD residential treatment providers reporting sentinel events to SWMBH changed as of the new fiscal year on 10/01/2022, with the transition to the new MDHHS reporting process. SUD residential treatment providers that SWMBH contracts with are required to notify SWMBH as sentinel events occur and SWMBH submits the information into the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). The SUD residential treatment providers are also required to prepare and submit a sentinel events data report semiannually to SWMBH that includes the number of sentinel events by event category, and plans of action or interventions, which occurred during the 6-month period. SWMBH aggregates the data and submits it to MDHHS by the designated due dates outlined in the contract requirements.

## FY23 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	Monthly
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	Monthly
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	Monthly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	Quality	QMC	Monthly

## SWMBH Incident and Event Flowchart



## 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 Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Only the techniques permitted by the Technical Requirement for and have been approved during person-centered planning by the member or his/her guardian may be used with members. SWMBH delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of the effectiveness of the Behavior Treatment Review Committee by stakeholders. Each CMHSP is also required to submit their BTRC data to SWMBH on a quarterly basis where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. The data includes the numbers of interventions and length of time the interventions were used per person. 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. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. 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. 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. Additionally, SWMBH evaluates each CMHSP BTRC process annually and participates in at least one BTRC meeting for each CMHSP each year.

### **FY23 Goals**

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The percentage of individuals who have an approved Behavior Treatment Plan, per 1,000 people served, will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The number of behaviors being addressed in a BTP per person will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The percent of emergency interventions (911 calls and physical management) will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly

## E. Member Experience - Customer Satisfaction Surveys

### Description

The QAPI 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, case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY23 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 through the National Council of Quality Assurance (NCQA) as best practice survey tools to gauge member experience of care. During FY23 the SWMBH Quality Department plans to collect consumer survey responses throughout the year, with the goal of achieving 2000 completed surveys. Surveys can be accessed 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.

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, SWMBH Consumer Advisory Committee, SWMBH Clinical Practices Committee, SWMBH Utilization Management Committee, the Regional Operations Committee, Quality Workgroups, and the 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 SWMBH website, newsletters, Annual QAPI Evaluation and other SWMBH annual publications. The results will 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 action steps will be outlined to follow up on the findings.

### FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1000 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 500 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QAPI	QMC Committee	Annually
Achieve a minimum of 350 completed surveys for each CCBHC site, utilizing MDHHS questions, criteria, and results/analysis reporting guidance.	QAPI	QMC and CCBHC Data and Reporting Workgroup	Annually

Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QAPI	QMC, CAC, CPC, and RUM Committees	Bi-Annual
Ensure that CMHSP develops improvement plans, specific to their findings/results/analysis.	QAPI	QMC, CAC, CPC, and RUM Committees	Bi- Annual
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 QAPI 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 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 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 action steps will be outlined to follow up on the findings.

### FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase the number of completed surveys compared to the previous year.	QAPI	QMC, SUD Directors Subgroup	Annually
Improve scores in at least four out of five survey categories from previous year's results.	QAPI	QMC, SUD Directors Subgroup	Annually
Revise the survey to collect SUD service program type to enable further analysis and process improvement of recovery-oriented care.	QAPI	QMC, SUD Directors Subgroup	Annually

## G. Provider Experience – Communication and Access to Services Survey

### **Description**

SWMBH ensures consumers access to behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements. SWMBH directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered.

To ensure SWMBH is meeting the needs/obligations of our delegated providers, SWMBH conducts an annual *"Provider Communications and Access to Services Survey"*. This survey is used to guide planning and performance improvement strategies for practitioner experiences in the following categories:

- Communications Process
- Timeliness of Care (*authorization of Routine, Urgent and Emergency Services*)
- Technical Assistance
- SWMBH Business Processes

The results/data from the annual survey process are reviewed by the Regional Utilization Management Committee, Regional Clinical Practices Committee, and the Regional Quality Management Committees. Goals are created around areas of improvement, noted by the provider/practitioner feedback. Progress on identified goals are reviewed and monitored by the said Regional Committees and compared against the previous year's survey data to identify trends and noted improvements. The following suggestions for improvement were identified during the 2022 survey cycle.

### **FY23 Goals**

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Provide better access to CMHSP reporting obligations and reporting requirements.	QAPI	QMC and RUM Committees	Annually
SWMBH to provide additional information on authorization for services for dually enrolled consumers.	UM and CP	RUM and RCP Committees	Annually
Provide further/clarification on who providers should contact for support or assistance authorizing a service.	UM and CP	RUM and RCP Committees	Annually
Provide more access for case consultation or peer review of complex cases.	UM and CP	RUM and RCP Committees	Annually
Provide a pathway for better communications between Social Workers and Care Coordinators.	UM and CP	RUM and RCP Committees	Annually



## H. 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.

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:

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)?

### **FY23 Goals**

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	Compliance	SWMBH Compliance Committee and SWMBH Regional Compliance Committee	Monthly



## I. Provider Network/Administrative and Delegated Function Site Reviews

### Description

#### **Provider Network Adequacy**

SWMBH completes an 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 during the fiscal year. The report is submitted to MDHHS for review and feedback.

### FY23 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 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

### Description

#### **Site Reviews**

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
- 2<sup>nd</sup> Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review
- Appeals File Review
- MMBPIS and Critical Incident File Review
- 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 Clinical Quality 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.

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

### **Subcontracted Providers**

For non-SUD subcontracted 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.

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).

### **FY23 Goal**

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete site reviews for the region (for Participant CMHSPs, SUD Providers, and 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

## 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 the following components for re-credentialing files:

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

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:

- Individual 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.

**FY23 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

## 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 has adopted these guidelines and assures that information related to the guidelines is made available to members and providers.

It is policy that the employees of SWMBH, Community Mental Health Service Providers (CMHSP), and the provider network must assure that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply 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 Clinical Quality.
- 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. Additionally, 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.

SWMBH's adopted practice guidelines include:

- Inclusion 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, 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 in 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.

Information and outcomes regarding evidence-based practices is reported from the SWMBH Regional Clinical Practices Committee, down to local clinical meetings at the county level. 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. All practice guidelines adopted for use are available on the SWMBH website.

### **FY23 Goals**

<b>Goal</b>	<b>Responsible Department</b>	<b>Where Progress Will Be Monitored</b>	<b>Frequency of Monitoring</b>
The Employment Works! Practice Guideline will be added to the CMH annual site review tool for 2023. It is expected that there is clear documentation that employment has been discussed with all members at least annually. The intended outcome is described in the Michigan Employment First Executive Order No. 2015-15 which "recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability..."	Clinical Quality	Delegated Function Site Review	Annually
Information sharing about Practice Guidelines, and SWMBH's commitment to Practice Guidelines, will be added to the SWMBH Provider Newsletter at least once/year.	Clinical Quality	Provider Newsletter	Annually

## 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). Michigan currently hosts the following HCBS Waivers:

- Children’s Waiver Program
- MI Health Link Waiver
- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
  - 1915(i)- (formerly known as 1915(b)(3))
  - 1115 Behavioral Health Demonstration

Southwest MI Behavioral Health 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:

- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
  - Children’s Waiver Program
- 1915(i)- (formerly known as 1915(b)(3))
  - 1115 Behavioral Health Demonstration

The Centers for Medicare & Medicaid Services (CMS) works closely with MDHHS to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services and assure optimal outcomes, such as independence health and quality of life.

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 new LTSS sections and breakouts of the existing MHSIP and YSS surveys. SWMBH’s QAPI department will incorporate a question to the annual MHISP and YSS surveys 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. In 2023,

we will establish baseline assessments of member experiences and identify areas of dissatisfaction needing improvement.

Furthermore, the CMH site review tool that has been adopted by all 8 CMHSPs in Region 4 includes items monitoring the appropriateness of care of members receiving. For reference, these items in the CMHSP site review tool currently state:

- 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. This should include minimally – making available the primary assessment, treatment plan updates, changes in level of care, med changes etc. to the PCP. Actual contact (phone or in person) with the physician is also counted/encouraged. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate releases for exchange of information must be present if SUD information is shared. There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.
- Clinical analysis and interpretive summary of the customer's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.
- Level of Functioning/Daily Living is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment completed annually and when there is significant change in individual's status.
- The psychosocial assessment clearly identifies the customer's strengths and barriers (may also be addressed in the plan of service).
- Plan 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.
- All needs identified in the assessment are addressed or deferred (including health/safety risks); needs not identified in the assessment are not included in the plan.
- The treatment plan identifies natural supports that will be used to assist the customer in being able to accomplish goals and objectives.
- 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 intervention identified in the IPOS are provided as specified in the Plan - including measurable goals/objectives, the type, amount, scope, duration, frequency, and timeframe for implementing. 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 clinical and quality assurance departments at both the CMHSP and PIHP levels and used to inform annual provider training that is offered to the LTSS provider network on an annual basis by CMHSP-level quality improvement efforts. A future addition will be to develop a regional approach to assess care between settings.



**FY23 Goals**

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Identify method to obtain LTSS status in MHSIP and YSS surveys, add questions related to accessibility in the 2023 surveys, and establish baseline LTSS survey results assessing the quality, availability, and accessibility of care.	Clinical Quality/QAPI	Clinical Quality	Annually
Add the topic of LTSS to at least two regional clinical meeting agendas to educate the Region 4 Network on how the LTSS population is defined, and how it can be better supported according to HSAG guidance.	Clinical Quality	Clinical Quality	Annually
Add information about LTSS to the provider newsletter once/year for the purpose of further educating the Region 4 Network and bring attention to the population.	Clinical Quality	Clinical Quality	Annually
Research and develop a regional approach to assessing care between LTSS settings that expands on current PIHP activities by 12/31/23. It will include a comparison of services and supports received with those set forth in the member's treatment/service plan.	Clinical Quality	Clinical Quality	Annually

## 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 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 specializing in Addictionology meets weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director who holds an unrestricted license is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

### **Determination of Medical Necessity**

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

- Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer.
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.
- 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).
- 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.
- Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential.
- 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**

- 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.
- Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
- The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
- 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.
- Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
- There are mechanisms to evaluate the effects of the program using data on customer satisfaction,

provider satisfaction or other appropriate measures.

- 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 percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
- The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services. F
- The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)
- 4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
- 4b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less

## Level of Intensity of Service Determination Decision

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 of the request. 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 the request. Prior authorization is required. If services are denied/appealed and deemed urgent, an Expedited Appeal is 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 of the request. Prior authorization is required.
Retrospective	Assessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided.	Within 30 calendar days of the 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 the request.

## Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/ Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals.

Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

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

- *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.
- *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).
- *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
- *Utilization Management.* Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

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

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

The Utilization Review (UR) 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, HSAG EQR, 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 focused 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).

### **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.

### **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.

### **Outlier Management Procedures**

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.

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

### **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 of 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.

### **FY23 Goals**

<b>Goal</b>	<b>Responsible Department</b>	<b>Where Progress Will Be Monitored</b>	<b>Frequency of Monitoring</b>
SWMBH will create a Utilization management Plan per MDHHS guidelines.	UM	RUM	Annually
Aggregate and review UM data to identify trends and service improvement recommendations and identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	UM, Clinical Quality, SUD	RUM, QMC	Monthly
Identify the levels of care and subsequent reports to manage utilization and uniform benefit.	UM, Clinical Quality, QAPI	RUM	Monthly
Ensure Inter-rater reliability (IRR) audits are completed by each CMHSP for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. Create IRR training and distribute regionally.	UM	RUM	Annually  Due by 3/31/22
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 Provider Network	RUM	Annually (or Interim, as needed)



Emergent and non-emergent cases will be periodically monitored to ensure compliance with standards.	UM, QAPI, Clinical Quality	RUM	Monthly
Ensure a call center monitoring plan is in place and provide routine quality assurance audits.	UM, QAPI	RUM, QMC	Monthly
Tracking and monitoring of all internal service lines (crisis, emergent, immediate, and routine).	UM, QAPI	RUM, QMC	Quarterly
Collect and analyze quarterly call reports submitted by CMHSPs.	UM, Customer Services, QAPI	RUM, QMC	Quarterly

## 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.

### FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Implement HSAG Corrective Action Plans and Recommendations to ensure contractual and federal requirements are met.	Customer Services	Regional Customer Service Committee	Annually
Update and Improve Advance Directives and Due Process materials/trainings in partnership with Building Better Lives project.	Customer Services	Regional Customer Service Committee	Annually
Review Grievance and Appeal files regionally for analysis of trends related to service utilization.	Customer Services	Regional Customer Service Committee	Semi-Annually

## O. Certified Community Behavioral Health Clinics (CCBHC)

### **Description**

In 2016, MDHHS applied to the Centers for Medicare & Medicaid Services (CMS) to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The two-year period began upon implementation. CMS requires a state to implement the demonstration in at least two sites – one rural and one urban. Moreover, per CMS, only the 14 prospective CCBHC Demonstration Sites named in Michigan’s 2016 application were eligible to participate in the state’s demonstration. These sites include 11 Community Mental Health Services Programs (CMHSPs) and 3 non-profit behavioral health entities, together serving 18 Michigan counties. CCBHC Demonstration Sites are selected in accordance with federal requirements, including the attainment of state based CCBHC certification, and available funding.

June 25, 2022, the Bipartisan Safer Communities Act approved expansion of the CCBHC Demonstration. This act enables Michigan to extend the duration of the demonstration to 6 years, allows current Demonstration agencies to expand with new locations, and additional agencies may be brought on as a part of the demonstration. By July 1, 2024, up to ten additional states may also join the Demonstration, and by 2030, all states will have had the opportunity to join. This Act also Contains a “rule of construction” allowing States to continue to cover items and services in the CCBHC bundle under the authority of the State plan using the PPS rate.

The CMS CCBHC Demonstration requires states and their certified sites to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder diagnosis. Moreover, the demonstration requires and emphasizes 24/7/365 crisis response services (e.g., mobile crisis services). Other critical elements include but are not limited to strong accountability in terms of financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems; and an emphasis on providing services to veterans and active-duty service members. To account for these requirements, the state must create a PPS reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michiganders regardless of insurance or ability to pay.

MDHHS will effectuate the demonstration with prospective CCBHC sites, the relevant Prepaid Inpatient Health Plans (PIHPs), and a multi-disciplinary team-based structure reflective of a collaborative care model. At the end of the demonstration, MDHHS will evaluate the program’s impact and assess the potential to continue or expand the initiative.

SWMBH currently has two participating CCBHCs (Community Mental Health and Substance Abuse Services of St. Joseph County and Integrated Services of Kalamazoo). While other CMHSPs within the region have CCBHC Expansion Grants, SWMBH is not responsible for monitoring these requirements.

### **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 as described below.

### **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. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers.

<b>Metric Name</b>	<b>Benchmark</b>	<b>State or CCBHC Reported Measure</b>
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
<b>Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) **</b>	<b>23.90%</b>	<b>CCBHC</b>
<b>Major Depressive Disorder: Suicide Risk Assessment (SRA-A) **</b>	<b>12.50%</b>	<b>CCBHC</b>
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
<b>Adherence to Antipsychotic Meds with Schizophrenia (SAA-BH) **</b>	<b>58.50%</b>	<b>State</b>
<b>Follow up after Hosp for Mental Illness, ages 21+ (FUH) **</b>	<b>58%</b>	<b>State</b>
<b>Follow up after Hosp for Mental Illness, ages 6-21 (FUH) **</b>	<b>70%</b>	<b>State</b>
Follow-up care for children prescribed ADHD meds (ADD)	n/a	State
Antidepressant Medication Management (AMM-BHH)	n/a	State
<b>Initiation and Engagement of Alcohol and other Drug Treatment (IET-BH) **</b>	<b>14 day- 42.5%; 34 day- 18.5%</b>	<b>State</b>

\*\*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. The QBP is based on 5% of the total CCBHC Medicaid Demonstration Year Costs. QBP for Demonstration Year 2 will also be calculated at 5% of total CCBHC Medicaid Demonstration Year Costs but will be based on DY2 Benchmarks (to be defined).

### **Reporting Requirements**

CCBHC-reported measures will be compiled by the CCBHC using the SAMHSA 2016 Data Reporting Template (XLSX file). CCBHCs are responsible for completing the “Case Load Characteristics” sheet and the reporting sheets for the clinic-reported measures (green colored tabs).

During DY2, CCBHCs should complete their 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 DY2 for purposes of monitoring and evaluation planning.

### **FY23 Goals**

<b>Goal</b>	<b>Responsible Department/Person</b>	<b>Where Progress Will Be Monitored</b>	<b>Frequency of Monitoring</b>
Track QBP measures and CCBHC-Reported Measures at least quarterly. Report to all CCBHC subgroups.	QAPI, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly, and as needed

Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBP measures.	QAPI, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
Establish and document the criteria that will be used to validate the measures routinely submitted to MDHHS and update process as needed.	QAPI, CCBHC Coordinator	CCBHC Subgroup Meetings	Due by 1/31/23, and as needed
PIHPS will collect, validate clinic-reported data templates and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	QAPI, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly by 1/31/23, 4/30/23, 7/31/23, 10/31/23  Annually by 3/31/2023 (DY1) 3/31/2024 (DY2)
Document and track stages of readiness for mandatory CCBHC Evidence Based Practices (EBP). Additional documentation of how and why CCBHCs self-scored to get a regional operational definition.	Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly and by 06/2023 for documentation
Respond to all financial requests to MDHHS related to CCBHC Finance by stated deadlines (agenda, forms, handbook versions) and following all conversations and communications with MDHHS, report back to workgroup at the next scheduled meeting.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Document year-end financial reporting, reconciliation, and cost settlement processes as soon as able to ensure 2023 processes are efficient and in compliance with MDHHS expectations.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
Maintain current frequency of subgroup meetings to continue close collaboration with current CCBHC sites.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Develop written guidelines and process maps to support new regional CCBHC sites.	QAPI, Clinical Quality, Finance, CCBHC Coordinator	All CCBHC Subgroup Meetings	Due 06/2023

## P. External Monitoring and Audits

### Description

The SWMBH Quality Department will coordinate the reviews by external audit vendors/entities including Michigan Department of Health and Human Services (MDHHS), Health Service Advisory Group (HSAG), and all other requests for audits, as necessary. The Quality Department will review all requests/documents/tools and other resources and communicate to the appropriate SWMBH functional area leaders. The Quality Department will work to ensure that SWMBH achieves established Board Ends Metric and Strategic Initiative benchmarks/targets. Results of SWMBH external audits will be presented to the Board of Directors. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPI Priorities and Evaluation Report for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be made available to MDHHS upon request.

### FY23 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will demonstrate an improvement in overall compliance scores (90% or top 2 scoring PIHP's) during the 2023 HSAG External Quality Review (EQR).	QAPI	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate a minimum of (90% compliance score) on the annual HSAG Performance Measure Validation Review (PMV).	QAPI	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate an improvement in compliance and number of Corrective Action Plans during the annual MDHHS 1915 (SEDW, CWP, HSW, HCBS, Autism) review.	QAPI/Clinical Quality	QMC, CPC and other Regional Committees as necessary	Annually
SWMBH will demonstrate Full Compliance with MDHHS Substance Use Disorder Administrative Protocols/Review.	QAPI/SUD	QMC, SUD workgroup and Board	Annually
SWMBH will demonstrate Full Compliance with the MDHHS 1915c Administrative Protocols/Review.	QAPI Lead with other SWMBH Functional Areas to Assist	QMC, SWMBH Senior Leadership	Annually
SWMBH will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy Standards.	Provider Network	Regional Provider Network/Compliance Committee, Regional Utilization Management Committee	Annually

## Q. Cultural Competency

### Description

SWMBH and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competency that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services. Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment, and economic factors, etc. SWMBH has outlined many of these initiatives within the 2023-2024 Strategic Plan and provided detail on each strategy within our 2023 Cultural Competency Plan. SWMBH also outlines strategies and business Practices within the Cultural and Linguistic Competency Policy 3.7.

### FY23 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Implement an annual staff/provider Cultural Accelerator survey to gauge organizational level of internal and external Cultural Competence.	SWMBH Operations	SWMBH Senior Leadership Meetings and Staff Meetings	Annually
Perform and utilize analysis on feedback received from consumers during annual Consumer Satisfaction and Recovery Services Surveys.	QAPI	QMC, RUM and RCP Committees	Annually
Promote continued Education throughout the organization and community by participating in or contributing to local organizations and public events.	Customer Services	Customer Services, Provider Network and Clinical Practices Committees	Annually
Complete an annual Network Adequacy analysis, which will identify deficiencies and interventions for providers' cultural competence as well as how the region collects and tracks languages spoken within the provider network.	Provider Network	Customer Services, Provider Network and Clinical Practices Committees	Annually
The Network Adequacy Plan, survey results and cultural competency plan will be shared with the SWMBH Board of Directors.	Provider Network and QAPI	SWMBH Operations Committee and Board of Directors	Annually
Confirm during CMHSP annual site reviews, that each CMHSP has an active and current Cultural Competency Plan in place. Plans should include goals and targeted initiatives for the current year.	QAPI	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 – BOARD ENDS METRICS

Metric	Description	Deliverable/Goal	Date Range & Current Status
<b>Strategic Imperative Category: Quality of Life</b> 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.			
<b>Metrics 1-5 are from the 2023 Performance Bonus Incentive Program</b>			
1. Achieve 95% of Veteran’s Metric Performance -Based Incentive Program monetary award based on FY23 MDHHS specifications. (25 pts. via MDHHS Contract)  *1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023.  SWMBH Metric Owner: Sarah Ameter and Natalie Spivak	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.1. PA 107 sec 105d) Identification of beneficiaries who may be eligible for services through the Veteran’s Administration.	a. Timely submission of Veteran Services Navigator collection form by the last day of the month following the end of each quarter. b. Submit BH TEDs data quality monitoring narrative report by 1/1/2023. c. Submit VSN – BH TEDs comparison narrative report by 7/1/2023.	Pending  Reporting Period 10/1/22 – 9/30/23  Metric Board Report Date: October 13, 2023
Metric	Description	Deliverable/Goal	Date Range & Current Status
2. Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications.  *1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023.  SWMBH Metric Owner: Natalie Spivak	This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.2. PA 107 sec 105d) Sending ADT messages for purposes of care coordination through health information exchange.	SWMBH will submit to MDHHS a narrative report by 7/31/2023, listing CMHSP’s sending ADT messages, and barriers for those who are not, along with remediation efforts and plans. In the event that MIHIN cannot accept or process contractor’s ADT submissions this will not constitute failure on Contractor’s part.	Pending  Reporting Period 10/1/22 – 9/30/23  Metric Board Report Date: October 13, 2023

Metric	Description	Deliverable/Goal	Date Range & Current Status
<p>3. SWMBH will achieve the FY23 Initiation and Engagement State Specified benchmarks and participate in DHHS led data validation activities.</p> <p>SWMBH Metric Owner: Joel Smith Supporting SLs: Jonathan Gardner Alena Lacey</p>	<p>This metric is listed under section P.3. PA 107 sec 105d in the 2023 MDHHS PBIP specification table. This metric is also utilized for the 2023 PBIP, CCBHCC and OHH bonus incentive programs. 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 <b>14 calendar</b> 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 <b>34 calendar days</b> of the initiation visit.</p>	<p>a. The PIHP must participate in DHHS-planned and DHHS-provided data validation activities and meetings. PIHPs will be provided IET data files by January 31 each year, and within 120 calendar days, return their data validation template, completed, to DHHS. 1 point</p> <p>b. CCBHC Goal – Participating CCBHC sites achieve IET- 14-day metric at 42.5% and the IET-34-day metric at 18.5% per state indicated benchmarks. ½ point each</p>	<p>Pending</p> <p>Data Collection Period 10/1/22 – 9/30/23</p> <p>Metric Board Report Date: November 10, 2023</p>
Metric	Description	Deliverable/Goal	Date Range & Current Status
<p>4. SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2023, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to Patient-Centered Care activities and programs throughout the PIHP region.</p> <p>*1 point will be awarded for successful completion. Confirmation via MDHHS official PBIP report received in December 2023.</p> <p>SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Alena Lacey</p>	<p>This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (P.4. PA 107 sec 105d) 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.</p>	<p>The Contractor must submit a narrative report of no more than 10 pages by November 15, 2023 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:</p> <ol style="list-style-type: none"> <li>1. Comprehensive Care</li> <li>2. Patient-Centered</li> <li>3. Coordinated Care</li> <li>4. Accessible Services</li> <li>5. Quality &amp; Safety</li> </ol>	<p>Pending</p> <p>Reporting Period 10/1/22 – 9/30/23</p> <p>Metric Board Report Date: February 9, 2024</p>

Metric	Description	Deliverable/Goal	Date Range & Current Status
<p>5. Achieve Compliance (based on MDHHS specified benchmarks) on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) for beneficiaries six year of age and older and show a reduction in disparity with one minority group.</p> <p>SWMBH Metric Owner: Alena Lacey</p>	<p>This metric is in direct alignment with the 2023 Performance Bonus Incentive Program (PBIP) (J.2. PA 107 sec 105d) The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.</p>	<p>a. Plans will meet set standard for follow-up within 30 days for each rate (ages 6-17) and (18 and older). Plans will be measured against the adult minimum standard of 58% and child minimum standard of 70%. The measurement period will be calendar year 2023.</p> <p>b. Data will be stratified by race/ethnicity by MDHHS and delivered to PIHP's. PIHP's will be incentivized to reduce a disparity between the index population and at least one minority group. The measurement will be a comparison of calendar year 2021 with calendar year 2022.</p>	<p>Pending</p> <p>Data Collection Period 1/1/23 – 12/31/23</p> <p>Metric Board Report Date: February 9, 2024</p>
<p><b>Strategic Imperative Category: Exceptional/Access to Care</b> Persons and families served are highly satisfied with the services they receive.</p>			
<p>6. 2023 Customer Satisfaction Surveys collected by SWMBH are at or above the 2022 results identified in (a &amp; b) and performance improvement areas/plans are identified.</p> <p>SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Sarah Ameter, Anne Wickham, and Mila Todd</p>	<p>This metric is in direct alignment with <i>Section V</i> of the 2023 MDHHS-PIHP contract '<i>Member Experience with Services</i>'</p> <p>a. The survey methodology must include a quantitative assessment (e.g., surveys) of member experience with services.</p> <p>b. The methodology must include a qualitative assessment (e.g., focus groups) of member experience with services.</p>	<p>a. Mental Health Statistic Improvement Project Survey (MHSIP) tool. (<i>Improved Functioning</i> – baseline: 84.1%) 1 point.</p> <p>b. Youth Satisfaction Survey (YSS) tools. (<i>Improved Outcomes</i> – baseline 81.3%) 1 point.</p> <p>c. Complete a series of Consumer oriented focus groups and work with the Consumer Advisory Committee to document, understand and act upon potential improvement efforts that impact overall Consumer Satisfaction. 1 point.</p>	<p>Pending</p> <p>Survey Collection Period 10/1/23 – 12/30/23</p> <p>Metric Board Report Date: February 9, 2024</p>

		d. Ensure that each CMHSP partner reviews site specific survey results and formulates Corrective Action Plans to drive identified or potential improvement areas.	
Metric	Description	Deliverable/Goal	Date Range & Current Status
<p>7. Michigan Mission Based Performance Indicator System (MMBPIS) Data, Tracking and Analysis</p> <p>SWMBH Metric Owner: Jonathan Gardner Supporting SLs: Joel Smith and Alena Lacey</p>	<p>As directed by the 2023 MDHHS-PIHP contract <i>Section I 'Performance Indicators'</i>. The PIHP must include performance measures established by MDHHS in the areas of access, efficiency and outcomes. The PIHP must track and perform analysis to ensure each performance indicator is meeting the minimum performance benchmark/standard. Currently (7) Indicators have targeted benchmarks.</p>	<p>a. 24/28 indicators meet the State Benchmark, throughout all FY23 for 4 consecutive quarters 1 point.</p> <p>b. Indicator 3a,b,c &amp; d achieve a 3% combined improvement (<i>through FY 23 all 4 Quarters</i>) over 2022 baseline (1/2 pt. each) 2 points.</p>	<p>Pending</p> <p>Data Collection Period 10/1/22 – 9/30/23</p> <p>Metric Board Report Date: February 9, 2024</p>
<p>8. 2023 CCBHC Program Customer Satisfaction Surveys collected by SWMBH represent an 85% First Year “<i>in agreement</i>” Satisfaction rate average across all categories measured.</p> <p>SWMBH Metric Owner: Jonathan Gardner and Ella Philander</p>	<p>Per the 2022 CCBHC codebook section 13.B.2 and 13.B.3; the PIHP is responsible for evaluation and overall member satisfaction of the CCBHC program. The survey and assessment should consider availability and accessibility to services for eligible consumers, not just those being served. Focus groups, satisfaction surveys or advisory councils should be reviewed to determine appropriateness of service site locations.</p>	<p>a. SWMBH will administer an annual CCBHC consumer satisfaction survey, collecting responses from CCBHC participants using a hybrid MHSIP and YSS survey tool approved by MDHHS. ½ point</p> <p>b. SWMBH will complete analysis and reports for MDHHS and CCBHC locations, delivering results and identified areas/opportunities for improvement by June 2023. ½ point</p>	<p>Pending</p> <p>Data Collection Period 10/1/22 – 3/30/23</p> <p>Metric Board Report Date: July 14, 2023</p>

### Strategic Imperative Category: Quality and Efficiency

The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

Metric	Description	Deliverable/Goal	Date Range & Current Status
<p>9. 2023 Health Service Advisory Group (HSAG) External Quality Compliance Review (EQR) Results and Improvement Strategies</p> <p>SWMBH Metric Owner: All SLs with contributors dependent on Standards selected for review</p>	<p>As directed by the 2023 MDHHS PIHP contract Attachment P 7.7.1.1 – Amendment 1 – Medicaid Managed Specialty Supports Services/Programs, the PIHP must adhere to annual audits of the following categories: Member Rights, Emergency Services, Availability of Services, Assurances and Capacity of Services, Coordination of Care, Provider Selection, Confidentiality, Grievance and Appeals System, Sub contractual Delegation, Practice Guidelines, Health Information Systems and Quality Assessment and Performance Improvement Programs.</p>	<p>a. All standards or corrective action plans reviewed, will receive a score of 90% compliance, or designation that the standard has been “Met” or “Accepted” or SWMBH will be within the <i>top 2</i> scoring Michigan PIHP’s.</p> <p>1 Point.</p>	<p>Pending</p> <p>Data Collection Period 10/1/22 – 9/30/23</p> <p>Metric Board Report Date: November 10, 2023</p>
<p>10. 2023 HSAG Performance Measure Validation (PMV) Audit Results and Improvement Strategies</p> <p>SWMBH Metric Owner: Natalie Spivak SL Contributors: Jonathan G and other contributors dependent on Standards selected for review during specified Fiscal Year</p>	<p>As directed by the 2023 MDHHS PIHP contract Attachment P 7.7.1.1 – Amendment 1 – Medicaid Managed Specialty Supports Services/Programs, the PIHP must adhere to annual audits of the following categories: Data Integration, Data Control, Data Accuracy and Performance Indicator Validation.</p>	<p>a. All standards or corrective action plans reviewed, will receive a score of 90% compliance, or designation that the standard has been “Met” or “Accepted” or SWMBH will be within the <i>top 2</i> scoring Michigan PIHP’s</p> <p>1 Point.</p>	<p>Pending</p> <p>Data Collection Period 1/1/23 – 6/30/23</p> <p>Metric Board Report Date: November 10, 2023</p>

<b>Strategic Imperative Category: Improved Health</b> Individual mental health, physical health and functionality are measured and improved			
<b>Metric</b>	<b>Description</b>	<b>Deliverable/Goal</b>	<b>Date Range &amp; Current Status</b>
11. SWMBH will achieve CCBHC Demonstration Year 1 Quality Bonus Payment Metrics (QBP's), against the States FY23 indicated Benchmarks.  SWMBH Metric Owner: Ella Philander and Jonathan Gardner CMHSP Contributions/Owners: Kalamazoo and St. Joseph	As directed by the 2023 CCBHC Handbook under Table 1.A.1 – QBP Metrics and Benchmarks. The Regional PIHP will work with CMSHP-CCBHC participant programs to define processes and strategies for collection and reporting data. The PIHP will be the primary liaison for the submission of all required reports and follow-ups as directed by MDHHS. SWMBH will submit reports based on the identified metrics to MDHHS within 6 months of <i>DY 1</i> or by 3/31/2023.	1. Child and Adolescent Major Depressive Disorder; Suicide Risk Assessment ( <i>SRA-BHC</i> - 23.9%) ½ pt. 2. Major Depressive Disorder, Suicide Risk Assessment ( <i>SRA-A</i> - 12.5%) ½ pt. 3. Adherence to Antipsychotic Meds for Individuals with Schizophrenia ( <i>SAA-AD</i> – 58.5%) ½ pt. 4. Follow-up after Hosp. for mental illness, ages 18+ ( <i>FUH-AD</i> – 58%) ½ pt. 5. Follow-up after Hospitalization for Children ( <i>FUH-CH</i> – 70%) ½ pt. 6. initiation and Engagement of Alcohol and other drugs ( <i>IET-14</i> – 42.5% & <i>IET-34</i> - 18.5%) ½ pt.	Pending  *.5 bonus point for each metric (1-6) successfully achieved.  Data Collection Period 10/1/22 – 3/30/24  Metric Board Report Date: November 10, 2023
12. SWMBH will retain 60% of (OHH) enrollees, enrolled after 9/30/22. Program Enrollees must maintain 'enrolled' status for at least 6 months.  SWMBH Metric Owner: Joel Smith	The retention metric is defined within the OHH handbook for Performance Year 2 goals (10/1/22 through 9/30/23). Further guidance on the metric can be found by clicking on the resource below. <a href="http://www.michigan.gov/OHH">www.michigan.gov/OHH</a> .	a. 334 Enrollees in the OHH Program as of 9/30/22. b. OHH retention Metric: 60% of enrollees enrolled after 9/30/22 will remain in "enrolled" status for at least 6 months. ( <i>200 enrolled members by March 31, 2023</i> ) 1 point	Pending  Data Collection Period 10/1/22 – 3/31/23  Metric Board Report Date: May 12, 2023
13. SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY23.  SWMBH Metric Owner: Natalie Spivak	As directed by the 2023 MDHHS-SWMBH contract, performance metrics table, SWMBH shall maintain a 95% compliance rate within the applicable Mental Health, Substance Use Disorder and Crisis BH TEDs fields. Each element (MH, SUD and Crisis) must have a matching and accepted BH TEDs record, as confirmed by the MDHHS quarterly status report.	a. 97% of applicable MH served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. 1 point b. 97% of applicable SUD served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. 1 point	Pending  Data Collection Period 1/1/23 – 12/31/23  Metric Board Report Date: January 12, 2024

		c. 97% of applicable Crisis served clients (with accepted encounter) will have a matching BH TEDS record, as confirmed by MDHHS quarterly status report. 1 point	
<b>Strategic Imperative Category: Mission and Value Driven</b> CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.			
Metric	Description	Deliverable/Goal	Date Range & Current Status
14. SWMBH will meet or exceed FY23 contractual Critical Incident Reporting timeliness and efficiency benchmarks utilizing the new DHHS Customer Management System (CRM)  SWMBH Metric Owner: Jonathan Gardner SL Contributors: Alena Lacey and SWMBH Chiefs	As of 10/1/2022, DHHS is requiring PIHP's to report through its new CRM system. The PIHP must meet the timeliness reporting standards to DHHS of: Immediate Events – 48 hours after becoming aware of the incident, Sentinel Events and Critical Incidents – 30 days after the end of the month in which the event occurred. The new CRM system requires that the PIHP provides timely updates as requested/assigned by DHHS.	a. SWMBH will submit all required incidents, meeting the identified benchmarks for Immediate, Sentinel and Critical Events. Final status will be provided through DHHS annual review results. 1 point  b. SWMBH will provide annual CI site review audits on CMHSP's to ensure; timely reporting of Critical Incidents, appropriate documentation, involving the appropriate personnel, and using the information to address quality of care at their sites. 1/2 Point  c. SWMBH will convene the internal Immediate/Sentinel Event review task force, as needed; to ensure root cause analysis and other required elements were in compliance with contractual policy standards.	Pending  Data Collection Period 10/1/22 – 9/30/23  Metric Board Report Date: November 10, 2023

Metric	Description	Deliverable/Goal	Date Range & Current Status
15. SWMBH will meet or exceed MDHHS FY23 Autism Benefit Waiver Access to Care and Timeliness Standards  SWMBH Metric Owner: Alena Lacey	SWMBH and MDHHS have placed emphasis on the underserved Autism population during 2023 and providing increased access and timeliness of services for those who have been waiting longer than 90 days for IPOS development and over 48 hours from referral to first scheduled appointment. The following metrics are State sponsored and targeted towards improving access and timeliness of service for consumers with an autism diagnosis.	a. Targeting Underserved Population: 30% improvement completing IPOS for consumers with Autism diagnosis who do not currently have an active IPOS in managed care system, or valid reason for inactivity listed in their record . <i>(baseline 125 – 37 completed IPOS by 9.30.23).</i> ½ point b. Decrease rate of overdue (over 90 days) autism ‘re-evaluations’ within the SWMBH region by 10% by (9.30.23). Current rate of overdue evaluations is 20% d. (86/859)=10%. ½ point	Pending  Data Collection Period 10/1/22 – 9/30/23  Metric Board Report Date: November 10, 2023

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

Pending: could represent that;

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

Not Met: could represent that;

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

Achieved:

- Evidence/proof exists that the Metric has been successfully completed.
- The Metric has been presented and approved by the SWMBH Board.



## ATTACHMENT C – SWMBH BOARD ROSTER



### 2023 Board Member Roster

#### Barry County

- Ruth Perino
- Robert Becker (Alternate)

#### Berrien County

- Edward Meny - Chair
- Nancy Johnson (Alternate)

#### Branch County

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

#### Calhoun County

- Sherii Sherban
- Kathy-Sue Vette (Alternate)

#### Cass County

- Louie Csokasy
- Jeanne Jourdan (Alternate)

#### Kalamazoo County

- Erik Krogh
- Karen Longanecker (Alternate)

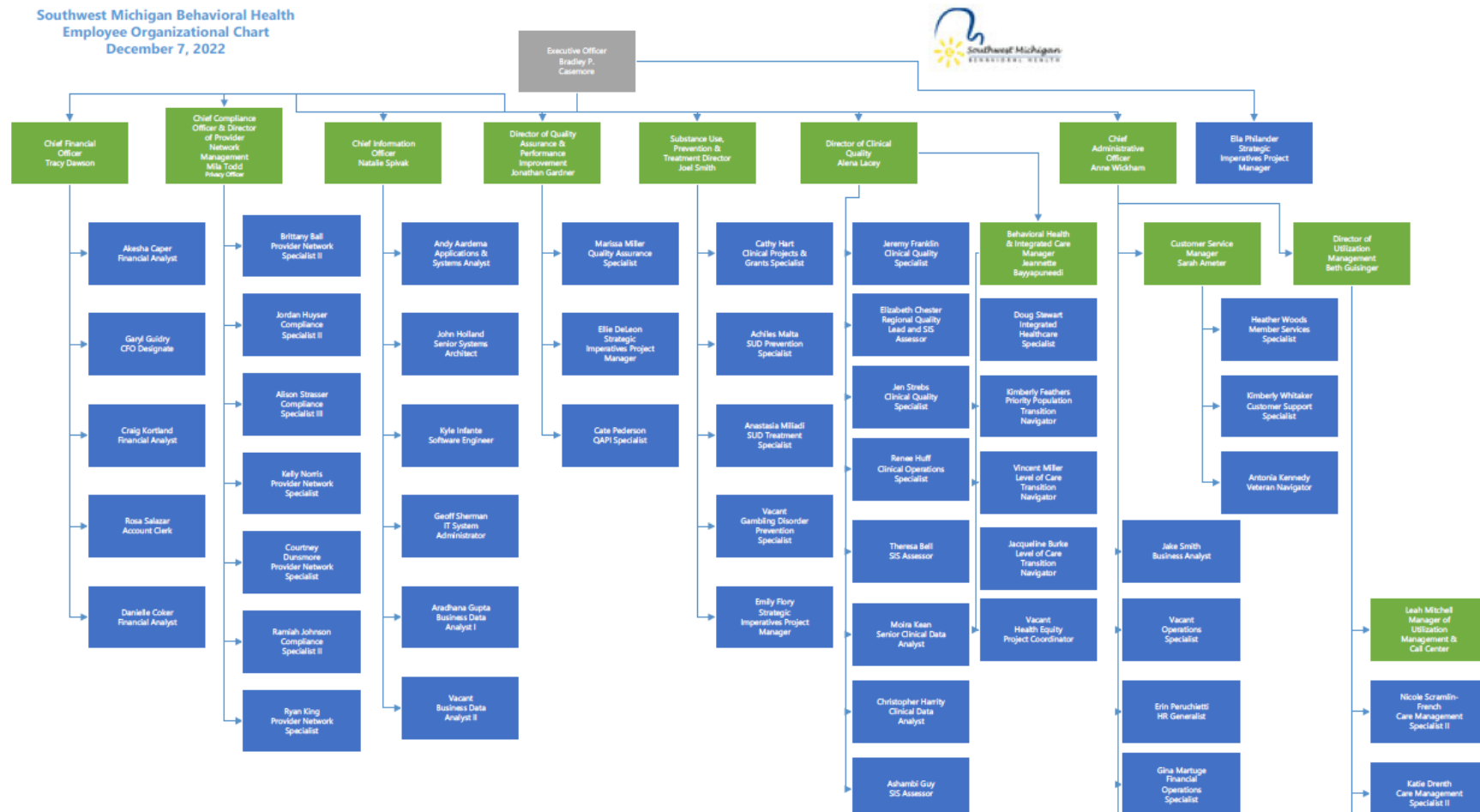
#### St. Joseph County

- Carole Naccarato
- Cathi Abbs (Alternate)

#### Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

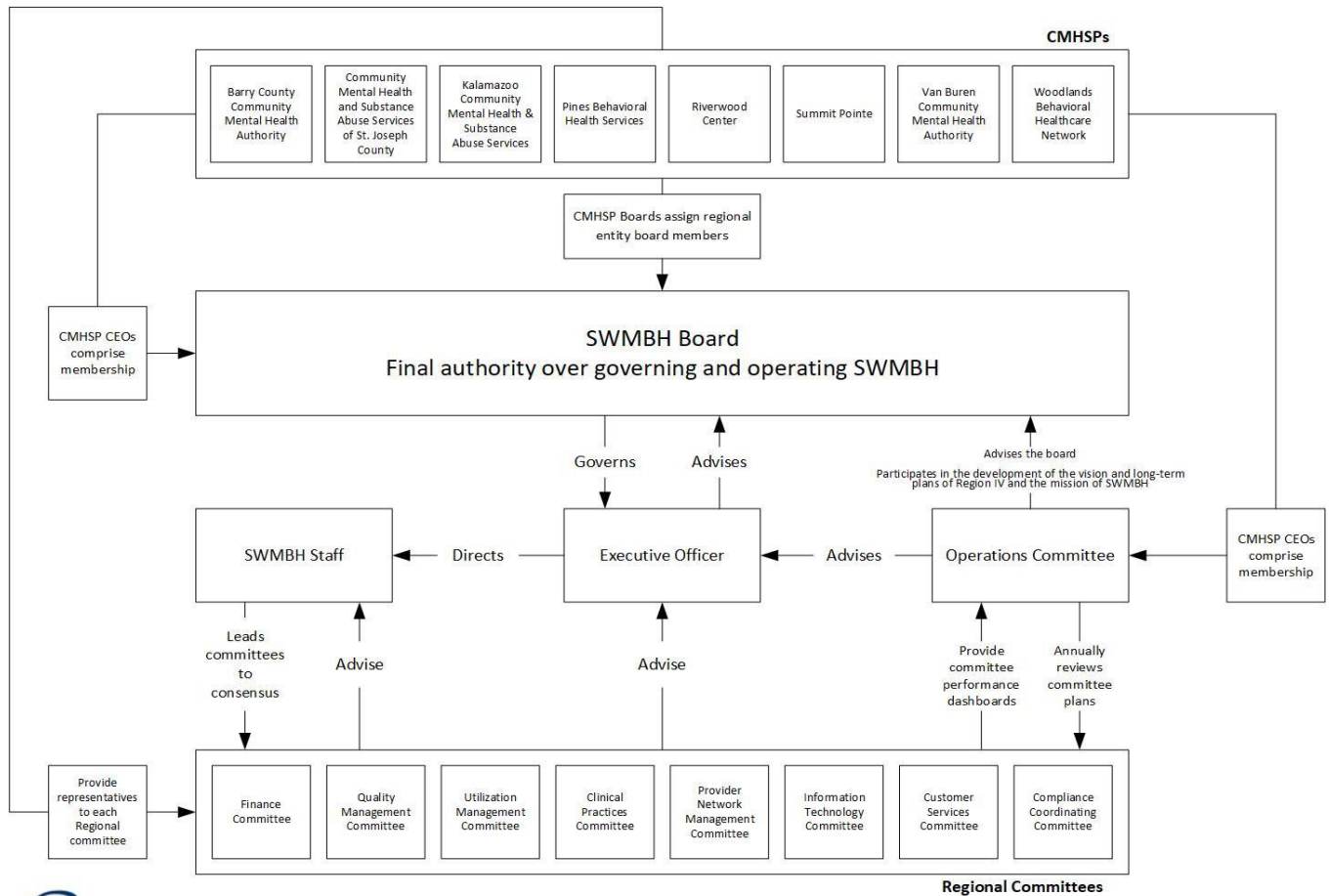
## ATTACHMENT D – SWMBH ORGANIZATIONAL CHART



(Continued on next page)



## ATTACHMENT E – SWMBH ORGANIZATIONAL AND COMMITTEE STRUCTURE



SWMB Organizational and Committee Structure

## ATTACHMENT F – 2023 Performance Bonus Incentive Program (PBIP) METRICS

### (30% of Total Withhold)

Category	Description	Deliverables	Responsibility
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Payor 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.	Payor
J.2. Follow Up after Hospitalization (FUH) for Mental Illness within 30 days using HEDIS descriptions. (40 points)	The percentage of discharges for members 6 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.	<p>Adult (ages 18 and older) minimum standard: 58%</p> <p>Child (ages 6-17) minimum standard: 70%</p> <p>Measurement Period: Calendar Year 2022 <b>(20 points)</b></p> <p>Data will be stratified by race/ethnicity and provided to plans. The Payor will be incentivized to reduce the disparity between the index population and at least one minority group.</p> <p>Measurement Period: Comparison of Calendar Year 2021 with Calendar Year 2022 <b>(20 points)</b></p>	Provider and Payor
J.3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence using HEDIS descriptions. (25 points)	Beneficiaries 13 years of age and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	<p>Data will be stratified by the State by race/ethnicity and provided to plans. The Payor will be incentivized to reduce the disparity between the index population and at least one minority group.</p> <p>Measurement Period: Comparison of Calendar Year 2021 with Calendar Year 2022</p>	Payor

### (45% of total Withhold)

Measure	Description	Deliverables	Responsibility
P.1. PA 107 of 2013 Sec. 105d(18): Identification of enrollees who may be eligible for services through the Veteran's Administration (25 points)	<p>1) Improve and maintain data quality on BH-TEDS military and veteran fields.</p> <p>2) Monitor and analyze data discrepancies between VSN and BH-TEDS data.</p>	<p>Due in January 2023:</p> <ol style="list-style-type: none"> <li>1) Resubmission of October 1 through March 31 of FY2022 comparison of the total number of individual veterans reported on BH-TEDS and the VSN form.</li> <li>2) Submission of April 1 through September 30 of FY2022 comparison of the total number of individual veterans reported on BH-TEDS and the VSN form.</li> </ol> <p>The Payor must compare the total number of individual veterans reported on BH-TEDS and the VSN between October 1 through March 31 of FY2023 and conduct a comparison. By July 1, the Payor must submit a 1-2 page narrative report on findings and</p>	Payor

		any actions taken to improve data quality. Timely submission constitutes metric achievement.	
P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers. (25 points)	Send ADT messages for purposes of care coordination through health information exchange.	Two or more CMHSPs within Payor's service area, or the Payor and one CMHSP, will be submitting Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY22. By July 31, 2023, Payor must submit to the State, a report no longer than 2 pages listing CMHSPs sending ADT messages, and barriers for those who are not, along with remediation efforts and plans. In the event that MiHIN cannot accept or process Payor's ADT submissions this will not constitute a failure on Payor's part.	Payor
P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence using HEDIS descriptions. (50 points)	<p>The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:</p> <ul style="list-style-type: none"> <li>- Initiation of AOD Treatment: The percentage of enrollees who initiate treatment within 14 calendar days of the diagnosis.</li> <li>- Engagement of AOD Treatment: The percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit.</li> </ul> <p>Points awarded based on PIHP participation in data validation activities and meetings.</p>	<p>Payor must participate in MDHHS-planned and MDHHS-approved data validation activities and meetings. PIHPs will be provide IET data files by January 31 each year, and within 120 calendar days, return their data validation template, completed, to MDHHS.</p> <p>Points are awarded based on Payor participation.</p>	Payor

**(25% of Total Withhold)**

Measure	Description	Deliverables	Responsibility
P.4. PA 107 of 2013 Sec 105d (18): Increased participation in patient-centered medical homes	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). The State will provide consultation draft review response to the Payor by January 15 <sup>th</sup> . The Payor will have until January 31 <sup>st</sup> to reply to the State with information.	<p>Submit a narrative report of no more than 10 pages by November 15<sup>th</sup> summarizing prior FY efforts, activities, and achievements to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is as follows:</p> <ol style="list-style-type: none"> <li>1. Comprehensive Care</li> <li>2. Patient-centered</li> <li>3. Coordinated Care</li> <li>4. Accessible Services</li> <li>5. Quality &amp; Safety</li> </ol>	Payor and Provider

## ATTACHMENT G – QUALITY MANAGEMENT COMMITTEE (QMC) CHARTER

# Quality Management Committee Charter



☒ SWMBH Committee Quality Management Committee (QMC) ☐ SWMBH Workgroup: \_\_\_\_\_

Duration: ☒ On-Going ☐ Deliverable Specific

Date Approved: 5/1/14

Last Date Reviewed: 1/28/22

Next Scheduled Review Date: 1/26/23

<b>Purpose</b>	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
<b>Accountability</b>	<p>The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH.</p> <p>The committee is to provide their expertise as subject matter experts.</p>
<b>Committee Purpose</b>	<ul style="list-style-type: none"> <li>▪ The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.</li> <li>▪ The QMC will implement the QAPI Program developed for the fiscal year.</li> <li>▪ The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.</li> <li>▪ The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.</li> <li>▪ The QMC will review annual survey processes, results and make recommendations for Regional Performance Improvement efforts.</li> <li>▪ The QMC will review and provide feedback related to policy and tool development.</li> </ul>

	<ul style="list-style-type: none"> <li>▪ The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan</li> <li>▪ The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.</li> <li>▪ Work with the other Regional Committee's to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.</li> </ul>
<b>Relationship to Other Committees</b>	<p>As needed, there will be planning and coordination with the other Operating Committees including:</p> <ul style="list-style-type: none"> <li>▪ Finance Committee</li> <li>▪ Utilization Management Committee</li> <li>▪ Clinical Practices Committee</li> <li>▪ Provider Network Management Committee</li> <li>▪ Health Information Services Committee</li> <li>▪ Customer Advisory Committee</li> <li>▪ Regional Compliance Coordinating Committee</li> </ul>
<b>Membership</b>	<p>The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair.</p> <ul style="list-style-type: none"> <li>▪ Members of the committee will <i>act as conduits and liaisons to share information decided on in the committee</i>. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations.</li> <li>▪ Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits, it is expected that committee members attend and are engaged in issues and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance.</li> </ul> <p>Membership shall include:</p> <ol style="list-style-type: none"> <li>1. Appointed QMC Chairperson by the SWMBH Executive Officer</li> <li>2. Appointed participant CMH representation</li> <li>3. Member of the SWMBH Customer Advisory Committee with lived experience</li> <li>4. SWMBH staff representation as appropriate</li> <li>5. Provider participation and feedback</li> </ol>



<b>Decision Making Process:</b>	<p>The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH.</p> <p>When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members and a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they will lose the right to participate in the voting structure for that meeting.</p>
<b>Deliverables/ Goals:</b>	<p>The Committee will support SWMBH Staff in the following Regional Objectives:</p> <ul style="list-style-type: none"> <li>▪ Annual Quality Work Plan development and review</li> <li>▪ Annual QAPI Evaluation Report development and review</li> <li>▪ Michigan Mission-Based Performance Indicator System (MMBPIS) regional report</li> <li>▪ Event Reporting Dashboard Review and action related to identified trends</li> <li>▪ Regional Survey Development, Analysis and improvement strategies (<i>including: The annual consumer satisfaction survey, RSA-r survey, Provider Communications survey and the Provider UM Access survey</i>)</li> <li>▪ Completion of Regional Strategic Imperatives or goals, assigned to the committee</li> <li>▪ Completion, feedback and analysis on any Performance Improvement <ul style="list-style-type: none"> <li>○ Projects assigned to, or relevant to the committee</li> </ul> </li> <li>▪ Assist in the review and formulation of the Annual Board Ends Metrics</li> <li>▪ Assist in the review of annual Regional Audit/Review results and make recommendations for corrective action plans as needed</li> <li>▪ Assist in the review and completion of the annual Performance Bonus Incentive Program (PBIP) Narrative Report</li> </ul>

FY 2023 Quality Management Committee Goals (Measurement Period: Oct 1, 2022 – Sept 30, 2023)

1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By 6/30/23)
  - Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project.
  - Identify common denominators and classify into strategic categories.
  - Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category).
  - Develop and target interventions to improve identify problem areas.
  - Determine tracking mechanisms and targets goals for each identified area.
  - Share results with Operations Committee and other relevant committees.
  - Identify alternative electronic methods of gathering consumer responses, other than telephonic.
  - Establish and maintain 'new' process to keep the survey open for consumer participation all year, opposed to isolated dates.
  - Identify tools/resources, which determine how many surveys have been completed and current scores (real time).
  - Each CMHSP should review their individual survey results and submit to the PIHP, a plan of action for improving identified areas of improvement. This should be well documented within CMHSP internal quality review, or other CMHSP workgroup meeting minutes/notes.
  - Review individual Performance improvement projects for each CMHSP, during the Regional Quality Management Committee meetings.
2. Review current survey tool for the 2023 Consumer Satisfaction Survey Project, to ensure that it meets CCBHC and Best Practice Methodology for Measurement and Analysis (By 3/30/23)
  - Identify NCQA approved consumer satisfaction survey tools, to ensure we are using the best option.
  - Review tools, questions and scoring methodology with relevant regional committees for feedback.
  - Identify survey distribution methods and possible process changes.
  - Communicate project logistics to CMHSP survey point persons and regional committees.
  - Complete analysis of results and distribute to internal and external stakeholders.
  - Evaluate selected tools effectiveness and make modifications, as necessary.
3. Redesign structure/format of the annual QAPI-UM Plan and Evaluation report. (By 6/30/2023)
  - Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.

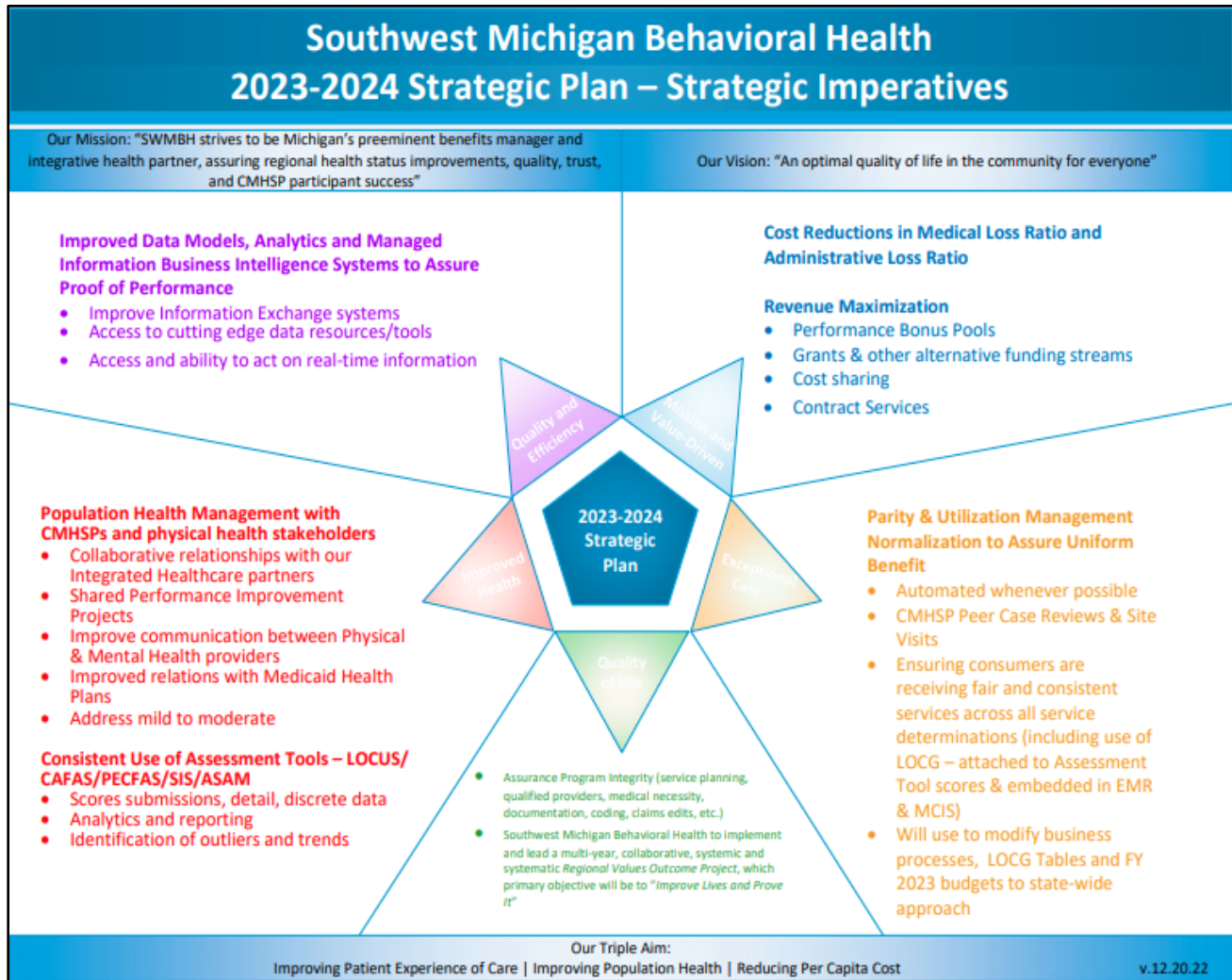
	<ul style="list-style-type: none"> <li>▪ Utilize the MDHHS suggested template.</li> <li>▪ Identify program weaknesses and strengths for each category evaluated.</li> <li>▪ Identify detailed plans/timeline to remediate identified weaknesses.</li> <li>▪ Ensure all elements/standards/MDHHS recommendations are included in the redesigned report.</li> </ul> <p>4. Create a flow chart for each quality related MDHHS contractually obligated reporting requirement. (By 12/30/2023)</p> <ul style="list-style-type: none"> <li>▪ Each chart should provide processes and steps for collecting data, reporting data, timelines, project point persons and additional resources available.</li> <li>▪ Identified areas to include such as MMBPIS, Grievance and Appeals, etc.</li> </ul> <p>5. Work with the Quality Management Committee and other Regional Committees to improve Health Service Advisory Group (HSAG) External Quality Review (EQR) results and corrective action plans. (By 10/30/2023)</p> <ul style="list-style-type: none"> <li>▪ Establish a schedule of review for each section not receiving a score of “Met” within the relevant Regional Committees.</li> <li>▪ Identify action plans for improvement and assign functional area leaders.</li> <li>▪ Ensure CMHSP’s and SWMBH are compliant with any standards/elements indicated as ‘Not Met’ within the 3-year audit cycle.</li> <li>▪ Ensure that all sections identified during each of the 3 year audit cycle meet compliance at a minimum of 90% or SWMBH is one of the top 2 performing PIHPs in Michigan.</li> </ul>
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#### Current Committee Roster

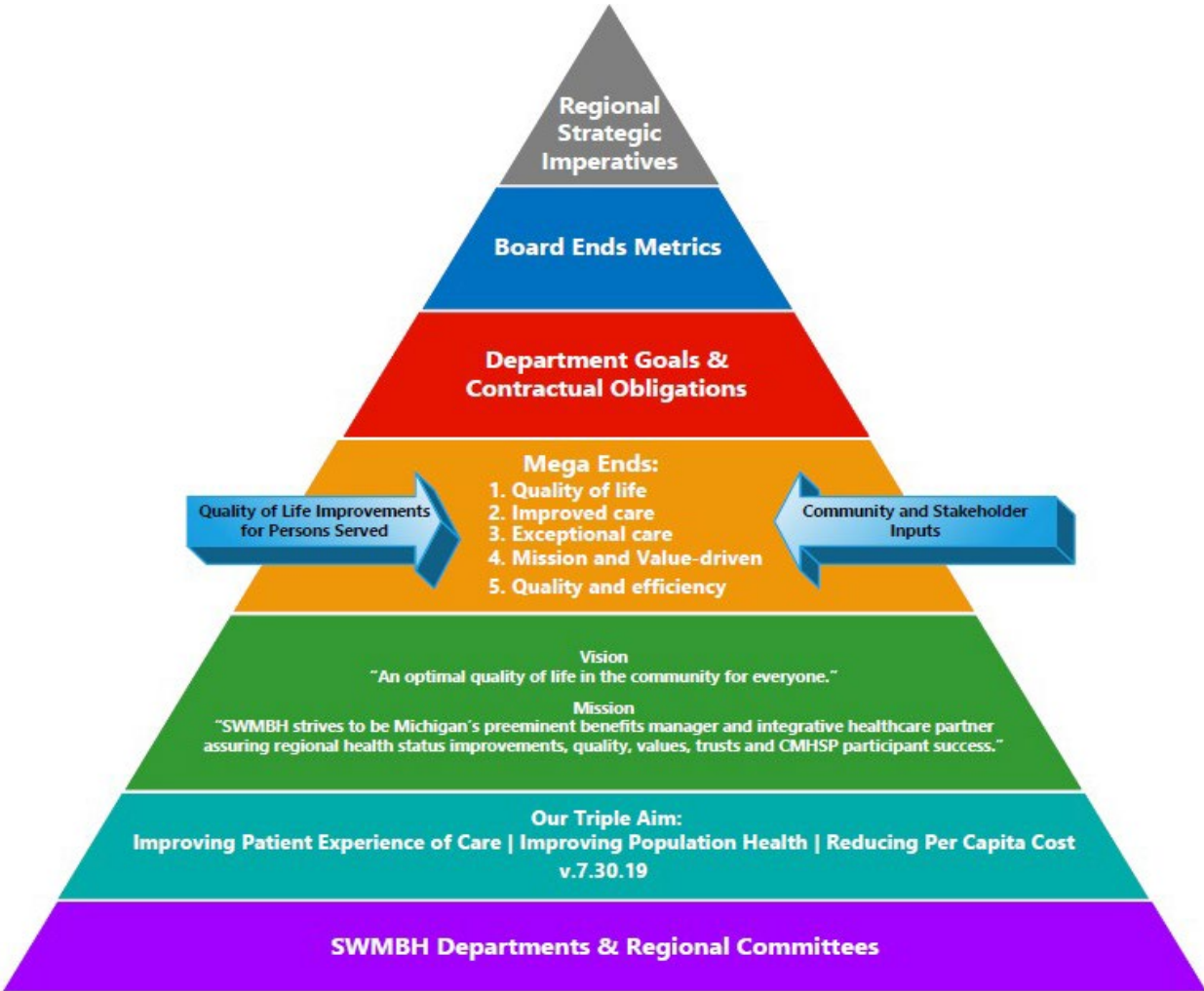
<b>Member Name</b>	<b>Organization/County</b>	<b>Type of member (Ad hoc, standing, voting, alternate)</b>
Jonathan Gardner Director of QAPI	SWMBH	Voting - Committee Chair
Ellie DeLeon Strategic Initiatives Project Manager	SWMBH	Voting
Cate Pederson Quality Assurance Specialist	SWMBH	Voting
Marissa Miller Quality Assurance Specialist	SWMBH	Voting
Chris Harrity Clinical Data Analyst	SWMBH	Voting
Alena Lacey Clinical Director	SWMBH	Voting
Jannette Bayyapuneedi Behavioral Health & Integrated Care Manager	SWMBH	Voting
Sarah Ameter Manager of Customer Services	SWMBH	Ad Hoc

<i>Dr. Ramesh Psychiatrist</i>	<i>SWMBH – Contract – As needed</i>	<i>Ad Hoc</i>
<i>Natalie Spivak CIO</i>	<i>SWMBH</i>	<i>Ad Hoc</i>
<i>Sandra Bell Consumer Representative</i>	<i>Member</i>	<i>Voting</i>
<i>Amy Gallick Analytics Manager</i>	<i>ISK</i>	<i>Voting</i>
<i>Sheila Hibbs Quality Director</i>	<i>ISK</i>	<i>Voting</i>
<i>Teresa Lewis Customer Services Manager</i>	<i>ISK</i>	<i>Voting</i>
<i>Emily Whisner Chief Clinical Officer/CIO</i>	<i>Barry</i>	<i>Voting</i>
<i>Brenna Ellison Compliance Officer/QI Manager</i>	<i>Barry</i>	<i>Voting</i>
<i>Pete Murphy CIO</i>	<i>Cass</i>	<i>Voting</i>
<i>Beth Miller Corporate Compliance Officer</i>	<i>Cass</i>	<i>Voting</i>
<i>Kyle Kenny Quality Improvement Specialist</i>	<i>Branch</i>	<i>Voting</i>
<i>Grae Miller Director of UM and Access</i>	<i>St. Joe</i>	<i>Voting</i>
<i>Joe Reed IT Director</i>	<i>St. Joe</i>	<i>Voting</i>
<i>Jarrett Cupp Compliance/Quality Director</i>	<i>St. Joe</i>	<i>Ad Hoc</i>
<i>Mandi Quigley Corporate Compliance Director</i>	<i>Calhoun</i>	<i>Voting</i>
<i>Bridget Avery Director of Revenue Cycle</i>	<i>Calhoun</i>	<i>Ad Hoc</i>
<i>Kyleen Gray Quality Director</i>	<i>Van Buren</i>	<i>Voting</i>
<i>Caleb Richardson Business Intelligence Manager</i>	<i>Berrien</i>	<i>Voting</i>
<i>Doris Glowacki Continuous QI Coordinator</i>	<i>Berrien</i>	<i>Voting</i>

## ATTACHMENT H – 2023-2024 STRATEGIC IMPERATIVES



ATTACHMENT I – 2023 REGIONAL STRATEGIC IMPERATIVE DECISION/PRIORITY MAP



**Southwest Michigan Behavioral Health Board Retreat  
Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001  
May 12, 2023  
10:45 am to 3:00 pm Following 9:30 – 10:30 Board Meeting  
Draft: 1/4/23**

**Possible Agenda for Board Discussion**

10:45 am-11:30 am	Welcome, Introductions, Session Objectives and Participant Statements
11:30 am-12:30 pm	Proposed: Farah Hanley, MDHHS Chief Deputy Director for Health, Executive Branch Priorities and Goals
12:30 pm - 1:15 pm	Lunch
1:15 pm – 2:15 pm	Proposed: Alan Bolter, Associate Director CMHAM, Public Policy Environmental Scan
2:15 pm - 2:45 pm	Summary Discussion and Next Steps
3:00 pm	Adjourn

Potential Facilitators: Scott Dzurka, Laura Vredevelde, others?

Potential Presenters: Farah Hanley, Alan Bolter, Dave Schneider, Jay Rosen, Lynda Zeller, key legislators, others?

Potential Focus Areas: SWMBH Board Ends and Interpretations; Michigan Public Policy and Advocacy Planning; Carver Policy Governance; Delegation, Oversight and Monitoring; SWMBH Support for Partner CMH Self-Identified Needs; others?

Invitees: SWMBH Board Members and Alternates, Substance Use Disorder Oversight Policy Board Chair and Vice Chair, Consumer Advisory Council Chair and Vice Chair, select SWMBH leaders. Consider CMH Board Members as observers?

# Southwest Michigan

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## BEHAVIORAL HEALTH

<b>Section:</b> Board Policy – Accomplishment	<b>Policy Number:</b> BG-004	<b>Pages:</b> 1
<b>Subject:</b> Board Ends and Accomplishment	<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input checked="" type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH EO		<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 04.11.2014	<b>Last Review Date:</b> 1/14/22	<b>Past Review Dates:</b> 12.12.14, 1/8/16, 1/13/17, 1/12/18, 1/11/19, 1/10/20, 1/8/21

**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.



	E	F	H	J	K	L	M	N	O	P	Q	R	S
1	<b>Southwest Michigan Behavioral Health</b>												
2	<i>Mos in Period</i>												
3	For the Fiscal YTD Period Ended 11/30/2022	P02FYTD22		2									
4	<i>(For Internal Management Purposes Only)</i>												
5													
6	<b>INCOME STATEMENT</b>	TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	Opioid Health Home Contract	CCBHC	MI Health Link	MH Block Grant Contracts	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	
7													
8	<b>REVENUE</b>												
9	Contract Revenue	57,029,970	37,425,319	8,600,559	3,236,385	278,098	6,346,785	262,345	-	573,023	307,455	-	
10	DHHS Incentive Payments	125,489	125,489	-	-	-	-	-	-	-	-	-	
11	Grants and Earned Contracts	61,208	-	-	-	-	-	-	61,208	-	-	-	
12	Interest Income - Working Capital	40,254	-	-	-	-	-	-	-	-	-	40,254	
13	Interest Income - ISF Risk Reserve	868	-	-	-	-	-	-	-	-	-	868	
14	Local Funds Contributions	214,892	-	-	-	-	-	-	-	-	-	214,892	
15	Other Local Income	-	-	-	-	-	-	-	-	-	-	-	
16													
17	<b>TOTAL REVENUE</b>	<b>57,472,682</b>	<b>37,550,808</b>	<b>8,600,559</b>	<b>3,236,385</b>	<b>278,098</b>	<b>6,346,785</b>	<b>262,345</b>	<b>61,208</b>	<b>573,023</b>	<b>307,455</b>	<b>256,015</b>	
18													
19	<b>EXPENSE</b>												
20	<b>Healthcare Cost</b>												
21	Provider Claims Cost	3,085,631	574,707	1,123,229	-	176,091	-	633,081	28,309	469,024	81,191	-	
22	CMHP Subcontracts, net of 1st & 3rd party	43,816,945	33,133,212	3,403,215	2,293,350	-	4,744,373	166,141	-	76,654	-	-	
23	Insurance Provider Assessment Withhold (IPA)	623,045	433,442	189,602	-	-	-	-	-	-	-	-	
24	Medicaid Hospital Rate Adjustments	-	-	-	-	-	-	-	-	-	-	-	
25	MHL Cost in Excess of Medicare FFS Cost	-	575,690	-	-	-	-	(575,690)	-	-	-	-	
26													
27	<b>Total Healthcare Cost</b>	<b>47,525,621</b>	<b>34,717,051</b>	<b>4,716,046</b>	<b>2,293,350</b>	<b>176,091</b>	<b>4,744,373</b>	<b>223,532</b>	<b>28,309</b>	<b>545,679</b>	<b>81,191</b>	<b>-</b>	
28	Medical Loss Ratio (HCC % of Revenue)	83.2%	92.5%	54.8%	70.9%	63.3%	74.8%	85.2%		95.2%	26.4%		
29	<b>Administrative Cost</b>												
30	Purchased Professional Services	59,268	-	-	-	-	-	-	-	-	-	59,268	
31	Administrative and Other Cost	1,201,761	-	-	-	-	-	-	32,899	8,214	-	1,162,557	
32	Interest Expense	-	-	-	-	-	-	-	-	-	-	-	
33	Depreciation	-	-	-	-	-	-	-	-	-	-	-	
34	Functional Cost Reclassification	-	-	-	-	-	-	-	-	-	-	-	
35	Allocated Indirect Pooled Cost	(0)	-	-	-	-	-	-	-	-	-	(1,909)	
36	Delegated Managed Care Admin	3,071,970	2,586,457	290,819	176,514	-	-	18,180	-	-	-	-	
37	Apportioned Central Mgd Care Admin	(0)	862,592	116,857	59,206	4,546	122,483	20,633	1,580	21,929	-	(1,209,827)	
38													
39	<b>Total Administrative Cost</b>	<b>4,332,999</b>	<b>3,449,049</b>	<b>407,676</b>	<b>235,720</b>	<b>4,546</b>	<b>122,483</b>	<b>38,813</b>	<b>34,479</b>	<b>30,143</b>	<b>-</b>	<b>10,089</b>	
40	Admin Cost Ratio (MCA % of Total Cost)	8.4%	9.0%	8.0%	9.3%	2.5%	2.5%	14.8%		5.2%	0.0%	2.3%	
41													
42	Local Funds Contribution	214,892	-	-	-	-	-	-	-	-	-	214,892	
43	PBIP Transferred to CMHPs	-	-	-	-	-	-	-	-	-	-	-	
44													
45	<b>TOTAL COST after apportionment</b>	<b>52,073,511</b>	<b>38,166,100</b>	<b>5,123,722</b>	<b>2,529,070</b>	<b>180,637</b>	<b>4,866,856</b>	<b>262,345</b>	<b>62,788</b>	<b>575,822</b>	<b>81,191</b>	<b>224,981</b>	
46													
47	<b>NET SURPLUS before settlement</b>	<b>5,399,170</b>	<b>(615,292)</b>	<b>3,476,837</b>	<b>707,315</b>	<b>97,462</b>	<b>1,479,929</b>	<b>-</b>	<b>(1,580)</b>	<b>(2,799)</b>	<b>226,263</b>	<b>31,034</b>	
48	Net Surplus (Deficit) % of Revenue	9.4%	-1.6%	40.4%	21.9%	35.0%	23.3%	0.0%	-2.6%	-0.5%	73.6%	12.1%	
49	Prior Year Savings	17,316,484	16,894,122	422,362	-	-	-	-	-	-	-	-	
50	Change in PA2 Fund Balance	(223,464)	-	-	-	-	-	-	-	-	(223,464)	-	
51	ISF Risk Reserve Abatement (Funding)	(868)	-	-	-	-	-	-	-	-	-	(868)	
52	ISF Risk Reserve Deficit (Funding)	-	-	-	-	-	-	-	-	-	-	-	
53	Settlement Receivable / (Payable)	(1,306,595)	2,093,182	(1,115,070)	(707,315)	(97,462)	(1,479,929)	-	-	2,799	(2,799)	-	
54	<b>NET SURPLUS (DEFICIT)</b>	<b>21,184,727</b>	<b>18,372,012</b>	<b>2,784,129</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(1,580)</b>	<b>-</b>	<b>-</b>	<b>30,166</b>	
55	HMP & Autism is settled with Medicaid												
56													
57	<b>SUMMARY OF NET SURPLUS (DEFICIT)</b>												
58	Prior Year Unspent Savings	14,430,403	14,078,435	351,968	-	-	-	-	-	-	-	-	
59	Current Year Savings	2,710,222	278,061	2,432,161	-	-	-	-	-	-	-	-	
60	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-	-	-	-	
61	Local and Other Funds Surplus/(Deficit)	4,044,101	4,015,516	-	-	-	-	-	(1,580)	-	-	30,166	
62	<b>NET SURPLUS (DEFICIT)</b>	<b>21,184,727</b>	<b>18,372,012</b>	<b>2,784,129</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(1,580)</b>	<b>-</b>	<b>-</b>	<b>30,166</b>	
63													

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health				Mos in Period		Estimate P02		Estimate P02		Estimate P02		Estimate P02	
2	For the Fiscal YTD Period Ended 11/30/2022				2									
3	(For Internal Management Purposes Only)				ok									
4	INCOME STATEMENT													
5		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA		
6	Medicaid Specialty Services													
7		37,425,319	3,739,856	33,685,463	1,709,645	6,887,042	1,902,659	6,866,379	2,352,751	8,649,039	1,735,906	3,582,042		
8		125,489	89,261	36,229	529	14,822	-	20,877	-	-	-	-		
9		Contract Revenue	37,550,808	3,829,116	33,721,692	1,710,174	6,901,864	1,902,659	6,887,256	2,352,751	8,649,039	1,735,906	3,582,042	
10														
11		External Provider Cost	26,324,940	574,707	25,750,233	729,083	4,732,467	1,398,611	5,002,520	1,291,602	8,442,105	2,157,828	1,996,015	
12		Internal Program Cost	7,632,591	-	7,632,591	673,902	1,785,557	546,521	1,810,669	764,210	440,275	206,521	1,404,938	
13		SSI Reimb. 1st/3rd Party Cost Offset	(83,472)	-	(83,472)	-	(38,778)	(12,070)	-	-	(23,811)	-	(8,813)	
14		Insurance Provider Assessment Withhold (IPA)	433,442	433,442	-	-	-	-	-	-	-	-	-	
15		MHL Cost in Excess of Medicare FFS Cost	400,452	400,452	-	-	-	-	-	-	-	-	-	
16		Total Healthcare Cost	34,707,954	1,408,602	33,299,353	1,402,985	6,479,246	1,933,062	6,813,189	2,055,812	8,858,569	2,364,349	3,392,140	
17		Medical Loss Ratio (HCC % of Revenue)	92.4%		98.7%	82.0%	93.9%	101.6%	98.9%	87.4%	102.4%	136.2%	94.7%	
18														
19		Managed Care Administration	3,467,229	862,592	2,604,637	181,337	501,888	117,382	522,177	279,212	516,175	246,481	239,987	
20		Admin Cost Ratio (MCA % of Total Cost)	9.1%	2.3%	6.8%	11.4%	7.2%	5.7%	7.1%	12.0%	5.5%	9.4%	6.6%	
21														
22		Contract Cost	38,175,184	2,271,193	35,903,990	1,584,322	6,981,133	2,050,444	7,335,366	2,335,024	9,374,744	2,610,830	3,632,127	
23		Net before Settlement	(624,375)	1,557,923	(2,182,298)	125,852	(79,270)	(147,785)	(448,110)	17,727	(725,705)	(874,924)	(50,085)	
24														
25		Prior Year Savings	16,894,122	16,894,122	-	-	-	-	-	-	-	-	-	
26		Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-	
27		Contract Settlement / Redistribution	2,093,182	(89,116)	2,182,298	(125,852)	79,270	147,785	448,110	(17,727)	725,705	874,924	50,085	
28		Net after Settlement	18,362,929	18,362,929	(0)	-	-	-	-	-	-	-	-	
29														
30	Eligibles and PMPM													
31		Average Eligibles	180,604	180,604	180,604	9,918	34,024	10,629	35,059	10,595	47,262	14,801	18,316	
32		Revenue PMPM	\$ 103.96	\$ 10.60	\$ 93.36	\$ 86.22	\$ 101.43	\$ 89.50	\$ 98.22	\$ 111.03	\$ 91.50	\$ 58.64	\$ 97.78	
33		Expense PMPM	\$ 105.69	\$ 6.29	\$ 99.40	\$ 79.87	\$ 102.59	\$ 96.46	\$ 104.61	\$ 110.19	\$ 99.18	\$ 88.20	\$ 99.15	
34		Margin PMPM	\$ (1.73)	\$ 4.31	\$ (6.04)	\$ 6.34	\$ (1.16)	\$ (6.95)	\$ (6.39)	\$ 0.84	\$ (7.68)	\$ (29.56)	\$ (1.37)	
35														
36	Medicaid Specialty Services													
37	Budget v Actual													
38														
39	Eligible Lives (Average Eligibles)													
40		Actual	180,604	180,604	180,604	9,918	34,024	10,629	35,059	10,595	47,262	14,801	18,316	
41		Budget	174,379	174,379	174,379	9,423	33,008	10,297	33,586	10,237	45,533	14,354	17,941	
42		Variance - Favorable / (Unfavorable)	6,225	6,225	6,225	495	1,016	332	1,473	358	1,729	447	375	
43		% Variance - Fav / (Unfav)	3.6%	3.6%	3.6%	5.3%	3.1%	3.2%	4.4%	3.5%	3.8%	3.1%	2.1%	
44														
45	Contract Revenue before settlement													
46		Actual	37,550,808	3,829,116	33,721,692	1,710,174	6,901,864	1,902,659	6,887,256	2,352,751	8,649,039	1,735,906	3,582,042	
47		Budget	43,726,351	4,250,978	39,475,373	1,686,408	7,390,781	2,115,274	6,915,469	2,153,880	12,766,212	2,853,306	3,594,045	
48		Variance - Favorable / (Unfavorable)	(6,175,543)	(421,862)	(5,753,682)	23,767	(488,917)	(212,614)	(28,212)	198,871	(4,117,173)	(1,117,400)	(12,003)	
49		% Variance - Fav / (Unfav)	-14.1%	-9.9%	-14.6%	1.4%	-6.6%	-10.1%	-0.4%	9.2%	-32.3%	-39.2%	-0.3%	
50														
51	Healthcare Cost													
52		Actual	34,707,954	1,408,602	33,299,353	1,402,985	6,479,246	1,933,062	6,813,189	2,055,812	8,858,569	2,364,349	3,392,140	
53		Budget	35,326,137	1,763,129	33,563,008	1,489,452	6,479,246	2,080,470	6,813,189	2,055,812	8,842,977	2,409,723	3,392,140	
54		Variance - Favorable / (Unfavorable)	618,183	354,527	263,655	86,467	-	147,408	-	-	(15,592)	45,373	-	
55		% Variance - Fav / (Unfav)	1.7%	20.1%	0.8%	5.8%	0.0%	7.1%	0.0%	0.0%	-0.2%	1.9%	0.0%	
56														
57	Managed Care Administration													
58		Actual	3,467,229	862,592	2,604,637	181,337	501,888	117,382	522,177	279,212	516,175	246,481	239,987	
59		Budget	3,779,003	1,428,796	2,350,207	188,006	501,888	76,839	522,177	279,212	446,781	95,318	239,987	
60		Variance - Favorable / (Unfavorable)	311,774	566,204	(254,430)	6,669	-	(40,543)	-	-	(69,394)	(151,163)	-	
61		% Variance - Fav / (Unfav)	8.3%	39.6%	-10.8%	3.5%	0.0%	-52.8%	0.0%	0.0%	-15.5%	-158.6%	0.0%	
62														
63	Total Contract Cost													
64		Actual	38,175,184	2,271,193	35,903,990	1,584,322	6,981,133	2,050,444	7,335,366	2,335,024	9,374,744	2,610,830	3,632,127	
65		Budget	39,105,140	3,191,925	35,913,215	1,677,458	6,981,133	2,157,309	7,335,366	2,335,024	9,289,758	2,505,040	3,632,127	
66		Variance - Favorable / (Unfavorable)	929,957	920,731	9,225	93,136	-	106,865	-	-	(84,986)	(105,790)	-	
67		% Variance - Fav / (Unfav)	2.4%	28.8%	0.0%	5.6%	0.0%	5.0%	0.0%	0.0%	-0.9%	-4.2%	0.0%	
68														
69	Net before Settlement													
70		Actual	(624,375)	1,557,923	(2,182,298)	125,852	(79,270)	(147,785)	(448,110)	17,727	(725,705)	(874,924)	(50,085)	
71		Budget	4,621,211	1,059,053	3,562,158	8,950	409,648	(42,036)	(419,898)	(181,144)	3,476,454	348,265	(38,082)	
72		Variance - Favorable / (Unfavorable)	(5,245,586)	498,870	(5,744,456)	116,903	(488,917)	(105,749)	(28,212)	198,871	(4,202,159)	(1,223,190)	(12,003)	
73														
74														

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health				Mos in Period		Estimate P02		Estimate P02		Estimate P02		Estimate P02	
2	For the Fiscal YTD Period Ended 11/30/2022				2									
3	(For Internal Management Purposes Only)				ok									
4	INCOME STATEMENT													
5														
75	Healthy Michigan Plan													
76	Contract Revenue		8,600,559	2,613,605	5,986,954	362,226	1,205,879	339,877	1,169,205	376,984	1,509,555	400,518	622,711	
77														
78	External Provider Cost		3,140,362	1,123,229	2,017,133	46,803	292,128	115,962	539,598	87,439	580,869	156,001	198,333	
79	Internal Program Cost		1,386,082	-	1,386,082	147,442	342,690	77,967	468,496	78,910	85,848	5,616	179,113	
80	SSI Reimb, 1st/3rd Party Cost Offset		-	-	-	-	-	-	-	-	-	-	-	
81	Insurance Provider Assessment Withhold (IPA)		189,602	189,602	-	-	-	-	-	-	-	-	-	
82	Total Healthcare Cost		4,716,046	1,312,831	3,403,215	194,246	634,818	193,929	1,008,094	166,349	666,717	161,617	377,446	
83	Medical Loss Ratio (HCC % of Revenue)		54.8%		56.8%	53.6%	52.6%	57.1%	86.2%	44.1%	44.2%	40.4%	60.6%	
84														
85	Managed Care Administration		407,676	116,857	290,819	25,106	48,881	16,746	81,193	22,593	38,744	30,852	26,704	
86	Admin Cost Ratio (MCA % of Total Cost)		8.0%	2.3%	5.7%	11.4%	7.1%	7.9%	7.5%	12.0%	5.5%	16.0%	6.6%	
87														
88	Contract Cost		5,123,722	1,429,688	3,694,034	219,352	683,698	210,675	1,089,287	188,942	705,461	192,469	404,150	
89	Net before Settlement		3,476,837	1,183,917	2,292,921	142,874	522,180	129,202	79,918	188,042	804,094	208,049	218,561	
90														
91	Prior Year Savings		422,362	422,362	-	-	-	-	-	-	-	-	-	
92	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-	
93	Contract Settlement / Redistribution		(1,115,070)	1,177,850	(2,292,921)	(142,874)	(522,180)	(129,202)	(79,918)	(188,042)	(804,094)	(208,049)	(218,561)	
94	Net after Settlement		2,784,129	2,784,129	-	-	-	-	-	-	-	-	-	
95														
96	Eligibles and PMPM													
97	Average Eligibles		79,001	79,001	79,001	4,030	15,400	3,767	14,450	4,794	22,871	6,113	7,579	
98	Revenue PMPM		\$ 54.43	\$ 16.54	\$ 37.89	\$ 44.95	\$ 39.15	\$ 45.12	\$ 40.46	\$ 39.32	\$ 33.00	\$ 32.76	\$ 41.08	
99	Expense PMPM		32.43	9.05	23.38	27.22	22.20	27.97	37.69	19.71	15.42	15.74	26.66	
100	Margin PMPM		\$ 22.01	\$ 7.49	\$ 14.51	\$ 17.73	\$ 16.95	\$ 17.15	\$ 2.77	\$ 19.61	\$ 17.58	\$ 17.02	\$ 14.42	
101														
102	Healthy Michigan Plan													
103	Budget v Actual													
104														
105	Eligible Lives (Average Eligibles)													
106	Actual		79,001	79,001	79,001	4,030	15,400	3,767	14,450	4,794	22,871	6,113	7,579	
107	Budget		74,889	74,889	74,889	3,793	14,729	3,546	13,688	4,485	21,571	5,873	7,204	
108	Variance - Favorable / (Unfavorable)		4,112	4,112	4,112	237	670	221	762	309	1,299	239	375	
109	% Variance - Fav / (Unfav)		5.5%	5.5%	5.5%	6.2%	4.6%	6.2%	5.6%	6.9%	6.0%	4.1%	5.2%	
110														
111	Contract Revenue before settlement													
112	Actual		8,600,559	2,613,605	5,986,954	362,226	1,205,879	339,877	1,169,205	376,984	1,509,555	400,518	622,711	
113	Budget		8,196,924	1,572,147	6,624,776	333,087	1,286,877	311,304	1,224,333	390,633	1,936,359	516,677	625,507	
114	Variance - Favorable / (Unfavorable)		403,636	1,041,458	(637,822)	29,139	(80,999)	28,573	(55,128)	(13,649)	(426,804)	(116,158)	(2,796)	
115	% Variance - Fav / (Unfav)		4.9%	66.2%	-9.6%	8.7%	-6.3%	9.2%	-4.5%	-3.5%	-22.0%	-22.5%	-0.4%	
116														
117	Healthcare Cost													
118	Actual		4,716,046	1,312,831	3,403,215	194,246	634,818	193,929	1,008,094	166,349	666,717	161,617	377,446	
119	Budget		5,656,218	1,388,524	4,267,694	224,699	634,818	426,944	1,008,094	166,349	927,332	502,012	377,446	
120	Variance - Favorable / (Unfavorable)		940,172	75,693	864,479	30,454	-	233,015	-	-	260,615	340,396	-	
121	% Variance - Fav / (Unfav)		16.6%	5.5%	20.3%	13.6%	0.0%	54.6%	0.0%	0.0%	28.1%	67.8%	0.0%	
122														
123	Managed Care Administration													
124	Actual		407,676	116,857	290,819	25,106	48,881	16,746	81,193	22,593	38,744	30,852	26,704	
125	Budget		493,498	217,079	276,419	28,363	48,881	22,928	81,193	22,593	32,877	12,881	26,704	
126	Variance - Favorable / (Unfavorable)		85,822	100,222	(14,399)	3,256	-	6,182	-	-	(5,867)	(17,971)	-	
127	% Variance - Fav / (Unfav)		17.4%	46.2%	-5.2%	11.5%	0.0%	27.0%	0.0%	0.0%	-17.8%	-139.5%	0.0%	
128														
129	Total Contract Cost													
130	Actual		5,123,722	1,429,688	3,694,034	219,352	683,698	210,675	1,089,287	188,942	705,461	192,469	404,150	
131	Budget		6,149,716	1,605,603	4,544,114	253,062	683,698	449,872	1,089,287	188,942	960,209	514,894	404,150	
132	Variance - Favorable / (Unfavorable)		1,025,994	175,914	850,080	33,710	-	239,197	-	-	254,748	322,425	-	
133	% Variance - Fav / (Unfav)		16.7%	11.0%	18.7%	13.3%	0.0%	53.2%	0.0%	0.0%	26.5%	62.6%	0.0%	
134														
135	Net before Settlement													
136	Actual		3,476,837	1,183,917	2,292,921	142,874	522,180	129,202	79,918	188,042	804,094	208,049	218,561	
137	Budget		2,047,208	(33,455)	2,080,663	80,026	603,179	(138,568)	135,046	201,692	976,149	1,783	221,357	
138	Variance - Favorable / (Unfavorable)		1,429,630	1,217,372	212,258	62,848	(80,999)	267,770	(55,128)	(13,649)	(172,056)	206,266	(2,796)	
139														
140														

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period			Estimate P02		Estimate P02		Estimate P02		Estimate P02	
2	For the Fiscal YTD Period Ended 11/30/2022			2										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
141	Autism Specialty Services			HCC%			4.1%	9.3%	3.5%	0.0%	4.1%	7.0%	0.1%	6.2%
142	Contract Revenue			3,236,385	128,814	3,107,571	169,573	587,393	173,204	645,746	-	935,429	259,728	336,498
143														
144	External Provider Cost			2,128,124	-	2,128,124	-	759,532	-	-	102,456	1,013,454	2,682	250,000
145	Internal Program Cost			165,226	-	165,226	74,126	217	79,887	-	-	-	-	10,996
146	SSI Reimb, 1st/3rd Party Cost Offset			-	-	-	-	-	-	-	-	-	-	-
147	Insurance Provider Assessment Withhold (IPA)			-	-	-	-	-	-	-	-	-	-	-
148	Total Healthcare Cost			2,293,350	-	2,293,350	74,126	759,748	79,887	-	102,456	1,013,454	2,682	260,996
149	Medical Loss Ratio (HCC % of Revenue)			70.9%	0.0%	73.8%	43.7%	129.3%	46.1%	0.0%	0.0%	108.3%	1.0%	77.6%
150														
151	Managed Care Administration			235,720	59,206	176,514	9,581	58,501	17,158	-	13,915	58,894	-	18,465
152	Admin Cost Ratio (MCA % of Total Cost)			9.3%	2.3%	7.0%	11.4%	7.1%	17.7%	0.0%	12.0%	5.5%	0.0%	6.6%
153														
154	Contract Cost			2,529,070	59,206	2,469,864	83,707	818,249	97,045	-	116,371	1,072,348	2,682	279,461
155	Net before Settlement			707,315	69,608	637,707	85,866	(230,856)	76,159	645,746	(116,371)	(136,919)	257,046	57,037
156	Contract Settlement / Redistribution			(707,315)	(69,608)	(637,707)	(85,866)	230,856	(76,159)	(645,746)	116,371	136,919	(257,046)	(57,037)
157	Net after Settlement			(0)	(0)	-	-	-	-	-	-	-	-	-
158														
159														
160	Certified Community Behavioral Health Clin			HCC%			0.0%	0.0%	0.0%	0.0%	0.0%	23.9%	33.7%	0.0%
161	Contract Revenue			6,346,785	82,093	6,264,692	-	-	-	-	-	4,923,742	1,340,950	-
162														
163	External Provider Cost			2,184,760	-	2,184,760	-	-	-	-	-	873,822	1,310,938	-
164	Internal Program Cost			2,559,613	-	2,559,613	-	-	-	-	-	2,559,613	-	-
165	SSI Reimb, 1st/3rd Party Cost Offset			-	-	-	-	-	-	-	-	-	-	-
166	Total Healthcare Cost			4,744,373	-	4,744,373	-	-	-	-	-	3,433,435	1,310,938	-
167	Medical Loss Ratio (HCC % of Revenue)			74.8%	0.0%	75.7%	0.0%	0.0%	0.0%	0.0%	0.0%	69.7%	97.8%	0.0%
168														
169	Managed Care Administration			122,483	122,483	-	-	-	-	-	-	-	-	-
170	Admin Cost Ratio (MCA % of Total Cost)			2.5%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
171														
172	Contract Cost			4,866,856	122,483	4,744,373	-	-	-	-	-	3,433,435	1,310,938	-
173	Net before Settlement			1,479,929	(40,390)	1,520,319	-	-	-	-	-	1,490,307	30,012	-
174	PPS-1 Supplemental Payment Difference			(1,668,456)	-	(1,668,456)	-	-	-	-	-	(1,698,469)	30,012	-
175	Contract Settlement / Redistribution			-	(148,137)	148,137	-	-	-	-	-	208,162	(60,025)	-
176	Net after Settlement			(188,527)	(188,527)	-	-	-	-	-	-	-	-	-
177														
178														
179	SUD Block Grant Treatment			HCC%			0.6%	0.3%	0.2%	0.0%	0.7%	0.0%	0.1%	0.3%
180	Contract Revenue			573,023	467,026	105,997	6,293	32,549	4,711	-	20,000	18,660	13,161	10,623
181														
182	External Provider Cost			469,024	469,024	-	-	-	-	-	-	-	-	-
183	Internal Program Cost			76,654	-	76,654	11,089	25,581	4,766	2,850	18,642	-	2,845	10,882
184	Insurance Provider Assessment Withhold (IPA)			-	-	-	-	-	-	-	-	-	-	-
185	Total Healthcare Cost			545,679	469,024	76,654	11,089	25,581	4,766	2,850	18,642	-	2,845	10,882
186	Medical Loss Ratio (HCC % of Revenue)			95.2%	100.4%	72.3%	176.2%	78.6%	101.2%	0.0%	93.2%	0.0%	21.6%	102.4%
187														
188	Managed Care Administration			21,929	21,929	-	-	-	-	-	-	-	-	-
189	Admin Cost Ratio (MCA % of Total Cost)			3.9%	3.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
190														
191	Contract Cost			567,608	490,953	76,654	11,089	25,581	4,766	2,850	18,642	-	2,845	10,882
192	Net before Settlement			5,415	(23,927)	29,343	(4,796)	6,969	(55)	(2,850)	1,358	18,660	10,317	(260)
193	Contract Settlement			2,799	32,142	(29,343)	4,796	(6,969)	55	2,850	(1,358)	(18,660)	(10,317)	260
194	Net after Settlement			8,214	8,214	-	-	-	-	-	-	-	-	-
195														
196														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Southwest Michigan Behavioral Health			Mos in Period			Estimate P02		Estimate P02	Estimate P02			Estimate P02
2	For the Fiscal YTD Period Ended 11/30/2022			2									
3	(For Internal Management Purposes Only)			ok									
4	INCOME STATEMENT		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
197	SWMBH CMHP Subcontracts												
198	Subcontract Revenue	56,182,072	7,031,395	49,150,677	2,247,736	8,712,862	2,420,451	8,681,331	2,749,735	16,036,425	3,750,264	4,551,873	
199	Incentive Payment Revenue	125,489	89,261	36,229	529	14,822	-	20,877	-	-	-	-	-
200	Contract Revenue	56,307,561	7,120,655	49,186,906	2,248,266	8,727,685	2,420,451	8,702,208	2,749,735	16,036,425	3,750,264	4,551,873	
201													
202	External Provider Cost	34,247,211	2,166,960	32,080,250	775,887	5,784,127	1,514,573	5,542,118	1,481,498	10,910,250	3,627,449	2,444,348	
203	Internal Program Cost	11,820,166	-	11,820,166	906,559	2,154,044	709,141	2,282,016	861,761	3,085,736	214,981	1,605,929	
204	SSI Reimb, 1st/3rd Party Cost Offset	(83,472)	-	(83,472)	-	(38,778)	(12,070)	-	-	(23,811)	-	(8,813)	
205	Insurance Provider Assessment Withhold (IPA)	623,045	623,045	-	-	-	-	-	-	-	-	-	-
206	PPS-1 Supplemental Payment Difference	(1,668,456)	-	(1,668,456)	-	-	-	-	-	1,698,469	(30,012)	-	-
207	MHL Cost in Excess of Medicare FFS Cost	400,452	400,452	-	-	-	-	-	-	-	-	-	-
208	Total Healthcare Cost	45,338,946	3,190,457	42,148,488	1,682,446	7,899,392	2,211,644	7,824,134	2,343,259	15,670,644	3,812,418	4,041,465	
209	Medical Loss Ratio (HCC % of Revenue)	80.5%	44.8%	85.7%	74.8%	90.5%	91.4%	89.9%	85.2%	97.7%	101.7%	88.8%	
210													
211	Managed Care Administration	4,255,037	1,183,067	3,071,970	216,024	609,269	151,286	603,370	315,720	613,813	277,333	285,155	
212	Admin Cost Ratio (MCA % of Total Cost)	8.6%	2.4%	6.2%	11.4%	7.2%	6.4%	7.2%	11.9%	3.8%	6.8%	6.6%	
213													
214	Contract Cost	49,593,983	4,373,525	45,220,458	1,898,470	8,508,662	2,362,930	8,427,504	2,658,979	16,284,457	4,089,751	4,326,620	
215	Net before Settlement	6,713,579	2,747,131	3,966,448	349,796	219,023	57,521	274,704	90,756	(248,032)	(339,487)	225,253	
216													
217	Prior Year Savings	17,316,484	17,316,484	-	-	-	-	-	-	-	-	-	-
218	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-	-
219	Contract Settlement	273,596	1,051,268	(777,672)	(349,796)	(219,023)	(57,521)	(274,704)	(90,756)	1,738,339	369,499	(225,253)	
220	Net after Settlement	24,303,658	21,114,882	3,188,776	-	(0)	(0)	0	0	1,490,307	30,012	(0)	
221													
222													

	F	G	H	I	J	K	L	M	N	O	P	Q	R										
1	Southwest Michigan Behavioral Health			Mos in Period			Estimate P02		Estimate P02		Estimate P02		Estimate P02										
2	For the Fiscal YTD Period Ended 11/30/2022			2																			
3	(For Internal Management Purposes Only)			ok																			
4	INCOME STATEMENT																						
5	Total SWMBH		SWMBH Central		CMH Participants		Barry CMHA		Berrien CMHA		Pines Behavioral		Summit Pointe		Woodlands Behavioral		Integrated Services of Kalamazoo		St Joseph CMHA		Van Buren MHA		
223	State General Fund Services			HCC%		2.6%		7.3%		3.2%		1.4%		3.0%		6.1%		1.3%		1.2%		3.3%	
224	Contract Revenue					2,143,569		155,887		368,064		146,768		309,917		144,515		650,086		173,760		194,572	
225																							
226	External Provider Cost					275,031		29,790		58,426		2,173		50,849		117,127		-		-		16,667	
227	Internal Program Cost					683,186		102,222		200,083		29,217		194,663		35,072		-		-		121,929	
228	SSI Reimb, 1st/3rd Party Cost Offset					-		-		-		-		-		-		-		-		-	
229	Total Healthcare Cost					958,217		132,012		258,508		31,389		245,512		152,200		-		-		138,595	
230	Medical Loss Ratio (HCC % of Revenue)					44.7%		84.7%		70.2%		21.4%		79.2%		105.3%		0.0%		0.0%		71.2%	
231																							
232	Managed Care Administration					151,704		19,235		19,905		6,275		72,357		23,043		-		-		10,889	
233	Admin Cost Ratio (MCA % of Total Cost)					13.7%		12.7%		7.1%		16.7%		22.8%		13.1%		0.0%		0.0%		7.3%	
234																							
235	Contract Cost					1,109,921		151,247		278,413		37,665		317,869		175,243		-		-		149,484	
236	Net before Settlement					1,033,648		4,640		89,651		109,103		(7,953)		(30,727)		650,086		173,760		45,088	
237																							
238	Other Redistributions of State GF					74,117		-		-		-		-		-		67,228		6,889		-	
239	Contract Settlement					(39,408)		(4,048)		-		-		-		-		-		-		(35,359)	
240	Net after Settlement					1,068,357		592		89,651		109,103		(7,953)		(30,727)		717,314		180,649		9,729	
241																							

**SWMBH FY 2022 Program Integrity - Compliance Board Report**  
**10/01/2021 – 09/30/2022**

**Train & Educate**

**Audit & Monitor**

**Report & Evaluate**

**Date Prepared: November 29, 2022**

**Chief Compliance Officer: Mila C. Todd**

**1. Compliance Allegations/Reports:**

Issue Reported	#	Investigation Opened		Investigation Completed		Complaint Substantiated		Outcome
		Yes	No	Yes	No	Yes	No	
Subcontracted provider not signing family training service documentation	NA		X					Contacted MI-OIG, gave SWMBH permission to NOT consider the unsigned documents invalid. No recoupments required, as the service documentation met all other Medicaid requirements. CMH educated the provider and documentation has met all requirements since.
Customer complaint: Felt pressured by CMH staff to exaggerate symptoms when calling SWMBH UM in order to qualify for a higher level of SUD care (residential vs out-patient)	2022-01	X		X			X	No FWA substantiated. Need for additional education to providers and peers/recovery coaches. UM/SUD staff provided education.
Methadone provider billing methadone dosing as telehealth	2022-02	X		X		X		No overpayment but claims using the telehealth place of service code were all corrected. On-going monitoring per quarterly audits.
Former CMH employee expressed a variety of concerns with her limited time at the CMH.	NA		X					No FWA or other compliance implications.
CFO at a CMH voided checks in SWMBH Streamline (SWMBH was adjudicating the CMH provider claims), checks had already been cut and sent to providers. New checks were then sent to the providers.	2022-03	X		X		X		Overpayments collected. CFO Streamline privileges were limited to avoid any additional issues.
SUD Provider manually changing start dates on Treatment Plans for the purpose of matching the Txt Plan dates to the	2022-04	X		X		X		Education provided on the authorization process and Treatment Plan requirements. On-going monitoring via

**SWMBH FY 2022 Program Integrity - Compliance Board Report**  
**10/01/2021 – 09/30/2022**

Train & Educate			Audit & Monitor			Report & Evaluate		
authorization request dates.								quarterly audits.
CMH employee reported that there was a break-in at the office, laptops and checks were stolen	NA		X					Reported to the CMH Compliance Officer and confirmed no PHI was able to be accessed.
Concern that SUD provider is assisting customers in inappropriately changing their address for the purpose of getting services through a different PIHP	NA		X					No FWA. Educated provider.
SUD Block Grant provider not following ATP policies/procedures	2022-05	X		X		X		Recoupments issued, CAP provided. On-going monitoring per quarterly audits.
SUD Provider requesting authorizations outside of Treatment Plan dates. Treatment Plan Addendums not being labeled as such and not signed appropriately by clinician & customer.	2022-06	X		X		X		CAP issued for Treatment Plan requirements. Education provided. CAP approved. On-going monitoring via quarterly audits.
Uncovered during a Medicaid audit that a CMH did not have active Treatment Plans for Meds Only customers-though the internal service had been authorized. Upon requesting additional information, it was found that this may be a more wide-spread issue	2022-07	X		X		X		Substantiated. CAP issued (to be monitored via additional Site Review CAPs) and recoupments processed. On-going monitoring per quarterly audits.
CMH reported that a subcontracted provider was rounding start/stop times when submitting claims.	2022-08	X		X			X	Not substantiated; however, it was discovered that the provider was not using the required U-modifiers for number of customers served. Claims reverted, CAP issued. On-going monitoring via quarterly audits.
ROIs in Streamline automatically merging with different customer records when uploading	2022-09	X		X		X		Issue corrected and resolved.
Spec Res provider asking about accepting gifts from customer family members	NA		X					Staff spoke with the caller and determined none of the gifts



**SWMBH FY 2022 Program Integrity - Compliance Board Report**  
**10/01/2021 – 09/30/2022**

Train & Educate		Audit & Monitor		Report & Evaluate				
								exceeded \$25 allowable amount per SWMBH policy.
Customer alleges that SUD Provider is upcoding for telehealth therapy and medication reviews. Additional concerns noted that may be more clinical quality than compliance	2022-10	X		X			X	Unsubstantiated. Clinical concerns addressed by SUD Team. Resolved.
SUD provider submitting duplicate drug screening claims (which were paid)	2022-11	X		X		X		Recoupments issued. SmartCare global rules updated to limit code to one unit/day per contract.
SUD Residential provider billing day of discharge	2022-12	X		X		X		Recoupments issued, CAP provided. On-going monitoring per monthly data-mining.
CLS/Respite subcontracting provider not meeting service documentation requirements	NA		X					Per quarterly Medicaid audit. Recoupments issued, live education provided, CAP provided. On-going monitoring per quarterly audits.
CMH board member expressed concerns with the CMH organizational culture	NA		X					Concern sent to Brad Casemore for follow-up.
SUD Block Grant provider not following ATP policies/procedures – repeat issue from provider (investigated FY21)	2022-13	X		X		X		Substantiated. Recoupments issued. Updated CAP required and provided. On-going monitoring per quarterly audits.
Inappropriate use of Q3014 telehealth site code per MDHHS memo/email.	2022-14	X		X		X		Only one CMH using this code-determined use was inappropriate. Encounters reverted.
SUD provider self-reported duplicate claims submitted and paid.	2022-15	X		X		X		Recoupments issued, CAP provided. Pre-payment monitoring. Discovered inappropriate “job” running in Streamline (in addition to the provide inappropriately submitting duplicate claims). Streamline issue resolved. Pre-payment review continues until 1/13/2023.
Former subcontracted	2022-16	X		X			X	Unable to substantiated

**SWMBH FY 2022 Program Integrity - Compliance Board Report**  
**10/01/2021 – 09/30/2022**

Train & Educate		Audit & Monitor		Report & Evaluate			
provider staff reporting falsification of service documentation.							claim after extensive documentation review. Further education to provider. CAP provide, recoupment issued. On-going monitoring per quarterly audits.
OIG Referred: Subcontracted provider owner accused of inappropriate usage of Medicaid dollars	2022-17	X		X		X	Unsubstantiated. Reported back to OIG, as required.
CMH staff falsified travel vouchers. Referred to OIG.	2022-18	X		X		X	Claim substantiated. Staff resigned prior to CMH termination. Pending OIG final response following additional audit per OIG request.
Subcontracted autism provider using multiple provider-qualification modifiers.	2022-19	X		X		X	Substantiated, no overpayment. Claims corrected.
Customer complaint that SUD Residential provider was billing for full stays when customers left program early, mice in facility, carbon dioxide issues within facility, general cleanliness concerns.	2022-20	X		X		X	Unsubstantiated. Some service documentation deficiencies noted, CAP required from provider.
SUD provider using inappropriate/disallowed place of service codes	2022-21	X		X		X	Substantiated. Claims corrected. No overpayment. On-going monitoring per quarterly audits.
CMH therapist inappropriately reporting telehealth service encounters.	2022-22	X		X		X	Referred to OIG. Overpayment under the \$5,000 limit for OIG to investigate. Therapist terminated. Investigation closed.
SUD customer authorized for SUD residential stay (claimed and paid). Discovered his actual address is in Indiana and he has been a resident of IN for the entire calendar year-still has Michigan Medicaid	NA		X				Reported to MDHHS per contractual obligations. Residential stay paid per MDHHS guidance. No further action.
Multiple CLS providers not using the correct modifiers/code for	NA		X				Informed all CMHs of the issue. CMHs are to work with providers to

**SWMBH FY 2022 Program Integrity - Compliance Board Report**  
**10/01/2021 – 09/30/2022**

	Train & Educate			Audit & Monitor			Report & Evaluate	
overnight health and safety.								educate and correct claims. Will be monitored via quarterly Medicaid audits.
Multiple concerns reported from two CMHs regarding a new autism provider. Concerns range from compliance FWA to clinical and recipient rights.								Pending SWMBH investigation following receipt of CMH investigation findings.
<b>Total</b>	<b>33</b>	<b>22</b>	<b>11</b>	<b>22</b>	<b>0</b>	<b>15</b>	<b>7</b>	

## 2. Privacy/Security Allegations/Reports

A total of forty-six (46) incidents were reported to the SWMBH Breach Team during Fiscal Year 2022. The Breach Team reviewed each incident and evaluated whether an exception applies under the law, and the probability of compromise to the Protected Health Information used or disclosed. Of the forty-six (46) incidents reviewed, NONE were determined to be reportable.

## 3. Planned Audits

<b>Audit</b>	<b># Services/Claims Reviewed</b>	<b>Result/Progress</b>	<b>Recoupments</b>
Medicaid Verification			
Quarter 1	453	Complete	29 recoupments (\$3,109.80)
Quarter 2	465	Complete	27 recoupments (\$3,572.66)
Quarter 3	465	Complete	23 recoupments (\$6,403.78)
Quarter 4	465	In Process	
MI Health Link			
Quarter 1	227	Completed	None
Quarter 2	240	Completed	None
Quarter 3	212	In Process	
Quarter 4	240	In Process	
SUD Block Grant Claims			
Quarter 1	30	Complete	2 recoupments (\$77.60)
Quarter 2	30	Complete	2 recoupments (\$189.00)
Quarter 3	30	Complete	None
Quarter 4	30	In Process	
SUD Coordination of Benefits			
Quarter 1	30	Completed	1 recoupment (\$68.64)
Quarter 2	30	Completed	None
Quarter 3	30	Completed	2 recoupments (\$81.66)
Quarter 4	30	In Process	

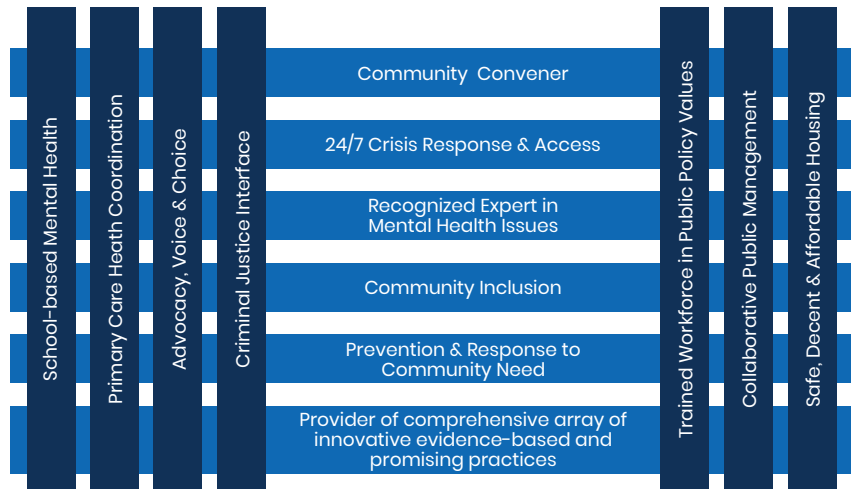
# MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

## Your Local Safety Net

Through both mission and contractual obligations community mental health agencies tie together essential community services with their unique role in the community as an "integrator" of services.

CMHSPs must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that are related to a shared consumer base.

Local coordination and collaboration with these entities will make a wider range of essential supports and services available...CMHSPs are encouraged to coordinate with these entities through participation in multipurpose human service collaborative bodies and other similar community groups.

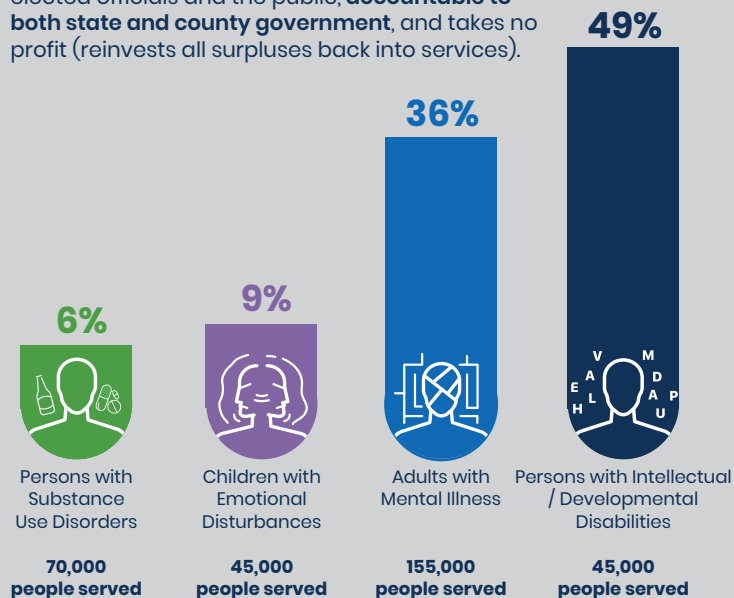


## Who we serve and how the money is spent

Michigan's Public Mental Health System Serves 4 Main populations:

Michigan is the **ONLY** state that serves all 4 populations in a managed care setting.

The system is a public system, that is tied to local elected officials and the public, **accountable to both state and county government**, and takes no profit (reinvests all surpluses back into services).

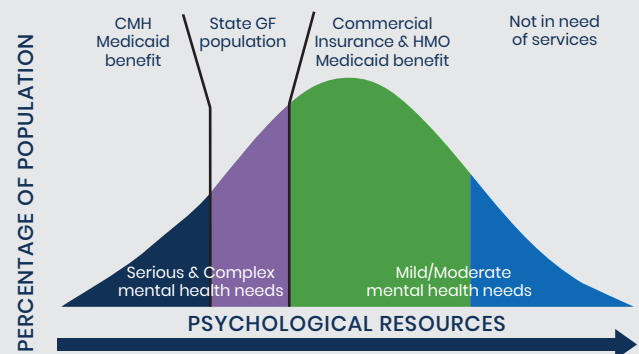


## The CMH system serves the most in need population

**1 in 5 people** in the State of Michigan suffer from a mental illness.

**That is 2M people total.**

Of those 2 million people, Michigan's public mental health system serves the most serious and complex individuals, which is about **300,000 people.**



(Well-Being Institute, University of Cambridge, 2011)

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT [CMHA.ORG](http://CMHA.ORG) OR CALL 517-347-6848.

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# Did you Know?



**83 counties** in Michigan are covered by the 46 CMHs & 10 PIHPs.



**94% medical loss ratio** (i.e. the percentage of dollars spent on actual care) of Michigan's public PIHP system has a statewide average spent on administrative costs of 6%.



**Since 1997**, Michigan has remained the only state in the nation that provides publicly managed care for all four major populations; adults with mental illness, children and adolescents with emotional disturbances, persons with intellectual / developmental disabilities, and those with substance use disorders **[saving the state more than \$1 billion!]**



**24 hours a day / 7 days a week**, mental health professionals provide services for people with mental illness, intellectual / developmental disabilities, and substance use disorders regardless of ability to pay. As outlined in Michigan's Mental Health Code, Public Act 258 of 1974, Michigan's public mental health system serves as the local public safety net for the state's most vulnerable citizens.



**91 percent** of the CMH budget is from Medicaid and Healthy MI plan. State General dollars that serve people without insurance makes up only 4% of the total budget.



**2 million people** statewide are impacted by one of the 300,000 people served by Michigan's public community mental health system when you include family, friends, neighbors, and co-workers.



Michigan's public community mental health system is a **\$3 billion industry** in our state employing more than **100,000 people**.



**750+** Michigan's CMH/PIHP system is leading the way with more than 750 on-the-ground healthcare integration initiatives across the state - co-location, electronic health records, and partnerships.

## Substance Use Disorders

Opioid deaths in Michigan are increasing. From 1999 to 2016, the total number of **overdose deaths involving any type of opioid increased more than 17 times in Michigan**, from 99 to 1,689.3 **Over six people in Michigan die every day from opioid-related causes.**

Every person can make a difference. Some things you can start doing today:

- Store medications safely.
- Don't share prescription medications.
- Learn to recognize the signs and symptoms of opioid abuse.
- Keep talking about the opioid epidemic and help break the stigma.

Healthy Michigan Plan provides dedicated and reliable funding for persons with substance use disorders and who have co-occurring mild to moderate mental disorders.

Prior to HMP (Medicaid Expansion), some regions had up to six month waiting lists for Medication Assisted Treatment (MAT) or withdrawal management /residential treatment. Oftentimes these are the most important services for people with opiate use disorders to begin the road to recovery.

**Over 70,000 people** receive Substance Use Disorder treatment and recovery services through Michigan's public system each year.



**Southwest Michigan Behavioral Health Board Meeting**  
**Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001**  
**February 10, 2023**  
**9:30 am to 11:30 am**  
(d) means document provided  
**Draft: 12/13/22**

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
  - None Scheduled
4. **Consent Agenda**
  - January 13, 2023 SWMBH Board Meeting Minutes (d)
5. **Operations Committee**
  - None
6. **Ends Metrics Updates (\*Requires motion)**

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

  - a. \*Fiscal Year 2022 Performance Bonus Incentive Program Narrative Report (J. Gardner) (d)
  - b. \*Fiscal Year 2022 Behavioral Health Treatment Episode Data Set (J. Gardner) (d)
7. **Board Actions to be Considered**
  - May Board Retreat Agenda
8. **Board Policy Review**

*Is the Board in Compliance? Does the Policy Need Revision?*

  - BG-007 Code of Conduct (d)
9. **Executive Limitations Review**

*Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?*

  - None
10. **Board Education**
  - a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d)
  - b. Fiscal Year 2022 Quality Assurance and Performance Improvement Program Evaluation (J. Gardner) (d)
  - c. Fiscal Year 2023 Utilization Management Plan (B. Guisinger) (d)

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

- a. Opioid Advisory Commission (B. Casemore) (d)
- b. March 10, 2023 Draft Board Agenda (d)
- c. Board Member Attendance Roster (d)
- d. March Board Policy Direct Inspection – BEL-001 Budgeting (C. Naccarato)

**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**

**Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001**

**March 10, 2023**

**9:30 am - 11:30 am**

2022 SWMBH Board Member & Board Alternate Attendance												
Name:	January	February	March	April	May	June	July	August	September	October	November	December
<b>Board Members:</b>												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Sherii Sherban (Calhoun)												
Marcia Starkey (Calhoun)												
Louie Csokasy (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarato (St. Joe)												
Susan Barnes (Van Buren)												
<b>Alternates:</b>												
Robert Becker (Barry)												
Randy Hyrns (Berrien)												
Nancy Johnson												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Jeanne Jourdan (Cass)												
Patricia Guenther (Kalamazoo)												
Karen Longanecker (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 12/9/22


Green = present

Red = absent

Black = not a member

Gray = meeting cancelled