Southwest Michigan

BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial-in: 1-844-655-0022
Access Code: 738 811 844
October 11, 2019
9:30 am to 11:00 am
10/9/19

1. **Welcome Guests/Public Comment**

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

3. **Consent Agenda**

    a. SWMBH Board Member – Michael McShane, Cass County/Woodlands - Conflict of Interest/Financial Disclosure Statement (P. Morey)
    b. September 13, 2019 SWMBH Board Meeting Minutes (d)
    c. Annual Financial Interest Disclosures with no new disclosures (P. Morey)
        Kathy-Sue Vette, Edward Meny, Moses Walker, Patricia Guenther, Patrick Garrett, Robert Nelson, Susan Barnes, Tom Schmelzer, Jon Houtz

4. **Board Education**

    - SWMBH Retirement Program Updates (d) (C. Doerschler of Rose Street Advisors)

5. **Operations Committee**

    a. Operations Committee Minutes August 28, 2019 (d)
    b. Operation Committee Report (d) (D. Hess)

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

    - *Year to Date Regional Habilitation Supports Waiver Slots (d) (R. Freitag)

7. **Board Actions to be Considered**

    a. Fiscal Year 2020 Budget Approval (d) (B. Casemore)
    b. Michigan Consortium for Healthcare Excellence Membership (d) (B. Casemore)
    c. Holiday Gathering – Bravo! December 13, 2019 11:45am

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

    a. EO-001 Executive Role & Job Description (d)
    b. EO-002 Monitoring Executive Performance (d)

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

    a. BEL-010 RE 501 (c) (3) Representation (d) (S. Barnes)
    b. BEL-008 Communication and Counsel (d) (P. Garrett)

10. **Board Education**

- Fiscal Year 2020 State Budget highlights (d) (B. Casemore)

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

a. Consolidated Fiscal year 2019 Year to Date Financial Statement (d) (B. Casemore)
b. Fiscal Year 2020 additional Habilitation Supports Waiver slots (B. Casemore) (d)
c. Board Member Attendance Roster (d)
d. 2020 Economic Forecast article (d)
e. CMS Medicaid article (d)
f. Rep. Mary Whiteford Behavioral Health Hearings (d)
g. Community Mental Health Association of Michigan – Fall Conference (d)
h. Waiver Information (d)
i. National Committee for Quality Assurance (NQCA) Fiscal Year 2019-2020 Medicaid Summary Report of Health Insurance Plan Ratings (d)
j. Pending Behavioral Health Legislation (d)
k. Center for Healthcare Integration & Innovation (d)
l. November Board: Executive Officer Evaluation
m. November Board: EO-003 Emergency Executive Officer Succession

12. **Public Comment**

13. **Adjournment**

Next SWMBH Board Meeting
November 8, 2019
9:30 am - 11:30 am
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
September 13, 2019
9:30 am-11:00 am
KVCC Groves Center, 7107 Elm Valley Drive, Room B1100, Kalamazoo, MI 49009
Draft: 9/19/19

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

Absent: Angie Price

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Petra Morey, Compliance Specialist III SWMBH; Jonathan Gardner, Director of Quality Assurance Performance Improvement, SWMBH; Joel Smith, Director of Substance Use Treatment and Prevention, SWMBH; Rhea Freitag, Behavioral Health Waiver & Clinical Quality Manager, SWMBH; Michelle Jorgboyan, Senior Operations Specialist and Rights Advisor, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Jeannie Goodrich, Summit Pointe; Debra Hess, VanBuren CMH; Richard Thiemkey, Barry County CMHA; Patricia Guenther, KCMHSAS Alternate

Welcome Guests

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

Public Comment

None

Agenda Review and Adoption

Motion Robert Nelson moved to accept the agenda.
Second Susan Barnes
Motion Carried

Recess Board Meeting

Motion Patrick Garrett moved to recess the SWMBH Board meeting for the Fiscal Year 2020 Budget Public Hearing.
Second Edward Meny
Motion Carried

Fiscal Year 2020 Budget Public Hearing

Tracy Dawson reported on the Fiscal Year (FY) 2020 Budget Assumptions and Draft Budget as documented. Tracy thanked the CMHSPs for their hard work on cost savings, reductions and

fiscal year FY 2020 budget. Tracy noted the projections for FY20 are ($242,176) as compared to FY19 projection of ($13,000,000). Discussion followed.

Reconvene Board Meeting

Motion Robert Nelson moved to close the Fiscal Year 2020 Budget Public Hearing and reconvene the Board meeting.
Second Edward Meny
Motion Carried

Consent Agenda

Motion Patrick Garrett moved to approve the 8-9-19 SWMBH Board Meeting Minutes.
Second Moses Walker
Motion Carried

Motion Susan Barnes moved to approve the Customer Advisory Committee member nominations for a two-year term as follows: Sharon Sheddan, Calhoun County; Ella Smith, Calhoun County; Jennifer Leigh, Kalamazoo County; Mary Bowers, St. Joseph County; and Junelle Hicks, Kalamazoo County.
Second Patrick Garrett
Motion Carried

Operations Committee

Operations Committee Minutes July 31, 2019

Tom Schmelzer asked for comments or questions. Minutes accepted.

Ends Metrics

Performance Bonus Incentive Program (PBIP)

Jonathan Gardner reported as documented. Discussion followed.

Board Actions to be Considered

Fiscal Year 2020 Budget Draft

Tracy Dawson reviewed as presented. Board discussed and determined that no action is required at this time due to information that is still needed from the State.

EO-002 Monitoring Executive Performance: Appoint Review Committee

Tom Schmelzer appointed the Executive Board Members to review SWMBH's Executive Officer. SWMBH's Executive Board Members are Tom Schmelzer, President, Edward Meny, Vice President and Susan Barnes, Secretary.

Board Policy Review

BG-008 Board Member Job Description

Tom Schmelzer reviewed the policy.

Motion Moses Walker moved that the Board is in compliance and the policy does not need any revision.

Second Robert Nelson

Motion Carried

Executive Limitations Review

BEL-009 Global Executive Constraints

Tom Schmelzer reviewed the policy.

Motion Edward Meny moved that the Executive Officer is in compliance and the policy does not need any revision.

Second Robert Nelson

Motion Carried

Board Education

SWMBH Region 4 – 1915(c) and Substance Use Disorder (SUD) Site Review

Rhea Freitag and Joel Smith reported as documented. Rhea noted zero citations and areas of improvement for the 1915(c) review. Joel noted full compliance for SUD review. Discussion followed.

Communication and Counsel to the Board

Consolidated Fiscal Year 2019 Year to Date Financial Statements

Tracy Dawson reported as documented noting significant positive changes this year as compared to the same time period last year. Discussion followed.

Michigan Health Endowment Fund (MHEF) Grant Outcome

Brad Casemore reported as documented thanking KCMHSAS and Family Health Center for their contributions and partnership with the grant.

BHDDA Letter

Brad Casemore reported as documented.

Cass County/Woodlands Update

Brad Casemore reported as documented. Discussion followed.

Community Mental Health Association of Michigan Responses

Brad Casemore reported as documented.

Centers for Medicare and Medicaid Services (CMS) New Enrollment Authorities

Brad Casemore reported as documented.

Miscellaneous Updates

Brad Casemore updated the Board on Mila Todd's leave, new addition of Richard Godfrey to the Regional Public Policy Committee, Chief Information Officer interviews, and hosting Senator Mike Shirkey at a recent Branch County Play entitled Next to Normal.

Board Member Attendance Roster

Brad Casemore reported as documented.

Closed Session

Motion	Susan Barnes moved to go into closed session to review August 9, 2019 closed session meeting minutes		
Second	Robert Nelson		
Roll Call Vote	Robert Nelson – yes	Edward Meny – yes	Tom Schmelzer – yes
	Patrick Garrett – yes	Moses Walker – yes	Susan Barnes - yes

Motion Carried

Open Session

Motion	Edward Meny moved to go into back into open session		
Second	Patrick Garrett		
Roll Call Vote	Robert Nelson – yes	Edward Meny – yes	Tom Schmelzer – yes
	Patrick Garrett – yes	Moses Walker – yes	Susan Barnes - yes

Motion Carried

Approve August 9, 2019 Closed Session Meeting Minutes

Motion	Edward Meny moved to approve August 9, 2019 closed session meeting minutes		
Second	Patrick Garrett		
Roll Call Vote	Robert Nelson – yes	Edward Meny – yes	Tom Schmelzer – yes
	Patrick Garrett – yes	Moses Walker – yes	Susan Barnes - yes

Motion Carried

Public Comment

None

Adjournment

Motion	Susan Barnes moved to adjourn at 10:55am
Second	Moses Walker

Motion Carried

Southwest Michigan Behavioral Health

Presented by:

Carl Doerschler, CMFC
Financial Advisor
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Jill Ingersoll
Financial Advisor
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Rose Street ADVISORS + HRM INNOVATIONS

Overview

Service Providers

- Vendor: Nationwide
- Administrator: Beene Garter
- Financial Advisors: Carl Doerschler and Jill Ingersoll at Rose Street Advisors

Sponsored Retirement Plans

- 457(b) – Employee Elective Deferrals (395-60000)
- 401(a) – Employer Match (395-80054)
- 401(a) – Social Security Alternative (SSA) (395-80055)

Services Provided to SWMBH

- Annual Fiduciary Review Meetings
- Co-Fiduciary (3(21)) Advisory Services
- Consult with Investment Committee
- Prepare and maintain Investment Policy Statement (IPS)
- Recommend specific investments for each plan
- Prepare Investment Performance Reports
- Provide participant advice including enrollments and education
- Provide plan benchmarking analysis
- Help with plan design consultation
- One-on-one education with each employee to talk about contribution rates and investments
- Personal one-on-one enrollments for new employees

Statistics / Demographics

457(b) Plan

- Plan Balance as of 9/30/2019: $1,121,033.53
- YTD (9/30/2019) Average Rate of Return per Participant: 13.54%
- 2018 Average Rate of Return per Participant: (8.42%)
- 2017 Average Rate of Return per Participant: 17.44%
- Currently, there are 61 eligible employees with 51 contributing, equaling an 84% participation rate.

401(a) Plan – Employer Match

- Plan Balance as of 9/30/2019: $1,299,110.46
- YTD (9/30/2019) Average Rate of Return per Participant: 13.49%
- 2018 Average Rate of Return per Participant: (8.79%)
- 2017 Average Rate of Return per Participant: 17.03%

401(a) Plan - Social Security Alternative

- Plan Balance as of 9/30/2019: $1,580,140.96
- YTD (9/30/2019) Average Rate of Return per Participant: 12.55%
- 2018 Average Rate of Return per Participant: (10.09%)
- 2017 Average Rate of Return per Participant: 15.03%
- Currently, there are 61 eligible employees with 36 contributing, equaling a 59% participation rate.

Recommendation / Changes

- SWMBH 457 Plan
  - Map all current balances and future contributions from the PIMCO Low Duration ESG Institutional (PLDIX) to the Baird Short-Term Bond Fund Institutional (BSBIX)
  - The PIMCO Low Duration ESG Institutional Fund no longer conformed to the guidelines articulated in the monitoring section of the Investment Policy Statement
  - Investment change took place on October 1st, 2019
- SWMBH Retirement Savings Plan 401(a) Employer Match
  - Map all current balances and future contributions from the PIMCO Low Duration ESG Institutional (PLDIX) to the Baird Short-Term Bond Fund Institutional (BSBIX)
  - The PIMCO Low Duration ESG Institutional Fund no longer conformed to the guidelines articulated in the monitoring section of the Investment Policy Statement
  - Investment change took place on October 1st, 2019
- SWMBH Social Security Alternative 401(a) Plan
  - No recommendations

Fee Benchmarking / Fee Reduction

Southwest Michigan Behavioral Health
Fee Benchmarking

	Nationwide (prior)	Nationwide (current)
Vendor Costs		
Asset Based Fee	0.64%	0.47%
Weighted Average Expense Ratio	0.28%	0.28%
Total Vendor/Fund Annual Cost	0.92%	0.75%
Financial Advisor Annual Fee	0.50%	0.40%
	1.42%	1.15%
TPA Cost Comparison		
Beene Garter		
Conversion Fee	N/A	N/A
Document Fee	N/A - Attorney Drafted	N/A - Attorney Drafted
Annual Administrative	$1,500	$1,500
	$10 / participant	$10 / participant

- The weighted average expense ratio used for all vendors assumes the current mutual funds used at Nationwide and their expenses.
- The estimated cost savings for all three retirement plans is $10,800. This is based on $4,000,284.95 in total plan assets with a 0.27% cost savings.

Questions & Answers

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: August 28, 2019
9:00am-2:00pm

Members Present – Debbie Hess, Sue Germann, Jeff Patton, Jane Konyndyk, Ric Compton, Kris Kirsch, Richard Thiemkey, Kathy Sheffield and Bradley Casemore

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; Kim Rychener, Summit Pointe; Brad Sysol, Summit Pointe, Pat Davis, KCMHSAS

Guests present via conference call – Roger Pierce, Riverwood Center; Robin Wilber, Pines BH; Kelly Jenkins, BCCMHA; David Ballmer, Summit Pointe; Cameron Bullock, SJCMHSAS; Tina Boyer, VBCMHA

Call to Order – Debbie Hess began the meeting at 9:02 am.

Review and approve agenda – Agenda was approved with additions of Wrap Around Services, Clubhouse, Action Notices, and Parent and Youth Peer Supports

Announcements – Jeff Patton announced that effective October 1, 2019 KCMHSAS will be known as Integrated Services of Kalamazoo (ISK) and KCMHSAS was awarded a 5-year SAMHSA grant for supported employment.

Review and approve minutes from 7/31/19 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2019 YTD Financials – Tracy Dawson reported as documented, noting net surplus is positive and commended everyone for their hard work. Tracy stated that Autism is still an issue and SWMBH will be compiling an eligibles report to send to CMHSPs. No news on rate file status. Discussion followed.

Public Policy Environment – Brad Casemore announced an upcoming Pulitzer Award Winning Play hosted by Pines Behavioral Health. Pines Behavioral Health and SWMBH to host Mike Shirkey, State Senator, at event. State has no budget as of this date.

Regional MI Health Link Meeting – Brad Casemore noted the proposed agenda in the packet for review and an October meeting date to be determined.

Opioid Health Homes (OHH) – Brad Casemore shared that the State approached SWMBH, KCMHSAS (ISK), and Summit Pointe regarding OHH. Preliminary meetings continue. State would like OHH implemented State-wide by Fiscal Year 2021. Discussion followed.

Cass Woodlands Authority Status – Brad Casemore reviewed history and SWMBH Board decision to release attorney opinion. Kathy Sheffield updated Committee on recent meetings with Cass County Commissioners and Cass County staff. Brad meets with Cass County representatives next week. Other meetings to continue. Discussion followed.

Lakeshore Regional Entity Update – There is a pre-trial conference scheduled for 9/3/19.

Michigan Health Endowment Fund (MHEF) – SWMBH was awarded a MHEF grant and are looking forward to working with KCMHSAS (ISK) and Family Health Center. Brad thanked the MHEF team for their hard work and participants will be announced the end of November.

Psychiatric needs and WMED – Brad Casemore reviewed recent meeting with Dr. Ramesh and Dr. Tandor. Mila reported as documented, noting regional needs and regional solutions. If there are any changes to the report, please contact Mila. Interest in using WMED psychiatry, contact them or SWMBH.

Encounters and Data Validations – Anne Wickham discussed the recent Data Exchange Workgroup meeting and stated that, except for Lakeshore Regional Entity, SWMBH is the worst PIHP in submitting Behavioral Health Treatment Episode Data Sets (BH TEDS). SWMBH will contact CMHSPs Data Exchange Workgroup representative weekly for status and updates on BH TEDS. Effective October 1, validations will not be accepted without a completed BH TEDS. A 90% completed BH TEDS rate is necessary by the end of the year. Brad Casemore reiterated the need for accurate, timely, complete BH TEDS and encounter submissions and their impact on our funding.

Gongwer News and Advocates Report – Brad Casemore reported as documented and encouraged CMH CEOs to share with their Boards. Discussion followed.

Managed Care Functional Review – Provider Network Management – Mila Todd reported as documented. Main recommendation was better system for tracking shared providers and information. Discussion followed.

Substance Use Disorder (SUD) Behavioral Health Treatment Episode Data Set (BH TEDS) – Anne Wickham reported as documented. Data Exchange Workgroup is discussing electronic transfer development with Streamline. Cost and implementation date to be determined. Discussion followed.

Fiscal Year 2020 Budget Development Updates – Tracy Dawson reviewed draft budget as documented noting the regional budget is 13 million upside down. Tracy asked CMH CEOs to go back and look for any cushions in their budgets. Brad Casemore asked the CMH CEOs to review the Medical Loss Ratio. Draft Budget to be presented at the September 13th Board meeting. Group discussed recent letters from providers regarding requested rate increases and the need to take a collective stance in communicating to providers that an increase is not possible at this time. Discussion followed.

Fiscal Year 2020 SWMBH and CMH Contract Version 2 – Mila Todd reported as documented. Discussion followed. No objections to executing the next iteration with changes raised.

Prevention Direct Services – Brad Casemore reported as documented and stated that issues will be referred to Clinical Programs, and return to Operations Committee in October for an update from Moira Kean. Discussion followed.

September SWMBH Board Agenda – Brad Casemore noted that a draft Board agenda is included in the packet for review and reminded group of location change.

HRA – Brad Casemore reported as documented. Discussion followed.

Action Notices – Anne Wickham reviewed Health Services Advisory Group (HSAG) corrective action plan regarding SWMBH notices sent to customers. Notices must be detailed, accurate, and site language relative to reason notice is being sent. Discussion followed.

Clubhouse – Mila Todd shared that SWMBH currently meets the State standard for number of required Clubhouses. Group discussed network adequacy and costs in running a clubhouse.

Parent and Youth Peer Support Services – Group discussed services provided and issues at each CMHSPs as it related to Parent and Youth Peer Supports.

CMH Focused Agenda time – Brad Casemore stated that agendas for future Operations Committee meetings will include a topic for CMH focused Agenda time. CMHs propose items to Debbie Hess or Brad Casemore. Also reminded all that any CEO can request a CEO-only session.

Adjourned – Meeting adjourned at 1:55pm

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for July, August and September 2019
Board Date 10/11/19

Action items:

- Approved Managed Care Functional Review Regional Provider Network Management Final Recommendations
- Approved changes to FY 20 PIHP-CMH contract

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 reviewed this quarter included:
    - Year to date financial reports and actions being taken to decrease expenditures
    - Budget Assumptions and SWMBH/CMHSPs visits
    - Fiscal Year 2020 Budget development
    - FY20 PIHP-CMH Contract proposed changes
    - 2020-2021 Board Ends Metrics
    - Public Policy Committee Status/Updates
    - Michigan Mission Based Performance Indicator System (MMBPIS) Results and New Standards
    - Managed Care Information Systems (MCIS) status, needs, and deadline
    - Changes to be implemented to reduce and eliminate double entry of Behavioral Health Treatment Episode Data Set in both SWMBH system and local CMH system
    - SWMBH policy changes including around required "Action Notices" (required if reducing services to a consumer)
    - Managed Care Functional Review (MCFR) Provider Network Management Workgroup progress, recommendations, and implementation
    - Autism Spectrum Disorder Services Workgroup reports
    - Issues related to a variety of services such as Wraparound; Clubhouse; Youth Peer Support; Parent support Partners; and Prevention Direct
    - Meeting and discussions of working more closely with WMed for meeting needs for psychiatrists
    - Grant Updates including award of grant from Michigan Health Endowment to SWMBH, Kalamazoo CMHSAS and Family Health Center
    - Status of MDHHS required Statewide Utilization Parity software implementation (MCG implementation)

Board Ends Metric Updates – October 11, 2019

Habilitation Supports Waiver Slots:

Regional Habilitation Supports Waiver slots are full at 99% throughout FY19. Metric Measurement Period: (10/1/18 - 9/30/19) Board Report Date: October 11, 2019 **Measurement:** (8,278) of waiver slot filled / (8,280) of waiver slots available =99.97% *+1-point bonus credit will be awarded for (5) or more *new* HSW Slots SWMBH receives from MDHHS during FY19.	**Metric Achieved** **99.97%** of available HSW slots have been filled during FY 19 SWMBH has been the best performing PIHP, over the past 3 years for HSW slot maintenance! Metric target has been achieved.

MDHHS Habilitation Supports Waiver (HSW) Slot Status Tracker

Report snapshot taken on: 9/24/19

			Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep
Region 4 - Southwest	2019	Owned	690	690	690	690	690	690	690	690	690	690	690	690
Region 4 - Southwest	2019	Loaned	0	0	0	0	0	0	0	0	0	0	0	0
Region 4 - Southwest	2019	Borrowed	0	0	0	0	0	0	0	0	0	0	1	0
Region 4 - Southwest	2019	Used	690	690	690	690	689	689	690	690	689	690	691	690
Region 4 - Southwest	2019	Available	0	0	0	0	1	1	0	0	1	0	0	0
Region 4 - Southwest	2019	% Used	100	100	100	100	99.9	99.9	100	100	99.9	100	100	100

Proposed Motion:

The data presented is Relevant and Compelling, the Executive Officer is in Compliance and the Ends needs no further Revision.

	E	F	G	H	I	J	K	L	N
1	***Southwest Michigan Behavioral Health***								
2	For the Fiscal YTD Period Ended 9/30/2020				**FY20 Budget**				
3	*(For Internal Management Purposes Only)*					**DRAFT**			
4	***INCOME STATEMENT***			**For Board Consideration**	**FY20 Budget Current Status**	**FY19 Projection**	**Change FY20B v FY19P Fav / (Unfav)**	**FY19 Budget**	**Proposed Cost Reductions**
5									
6									
7	**REVENUE**								
8	**Contract Revenue**								
9	Medicaid Capitation			209,466,803	209,466,803	201,325,331	8,141,472	202,968,849	
10	Healthy Michigan Plan Capitation			32,039,762	32,039,762	30,777,859	1,261,903	29,027,015	
11	Autism Services Capitation			12,559,000	12,559,000	12,064,361	494,639	11,066,907	
12	Dual Eligibles Demonstration Project			3,414,767	3,414,767	3,414,767	-	3,200,000	
13	SA Block Grant Funding			8,171,316	8,171,316	8,171,316	-	7,005,139	
14	SA PA2 Funding			1,884,850	1,884,850	1,884,850	-	1,871,835	
15									
16	Contract Revenue			267,536,499	267,536,499	257,638,485	9,898,014	255,139,745	
17	DHHS Incentive Payments			650,920	650,920	650,920	-	1,100,000	
18	Grants and Earned Contracts			461,128	461,128	461,128	-	132,895	
19	Interest Income - Working Capital			198,574	198,574	198,574	-	139,752	
20	Interest Income - ISF Risk Reserve			48,015	48,015	48,015	-	103,319	
21	Local Funds Contributions			2,163,020	2,163,020	2,163,020	-	2,163,020	
22	Other Local Income			243,099	243,099	243,099	-	88	
23									
24	**TOTAL REVENUE**			**271,301,256**	**271,301,256**	**261,403,241**	**9,898,014**	**258,778,818**	
25									
26	**EXPENSE**								
27	**Healthcare Cost**								
28	Provider Claims Cost			22,415,051	22,415,051	22,415,051	-	20,822,854	
29	CMHP Subcontracts, net of 1st & 3rd party			214,875,411	218,025,411	208,914,989	9,110,422	212,682,714	**3,150,000**
30	Insurance Provider Assessment Withhold (IPA)			2,590,858	2,590,858	2,590,858	-	2,231,189	
31	Medicaid Hospital Rate Adjustments			139,821	139,821	139,821	-	3,735,971	
33									
34	**Total Healthcare Cost**			**240,021,141**	**243,171,141**	**234,060,719**	**9,110,422**	**239,472,729**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**89.5%**	**90.7%**	**90.6%**	**92.0%**	**93.5%**	**89.5%**
36									
37	**Administrative Cost**								
38	Purchased Professional Services			623,000	623,000	676,054	(53,054)	924,500	
39	Administrative and Other Cost			8,293,670	8,293,670	7,415,210	878,460	7,945,281	
41	Depreciation			109,640	109,640	109,640	-	176,048	
44	Delegated Managed Care Admin			14,585,702	16,835,702	15,752,284	1,083,419	14,798,863	**2,250,000**
46									
47	**Total Administrative Cost**			**23,612,012**	**25,862,012**	**23,953,187**	**1,908,825**	**23,844,691**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.6%**	**9.3%**	**17.3%**	**9.1%**	**9.0%**
49									
50	Local Funds Contribution			2,163,020	2,163,020	2,163,020	-	2,163,020	
51									
52	**TOTAL COST after apportionment**			**265,796,174**	**271,196,174**	**260,176,927**	**11,019,247**	**265,480,440**	5,400,000
53									
54	**NET SURPLUS before settlement**			**5,505,082**	**105,082**	**1,226,315**	**(1,121,233)**	**(6,701,622)**	
55	**Net Surplus (Deficit) % of Revenue**			**2.0%**	**0.0%**	**0.5%**	**-11.3%**	**-2.6%**	
56									
57	Prior Year Savings			735,085	735,085	-	735,085	-	
58	Change in PA2 Fund Balance			(30,389)	(30,389)	(30,389)	-	-	
59	ISF Risk Reserve Abatement (Funding)			(48,015)	(48,015)	(48,015)	-	-	
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	6,822,000	
61	Settlement Receivable / (Payable)			(17,147)	(17,147)	-	(17,147)	-	
62	**NET SURPLUS (DEFICIT)**			**6,144,616**	**744,616**	**1,147,911**	**(403,295)**	**120,378**	
63	*HMP & Autism is settled with Medicaid*								
64									
65	**SUMMARY OF NET SURPLUS (DEFICIT)**								
67	Current Year Savings			339,443	339,443	735,085	(395,642)	-	
69	Local and Other Funds Surplus/(Deficit)			405,173	405,173	412,826	(7,652)	120,378	
70									
71	**NET SURPLUS (DEFICIT)**			**744,616**	**744,616**	**1,147,911**	**(403,295)**	**120,378**	
72									

SWMBH

Memo

To: SWMBH Board

From: Bradley P. Casemore, Executive Office

cc:

Date: October 11, 2019

Re: Michigan Consortium for Healthcare Excellence (MCHE); Board Policy BEL-010

Introduction

Board Policy BEL-010 Regional Entity 501(c)3 Representation states in II.4. "The SWMBH Board will evaluate on at least an annual basis in October of each year whether SWMBH will continue to hold a membership interest in MCHE…"

Recommendation

I recommend that SWMBH continue to hold a membership interest in MCHE, and that the Board state such via a formal motion.

Basis for Recommendation

SWMBH was an early proponent of PIHPs gaining joint membership in MCHE (formerly MASACA Michigan Association of Coordinating Agencies) when the Coordinating Agencies ceased and PIHPs assumed Coordinating Agency role and functions.

Subsequently MCHE continues to operate and has been a helpful vehicle largely for group purchasing and group contracting. Examples include group purchase of a. a web-based state-wide group work portal; b. state-wide inpatient utilization management software solution; and c. group contracting for state-wide subscription to *Legal Action Center* technical assistance resource. These are items valuable to our region.

Given the no-dues nature of our membership in MCHE, the benefits of group purchasing, and the potential for MCHE into the future, the benefits and potential are superior to costs or risks.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: EO-001	Pages: 1
Subject: Executive Role and Job Description	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	9.14.18	10.12.14, 10.9.15, 10.14.16, 10.13.17

I. **PURPOSE:**
To define the executive role and job description.

II. **POLICY:**
The EO is accountable to the board acting as a body. The Board will instruct the EO through written policies or directives consistent with Board policies, delegating to the EO the interpretation and implementation of those policies and Ends.

III. **STANDARDS:**
Accordingly:
1. The Board will not give instructions to persons who report directly or indirectly to the EO.

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

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: EO-002	Pages: 2
Subject: Monitoring of Executive Officer Performance	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:
03.14.14	11.12.18	07.11.2014, 03.13.15, 05.13.16 11/11/16, 11.10.17

I. **PURPOSE:**
To ensure Executive Officer performance is monitored and evaluated.

II. **POLICY:**
Monitoring Executive Officer, EO, performance is synonymous with monitoring organizational performance against Board policies on Ends and on Executive Limitations. Any evaluation of EO performance, formal or informal, may be derived from these monitoring data.

III. **STANDARDS:**
Accordingly,

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

2. A given policy may be monitored in one or more of three ways; with a balance of using all of the three types of monitoring:
   a. Internal report: Disclosure of compliance information to the Board from the Executive Officer.
   b. External report: Discovery of compliance information by a disinterested, external auditor, inspector or judge who is selected by and reports directly to the Board. Such reports must assess Executive Officer performance only against policies of the Board, not those of the external party unless the Board has previously indicated that party's opinion to be the standard.
   c. Direct Board inspection: Discovery of compliance information by a Board Member, a Committee or the Board as a whole. This is a Board inspection of documents, activities or circumstances directed by the Board which allows a "prudent person" test of policy compliance.

3. Upon the choice of the Board, any policy can be monitored by any method at any time. For regular monitoring, however, each Ends and Executive Limitations policy will be classified by the Board according to frequency and method.
   a. Internal
   b. External
   c. Direct Inspection

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

5. The Executive Committee, (Chair, Vice Chair, and Secretary), will take data and information from the bulleted documents below upon which the annual performance of the EO will be evaluated. The overall evaluation consists of compliance with Executive Limitations Policies, Ends Interpretation and Ends Monitoring reports and supporting documentation, (as per the Board developed schedule), and follow through on Board requests, (what we ask for in subsequent meetings and what we want to see on the agendas). For the performance review the following should be documents given the Executive Committee at least one month prior, (October), to the Board EO evaluation, (November).
   - Minutes of all meetings
   - Ends Monitoring reports for the past year along with the Ends Interpretation for each Ends Monitoring report
   - Any supporting Ends documentation
   - Ends Monitoring Calendar
   - Other policies monitoring calendar

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-010	Pages: 1
Subject: Regional Entity 501 (c)(3) Representation	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 02.13.2015	Last Review Date: 10.12.18	Past Review Dates: 2.13.15, 3.11.16, 10.14.16, 10.13.17

I. **PURPOSE:**

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership. On August 12, 2016, the SWMBH Board approved the revised Bylaws presented by the MASACA Board including the fact that the name will be changed to the Michigan Consortium for Healthcare Excellence (MCHE) and on October 5, 2016, the MASACA/MCHE Board accepted the revised MCHE Bylaws.

II. **POLICY:**

1. The SWMBH Board has approved SWMBH becoming a member of MCHE; and
2. the EO of SWMBH is hereby authorized to serve as SWMBH's representative and a Director of the MCHE Board, the latter being subject to the approval of the Board Members of MCHE in accordance with its Bylaws; and
3. the EO is hereby authorized and directed to execute and deliver any and all instruments, certificates, agreements and other documents necessary for SWMBH to hold a membership interest in MCHE; and
4. the SWMBH Board will evaluate on at least an annual basis in October of each year whether SWMBH will continue to hold a membership interest in MCHE or withdraw from such membership.

III. **STANDARDS:**

Accordingly, the Executive Officer as SWMBH representative to MCHE shall:

1. Provide semi-annual written MCHE status reports to the SWMBH Board; and
2. Provide verbal reports to the SWMBH Board if there are items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy or finances; and
3. Present to the Board, for its approval, all contracts and payments from SWMBH to MCHE prior to executing; and
4. Present MCHE Articles of Incorporation revisions to the Board prior to voting on them; and
5. Present MCHE Bylaws revisions to the Board prior to voting on them and also after the adoption of them by MCHE Board;
6. Adhere to the Board standard that total direct fiscal year annual costs payable to MCHE shall not exceed $5,000, absent prior official approval of the Board.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Date October 11, 2019

Policy Number: BEL-010
Policy Name: Regional Entity 501 (c) 3 (Michigan Consortium for Healthcare Excellence) Representation
Assigned Reviewer: Susan Barnes
Review Period: October 2018 – September 2019

POLICY PURPOSE:

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership. On August 12, 2016, the SWMBH Board approved the revised Bylaws presented by the MASACA Board including the fact that the name will be changed to the Michigan Consortium for Healthcare Excellence (MCHE) and on October 5, 2016, the MASACA/MCHE Board accepted the revised MCHE Bylaws.

II. **POLICY:**

1. The SWMBH Board has approved SWMBH becoming a member of MCHE; and
2. the EO of SWMBH is hereby authorized to serve as SWMBH's representative and a Director of the MCHE Board, the latter being subject to the approval of the Board Members of MCHE in accordance with its Bylaws; and
3. the EO is hereby authorized and directed to execute and deliver any and all instruments, certificates, agreements and other documents necessary for SWMBH to hold a membership interest in MCHE; and
4. the SWMBH Board will evaluate on at least an annual basis in October of each year whether SWMBH will continue to hold a membership interest in MCHE or withdraw from such membership.
   Executive Officer Response: Please see related Board Agenda item and related Memo.

III. **STANDARDS:**

Accordingly, the Executive Officer as SWMBH representative to MCHE shall:

1. Provide semi-annual written MCHE status reports to the SWMBH Board.
   Executive Officer Response: January 11, 2019; July 12, 2019
2. Provide verbal reports to the SWMBH Board if there are items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy or finances.
   Executive Officer Response:
   October 12, 2018 (MCG monetary approval); November 9, 2018 (MCHE Annual Meeting); April 12, 2019 (retirement of MCHE President, Jane Terwilliger)

3. Present to the Board, for its approval, all contracts and payments from SWMBH to MCHE prior to executing.
   Executive Officer Response: There was one payment of $1,560 made to MCHE for our share of the state-wide training expense during the review period. My interpretation on this was focused on the $5,000 limit. Thus, I am not in compliance with this standard. I recommend the Board consider the current language perhaps to become "...all contracts and any payments in a fiscal year above a $5,000 total amount."
4. Present MCHE Articles of Incorporation revisions to the Board prior to voting on them.
   Executive Officer Response: No revisions of MCHE Bylaws occurred during the review period.
5. Present MCHE Bylaws revisions to the Board prior to voting on them and after the adoption of them by MCHE Board.
   Executive Officer Response: No revisions of MCHE Bylaws occurred during the review period.
6. Adhere to the Board standard that total direct fiscal year annual costs payable to MCHE shall not exceed $5,000, absent prior official approval of the Board.
   Executive Officer Response: Please see attached General Ledger output for the review period. Other than the payment to MCG the total did not exceed $5,000. The Board approved the payment to MCHE for MCG in the amount of $80,000 at the October 18, 2018 Board meeting.

Payment made to MCHE FY19

Check #	Date of Check	Amount of Check	Decription of cost
2506	10/26/2018	40,463.13	MCG Cost Sharing
3821	8/9/2019	1,500.00	Training Reciprocity Hosting
3896	8/23/2019	60.00	Training Reciprocity Hosting Admin Fee
4056	9/27/2019	577.77	Legal Action Center (LAC)
	9/27/2019	(577.77)	Check voided per Brad Casemore
	Total $	**42,023.13**	

9/27/2019

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-008	Pages: 2
Subject: Communication and Counsel to the Board	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: 10.12.18	Past Review Dates: 10.12.14, 10.09.15, 10.14.16, 10.13.17

I. PURPOSE:

To make appropriate decisions the board must be provided with accurate, timely and relevant information.

II. POLICY:

The Executive Officer shall not cause or allow the Board to be uninformed or unsupported in its work.

III. STANDARDS:

The EO will not;

1. Neglect to submit monitoring data required by the Board in Board Policy and Direction in a timely, accurate, and understandable fashion, directly addressing provisions of Board policies being monitored, and including Executive Officer interpretations as well as relevant data.

2. Allow the Board to be unaware of any actual or anticipated noncompliance with any Ends or Executive Limitations policy of the Board regardless of the Board's monitoring schedule.

3. Allow the Board to be without decision information required periodically by the Board or let the Board be unaware of relevant trends.

4. Let the Board be unaware of any significant incidental information it requires including anticipated media coverage, threatened or pending lawsuits, and material internal and external changes.

5. Allow the Board to be unaware that, in the Executive Officer's opinion, the Board is not in compliance with its own policies, particularly in the case of Board behavior that is detrimental to the work relationship between the Board and the Executive Officer.

6. Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation, and other.

7. Allow the Board to be without a workable mechanism for official Board, Officer, or Committee communications.

8. Deal with the Board in a way that favors or privileges certain Board Members over others, except when fulfilling individual requests for information or responding to Officers or Committees duly charged by the Board.

9. Fail to submit to the Board a consent agenda containing items delegated to the Executive Officer yet required by law, regulation, or contract to be Board-approved, along with applicable monitoring information.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
October 11, 2019

Policy Number: BEL008
Policy Name: Communication and Counsel to the Board
Board Date: October 11, 2019
Assigned Reviewer: Patrick Garrett
For the time period October, 2018 through September, 2019

Purpose: To make appropriate decisions the board must be provided with accurate, timely and relevant information.

Policy: The Executive Officer shall not cause or allow the board to be uninformed or unsupported in its work.

Standards: The EO will not;

a. Neglect to submit monitoring data required by the board in Board Policy and direction in a timely, accurate, and understandable fashion, directly addressing provisions of Board policies being monitored, and including Executive Officer interpretations as well as relevant data.

   EO Response: *The EO has submitted all monitoring data required by the Board in this manner as evidenced by retrospective Board materials and Board meeting Minutes which reflect acceptance or approval of the submissions. Submissions of the Board have included written reports or summaries of all external entity reviews of SWMBH including but not limited to Health Services Advisory Group (HSAG), MDHHS, Aetna or Meridian (our Mi Health Link Integrated Care Organizations), external financial audit, external compliance audit, etc.*

b. Allow the board to be unaware of any actual or anticipated noncompliance with any Ends or Executive Limitations policy of the board regardless of the Board's monitoring schedule.

   EO Response: *The EO has reported to the Board actual or anticipated noncompliance with any Ends or Executive Limitations policy of the board as evidenced by retrospective Board materials and meeting Minutes. Ends Metrics reports are provided monthly. On occasion the EO has urged the*

Board to officially recognize when an Ends Metric was not met to the letter of the Board-approved threshold.

c. Allow the board to be without decision information required periodically by the board or let the board be unaware of relevant trends.

   EO Response: *The EO has assured the Board has decision-making information required and has routinely briefed the Board and provided materials on relevant trends as evidenced by retrospective Board materials, Board meeting Minutes, Board retreat materials and exposure to knowledgeable others from MDHHS such as Nick Lyon, etc.*

d. Let the board be unaware of any significant incidental information it requires including anticipated media coverage, threatened or pending lawsuits, and material internal and external changes.

   EO Response: *The EO has provided all significant incidental information related to anticipated media coverage, threatened or pending lawsuits, and material internal and external changes as evidenced by retrospective Board materials and Board meeting Minutes.*

e. Allow the board to be unaware that, in the Executive Officer's opinion, the board is not in compliance with its own policies, particularly in the case of board behavior that is detrimental to the work relationship between the board and the Executive Officer.

   EO Response: *The EO has not failed to bring information of this type forward. The EO has commented favorably on these policy matters at Board meetings as these related policies were self-assessed by the Board.*

f. Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation, and other.

   EO Response: *The EO has presented information in proper formats and contents as evidenced by retrospective Board materials and Board meeting minutes. Where collective Board preferences and desires were made known, modifications have been made.*

g. Allow the board to be without a workable mechanism for official board, officer, or committee communications.

   EO Response: *The EO has initiated workable mechanisms for official communications with and for official board, officer and committee communications, including but not limited to and as evidenced by regular contact with the Chair and* ad hoc *Board Committees.*

h. Deal with the board in a way that favors or privileges certain board members over others, except when fulfilling individual requests for information or responding to officers or committees duly charged by the board.

   EO Response: *The EO has not violated these principles, as evidenced by an absence of known complaints to the EO or Board Chairman in this area.*

i. Fail to submit to the board a consent agenda containing items delegated to the Executive Officer yet required by law, regulation, or contract to be board-approved, along with applicable monitoring information.

   EO Response: *The EO has regularly provided a consent agenda approach for items referenced above as evidenced by retrospective Board materials and Board meeting Minutes.*

   Materials offered:

   Retrospective Board packets with Board meeting Minutes for the time period October, 2018 through September, 2019.

Summary: FY 2020 Line Item Vetoes
Totals by Department

Department	Number	$ Amount (Thousands) GF	SAF	Gross
Agriculture & Rural Development	4	$4,700.0	$0.0	$4,700.0
Attorney General	0	$0.0	$0.0	$0.0
Civil Rights	0	$0.0	$0.0	$0.0
Corrections	8	$8,914.6	$0.0	$14,814.6
Education	1	$0.0	$0.0	$10.8
Environment, Great Lakes, & Energy	5	$15,000.0	$0.0	$16,475.0
Executive Office	0	$0.0	$0.0	$0.0
Health & Human Services	48	$79,290.7	$0.0	$233,942.0
Insurance & Financial Services	3	$0.0	$0.0	$75.0
Judiciary	1	$348.6	$0.0	$348.6
Labor & Economic Opportunity	3	$23,588.8	$0.0	$84,760.9
Legislature	0	$0.0	$0.0	$0.0
Licensing & Regulatory Affairs	0	$0.0	$0.0	$0.0
Military & Veterans Affairs	5	$4,552.5	$0.0	$4,552.5
Natural Resources	2	$0.0	$0.0	$1,032.3
State	0	$0.0	$0.0	$0.0
State Police	4	$2,620.0	$0.0	$14,348.8
Technology, Management & Budget	5	$0.3	$0.0	$750.3
Transportation	10	$375,000.0	$0.0	$375,172.2
Treasury	6	$23,991.2	$0.0	$29,351.6
Treasury - Revenue Sharing	0	$0.0	$0.0	$0.0
Subtotal - General	**105**	**$538,006.7**	**$0.0**	**$780,334.6**
Community Colleges	0	$0.0	$0.0	$0.0
Higher Education	2	$4,075.9	$0.0	$38,171.5
School Aid	40	$12,730.0	$75,850.0	$128,580.0
Subtotal - Education	**42**	**$16,805.9**	**$75,850.0**	**$166,751.5**
Grand Total - FY 2020	**147**	**$554,812.6**	**$75,850.0**	**$947,086.1**

FY 2019 Supplemental (DHHS budget/Gen Gov bill)	**1**	**$3,000.0**	**$0.0**	**$8,438.8**

FY 2020 VETOES

Dept	Line or BP Veto	BP Sec	Program - Description	Veto Amounts (Thousands)			
				FTEs	GF/GP	SAF	Gross
Agriculture & Rural Development	Line	902	Conservation Districts Pilot Project (One-Time)	0.0	$200.0	$0.0	$200.0
Agriculture & Rural Development	Line	901	Farm Stress Program (One-Time)	0.0	$500.0	$0.0	$500.0
Agriculture & Rural Development	Line		Michigan Animal Agriculture Alliance	0.0	$3,000.0	$0.0	$3,000.0
Agriculture & Rural Development	Line	805	County Fairs, Shows and Exhibition Grant Reduction	0.0	$1,000.0	$0.0	$1,000.0
Corrections	Line	414	County Jail Reimbursement Program	0.0	$8,914.6	$0.0	$14,814.6
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Training New Custody Staff	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Replacing Electronic Tethers	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Substance Abuse Parole Certain Sanction Program	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Post-Traumatic Stress Disorder Training and Wellness Support for Department Employees	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Demolition of Former Deerfield Correctional Facility	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Replacing Corrections Officers Training Binders with Electronic Equipment	0.0	$0.0	$0.0	$0.0
Corrections	BP	226	Re-Appropriation of Unexpended Work Project Appropriations - Requalifying Corrections Officers in Handgun Training	0.0	$0.0	$0.0	$0.0
Education	BP	239	Labor Day Report - Boilerplate report	0.0	$0.0	$0.0	$10.8
Environment, Great Lakes, & Energy	BP	412	Surface Water - Grants to watershed councils	0.0	$0.0	$0.0	$675.0
Environment, Great Lakes, & Energy	BP	239	Central Services - Funds for the environmental rules review committee	0.0	$0.0	$0.0	$150.0
Environment, Great Lakes, & Energy	BP	413	Surface Water - Cooperative lakes monitoring program	0.0	$0.0	$0.0	$150.0
Environment, Great Lakes, & Energy	BP	503	Renewing Michigan's Environment - Michigan geological survey	0.0	$0.0	$0.0	$500.0
Environment, Great Lakes, & Energy	BP	1002	PFAS and Emerging Contaminants - Grants to municipal airports	0.0	$15,000.0	$0.0	$15,000.0
Health & Human Services	Line	450	School Success Partnership Program	0.0	$0.0	$0.0	$525.0
Health & Human Services	BP	559	Adoptive Family Support Network Contract	0.0	$250.0	$0.0	$250.0

				Veto Amounts (Thousands)			
Dept	Line or BP Veto	BP Sec	Program - Description	FTEs	GF/GP	SAF	Gross
Health & Human Services	Line	625	SSI Advocacy Legal Services Grant	0.0	$175.0	$0.0	$175.0
Health & Human Services	Line	972	Michigan CARES Hotline	0.0	$2,000.0	$0.0	$2,000.0
Health & Human Services	Line	1307	Real Alternatives	0.0	$0.0	$0.0	$700.0
Health & Human Services	Line	1228	Pediatric Traumatic Brain Injury Project	0.0	$1,500.0	$0.0	$1,500.0
Health & Human Services	BP	523	Private Agency Rate Increase for Family Preservation Programs	0.0	$1,000.0	$0.0	$2,075.0
Health & Human Services	BP	1143	Islands Clinics Funding	0.0	$675.0	$0.0	$675.0
Health & Human Services	BP	1319	Oral Health Assessment Grant	0.0	$2,000.0	$0.0	$2,000.0
Health & Human Services	BP	1625	Pharmacy Dispensing Fee Increase Managed Care	0.0	$1,900.0	$0.0	$7,597.2
Health & Human Services	Line	521	Child Care Fund Indirect Costs	0.0	$4,211.4	$0.0	$4,211.4
Health & Human Services	Line	1928	Andy's Angel Program (Opioid Transitional Housing and Services Grant - One-Time)	0.0	$750.0	$0.0	$750.0
Health & Human Services	Line	1927	Asian American Health and Wellness Initiative (One-Time)	0.0	$150.0	$0.0	$150.0
Health & Human Services	Line	1920	Autism Navigator (One-Time)	0.0	$1,025.0	$0.0	$1,025.0
Health & Human Services	Line	1930	Autism Train the Trainer Grant (One-Time)	0.0	$100.0	$0.0	$100.0
Health & Human Services	Line	1911	Child and Adolescent Health Centers Statewide (One-Time)	0.0	$1,000.0	$0.0	$1,000.0
Health & Human Services	Line	1925	Children's Behavioral Health Counseling Services (One-Time)	0.0	$100.0	$0.0	$100.0
Health & Human Services	Line	1912	Co-Responder Crisis Services Pilot (One-Time)	0.0	$60.0	$0.0	$60.0
Health & Human Services	Line	1921	Employment First (One-Time)	0.0	$500.0	$0.0	$500.0
Health & Human Services	Line		Kids' Food Basket (One-Time)	0.0	$250.0	$0.0	$250.0
Health & Human Services	Line	1933	Project ECHO Opioid Intervention (One-Time)	0.0	$40.0	$0.0	$40.0
Health & Human Services	Line	1929	Refugee Assistance (One-Time)	0.0	$175.0	$0.0	$175.0
Health & Human Services	Line	596	Runaway and Homeless Youth Services Program (One-Time & Ongoing)	0.0	$300.0	$0.0	$800.0
Health & Human Services	Line	1918	SUD Community and School Outreach (One-Time) - SAFE Substance Abuse Coalition	0.0	$100.0	$0.0	$100.0

				Veto Amounts (Thousands)			
Dept	Line or BP Veto	BP Sec	Program - Description	FTEs	GF/GP	SAF	Gross
Health & Human Services	Line	1914	Team CARES (One-Time)	0.0	$150.0	$0.0	$150.0
Health & Human Services	Line	1922	Wraparound Services For Out of School Time (One-Time)	0.0	$600.0	$0.0	$600.0
Health & Human Services	Line		U-D Dental Clinics (One-Time)	0.0	$1,000.0	$0.0	$1,000.0
Health & Human Services	Line	1936	Portage Senior Center Grant (Healthy Seniors Grant - One-Time)	0.0	$1,000.0	$0.0	$1,000.0
Health & Human Services	Line	1932	Legal Assistance (One-Time) - Allegan County Legal Assistance Center	0.0	$60.0	$0.0	$60.0
Health & Human Services	Line	1923	Senior Citizen Program Grants (One-Time)	0.0	$500.0	$0.0	$500.0
Health & Human Services	Line	1924	Michigan Dementia Care & Support Program (One-Time) - Alzheimer's Assoc. of Michigan	0.0	$400.0	$0.0	$400.0
Health & Human Services	BP	298	Medicaid Behavioral Health Integration Pilots	0.0	$1,000.0	$0.0	$3,088.2
Health & Human Services	BP	253	Information Technology Investment Board and Contract Requirement	0.0	$500.0	$0.0	$1,000.0
Health & Human Services	BP	1645	Nursing Facility Current Asset Value	0.0	$1,747.6	$0.0	$4,862.6
Health & Human Services	BP	977	State Opioid Grant for Recovery High School	0.0	$0.0	$0.0	$600.0
Health & Human Services	BP	978	State Opioid Response Grant for Recovery Community Organization	0.0	$0.0	$0.0	$600.0
Health & Human Services	BP	926 (1)	St. Mary's SUD Program	0.0	$500.0	$0.0	$500.0
Health & Human Services	BP	926 (2)	Kent County SUD Program	0.0	$500.0	$0.0	$500.0
Health & Human Services	BP	1870	MiDocs GME Consortium	0.0	$3,750.0	$0.0	$17,500.0
Health & Human Services	BP	1802 (1)	Hospital GF Payments - Rural Obstetrician (OB) Pool	0.0	$7,995.2	$0.0	$7,995.2
Health & Human Services	BP	1802 (2)	Hospital GF Payments - Rural and Sole Community Hospital Pool	0.0	$13,904.8	$0.0	$16,625.4
Health & Human Services	BP	1807	Hospital Outpatient 7% Rate Increase	0.0	$14,286.3	$0.0	$95,180.9
Health & Human Services	BP	1807	Critical Access Hospital Rate Increase	0.0	$5,099.1	$0.0	$34,265.1
Health & Human Services	BP	1790	Pediatric Psychiatric Rate Increase	0.0	$3,861.3	$0.0	$10,743.6
Health & Human Services	BP	1791	Neonatologist Rate Increase	0.0	$1,875.0	$0.0	$5,217.0
Health & Human Services	BP	1702	Private Duty Nursing Rate Increase	0.0	$1,400.0	$0.0	$3,895.4

				Veto Amounts (Thousands)			
Dept	Line or BP Veto	BP Sec	Program - Description	FTEs	GF/GP	SAF	Gross
Health & Human Services	BP	1508	Michigan Dental Registry	0.0	$700.0	$0.0	$700.0
Health & Human Services	BP	1504	Cloud-Based IT Services	0.0	$200.0	$0.0	$200.0
Insurance & Financial Services	BP	304	Insurance Marketplace Feasibility Study	0.0	$0.0	$0.0	$25.0
Insurance & Financial Services	BP	305	Anti-Fraud Unit Cost Savings Report	0.0	$0.0	$0.0	$25.0
Insurance & Financial Services	BP	307	Marijuana Banking Materials	0.0	$0.0	$0.0	$25.0
Judiciary	Line	403	Expansion of Problem Solving Courts (One-Time)	0.0	$348.6	$0.0	$348.6
Labor & Economic Opportunity	Line	1053	Pure Michigan	0.0	$6,500.0	$0.0	$37,500.0
Labor & Economic Opportunity	Line	1064, 1066, 1067, 1070	Going Pro	0.0	$7,088.8	$0.0	$37,260.9
Labor & Economic Opportunity	BP	1048	Rural Jobs and Capital Investment Fund	0.0	$10,000.0	$0.0	$10,000.0
Military & Veterans Affairs	Line	410	County Veteran Services Fund	0.0	$4,000.0	$0.0	$4,000.0
Military & Veterans Affairs	Line	603	Veterans Benefit Eligibility Study (One-time)	0.0	$250.0	$0.0	$250.0
Military & Veterans Affairs	Line	601	Buddy to Buddy Program (One-time)	0.0	$250.0	$0.0	$250.0
Military & Veterans Affairs	Line	602	National Guard Uniforms (One-time)	0.0	$50.0	$0.0	$50.0
Military & Veterans Affairs	BP	411	Military Cemetery Feasibility Study	0.0	$2.5	$0.0	$2.5
Natural Resources	Line		IDG from Forest Development Fund to the Department of Agriculture and Rural Development	0.0	$0.0	$0.0	$997.3
Natural Resources	BP	1202	Lake Level Assessments	0.0	$0.0	$0.0	$35.0
State Police	Line	706	Secondary Road Patrol Program	1.0	$2,000.0	$0.0	$13,074.3
State Police	Line		Training Grants to Local Law Enforcement Agencies	0.0	$0.0	$0.0	$654.5
State Police	Line		Michigan International Speedway Traffic Control (One-time)	0.0	$600.0	$0.0	$600.0
State Police	Line		Civil Air Patrol	0.0	$20.0	$0.0	$20.0
Technology, Management & Budget	Line		Capital Outlay Planning Authorization - Saginaw Valley State University, Brown Hall Renovation (total cost $19.75M; state share $12.0M)	0.0	$0.1	$0.0	$0.1
Technology, Management & Budget	Line	883	Capital Outlay Planning Authorization - DHHS, new northern satellite psychiatric facility (total cost $TBD)	0.0	$0.1	$0.0	$0.1

Resolution 2019-7, DHHS

SBO
State Budget Office

- Transfer adjustments comes from a variety of funding lines within DHHS, including the elimination of one-time earmarks.

- From the transferred funding:
  - Authority is increased by $6.1 million General Fund in Healthy Michigan Plan Administration to support implementation of new work requirements within the program.
  - $1.5 million General Fund in the Healthy Homes program to support lead and copper rule initiatives,
  - $945,900 General Fund in the Family Independence Program to support child support pass-through payments,
  - $935,300 General Fund in the Field Services Contractual Services Supplies, Materials, and Travel line to maintain reimbursement for volunteer services,
  - $2.0 million General Fund in the Medicaid Mental Health Line to restore State Disability Assistance payments to individuals in SUD residential treatment facilities,
  - $10.1 million General Fund distributed to various appropriations to maintain base program funding, and
  - $1.0 million Crime Victims Rights Fund in Crime Victims Rights Services Grants to support statewide funding to organizations assisting crime victims.

	E	H	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		*Mos in Period*								
2	For the Fiscal YTD Period Ended 8/31/2019	P11FYTD19	11								
3	*(For Internal Management Purposes Only)*										
4	***INCOME STATEMENT***	TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ASO Activities	Indirect Pooled Cost
5											
7	**REVENUE**										
16	Contract Revenue	237,707,012	185,682,957	28,197,507	11,086,311	3,141,817	7,655,542	1,942,878	-	-	-
17	DHHS Incentive Payments	616,856	616,856	-	-	-	-	-	-	-	-
18	Grants and Earned Contracts	459,474	-	-	-	-	407,681	-	51,794	-	-
19	Interest Income - Working Capital	192,808	-	-	-	-	-	-	192,808	-	-
20	Interest Income - ISF Risk Reserve	37,679	-	-	-	-	-	-	37,679	-	-
21	Local Funds Contributions	1,982,768	-	-	-	-	-	-	1,982,768	-	-
22	Other Local Income	182,324	-	-	-	-	-	-	182,324	-	-
23											
24	**TOTAL REVENUE**	241,178,922	186,299,813	28,197,507	11,086,311	3,141,817	8,063,223	1,942,878	2,447,373	-	-
25											
26	**EXPENSE**										
27	**Healthcare Cost**										
28	Provider Claims Cost	21,381,375	3,259,253	5,460,944	-	3,517,684	7,223,408	1,920,086	-	-	-
29	CMHP Subcontracts, net of 1st & 3rd party	192,331,051	157,698,152	17,624,015	15,032,988	1,529,623	446,274	-	-	-	-
30	HICA and Use Tax Expense	2,582,830	2,582,830	-	-	-	-	-	-	-	-
32	MHL Cost in Excess of Medicare FFS Cost	-	2,192,144	-	-	(2,192,144)	-	-	-		
33											
34	**Total Healthcare Cost**	216,295,255	165,732,379	23,084,959	15,032,988	2,855,162	7,669,682	1,920,086	-	-	-
35	**Medical Loss Ratio (HCC % of Revenue)**	90.8%	89.0%	81.9%	135.6%	90.9%	100.2%	98.8%			
36											
37	**Administrative Cost**										
38	Purchased Professional Services	611,468	-	-	-	-	-	-	611,468	-	-
39	Administrative and Other Cost	6,703,648	-	-	-	-	-	-	6,703,318	-	330
41	Depreciation	100,583	-	-	-	-	-	-	100,583	-	-
42	Functional Cost Reclassification	-	-	-	-	-	128,329	-	(128,329)	-	-
43	Allocated Indirect Pooled Cost	0	-	-	-	-	-	-	330	-	(330)
44	Delegated Managed Care Admin	14,424,597	11,868,015	1,316,659	1,124,929	114,995	-	-	-	-	-
45	Apportioned Central Mgd Care Admin	(0)	5,474,201	785,125	511,276	171,660	265,212	-	(7,207,474)	-	-
46											
47	**Total Administrative Cost**	21,840,296	17,342,216	2,101,784	1,636,204	286,655	393,541	-	79,895	-	-
48	**Admin Cost Ratio (MCA % of Total Cost)**	9.2%	9.5%	8.3%	9.8%	9.1%	4.9%	0.0%	3.0%		
49											
50	Local Funds Contribution	1,982,768	-	-	-	-	-	-	1,982,768	-	-
51											
52	**TOTAL COST after apportionment**	240,118,320	183,074,594	25,186,743	16,669,192	3,141,817	8,063,223	1,920,086	2,062,664	-	-
53											
54	**NET SURPLUS before settlement**	1,060,602	3,225,218	3,010,763	(5,582,881)	-	-	22,791	384,710	-	-
55	**Net Surplus (Deficit) % of Revenue**	0.4%	1.7%	10.7%	-50.4%	0.0%	0.0%	1.2%	15.7%		
56											
57	Prior Year Savings	-	-	-	-	-	-	-	-		
58	Change in PA2 Fund Balance	(22,791)	-	-	-	-	-	(22,791)	-		
59	ISF Risk Reserve Abatement (Funding)	(37,679)	-	-	-	-	-	-	(37,679)		
60	ISF Risk Reserve Deficit (Funding)	-	-	-	-	-	-	-	-		
61	Settlement Receivable / (Payable)	-	(3,225,218)	(2,357,662)	5,582,881	-	-	-	-		
62	**NET SURPLUS (DEFICIT)**	1,000,132	-	653,101	-	-	-	-	347,031	-	-
63	*HMP & Autism is settled with Medicaid*										
64											
65	**SUMMARY OF NET SURPLUS (DEFICIT)**										
66	Prior Year Unspent Savings	-	-	-	-	-	-	-	-		
67	Current Year Savings	653,101	-	653,101	-	-	-	-	-		
68	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-		
69	Local and Other Funds Surplus/(Deficit)	347,031	-	-	-	-	-	-	347,031	-	-
70											
71	**NET SURPLUS (DEFICIT)**	1,000,132	-	653,101	-	-	-	-	347,031	-	-
72											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2019			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			*HCC%*	78.9%	76.6%	79.0%	74.5%	74.9%	82.7%	81.3%	81.2%	78.8%
7	Subcontract Revenue		185,682,957	12,861,674	172,821,283	6,986,077	34,218,863	9,066,327	32,071,154	9,344,367	52,755,084	11,753,408	16,626,002
8	Incentive Payment Revenue		616,856	105,345	511,511	26,475	34,000	28,121	104,241	3,754	270,359	23,912	20,650
9	**Contract Revenue**		**186,299,813**	**12,967,019**	**173,332,794**	**7,012,551**	**34,252,863**	**9,094,448**	**32,175,395**	**9,348,122**	**53,025,443**	**11,777,320**	**16,646,652**
10													
11	External Provider Cost		118,786,402	3,259,253	115,527,149	3,714,998	22,188,185	5,861,381	19,902,093	5,713,615	41,779,182	7,320,529	9,047,166
12	Internal Program Cost		44,665,236	-	44,665,236	3,053,021	9,301,767	2,388,413	8,905,145	2,825,901	6,985,887	4,339,716	6,865,386
13	SSI Reimb, 1st/3rd Party Cost Offset		(970,848)	-	(970,848)	(63,197)	(237,811)	(47,561)	(208,871)	(10,174)	(293,637)	(25,821)	(83,776)
14	HICA & Use Tax, HRA		2,582,830	2,582,830	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		547,527	547,527	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**165,611,147**	**6,389,610**	**159,221,537**	**6,704,821**	**31,252,141**	**8,202,233**	**28,598,368**	**8,529,342**	**48,471,433**	**11,634,423**	**15,828,775**
17	**Medical Loss Ratio (HCC % of Revenue)**		**88.9%**	**49.3%**	**91.9%**	**95.6%**	**91.2%**	**90.2%**	**88.9%**	**91.2%**	**91.4%**	**98.8%**	**95.1%**
18													
19	**Managed Care Administration**		**17,457,210**	**5,474,201**	**11,983,009**	**546,288**	**2,414,107**	**673,494**	**1,959,098**	**638,622**	**4,037,879**	**688,056**	**1,025,464**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.5%**	**3.0%**	**6.5%**	**7.5%**	**7.2%**	**7.6%**	**6.4%**	**7.0%**	**7.7%**	**5.6%**	**6.1%**
21													
22	**Contract Cost**		**183,068,357**	**11,863,811**	**171,204,546**	**7,251,109**	**33,666,248**	**8,875,727**	**30,557,466**	**9,167,964**	**52,509,312**	**12,322,479**	**16,854,240**
23	**Net before Settlement**		**3,231,456**	**1,103,208**	**2,128,248**	**(238,558)**	**586,614**	**218,721**	**1,617,929**	**180,157**	**516,131**	**(545,159)**	**(207,588)**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(3,225,218)	(1,096,970)	(2,128,248)	238,558	(586,614)	(218,721)	(1,617,929)	(180,157)	(516,131)	545,159	207,588
28	**Net after Settlement**		**6,238**	**6,238**	-	-	-	-	-	-	-	-	-
29													
30	Eligibles and PMPM												
31	Average Eligibles		145,940	145,940	145,940	7,501	28,485	8,088	27,396	8,519	38,491	11,982	15,478
32	Revenue PMPM		$ 116.05	$ 8.08	$ 107.97	$ 84.99	$ 109.32	$ 102.22	$ 106.77	$ 99.76	$ 125.24	$ 89.36	$ 97.77
33	Expense PMPM		$ 114.04	$ 7.39	$ 106.65	$ 87.88	$ 107.44	$ 99.76	$ 101.40	$ 97.83	$ 124.02	$ 93.49	$ 98.99
34	Margin PMPM		$ 2.01	$ 0.69	$ 1.33	$ (2.89)	$ 1.87	$ 2.46	$ 5.37	$ 1.92	$ 1.22	$ (4.14)	$ (1.22)
35													
36	**Medicaid Specialty Services**												
37	Budget v Actual												
38													
39	Eligible Lives (Average Eligibles)												
40	Actual		145,940	145,940	145,940	7,501	28,485	8,088	27,396	8,519	38,491	11,982	15,478
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		(2,467)	(2,467)	(2,467)	(20)	(487)	(349)	(517)	(31)	(632)	(240)	(191)
43	% Variance - Fav / (Unfav)		-1.7%	-1.7%	-1.7%	-0.3%	-1.7%	-4.1%	-1.9%	-0.4%	-1.6%	-2.0%	-1.2%
44													
45	Contract Revenue before settlement												
46	Actual		186,299,813	12,967,019	173,332,794	7,012,551	34,252,863	9,094,448	32,175,395	9,348,122	53,025,443	11,777,320	16,646,652
47	Budget		187,063,112	15,805,202	171,257,910	6,780,012	34,096,460	9,156,793	31,426,178	8,939,664	52,951,442	11,495,889	16,411,470
48	Variance - Favorable / (Unfavorable)		(763,299)	(2,838,183)	2,074,884	232,539	156,403	(62,345)	749,217	408,457	74,001	281,431	235,182
49	% Variance - Fav / (Unfav)		-0.4%	-18.0%	1.2%	3.4%	0.5%	-0.7%	2.4%	4.6%	0.1%	2.4%	1.4%
50													
51	Healthcare Cost												
52	Actual		165,611,147	6,389,610	159,221,537	6,704,821	31,252,141	8,202,233	28,598,368	8,529,342	48,471,433	11,634,423	15,828,775
53	Budget		174,761,798	9,469,206	165,292,592	7,128,162	33,415,307	8,762,611	29,466,027	8,485,377	50,100,882	11,890,780	16,043,446
54	Variance - Favorable / (Unfavorable)		9,150,652	3,079,596	6,071,056	423,340	2,163,166	560,378	867,659	(43,965)	1,629,450	256,356	214,671
55	% Variance - Fav / (Unfav)		5.2%	32.5%	3.7%	5.9%	6.5%	6.4%	2.9%	-0.5%	3.3%	2.2%	1.3%
56													
57	Managed Care Administration												
58	Actual		17,457,210	5,474,201	11,983,009	546,288	2,414,107	673,494	1,959,098	638,622	4,037,879	688,056	1,025,464

	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 8/31/2019			11									
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													
59	Budget		18,870,283	6,387,269	12,483,015	530,799	2,490,846	731,786	2,126,608	650,179	4,211,651	742,430	998,717
60	Variance - Favorable / (Unfavorable)		1,413,073	913,068	500,006	(15,489)	76,739	58,291	167,509	11,557	173,771	54,374	(26,747)
61	% Variance - Fav / (Unfav)		7.5%	14.3%	4.0%	-2.9%	3.1%	8.0%	7.9%	1.8%	4.1%	7.3%	-2.7%
62													
63	Total Contract Cost												
64	Actual		183,068,357	11,863,811	171,204,546	7,251,109	33,666,248	8,875,727	30,557,466	9,167,964	52,509,312	12,322,479	16,854,240
65	Budget		193,632,082	15,856,474	177,775,607	7,658,960	35,906,153	9,494,397	31,592,634	9,135,557	54,312,533	12,633,210	17,042,163
66	Variance - Favorable / (Unfavorable)		10,563,725	3,992,663	6,571,061	407,851	2,239,905	618,670	1,035,168	(32,408)	1,803,221	310,730	187,924
67	% Variance - Fav / (Unfav)		5.5%	25.2%	3.7%	5.3%	6.2%	6.5%	3.3%	-0.4%	3.3%	2.5%	1.1%
68													
69	Net before Settlement												
70	Actual		3,231,456	1,103,208	2,128,248	(238,558)	586,614	218,721	1,617,929	180,157	516,131	(545,159)	(207,588)
71	Budget		(6,568,970)	(51,272)	(6,517,697)	(878,948)	(1,809,693)	(337,603)	(166,457)	(195,892)	(1,361,091)	(1,137,320)	(630,693)
72	Variance - Favorable / (Unfavorable)		9,800,426	1,154,480	8,645,946	640,390	2,396,308	556,325	1,784,386	376,049	1,877,222	592,161	423,106
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 8/31/2019			11									
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													
75	***Healthy Michigan Plan***			*HCC%*	8.7%	13.6%	6.7%	12.4%	12.1%	6.9%	7.4%	9.6%	6.4%
76	Contract Revenue		28,197,507	5,265,839	22,931,668	1,131,887	4,690,487	1,083,332	4,187,378	1,356,611	6,441,562	1,766,749	2,273,662
77													
78	External Provider Cost		15,089,109	5,460,944	9,628,165	500,899	1,250,555	784,507	2,195,613	317,881	3,424,768	561,650	592,293
79	Internal Program Cost		7,995,850	-	7,995,850	686,237	1,407,316	578,696	2,414,323	392,845	993,697	821,404	701,332
80	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
81	Total Healthcare Cost		23,084,959	5,460,944	17,624,015	1,187,136	2,657,871	1,363,203	4,609,936	710,726	4,418,464	1,383,054	1,293,624
82	Medical Loss Ratio (HCC % of Revenue)		81.9%	103.7%	76.9%	104.9%	56.7%	125.8%	110.1%	52.4%	68.6%	78.3%	56.9%
83													
84	Managed Care Administration		2,101,784	785,125	1,316,659	96,724	205,310	111,934	315,798	53,215	368,077	81,793	83,807
85	Admin Cost Ratio (MCA % of Total Cost)		8.3%	3.1%	5.2%	7.5%	7.2%	7.6%	6.4%	7.0%	7.7%	5.6%	6.1%
86													
87	Contract Cost		25,186,743	6,246,069	18,940,674	1,283,861	2,863,181	1,475,137	4,925,734	763,941	4,786,541	1,464,847	1,377,432
88	Net before Settlement		3,010,763	(980,230)	3,990,994	(151,973)	1,827,306	(391,806)	(738,356)	592,670	1,655,021	301,902	896,230
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,357,662)	1,633,331	(3,990,994)	151,973	(1,827,306)	391,806	738,356	(592,670)	(1,655,021)	(301,902)	(896,230)
93	Net after Settlement		653,101	653,101	-	-	-	-	-	-	-	-	-
94													
95	Eligibles and PMPM												
96	Average Eligibles		49,727	49,727	49,727	2,483	10,181	2,379	8,998	2,962	13,931	3,833	4,960
97	Revenue PMPM		$ 51.55	$ 9.63	$ 41.92	$ 41.45	$ 41.88	$ 41.39	$ 42.31	$ 41.64	$ 42.04	$ 41.90	$ 41.67
98	Expense PMPM		46.05	11.42	34.63	47.01	25.57	56.36	49.77	23.45	31.24	34.74	25.24
99	Margin PMPM		$ 5.50	$ (1.79)	$ 7.30	$ (5.56)	$ 16.32	$ (14.97)	$ (7.46)	$ 18.19	$ 10.80	$ 7.16	$ 16.43
100													
101	***Healthy Michigan Plan***												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
105	Actual		49,727	49,727	49,727	2,483	10,181	2,379	8,998	2,962	13,931	3,833	4,960
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)		(1,842)	(1,842)	(1,842)	(30)	(230)	(52)	(170)	(13)	(1,121)	(84)	(143)
108	% Variance - Fav / (Unfav)		-3.6%	-3.6%	-3.6%	-1.2%	-2.2%	-2.1%	-1.9%	-0.4%	-7.4%	-2.1%	-2.8%
109													
110	Contract Revenue before settlement												
111	Actual		28,197,507	5,265,839	22,931,668	1,131,887	4,690,487	1,083,332	4,187,378	1,356,611	6,441,562	1,766,749	2,273,662
112	Budget		26,608,097	4,598,183	22,009,915	1,062,650	4,440,841	1,031,459	3,938,517	1,254,284	6,462,144	1,665,456	2,154,563
113	Variance - Favorable / (Unfavorable)		1,589,409	667,656	921,753	69,237	249,646	51,873	248,861	102,327	(20,582)	101,293	119,099
114	% Variance - Fav / (Unfav)		6.0%	14.5%	4.2%	6.5%	5.6%	5.0%	6.3%	8.2%	-0.3%	6.1%	5.5%
115													
116	Healthcare Cost												
117	Actual		23,084,959	5,460,944	17,624,015	1,187,136	2,657,871	1,363,203	4,609,936	710,726	4,418,464	1,383,054	1,293,624
118	Budget		23,033,747	5,328,608	17,705,139	1,265,691	2,647,749	1,160,344	4,366,817	900,565	4,700,922	1,068,204	1,594,848
119	Variance - Favorable / (Unfavorable)		(51,212)	(132,336)	81,124	78,554	(10,122)	(202,860)	(243,119)	189,839	282,458	(314,850)	301,224
120	% Variance - Fav / (Unfav)		-0.2%	-2.5%	0.5%	6.2%	-0.4%	-17.5%	-5.6%	21.1%	6.0%	-29.5%	18.9%
121													
122	Managed Care Administration												
123	Actual		2,101,784	785,125	1,316,659	96,724	205,310	111,934	315,798	53,215	368,077	81,793	83,807
124	Budget		2,205,186	871,348	1,333,837	94,250	197,369	96,903	315,160	69,004	395,176	66,696	99,281
125	Variance - Favorable / (Unfavorable)		103,401	86,223	17,178	(2,474)	(7,942)	(15,031)	(639)	15,790	27,098	(15,097)	15,473
126	% Variance - Fav / (Unfav)		4.7%	9.9%	1.3%	-2.6%	-4.0%	-15.5%	-0.2%	22.9%	6.9%	-22.6%	15.6%
127													

	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 8/31/2019			11									
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													
128	**Total Contract Cost**												
129	Actual		25,186,743	6,246,069	18,940,674	1,283,861	2,863,181	1,475,137	4,925,734	763,941	4,786,541	1,464,847	1,377,432
130	Budget		25,238,933	6,199,956	19,038,977	1,359,940	2,845,118	1,257,247	4,681,977	969,570	5,096,098	1,134,899	1,694,129
131	Variance - Favorable / (Unfavorable)		52,189	(46,113)	98,302	76,080	(18,063)	(217,891)	(243,757)	205,629	309,556	(329,948)	316,697
132	% Variance - Fav / (Unfav)		0.2%	-0.7%	0.5%	5.6%	-0.6%	-17.3%	-5.2%	21.2%	6.1%	-29.1%	18.7%
133													
134	**Net before Settlement**												
135	Actual		3,010,763	(980,230)	3,990,994	(151,973)	1,827,306	(391,806)	(738,356)	592,670	1,655,021	301,902	896,230
136	Budget		1,369,165	(1,601,773)	2,970,938	(297,290)	1,595,724	(225,788)	(743,460)	284,715	1,366,046	530,557	460,434
137	Variance - Favorable / (Unfavorable)		1,641,599	621,543	1,020,056	145,317	231,582	(166,018)	5,103	307,955	288,975	(228,654)	435,796
138													
139		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2019			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
140	**Autism Specialty Services**			*HCC%*	7.4%	6.1%	9.9%	8.2%	7.0%	4.0%	6.2%	5.7%	10.4%
141	Contract Revenue		11,086,311	153,277	10,933,035	573,557	2,042,130	599,721	1,998,160	505,235	3,228,027	892,799	1,093,405
142													
143	External Provider Cost		12,819,006	-	12,819,006	3,990	3,900,585	876,205	1,155,105	407,961	3,696,343	807,886	1,970,931
144	Internal Program Cost		2,213,982	-	2,213,982	528,078	2,319	21,992	1,530,115	1,528	-	12,592	117,359
145	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		15,032,988	-	15,032,988	532,068	3,902,903	898,197	2,685,219	409,488	3,696,343	820,478	2,088,290
147	Medical Loss Ratio (HCC % of Revenue)		135.6%	0.0%	137.5%	92.8%	191.1%	149.8%	134.4%	81.0%	114.5%	91.9%	191.0%
148													
149	Managed Care Administration		1,636,204	511,276	1,124,929	43,351	301,484	73,752	183,948	30,660	307,921	48,523	135,289
150	Admin Cost Ratio (MCA % of Total Cost)		9.8%	3.1%	6.7%	7.5%	7.2%	7.6%	6.4%	7.0%	7.7%	5.6%	6.1%
151													
152	**Contract Cost**		16,669,192	511,276	16,157,916	575,419	4,204,388	971,949	2,869,167	440,148	4,004,265	869,001	2,223,579
153	**Net before Settlement**		(5,582,881)	(357,999)	(5,224,882)	(1,862)	(2,162,258)	(372,228)	(871,007)	65,087	(776,237)	23,798	(1,130,174)
154	Contract Settlement / Redistribution		5,582,881	357,999	5,224,882	1,862	2,162,258	372,228	871,007	(65,087)	776,237	(23,798)	1,130,174
155	**Net after Settlement**		-	0	-	-	-	-	-	-	-	-	-
156													
157		x											
158	**SUD Block Grant Treatment**			*HCC%*	0.2%	0.4%	0.4%	0.4%	0.0%	0.6%	0.0%	0.7%	0.2%
159	Contract Revenue		7,655,542	6,427,164	1,228,378	83,823	435,589	40,047	-	135,331	248,564	175,324	109,701
160													
161	External Provider Cost		7,223,408	7,223,408	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		446,274	-	446,274	34,120	176,799	46,673	-	58,837	2,909	95,599	31,338
163	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		7,669,682	7,223,408	446,274	34,120	176,799	46,673	-	58,837	2,909	95,599	31,338
165	Medical Loss Ratio (HCC % of Revenue)		100.2%	112.4%	36.3%	40.7%	40.6%	116.5%	0.0%	43.5%	1.2%	54.5%	28.6%
166													
167	Managed Care Administration		(14,140)	(14,140)	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		-0.2%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	**Contract Cost**		7,655,542	7,209,268	446,274	34,120	176,799	46,673	-	58,837	2,909	95,599	31,338
171	**Net before Settlement**		-	(782,104)	782,104	49,703	258,790	(6,626)	-	76,494	245,656	79,725	78,363
172	Contract Settlement		-	782,104	(782,104)	(49,703)	(258,790)	6,626	-	(76,494)	(245,656)	(79,725)	(78,363)
173	**Net after Settlement**		-	-	-	-	-	-	-	-	-	-	-
174													
175		x	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2019			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		232,622,317	24,707,953	207,914,364	8,775,344	41,387,068	10,789,427	38,256,692	11,341,544	62,673,238	14,588,280	20,102,770
178	Incentive Payment Revenue		616,856	105,345	511,511	26,475	34,000	28,121	104,241	3,754	270,359	23,912	20,650
179	**Contract Revenue**		233,239,173	24,813,298	208,425,875	8,801,818	41,421,068	10,817,548	38,360,933	11,345,298	62,943,597	14,612,192	20,123,421
180													
181	External Provider Cost		153,917,925	15,943,605	137,974,320	4,219,887	27,339,325	7,522,093	23,252,811	6,439,456	48,900,293	8,690,065	11,610,389
182	Internal Program Cost		55,321,342	-	55,321,342	4,301,456	10,888,200	3,035,774	12,849,583	3,279,111	7,982,492	5,269,310	7,715,415
183	SSI Reimb, 1st/3rd Party Cost Offset		(970,848)	-	(970,848)	(63,197)	(237,811)	(47,561)	(208,871)	(10,174)	(293,637)	(25,821)	(83,776)
184	HICA & Use Tax, HRA		2,582,830	2,582,830	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		547,527	547,527	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		211,398,775	19,073,962	192,324,813	8,458,145	37,989,714	10,510,306	35,893,523	9,708,394	56,589,149	13,933,554	19,242,028
187	**Medical Loss Ratio (HCC % of Revenue)**		90.6%	76.9%	92.3%	96.1%	91.7%	97.2%	93.6%	85.6%	89.9%	95.4%	95.6%
188													
189	**Managed Care Administration**		21,181,059	6,756,462	14,424,597	686,363	2,920,902	859,180	2,458,845	722,497	4,713,878	818,372	1,244,561
190	**Admin Cost Ratio (MCA % of Total Cost)**		9.1%	2.8%	6.2%	7.6%	7.1%	7.6%	6.4%	6.9%	7.7%	5.6%	6.1%
191													
192	**Contract Cost**		232,579,834	25,830,424	206,749,411	9,144,508	40,910,616	11,369,486	38,352,368	10,430,890	61,303,027	14,751,926	20,486,589
193	**Net before Settlement**		659,339	(1,017,126)	1,676,465	(342,690)	510,452	(551,939)	8,565	914,408	1,640,570	(139,734)	(363,168)
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		-	1,676,465	(1,676,465)	342,690	(510,452)	551,939	(8,565)	(914,408)	(1,640,570)	139,734	363,168
198	**Net after Settlement**		659,339	659,339	0	(0)	(0)	0	0	0	0	0	(0)
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2019			11									
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													
201	***State General Fund Services***			*HCC%*	4.8%	3.4%	3.9%	4.6%	6.0%	5.8%	5.1%	2.8%	4.2%
202	Contract Revenue				9,824,618	597,371	1,677,663	570,596	1,906,274	576,260	3,304,268	408,137	784,049
203													
204	External Provider Cost				3,646,961	72,770	468,195	157,007	415,198	299,873	1,946,761	239,200	47,958
205	Internal Program Cost				6,041,636	220,782	1,082,762	349,771	1,875,082	300,891	1,264,492	159,443	788,413
206	SSI Reimb, 1st/3rd Party Cost Offset				(144,092)	-	-	-	-	-	(144,092)	-	-
207	**Total Healthcare Cost**				9,544,505	293,552	1,550,958	506,778	2,290,280	600,764	3,067,161	398,643	836,371
208	**Medical Loss Ratio (HCC % of Revenue)**				97.1%	49.1%	92.4%	88.8%	120.1%	104.3%	92.8%	97.7%	106.7%
209													
210	**Managed Care Administration**				803,068	26,692	133,579	46,277	173,795	49,617	286,550	26,368	60,189
211	**Admin Cost Ratio (MCA % of Total Cost)**				7.8%	8.3%	7.9%	8.4%	7.1%	7.6%	8.5%	6.2%	6.7%
212													
213	Contract Cost				10,347,573	320,244	1,684,537	553,055	2,464,075	650,381	3,353,711	425,011	896,560
214	**Net before Settlement**				(522,955)	277,127	(6,874)	17,541	(557,801)	(74,121)	(49,443)	(16,874)	(112,511)
215													
216	Other Redistributions of State GF				(192,717)	6,674	-	(431)	(29,777)	-	(142,420)	-	(26,763)
217	Contract Settlement				(273,638)	(266,044)	-	(7,594)	-	-	-	-	-
218	**Net after Settlement**				(989,310)	17,757	(6,874)	9,516	(587,578)	(74,121)	(191,863)	(16,874)	(139,273)
219													

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

September 17, 2019

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

Dear Mr. Casemore:

The Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) is obligated to monitor and manage the Habilitation Supports Waiver (HSW) slot utilization for the State of Michigan. BHDDA has noted that Southwest Michigan Behavioral Health has consistently utilized at or near 100 percent of your allocated HSW slots.

Per Appendix B: Participant Access and Eligibility of the HSW application, the methodology for determining the number of slots each PIHP was issued is based on several factors:

- The historical demand/use of the HSW when the concurrent §1915(b)/(c) waiver was established;
- The penetration rate for each PIHP of persons served with developmental disabilities compared to the number of HSW slots allocated;
- Input from PIHPs that either are requesting additional HSW slots or have unused capacity; and
- The usage by PIHP on the HSW database.

In applying the above standards to your current HSW slot utilization, BHDDA has **increased the total number of HSW slots for Southwest Michigan Behavioral Health from 690 to 710, effective October 1, 2019.**

Please submit the new HSW packets to BHDDA **by October 15, 2019** to meet the deadline for October HSW enrollment. Please remember that the compliance requirement on HSW slot utilization is to maintain at least 95 percent utilization each month.

Thank you for your continued efforts in maintaining this goal! If you have any further questions, please contact me at HawksB@michigan.gov

Sincerely,

Belinda Hawks

Belinda Hawks, QIDP, BS, MPA
Director
Division of Quality Management & Planning
Behavioral Health and Developmental Disabilities Administration

cc: George Mellos
Jeffery Wieferich
John Duvendeck
Kendra Binkley
Morgan VanDenBerg
Emilea Brook

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

as of 8/9/19

Timothy Carmichael (St. Joe)		
James Blocker (Calhoun)		
Anthony Heiser (St. Joe)		

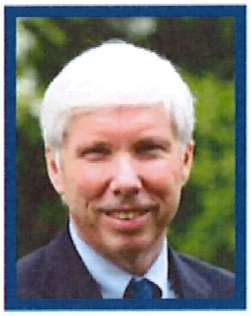
Green = present
Red = absent
Black = not a member
Gray = meeting cancelled

2020 Economic Forecast Report

2020 Economic Outlook for Michigan

First National Bank of Michigan & the W.E. Upjohn Institute have partnered to bring you the third annual Economic Outlook. We invite you to hear from our distinguished speakers regarding the condition of our state & country for the upcoming year.

Thursday, Oct. 31st
7:30 - 9 AM | Kalamazoo Institute of Arts



Dr. Randall W. Eberts
President,
W.E. Upjohn Institute for Employment Research

Dr. Jim Robey
Director, Regional Economic Planning Services,
W.E. Upjohn Institute for Employment Research

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September 25, 2019 04:30 PM UPDATED 15 HOURS AGO

CMS focused on Medicaid integrity, agency deputy says

MICHAEL BRADY

As Medicaid spending continues to increase, the CMS hopes focusing on flexibility, accountability and the integrity of managed care plans will help slow that growth, an agency official said Wednesday.

CMS' acting deputy administrator and acting director Calder Lynch called the spending growth "unsustainable," as it's slated to hit $1 trillion per year by 2026. That encourages the CMS to continue its push to curb growing healthcare spending by giving state Medicaid programs more flexibility and help with value-based payment experiments. The agency will also continue its efforts to reduce unnecessary regulatory burdens for states, plans and providers, he said during remarks at America's Health Insurance Plans' 2019 national conference on Medicaid.

Better administrative and quality accountability measures such as a new Medicaid and Children's Health Insurance Program scorecard would improve the ability of states and the CMS to advance multi-payer alignment through streamlined payment policies, quality measurements, administrative practices and data sharing, Lynch said.

Every state is required to have a written Medicaid quality strategy and related performance assessments, but Lynch said that they often fail to inform a comprehensive strategy to improve state Medicaid programs.

"Too often they become a check-the-box exercise," he said.

The agency will focus on improved data collection and sharing over the next year, and it's now collecting transformed Medicaid statistical information system data from all states. That data provides more comprehensive claims and beneficiary information to the agency.

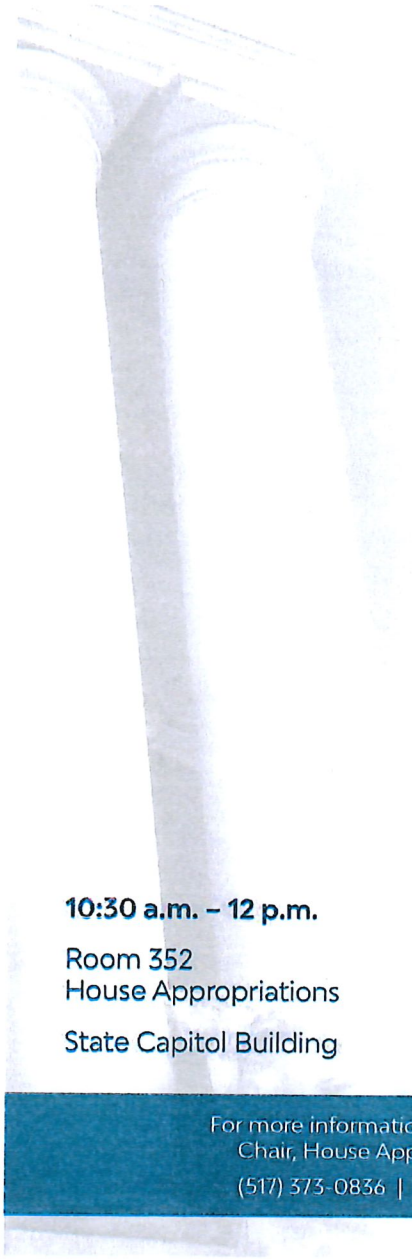
"It's a critical element for us to get a full picture of the quality of services that are being delivered," Lynch said. But the data has its problems and "patience for complete and accurate Medicaid data is running out."

Focusing on Medicaid integrity will also help improve the accuracy of medical-loss ratios, Lynch said, noting that managed care plans had artificially inflated their MLRs through improper reporting to increase their earnings.

"This is going to be a trust, but verify kind of activity," he said.

The agency is also working to make sure that states and managed care plans aren't enrolling ineligible people in Medicaid, citing recent reports that states often fail to prevent ineligible people from enrolling in the program. Lynch said it's especially true for states where the federal government is paying for most of the Medicaid costs.

"There's little incentive for states to make sure they're guarding against inappropriate enrollments," he said.



House Appropriations Subcommittee on
HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH HEARINGS

WEDNESDAY, OCTOBER 2

History and Overview of Public Behavioral Health Financing in Michigan

Jeff Patton – Kalamazoo CMH CEO

Jim Haveman – Former Director of Department of Community Health

WEDNESDAY, OCTOBER 16

CMH Perspective: Benefits and challenges of the CMH, PIHP system including House fiscal analysis of Michigan's behavioral health carve out

Bob Sheehan/Alan Bolter – CMHAM

House Fiscal Agency

WEDNESDAY, OCTOBER 22

The case for Behavioral Health Integration from the former Medicaid Director of Arizona

Thomas Betlach – former Arizona Medicaid Director

10:30 a.m. – 12 p.m.

Room 352
House Appropriations

State Capitol Building

WEDNESDAY, OCTOBER 30

Public Input

WEDNESDAY, NOVEMBER 6

Public Input

For more information, please contact **STATE REP. MARY WHITEFORD**
Chair, House Appropriations Subcommittee on Health and Human Services
(517) 373-0836 | MaryWhiteford@house.mi.gov | www.RepWhiteford.com

Directors and Executive Assistants:

This email is to remind you that the Association's membership voted last year to hold only ONE MEMBER ASSEMBLY meeting per year, and that meeting is held at the Spring Conference.

There is no longer a Member Assembly meeting at the Winter or Fall Conferences; therefore, NO VOTING DELEGATES are needed. Please do not appoint Board Members as Voting Delegates.

Thank you!~ ☺

CMHA

Monique Francis

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BEHAVIORAL HEALTH 1915(i) STATE PLAN BENEFIT
FREQUENTLY ASKED QUESTIONS

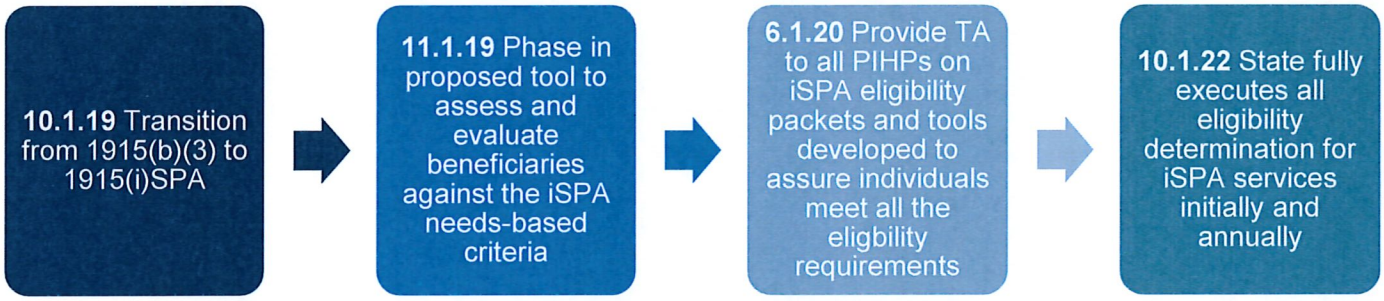
General Information

What is the background for the transition from (b3) waiver services to 1915(i) State Plan Amendment (SPA) services?

Following CMS's guidance, Michigan will transition all of the specialty behavioral health services and supports currently covered under 1915(b)(3) authority to a 1115 Behavioral Health Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations that were previously served through the Managed Specialty Services & Supports 1915(b1)(b3) waiver authorities within Federal guidelines.

The 1915(i) State Plan will operate concurrently with the 1115 Demonstration, which establishes the provision of behavioral health community-based services AND evaluation/re-evaluation of eligibility function through Michigan's managed-care contract with the regional Prepaid Inpatient Health Plans (PIHP).

What is the timeframe for transition of eligibility determination of this benefit to the MDHHS/BHDDA ?



Is the expectation that the PIHP to be reviewing every (b3)/1915(i) State Plan case in order to determine eligibility effective 10/1/2019?

The expectation of the PIHP and their networks will be to work as partners with MDHHS/BHDDA to develop systems with tools to evaluate "needs-based criteria" for the benefit in accordance with the State's approved 1115 special terms and conditions to fully transition the administrative function of eligibility evaluation back to MDHHS/BHDDA. It is recommended that prior or on 10/1/19 that all PIHPs/CMHSP's familiarize themselves with the iSPA target group, evaluation/re-evaluation of eligibility process, and the needs-based criteria that is available now on the MDHHS website.

How can I stay up to date with the changes related to the 1915(i)SPA implementation and progress?

There is a 1915(i)SPA GovDelivery listserv that you can sign up for. Please contact Emilea Brook (brooke@michigan.gov) and Jordan Milham (milhamj@michigan.gov) for more information on signing up for this listserv.

Does the PIHP need to have a work plan for how they will implement establishing eligibility for the next two years?

MDHHS has does not have pre-established PIHP expectation of a "work-plan" but will partner with PIHP's and their current systems to stand up or "phase in" the key components that will be required in evaluating eligibility of the iSPA benefit. We also recommend that you evaluate the scope of beneficiaries receiving B3 services regionally and locally, so you can start thoughtfully planning and projecting future staffing/admin resources this switch in authority may require. PIHP's should begin to evaluate/re-evaluate individuals beginning 10/1/19 based upon the needs-based criteria in preparation for meeting CMS milestones for process change.

Coverage

What services are covered under this benefit?

The 1915(i)SPA benefit includes Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies (formerly known as Assistive Technology), Supported/Integrated Employment, and Vehicle Modification (formerly known as Assistive Technology). The 1915(i)SPA benefit does not include Goods and Services.

Do children under 21 need to be enroll in the 1915(i)SPA benefit?

Children under 21 would need to be evaluated and enroll in the benefit if there is an assessed need for respite services. The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a comprehensive array of services for children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

What services that were provided through the 1915(b3) waiver authority are not included under the 1915(i) benefit?

No services have been eliminated, but some services were moved to the State Plan or EPDST authority instead of being included in the 1915(i) benefit. One service labeled as Assistive Technology remains, but the State was instructed to separate the large definition into two separate services, that contain the same coverage, services, and providers.

Where will Prevention-Direct services be covered now?

These services will be covered under EPSDT for children up to age 21. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

Eligibility

Will there be a limit on the number of individuals eligible for the 1915(i)SPA benefit?

The 1915(i) SPA benefit does not have a cap to the number of eligible beneficiaries it enrolls.

What will the eligibility criteria for the 1915(i) benefit?

The 1915(i)SPA target groups include individual beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

To be eligible for 1915(i) services, an individual must meet the following needs-based criteria:

A. Have a substantial functional limitation in 1 or more of the following areas of major life activity:
    1. Self-care
    2. Communication
    3. Learning
    4. Mobility
    5. Self-direction
    6. Capacity for independent living
    7. Economic self-sufficiency; and
B. Without 1915(i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation.

In the 1915(i)SPA benefit, who is responsible for the individual face-to-face assessments to determine eligibility?

The PIHP provider network will perform the face-to face assessments. The PIHP's network will conduct assessments that identifies the beneficiary meets all the eligibility requirements for 1915(i) benefit. This network will assist in identifying level of need, administer assessments related to the individual's functional abilities and identify services and supports required to reach the expected outcomes of community inclusion and participation.

In the webinar I heard you say that establishing eligibility could not be delegated, however we currently delegate this function. Does that need to change effective 10/1/19?

In a 1915(i) State plan authority the State Medicaid Agency (SMA)/MDHHS cannot delegate the responsibility for performing evaluations/reevaluations of eligibility for the benefit to the PIHP's and must retain this line of authority. This differs from how service eligibility is determined currently under the 1915(b)(b3) authority. If you currently delegate this authority that does not need to change immediately, but again PIHP and their network will want to start looking at your system and start to phase in new expectations in preparation of looking at this eligibility requirement for the (i)SPA benefit, so you and the network are ready to fully execute the responsibility in accordance with our 1115 STC's milestones that bestows authority for a three year period, for the process change to come into compliance with the eligibility determination requirements for the Medicaid 1915(i) HCBS state plan benefit, which will sunset effective 10/1/22.

Annual eligibility determination for (b)(3) waiver services (now 1915(i)SPA services) is a significant change. What will this look like from the PIHPs to MDHHS/BHDDA?

The process for annual eligibility determination will be similar to the current HSW/SEDW/ABA WSA eligibility, certifications, recertifications, re-evaluations, etc.

We also recommend that you evaluate the scope of beneficiaries receiving B3 services regionally and locally, so you can start thoughtfully planning and projecting future staffing/admin resources this switch in authority may require. should begin to evaluate/re-evaluate individuals beginning 10/1/19 based upon the needs-based criteria in preparation for meeting CMS milestones for process change.

Does the 1915(i)SPA benefit eligibility need to be determined for each individual service covered under the benefit?

Each beneficiary's eligibility is evaluated annually to determine they meet the needs-based criteria for the 1915(i) **benefit,** which includes an array of services. Each individual service within the benefit will be based on the unique needs of the beneficiary in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation

Who is responsible for conducting the 1915(i) benefit independent evaluation of eligibility?

Currently, Michigan authorizes a managed care arrangement with the PIHP. This arrangement allows the PIHP network to perform eligibility evaluations and determinations for beneficiaries receiving 1915(b)(3) services. Following CMS's guidance, Michigan will transition all of the specialty behavioral health services and supports currently covered under 1915(b)(3) authority to a 1115 Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan's PIHP will not be able to function in the same manner under this new authority due to not being a "separate agency of the state" nor will the state have sufficient time to move this currently delegated function back to the administration of the state agency.

CMS has granted MDHHS/BHDDA time for process change through established milestones to complete all evaluations and re-evaluations of beneficiaries enrolled in and/or seeking 1915(i) HCBS state plan service benefits by October 1, 2022. At that time MDHHS/BHDDA will determine 1915(i)SPA eligibility and the PIHP provider network will be responsible for perform face-to-face assessments, compile required documentation, and submit findings to the MDHHS/BHDDA. The MDHHS/BHDDA will make the determination of needs-based criteria through an independent evaluation and re-evaluation.

On or before 10/1/22 how will the PIHP be notified by MDHHS/BHDDA once eligibility has been determined for the 1915(i)SPA benefit?

Once the WSA application is functional for the 1915(i), the PIHP will receive notification electronically through the WSA. This is similar to the current notification process for HSW/SEDW/ABA WSA applications.

It is recommended that prior or on 10/1/19 that all PIHPs/CMHSP's familiarize themselves with the 1915(i) HCBS state plan service benefit's target group, evaluation/re-evaluation eligibility process, and the needs-based criteria that is available now to the public on MDHHS's website. MDHHS will be pulling together additional resources with key information and tools, so the PIHP network can start to focus on the eligibility evaluation process with clear expectations of what will be required by MDHHS in

the form of data, evidence, and documentation in order to make annual needs-based eligibility determination for the 1915(i) HCBS state plan service benefit.

Provider Qualifications

What are the qualifications needed for Qualified Intellectual Disability Professional (QIDP)/Qualified Mental Health Professional (QMHP) providers under the 1915(i) benefit?

Effective 10/1/19 the definition of a QIDP and QMHP are as follows;

QIDP: Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) **OR** one year experience in treating or working with a person who has intellectual disability; **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, **OR** a human services professional with at least a bachelor's degree or higher in a human services field.

QMHP: Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) **OR** one year experience in treating or working with a person who has mental illness; **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant **OR** a human services professional with at least a bachelor's degree or higher

NCQA Health Insurance Plan Ratings 2019-2020 - Summary Report (Medicaid)

Search for a health insurance plan by state, plan name or plan type (private, Medicaid, Medicare). Click a plan name for a detailed analysis.

In 2019, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. Ratings emphasize care outcomes (the results of care) and what patients say about their care.

Note: The overall rating is the weighted average of all measures, not the average of the three composites (Consumer Satisfaction, Prevention, Treatment). For more information about the ratings, including how they are calculated, visit our 2019 ratings page.

Medicaid | Michigan | Enter Plan Name | Search

Lower Performance ≤1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 4.5 | 5.0 Higher Performance

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
4.5	Upper Peninsula Health Plan, LLC	MI	HMO	Yes	4.0	3.5	4.0
4.0	Meridian Health Plan of Michigan, Inc.	MI	HMO	Yes	3.5	3.5	3.5
4.0	Priority Health	MI	HMO	Yes	3.5	4.0	3.5
3.5	Blue Cross Complete of Michigan	MI	HMO	Yes	3.5	3.0	3.0
3.5	HAP Midwest Health Plan, Inc.	MI	HMO	Yes	4.0	2.0	3.0
3.5	McLaren Health Plan, Inc.	MI	HMO	Yes	3.0	2.5	3.5
3.5	Molina Healthcare of Michigan	MI	HMO	Yes	2.5	3.0	3.0
3.5	Total Health Care, Inc.	MI	HMO	Yes	3.0	2.5	3.0
3.5	UnitedHealthcare Community Plan, Inc. dba UnitedHealthcare Community Plan (MI)	MI	HMO	Yes	2.5	3.0	3.5
3.0	Aetna Better Health of Michigan, Inc.	MI	HMO	Yes	2.5	2.5	2.5
2.5	Trusted Health Plan Michigan	MI	HMO	Yes (Interim)	2.0	2.0	2.5

- NCQA Accreditation as of June 30, 2019.
- I = Insufficient data; NC = No Credit; NA = Not Applicable; NP = Not Publicly Reported
- † = Special Needs Plan (SNP), according to CMS
- * = NCQA recommends exercising caution when comparing HEDIS 2019 health plan performance on Use of Opioids at High Dosage (UOD) and Use of Opioids from Multiple Providers (UOP) due to health plan variation in denominator size and different state requirements.
- Contact us at my.ncqa.org to ask about licensing the ratings data for research or display.

PENDING BEHAVIORAL HEALTH LEGISLATION—116TH CONGRESS, FIRST SESSION, 2019

STRENGTHENING PARITY

- *Mental Health Parity Compliance Act.* (HR 3165, Rep. Katie Porter (D-CA); S 1737, Sen. Chris Murphy (D-CT)). The bill would further strengthen parity in mental health and substance use disorder benefits, with improved monitoring and reporting features.
- *Parity Enforcement Act* (HR 2848, Rep. Donald Norcross (D-NJ)). The bill would allow the Labor Department to impose penalties against health insurers and plan sponsors for parity violations; protect issuers and sponsors that exercise "reasonable diligence" to comply and correct violations within 30 days of being known.
- *Behavioral Health Coverage Transparency Act* (HR 2874, Rep. Joseph P. Kennedy (D-MA); S 1576, Sen. Elizabeth Warren (D-MA)). The bill would strengthen enforcement of parity laws by increasing mandatory federal audits of health plans, requiring insurance companies to disclose how they make decisions on behavioral health care coverage, and establishing a Consumer Parity Portal, a one-stop shop where consumers could learn about their rights and submit complaints about their insurers.

WORKFORCE

- *Mental Health Professionals Workforce Shortage Loan Repayment Act* (HR 2431, Reps. John Katko (D-NY) Grace Napolitano (D-CA); S 2500, Sen. Kamala Harris (D-CA). The bill would amend the PHS Act to authorize loan repayments for mental health professionals to relieve workforce shortages, and for other purposes.
- *Defending Access to Mental Health Care Act* (S. 1668, Sen. John Tester (D-MT)). The bill expands the National Health Service Corps to include service in pediatric inpatient mental health facilities (such facilities may qualify as health professional shortage areas under the program).

APPROPRIATIONS

- *Certified Community Behavioral Health Centers* (CCBHCs) expansion grants were funded through November 21, 2019, under the continuing resolution recently signed by the President. The program needs to keep getting funded through the entirety of FY 2020, as do all current behavioral health programs, including not only services, but also workforce growth, Medicaid/Medicare, justice/behavioral health interface, insurance/parity and legal issues.

JUSTICE-INVOLVED POPULATIONS

- *The Medicaid Re-entry Act.* (HR 1329, Reps. Paul Tonko (D-NY), Michael Turner (R-OH)). The measure allows states to begin or restart benefits for Medicaid-eligible individuals for addiction treatment up to 30 days *before* release from jail or prison. The provisions apply equally to individuals with mental disorders and intellectual/developmental disabilities.

SCHOOL SAFETY AND SUICIDE PREVENTION

- *Barriers to Suicide Act.* (HR 2599, Reps. Don Beyer (D-VA), John Katko (D-NY) and Grace Napolitano (D-CA)). The bill makes grants to state and local governments to fund nets and barriers on bridges, a practice shown to reduce suicide.
- *Suicide and Threat Assessment Nationally Dedicated to Universal Prevention (STANDUP) Act.* (HR 2599, Reps. Scott Peters (D-Ca), Gus Bilirakis (R-FL) and S 2492, Sens. Gardner (R-CO), Doug Jones (D-AL)) The House bill encourages section Project AWARE and other school-based suicide prevention grant recipients to implement student suicide prevention awareness and training policies and school threat assessment team policies. The Senate version addresses *only* student suicide prevention awareness and training policies. It does not include school threat assessment.
- *Increasing Access to Mental Health in Schools Act* (HR 2958, Rep. Judy Chu (D-CA); S 1642, Sen. John Tester (D-MT)). The bill would increase the recruitment and retention of school-based mental health services providers by low-income local educational agencies
- *Mental Health Services for Students Act* (HR 1109, Rep. Grace Napolitano (D-CA); S 1122, Sen Tina Smith (D-MN)). The bill would add funds and expand the scope of the Project AWARE State Educational Agency Grant Program to provide access to more comprehensive school-based mental health services and supports, including universal evidence-based screening of children for potential emotional disorders, comprehensive staff development, for comprehensive training for families/caregivers to improve health and academic outcomes for children with, or at risk for, mental disorders.

MIXED-TOPIC (DRUG COSTS/ACA SAFEGUARDS/SOCIAL DETERMINANTS) LEGISLATION

- *Strengthening Health Care and Lowering Prescription Drug Costs Act* (HR 987, adopted by House 234-183). The House-passed measure rolls a number of bills together, including provisions to stop drug companies from purposely slowing the progress of cheaper generic drugs to market and to help lower patient drug costs by increasing competition in the generic drug market. Also included in the package were provisions to *reverse Administration rules* to promote short-term health insurance plans that don't have to meet ACA requirements and to allow states to use Section 1115 waivers to impose work requirements and other strictures; to *make $10 billion available for state reinsurance programs* protecting insurers from high-cost enrollees; and to *restore funding for the ACA's state and local Navigator program.* The package is now pending on the Senate calendar.
Utilizing National Data, Effectively Reforming Standards and Tools, to Address Negative Determinants of Health (UNDERSTAND) Act. (S. 1323, Sens. Rob Porter (R-OH), Bob Casey (D-PA)). The bill would collect information under Medicare, Medicaid, and the Children's Health Insurance Program related to social determinants of health. Data would be collected from licensed health professionals and community health workers on topics including education and literacy; employment and unemployment; occupational exposure risks; housing and economic circumstances; social environment; family/primary support groups; civil or criminal convictions; and pregnancy. A report on the findings would be made to Congress within 5 years of enactment.

SAVING ACA

- *Resolution providing for congressional disapproval under Chapter 8 of title 5, United States Code, of the rule submitted by the Secretary of the Treasury and the Secretary of HHS relating to "State Relief and Empowerment Waivers.* (H J Res 74, Rep. Annie Kuster (D-NH); S J Res 52, Sen. Mark Warner (D-VA)). The joint resolution would force CMS to rescind its Section 1332 waiver rule that would allow states to greenlight junk insurance plans that don't fully protect people with pre-existing conditions. All 47 Senate Democrats cosponsored the resolution. Moreover, and more critically, *because the resolution is filed under the Congressional Review Act a vote is required within 60 legislative days and passage requires a simple 50 vote Senate majority.*
- *Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act* (S 1905, Sens. Tammy Baldwin (D-WI) and Bob Casey (D-PA)). The bill would restore $100 million in funding for the Navigator program that helps American families get the information and support they need to find a quality health care plan at a price they can afford. The measure is cosponsored by 20 or more Senate Democrats. A House companion passed as part of HR 987 (234-183)
- *State Allowance for a Variety of Exchanges (SAVE) Act.* (S 1400, Sens. Bob Menendez (D-NJ), Cory Booker (D-NJ); HR 1385, Rep. Andy Kim (D-NJ)). The bill would make $200 million in grants available to states choosing to establish their own state-based ACA marketplaces in lieu of remaining part of the federal marketplace program.

MEDICAL RECORD PRIVACY

- *Overdose Prevention and Patient Safety Act* (House); *Protecting Jessica Grubb's Legacy Act* (Senate). SUBSTANCE USE TREATMENT RECORD PRIVACY. (HR 2062 Reps. Earl Blumenauer (D-OR), Markwayne Mullin (R-OK); S 1012 Sens. Joe Manchin (D-WV), Shelley Moore Capito (R-WV). The bipartisan bill would modify the federal statute requiring explicit patient consent before sharing substance use treatment records to align with Part 2 patient privacy protections permitting the medical community to use substance use disorder treatment records in the same manner as all other medical records. The legislation incorporates language to safeguard against unauthorized invasion of patient privacy and discriminatory activity.

SUBSTANCE ABUSE TREATMENT PROGRAMS

- *Mainstreaming Addiction Treatment Act* (HR 2482, Rep. Paul Tonko (D-NY); S 2074, Sen. Margaret Hassan (D-NH)). The bill would increase access to buprenorphine treatment within our communities by eliminating separate registration requirement for dispensing narcotic drugs in schedule III, IV, or V (such as buprenorphine) for maintenance or detoxification treatment.

SURPRISE MEDICAL BILLS

- *Lower Health Care Costs Act (LHCCA)* (S. 1895, Sens. Lamar Alexander (R-TN), Patty Murray (D-WA)). The measure, awaiting Senate floor action, specifically protects against surprise bills, covers out-of-network emergency services and protects against out-of-network deductible charges in emergencies; guarantees in-network coverage; benchmark pricing for out-of-network payments to providers and hospitals; and *parity analyses by plan, subject to complaint-driven federal review*. This last provision requires all health plans and insurance coverage to analyze and

compare nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits with those used for mental health and SUD benefits. (As NACBHDD members recall, NQTLs remain the primary obstacle in many health plans that stand in the way of accessing high-quality behavioral health treatment.) The provision represents progress for parity advocates, who have been pushing for meaningful enforcement of the parity act for over a decade.

UNIVERSAL COVERAGE AND ALTERNATIVES

- *Medicare for All.* (HR 1384, Rep. Pramila Jayapal (D-WA); S. 1129, Sen. Bernie Sanders (I-VT)). Within 4 years of enactment, a single payer system is established, providing comprehensive health care coverage, including dental, vision and long-term care, to all Americans. Because it could not cover the same services as the single payer system, private insurance would be virtually eliminated, as would Medicaid, though the IHS and VHA would be retained, at least temporarily.
- *Medicare for America.* (HR 2452, Reps. Rosa DeLauro (D-CT), Jan Schakowsky (D-IL)). The bill allows workers to keep an employer's health insurance plan or to switch to an expanded Medicare program into which uninsured people, neonates and those on Medicare, Medicaid, CHIP or the ACA automatically are enrolled. Plan premiums and deductibles are based on income. Medicare Advantage and plans managed by private insurance companies would be maintained. Large employers could continue to offer coverage if it is comparable to the new Medicare plans. Alternatively, employers could contribute to the Medicare plan on behalf of their employees.
- *Medicare-X Choice Act.* (HR 2000, Reps. Antonio Delgado (D-NY), John Larson (D-CT), Brian Higgins D-NY); S 981, Sens Michael Bennet (D-CO), Tim Kaine (D-VA)). The bill retains the existing health care system and creates a public option health plan, administered by Medicare and available for purchase through the ACA's individual and small business health insurance Marketplaces. Under the bill, the Medicare provider network expands to include pediatricians, children's hospitals and others. The Act ensures Essential Health Benefits like maternity, newborn care, and pediatric services are covered and allows for prescription drug negotiation through Medicare Part D. The plans are made available across the country over a period of four years and cover the ACA's 10 required benefits, including maternity care and mental health services. It expands access to tax credits to help people buy coverage and allows those credits to be used for Medicare-X plans while boosting the size of those credits for people with lower incomes.
- *Medicare at 50 Act/Medicare Buy-In and Health Care Stabilization Act.* (HR 3748, Rep. Brian Higgins (D-NY); S 470, Sen. Debbie Stabenow (D-MI)). US citizens between the ages of 50 and 64 can buy a Medicare plan. Like the Medicare-X Choice Act, individuals could use ACA subsidies to purchase plans. It is pitched as an incremental step to universal coverage.
- *Choose Medicare Act.* (S 1261, Sens. Chris Murphy (D-CT), Jeff Merkley (D-OR)). The bill creates a public option for individuals and employers, giving everyone not eligible for Medicaid or Medicare the opportunity to enroll in the program as an individual. While it doesn't go as far as Medicare for America, Choose Medicare creates a new Medicare Part E to be offered on all state and federal Marketplaces. People can use existing ACA subsidies to help pay for it and employers can purchase Medicare for their employees.

10-1-19

CHI²

Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

The perfect storm for fiscal distress in Michigan's mental health system:

The convergence of revenue and demand factors leading to the current fiscal stress in Michigan's public mental health system

September 2019

Center for Healthcare Integration and Innovation
Community Mental Health Association of Michigan

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September 2019

Executive Summary

The Center for Healthcare Integration and Innovation (CHI2) examined financial and service delivery records of Michigan's public mental health system – its Community Mental Health Centers (CMHs), Prepaid Inpatient Health Plans (PIHPs), and provider network - to determine the causes of the fiscal distress experienced by this system from Fiscal Year 2014 through FY 2019.

That study found that the convergence of a number of factors, starting in 2014 led to the sustained, system-wide revenue shortages and event deeper fiscal distress in a number of regions throughout the state.

The causes of **system-wide fiscal distress**, all tied to the changes initiated in 2014, were identified as:

1. State funding to public mental health system not keeping pace with increased demand and health care cost increases, from FY 2014 to the present
2. Deep cut of $200 million (representing a 60% cut) in General Fund support eliminated a key part of CMH fiscal infrastructure
3. Increased demand for substance use disorder services, especially opioid treatment
4. Dramatically expanding autism benefit without matching revenues
5. Revenue loss (an 80% cut in per enrollee revenues) due to high cost traditional Medicaid enrollees moving to low revenue Healthy Michigan Plan
6. Failure of the state to fund federally required contributions to public mental health system's risk reserves
7. Inappropriate state demand that local funds be used to close Medicaid funding gap

Causes of **uneven impact of fiscal distress** across the state - 2014 to the present

1. Widely disparate impact of FY 2016 and FY 2018 Medicaid ratesetting
2. Dramatic differences in demand for services not matched by funding
3. Insufficient number of higher-revenue Habilitative Support Waiver slots to meet high-cost needs

Structure of Michigan's public mental health system:

Michigan's public mental health system is made up of public, county-government based Community Mental Health centers (CMHs), the Prepaid Inpatient Health Plans (PIHPs; the public Medicaid specialty health plans formed and governed by the CMHs in the region covered by each PIHP), and the private provider organizations making up, along with the CMHs, the provider network managed by the CMHs and PIHPs. This system, operating under a risk-based Medicaid capitation-funding arrangement with a much smaller state General Fund funding component, manages and provides a wide range of mental health services to over 300,000 persons, annually, with serious mental illness, children with serious emotional disturbance, persons with intellectual and developmental disabilities, and persons with substance use disorders. This system converted from a Medicaid fee-for-service system to a risk-based capitated system in October 1997 and continues to operate as such a system currently.

Convergence of factors causing fiscal distress to the system

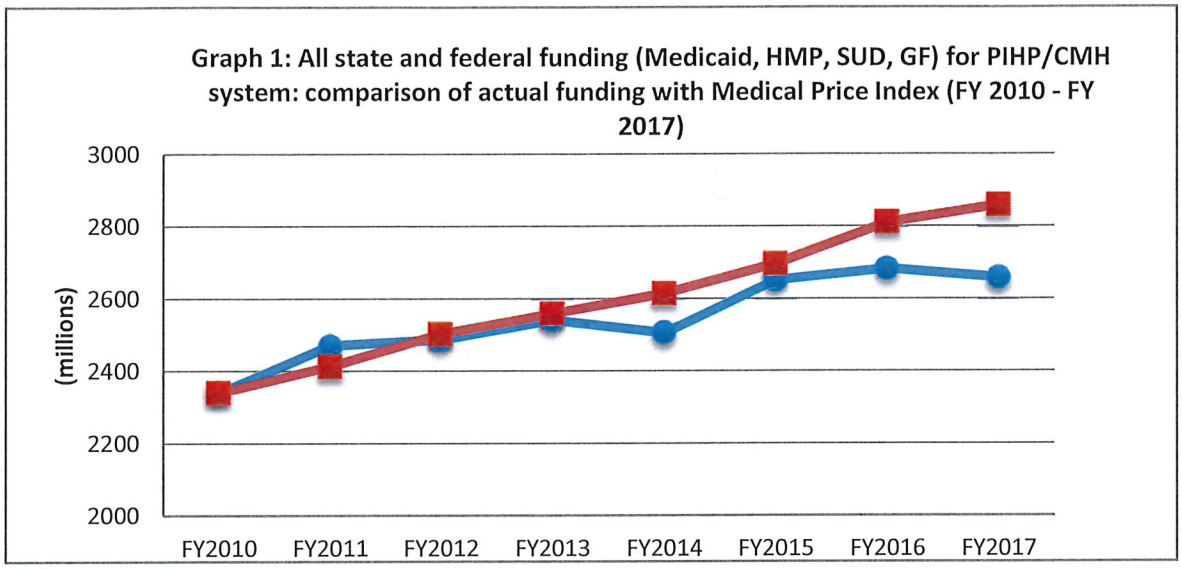
While the system was never flush with funding, this system was fiscally sound, under the risk-based capitated system until FY 2014. **However, from 2014 through 2019, a number of factors converged to cause systemic system-wide fiscal distress, with the impact of this fiscal distress being felt very unevenly across the state.**

During discussions with system observers and policy makers, in the spring of 2019, the question was raised regarding the factors, not present in the more distant past (from 1998 through 2014), but that are the causes of the fiscal stress in the state's CMH/PIHP system, starting in FY 2014 through the present and most acutely from FY 2016 through the present. This is the central question around which this report is built.

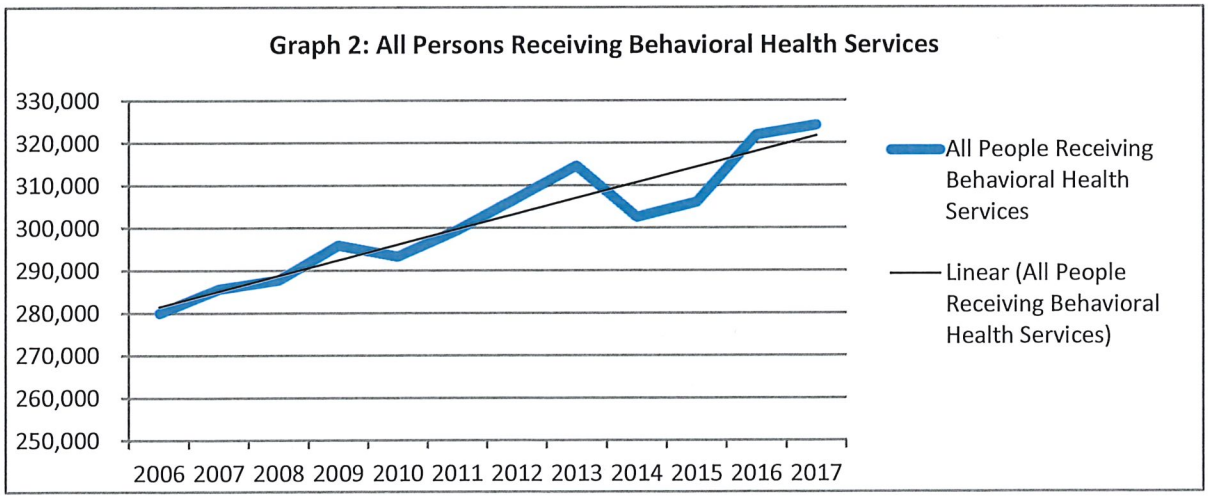
The CMH Association examined the factors that came together in this period (2014 to the present) that have caused statewide fiscal stress, and those have caused this stress to be experienced differentially across the state. Those factors are outlined below.

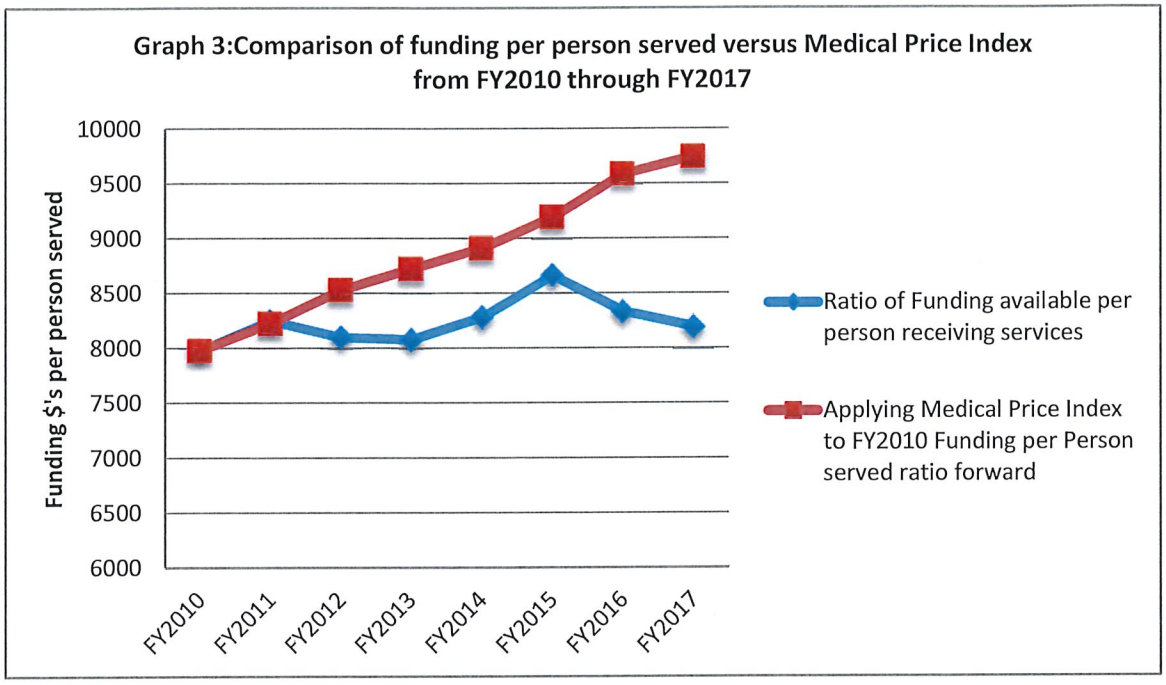
Causes of statewide fiscal stress – 2014 to the present

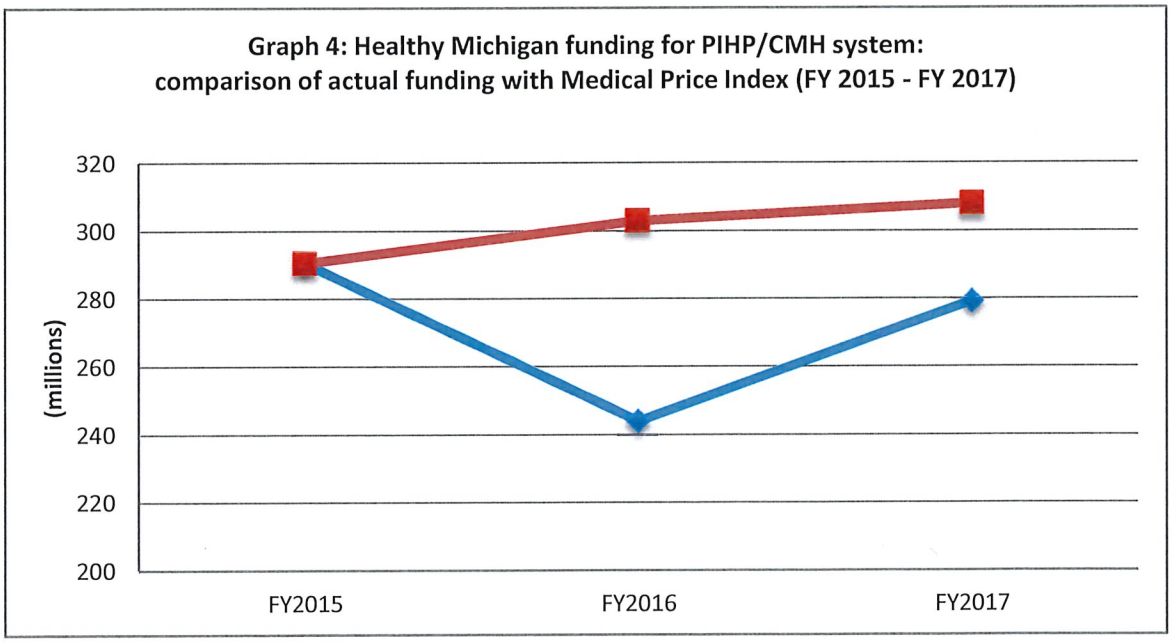
1. State funding to public mental health system not keeping pace with increased demand and health care cost increases, from FY 2014 to the present: The funding to Michigan's public mental health system started to lag in FY 2014 and has increase since that time (**See Graph 1**),



While the **number of persons served by Michigan's public mental health system continued to climb** (**See Graph 2**), this gap in funding, led to dramatic drops in the public dollars available, per person served, to meet the mental health needs of Michiganders. (**See Graph 3**)







Additionally, the Healthy Michigan Plan (HMP) Introduced in 2014 with a lag in demand; penetration and intensity of needed care are now strong. As a result of the slow uptake by HMP enrollees, the **HMP rates were dramatically cut in FY 2016 (over 20% cut) at the time that substantial demand for HMP was being experienced by the system and have not been restored leaving a sizeable revenue gap (See Graph 4)**. The intensity of treatment needed by HMP enrollees is far greater than initially projected causing the current rates to be far below the funds necessary to meet these needs.

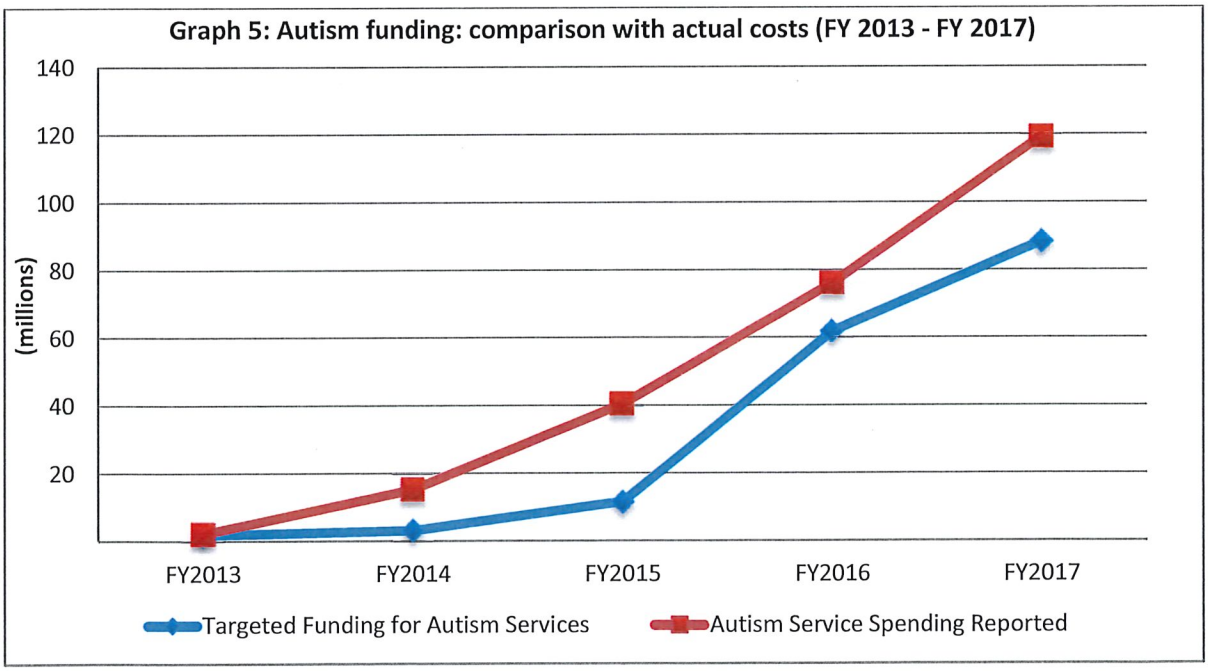
2. Deep cut of $200 million (representing a 60% cut) in General Fund support eliminated a key part of CMH fiscal infrastructure: As part of the implementation of Healthy Michigan, in FY 2014 and 2015, 60% of the state's General Fund support for the CMH system was eliminated ($200 million). These General Fund dollars were part of the fiscal infrastructure of the CMH system, used to serve persons without Medicaid and to buffer against Medicaid demand and cost fluctuations. This loss of these dollars, 8% of the system's entire revenues – greater, in fact, than the risk reserves allowed to be held by the PIHPs – left the system without one of the key components of its fiscal infrastructure.

3. Increased demand for substance use disorder services, especially opioid treatment: In 2015, the state's PIHPs also took on the role as the public manager of the state's substance use disorder service delivery system. Taking this role coincided with dramatic increases in demand for substance use disorder services, especially opioid use disorder treatment.

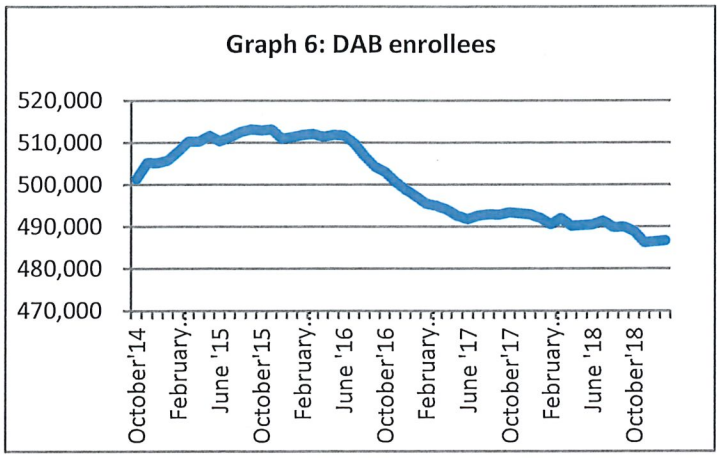
Additionally, the influx of federal State Targeted Response (STR) and State Opioid Response (SOR) dollars, aimed at increasing outreach to persons with opioid use disorders, awareness of the need for treatment, and the provision of treatment-related supports (training of practitioners on evidence-based practices, recovery housing, peer recovery coaches) served to dramatically increase the demand, on the public system, for opioid treatment – medication assisted treatment (MAT) and therapy – **increases demand for opioid treatment but without adding dollars to the treatment system to meet this increased demand.**

4. Dramatically expanding autism benefit without matching revenues: Michigan's Medicaid autism benefit was Introduced during this period, initially limited to children ages 0 through 6, with the age range greatly expanded, to age 21, soon after the benefit's introduction. The downward pressure on appropriations and actuarial rates has caused revenues to be far below the revenues needed to meet demand. (**See Graph 5.**)

Graph 5: Autism funding: comparison with actual costs (FY 2013 - FY 2017)

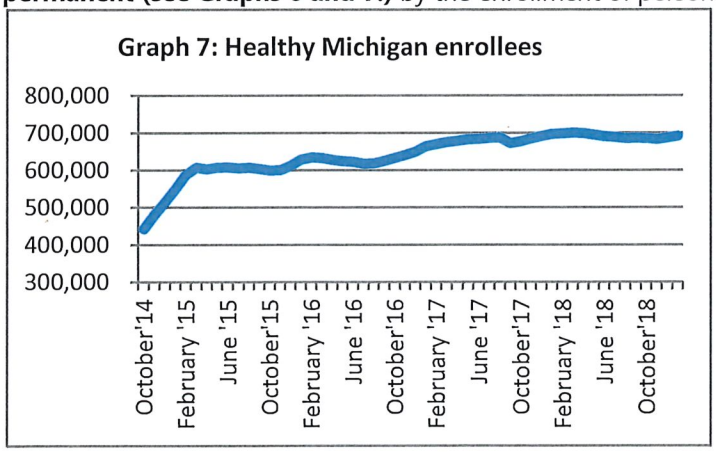


5. Revenue loss (an 80% cut in per enrollee revenues) due to high cost traditional Medicaid enrollees moving to low revenue Healthy Michigan Plan: The introduction of the Healthy Michigan Plan (HMP) saw a large and unprecedented number of persons with Disabled, Aged, and Blind (DAB) Medicaid status leave this program and move to the Healthy Michigan Program.

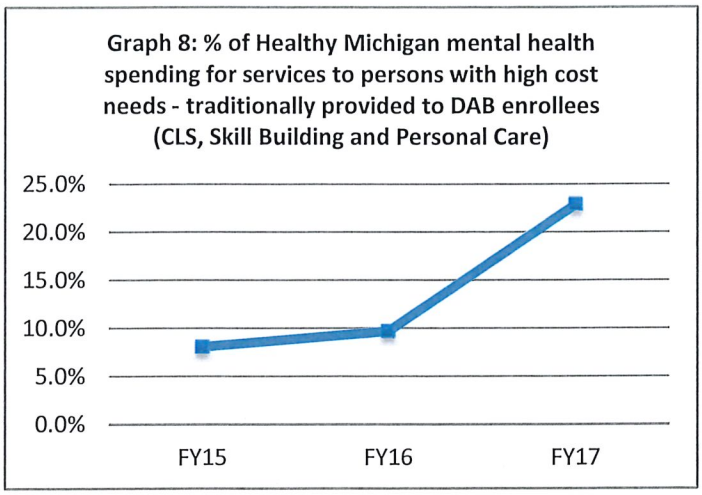


This movement of Medicaid enrollees to Healthy Michigan, starting in early 2016, caused, and continues to cause, a deep revenue hole for the PIHP and CMH system given that **revenue received by the CMHs/PIHPs for these enrollees dropped by 80% when they moved from traditional Medicaid to the Healthy Michigan Plan**. This revenue reduction is due to the fact that the Medicaid DAB rate is designed to meet the high cost services needed by these enrollees, while the Healthy Michigan Plan is a program designed for persons with much lower cost needs. This 80% cut in this large segment of the CMH/PIHP budget leaves the CMH/PIHP system with a substantial fiscal hole.

The sustained low enrollment in DAB and movement to HMP continues and is being made permanent (see Graphs 6 and 7.) by the enrollment of persons who would formerly have enrolled in DAB status, enrolling, directly, into HMP.



This movement, to HMP, designed, with revenues to match, for persons with mild to moderate mental health needs, of persons with much higher cost needs, those that should be served through obtaining DAB status, with much higher revenues, underscored, in **Graph 8**. This analysis show the **dramatic growth in the provision of high cost services to the HMP population** (now making up 22% of all HMP expenditures) – services traditionally received by DAB enrollees (Community Living Supports (CLS), Personal Care, and Skill Building services) – without changes in the HMP payments to the CMHs/PIHPs to match these much higher costs.



The migration of DAB to HMP, by these enrollees (for good reasons – ease of gaining and retaining Medicaid/HMP eligibility and the elimination of spend down requirements - is not the problem. The problem is that the rates paid the CMHs/PIHPs for the Medicaid program to which they are enrolling, HMP, need to be increased to cover the much higher costs of these persons who would normally be DAB enrollees.

6. Failure of the state to fund federally required contributions to public mental health system's risk reserves: The fiscal stability of the state's public mental health system is weakened by the lack of a standard risk-based financing practice – a practice contained in risk-based contracts across the country and used with the state's private Medicaid managed care plans.

For the past twenty years, during the entire period during which Medicaid managed care has existed in Michigan, the Medicaid capitated rates provided to the state's public mental health system **did not include the federally required component that would have allowed Michigan's public mental health system to build and retain the necessary risk reserves** – reserves necessary for any risk-bearing managed care entity. The federal requirement for such a payment to the state's public mental health system is clear:

> 42 C.F.R. § 438.5. (e) *Non-benefit component of the rate.* The development of the non-benefit component of **the rate must include** reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, **contribution to reserves, risk margin**, cost of capital, and other operational costs associated with the provision of services identified in §438.3(c)(1)(ii) to the populations covered under the contract.

This lack of appropriate financing has harmed the ability of the state's public mental health system to build and hold reserves sufficient to ensure that they could withstand the fiscal risk inherent in a managed care system – fiscal risk exacerbated by the insufficient benefit component of the rates. As a result, the state's PIHPs now have half of the funds necessary to cover the risk corridor for which they are responsible.

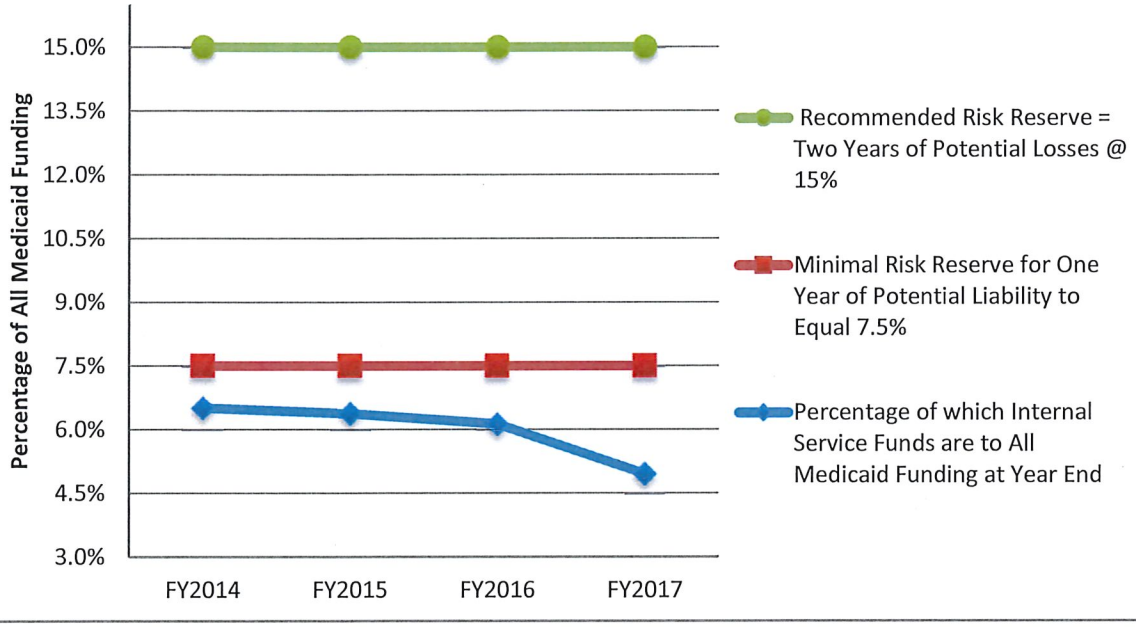
If the Medicaid rates paid to the PIHP/CMH system had included even a modest component (2%) to provide for contributions to reserves and risk margins, the PIHP/CMH system would have **received $50 million more in Medicaid payments in the current fiscal year**, FY 2018.

If a similar contribution to reserves and risk margins had been included in the rates paid the public mental health system over the twenty years during which that system has served as the state's at-risk Medicaid managed care entity for behavioral health, the **public mental health system should have received approximately $700 million in additional Medicaid revenue over that period** – funds that would have

improved the ability of the public mental health system to adequately meet the needs of the Medicaid enrollees in their communities while ensuring fiscal stability of their organizations.

This lack of federally mandated risk reserve contributions, when combined with the insufficient rates have left the public PIHP system with anemic risk reserves (**See Graph 9)**

Graph 9: Comparison Between Recommended Internal Service Fund Levels, Minimal Levels, and Current Levels (FY 2014 - FY 2017)



7. Inappropriate state demand that local funds be used to close Medicaid funding gap: Local funds, those revenues received by the CMH system that do not come from state nor federal sources, are inappropriately drained from the system to cover state Medicaid obligations. For the past decade, the State of **Michigan has required that the public mental health system use of local dollars – the bulk of them coming from Michigan counties – to underwrite part of the state's share of the Medicaid mental health budget. Over $25 million is annually used to cover this obligation.** These funds, if not used to meet these Medicaid obligations, would be used to meet the needs of the person, in communities across the state, without Medicaid coverage.

Causes of differential/uneven impact of fiscal distress across the state - 2014 to the present

1. Widely disparate impact of FY 2016 and FY 2018 Medicaid ratesetting: The Medicaid rate setting process (often termed, rebasing), implemented over the last several years caused dramatic and widely varying swings in Medicaid funding. During this period, the **cumulative changes in rates ranged from PIHP revenue cuts of 8.5% to increases of 20%** - at a time during which demand for services continued to grow. Acute and widely varying revenue swings of this magnitude, implemented in a very timeframe, caused dramatic differences in the fiscal health or stress of the state's PIHPs and their CMH members.

It is key to recognize that **the revenue increases received by the appropriately funded PIHPs are not the problem**. The revenue increases to the state's PIHPs, even those that are appropriately funded, in fact were very small, given the dramatic growth in the HMP population over this period. The problem lies in the lack of revenue increases provided to the system as a whole and especially **acute for those with the lowest revenue gains or revenue reductions over the past four years.**

As a result, those regions without sufficient revenue increases or with revenue losses, over this period, **are short tens of millions of dollars every year for the past several years** – thus leading to the fiscal instability of the PIHPs in these regions.

2. Dramatic differences in demand for services not matched by funding: The demand for Medicaid mental health services and the intensity of the needed services are not uniform across the state. These demand differences for all services, most notably autism, HMP, intellectual and developmental disabilities, and opioid treatment services, cause dramatic differences in the expenses incurred by the CMHs and PIHPs across the state.

3. Insufficient number of higher-revenue Habilitative Support Waiver slots to meet high-cost needs: A program within Michigan's Medicaid system, the Habilitative Support Waiver, provides increased funding to the state's PIHPs to serve persons with intellectual and developmental disabilities with complex and high cost needs. This funding is provided through the use of a finite number of HSW slots to the state's PIHPs. The funding for these "slots" is over 10-times the funding provided to the PIHP system for a typical Medicaid enrollee with intellectual and developmental disabilities. A CMH/PIHP without access to these waiver slots must provide the same level of services to the Medicaid enrollees with high cost needs, but with 1/10 of the revenue for that enrollee. While variation in demand and need is expected, as noted above, **the current limit on the number of Habilitative Support Waiver slots causes some PIHPs to have a sufficient number of these slots while others receive far fewer slots than their community needs.**

The lack of Hab Waiver slots is clearly seen when the **57.6 Hab Waiver Slots are available, per 10,000 Medicaid enrollees**, in some parts of the state (a sound ratio, reflecting real need) while **16.8 Hab Waiver slots are available, per 10,000 Medicaid enrollees**, in other parts of the state.

As with the Medicaid revenue discussion above, it is key to recognize that **the number of waiver slots awarded to the PIHPs with the higher waiver slot ratios is not the problem**. The number of waiver slots, even in the communities with higher ratios of waiver slots, are insufficient to fund the needs of persons in those communities. The **problem lies in the lack of Hab Waiver slots** provided to the system as a whole and especially acute for those with the lowest Hab waiver slot ratios.

The Center for Healthcare Integration and Innovation (CHI²) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing the state's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.