Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

Please join the meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/515345453
You can also dial in using your phone:
1-571-317-3116 - Access Code: 515-345-453
January 8, 2021
9:30 am to 11:00 am
(d) means document provided
Draft: 1/4/21

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 11, 2020 SWMBH Board Meeting Minutes (d) p. 3

5. **Operations Committee**

   a. Operations Committee Minutes November 18, 2020 (D. Hess) (d) p. 11
   b. Operations Committee Quarterly Report (D. Hess) (d) p. 15

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

   - None

7. **Board Actions to be Considered *(Requires motion)***

   - Fiscal Year 2021 Utilization Management Plan (A. Wickham) (d) p. 16

8. **Board Policy Review *(Requires motion)***
   Is the Board in Compliance? Does the Policy Need Revision?

   a. BG-001 Committee Structure (d) p. 39
   b. BG-004 Board Ends and Accomplishments (d) p. 40
   c. BG-007 Code of Conduct (d) p. 41

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

   - None

10. **Board Education**

    a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d) p. 43
    b. Fiscal Year 2021 Quality Assurance Performance and Improvement Plan (J. Gardner) (d) p. 51
    c. Fiscal Year 2020 Customer Services Report (S. Ameter) (d) p. 126
    d. Fiscal Year 2020 Program Integrity Compliance Report (M. Todd) (d) p. 143

11. Communication and Counsel to the Board

a. Fiscal Year 2020 Medicaid Services Verification Report (M. Todd) (d) p. 147
b. Intergovernmental Contract Status (B. Casemore) (d) p. 153
c. February 12, 2021 Board Agenda (d) p. 154
d. 2020 Board Member Attendance to CMHSPs
e. Board Member Attendance Roster (d) p. 156
f. 2020 SWMBH Retirement Plan Fiduciary Review (B. Casemore)
g. 2020-2021 Outlook Biden's Policy Agenda and SDOH Investing (B. Casemore) (d) p. 157
h. MDHHS COVID-19 Interactive Dashboard (B. Casemore) (d) p. 162
i. Substance Abuse Block Grant Memo (B. Casemore) (d) p. 165
j. February Board Policy Direct Inspection – BEL-001 Budgeting (S. Barnes)

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.

SWMBH Board Planning Session
January 8, 2021
11:15 am – 1:15 pm

Next SWMBH Board Meeting
February 12, 2021
9:30 am - 11:00 am

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
December 11, 2020
9:30 am-11:30 am
GoTo Webinar and Conference Call
Draft: 12/11/20

Members Present via phone: Edward Meny, Tom Schmelzer, Susan Barnes, Mary Middleton, Patrick Garrett, Pat Guenther, Ruth Perino and Carol Naccarato

Guests Present via phone: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Joel Smith, Director of SUD Treatment and Prevention Services, SWMBH; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Kris Kirsch, St. Joseph CMH; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe; Jeff Patton, ISK, Randy Hyrns, Board Alternate, Terry Proctor, and Paul Yeagar.

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

Public Comment
None

Agenda Review and Adoption

Motion	Tom Schmelzer moved to accept the agenda with the addition of Jon Houtz to the Financial Interest Disclosure Handling	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes
Motion Carried		

Financial Interest Disclosure Handling
Carol Naccarato has been appointed by St. Joseph County CMH as its primary representative to the SWMBH Board of Directors, and SWMBH as received the St. Joseph County CMH Board Resolution reflecting this. Ms. Naccarato completed the SWMBH Financial Interest Disclosure Statement listing only the inherent conflict arising from simultaneous service to the St. Joseph CMH Board and the SWMBH Board. The SWMBH Board considered the matter and voted to grant a Waiver, as below:

Motion Tom Schmelzer moved:

1. A conflict exists
2. The Board, with reasonable efforts, is not able to obtain a more advantageous transaction or arrangement from someone other than Carol Naccarato
3. The Financial Interest disclosed is not so substantial as to be likely to affect the integrity of the services the Board can expect to receive from Carol Naccarato
4. The conflict should be waived.

Second	Mary Middleton	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Jon Houtz is an alternate member of the SWMBH Board appointed by Pines Behavioral Health. Mr. Houtz updated his Financial Interest Disclosure Statement to include his position as a Branch County Commissioner. The SWMBH Board considered the matter and voted to grant a Waiver covering this disclosure, as below:

Motion Susan Barnes moved:

1. A conflict exists
2. The Board, with reasonable efforts, is not able to obtain a more advantageous transaction or arrangement from someone other than Jon Houtz;
3. The Financial Interest disclosed is not so substantial as to be likely to affect the integrity of the services the Board can expect to receive from Jon Houtz;
4. The conflict should be waived.

Second	Ruth Perino	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Consent Agenda

Motion	Patrick Garrett moved to approve the November 13, 2020 Board meeting minutes as presented.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes

	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Operations Committee

Operations Committee Minutes October 28, 2020

Edward Meny noted the minutes as documented. Debbie Hess stated that she did not have any additional comments. Minutes accepted.

Ends Metrics

None

Board Actions to be Considered

2021-2022 Board Ends Metrics

Jonathan Gardner presented the 2021-2022 Board Ends Metrics to the Board and entertained discussion with the Board on each of the (17) metrics as presented.

Motion	Mary Middleton moved that The SWMBH Board approves the (17) 2021-2022 Board Ends Metrics with no revisions needed.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

PA 228 of 2020

Brad Casemore reported as documented noting history and report presented at last month's meeting.

Motion	Patrick Garrett moved that after consideration the Board has determined that the SWMBH Board room cannot adhere to the current MDHHS COVID-19 inside gatherings limitations Executive Orders. Therefore, so long as those or more stringent Executive Orders remain in effect the SWMBH Board shall maintain remote Board Meetings which meet the public access requirements of PA 228 of 2020. Management is instructed to follow subsequent MDHHS or other related Executive Orders or Court opinions and advise the Board accordingly.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes

	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Membership in Michigan Consortium for Healthcare Excellence (MCHE)

Brad Casemore reported as presented noting background and context of SWMBH's participation in MCHE.

Motion	Pat Guenther moved that SWMBH should maintain its membership in MCHE for the calendar year 2021.	
Second	Mary Middleton	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Calendar Year 2021 Board Policy Direct Inspection Assignments and Events Calendars

Brad Casemore reported as documented.

Motion	Tom Schmelzer moved to approve the calendar year 2021 Board Policy Direct Inspection Assignments and Events Calendars and presented.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

BG-012 Open Meetings Act and Freedom of Information Act

Brad Casemore reported as documented.

Motion	Ruth Perino moved to approve the revised policy BG-012 Open Meetings Act and Freedom of Information Act with one change from 220 to 2020 in the first paragraph.	
Second	Patrick Garrett	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes

	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Financial Risk Management Plan, Financial Management Plan and Cost Allocation Plan

Tracy Dawson reported as documented.

Motion	Pat Guenther moved to approve the Financial Risk Management Plan, Financial Management Plan and Cost Allocation Plan as presented.	
Second	Ruth Perino	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Closed Board Session

Motion	Patrick Garrett motioned to go into closed session.	
Second	Mary Middleton	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarto	yes
	Susan Barnes	yes

Motion Carried

Motion	Mary Middleton motioned to leave closed session.	
Second	Sue Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarto	yes
	Susan Barnes	yes

Motion Carried

Open Board Session

Motion	Ruth Perino motioned to go into open session.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

Board Policy Review

BG-005 Chairperson's Role

Edward Meny reported as documented.

Motion	Edward Meny moved the Board is in compliance and the Policy BG-005 Chairperson's Role does not need revision.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Susan Barnes	yes

Motion Carried

Executive Limitations Review

BEL-003 Asset Protection

Susan Barnes reported as documented.

Motion	Susan Barnes moved the Executive Officer is in compliance and the Policy BEL-003 Asset Protection does not need revision.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarto	yes
	Susan Barnes	yes

Motion Carried

BEL-010 Regional Entity 501 (c) (3) Representation

Mary Middleton reported as documented.

Motion	Mary Middleton moved the Executive Officer is in compliance and the Policy BEL-010 Regional Entity 501 (c) (3) Representation does not need revision.	
Second	Pat Guenther	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

Board Education

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Information Systems Update

Natalie Spivak reported as documented.Discussion followed.

Communication and Counsel to the Board

PIHP Complex Care Management Proposal

Brad Casemore reported as documented noting the potential for additional roles and responsibilities with Behavioral Health.

Intergovernmental Contract

Brad Casemore reported as documented noting that SWMBH has received signed contracts from seven of the eight counties.

Public Act 2 Outcomes Report

Joel Smith reported as documented. Discussion followed.

2020 Filonow Award of Excellence

Brad Casemore reported as documented noting that SWMBH nominated Jonathan Gardner for this prestigious award and remarked on Jonathan Gardner's deservedness of the award. The Board concurred.

Brad Casemore Employment Agreement

Edward Meny noted that the Board Executive Committee has met and discussed a 2-year extension to Brad Casemore' employment agreement. The Board Executive Committee is in favor of this extension noting Brad Casemore's high value to SWMBH. The Board Executive Committee also wanted to offer the Board and Board Alternates an opportunity to review the employment agreement and meet with

Roselyn Parmenter if so desired. Brad Casemore and Michelle Jacobs to follow up with Board and Board Alternates on arrangements for this opportunity.

February Board Meeting
Edward Meny noted the history of cancelling the February Board meetings due to Board members traveling out of state. Discussion followed. The Board agreed to meet in February of 2021 due to availability of remote participation.

Public Comment
None

Adjournment

Motion	Tom Schmelzer moved to adjourn at 11:45am	
Second	Patrick Garrett	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Pat Guenther	yes
	Carol Naccarato	yes
	Susan Barnes	yes
Motion Carried		

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: November 18, 2020 9:00am-12:00pm

Members Present via phone – Jeannie Goodrich, Jeff Patton, Richard Thiemkey, Bradley Casemore, Sue Germann, Kris Kirsch, Tim Smith, Ric Compton, Jane Konyndyk, Tina Boyer

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Sarah Ameter, Customer Services Manager, SWMBH; Andy Aardema, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Gale Hackworth, Clinical Consultant, SWMBH; Brad Sysol, Summit Pointe, Pat Davis, Integrated Services of Kalamazoo

Call to Order – Brad Casemore began the meeting at 9:01 am.

CMH Updates – Brad Casemore

Barry County (Barry CCMHA) – Richard Thiemkey gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff
- Reducing face to face contact when possible
- Outreach Program consisting of one case manager and one peer working with law enforcement and United Way to reach the homeless regarding services

Berrien County (Riverwood) – Ric Compton gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff
- New Health System/Service with some mental health and substance abuse services-two staff serving there
- Exploring ride along with law enforcement
- Staff Implicit Bias and Racism training, staff survey on racism, staff book club, and other staff trainings

Branch County (Pines BH) – Sue Germann gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff – staff fatigue and new staff issues
- Services are continuing without interruption-blend of face to face and Zoom
- Two new mobile teams
- Coordinating Public Announcements

Calhoun County (Summit Pointe) – Jeannie Goodrich gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff – balance staff needs, safety and services
- Work continues on two SAMHSA grants awarded last year
- Local Foundation funds used to purchase new building on College St. that will house urgent psychiatric care and eventually house all of Summit Pointe in 2022
- Provided law enforcement with CIT trainings and ride along
- Community Service Meetings to address needs in the community
- Purchase of Credible Minds software

Cass County (Woodlands) – Tim Smith gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff
- New CFO, Jon Rydel, working with Roger Pierce and Jill Brindley

Kalamazoo County (ISK) – Jeff Patton gave the following updates:

- Executive Team revising/amending emergency preparedness plan and organizational response plan
- COVID hitting Kalamazoo County hard, both staff and clients - reducing on site administrative staff
- Launched recovery initiative with Gryphon Place
- Central services still be provided
- Opened two additional homeless shelters
- Trauma and racial trauma trainings

St. Joseph County (St. Joseph CMHSAS) – Kris Kirsch gave the following updates:

- Executive Team revising/amending emergency preparedness plan
- Reducing on site administrative staff
- Ride along with law enforcement when safe to do so – calling and welfare checks during COVID pandemic

Van Buren County (Van Buren CMHA) – Tina Boyer gave the following updates:

- Executive Team revising/amending emergency preparedness plan – weekly meetings
- Reducing on site administrative staff
- Moving two to one services to one to one services whenever possible

Review and approve agenda – Agenda approved with addition of Data Use Agreements.

Review and approve minutes from 10/28/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported as documented, noting 2020 financials will be finalized in March. SWMBH received the first payment from the state which was better than expected and SWMBH is waiting for December payment to review consistency. Discussion followed.

Fiscal Year 2020 Encounters – Tracy Dawson reported as documented noting that the encounter reports are available on Tableau.

2020 Closeout Tasks and Calendar – Tracy Dawson stated that templates and instructions have not been received from the state and Milliman has not released a date for pulling encounter data. SWMBH's target closeout date is 12/15/20.

Cost Allocation, EQI and Rate Setting Development Workgroup – Jeannie Goodrich who serves on the CEO cost allocation workgroup stated that workgroup met on 11/16 and discussed standardization of admin costs, transportation costs and grouping costs such as skill building and CLS. Pat Davis shared that the workgroup she serves on has not met recently.

Data Use Agreements – Mila Todd stated that data use agreements will be down streamed to CMHSPs as soon as SWMBH receives them from the state.

Regional HR Needs – Anne Wickham reported as documented noting that SWMBH has several staff with HR education and experience and the CMHSPs could utilize their assistance if needed. Discussion followed.

Fiscal Year 2021 Rate Setting Files Analysis – Tracy Dawson noted concerns with members per month. Pat Davis reported as documented, thanked Andy Aardema for his work on the reports and noted that Milliman appears to have missed certain autism call within the 97,000 coding. Pat Davis summarized other findings and responses. Discussion followed. Both Brad Casemore and Jeff Patton stated the importance of continued work on this a high priority item.

Direct Care Wage (DCW) October – December – Tracy Dawson that once SWMBH receives the DCW funding it will be distributed to the CMHSPs.

Provider Network Stability Plan – Mila Todd noted that she requested an update from the CMHSPs which is due to SWMBH by 11/20 for submission to the state by 11/30.

Telephonic Services – Anne Wickham reviewed email with group and noted what codes Medicare will and will not pay for. For some codes a Medicaid denial is needed first, although Medicaid will pay for codes which would a problem if/when audited. Brad Casemore, Mila Todd and Anne Wickham will discuss next steps/action and report back to the group.

2021 Operations Committee Calendar – Brad Casemore reported as documented. Group approved the 2021 Operations Committee calendar meetings as presented.

2021-2022 Board Ends Metrics – Jonathan Gardner reported as documented and asked for the Operations Committee endorsement of the metrics for presentation at the December SWMBH Board meeting. Jonathan Gardner will email Van Buren County for their vote. Operations Committee vote as follows:

Barry County	yes	Cass County	yes
Berrien County	yes	Kalamazoo County	yes
Branch County	yes	St. Joseph County	yes
Calhoun County	yes	Van Buren County	(absent)

2020 Performance Bonus Incentive Program (PBIP) – Jonathan Gardner thanked the CMHSPs for their work on the PBIP which was submitted to the state on 11/17/20.

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd stated that MDHHS-PIHP contract negotiations is scheduled for this Friday, November 20th and SWMBH will provide updates as applicable.

Behavioral Health Care Solutions – Mila Todd reported as documented noting Behavioral Care Solutions (BCS) is a provider that provides mental health services to residents in nursing facilities, under arrangements with the nursing facilities. BCS contacted SWMBH to request payment for these services delivered to MI Health Link beneficiaries. SWMBH researched the matter, as well as checked with one of our MHL ICOs and its contract manager at MDHHS and takes the position that SWMBH is not the entity responsible for reimbursement for the services delivered by BCS. This was relayed to BCS in a phone call on Wednesday 11/11/2020. BCS was also provided a written summary of SWMBH's position. SWMBH committed to notifying BCS if and when we receive any additional information from MDHHS, and BCS committed to following up with its legal department on pursuing the matter further.

Building Better Lives Project – Sarah Ameter reported as documented covering Introduction, Rationale, Purpose, Goals and Accomplishments to date for this project. Sarah Ameter asked the group for any feedback, suggestions, or concerns.

Intergovernmental Contract Update – Brad Casemore shared that of the eight counties in the region SWMBH is waiting for signed contracts from Cass, Kalamazoo and St. Joseph counties. Discussion followed.

Moira Kean Leave of Absence – Brad Casemore stated that Moira Kean is on Leave of Absence for the remainder of 2020.

Adjourned – Meeting adjourned at 11:01am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for October, November, December 2020
Board Date 1/8/21

Action items:

- Reviewed 2020-2023 SWMBH Strategic Business Plan
- Reviewed Fiscal Year 2021 draft Budget

Discussion items:

- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some of the topics from this quarter included:
    - CMHSP CEOS's shared current updates and sought input from colleagues focused on response plans to the pandemic, challenges, and regulations. Also highlighted new grants and projects unrelated to the pandemic.
    - Reviewed year to date financial reports, actions being taken to decrease expenditures, and reviewed state level actions which impact financials
    - Reviewed Fiscal Year 2021 Budget Assumptions
    - Reviewed Fiscal Year 2020-2021 Contract Status/Updates
    - Reviewed Fiscal Year 2021 Performance Bonus Incentive Program developments
    - Reviewed State changes regarding Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI)
    - Reviewed Fiscal Year 2020 Encounter Volumes
    - Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status and review
    - Reviewed Autism Spectrum Disorder Services reports and recommended guidelines
    - Reviewed SWMBH Quality Assurance Performance Improvement and Utilization Management Plans
    - Reviewed and discussed various State and Milliman rate setting documents and Cost Allocation Workgroup updates
    - Reviewed Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and External Quality Review
    - Reviewed Provider Stability Plan and MDHHS Funding (CMH General Fund and PIHP Risk Corridor)
    - Reviewed MI Health Link meetings and status
    - Reviewed Direct Care Premium Pay Implementation
    - Reviewed Managed Care Functional Review Provider Network Management Phases of implementation
    - Reviewed status of renewal of Substance Use Disorder Oversight Policy Board Intergovernmental Contract which is set to expire on 12/31/20.
    - Reviewed 2020-2023 SWMBH Strategic Imperative Descriptions, Priorities and Timelines
    - Reviewed upcoming SWMBH Board planning meetings

Southwest Michigan Behavioral Health

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

FY 2021 (October 1,2020 – September 30, 2021)

Table of Contents

Introduction

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

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

Purpose

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

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

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

Values

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

Authority and Structure

Program Oversight

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

Committee

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

Staffing

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

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

Roles of the Committee

The RUM is charged with the following

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

Standards and Philosophy

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

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

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

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

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

Access to SWMBH Behavioral Health Services

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

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

Access Standards

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

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

Level of Intensity of Service Determination

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

Coordination and Continuity of Care

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

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

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

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

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

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

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

The outlier management process and subsequent reports to manage it, including Over and 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.

Review Activities

Utilization Management

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and 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. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

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

Process Used to Review and Approve the Provision of Medical Services

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

Use of Incentives

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

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

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

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

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

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

Crisis Services
Crisis services are considered a benefit for any SWMBH customer or anyone who is physically in a county of the SWMBH region who needs urgent intervention. Crisis services are not considered a Level of Care and do not require prior authorization. Appropriately trained and qualified CMHSP behavioral health practitioners with sufficient clinical experience who meet the qualifications for a preadmission unit

pursuant to Michigan Mental Health Code 330.1409 Sec 409 provide prescreening services and authorization of 1-3 days of psychiatric inpatient or crisis residential, and any appropriate diversion and/or second opinion services.

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

Level VI- Intensive High Need/Acute (Medically Managed Residential)

Customers receiving services at this level of care are adults with a LOCUS score typically of 28 or higher including a score of 4 on dimension I and who present as a persistent danger to self or others. Treatment is typically provided in an inpatient setting and is aimed at ensuring safety and minimizing danger to self and others and alleviating the acute psychiatric crisis.

Level V – Intense Need/Acute (Medically Monitored Residential)

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

Level IV – High Need (Medically Monitored Non- Residential Services)

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

Level III – Moderate Need (High Intensity Community Based Services)

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

Level II – Low Need (Low Intensity Community Based Need)

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

Level I – Minimal Need (Recovery Maintenance and health Management)

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

Level 0 -- Basic Services

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

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

Eligible for PIHP Medicaid Services (Severe need):

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

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

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

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

Level IV -- Intense Need

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

Level III – High Need

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

Level II – Moderate Need

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

Level I – Low Need

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

Level 0 – Minimal Need

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

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

Eligible for PIHP Medicaid Services (Severe need):

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

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

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

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

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

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

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

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

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

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

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

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

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

Level II – Low Need (Moderate functional support needs, low medical and behavioral support needs. ABE Score 22-27, and Medical Score 0-3, and Behavior 0-3

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

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

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

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

Level V – Intense Need

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

Level IV – High Need

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

Level III – Moderate Need

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

Level II – Low Need

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

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

Level I – Minimal Need

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

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

Level 0.5 – Early Intervention

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

Level 1.0 – Outpatient Services

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

Level 2.1 – Intensive Outpatient

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

Level 2.5 – Partial Hospitalization

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

Level 3.1 – Clinically-Managed Low-Intensity Residential

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

Level 3.3 – Clinically-Managed Medium-Intensity Residential

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

Level 3.5 – Clinically Managed High Intensity Residential

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

Level 3.7 – Medically-Monitored Intensive Inpatient

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

Level 4 – Medically-Managed Intensive Inpatient

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

Level I-D – Detoxification

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

Level OMT – Opioid Maintenance Therapy

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

Review Process

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

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

Outlier Management

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

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

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

3. Outlier Management Procedures

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

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

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

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

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

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

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

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

Data Management

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

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

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

Communication

UM Program Plan

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

Availability of Utilization Management Staff

SWMBH UM staff are available by telephone (toll free) from 8:00 a.m. to 5:00 p.m. Monday through Friday of each normal business day. Utilization Review staff respond to email and telephonic communications within one business day during provider's normal business hours. UM staff identify themselves by name, title and organization during correspondence. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, SWMBH provides the opportunity for the requesting customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

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

Peer Clinical Review

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

Evaluation

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Roles

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

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

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

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

References/Additional Guiding Document

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

Plan Review and Approval

Medical Director: _____
Signature/date of review

Chief Administrative Officer: _____
Signature/date of review

Director of Clinical Quality: _____
Signature/date of review

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-001	Pages: 1
Subject: Committee Structure	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
03.14.2014	1/10/20	3.13.15, 3/11/16, 3/10/17, 3/9/18,1/11/19

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

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

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

Southwest Michigan
BEHAVIORAL HEALTH

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

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

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

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

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

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

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

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

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

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

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Management/Governance	Policy Number: BG-007	Pages: 2
Subject: Code of Conduct	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH Executive Officer (EO)		Required Reviewer: SWMBH Board
Effective Date: 01.10.2014	Last Review Date: 1/10/20	Past Review Dates: 1.09.15, 1/8/16, 1/13/17, 2/9/18,1/11/19

I. **PURPOSE:**

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

II. **POLICY:**

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

III. **STANDARDS:**

1. Members will follow the SWMBH Conflict of Interest Policy

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

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

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

5. Members will be properly prepared for Board deliberation.

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

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

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

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

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

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

	E	F	G	H	J	K	L	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***				***Mos in Period***									
2	For the Fiscal YTD Period Ended 11/30/2020			**P02FYTD21**	**2**									
3	*(For Internal Management Purposes Only)*													
4	***INCOME STATEMENT***			**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**	**Indirect Pooled Cost**	
5														
6														
7	**REVENUE**													
16	Contract Revenue			53,384,888	40,717,716	7,116,024	3,877,853	576,374	-	731,163	365,759	-	-	
17	DHHS Incentive Payments			219,688	219,688	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			24,711	-	-	-	-	24,711	-	-	-	-	
19	Interest Income - Working Capital			1,558	-	-	-	-	-	-	-	1,558	-	
20	Interest Income - ISF Risk Reserve			194	-	-	-	-	-	-	-	194	-	
21	Local Funds Contributions			287,699	-	-	-	-	-	-	-	287,699	-	
22	Other Local Income			-	-	-	-	-	-	-	-	-	-	
23														
24	**TOTAL REVENUE**			**53,918,738**	**40,937,404**	**7,116,024**	**3,877,853**	**576,374**	**24,711**	**731,163**	**365,759**	**289,451**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			3,043,544	616,692	1,276,703	-	472,614	3,035	594,323	80,179	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			38,620,260	32,279,064	3,394,720	2,578,307	265,335	-	102,833	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			540,366	540,366	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			1,246,476	1,246,476	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	203,507	-	-	(203,507)		-	-	-		
33														
34	**Total Healthcare Cost**			**43,450,646**	**34,886,105**	**4,671,423**	**2,578,307**	**534,441**	**3,035**	**697,156**	**80,179**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**81.1%**	**85.2%**	**65.6%**	**66.5%**	**92.7%**		**95.3%**	**21.9%**			
37	**Administrative Cost**													
38	Purchased Professional Services			69,655	-	-	-	-	-	-	-	69,655	-	
39	Administrative and Other Cost			1,195,198	-	-	-	-	21,676	12,997	-	1,161,002	(477)	
40	Interest Expense			-	-	-	-	-	-	-	-	-	-	
41	Depreciation			14,792	-	-	-	-	-	-	-	14,792	-	
42	Functional Cost Reclassification			-	-	-	-	-	-	-	-	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	-	(477)	477	
44	Delegated Managed Care Admin			2,889,055	2,419,441	253,929	195,585	20,100	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			-	973,244	138,207	76,281	21,833	731	21,010	-	(1,231,306)	-	
46														
47	**Total Administrative Cost**			**4,168,699**	**3,392,685**	**392,136**	**271,866**	**41,933**	**22,407**	**34,007**	**-**	**13,665**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**8.8%**	**8.9%**	**7.7%**	**9.5%**	**7.3%**		**4.7%**	**0.0%**	**2.6%**		
49														
50	Local Funds Contribution			287,699	-	-	-	-	-	-	-	287,699	-	
51	PBIP Transferred to CMHPs			-								-		
52														
53	**TOTAL COST after apportionment**			**47,907,044**	**38,278,790**	**5,063,558**	**2,850,174**	**576,374**	**25,442**	**731,163**	**80,179**	**301,364**	**-**	
54														
55	**NET SURPLUS before settlement**			**6,011,694**	**2,658,614**	**2,052,465**	**1,027,679**	**-**	**(731)**	**(0)**	**285,581**	**(11,913)**	**-**	
56	**Net Surplus (Deficit) % of Revenue**			**11.1%**	**6.5%**	**28.8%**	**26.5%**	**0.0%**	**-3.0%**	**0.0%**	**78.1%**	**-4.1%**		
58	Prior Year Savings			-	-	-	-	-		-	-	-		
59	Change in PA2 Fund Balance			(285,581)	-	-	-	-		-	(285,581)	-		
60	ISF Risk Reserve Abatement (Funding)			(194)	-	-	-	-		-	-	(194)		
61	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-		-	-	-		
62	Settlement Receivable / (Payable)			-	945,337	82,342	(1,027,679)	-	-	0	(0)	-		
63	**NET SURPLUS (DEFICIT)**			**5,725,920**	**3,603,951**	**2,134,807**	**-**	**-**	**(731)**	**-**	**-**	**(12,107)**	**-**	
64	*HMP & Autism is settled with Medicaid*													
65														
66	**SUMMARY OF NET SURPLUS (DEFICIT)**													
67	Prior Year Unspent Savings			-	-	-	-	-		-	-	-		
68	Current Year Savings			5,738,758	3,603,951	2,134,807	-	-		-	-	-		
69	Current Year Public Act 2 Fund Balance			-	-	-	-	-		-	-	-		
70	Local and Other Funds Surplus/(Deficit)			(12,838)	-	-	-	-	(731)	-	-	(12,107)	-	
72	**NET SURPLUS (DEFICIT)**			**5,725,920**	**3,603,951**	**2,134,807**	**-**	**-**	**(731)**	**-**	**-**	**(12,107)**	**-**	
73														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2020			2									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5										P02 projected by SWMBH			
6	**Medicaid Specialty Services**			*HCC%*	80.7%	78.1%	79.0%	81.6%	78.0%	80.5%	82.7%	83.8%	82.5%
7	Subcontract Revenue		40,717,716	2,434,230	38,283,486	1,670,526	7,659,834	2,125,723	6,921,040	1,892,029	11,814,289	2,529,897	3,670,148
8	Incentive Payment Revenue		219,688	165,399	54,289	4,765	-	15,885	28,063	810	-	4,765	-
9	**Contract Revenue**		**40,937,404**	**2,599,629**	**38,337,775**	**1,675,292**	**7,659,834**	**2,141,607**	**6,949,103**	**1,892,840**	**11,814,289**	**2,534,662**	**3,670,148**
10													
11	External Provider Cost		24,826,309	616,692	24,209,618	791,248	4,645,768	1,016,316	4,945,366	1,025,024	8,159,831	1,638,257	1,987,808
12	Internal Program Cost		8,426,004	-	8,426,004	490,279	1,634,290	489,842	1,696,280	559,691	1,471,350	805,304	1,278,969
13	SSI Reimb, 1st/3rd Party Cost Offset		(91,223)	-	(91,223)	(722)	(10,748)	(6,284)	(13,059)	(7,169)	(38,456)	(5,577)	(9,206)
14	Insurance Provider Assessment Withhold (IPA)		1,786,842	1,786,842	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(81,928)	(81,928)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**34,866,005**	**2,321,606**	**32,544,399**	**1,280,804**	**6,269,310**	**1,499,874**	**6,628,587**	**1,577,546**	**9,592,725**	**2,437,983**	**3,257,570**
17	**Medical Loss Ratio (HCC % of Revenue)**		**85.2%**	**89.3%**	**84.9%**	**76.5%**	**81.8%**	**70.0%**	**95.4%**	**83.3%**	**81.2%**	**96.2%**	**88.8%**
18													
19	**Managed Care Administration**		**3,412,785**	**973,244**	**2,439,541**	**136,753**	**489,385**	**127,931**	**429,235**	**143,523**	**778,030**	**135,144**	**199,540**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**8.9%**	**2.5%**	**6.4%**	**9.6%**	**7.2%**	**7.9%**	**6.1%**	**8.3%**	**7.5%**	**5.3%**	**5.8%**
21													
22	**Contract Cost**		**38,278,790**	**3,294,849**	**34,983,940**	**1,417,557**	**6,758,695**	**1,627,805**	**7,057,821**	**1,721,068**	**10,370,755**	**2,573,128**	**3,457,111**
23	**Net before Settlement**		**2,658,614**	**(695,220)**	**3,353,834**	**257,734**	**901,139**	**513,803**	**(108,718)**	**171,771**	**1,443,534**	**(38,466)**	**213,038**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		945,337	4,299,172	(3,353,834)	(257,734)	(901,139)	(513,803)	108,718	(171,771)	(1,443,534)	38,466	(213,038)
28	**Net after Settlement**		**3,603,951**	**3,603,951**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		161,560	161,560	161,560	8,624	31,156	9,201	30,606	9,565	42,252	13,303	16,853
32	Revenue PMPM		$ 126.69	$ 8.05	$ 118.65	$ 97.13	$ 122.93	$ 116.38	$ 113.53	$ 98.95	$ 139.81	$ 95.27	$ 108.89
33	Expense PMPM		$ 118.47	$ 10.20	$ 108.27	$ 82.19	$ 108.47	$ 88.46	$ 115.30	$ 89.97	$ 122.73	$ 96.71	$ 102.57
34	Margin PMPM		$ 8.23	$ (2.15)	$ 10.38	$ 14.94	$ 14.46	$ 27.92	$ (1.78)	$ 8.98	$ 17.08	$ (1.45)	$ 6.32
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		161,560	161,560	161,560	8,624	31,156	9,201	30,606	9,565	42,252	13,303	16,853
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		13,153	13,153	13,153	1,103	2,184	764	2,693	1,015	3,129	1,081	1,184
43	% Variance - Fav / (Unfav)		8.9%	8.9%	8.9%	14.7%	7.5%	9.1%	9.6%	11.9%	8.0%	8.8%	7.6%
44													
45	**Contract Revenue before settlement**												
46	Actual		40,937,404	2,599,629	38,337,775	1,675,292	7,659,834	2,141,607	6,949,103	1,892,840	11,814,289	2,534,662	3,670,148
47	Budget		34,011,475	2,873,673	31,137,802	1,232,730	6,199,356	1,664,872	5,713,851	1,625,394	9,627,535	2,090,162	2,983,904
48	Variance - Favorable / (Unfavorable)		6,925,929	(274,044)	7,199,973	442,562	1,460,477	476,736	1,235,253	267,446	2,186,754	444,500	686,244
49	% Variance - Fav / (Unfav)		20.4%	-9.5%	23.1%	35.9%	23.6%	28.6%	21.6%	16.5%	22.7%	21.3%	23.0%
50													
51	**Healthcare Cost**												
52	Actual		34,866,005	2,321,606	32,544,399	1,280,804	6,269,310	1,499,874	6,628,587	1,577,546	9,592,725	2,437,983	3,257,570
53	Budget		31,774,872	1,721,674	30,053,199	1,296,029	6,075,510	1,593,202	5,357,459	1,542,796	9,109,251	2,161,960	2,916,990
54	Variance - Favorable / (Unfavorable)		(3,091,133)	(599,932)	(2,491,201)	15,225	(193,800)	93,328	(1,271,127)	(34,750)	(483,474)	(276,023)	(340,580)
55	% Variance - Fav / (Unfav)		-9.7%	-34.8%	-8.3%	1.2%	-3.2%	5.9%	-23.7%	-2.3%	-5.3%	-12.8%	-11.7%
56													
57	**Managed Care Administration**												
58	Actual		3,412,785	973,244	2,439,541	136,753	489,385	127,931	429,235	143,523	778,030	135,144	199,540
59	Budget		3,430,961	1,161,322	2,269,639	96,509	452,881	133,052	386,656	118,214	765,755	134,987	181,585
60	Variance - Favorable / (Unfavorable)		18,176	188,078	(169,902)	(40,244)	(36,504)	5,121	(42,579)	(25,308)	(12,275)	(157)	(17,955)
61	% Variance - Fav / (Unfav)		0.5%	16.2%	-7.5%	-41.7%	-8.1%	3.8%	-11.0%	-21.4%	-1.6%	-0.1%	-9.9%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 11/30/2020			**2**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P02 projected by SWMBH**			
62													
63	**Total Contract Cost**												
64	Actual		38,278,790	3,294,849	34,983,940	1,417,557	6,758,695	1,627,805	7,057,821	1,721,068	10,370,755	2,573,128	3,457,111
65	Budget		35,205,833	2,882,995	32,322,838	1,392,538	6,528,392	1,726,254	5,744,115	1,661,010	9,875,006	2,296,947	3,098,575
66	Variance - Favorable / (Unfavorable)		(3,072,957)	(411,854)	(2,661,103)	(25,019)	(230,304)	98,449	(1,313,706)	(60,058)	(495,749)	(276,181)	(358,535)
67	% Variance - Fav / (Unfav)		-8.7%	-14.3%	-8.2%	-1.8%	-3.5%	5.7%	-22.9%	-3.6%	-5.0%	-12.0%	-11.6%
68													
69	**Net before Settlement**												
70	Actual		2,658,614	(695,220)	3,353,834	257,734	901,139	513,803	(108,718)	171,771	1,443,534	(38,466)	213,038
71	Budget		(1,194,358)	(9,322)	(1,185,036)	(159,809)	(329,035)	(61,382)	(30,265)	(35,617)	(247,471)	(206,785)	(114,671)
72	Variance - Favorable / (Unfavorable)		3,852,972	(685,898)	4,538,870	417,543	1,230,174	575,185	(78,453)	207,388	1,691,005	168,320	327,709
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2020			2									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P02 projected by SWMBH**			
75	***Healthy Michigan Plan***			*HCC%*	8.4%	13.1%	8.2%	8.3%	9.9%	7.3%	6.9%	8.8%	8.5%
76	**Contract Revenue**		**7,116,024**	**1,374,020**	**5,742,003**	**289,033**	**1,159,086**	**277,790**	**1,056,168**	**315,884**	**1,640,850**	**447,454**	**555,738**
77													
78	External Provider Cost		3,091,738	1,276,703	1,815,035	91,963	364,264	62,493	368,358	28,181	635,665	85,550	178,562
79	Internal Program Cost		1,579,685	-	1,579,685	123,473	287,313	89,462	476,064	115,734	161,962	170,486	155,191
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**4,671,423**	**1,276,703**	**3,394,720**	**215,436**	**651,577**	**151,956**	**844,421**	**143,915**	**797,627**	**256,036**	**333,753**
82	**Medical Loss Ratio (HCC % of Revenue)**		**65.6%**	**92.9%**	**59.1%**	**74.5%**	**56.2%**	**54.7%**	**80.0%**	**45.6%**	**48.6%**	**57.2%**	**60.1%**
83													
84	**Managed Care Administration**		**392,136**	**138,207**	**253,929**	**23,002**	**50,862**	**12,961**	**54,681**	**13,093**	**64,693**	**14,193**	**20,444**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**7.7%**	**2.7%**	**5.0%**	**9.6%**	**7.2%**	**7.9%**	**6.1%**	**8.3%**	**7.5%**	**5.3%**	**5.8%**
86													
87	**Contract Cost**		**5,063,558**	**1,414,910**	**3,648,649**	**238,439**	**702,439**	**164,917**	**899,102**	**157,008**	**862,320**	**270,228**	**354,197**
88	**Net before Settlement**		**2,052,465**	**(40,890)**	**2,093,355**	**50,594**	**456,647**	**112,873**	**157,067**	**158,876**	**778,531**	**177,226**	**201,541**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		82,342	2,175,697	(2,093,355)	(50,594)	(456,647)	(112,873)	(157,067)	(158,876)	(778,531)	(177,226)	(201,541)
93	**Net after Settlement**		**2,134,807**	**2,134,807**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		63,594	63,594	63,594	3,205	12,854	3,064	11,516	3,851	17,954	4,958	6,194
97	Revenue PMPM		$ 55.95	$ 10.80	$ 45.15	$ 45.10	$ 45.09	$ 45.33	$ 45.86	$ 41.01	$ 45.70	$ 45.13	$ 44.86
98	Expense PMPM		39.81	11.12	28.69	37.20	27.32	26.91	39.04	20.39	24.02	27.25	28.59
99	Margin PMPM		$ 16.14	$ (0.32)	$ 16.46	$ 7.89	$ 17.76	$ 18.42	$ 6.82	$ 20.63	$ 21.68	$ 17.87	$ 16.27
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		63,594	63,594	63,594	3,205	12,854	3,064	11,516	3,851	17,954	4,958	6,194
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		12,025	12,025	12,025	692	2,443	633	2,348	876	2,901	1,041	1,091
108	% Variance - Fav / (Unfav)		23.3%	23.3%	23.3%	27.6%	23.5%	26.0%	25.6%	29.5%	19.3%	26.6%	21.4%
109													
110	**Contract Revenue before settlement**												
111	Actual		7,116,024	1,374,020	5,742,003	289,033	1,159,086	277,790	1,056,168	315,884	1,640,850	447,454	555,738
112	Budget		4,837,836	836,033	4,001,803	193,209	807,426	187,538	716,094	228,052	1,174,935	302,810	391,739
113	Variance - Favorable / (Unfavorable)		2,278,188	537,987	1,740,201	95,824	351,660	90,252	340,074	87,832	465,915	144,644	163,999
114	% Variance - Fav / (Unfav)		47.1%	64.3%	43.5%	49.6%	43.6%	48.1%	47.5%	38.5%	39.7%	47.8%	41.9%
115													
116	**Healthcare Cost**												
117	Actual		4,671,423	1,276,703	3,394,720	215,436	651,577	151,956	844,421	143,915	797,627	256,036	333,753
118	Budget		4,187,954	968,838	3,219,116	230,126	481,409	210,972	793,967	163,739	854,713	194,219	289,972
119	Variance - Favorable / (Unfavorable)		(483,469)	(307,865)	(175,604)	14,689	(170,168)	59,016	(50,454)	19,824	57,086	(61,817)	(43,780)
120	% Variance - Fav / (Unfav)		-11.5%	-31.8%	-5.5%	6.4%	-35.3%	28.0%	-6.4%	12.1%	6.7%	-31.8%	-15.1%
121													
122	**Managed Care Administration**												
123	Actual		392,136	138,207	253,929	23,002	50,862	12,961	54,681	13,093	64,693	14,193	20,444
124	Budget		400,943	158,427	242,516	17,136	35,885	17,619	57,302	12,546	71,850	12,127	18,051
125	Variance - Favorable / (Unfavorable)		8,807	20,220	(11,413)	(5,866)	(14,977)	4,658	2,621	(547)	7,158	(2,066)	(2,393)
126	% Variance - Fav / (Unfav)		2.2%	12.8%	-4.7%	-34.2%	-41.7%	26.4%	4.6%	-4.4%	10.0%	-17.0%	-13.3%
127													
128	**Total Contract Cost**												
129	Actual		5,063,558	1,414,910	3,648,649	238,439	702,439	164,917	899,102	157,008	862,320	270,228	354,197
130	Budget		4,588,897	1,127,265	3,461,632	247,262	517,294	228,590	851,269	176,285	926,563	206,345	308,023
131	Variance - Favorable / (Unfavorable)		(474,662)	(287,645)	(187,016)	8,823	(185,145)	63,674	(47,833)	19,277	64,243	(63,883)	(46,173)

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 11/30/2020			**2**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P02 projected by SWMBH**			
132	% Variance - Fav / (Unfav)		-10.3%	-25.5%	-5.4%	3.6%	-35.8%	27.9%	-5.6%	10.9%	6.9%	-31.0%	-15.0%
133													
134	**Net before Settlement**												
135	Actual		2,052,465	(40,890)	2,093,355	50,594	456,647	112,873	157,067	158,876	778,531	177,226	201,541
136	Budget		248,939	(291,232)	540,171	(54,053)	290,132	(41,052)	(135,174)	51,766	248,372	96,465	83,715
137	Variance - Favorable / (Unfavorable)		1,803,526	250,342	1,553,184	104,647	166,515	153,926	292,241	107,110	530,159	80,761	117,826
138													
139													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2020			2									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										P02 projected by SWMBH			
140	***Autism Specialty Services***			*HCC%*	6.4%	5.7%	8.7%	3.9%	6.5%	4.9%	7.0%	4.5%	3.4%
141	**Contract Revenue**		**3,877,853**	**56,169**	**3,821,683**	**201,412**	**731,701**	**220,339**	**709,649**	**143,468**	**1,112,711**	**313,544**	**388,860**
142													
143	External Provider Cost		2,236,605	-	2,236,605	-	691,729	71,410	308,975	95,740	808,254	127,094	133,404
144	Internal Program Cost		341,703	-	341,703	92,681	968	-	242,365	431	-	3,156	2,102
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**2,578,307**	**-**	**2,578,307**	**92,681**	**692,697**	**71,410**	**551,339**	**96,171**	**808,254**	**130,250**	**135,506**
147	**Medical Loss Ratio (HCC % of Revenue)**		**66.5%**	**0.0%**	**67.5%**	**46.0%**	**94.7%**	**32.4%**	**77.7%**	**67.0%**	**72.6%**	**41.5%**	**34.8%**
148													
149	**Managed Care Administration**		**271,866**	**76,281**	**195,585**	**9,896**	**54,072**	**6,091**	**35,702**	**8,749**	**65,554**	**7,220**	**8,300**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.5%**	**2.7%**	**6.9%**	**9.6%**	**7.2%**	**7.9%**	**6.1%**	**8.3%**	**7.5%**	**5.3%**	**5.8%**
151													
152	**Contract Cost**		**2,850,174**	**76,281**	**2,773,893**	**102,576**	**746,769**	**77,500**	**587,041**	**104,920**	**873,809**	**137,470**	**143,807**
153	**Net before Settlement**		**1,027,679**	**(20,112)**	**1,047,791**	**98,836**	**(15,068)**	**142,839**	**122,608**	**38,547**	**238,902**	**176,074**	**245,053**
154	Contract Settlement / Redistribution		(1,027,679)	20,112	(1,047,791)	(98,836)	15,068	(142,839)	(122,608)	(38,547)	(238,902)	(176,074)	(245,053)
155	**Net after Settlement**		**-**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.2%	0.5%	0.5%	0.6%	0.0%	0.9%	0.0%	0.4%	0.4%
159	**Contract Revenue**		**731,163**	**654,791**	**76,372**	**-**	**-**	**-**	**-**	**24,606**	**18,660**	**13,161**	**19,945**
160													
161	External Provider Cost		594,323	594,323	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		102,833	-	102,833	7,823	39,886	10,943	-	16,699	894	10,839	15,748
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**697,156**	**594,323**	**102,833**	**7,823**	**39,886**	**10,943**	**-**	**16,699**	**894**	**10,839**	**15,748**
165	**Medical Loss Ratio (HCC % of Revenue)**		**95.3%**	**90.8%**	**134.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**67.9%**	**4.8%**	**82.4%**	**79.0%**
166													
167	**Managed Care Administration**		**21,010**	**21,010**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**2.9%**	**2.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**718,166**	**615,333**	**102,833**	**7,823**	**39,886**	**10,943**	**-**	**16,699**	**894**	**10,839**	**15,748**
171	**Net before Settlement**		**12,997**	**39,458**	**(26,461)**	**(7,823)**	**(39,886)**	**(10,943)**	**-**	**7,907**	**17,765**	**2,323**	**4,197**
172	Contract Settlement		0	(26,461)	26,461	7,823	39,886	10,943	-	(7,907)	(17,765)	(2,323)	(4,197)
173	**Net after Settlement**		**12,997**	**12,997**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 11/30/2020			2									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										P02 projected by SWMBH			
176	**SWMBH CMHP Subcontracts**												
177	Subcontract Revenue		52,442,755	4,519,210	47,923,545	2,160,972	9,550,620	2,623,852	8,686,857	2,375,987	14,586,510	3,304,056	4,634,691
178	Incentive Payment Revenue		219,688	165,399	54,289	4,765	-	15,885	28,063	810	-	4,765	-
179	**Contract Revenue**		**52,662,443**	**4,684,610**	**47,977,833**	**2,165,737**	**9,550,620**	**2,639,737**	**8,714,920**	**2,376,797**	**14,586,510**	**3,308,821**	**4,634,691**
180													
181	External Provider Cost		30,748,974	2,487,717	28,261,257	883,211	5,701,761	1,150,219	5,622,698	1,148,945	9,603,751	1,850,900	2,299,773
182	Internal Program Cost		10,450,225	-	10,450,225	714,256	1,962,458	590,247	2,414,708	692,555	1,634,207	989,784	1,452,011
183	SSI Reimb, 1st/3rd Party Cost Offset		(91,223)	-	(91,223)	(722)	(10,748)	(6,284)	(13,059)	(7,169)	(38,456)	(5,577)	(9,206)
184	Insurance Provider Assessment Withhold (IPA)		1,786,842	1,786,842	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(81,928)	(81,928)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**42,812,891**	**4,192,631**	**38,620,260**	**1,596,744**	**7,653,470**	**1,734,182**	**8,024,347**	**1,834,330**	**11,199,501**	**2,835,107**	**3,742,577**
187	**Medical Loss Ratio (HCC % of Revenue)**		**81.3%**	**89.5%**	**80.5%**	**73.7%**	**80.1%**	**65.7%**	**92.1%**	**77.2%**	**76.8%**	**85.7%**	**80.8%**
188													
189	**Managed Care Administration**		**4,097,797**	**1,208,742**	**2,889,055**	**169,651**	**594,320**	**146,983**	**519,617**	**165,365**	**908,277**	**156,557**	**228,285**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.7%**	**2.6%**	**6.2%**	**9.6%**	**7.2%**	**7.8%**	**6.1%**	**8.3%**	**7.5%**	**5.2%**	**5.7%**
191													
192	**Contract Cost**		**46,910,688**	**5,401,373**	**41,509,315**	**1,766,395**	**8,247,790**	**1,881,165**	**8,543,964**	**1,999,696**	**12,107,778**	**2,991,665**	**3,970,862**
193	**Net before Settlement**		**5,751,755**	**(716,764)**	**6,468,519**	**399,342**	**1,302,831**	**758,571**	**170,956**	**377,101**	**2,478,732**	**317,157**	**663,829**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		0	6,468,519	(6,468,519)	(399,342)	(1,302,831)	(758,571)	(170,956)	(377,101)	(2,478,732)	(317,157)	(663,829)
198	**Net after Settlement**		**5,751,755**	**5,751,755**	**-**	**-**	**-**	**-**	**(0)**	**-**	**-**	**-**	**-**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 11/30/2020			**2**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P02 projected by SWMBH**			
201	***State General Fund Services***			*HCC%*	4.3%	2.6%	3.6%	5.6%	5.6%	6.4%	3.5%	2.5%	5.2%
202	**Contract Revenue**				**1,944,699**	**132,208**	**336,546**	**125,256**	**328,256**	**101,964**	**625,430**	**123,983**	**171,056**
203													
204	External Provider Cost				741,555	20,381	100,356	18,634	135,040	81,431	272,361	39,259	74,092
205	Internal Program Cost				991,520	21,973	184,590	84,640	340,696	44,565	150,050	34,239	130,767
206	SSI Reimb, 1st/3rd Party Cost Offset				(22,031)	-	-	-	-	-	(22,031)	-	-
207	**Total Healthcare Cost**				**1,711,044**	**42,354**	**284,946**	**103,275**	**475,736**	**125,996**	**400,379**	**73,498**	**204,859**
208	**Medical Loss Ratio (HCC % of Revenue)**				**88.0%**	**32.0%**	**84.7%**	**82.5%**	**144.9%**	**123.6%**	**64.0%**	**59.3%**	**119.8%**
209													
210	**Managed Care Administration**				**140,742**	**5,085**	**24,930**	**9,881**	**34,127**	**12,521**	**35,784**	**4,555**	**13,858**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.6%**	**10.7%**	**8.0%**	**8.7%**	**6.7%**	**9.0%**	**8.2%**	**5.8%**	**6.3%**
212													
213	**Contract Cost**				**1,851,786**	**47,439**	**309,876**	**113,156**	**509,863**	**138,517**	**436,163**	**78,053**	**218,718**
214	**Net before Settlement**				**92,913**	**84,769**	**26,670**	**12,100**	**(181,607)**	**(36,553)**	**189,267**	**45,930**	**(47,662)**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(346,867)	(83,461)	(23,857)	(10,068)	-	-	(186,983)	(42,498)	-
218	**Net after Settlement**				**(253,954)**	**1,308**	**2,812**	**2,032**	**(181,607)**	**(36,553)**	**2,284**	**3,432**	**(47,662)**
219													

2021 Quality Assurance and Performance Improvement Plan Overview (QAPIP)

January 10, 2020

Southwest Michigan
BEHAVIORAL HEALTH

Introduction

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

42 CFR section 438-210 indicates that;

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

42CFR section 438-230 indicates that;

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

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

Authority and Structure

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

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

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

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

Purpose

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

Additional purposes of the QAPIP are to:

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


THAT'S GOOD ENOUGH.
QUALITY CONTROL

2021 Goals

1. Implementation of a Consumer Satisfaction Survey Performance Improvement Project, based on Consumer Feedback.
   (By: 6/30/21)
2. Select a new (NCQA approved) tool to be utilized for the 2021 Customer Satisfaction Survey Project
   (By: 9/30/21)
3. Redesign the format of the 2021 QAPI-UM evaluation report
   (By: 12/30/21)
4. Create a flow chart for each QAPI contractually obligated report and business process.
   (By 12/30/21)

Data Management

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

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

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

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

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

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

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

Communication

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

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

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

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

Evaluation

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

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

QAPI 2021 Work Plan Key Performance Metrics

Activities/Programs Covered in 2021 Work Plan Include	
Annual Department and Regional Committee Goals and Objectives	Consumer Satisfaction Surveys and Analysis Provider Access to Services Survey BH/PH Provider Communication Survey RSA-r Survey (Person in Recovery SUD)
Oversight of External Audits/Reviews (MDHHS, HSAG, NCQA, ICO's)	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 Tracking/Monitoring
Call Center Monitoring	Jail Diversion Data Analysis
Behavior Treatment Review Data	Performance Improvement Projects (PIPs)
Board Ends Metrics and Key Performance Metric Analysis and Reporting	Communication of Data and Outcomes to Internal and External Stakeholders

Questions?

Southwest Michigan Behavioral Health
2021 Quality Assurance and Performance Improvement Program
All SWMBH Business Lines

Year 2021 (October 1, 2020 - September 30, 2021)

Final Version Approved: _____

Approved by SWMBH Board: _____
Submitted to MDHHS for Review: requested before 1/31/21
Reviewed by SWMBH Quality Management Committee: 11/19/2020
Reviewed by SWMBH MI Health Link Committee: 12/11/2020

Table of Contents

I. Introduction

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

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

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

II. Purpose

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

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

Additional purposes of the QAPIP are to:

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

III. Guiding Principles

During the December 11, 2020 Board Meeting, the SWMBH Board approved the 2021-2022 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for the development of annual Board Ends Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. Please see attachment (*Please see Attachment G - Strategic Alignment and Annual Goal Setting*)

Mega Ends

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

IV. Strategic Imperatives

Strategic Imperatives: During the May 8, 2020 Board Retreat and Board Meeting, the Board voted on and established a new set of Strategic Imperatives. It is critical to the success of SWMBH and the Region that these Strategic Imperatives are tracked and monitored for success. The following are the approved 2020-2022 Strategic Imperatives:

1. Public Policy and Legislative initiatives
2. Uniformity of Benefit
3. Integrated Health Care
4. Population Health Management
5. Revenue Maximization/Diversification
6. Improve Healthcare Information Exchange, Analytics and Business Intelligence
7. Managed Care Functional Review
8. Proof of Value and Improved Outcomes

The SWMBH Strategic Imperatives also align with the 2021-2022 Michigan Department of Health and Human Services Strategic Pillars, which were released in June of 2020 for review and feedback.

V: Core Values of Quality Assurance and Improvement

1. **Quality healthcare will result from a benefit management system embracing input from all stakeholders**
    a. Educating all customers of SWMBH on continuous improvement methodologies, including providing support to other SWMBH departments and providers as requested. The inclusion of customers, families, stakeholders, and providers in the performance improvement design will promote optimal results.
    b. Promoting a person-centered philosophy will promote customer satisfaction as well as optimal treatment outcomes.
2. **Poor performance is costly**
    a. Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risk.
    b. Quality Improvement projects are best approached systemically; best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.
    c. Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making.
        i. Making data accessible will impact value and reduce risk to SWMBH.
3. **Data Collection Values**
    a. Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
    b. Providers submitting data to SWMBH shall certify data integrity and have available for review the process used to collect the data.
    c. Performance that has demonstrated instability or significant variance to comparison performance on an ongoing basis will be monitored closely. Significant variation in results will indicate the need for a corrective action/performance improvement plan

VI. Authority and Structure

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

In addition, review by the SWMBH Board and SWMBH EO, the QAPIP, and QAPI & UM Effectiveness Review/ Evaluation will be taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement throughout the Region. The SWMBH Operations Committee consists of the Executive Officer (EO), or their designee, for each of the (8) participating Community Mental Health System Providers (CMHSP).

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

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

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

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

Adequacy of Quality Management Resources

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

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	40%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management	UM	20%
Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	30%
Senior Software Engineer	IT	20%
Member Engagement Specialist	UM	15%
Waiver and Clinical Quality Manager	PNM	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner (primary through Regional Committees)	UM/PN	20%
Chief Compliance and Operations Officers	Com/Ops	15%

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

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

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

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

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

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

VII. Committees

Quality Management (QM) Committee

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

CMHSPs are responsible for the development and maintenance of a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC. To assure a responsive system, the needs of those that use or oversee the resources, (e.g., active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever

possible. Training on performance improvement technology and methods, along with technical assistance, is provided as requested or as necessary.

Quality Management Committee (QMC) Membership

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

QMC Committee Commitments include:

1. Everyone participates.
2. Be passionate about the purpose
3. All perspectives are professionally Expressed and Heard
4. Support Committee and Agency Decisions
5. Members share relevant information with their colleagues
6. Celebrate Success

Decision Making Process

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

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

QMC Roles and Responsibilities

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

of improving consumer outcomes.

2021 Quality Management Committee Goals (Measurement period: January 1, 2021 – December 31, 2021)

1. **Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By: 6/30/21)**
   i. Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project
   ii. Identify common denominators and classify into strategic categories
   iii. Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category)
   iv. Develop and target interventions to improve (3) identified problem areas
   v. Determine tracking mechanisms and targets goals for each identified area
   vi. Share results with Operations Committee and other relevant committees
   vii. Identify alternative electronic methods of gathering consumer responses, other than telephonic.
   vii. Identify tools/resources, which determine how many surveys have been completed and current scores.

2. **Select a new (NCQA approved) survey tool for the 2021 Consumer Satisfaction Survey Project, to replace the MHSIP and YSS tools (By: 9/30/2021)**
   i. Identify NCQA approved consumer satisfaction survey tools.
   ii. Review tools, questions and scoring methodology with relevant regional committees for feedback.
   iii. Identify survey distribution methods and possible process changes.
   iv. Communicate project logistics to CMHSP survey point persons and regional committees.
   v. Complete analysis of results and distribute to internal and external stakeholders.
   vi. Evaluate selected tools effectiveness and make modifications as necessary.

3. **Redesign structure/format of the annual QAPI-UM evaluation report.**
   i. Edit format; to allow each section evaluated to receive a performance grade, improvement areas and timeline for completion.
   ii. Identify program weaknesses and strengths for each category evaluated.
   iii. Identify detailed plans/timeline to remediate identified weaknesses.

4. **Create a flow chart for each QAPI contractually obligated reporting requirement.**
   i. Each chart should provide processes and steps for collecting data, reporting data, timelines, project Point persons and additional resources available.
   ii. Identified areas to include; MMBPIS, Critical Incidents, Jail Diversion and BTRC.

MI HEALTH LINK BUSINESS LINE OVERVIEW

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons with both Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan (*now Centene as of 2020*). As such, SWMBH will be held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS), CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment, and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and

National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD, and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

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

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

MI Health Link Committee Membership

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

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

Decision Making Process

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

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

The below grid represents the MI Health Link Committee Functional Area Reporting Responsibilities:

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

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

MI Health Link Committee Roles and Responsibilities:

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

- Documents and conducts activities to improve coordination between medical care and behavioral healthcare.
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities.
- Ensures a care management quality control program is always maintained.

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

2021 Quality Performance Withhold Measures:

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

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

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

2021 MI Health Link Provider Performance Indicators and Objectives:

Each year, the Michigan Department of Health and Human Services and Integrated Care Departments formulate a set of Contractually obligated Key Performance Indicators. Each Performance Indicator has an established measurement period and Target/benchmark attached to it. The Performance indicator status is analyzed by SWMBH and is discussed during Regional Committees, which involve providers such as; Utilization Management Committee, Clinical Practices Committee and the Quality Management Committee. The below Performance Indicators have been established for the 2021 reporting period:

1. Percentage of Enrollees who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment at least 180 days. Goal – 70%
2. Percentage of discharges from inpatient psychiatric hospitalization who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. Goal – 80%
3. Percentage of new Enrollees referred to Provider with Level II (PIHP/Provider) assessments completed within 15 days of Level I (ICO) assessment. Goal – 80%
4. The percentage of new Enrollees referred to Provider who start services within 14 days of completion of the initial IISCP for nonemergent needs. Goal – 80%
5. For SUD service providers: The percentage of Enrollees with a new episode of diagnosed SUD who received the following:
   1. Initiation of SUD Treatment - The percentage of Enrollees referred to Provider who initiate treatment through an outpatient visit or intensive outpatient encounter within 14 days of the diagnosis.
   2. Engagement of SUD Treatment- The percentage of Enrollees referred to Provider who initiated treatment and who had two or more additional services with a diagnosis of SUD within 30 days of the initiation visit. (Two-part measure) Goals – 70% and 70%

VIII. MI Health Link Quality Standards and Philosophy

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

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

Other methodologies are used to control process include:

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

IX. Review of MI Health Link Activities (CY - January 1, 2021 – December 31, 2021)

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

Review Activity	Activity Description
1. Annual QAPI Plan	The QAPI plan is a document that reflects the ongoing progress on QAPI activities throughout the year. The QAPI plan is developed by the QAPI Department with guidance from the QMC, RCP, and RUM. The Plan is reported annually to the EO, Operations Committee the SWMBH Board, and to customers and other stakeholders. The plan consists of the quality improvement, performance and outcome goals to be achieved throughout the year and addresses: • Yearly planned QI objectives/goals for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Time frame for each objective/goal's completion. • Lead staff responsible for each objective/goal. • Monitoring of previously identified issues. • Evaluation of the QAPIP. ***--See Section XI, "2021 Quality Assurance Improvement Plan"***
2. Annual QAPI & UM Effectiveness Review & Evaluation	Monitoring, evaluation and reporting occurs on an on-going basis. Evaluation results will be shared annually with the EO, Operations Committee, the SWMBH Board, relevant Committees, customers and other stakeholders. The QM department will on an annual basis will do an effectiveness review/evaluation of the QAPIP that will include: • A description of completed and ongoing objectives/goals that address quality and safety of clinical care and quality of service. • Trending of measures to assess performance in the quality and safety of clinical care and quality of service. • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the organization. • Identification of any performance improvement needs or gaps in service. • Adequacy of QAPIP resources and staff including practitioner participation and leadership involvement in the QAPIP. • Remediation and corrective action plans. • Analysis of overall results for MDHHS quality & UM reporting metrics, such as: • MMBPIS Performance Indicators, Critical Incidents, Jail Diversion, Call Center Performance Metrics, Inter-Rater Reliability testing, Consumer Satisfaction Survey Results, RSA-r Survey Results, Program and Service Audit results and more.
3. Annual Goals and Objectives – Reports, Dashboards,	• Annual Goals and Objectives are discussed, monitored, and reported as defined by the objective scope. All Department and Regional Committee goals should align with SWMBH Board Ends Metrics and SWMBH Strategic Guidance

Outcome monitoring	• Document, which is the overarching tool to maintain strategy and tactical objectives, as defined by the Board. • Key Performance indicators will be compared and monitored with reports created. (Board Ends Metrics, Dept. Goals, Regional Committee Goals) • Training and monitoring of best practice standards will be completed as necessary. ***see attachment (G) – "2021-2022 Board Ends Metrics"***
4. Access Standards	• SWMBH will monitor that customers will have a face-to-face level II assessment completed within 15 days. • Contracts with providers will be monitored to assess customer access to services within Medicare and Medicaid standards on geography and type. • Assessments against standards related to regular and routine appointments, urgent/emergency care, after-hours care, and call center rates. • Behavioral Health will meet the following standards: **1.** Routine Non-Life-Threatening Emergency within 6 hours **2.** Urgent Care within 48 hours **3.** Routine Office Visits within 10 business days **4.** Call Center calls will be answered by a live voice within 30 seconds **5.** Telephone call abandonment rate is within 5%
5.Key Administrative Functions	In keeping with the need to provide performance oversight across a broad array of PIHP administrative functions, key areas of performance are reviewed by the identified functional committee(s): • *Provider Network* • *Compliance* • *Customer Services* • *Utilization Management* • *Administrative Support* Performance measures for respective functional areas are further described in functional documents, which provides description of associated plans, performance measures, and tracking processes
6. External Monitoring Reviews	The QAPI department will coordinate the reviews by external entities, including ICO's, MDHHS, HSAG, NCQA review organization, and any accreditation organization as identified by the SWMBH Board. The QAPI department will also be available to assist affiliates in their external reviews.
7. Customer Provider Assessments	Surveys are collected throughout the year; and are reviewed by the QMC and MHL Committee and required by PIHP/MDHHS contract. Results are Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. The MHSIP survey is used for adult participants 17 years of age and over and the YSS survey is used for Youth under the age of 17.

8. Customer and Provider Assessments (MIHL)	Surveys are collected throughout the year; and are determined by the QMC and MHL Committee and required by PIHP contract. Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. When available; results are compared to State and National values, to provide performance benchmarks.
9. Michigan Mission Based Performance Indicators (MMBPIS)	A collection of state defined indicators that are aimed at measuring access, quality of service, and provide benchmarks for the state. Data is reported to Michigan Department of Health and Human Services (MDHHS), results are additionally communicated to the EO, the Operations Committee, the SWMBH Board, customers, and other stakeholders. The SWMBH maintains a dashboard to monitor the progress on each indicator throughout a year. The SWMBH QAPI Department reviews and approves plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time.
10. Critical Incidents/Sentinel Events/Risk Events	The state has provided definitions for three categories of events that the SWMBH monitors through the QAPIP. For further information see SWMBH Policy (3.5) Critical Incidents/Sentinel Events/Risk Events.
11. Customer Grievances and Appeals	Collected and monitored by the SWMBH and analyzed for trends and improvement opportunities. Categories will be used for reporting including: Quality of Care Complaints, Access, Attitude and Service, Bill/Financial, and Quality of Practitioner Office Site. These trends will be reviewed quarterly and annually.
12. Behavior Treatment Review Data	Collected by the SWMBH from the affiliates and available for review. For more information see SWMBH Policy Behavior Treatment Review Committee. The PIHP shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.
13. Utilization Management	An annual Utilization Management (UM) Plan is developed and UM activities are conducted across the Affiliation to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. UM data will be aggregated and reviewed by the Regional UM Committee as well as QMC for trends and service improvement recommendations. To ensure that the UM program remains current and appropriate, QM will do an annual evaluation of the UM program. The Utilization Management (UM) Plan Evaluation Components include: a) 2021 UM Program Description & Plan b) Policies and Procedures in compliance with contractual, state and regulatory and. accreditation requirement. c) Department Compliance with Established UM standards. d) Adequate Access a. Telephone Access to Services and Staff. e) Timeliness of UM Decisions a. Services b. Appeals f) UM Decision-Making a. Clinical Criteria

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

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

X. 2021 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 retreat on May 10, 2020. The following represent a list of those Strategic Imperatives: (***Please see attachment E for more details on completion of Strategic Imperatives***)

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

XI. Data Management

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

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

XII. Data Management Continued

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

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

XIII. Communication

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

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

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

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

XIV. 2020 Quality Assurance and Performance Improvement Plan (Medicaid Business Line)

(FY - October 1, 2020- September 30,2021)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
1. Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures reported to State.	➢ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ➢ Report indicator results to MDHHS on a Quarterly basis. ➢ Status updates to relevant Committees such as: QMC; RUM; RCP and Operations Committee. ➢ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ➢ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated bench mark. ➢ Ensure CMSHP Corrective Action Plans are achieved and improvements are recognized. ➢ Participate in MDHHS Performance indicator workgroup and communicate any changes with indicator measurement or reporting to internal and external stakeholders.	January 2021 – December 2021	QAPI Director QAPI Specialist Clinical Quality Director SUD Manager	Quarterly Submissions to MDHHS: *Q1 - 3/31/21 *Q2 - 6/30/21 *Q3 - 9/30/21 *Q4 - 12/30/21 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs beginning in June 2021.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
2.Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	➢ Event Reporting- trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualified events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	➢ Event Reporting Quarterly reports to QMC; RUM, RCP and MHL committees as part of process. ➢ Quarterly Reports of any qualified events to MDDHS including: ○ Suicide ○ Non-Suicide Death ○ Emergency Medical Treatment Due to medication error ○ Hospitalization due to injury or medication error ○ Arrest of a consumer that meets population standards	October 2020 – September 2021	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for review.
3.Uniformity of Benefits (Cross functional Goal)	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	➢ Perform analysis on tool scores relative to medically necessary level of care (LOC). ➢ Identify and schedule reports on functional assessment tool scores. ➢ Ensure functional assessment data related to the LOCUS, SIS, CAFAS and ASAM are being received in the SWMBH data warehouse.	October 2020 – September 2021	Utilization Management Director Clinical Quality Manager Data Analyst Director of QAPI QAPI Specialist	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
4.Behavioral Treatment Review Committee Data Cross Functional Goal (Cross functional Goal)	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify ➢ opportunities for improving care.	➢ The QMC Committee will review the data collected from CMHs for trends and outliers on a quarterly basis. ➢ If trends are identified the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ➢ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2020 – September 2021	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly
5.Jail Diversion Data Collection	➢ SWMBH collects and reports the number of jail diversions (pre- booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities	➢ The QMC will evaluate data trends and specific CMHSP results. ➢ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ➢ Identified Trends and suggestions for policy change are share with Regional Entities through the Operations Committee and Utilization Management Committee as needed. ➢ Review Trends related to co-occurring MH/SUD events.	October 2020 – September 2021	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
6.External Monitoring Reviews	➢ Ensure that the participant has achieved each Quality element, as identified in the 2021 site review tool with satisfactory results. ➢ Help to formulate Corrective Action Plans for any Quality Review Elements scored out of compliance.	➢ Participant written Quality Improvement Plan for the fiscal year. ➢ Review participants Sentinel event and Critical Incident policy. ➢ Ensure participant has a BTRC that meets MDHHS requirements. ➢ The participants Jail Diversion Policy is compliant. ➢ Review of MMBPIS Performance Indicators, primary source verification documentation and protocols. ➢ Call Data Reports are submitted on a quarterly schedule (*i.e., call abandonment rate, average answer time in seconds and total incoming call volume*) ➢ Assist with formulation of the Regional audit results presentation.	October 2020 – September 2021	QAPI Specialist QAPI Director	Annually or as needed, depending on Corrective Action Plan's (CAP's)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
7.Review of Provider Network Audits, Guidelines, and Medicaid Verification **(Cross functional Goal)**	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities. ➢ Assist with automating reports needed for compliance dept. review.	➢ Annual report to QMC Committee on any findings or opportunities for improvement. ➢ Corrective Action Plans (CAP) developed, issued and tracked as needed. ➢ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the QAPI annual Evaluation report. ➢ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2020 – September 2021	QAPI Specialist QAPI Director Chief Compliance Officer Director of Clinical Quality	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
8.Monitor the Complaint Tracking System for Providers and Customers (Cross functional Goal)	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints for all business lines ➢ Work through Regional Committees if trends are identified to improve outcomes	➢ At a minimum, quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUM Committee and RCP Committee are reviewed. ➢ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: ➢ Billing or Financial Issues ➢ Access to Care ➢ Quality of Practitioner Site ➢ Quality of Care ➢ Attitude & Service	October 2020 – September 2021	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
9.External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ➢ ICO's, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics or meets the reviewing organizations expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations and other contractual standards and provide education and resources to SWMBH and CMHSPs.	➢ The Quality Department will ensure all documentation is returned to the external monitoring agency in a timely manner. ➢ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ➢ The SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2021 – December 2021	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Annually or audits as scheduled

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
10. Utilization Management (Cross functional Goal)	➢ UM data will be aggregated and reviewed by the Regional UM Committee and Quality Management Committee for trends and service improvement recommendations. ➢ Identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	❖ Annual UM Evaluation (FY 2021): ○ Department Compliance with Established UM standards ○ Adequate Access/Telephone Access to Services & Staff ○ Timeliness of UM Decisions: Service & Appeal ○ UM Decision-Making: Clinical Criteria; Availability of Criteria; Consistency of Applying Criteria; Inter-rater reliability (IRR audit) ○ Coordination of Care ○ Quality of Care ○ Outlier Management ○ Over or under utilization ○ Hospital Follow-Up ○ Level II Assessments ○ Customer Satisfaction on service experienced with UM Department	October 2020 – September 2021	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
11. Emergent and Non – Emergent Access (Cross functional Goal)	➢ Emergent and non-emergent cases are periodically monitored to ensure compliance with standards.	➢ All crisis/emergent Calls are immediately transferred to a qualified practitioner. ➢ Non-emergent time on-hold must not exceed three minutes. ➢ All non-emergent call backs should occur within one business day. ➢ Individuals with emergent needs, shall be provided an immediate intervention.	October 2020 – September 2021	QAPI Specialist QAPI Director Director of Clinical Quality Chief Operations Officer Utilization Manager	Monthly
12. Call Center Monitoring (SWMBH reporting) *for MI Health Link and Medicaid Business Lines*	➢ Ensure that a call center monitoring plan is in place. ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ➢ Tracking and monitoring of all internal service lines (crisis, emergent, immediate and routine) ➢ Collect and analyze quarterly call reports submitted by CMHSPs	➢ A review of calls and agent performance to meet a scoring criterion of 96.25% performance rate is completed and evaluated. (*not required)* ➢ Achieve a call abandonment rate of 5% or less. ➢ Monitor number of calls received for each service line. ➢ Average answer time is confirmed as; 30 seconds or less. ➢ Service level standard of 75% or above. ➢ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	October 2020 – September 2021	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly Reviews during Regional QMC and MI Health Link Committee Meetings

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
13. Management of Quality Related Systems and Data Review/Reporting (Cross functional Goal)	➢ Quality Department; QMC and MHL Committee to review quality and timeliness of data reporting. ➢ Ensure Reports are timely and accurate for internal/external stakeholders.	➢ Ensure timeliness and accuracy of Quality Indicator submissions to MDHHS. ➢ Grievance and Complaint tracking analysis. ➢ Tracking and analyzing services, cost by population groups and special needs categories. ➢ Access to care tracking (Level II Timeliness report). ➢ Monitor Data Quality, Timeliness and Completeness: ➢ Volume: Encounters submitted at 85% of monthly rolling average. ➢ Completeness: 99.8% of encounters are submitted and accepted by MDHHS (CMHSP to supply the num/denom. ➢ Timeliness: 95% of encounters adjudicated through submission cycle within 30 days or less. ➢ Assessments: 90% of consumers received the appropriate assessment ➢ 97% of Encounters have a BH TEDs match or close match	October 2020 – December 2021	QAPI Director Chief Information Officer Chief Operations Officer Senior Systems Architect Applications and systems Analyst	Monthly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
14. Coordination of Care (Cross functional Goal)	➢ Quality Dept. Assists with relevant care measures related Performance Bonus Incentive Project (PBIP) and Quality Withhold Performance Measures. ➢ Assists with Quantitative and causal analysis of data to identify improvement opportunities	➢ Administration and analysis of Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ➢ dentification of beneficiaries who may be eligible for services through the Veteran's Administration ➢ Increased data sharing with providers using ADT messages. ➢ Submission of annual PBIP narrative report related to: Comprehensive Care, Patient Centered Medical Homes, Coordination of Care and Accessibility of Services.	October 2020 – September 2021	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant Chief Compliance Officer	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
15. Safety of Consumer Care (Cross functional Goal)	➢ Track patient safety/risk events and make recommendation for regional improvement. ➢ Provide a comparative report using current year and previous year's data to identify safety/risk concerns and trends. ➢ Analysis of reported risk events to identify trends.	➢ Complete an annual analysis of patient safety activities. ➢ Track and provide analysis on patient safety concerns, risk incidents including Adverse incidents, Critical Incidents or Sentinel Event that are reported by CMHSPs on a monthly basis. ➢ Monitoring and collect minutes during the BRTC meetings. ➢ Cover and identified network-wide safety issues during Regional Clinical and Quality meetings.	October 2020 - September 2021	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
16. Member Experience	➢ Develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints. ➢ Data is used to identify trends and make improvements for the customer experience and improved outcomes.	➢ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey time period. ➢ Distribution, collection and analysis of annual Person in Recovery Survey (RSA-r). ➢ Medicaid Member Service Satisfaction Surveys. ➢ Medicare Member Service Satisfaction Surveys. ➢ MI Health Link – Dual Eligible Member Satisfaction Surveys. ➢ Complex Case Management Member Experience Survey. ➢ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys. ➢ Causal analysis of grievance and appeal data broken into categories including: Quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site.	January 2021 - December 2021	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

		➢ Member Grievance and Appeals data ➢ Complex Case Management. ➢ Grievance and Appeals data ○ Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RCP, RUM, SWMBH Board and other stakeholders annually.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
17. Sharing and Communication of Information	➢ The Quality Department will demonstrate Sharing of information and communication through various internal and external resources to its membership and providers.	➢ Ensure availability of information about QI program and results through newsletter, mailings, website, and member handbook and practitioner agreements. ➢ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ➢ Provide access to QMC and MHL meeting minutes and materials to internal customers. ➢ Access to the SWMBH website for various publications and Provider Directory. ➢ Access to the SWMBH SharePoint Portal	January 2021 - December 2021	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager News Letter Editor Chief Information Technology Officer	Quarterly

		for internal and external stakeholders, as a collaborative information sharing resource and report delivery system.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
18. Serving Culturally and Linguistically Diverse Members (Cross functional Goal)	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership. ➢ Review the annual Network Adequacy Plan and provide feedback for improvement projects/interventions.	➢ Ensure that Cultural Competency policies are being followed. ➢ Review Cultural Competency Plan on an annual basis to address any identified barriers to care. ➢ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ➢ Work with Provider Network to perform analysis on the network adequacy report and support identification of culturally diverse provider resources. ➢ Review Annual Cultural Competency Policies and Plan. ➢ Annually review and update Cultural Competency Goals and work plan. ➢ Annually review CMHSP partner Cultural Competency Plans.	October 2020 - September 2021	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
19. Serving Members with Complex Health Needs (*function of Clinical Quality*) **(Cross functional Goal)**	➢ The Quality Management Department will work with the Utilization Management and Clinical Departments to use process and outcome measures to improve quality and performance.	➢ Measure program effectiveness, process, member satisfaction data and outcomes to help improve the Complex Care Management Program. ➢ Causal Analysis of Complex Case Management Grievance and Appeal Data ➢ Monitor and Evaluate Access to care standards to ensure members are receiving timely services. ➢ Help to identify population health trends and plan programs and services accordingly. ➢ Qualitative and Quantitative Analysis ➢ Evaluate and monitor efforts to identify eligible CCM members.	October 2020 – September 2021	Integrated Care Nurse QAPI Director Medical Director or Consultant Director of Clinical Quality Director of Utilization Management	Quarterly

XV. QAPI – UM Evaluation

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

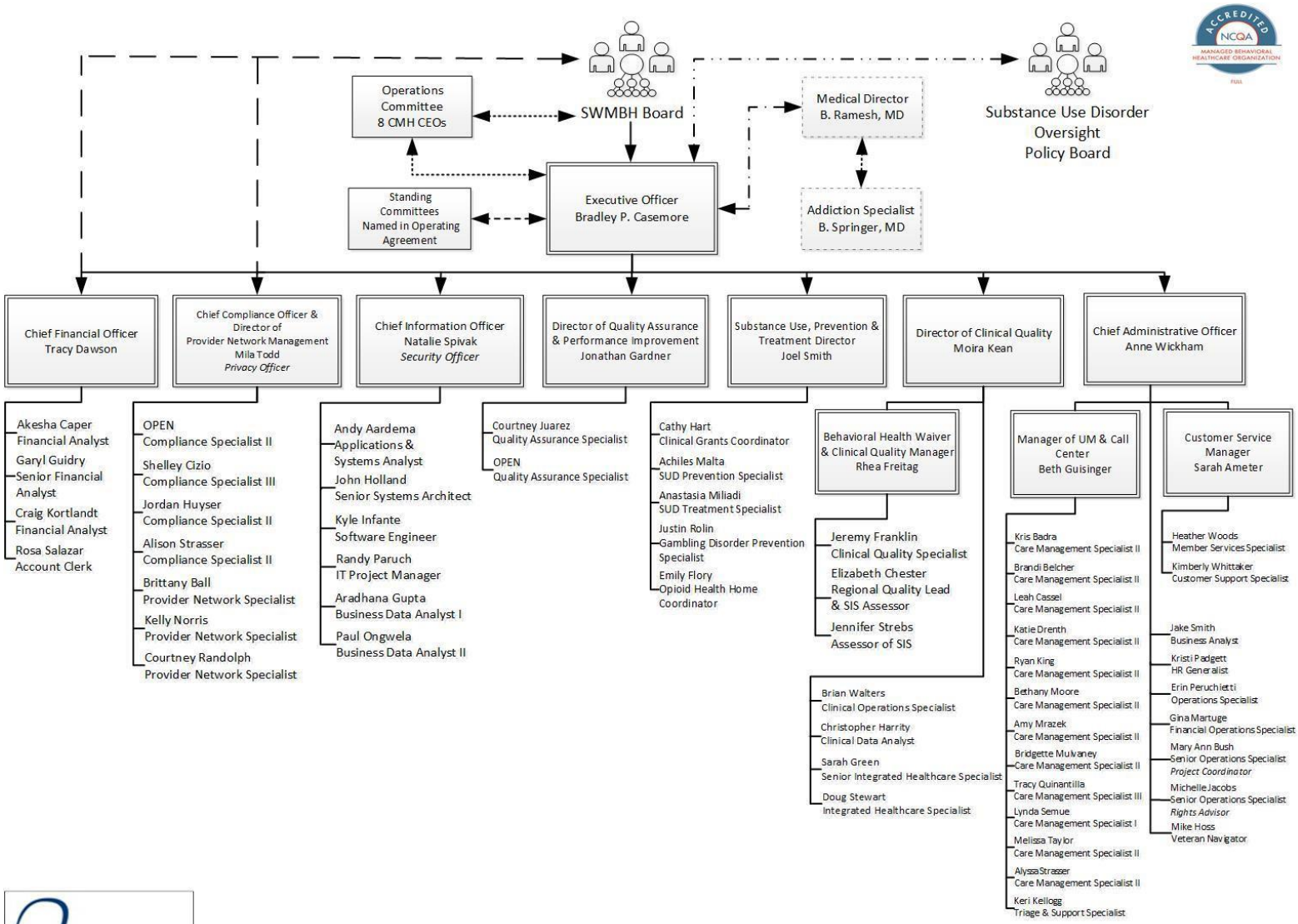
A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement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

XVI. References:

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

XVII. Attachments

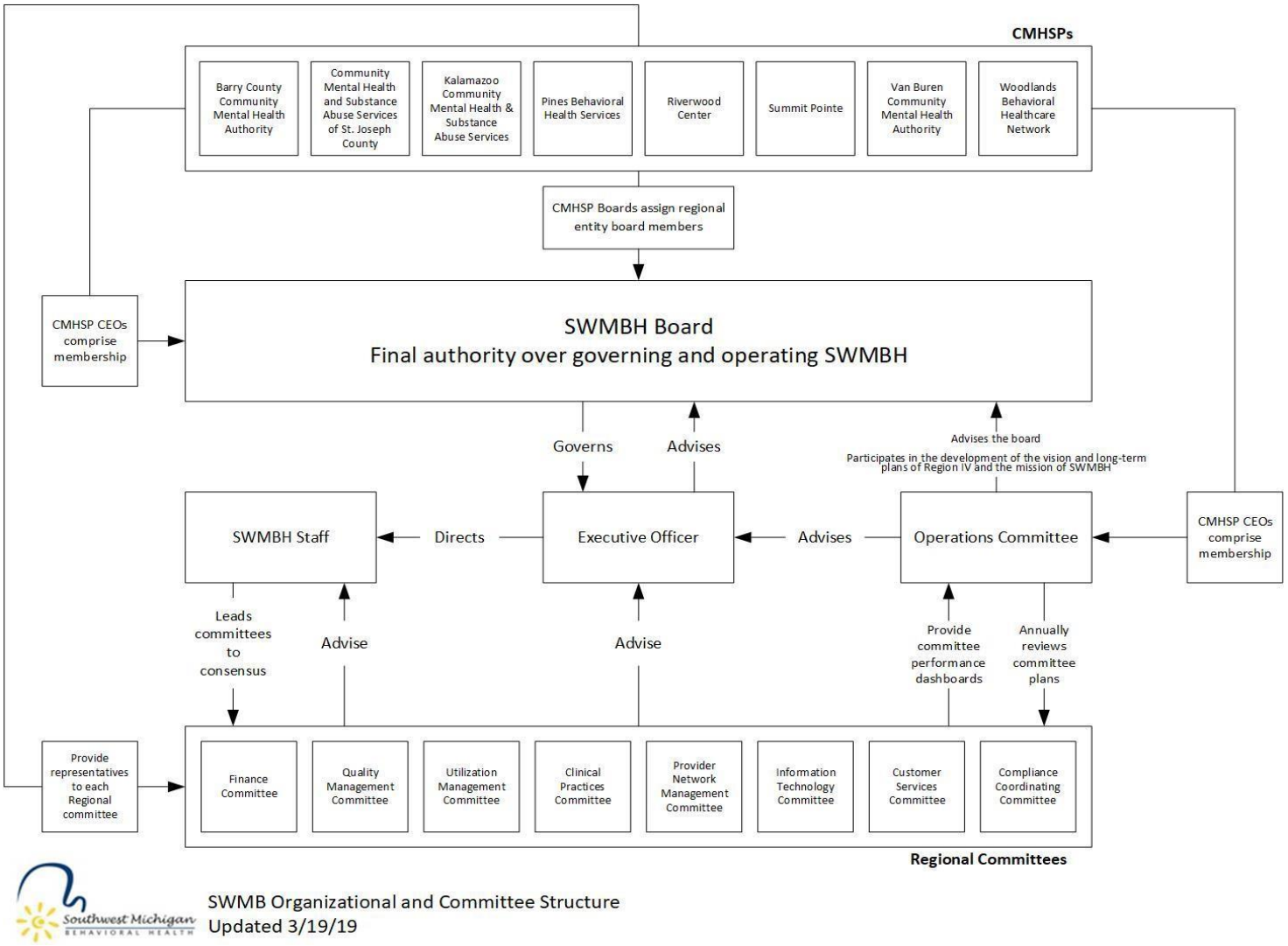
Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Organizational Chart
Revised 11/17/2020

Attachment B: SWMBH Regional Committee Structure

SWMBH Organizational and Committee Structure



Southwest Michigan Behavioral Health

SWMB Organizational and Committee Structure
Updated 3/19/19

Attachment C: MI Health Link Quality Management Committee Charter

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

Charter Effective Date: 6/1/15
Charter last Review Date: 10/17/20

Approved By:
_____
Signature:
_____
Date:
_____

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

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

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

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

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

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

Utilization Management Committee:

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

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

Cultural Competency Management Committee:

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

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

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

Attachment D: Quality Management Committee Charter

Quality Management CommitteeCharter

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

Date Approved: **5/1/14**

Last Date Reviewed: **11/19/20**

Next Scheduled Review Date: **11/18/21**

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

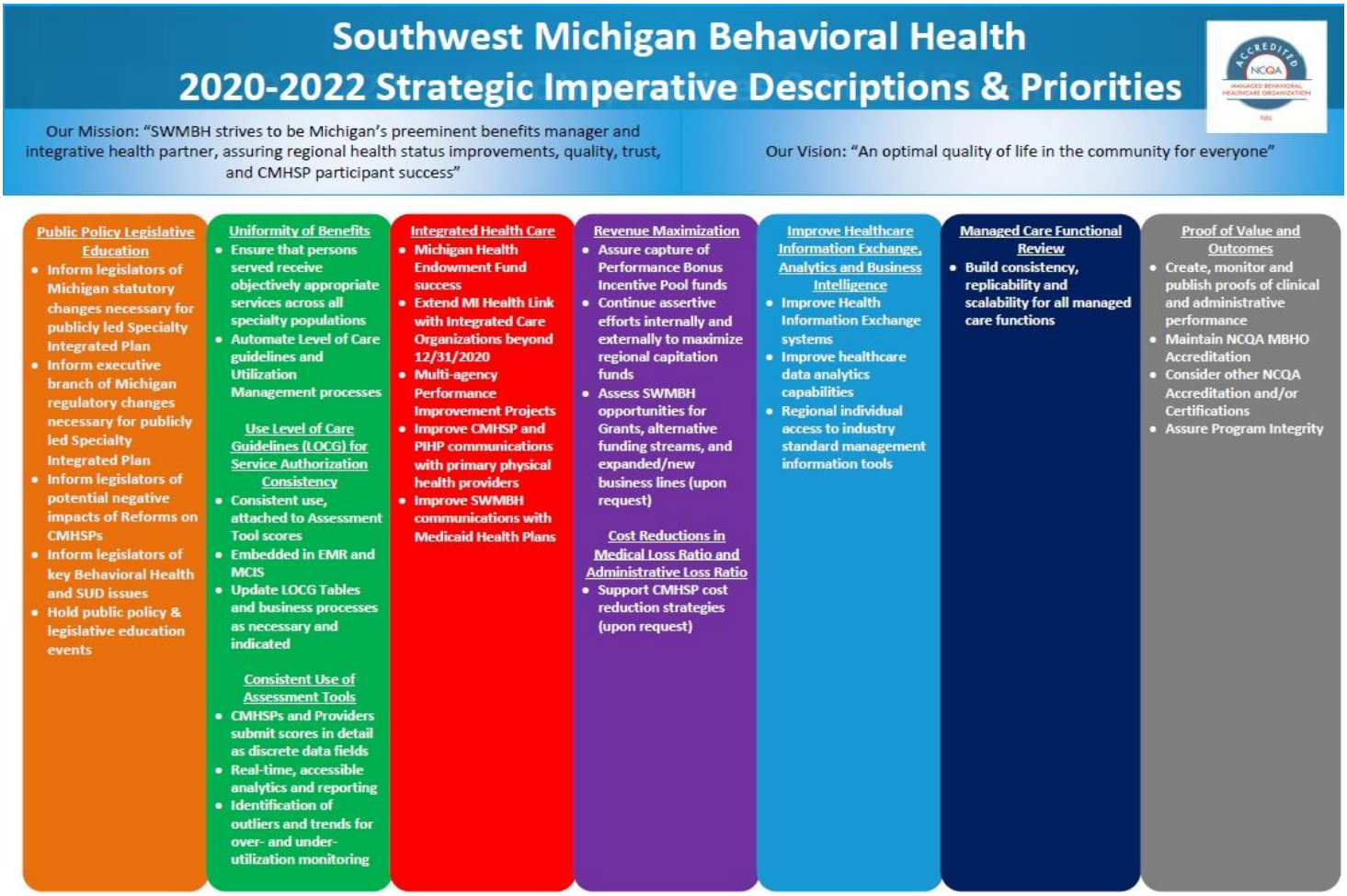
Committee Purpose:	• *The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined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

	• *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *Assist the RITC Committee with management and oversight of the Data Exchange sub-workgroup related to regional strategic imperatives and CMH data submission quality and completeness.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees including: • Finance Committee • Utilization Management Committee • Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee

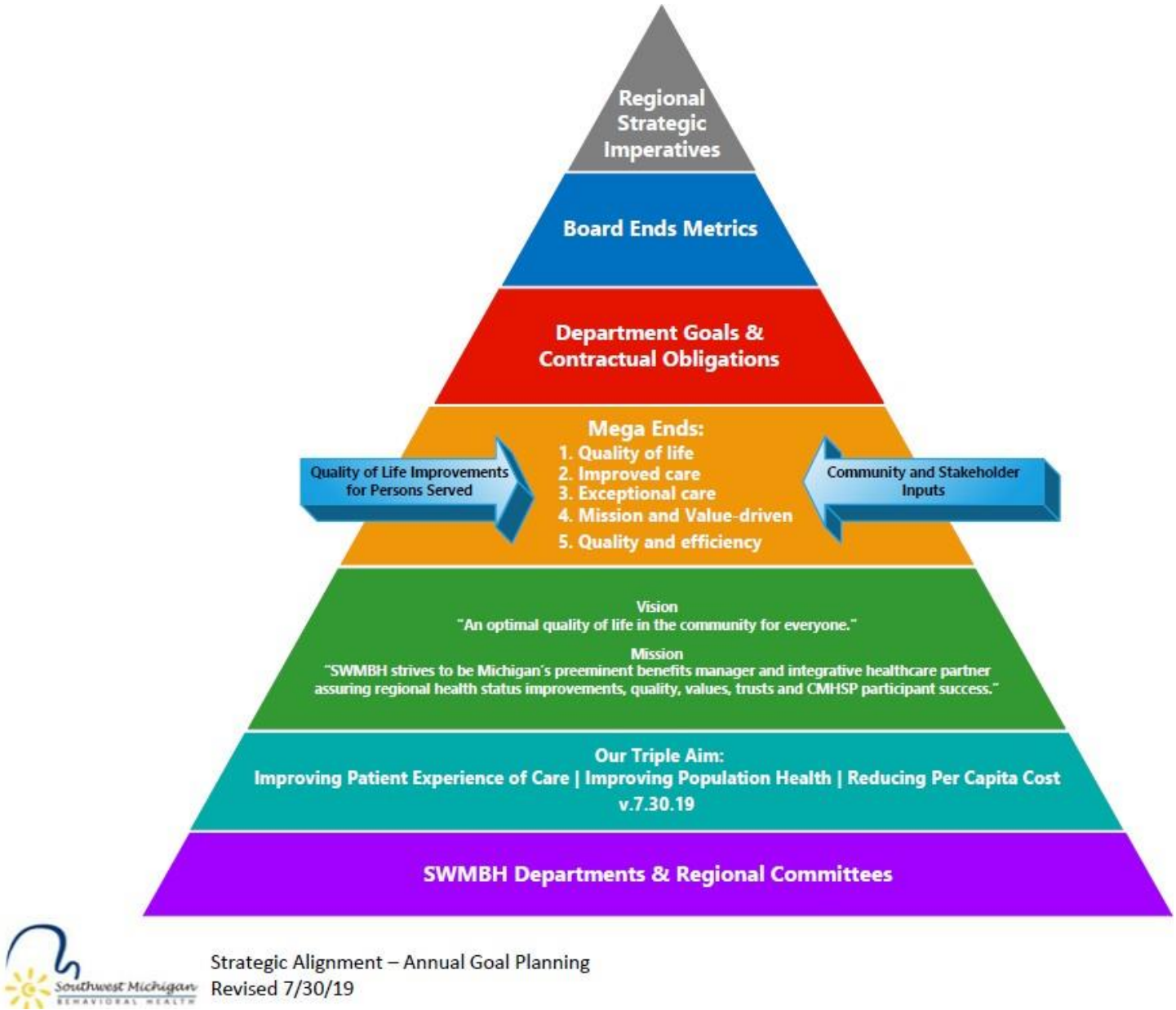
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits, it is expected that committee members attend and are engaged in issues and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members and a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they will lose the right to participate in the voting structure for that meeting.

Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dash Board • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment E: 2021-2022 SWMBH Strategic Imperatives and Descriptions



Attachment F: Regional Strategic Imperative Planning Flow Chart



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

Attachment G: 2019-2022 Strategic Plan – Board Ends Metrics

Attachment H: 2021 Board Member Roster

2021 Board Member Roster

Barry County
- Ruth Perino
- Robert Becker (Alternate)

Berrien County
- Edward Meny - Chair
- Randy Hyrns (Alternate)

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

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

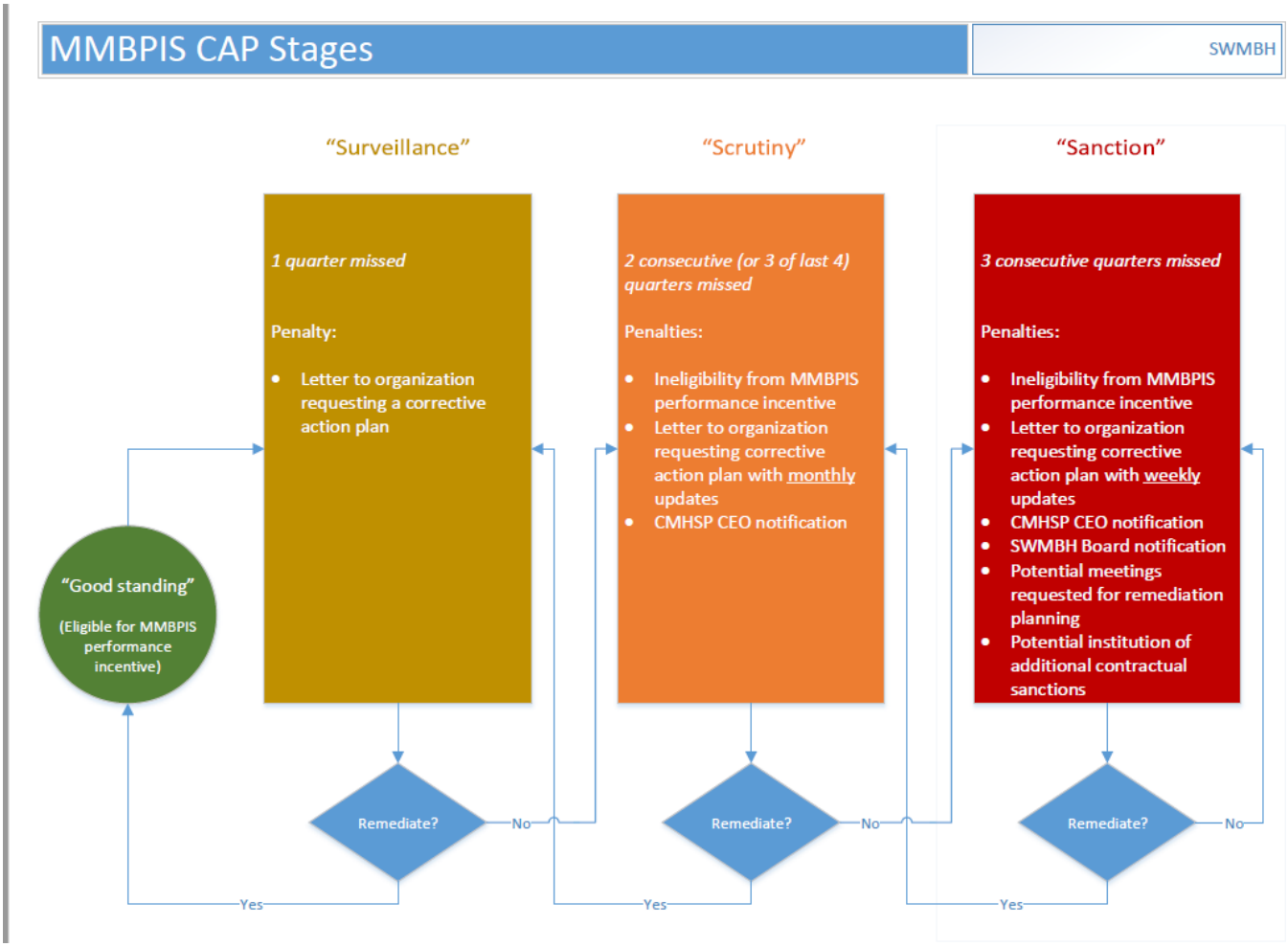
Cass County
- Vacant
- Mary Middleton

Kalamazoo County
- Erik Krogh
- Patricia Guenther (Alternate)

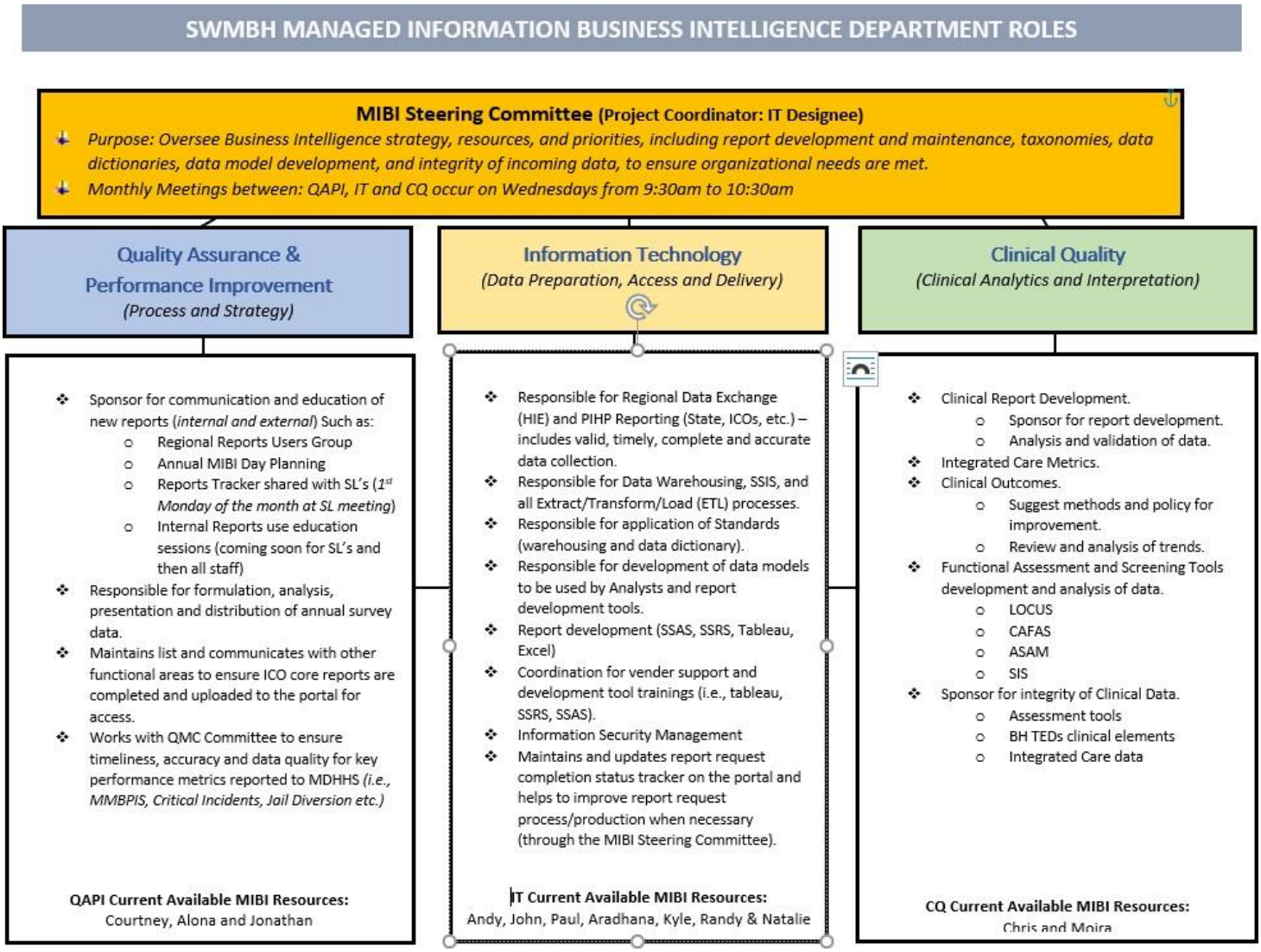
St. Joseph County
- Carole Naccarto
- Cathi Abbs (Alternate)

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

Attachment H: MMBPIS CAP Stages



Attachment I: Managed Information Business Intelligence Department Roles



Attachment J: SWMBH Value Framework

Value Framework

Our Mission

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

Mega Ends

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

Triple Aim

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

Our Vision

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

Attachment K: 2021-2022 Board Ends Metrics

2021 – 2022 SWMBH Board Ends Metrics
(Final Version 12.1.20)
Fiscal and Calendar Year Metrics
Board Approved: December 11, 2020

2021-2022 Board Ends Metrics Review and Approval Schedule:

- *Operations Committee Review and Endorsement: 11/18/20*
- *Utilization Management and Clinical Practices Committee Review and Endorsement: 11/9/20*
- *Quality Management Committee Review and Endorsement: 10/22/20*
- *Board Review: 12/11/2020*

PERFORMANCE METRIC DESCRIPTION
1. Achieve 95% of Veteran's Metric Performance-Based Incentive Program monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/20 - 3/1/21) Metric Board Report Date: August 13, 2021 A. **Identification of beneficiaries who may be eligible for services through the Veteran's Administration**: **i.** Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. *Deliverables:* The VSN Data Collection form will be submitted to BHDDA by the last day of the month following the end of each quarter. **ii.** Improve and maintain data quality on BH-TEDS military and veteran fields. *Deliverables:* BH TEDS quality monitoring reports delivered (10/1/20 through 3/31/21). **iii.** Monitor and analyze data discrepancies between VSN and BH TEDS data. *Deliverables:* By July 1, 2021, Plans will submit a 1-2-page narrative report on findings and any actions to improve data quality. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION
2. Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 Interim report to the Board in August 2021 A. **Increased data sharing with other providers**: i. Send ADT messages for purposes of care coordination through the health information exchange. *Deliverable 1*: At least one CMHSP within a contractor's service area (or the contractor) will be submitting ADT messages to the MIHIN EDI pipeline by the end of FY21. ii. *Deliverable 2:* By July 31, 2021, the contractor must submit, to BHDDA, a report no longer than 2 pages listing the CMHSPs sending ADT messages, barriers for those who are not, along with remediation efforts and plans. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. If MIHIN cannot accept or process the contractor's ADT submissions, this shall not constitute a failure of the metric and will be communicated to the Board and updated appropriately. **Possible Points:** 1 point awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION
3. SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2021, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to the following areas: 1. Comprehensive Care 2. Patient-Centered Medical Homes 3. Coordination of Care 4. Accessibility to Services 5. Quality and Safety Metric Measurement Period: (10/1/20 - 11/15/21) Metric Board Report Date: January 8, 2022 **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION
4. Achieve 95% of possible points on collaboration between entities for the ongoing coordination and integration of services for shared MHL consumers. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 Interim report to the Board in March 2021 A. Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk, who have been identified as receiving services from both entities. B. Risk stratification criteria are determined in writing by the contractor in consultation with the State. MDHHS will select beneficiaries quarterly at random and review their care plans in CC360 for accuracy and compliance. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval.
PERFORMANCE METRIC DESCRIPTION
5. Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) and show a reduction in disparity with one minority group. Metric Measurement Period: 7/1/20 - 6/20/21) Metric Board Report Date: August 13, 2021 Interim report presented to the Board on B. In January 2021 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%. 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. (7/1/20 – 6/30/21) **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval. ½ point each, child and adult.
PERFORMANCE METRIC DESCRIPTION
6. 2021 Customer Satisfaction Surveys collected by SWMBH are at or above the 2020 results for the following categories: Metric Measurement Period: (1/1/21 - 9/30/21) Metric Board Report Date: December 10, 2021 *A.* Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning – baseline: 85.1%) ½ point.* *B.* Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes – baseline 81.3%) ½ point.* *C.* A complete study exploring other survey distribution methods and automation of results collection process (*By August 31, 2021*) 1 point. **Measurement:** Confirmation via selected survey vender of a valid process, survey data, and results report. **Possible Points:** 2 points awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION
7. Implementation of the "*MDHHS approved SUD Standardized Assessment Tool*" for FY21 by 10/1/2021 Per MDHHS Contract. Metric Measurement Period: (9/1/20 - 10/1/21) Metric Board Report Date: February 11, 2022 Interim Report Presented to Board in September 2021. A. Training and certifying all relevant clinicians to administer the approved SUD Assessment (By 8/1/21). ½ point. B. Full system implementation and integration by CMHSP's and Provider sites (By 10/1/21). ½ point. C. SWMBH to implement reporting standards, validation, accuracy and targets in FY21 for FY22 metrics/targets reporting process via MDHHS calendar. ½ point. **Measurement:** Confirmation via selected survey vender of a valid process, survey data, and results report. **Possible Points:** ½ point for each component awarded upon official Board approval. Total of 1 ½ points possible.

PERFORMANCE METRIC DESCRIPTION
8. Each quarter, at least 53% of parents and/or caregivers of youth and young adults receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Guidance. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: December 10, 2021 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter # of youth/young adults receiving ABA services **Possible Points:** 1 point awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION
9. SWMBH will achieve 225 enrollees for the Opioid Health Homes Program (OHH) during year 1 of implementation. Metric Measurement Period: (1/1/21 - 9/30/21) Metric Board Report Date: October 8, 2021 and August 12, 2022 A. Target: 225 total enrollees 1/1/21 – 9/30/21. ½ point B. Based on 2021 baseline enrollment data, SWMBH will establish a retention value for enrollees starting 1/1/22 who remain in OHH program for six months or more. ½ point. **Possible Points:** ½ point awarded for each component upon official Board approval. Total of 1 point possible.

PERFORMANCE METRIC DESCRIPTION
10. 24/28 or 85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 21. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: January 14, 2022 **Measurement:** Results are verified and certified through the quarterly consultative draft report produced by MDHHS. Total number of indicators that met State Benchmark / Total number of indicators measured **Possible Points:** 1 point awarded upon official Board approval.
PERFORMANCE METRIC DESCRIPTION
11. Regional Habilitation Supports Waiver slots are full at 98% throughout FY21. Metric Measurement Period: (10/1/21 - 9/30/21) Metric Board Report Date: October 8, 2021 (*or when MDHHS posts yearend report*). Interim Board Report with (MK or RF) in April 2021 **Measurement:** Results are verified and certified through the MDHHS HSW performance dashboard. (%) of waiver slots (months) filled x 12 / (#) of waiver slots (months) available **Possible Points:** 1 point awarded upon official Board approval. +1 bonus point awarded for (5) or more *new* slots awarded to SWMBH by MDHHS during FY21.
PERFORMANCE METRIC DESCRIPTION
12. 2021 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and corrective action plan evaluated will receive a score of 90% or designation that the standard has been "Met." Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. The number of standards/elements identified as "Met." / Total number of standards/elements evaluated **Possible Points:** 1 point awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION

13. 2021 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met")

Metric Measurement Period: (1/1/2021 - 6/30/21)
Metric Board Report Date: September 12, 2021
(dependent on the final completion date of the annual audit report)

Measurement: Results are verified, certified by the MDHHS/HSAG annual audit report.

$$\frac{\text{Number of Critical Measures that achieved the status of "Met," "Achieved," or "Reportable."}}{\text{Total number of critical measures evaluated}}$$

Possible Points: 1 point awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION

14. SWMBH will meet and exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY21.

Metric Measurement Period: (1/1/2021 - 12/31/21)
Metric Board Report Date: January 14, 2022
Interim Board report with (NS) in June 2021

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. ½ 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. ½ point

Measurement: Results are verified, certified by the MDHHS quarterly BH TEDS Regional compliance reports.

$$\frac{\text{Number of reportable MH/SUD encounters}}{\text{Number of MH/SUD encounters with a matching BH TEDS record}}$$

Possible Points: ½ point each awarded upon official Board approval.

PERFORMANCE METRIC DESCRIPTION

15. SWMBH will achieve 90% of the available CY21 monetary bonus award to achieve (*contractually specified*) quality withhold performance measures, agreed upon by the Integrated Care Organizations (ICO's).

Metric Measurement Period: (1/1/2021 - 12/31/21)
Metric Board Report Date: January 14, 2022
or upon finalization with ICO's

A. 90% of claims processed submitted by the 15th of the following month.
B. 80% of claims per final reconciliation were timely received.
C. 95% CMS initial acceptance rate.
D. 95% of enrollees will have a completed level II assessment within 15 days of ICO referral unless previously completed within 12 months.
E. 80% of enrollees with an inpatient psychiatric admission for whom a transition record was transmitted within 24 hours of discharge.
F. 95% of enrollees will have documented discussions of care goals documented in the ICBR system.
G. 56% of enrollees will have a follow-up visit with a behavioral health practitioner within 30 days of release from an

inpatient setting.

Measurement: Results will be verified through the SWMBH/ICO settlement agreement.

Possible Bonus Points: 1 point awarded upon official Board approval. ½ point each for Aetna and Meridian.

PERFORMANCE METRIC DESCRIPTION

16. SWMBH will achieve Recertification of National Committee for Quality Assurance (NCQA) – Managed Behavioral Healthcare Organization Medicare Service Line.

Metric Measurement Period: (12/1/2020 - 3/31/21)
Metric Board Report Date: June 11, 2021

A. SWMBH will prepare all required evidence for each standard/element and submit through the IRT tool to NCQA by 12/15/20.
B. SWMBH will prepare and complete the on-site survey review process by 3/31/21.

Measurement: Results are verified, certified by the NCQA final compliance report to be received by June 2021.

Possible Points:

- 1 point awarded upon official Board approval.
- +1/2 bonus points awarded for achievement of (Full – 3 years) Accreditation.

PERFORMANCE METRIC DESCRIPTION

17. SWMBH will pursue and apply for a Substance Abuse and Mental Health Services Administration (SAMHSA) Grant by 9/30/21
Stretch Goal - Bonus Metric not to be counted in denominator

Metric Measurement Period: (1/1/2021 - 12/31/21)
Metric Board Report Date: January 8 , 2021

A. SWMBH will prepare all documents/evidence/communication required for application submission.

Measurement: Results are verified through the SAMHSA website and official notification from SAMHSA.

Possible Points:

- 1 point awarded upon official Board approval.
- +1 bonus points awarded for a successful Grant award (above $500,000 for duration of Grant).

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

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

Pending: proof could mean that;

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

Goal Not Met: proof could mean that;

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

Completed Goal:

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

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

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

Southwest Michigan
BEHAVIORAL HEALTH

FY 20 Customer Service Annual Report

January 8, 2021

SWMBH Customer Services Office Responsibilities

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

SWMBH Customer Services Office Responsibilities

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

SWMBH Customer Services Activities

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

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

SWMBH Customer Services Activities

- NCQA reaccreditation preparation
  - Lead to the implementation of a new process
    - Member notification of denial of claims
- MHL reporting requirements-ICO audits
  - Lead to the implementation of a new process
    - Member notification of denial of claims
- Created and implemented a new regional G&A reporting tool
  - Many different categories within each system being reported
  - Agreed to main categories to be reported out as region, created crosswalk to capture/define the various categories

SWMBH Customer Services Activities

- Customer Advisory Committee (CAC) convened 10 times in FY 20
- Currently meeting via phone or GoTo Meeting since May 2020
- Increased stipend rate for participation effective FY21
  - Two rates now- $40 for in-person meeting, $25 for virtual participation
  - Currently paying our members the in-person rate until restrictions have been lifted
- Added 2 new members in November 2019
- Still need representation from Barry, Berrien and Branch Counties
- Seated county representatives on operating committees

SWMBH Customer Services Activities

- October 2019- September 2020 Customer/Member Services fielded 2482 phone calls on the designated lines
  - MA Customer Service line received 1419 calls
  - MHL Member Service line received 1063 calls

- Completed follow up calls
  - Members discharged from Substance Use Disorder residential settings = 797
  - Calls to members who were discharged from Inpatient Psychiatric setting was transferred to Integrated Health for FY 20. This task has since been returned to Customer Service as of Nov. 2020

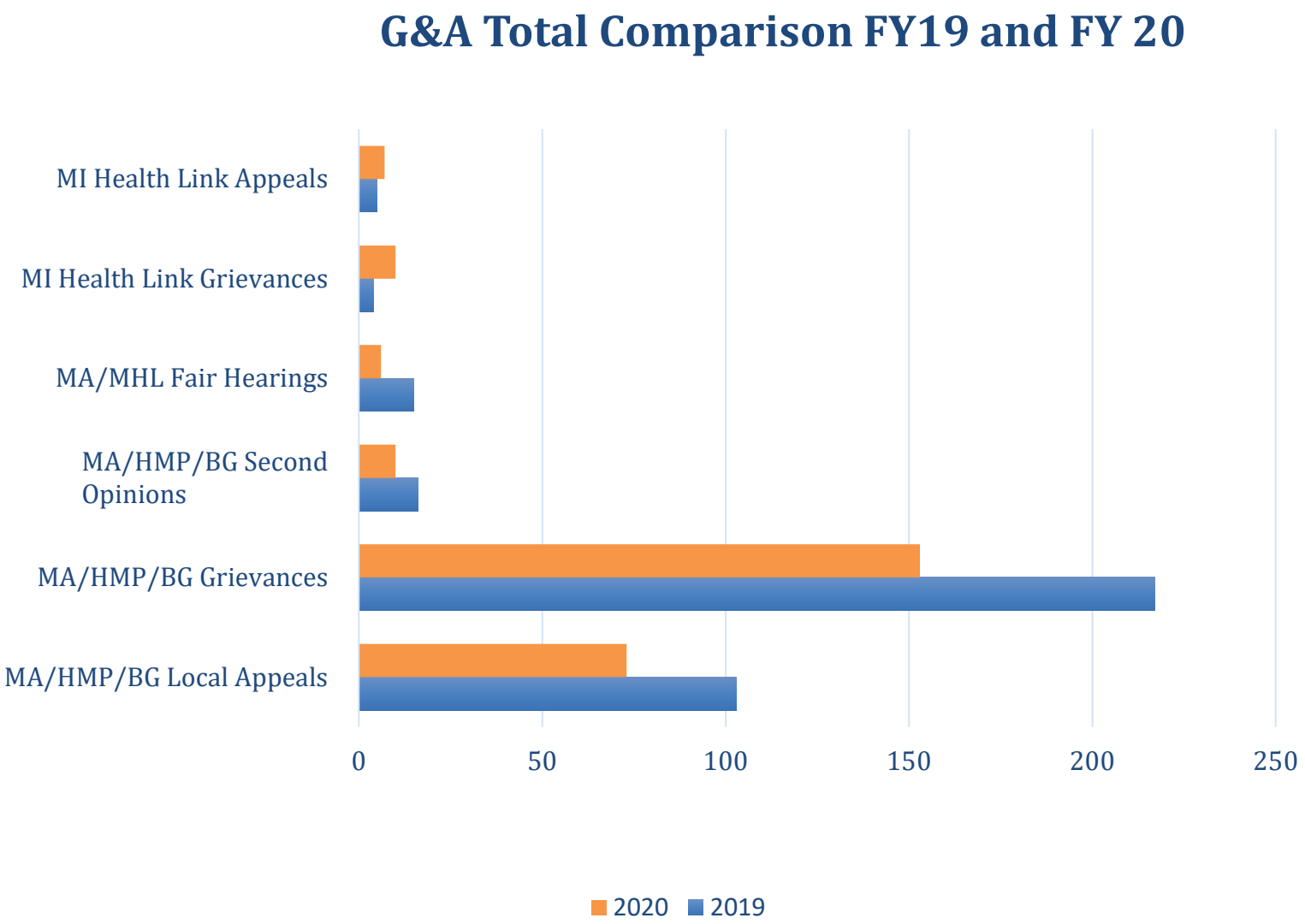
While call volume has decreased this year, the intensity and complexity of the calls has increased due to heightened challenges due to COVID 19 restriction

SWMBH Customer Services Activities

SWMBH and 8 affiliate CMH providers managed and/or provided oversite of 249 Medicaid and MI Health Link Grievances, Appeals and 2nd Opinions

- MA/HMP/BG Local Appeals reported: 73
- MA/HMP/BG Grievances reported: 143
- MA/HMP/BG Second Opinions reported: 10
- MA/MHL Fair Hearings reported: 6
- MI Health Link Grievances reported: 10
- MI Health Link Appeals reported: 7

SWMBH Customer Services Activities

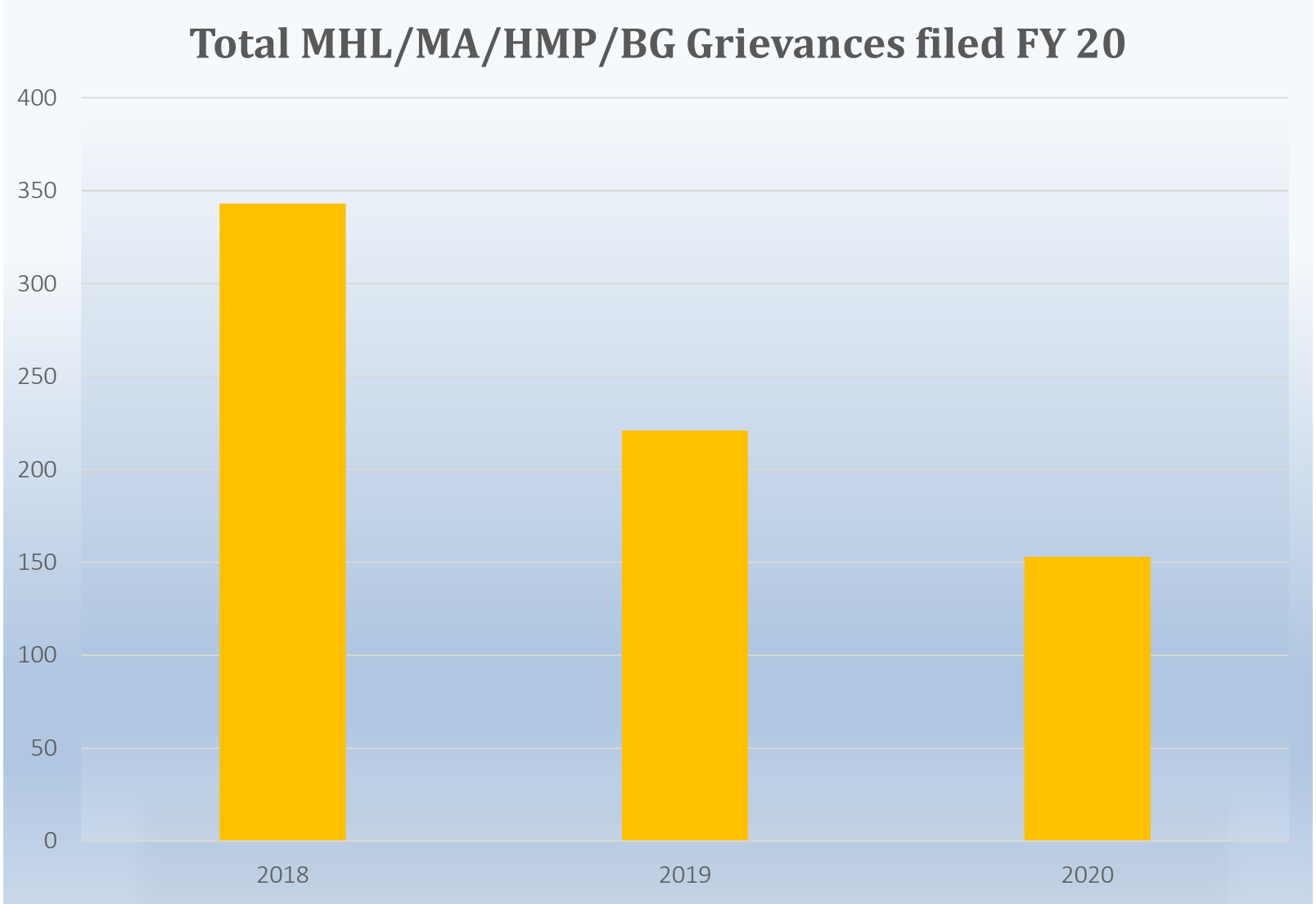


SWMBH Customer Services Activities

SWMBH REGIONAL GRIEVANCE TOTALS (*MHL/MA/HMP/BG*)
FY 2019 - 2020

Category	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Access to Services	6	2	3	5	16
Attitude and Service	26	19	20	19	84
Quality of Care	16	14	6	14	50
Quality of Office Site	2	1	0	0	3
Grand Total	**50**	**36**	**29**	**38**	**153**

SWMBH Customer Services Activities

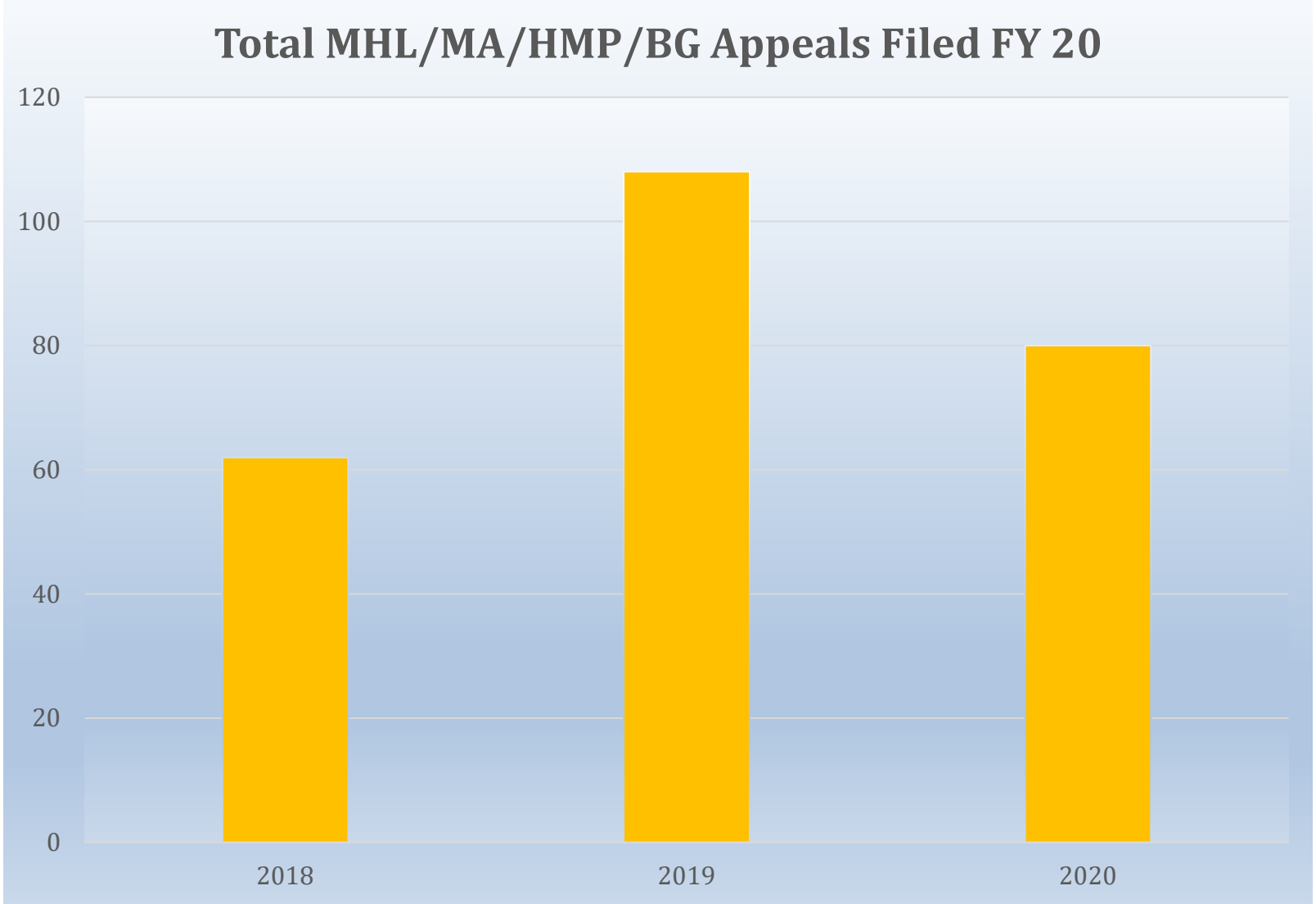


SWMBH Customer Services Activities

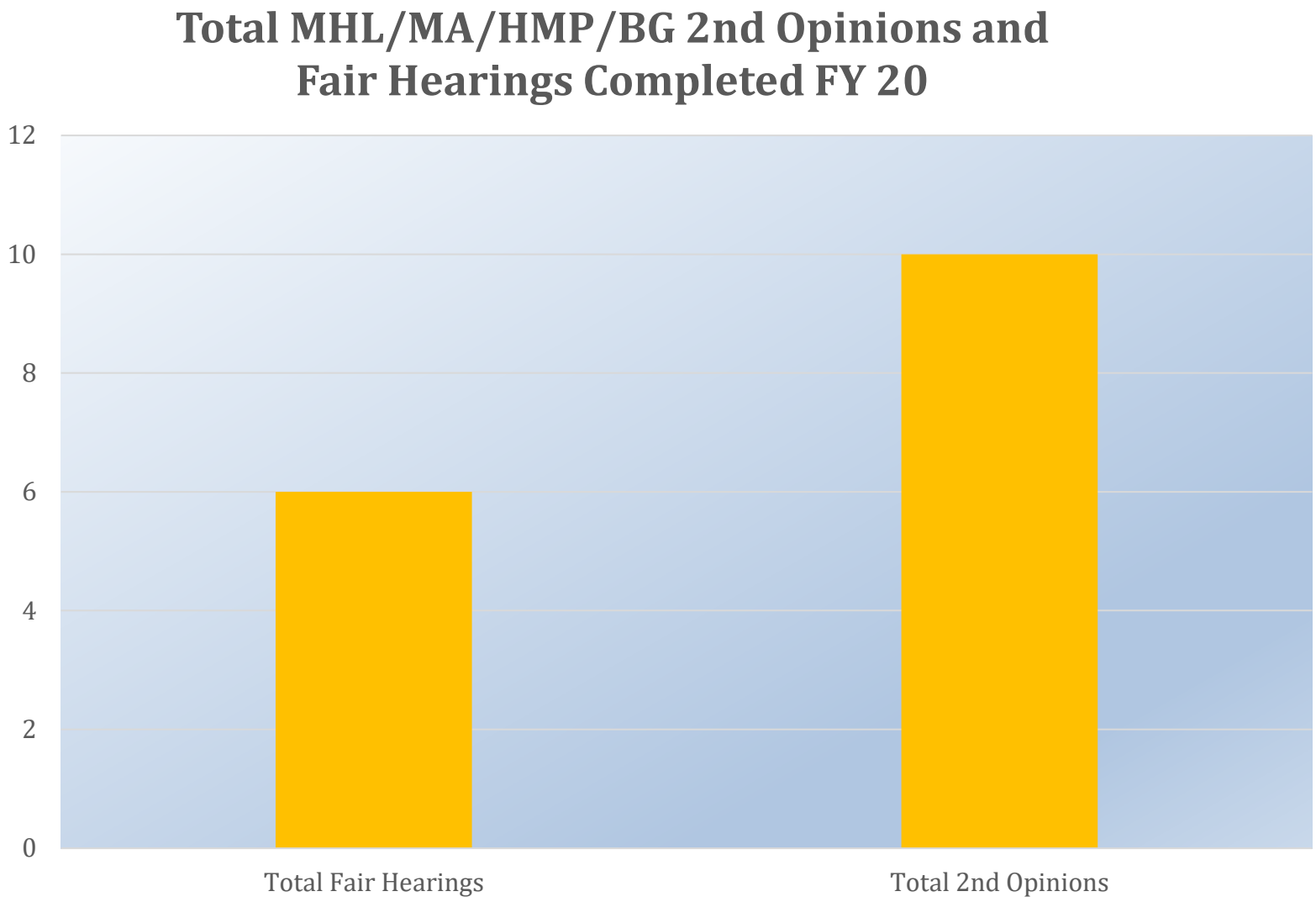
SWMBH REGIONAL APPEAL TOTALS (*MHL, MA, HMP, BG*)
FY 2019-2020

Category	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Affirmed	9	13	9	7	38
Reversed	10	10	3	6	29
Split Resolution	1	1		1	3
Withdrawn/Dismissed	1	4	2	3	10
Grand Total	**21**	**28**	**14**	**17**	**80**

SWMBH Customer Services Activities



SWMBH Customer Services Activities



Community and Advocacy Events

- SWMBH participated in very few community events region-wide due to COVID restrictions. However, we were able to participate in a few during the fall 2019:
  - Michigan CIT Conference,
  - VA Stand Downs (St. Joseph, Van Buren, and Calhoun Counties),
  - Trunk or Treat (pumpkins donation).
  - Portage Christmas Tree display
- SMMBH continues to provide training, education and informational materials virtually when possible

Looking to FY 21

- Complete the NCQA Re-Accreditation successfully for Utilization Management and Rights and Responsibilities.
- Advance Directives – Create and update educational and training materials related to Advance Directives.
- Mediation Process: Ensure region is following mediation practices according to the Michigan Mental Health Code.
- Independent Facilitation: Collaborate and participate with TBD Solutions and Building Better Lives Project to increase awareness and availability of Independent Facilitators within the region by:
- Increase communication options to ensure access to customer service offices and functions throughout the region.

Southwest Michigan
BEHAVIORAL HEALTH

Questions

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

Date Prepared: December 18, 2020
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	
SUD detox and SUD residential per diem codes billed overlapping by three (3) different providers	2020-01	x		x		x		Recoupments totaling $9,645.34
Provider submitted an Authorization request for DOS while customer reported being incarcerated.	2020-02	X		X		X		Compliance reviewed for inappropriate use of Medicaid funds – no funds expended. Authorization request was denied.
Duplicate billing; Global billing rules not functioning appropriately	2020-03	X		X		X		Recoupments totaling $3,016.18; Global billing rules corrected
CMH referral to SWMBH – CLS worker providing services to multiple customers at the same time then billing for each separately (increases hours worked)	2020-04	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. $931.42 reverted to CMH General Funds.
CMH referral to SWMBH – Self-D worker submitted timesheet and progress note for a DOS that customer was inpatient.	2020-05	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. Self-D arrangement terminated. $311.55 in improper payments.
CMH referral to SWMBH - Customer's commercial insurance terminated retroactively, making Medicaid responsible for multiple inpatient psych	2020-06	X		X			X	CMH referred to SWMBH; SWMBH referred to MI OIG. OIG found no improper

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

Train & Educate		Audit & Monitor			Report & Evaluate			
stays. Questions re: conflicts of interest.								action.
CMH referral to SWMBH – Self-D worker submitted timesheets with inaccurate times.	2020-07	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. Recoupment totaling $1,006.36. Self-D worker terminated.
OIG referral to SWMBH – anonymous complaint that an Autism provider was not appropriately qualified to perform service being delivered.	2020-08	X		X			X	Report sent to MI OIG. Initial allegations not substantiated. Documentation discrepancies identified and a recoupment totaling $2,305.00 is indicated.
Duplicate billing identified as part of MHL audit.	2020-09	X		X		X		Recoupment totaling $1,527.96. Duplicate billing unintentional.
CMH referral to SWMBH – Provider “recreated” documentation when it was requested by a CMH.	2020-10	X		X		X		CMH implemented a Corrective Action Plan for the provider.
CMH referral to SWMBH – subcontracted provider staff billing for services that did not occur. Customer was on a spenddown.	2020-11	X		X		X		CMH made referral to MI OIG and the implicated funds were GF due to spenddown not being met.
SUD provider notified SWMBH that it identified one of its staff submitting inappropriate documentation times (billing for longer services than were provided).	2020-12	X		X		X		SWMBH referred to MI OIG. Recoupment totaling $1,960.
CMH referral to SWMBH – staff completed an Assessment and Treatment Plan without making contact with the customer. Assessment and Treatment Plan were	2020-13	X		X		X		No recoupment indicated. Inappropriate documentation practices did not result in damage to

NOT billed to Medicaid, but subsequent services were.								Medicaid. MDHHS instruction that services to continue during COVID.
OIG referral to SWMBH – report that provider staff was billing for services not rendered.	2020-14	X		X			X	Allegations were not substantiated. Recoupment totaling $228.53 based on documentation deficiencies.
CMH referral to SWMBH – provider identified fraudulent billing but did not correct the claims.	2020-15	X		X			X	Referred to MI OIG. Provider corrected the billing during the course of CMH's compliance review, but without knowledge of the compliance review.
Total	**15**	**15**		**15**		**11**	**4**	

2. Privacy/Security Allegations/Reports

A total of thirty-one (31) incidents were reported to the SWMBH Breach Team in FY2020. 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 thirty-one (31) incidents reviewed, NONE were determined to be reportable.

3. Planned Audits

Audit	# Services/Claims Reviewed	Result/Progress	Recoupments
Medicaid Verification	1,800	Completed	54 payment adjustments ($24,654.49)
MI Health Link			
Quarter 1	240	Completed	2 recoupments ($51.10)
Quarter 2	239	Completed	None
Quarter 3	284	In-process	
Quarter 4	277	In-process	
SUD Block Grant Claims	219	Completed	1 recoupment ($54.00) 54 reallocations to Medicaid/HMP ($3,954.02)

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

SUD Coordination of Benefits			
Quarter 1	30	Completed	None
Quarter 2	30	Completed	None
Quarter 3	30	Completed	None
Quarter 4	30	In-process	

Medicaid Claims/Service Encounter Verification Report
Southwest Michigan Behavioral Health

Prepaid Inpatient Health Plan/Regional Entity

For the time period 10/01/2019 – 09/30/2020
Submitted December 14, 2020

Pursuant to MDHHS-SWMBH FY20 Contract
Section 6.4 Medicaid Services Verification

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

Introduction:

Southwest Michigan Behavioral Health (SWMBH) is the Regional Entity and Medicaid Prepaid Inpatient Health Plan (PIHP) for eight counties and Community Mental Health Service Programs (CMHSP) in southwest Michigan. These eight CMHSPs are: Barry County Community Mental Health Authority, Riverwood Center (Berrien County Community Mental Health Authority), Pines Behavioral Health Services (Branch County Community Mental Health Authority), Summit Pointe (Calhoun County Community Mental Health Authority), Woodlands Behavioral Healthcare Network (Cass County Community Mental Health Authority), Integrated Services of Kalamazoo (Kalamazoo County Community Mental Health Authority), Community Mental Health and Substance Abuse Services of St. Joseph County (St. Joseph County Community Mental Health Authority), and Van Buren County Community Mental Health Authority. The Quality Assessment and Performance Improvement Programs for PIHP Standards (Contract Attachment P 7.9.1) contains a requirement that PIHPs verify whether services reimbursed by Medicaid were actually furnished to enrollees by CMHSPs, contracted providers and subcontractors. To that end, SWMBH has conducted verification of Medicaid claims as detailed by the methodology outlined below, in conformity with the Medicaid Services Verification Technical Advisory (Contract Attachment P 6.4.1).

In conducting the verification of sampled Medicaid claims, SWMBH conducted the internal audit of CMHSP service encounters for each CMHSP, all respective county substance use disorder providers, and SWMBH reviewed claims from service providers subcontracted with Participant CMHSPs. The following is SWMBH's Medicaid Verification report with audit activities and results.

Data Collection Methodology:

The universe of claims for the Medicaid Verification testing process consisted of a quarterly review of Medicaid claims approved for payment by SWMBH between the dates of October 1, 2019 and September 30, 2020. The Random Number function of the OIG's statistical software package, RAT-STATS, was used to select the random samples of claims for review from the total universes.

The Medicaid Verification testing sample size was a total of one thousand eight hundred (1,800) claims/encounters. These claims/encounters were reviewed based on Fiscal Year Quarters, divided as follows:

- Thirty (30) unique dates of service from each of the eight participant CMHSPs, stratified to include fifteen (15) encounters (CMHSP-provided services) and fifteen (15) subcontracted provider claims.
    - Nine hundred sixty (960) unique dates of service reviewed in total for FY20;
    - Represented eight thousand fourteen (8,014) units and $298,450.35.
- Thirty (30) claims/encounters for the total universe of Substance Use Disorder providers, stratified to remove claims from providers already reviewed in the CMHPs or Region-Wide samples, per quarter.
    - One hundred twenty (120) claims/encounters reviewed in total for FY20;
    - Represented one hundred forty-seven (147) units and $4,013.33.

- Fifteen (15) claims/encounters for each of the top three hospital providers (by dollar volume) subcontracted with a Participant CMHSP, per quarter.
    - One hundred eighty (180) claims reviewed in total for FY20;
    - Represented seven hundred twenty-two (722) units and $683,836.67.
- Thirty (30) claims for each of the top three service providers (by dollar volume), stratified to remove the top three service providers from FY19, subcontracted with a Participant CMHSP, per quarter.*
    - Three-hundred sixty (300) claims reviewed in total for FY20;
    - Represented three thousand six hundred ninety-seven (3,697) units and $126,542.14.
    - * For quarter two, due to COVID-19 each top provider had a sample of 10 claims.
- Sixty (60) claims/encounters from a region-wide universe that was stratified to remove claims for services provided by any of the top three hospitals already reviewed, or by any of the top three external subcontracted providers already reviewed, per quarter.
    - Two-hundred forty (240) claims/encounters reviewed in total for FY20;
    - Represented one thousand five hundred fifty (1,550) units and $58,837.62.

Analysis Summary:

SWMBH's findings of the internal and external clinical records of participant CMHSPs and Substance Use Disorder providers show an overall compliance rate of 97.11% encompassing all review questions.

Identified Deficiencies. Out of a total sample of one thousand eight hundred (1,800) claims/encounters reviewed, one thousand seven hundred forty-eight (1,748) were verified to be a valid service reimbursable by Medicaid. The following is a summary of the deficiencies noted among the seven questions addressed in the review tool for the fifty-two (52) invalid claims:

- Was the person eligible for Medicaid coverage on the date of service reviewed? **1 deficiency**
- Is the provided service eligible for payment under Medicaid? **0 deficiencies**
- Is there a current treatment plan on file which covers the date of service? **34 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed? **13 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer? **82 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **4 deficiencies**
- Was the appropriate amount paid (contract rate or less)? **30 deficiencies**

Verification Process:

Medicaid Verification was facilitated through site visits and/or through a remote desk review of each applicable provider, of relevant documents maintained within the electronic medical record used by all participant CMHSPs. The site visits and/or remote desk reviews were scheduled between January 2020 and December 2020. A standardized verification tool was developed and used by all reviewers for both claims and encounters. The questions on the review tool included the following:

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

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

Medicaid Eligibility Assurance:

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

Description of Follow-up Activities and Improvements:

Over the course of Fiscal Year 2020, SWMBH reviewed the service documentation and claims processing procedures of each participant CMHSP to ensure that both the applicable delegated and non-delegated functions follow Medicaid regulations and SWMBH policies.

In regard to the deficiencies noted pertaining to a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the

service billed, the majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with a clinician signature prior to the provision of service and within 15 business days of the effective date of the plan. SWMBH will continue to work with our CMHSPs and sub-contracted providers to address the timeliness of treatment planning and the signatures of the clinician validating the treatment plan. Additionally, SWMBH will continue to educate providers on the importance of specific and individualized goals/objectives/interventions for services contained within the treatment plan.

With regard to the deficiencies noted regarding documentation on file to support that the service was provided, many providers struggled with the MDHHS requirement of a provider signature and signature date on documentation and the inclusion of actual begin and end times of face-to-face per unit services. SWMBH has been working and will continue to work with CMHSPs and sub-contracted providers to ensure adherence to all MDHHS clinical records policies and requirements.

With regard to the deficiencies noted for the appropriate amount paid (contracted rate or less), SWMBH identified claims/encounters which were paid appropriately (contracted rate or less) but which did not use the required/appropriate place of service code. All disallowed/inappropriate place of service codes were corrected by the provider following the claim review.

In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative documentation review process, designed to provide ongoing feedback to both participant CMHSPs and external service providers in order to continue improving documentation and claims submission efforts.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in the area of Medicaid fraud and abuse prevention. In Fiscal Year 2021, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan timeliness, the appropriate use of place of service codes, and service documentation standards. Additionally, SWMBH will be closely monitoring the reporting of in-home Community Living Support claims following the transition of the per diem code to the per unit code.

Corrective Action and Follow-Up Process

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

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

Given this year's findings, ongoing education and training will be provided with an emphasis on documentation standards, treatment planning timeliness, and place of service codes. As a result of the anticipated staff training, efforts to continuously improve in this area will be ongoing. The Medicaid Verification findings are reported to the SWMBH Board of Directors and the Member Advisory Committee. The SWMBH Executive Officer, the Chief Compliance Officer, the SWMBH Corporate Compliance Oversight Committee and the SWMBH Leadership Team will also review the findings and identify any additional strategies needed to improve the findings. Given the overall compliance rate of 97.11% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP is not required and will not be submitted; however, SWMBH will continue the efforts described above in order to improve service claim processes congruous with Medicaid requirements.

The fifty-two (52) claims/encounters identified as invalid represent a total of five hundred fifty (550) units and resulted in payment adjustments totaling $24,654.49. Payment adjustments were communicated to the applicable agency via a recoupment ticket contained in the final audit report. Applicable agencies were advised of their appeal rights, and that once the appeal period had passed (30 days) the invalid claims will be reverted, and the funds recouped. When the claims are reverted and denied, the encounter that was previously submitted to MDHHS is voided.

County	Letters mailed July 2020	Signed Contract received
Barry	X	9/22/2020
Berrien	X	9/24/2020
Branch	X	7/13/2020
Calhoun	X	8/6/2020
Cass	X	12/2/2020
Kalamazoo	X	12/15/2020
St. Joesph	X	12/3/2020
Van Buren	X	8/11/2020

as of 12/17/20

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

February 12, 2021
9:30 am to 11:00 am
(d) means document provided
Draft: 12/14/20

1. **Welcome Guests/Public Comment**

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

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

    - **List name(s) and Agency or None Scheduled**

4. **Consent Agenda**

    - January 8, 2021 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

    - Operations Committee Minutes December 16, 2020 (d)

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

    - Tools Update (M. Kean) (d)
        i. *Intellectual Developmental Disabilities (Supports Intensity Scale)
        ii. *Substance Use Disorders (American Society of Addiction Medicine)
        iii. *Serious Mental Illness (Level Of Care Utilization System)
        iv. *Serious Emotional Disturbances (Child and Adolescent Functional Assessments Scale)
    - None Scheduled

7. **Board Actions to be Considered**

    - Executive Officer Employment Agreement

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

    - None Scheduled

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

    - None Scheduled

10. **Board Education**

    a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d)
    b. Fiscal Year 2021 Budget Update (T. Dawson)
    c. Fiscal Year 2020 Medicaid Verification Results (M. Todd) (d)

11. Communication and Counsel to the Board

a. Intergovernmental Contract Status (B. Casemore) (d)
b. March 12, 2021 Board Agenda (d)
c. Board Member Attendance Roster (d)
d. March Board Policy Direct Inspection - none

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 SWMBH Board Meeting
March 12, 2021
9:30 am - 11:00 am

2013 SWMBH Board Member and Alternate Attendance						
Name	**July**	**August**	**September**	**October**	**November**	**December**
Randy Hyrns (Berrien)						
Barbra Parker (St. Joe)						
Richard Allman (Calhoun)						
Linda Maupin (Barry)						
Tom Schmelzer (Branch)						
Robert Wagel (Cass)						
Moses Walker (Kalamazoo)						
Susan Barnes (Van Buren)						
Alternates						
Mary Myers (A-Cass)						
David Selent (A-Van Buren)						
Robin Baker (A-St. Joe)						
Patricia Guenther (A-Kalamazoo)						
Former Members						
Pamela Jarvis						

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3) Does all SDOH funding flow through plans?

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

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

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

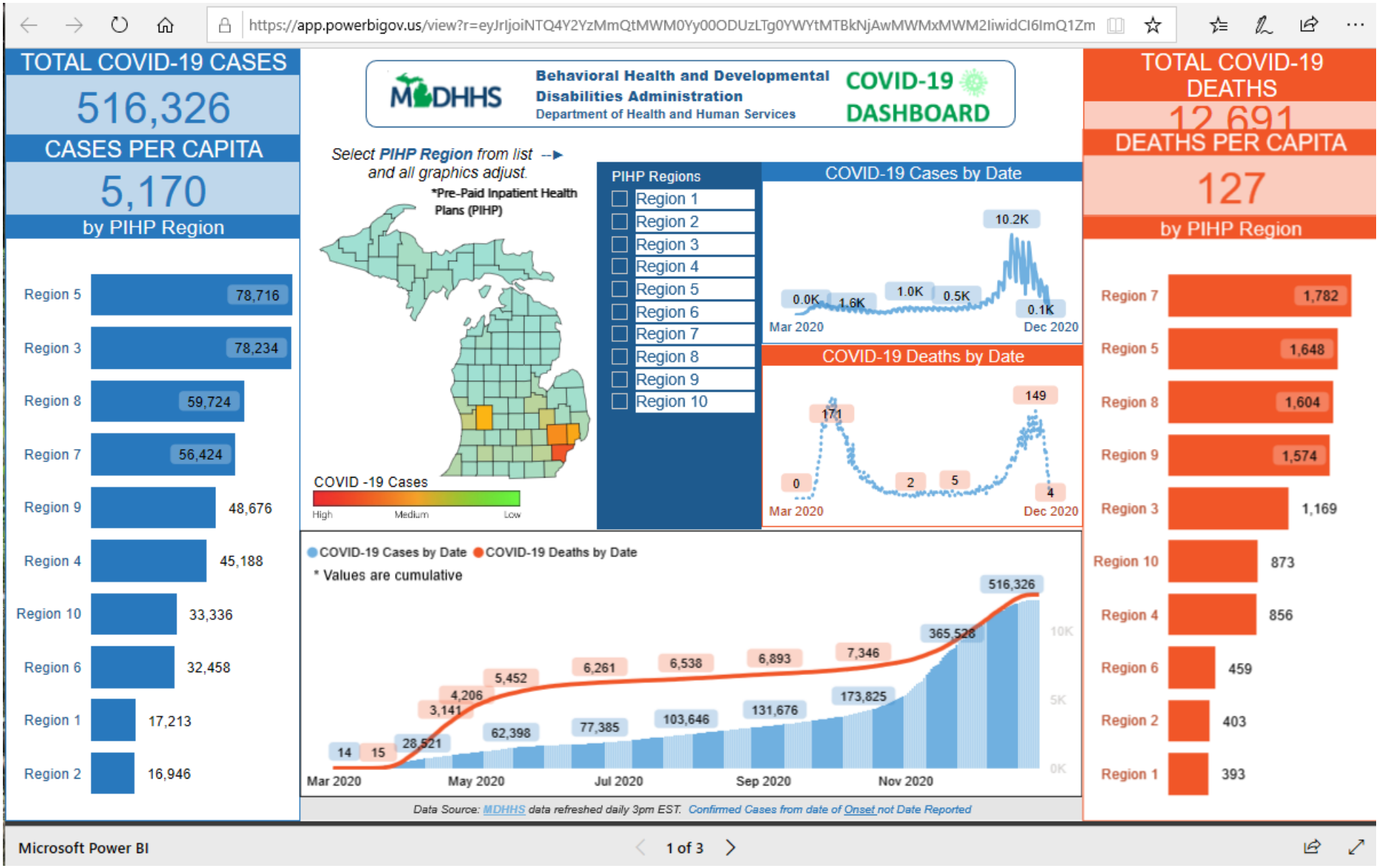
5) How do you measure the ROI on community health workers?

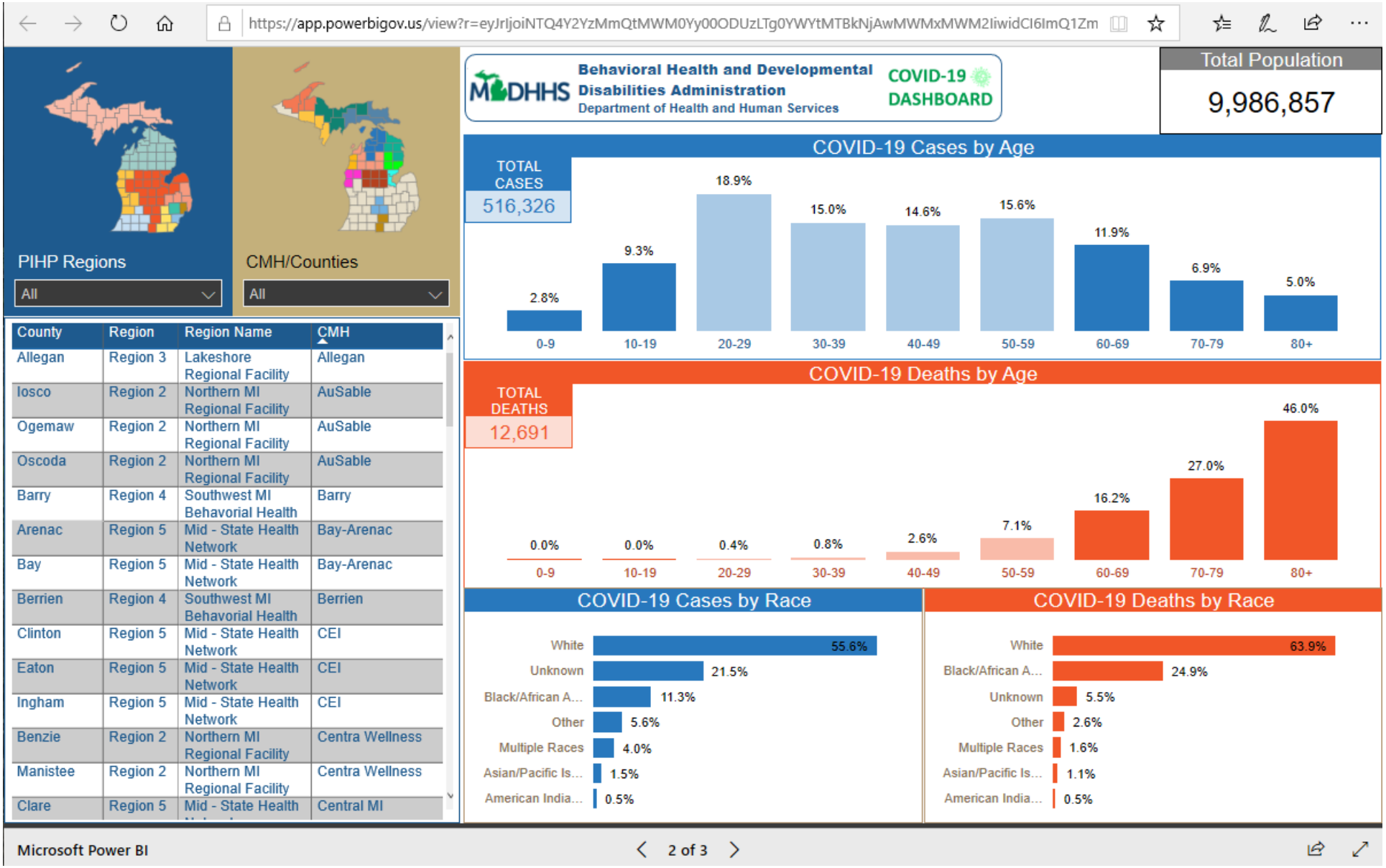
Response: Mr. Gorman outlined taking the baseline cost of the intervention population before intervening and checking annually to project the costs of the population going forward. Generally, community health workers have complex interventions, so he recommends a low panel size of 30-50 workers to track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

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

MDHHS COVID-19 Dashboard – Entire contents for Page 3 must be accessed at the following website: Highlight and open hyperlink for complete report.

https://app.powerbigov.us/view?r=eyJrIjoiNTQ4Y2YzMmQtMWM0Yy00ODUzLTg0YWYtMTBkNjAwMWMxMWM2IiwidCI6ImQ1ZmI3MDg3LTM3NzctNDJhZC05NjZhLTg5MmVmNDcyMjVkMSJ9&pageName=ReportSectiona1bd1bb5eb5c45852eba





County	Region	Region Name	CMH
Allegan	Region 3	Lakeshore Regional Facility	Allegan
Iosco	Region 2	Northern MI Regional Facility	AuSable
Ogemaw	Region 2	Northern MI Regional Facility	AuSable
Oscoda	Region 2	Northern MI Regional Facility	AuSable
Barry	Region 4	Southwest MI Behavorial Health	Barry
Arenac	Region 5	Mid - State Health Network	Bay-Arenac
Bay	Region 5	Mid - State Health Network	Bay-Arenac
Berrien	Region 4	Southwest MI Behavorial Health	Berrien
Clinton	Region 5	Mid - State Health Network	CEI
Eaton	Region 5	Mid - State Health Network	CEI
Ingham	Region 5	Mid - State Health Network	CEI
Benzie	Region 2	Northern MI Regional Facility	Centra Wellness
Manistee	Region 2	Northern MI Regional Facility	Centra Wellness
Clare	Region 5	Mid - State Health	Central MI

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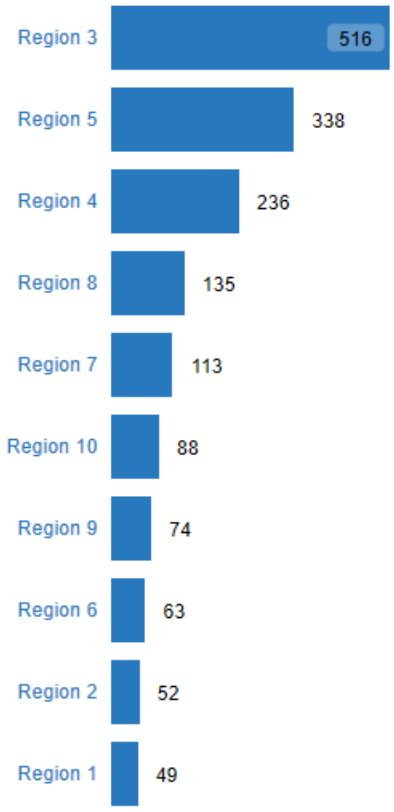
ADULT FOSTER CARE COVID-19 CASES

1,707

by PIHP Region



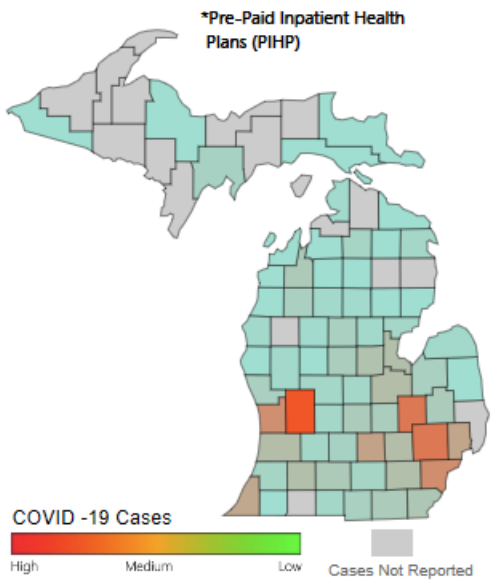
MDHHS Behavioral Health and Developmental Disabilities Administration
Department of Health and Human Services

COVID-19 DASHBOARD

Adult Foster Care Facilities

Data Source MDHHS Data refreshed by 4pm EST. Each Monday
Data from Adult Foster Care Facilities (AFC)

*Select **PIHP Region** from list --►*
and all graphics adjust.



PIHP Regions
- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9
- Region 10

This information does not replace a thoughtful conversation with facility staff about their current infection control practices and mitigation strategies. Questions that families might ask a care facility include:

- What are you doing currently to protect residents from COVID-19?
- What precautions do you take when you do identify a person who is symptomatic of COVID-19?
- How are families kept apprised of changes related to your infection control policies?

***Note:** Some facilities are actively performing regular testing on all staff and residents, so counts may fluctuate as pending results become available.*

Facility Name	County	Cases
AC Flower House LLC	Barry	0
Addie's Acres, LLC	Clinton	0
Addington Place of Dewitt 2	Clinton	0
Addington Place of DeWitt 3	Clinton	0
Addington Place of East Paris #3	Kent	0
Addington Place of East Paris #5	Kent	0
Addington Place of East Paris #6	Kent	0
Addington Place of East Paris #7	Kent	4
Addington Place of East Paris #8	Kent	3
Addington Place of Grand Blanc 1	Genesee	0
Addington Place of Grand Blanc II	Genesee	0
Addington Place of Grand Rapids Bay Pointe	Kent	0
Addington Place of Grand Rapids Nantucket	Kent	0
Addington Place of Grand Rapids Peace Harbor	Kent	0
Addington Place of Grand Rapids Seaside	Kent	0
Agape Home At Blueberry Fields	Muskegon	14
AHSL Holland Bay Pointe	Ottawa	1
AHSL Holland Beachside	Ottawa	6
AHSL Holland Boardwalk	Ottawa	5
AHSL Holland Driftwood	Ottawa	0
AHSL Holland Lakeshore	Ottawa	0
AHSL Holland Lighthouse	Ottawa	1
AHSL Jenison Beechwood	Ottawa	0
AHSL Jenison Cherrywood	Ottawa	0
AHSL Jenison Cottonwood	Ottawa	5
AHSL Jenison Maplewood	Ottawa	5
AHSL Jenison Sandalwood	Ottawa	0
AHSL Jenison Willowood	Ottawa	10
AHSL Kentwood Cobblestone	Kent	0
AHSL Kentwood Fieldstone	Kent	5
Total		**1,707**

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

MEMORANDUM

DATE: December 22, 2020

TO: PIHP Directors

FROM: Allen Jansen, Senior Deputy Director AJ
Behavioral Health and Developmental Disabilities Administration

SUBJECT: Reduction on Substance Abuse Block Grant (SABG) Funding

In response to your request regarding information on the cause of the reduction in SABG funding, we provide the following explanation.

The reduction in federal Substance Abuse Block Grant (SABG) dollars to be received by Michigan's PIHPs in fiscal year (FY) 2021, from the FY 2020 funding level, is due to the fact that the Block Grant funds distributed to the PIHPs over the past several years included unspent dollars from prior years. Due to a number of causes – chief among them being increases in demand for Substance Use Disorder (SUD) services by persons with Medicaid or other insurance coverage – these unspent dollars, from prior years, are not available to be included in the Community Grant dollars which include federal Block Grant and matching state General Fund dollars allocated to the State's PIHPs in FY 2021.

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

MDHHS/BHDDA will continue to explore pathways to secure additional federal funding to enhance and increase prevention, treatment and recovery services provided to Michigan residents at risk or living with substance use disorders.

If you have additional questions, please let me know. As always, we appreciate your advocacy and support.

cc: Jeffery Wieferich
Larry Scott