Southwest Michigan Behavioral Health Board Meeting

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

October 13, 2023

9:30 am to 11:30 am

(d) means document provided

Draft: 10/3/23

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda (2 minutes)**

   a. September 8, 2023 SWMBH Board Meeting Minutes (d) pg.3
   b. July 26, 2023 Operations Committee Meeting Minutes (d) pg.7

5. **Required Approvals (5 minutes)**
   a. Credentialing of Behavioral Health Practitioners (M. Todd) (d) pg.9
   b. Credentialing of Organizational Providers (M. Todd) (d) pg.19
   c. Fiscal Year 2024 Program Integrity Compliance Plan (M. Todd) (d) pg.27

6. **Ends Metrics Updates *(*Requires motion)* (10 minutes)**
   Proposed Motion: The Board accepts the interpretation of Ends Metrics as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.

   a. *Health Services Advisory Group Performance Measure Validation Audit (N. Spivak;Lacey) (d) pg.54
   b. *CCBHC Consumer Satisfaction Survey Results (E. Philander) (d) pg.60

7. **Board Actions to be Considered (20 minutes)**

   a. Fiscal Year 2024 Budget Approval (G. Guidry) (d) pg.63
   b. Michigan Consortium for Healthcare Excellence Membership (B. Casemore)
   c. SWMBH Board Policy BEL-006 Investments (G. Guidry) (d) pg.67
   d. Holiday Gathering

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

   - None scheduled

9. **Executive Limitations Review (10 minutes)**
   Proposed Motion: The Board accepts the interpretation of Policy _____ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.

   a. BEL-002 Financial Conditions (L. Csokasy) (d) pg.73
   b. EO-003 Emergency Executive Officer Succession (d) pg.78

10. Board Education (15 minutes)

a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d) pg.79
b. Michigan Consortium for Healthcare Excellence Update (B. Casemore) (d) pg.87
c. Healthcare Policy Forum debrief (B. Casemore)

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

a. Intergovernmental Contract Renewal Contract Status (M. Jacobs)
b. Executive Officer Performance Review Process (E. Meny)
c. November Board Policy Direct Inspection – BEL-010 RE 501 (c) (3) Representation (S. Sherban) EO-002 Monitoring Executive Performance

12. Public Comment

13. Adjournment

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

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

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

Next Board Meeting

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

Southwest Michigan
BEHAVIORAL HEALTH

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

Members Present: Edward Meny, Tom Schmelzer, Cathi Abbs, Mark Doster, Louie Csokasy, Susan Barnes, Karen Longanecker, Sherii Sherban

Members Absent: Carol Naccarato, Erik Krogh

Guests Present: Bradley Casemore, Executive Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Joel Smith, Director of Substance Use Disorder and Prevention Services, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Ella Philander, Strategic Imperatives Project Manager; SWMBH; Richard Thiemkey, Barry County; Cameron Bullock, Pivotal; Jeannie Goodrich, Summit Pointe, Debbie Hess, VanBuren CMH; Jon Houtz, Pines Board Alternate; Nancy Johnson, Riverwood Board Alternate; Susan Radwan, Leading Edge Mentoring; Sarah Ameter, Manager of Customer Services, SWMBH; Geoff Sherman, IT Analyst, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; John Ruddell, Woodlands BHN; Alex Wideman, Administrative Intern, SWMBH; Randall Hazelbaker, Branch County; Richard Godfrey, Van Buren County; Beth Ann Meints, ISK; Jeff Patton, ISK; State Representative Julie Rogers

Welcome Guests
Edward Meny called the meeting to order at 9:32 am and introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion	Sherii Sherban moved to approve the agenda as presented.
Second	Susan Barnes
Motion Carried	

State Representative Julie Rogers
State Representative Julie Rogers presented SWMBH with a State of Michigan One Hundred and Second Legislature Special Tribute to SWMBH in recognition of SWMBH's 10 years of partnership, work and commitment to Behavioral Health and Integrated Care of persons served in the Southwest Michigan Region.

Financial Interest Disclosure (FID) Handling

Mila Todd reviewed Mark Doster's Board appointment documentation from Barry County.

Motion Tom Schmelzer moved that a conflict exists and that:

1) The Board is not able to obtain a more advantageous arrangement with someone other than Mark Doster;
2) The Financial Interest disclosed by Mark Doster not so substantial as to be likely to affect the integrity of the services that SWMBH may expect to receive; and
3) A Conflict of Interest Waiver should be granted.

Second Susan Barnes

Motion Carried

Consent Agenda

Motion Louie Csokasy moved to approve the August 11, 2023, Board minutes as presented.

Second Tom Schmelzer

Motion Carried

Ends Metrics

None

Board Actions to be Considered

Fiscal Year 2024 Draft Budget

Garyl Guidry reported as documented, noting a decrease in Healthy Michigan revenue, a decrease in Medicaid Specialty Services enrollees due to the Public Health Emergency ending. The draft budget projects a 18.5 million dollar deficit with projected use of prior year savings and possible use of Internal Service Funds (ISF). Brad Casemore noted that final budgets are due on September 25th with an Operations Committee review on September 27th. A final Fiscal Year 2024 Budget will be presented at the October 13th Board meeting for approval. Discussion followed.

BEL-006 Investments

Louie Csokasy noted that work continues on SWMBH Policy BEL-006 Investments. Louie and Garyl will work with Susan Radwan and bring a revised policy to the October 13th Board meeting for discussion and approval.

2024 Board Ends Development

Susan Radwan reported as documented. The Board supported the Owner Linkage Ends Development Plan and authorized Susan and Brad to visit each CMH Board. Discussion followed.

Board Policy Review

BG-008 Board Member Job Description

Edward Meny reviewed the policy as documented.

Motion Sue Barnes moved that the Board is in compliance with BG-008 Board Member Job Description and the policy does not need revision.

Second Mark Doster

Motion Carried

Executive Limitations Review

BEL-005 Treatment of Plan Members

Louie Csokasy reported as documented.

Motion Louie Csokasy moved that the Executive Officer is in compliance with policy BEL-005 Treatment of Plan Members and the policy does not need revision.

Second Mark Doster

Motion Carried

BEL-008 Communication and Counsel to the Board

Tom Schmelzer reported as documented.

Motion Tom Schmelzer moved that the Executive Officer is in compliance with policy BEL-008 Communication and Counsel to the Board and the policy does not need revision.

Second Louie Csokasy

Motion Carried

EO-001 EO Role and Job Function

Edward Meny reported as documented.

Motion Edward Meny moved that the Executive Officer is in compliance with policy EO-001 EO Role and Job Function and the policy does not need revision.

Second Susan Barnes

Motion Carried

Board Education

Fiscal Year 2023 Year to Date Financial Statements

Garyl Guidry reported as documented noting that there is a deficit in Medicaid and a surplus in Healthy Michigan Plan. Discussion followed.

Marijuana Presentation

Alex Wideman reported as documented. Discussion followed.

Operating Agreement

Brad Casemore reminded Board members of the Operating Agreement and the guidance that the document gives for Regional Leaders and the work of SWMBH.

Region 4 State Opioid Response Site View Review

Joel Smith reported as documented on the successful site review visit from MDHHS.

Communication and Counsel to the Board

Intergovernmental Contract Status

Michelle Jacobs noted that Van Buren, Kalamazoo and Calhoun counties have signed and returned their Intergovernmental Contract. Barry, Branch, Berrien, Cass and St. Joseph counties remain outstanding.

New Board Member Orientation
Michelle Jacobs is working with new Board member Mark Doster on Board Orientation and reminded members that they could attend again if desired.

October Board Policy Direct Inspections
Brad Casemore noted October direct inspections.

Public Comment

None

Adjournment

Motion Susan Barnes moved to adjourn.
Second Tom Schmelzer
Motion Carried

Meeting adjourned at 11:21am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: July 26, 2023 10:00am-12:30pm

Members Present (partial)
Ric Compton, Jeff Patton, Debbie Hess, Richard Thiemkey, Sue Germann, Jeannie Goodrich, John Ruddell, Cameron Bullock (departed at noon).

Guests present.
Brad Casemore, CEO, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Alena Lacey Director of Clinical Quality and Quality Assurance and Performance Improvement, SWMBH; Ella Philander, Strategic Initiatives Project Manager, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Kelly Jenkins, Barry County; David Ballmer, Summit Pointe; Amy Rottman, ISK; Charlotte Bowser, ISK; Emily Versteeg, Pivotal; Tina Boyer, Van Buren County; Craig Kortlandt, SWMBH; Tim Brown, Pines BH.

Call to Order
Ric Compton began the meeting at 10:23 am.

Review and approve agenda.
Agenda approved with additions of Wakely, Youth Cases and MICANS.

Review and approve minutes from 6/21/23 Operations Committee Meeting
Minutes were approved by the Committee.

Fiscal Year 2023 Year to Date Financials
Garyl Guidry reported as documented noting a deficit in Medicaid Specialty Services. Discussion followed. Brad stressed the seriousness of the situation for FY'23 and dire estimates for FY '24.

Fiscal Year 2024 Budget
Garyl Guidry reported as documented noting a projected 29-million-dollar deficit completely exhausting the ISF and going into shared risk corridor with MDHHS. Regional Finance Committee is meeting on August 7 to continue work, revisions and analysis on FY24 budget. First iteration due to SWMBH soon after the meeting. CCBHC finances will be discussed and at other regional committee meetings. Discussion followed.

August Fiscal Year 2024 Budget Meeting
Group discussed another FY24 Budget meeting, and one was scheduled for August 30th for a review of the then current FY '24 proposed budget.

Performance Bonus Incentive Program Fiscal Year 2023
Group discussed at CEO only portion of the meeting with nothing further for the minutes.

Conflict Free Access and Planning (CFAP) Update
Alena Lacey stated that case testing with the CFAP workgroup began with expanded testing scheduled for August 1st. Projected implementation is October of 2024. Brad Casemore added that CFAP will change scope of responsibilities and roles of CMHSPs.

Michigan Child and Adolescent Needs and Strengths (**MICANS)**
Alena Lacey stated that projected implementation is Fiscal Year 2025 and testing has started.

Inpatient Psychiatric Rates
Mila Todd stated that credentialing with Bronson Hospital continues, and contract development is underway. A report for Fiscal Year 2022 was compiled showing utilization by CMHSP. This report was sent to the Operations Committee. Regional Provider Network and Regional Finance Committee to meet to discuss Autism Provider and Inpatient Psychiatric rates.

Youth Cases
Brad Casemore reviewed history of MI KIDS Now. SWMBH and DHHS met to discuss collaboration with DHHS including analyzing data and services to ensure best services for youth along with roles and responsibilities of DHHS, PIHPs and CMHSPs. Discussion followed.

Wakely
Brad Casemore stated that Michigan Consortium for Healthcare Excellence is working with Wakely regarding Milliman/DHHS statewide PIHP rates.

Other
The group agreed to invite Farah Hanley via Teams to September OC meeting. Michelle will arrange this.

Adjourned
Meeting adjourned at 12:18 pm

Section: **Provider Network Management**	Policy Name: **Credentialing & Re-Credentialing: Behavioral Health Practitioners**	Policy Number: **02.02**
Owner: **Chief Compliance & Privacy Officer**	Reviewed By: **Mila Todd**	Total Pages: **10**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **Other (please specify):** _____	Final Approval By: **Approved by SWMBH Board**	Date Approved:
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/14**

Policy: Southwest Michigan Behavioral Health (SWMBH), its participant Community Mental Health Service Providers (CMHSP), and network organizational providers with contractual credentialing responsibilities will ensure the credentialing and re-credentialing of behavioral health practitionerswhom they employ, contract with, and who fall within their scope of authority. The credentialing process will be completed in compliance 42 CFR 422.204 and MDHHS Credentialing and Recredentialing standards. Practitioners may not provide care for SWMBH members until they have been credentialed in accordance with this policy.

SWMBH and its participant CMHSPs will not discriminate against any provider solely on the basis of race, ethnic/national identity, gender, age, sexual orientation, licensure, registration or certification. SWMBH and its participant CMHSPs will not discriminate against health care professionals who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

Purpose: To ensure that all customers receiving services within the SWMBH Region receive care from practitioners who are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network ManagementParticipant CMHSPs Network Providers

Responsibilities: SWMBH Provider Network Management, Participant CMHSPs, and network providers mustfollow the below requirements as it relates to practitioner credentialing activities.

Definitions:

A. Practitioner: A professional who provides health care services within the scope of practice that he/she is legally authorized to do so by the State in which he or she delivers the services.

Standards and Guidelines:

A. **Practitioner Types Requiring Credentialing**

1. Credentialing will be completed for all practitioners as required by this policy and all applicable Michigan and Federal laws. Specifically, the following types of practitioners will be credentialed:
   a. Physicians (M.D.s or D.O.s)
   b. Physician Assistants
   c. Psychologists (Licensed, Limited License, and Temporary License),
   d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
   e. Licensed Professional Counselors
   f. Board Certified Behavior Analysts
   g. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
   h. Occupational Therapists and Occupational Therapist Assistants
   i. Physical Therapists and Physical Therapist Assistants
   j. Speech Pathologists
   k. Licensed Marriage and Family Therapists
   l. Other behavioral healthcare specialists licensed, certified, or registered by the State

B. **Timeframes for Credentialing and Re-Credentialing Individual Practitioners**

1. Initial credentialing of individual practitioners applying for inclusion in the SWMBH network must be completed within 90 calendar days.
   a. The 90-day timeframe starts when SWMBH or the participant CMHSP has received a completed, signed and dated credentialing application from the individual practitioner.
   b. The completion time is the date written communication is sent to the individual practitioner notifying them of SWMBH or the participant CMHSP's decision.
   c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. Re-credentialing shall occur at least every two (2) years.

C. **Initial Credentialing Process**

1. Practitioners requesting inclusion in the SWMBH provider network will complete the current SWMBH Individual Practitioner Credentialing Application, with signed and dated attestations regarding:
   a. lack of present illegal drug use;
   b. history of loss of license, registration, certification, and/or any felony convictions;
   c. any history of loss or limitation of privileges or disciplinary action;
   d. accuracy and completeness of information in the application;
   e. ability to perform the essential functions of the position with or without accommodation; and

f. consent allowing verification of license, education, competence and any other related information.

2. Credentialing staff will verify information obtained in the credentialing application as described below. Copies of verification sources will be maintained in the practitioner credentialing file. When source documentation is not electronically dated, staff will initial and date with the current date.
3. Credentialing criteria for physicians and practitioners, and verification methods, are as follows:

Credentialing Criteria	**Verification Method(s)**
Current valid and unrestricted license to practice in the state in which the practitioner practices	• Verification of the license will be made directly with state licensing agency internet web site (LARA website for the state of Michigan http://w3.lara.state.mi.us/free/)
A valid and unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) for those practitioners who prescribe medication.	• A DEA or CDS may be verified by a copy of the DEA or CDS certificate provided by the practitioner, with the state licensing agency via internet website, or the National Information Service (NTIS) database.
(If a practitioner's DEA certificate is pending, the practitioner may make arrangements with a participating practitioner to write all prescriptions requiring a DEA number until the practitioner has a valid DEA certificate and the practitioner will provide documentation of such arrangement in writing.)	
Work history for the past five years, with each gap in work history of six (6) months or more clarified in writing from the practitioner.	• Work history is verified through practitioner's credentialing application. • Gaps in work history of six (6) months or more must be explained in writing.

Board certification, or education appropriate to license and area of practice.	• Verification of education shall be completed through primary source verification to the educational institution or certification board. Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education. If a practitioner is not board certified, verification of the medical education at the highest level is verified. • The American Medical Association (AMA) or American Osteopathic Association (AOA) Master Files may be used as the source for education verification for physicians. • The Educational Commission for Foreign Medical Graduates (ECFMG) may be used to verify education of foreign physicians educated after 1986 (for practitioners who are not board certified and verification of completion of a residency program or graduation from a foreign medical school are not verifiable with the primary source). • LARA license may be used in lieu of official transcript of graduation form an accredited school.
Current professional liability insurance meeting the standards defined by contract.	• Copy of current certificate of insurance.

Credentialing Criteria	Verification Method(s)
No malpractice lawsuits and/or judgments or settlements from within the last five (5) years.	• A query to the National Practitioner Data Bank (NPDB) will be completed via web-based access to the NPDB site for each practitioner. The NPDB query contains malpractice history which was reported by malpractice carriers to the NPDB. • A written description of any malpractice lawsuits and/or judgments from the last five (5) years will be provided either by the practitioner or their malpractice carrier.
The practitioner must not be excluded from participation in Medicare, Medicaid, or other federal contracts, and is not excluded from participation through the MDHHS Sanctioned Provider list.	• Queries will be made to the System for Award Management (SAM), the Office of Inspector General (OIG), and the MDHHS Sanctioned Provider list to ensure that practitioners have not been suspended or debarred from participation with Medicare, Medicaid or other Federal contracts (initial credentialing). • Queries will be made monthly thereafter as part of on-going monitoring and for re-credentialing purposes.
No state sanctions or restrictions on licensure in the past ten (10) years.	• Verification of the license will be made directly with state licensing agency internet web site (LARA website for the state of Michigan http://w3.lara.state.mi.us/free/)

D. **Re-credentialing Process.**

1. Re-credentialing will be completed at least every two (2) years. The Credentialing Committee may recommend re-credentialing for a lesser period of time.
2. Every practitioner will complete or update the current SWMBH Practitioner Credentialing Application and related materials required for the re-credentialing process. Additionally, the practitioner will provide the relative information supporting any changes in their credentials. The application will be processed by the credentialing staff.
3. Re-credentialing criteria and application processing includes review of the re-credentialing application for completeness and accuracy. Primary source verification and re-credentialing criteria for physicians and practitioners is as previously outlined in Section C.3. above, with the exception of the following:
   a. Education, Training and Work History: Education and Training are considered 'static' and no re-verification is conducted during re-credentialing. However, work history may change and will be re-verified.
   b. Board Certification will be re-verified.
   c. The practitioner is required to sign and date the attestation statement attesting to the

correctness and completeness of the application. The practitioner is required to sign any relevant addenda concerning the following:

i. the reasons for inability to perform essential functions,
ii. lack of present illegal drug use,
iii. history of loss of license,
iv. history of loss or limitation of privileges,
v. current malpractice coverage that was not provided with the re- credentialing application and signed attestation.

d. Quality information and member complaint data will be considered at re-credentialing. This includes but is not limited to grievances and appeals, recipient rights complaints, customer services complaints, and compliance-related issues including fraud/waste/abuse.
e. To ensure quality and safety of care between credentialing cycles, SWMBH performs on-going monitoring of the following, in accordance with SWMBH Policy 2.18:
   i. Member complaints, adverse events, and information from quality improvement activities related to identified instances of poor quality,
   ii. Any incidences of Medicaid and Medicare sanctions and,
   iii. Restrictions and/or sanctions on licensure and/or certification.

E. **Temporary/Provisional Credentialing Process**

1. Temporary or provisional status can be granted one time to practitioners until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.
2. **Timeframes.**
   a. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below.
   b. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.
   c. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.
3. **Requirements.**
   a. Providers seeking temporary or provisional status must complete and sign the current approved SWMBH Practitioner Credentialing Application, including attestations regarding:
      i. Lack of present illegal drug use;
      ii. History of loss of license, registration, certification, and/or felony convictions;
      iii. Any history of loss or limitation of privileges or disciplinary action;
      iv. The accuracy and completeness of the application.
   b. SWMBH and/or participant CMHSPs shall perform verification from primary sources of:
      i. Current valid license or certification, in good standing.
      ii. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
      iii. Official transcript of graduation from an accredited school and/or LARA license.

iv. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
   a. Minimum five (5) year history of professional liability claims resulting in a judgment of settlement;
   b. Disciplinary status with regulatory board or agency; and
   c. Medicare/Medicaid sanctions and exclusions.

v. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

c. SWMBH/Participant CMHSPs shall evaluate the individual practitioner's work history for the prior five (5) years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.

4. SWMBH/Participant CMHSPs shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

F. **Credentialing Reciprocity (Deemed Status).**

1. **Out of Region.** SWMBH and its participant CMHSPs may accept credentialing activities conducted by any other Region in lieu of completing its own credentialing activities. If SWMBH chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the SWMBH/Participant CMHSP credentialing file.
2. **In Region.** SWMBH and its participant CMHSPs shall work collaboratively to reduce the burden on shared network providers (providers that contract with two or more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/recredentialing through a single participant CMHSP or SWMBH, and that those credentialing/recredentialing results are shared with the Region.
3. **Reciprocity Procedure.** When accepting credentialing activities performed by another Region or another in-Region entity, SWMBH and its participant CMHSPs shall follow the SWMBH Procedure 02.03.01 – Credentialing Reciprocity.

G. **Practitioner Right for Request for Review**

1. The Applicants Rights for Credentialing and Re-credentialing will be included in the initial credentialing packet sent to Applicants applying to be providers in the SWMBH provider network.
2. Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact the credentialing staff via telephone, in writing or email as to the status oftheir application.
3. Applicants have the right to review the information submitted in support of their credentialing application. This review is at the applicant's request. The following information is excluded from a request to review information:
   a. Southwest Michigan Behavioral Health is not required to provide the applicant with information that is peer-review protected.
   b. Information reported to the National Practitioner Data Bank (NPDB).
   c. Criminal background check data.
4. Should the information provided by the applicant on their application vary substantially from the information obtained and/or provided to SWMBH/participant CMHSPs by other individuals or organizations contacted as part of the credentialing and/or re-credentialing process, credentialing staff will contact the applicant within 180 days from the date of the signed attestation and authorization statement to advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is erroneous.
5. The applicant will submit any corrections in writing within fourteen (14) calendar days to the credentialing staff. Any additional documentation will be date stamped and kept as part of the applicant's credentialing file.

H. **Credentialing Decisions**

1. Credentialing decisions shall be made in accordance with SWMBH policies 02.02 (Clean Credentialing & Re-Credentialing Files) and 02.05 (Credentialing Committee, Confidentiality of Credentialing Records, & Provider Nondiscrimination). Practitioners not selected for inclusion in the network will be given written notice of the reason for the decision.
2. SWMBH and/or participant CMHSPs shall notify an individual practitioner that is denied credentialing or re-credentialing of the reason(s) for the adverse credentialing decision in writing within thirty (30) days of the decision. This written adverse credentialing decision notification must include information on the appeal process available to the practitioner, in accordance with SWMBH Policy 2.14.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

I. **Reporting Requirements.**

1. **Routine.**
   a. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.

b. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS-PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.

2. **Ad hoc.**
   a. Participant CMHSPs shall promptly report to SWMBH's Director of Provider Network information about an organizational provider which could result in suspension or termination from the SWMBH network, including but not limited to:
      i. Known improper conduct (e.g. fraud, threats to member health and safety, etc.);
      ii. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13;
      iii. Any other information that may affect the practitioner's status as a SWMBH network provider.
   b. SWMBH shall report any known improper conduct of an individual practitioner which could result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, AG, provider's governing board, etc.).

Procedures: 02.03.01 Credentialing Reciprocity

Effectiveness Criteria: N/A

References: 42 CFR § 438.214 (a-e)
MDHHS-PIHP Contract Schedule A, Section 1(N)(1)
MDHHS BPHASA Credentialing and Recredentialing Processes
Public Act 218 as amended by Act 59 section 400.734b
42 FR 422.204
SWMBH Policy 2.18
SWMBH Policy 10.13

Attachments: 02.02A Applicant Credentialing Rights

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	5/10/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
5	01/10/20	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
6	09/28/21	Paragraph G	Added Reporting Requirements	Mila Todd
7	11/12/21	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
8	02/14/23	Multiple	Revised entire policy to be consistent with updated MDHHS Credentialing Process.	Mila Todd
9	03/17/23	N/A	Reviewed by Regional PNM Committee.	Mila Todd
10	10/13/23	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board

Section: Provider Network Management	Policy Name: **Credentialing & Re-Credentialing: Organizational Providers**	Policy Number: **02.03**
Owner: **Director of Provider Network Management**	Reviewed By: **Mila Todd**	Total Pages: **8**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **Other (please specify):** _____	Final Approval By: **Approved by SWMBH Board**	Date Approved:
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/14**

Policy: Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (CMHSPs) will credential and re-credential behavioral health organizational providers with whom they contract and that fall within their scope of authority and action. Neither SWMBH nor its participant CMHSPs will discriminate against any provider solely on the basis of licensure, registration or certification. Neither SWMBH nor its participant CMHSPs will discriminate against health care professionals or organizations who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

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

Scope: SWMBH Provider Network ManagementParticipant CMHSPs Network Providers

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

Definitions: Organizational provider: An entity that directly employs and/or contracts with individuals to provide health care services. Examples of organizational providers include, but are not limited to, community mental health services programs (CMHSPs); hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance use disorder programs; and home health agencies

Standards and Guidelines:

A. **Process for Credentialing and Re-Credentialing Organizational Providers**

1. Initial credentialing of all organizational providers applying for inclusion in the SWMBH network must be completed within 90 calendar days.
    a. The 90-day time frame starts when SWMBH or the participant CMHSP has received a completed, signed and dated credentialing application from the organizational provider.
    b. The completion time is the date when written communication is sent to the organizational provider notifying them of SWMBH or the participant CMHSP's decision.
    c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. During initial credentialing and at re-credentialing, SWMBH or participant CMHSPs will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding the inclusion on the SWMBH Provider Network. Packets will be reviewed for completeness prior to committee meeting. If files meet clean file criteria in every category listed, the medical director or designee may sign off to approve the provider, in lieu of taking to Credentialing Committee.
3. During initial credentialing and at re-credentialing, SWMBH and its participant CMHSPs will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision, the organizational provider will be notified of the reason(s) in writing and of their right to and process for appealing/disputing the decision in accordance with SWMBH Policy 2.14.

B. **Organizational Provider Assignments**

1. SWMBH is responsible for credentialing/recredentialing the following organizational provider types, on behalf of the Region:
    a. Substance Use Disorder
    b. Psychiatric Inpatient
    c. Crisis Residential
    d. Autism Services
    e. Financial Management Services
    f. Specific Specialized Residential service providers as determined by the Regional Provider Network Management Committee
2. Participant CMHSPs are responsible for credentialing/recredentialing all other organizational provider types for inclusion in each participant CMHSP subcontracted network of providers.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

C. **Requirements for Credentialing and Re-Credentialing Organizational Providers**

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require organizational providers wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application.
2. The application will contain the following:

a. A signed and dated statement from an authorized representative.
b. Documentation collected and verified for organizational providers will include (as applicable), but are not limited to, the following information:

Documentation Requirement	Clean File Criteria
Complete application with a signed and dated statement from an authorized representative of the organizational provider attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization for SWMBH or CMHSP to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure or certification information. License/certification status and any violations or special investigations thereof incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license/certification violations and no special state investigations in timeframe (in past five years for initial credentialing and past two years for re-credentialing).
Accreditation by a national accrediting body (if such accreditation has been obtained). Substance abuse treatment providers are required to be accredited. If an organization is not accredited, an on-site quality review will occur by SWMBH or CMHSP provider network staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction for an on-site pre-credentialing site review. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, NCQA, CHAPS, COA, and AOA.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgments from within the last five (5) years.
Verification that the organization and any individuals listed as a "Screened Person" under SWMBH Policy 10.13 have not been excluded from participation in Medicare, Medicaid, or other Federal contracts, and are not excluded from participation through the MDHHS Sanctioned Provider list.	Organization and its "Screened Persons" are not listed as sanctioned and/or excluded by the OIG, the System for Award Management (SAM), or the Michigan Sanctioned Provider list (for initial credentialing). Queries will be made monthly thereafter as part of on-going

	monitoring and for re-credentialing. Provider and its Screened Persons must not have been listed as excluded during any month since the prior credentialing activity (re-credentialing).
A copy of the organization's liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.
Any other information necessary to determine if the organization meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of organization.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals, recipient rights, and customer services complaints are within the expected threshold given the provider size; there are no substantiated fraud; MMBPIS and other performance indicators substantially meet set standards (if applicable).

D. **Temporary/Provisional Credentialing Process**

a. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.

b. **Timeframes.**

i. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below.

ii. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.

iii. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.

c. **Requirements.**

i. Providers seeking temporary or provisional status must complete the current approved SWMBH Organizational Credentialing Application, signed and dated by an authorized representative.

ii. SWMBH and/or Participant CMHSPs shall perform verification from primary sources of:

1. Current valid license or certification and in good standing as necessary to operate in the State of

Michigan.

2. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following:
    a. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement; and
    b. Disciplinary status with regulatory board or agency.
3. Medicare/Medicaid sanctions (OIG, SAM, and Michigan Sanctioned Provider lists)

iii. SWMBH and/or Participant CMHSPs shall evaluate the organizational provider's continuing operation as a provider for the prior five (5) years. Gaps in operation of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.

d. SWMBH/Participant CMHSPs shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

E. **Credentialing Reciprocity (Deemed Status).**

a. **Out of Region.** SWMBH and its participant CMHSPs may accept credentialing activities conducted by any other Region in lieu of completing its own credentialing activities. If SWMBH chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the SWMBH/Participant CMHSP credentialing file.

b. **In Region.** SWMBH and its participant CMHSPs shall work collaboratively to reduce the burden on shared network providers (providers that contract with two are more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/recredentialing through a single participant CMHSP or SWMBH, and that those credentialing/recredentialing results are shared with the Region.

c. **Reciprocity Procedure.** When accepting credentialing activities performed by another Region or another in-Region entity, SWMBH and its participant CMHSPs shall follow the SWMBH Procedure 02.03.01 – Credentialing Reciprocity.

F. **Site Reviews and Quality Assessments**

a. Initial Credentialing.

i. On-site reviews must be performed prior to initial credentialing/contracting for the following:
    1. Non-accredited organizational providers that are not solely community-based; and
    2. Specialized Residential sites (homes).
        a. The Specialized Residential parent organization's accreditation does not eliminate the requirement for an on-site review of each specialized residential site (home).

ii. For solely community-based providers (e.g. ABA or CLS in private residences), an on-site review is not required. An alternative quality assessment shall be performed in lieu of an on-site review. The alternative quality assessment shall be performed prior to initial credentialing/contracting.

iii. SWMBH and its participant CMHSPs may accept on-site reviews performed by another Region as part of Credentialing Reciprocity.

b. Re-credentialing

i. The most recent annual site review/monitoring results shall be reviewed during the re-credentialing process.
ii. The following information will be reviewed as part of the Quality checks during recredentialing:
    1. Grievances and appeals;
    2. Recipient Rights complaints;
    3. Customer Services complaints;
    4. Compliance-related issues including fraud/waste/abuse;
    5. If applicable, status of MMBPIS and other performance indicators.
iii. SWMBH and its participant CMHSPs will perform on-going monitoring of network providers in accordance with SWMBH Policy 2.18 – Ongoing Monitoring of Network Practitioners and Organizations.

G. **Organizational Provider credentialing of its direct employees and contractors.**

a. Organizational providers may be held responsible for credentialing and re-credentialing their direct employees and subcontracted professional service providers per SWMBH or SWMBH participant CMHSP contractual requirements.
b. Organizational providers shall maintain written credentialing/re-credentialing policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements.
c. Organizational providers shall perform credentialing/re-credentialing activities in accordance with applicable contractual requirements, SWMBH policies and procedures, MDHHS policies and procedures, and any other applicable requirements.
d. SWMBH or a participant CMHSP shall verify through annual on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

H. **Reporting Requirements.**

a. **Routine.**
    i. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.
    ii. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS-PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.
b. **Ad hoc.**
    i. Participant CMHSPs shall promptly report to SWMBH's Director of Provider Network information about an organizational provider which could result in suspension or termination from the SWMBH network, including but not limited to:
        1. known improper conduct (e.g. fraud, threats to member health and safety, etc.);
        2. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13;
        3. Any other information that may affect the organizational provider's status as a SWMBH network provider.
    ii. SWMBH shall report any known improper conduct of an organizational provider which could

result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, MI AG, provider's governing board, etc.).

Procedures: SWMBH Operating Procedure 2.03.01 Credentialing Reciprocity

Effectiveness Criteria: N/A

References:

MDHHS-PIHP Contract Schedule A, Section 1(N)(1)
MDHHS BPHASA Credentialing and Re-Credentialing Processes
BBA § 438.214
SWMBH Policy 2.18

Attachments:

2.03A SWMBH Organizational Credentialing Application
2.03B SWMBH Organizational Credentialing Checklist

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	12/1/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
5	01/10/20	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
6	09/28/21	Paragraph E	Added Reporting Requirements	Mila Todd
7	11/12/21	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
8	02/10/23	Multiple	Revised entire policy to ensure alignment with revised MDHHS Credentialing Policy, and to add specificity around Quality checks and Reciprocity process.	Mila Todd
9	03/17/23	N/A	Reviewed by Regional PNM Committee	Mila Todd
10	10/13/23	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board

Southwest Michigan Behavioral Health
CORPORATE COMPLIANCE PLAN

Approved by SWMBH Board of Directors
10~~1~~/12~~1~~/2023~~2~~

Mila C. Todd
SWMBH Chief Compliance Officer

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ORGANIZATIONAL STRUCTURE

Southwest Michigan Behavioral Health (SWMBH) serves as both the Medicaid Prepaid Inpatient Health Plan (PIHP) and Coordinating Agency (effective no later than 10/1/14) for the following eight county region:

Barry County:	Barry County Community Mental Health Authority;
Berrien County:	Berrien Mental Health Authority d/b/a Riverwood Center;
Branch County:	Branch County Community Mental Health Authority, d/b/a Pines Behavioral Health Services;
Calhoun County:	Calhoun County Community Mental Health Authority, d/b/a Summit Pointe;
Cass County:	Cass County Community Mental Health Authority d/b/a Woodlands Behavioral Healthcare Network;
Kalamazoo County:	Kalamazoo County Community Mental Health Authority d/b/a Integrated Services of Kalamazoo;
St. Joseph County:	~~Community Mental Health and Substance Abuse Services of~~ St. Joseph County Community Mental Health Authority d/b/a Pivotal;
Van Buren County:	Van Buren Community Mental Health Authority

The Participant community mental health authorities have elected to configure SWMBH under the Michigan Mental Health Code Section 3301.1204b. It is also a selected participant Region for the Medicare-Medicaid Eligibles (MME) Demonstration effective July 1, 2014.

- **SWMBH as the PIHP**
  SWMBH serves as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the region with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory and contractual obligations related to the applicable waiver(s) and MDHHS contract(s). The role of SWMBH as the PIHP is defined in federal statute, specifically 42 CFR 438 and the MDHHS/PIHP Contract.

  SWMBH is the contracting entity for Medicaid contracts with MDHHS and Medicare behavioral health contracts with the Integrated Care Organizations (ICO), Aetna Better Health of Michigan and Meridian Health Plan. Contracts include Medicaid 1115 Demonstration Waiver, 1915(c)/(i) Specialty Supports and Services, the Healthy Michigan Program, the Flint 1115 Waiver, Substance Use Disorder Community Grant Programs, and/or other(s).

- **SWMBH as the Coordinating Agency**
  Beyond a Medicaid role, SWMBH also serves as the Coordinating Agency (CA) for member counties with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory and contractual obligations related to that role and its contracts. SWMBH, as a designated CA, manages SAPT Block Grant funds, other federal/state non-Medicaid SUD funds, and PA2 liquor tax funds.

SWMBH: MISSION, VISION AND VALUES

Philosophy:
"Excellence through Partnership."

Mission:
*"SWMBH strives to be Michigan's pre-eminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success.***"**

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

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

The Vision of SWMBH is to ensure persons with specialty care needs reside in their own community, have a quality and healthy lifestyle, and are fully accepted.

Values:
- Customer Driven
- Person-Centered
- Recovery Oriented
- Evidenced-Based
- Integrated Care
- Trust
- Integrity
- Transparency
- Inclusive
- Accessibility
- Acceptability
- Impact
- Value
- Culturally Competent & Diverse Workforce
- High Quality Services
- Regulatory Compliance

OVERVIEW

This Corporate Compliance Plan documents SWMBH's approach to assuring that federal and state regulatory and contractual obligations related to compliance of the Prepaid Inpatient Health Plan (PIHP) are fulfilled.

The SWMBH Corporate Compliance Plan addresses SWMBH's regulatory compliance obligations as a Prepaid Inpatient Health Plan (PIHP) and how, where it has obligations, it will oversee the PIHP functions it delegates to the Participant Community Mental Health Service Providers (CMHSP). SWMBH's Corporate Compliance Program is designed to further SWMBH's commitment to comply with applicable laws, promote quality performance throughout the SWMBH region, and maintain a working environment for all SWMBH personnel that promotes honesty, integrity and high ethical standards. SWMBH's Corporate Compliance Program is an integral part of SWMBH's mission, and all SWMBH personnel, Participant CMHSPs and contracted and sub- contracted Providers are expected to support the Corporate Compliance Program. SWMBH's Compliance Plan is comprised of the following principal elements as outlined in the Federal Sentencing Guidelines:

1) The development and distribution of written standards of conduct, as well as written policies and procedures, that promote SWMBH's commitment to compliance and that address specific areas of potential fraud;
2) The designation of a Chief Compliance Officer and other appropriate bodies, (e.g., a Corporate Compliance Committee), charged with the responsibility and authority of operating and monitoring the compliance program;
3) The development and implementation of regular, effective education and training programs for all affected employees;
4) The development of effective lines of communication between the Chief Compliance Officer and all employees, including a hotline to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect callers from retaliation;
5) The use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas within delivered services, claims processing and managed care functions;
6) The development of disciplinary mechanisms to consistently enforce standards and the development of policies addressing dealings with sanctioned and other specified individuals; and
7) The development of policies to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to Government authorities when appropriate.

SWMBH's Corporate Compliance Program is committed to the following:

- Minimizing organizational risk and improving compliance with the service provision, documentation, and billing requirements of Medicaid and Medicare;

- Maintaining adequate internal controls throughout the region and provider network;
- Encouraging the highest level of ethical and legal behavior from all employees and providers;
- Educating employees, contract providers, board members, and stakeholders on their responsibilities and obligations to comply with applicable local, state, and federal laws; and
- Providing oversight and monitoring functions.

There are numerous laws that affect the regulatory compliance of SWMBH and its provider network; however, in formalizing the PIHP's compliance program, the legal basis of the SWMBH compliance program centers around four key laws and statutes:

- **The Affordable Care Act** (2010) This Act requires the PIHP to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste and abuse across the PIHP's provider network. All programs funded by the PIHP including CMHSPs, sub- contracted provider organizations and practitioners, board members and others involved in rendering PIHP covered services fall under the purview and scope of SWMBH's compliance program.
- **The Federal False Claims Act** This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; conspires with others to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal government (or its designated entity).
- **The Michigan False Claims Act** This Act prohibits fraud in the obtaining of benefits or payments in conjunction with the MI Medical assistance program; prohibits kickbacks or bribes in connection with the program; prohibits conspiracies in obtaining benefits or payments; and authorizes the MI Attorney General to investigate alleged violations of this Act.
- **The Anti-Kickback Statute** This Act prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the Federal government or for any good or service paid for in connection with consumer service delivery.

There are numerous Federal and State regulations that affect the SWMBH compliance program. Some of these laws not referenced above include but are not limited to:

- The Medicaid Managed Care Final Rules (42 CFR Part 438)
- The Deficit Reduction Act of 2005
- Social Security Act of 1964 (Medicare & Medicaid)

- Privacy and Security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)
- 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records
- Code of Federal Regulations
- Letters to State Medicaid Directors
- The MI Medicaid False Claims Act (Current through amendments made by Public Act 421 of 2008, effective 1/6/2009)
- Michigan Whistleblowers Act, Act 469 of 1980
- Michigan Mental Health Code and Administrative Rules
- Medical Services Administration (MSA) Policy Bulletins
- State Operations Manual
- State of Michigan PIHP contract provisions
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- Michigan State Licensing requirements
- Michigan Medical Records Act
- Civil Monetary Penalty Law of 1981
- American with Disabilities Act of 1990

The SWMBH Compliance Plan is subject to the following conditions:

A. SWMBH's Chief Compliance Officer (CCO) may recommend modifications, amendments or alterations to the written Corporate Compliance Plan as necessary and will communicate any changes promptly to all personnel and to the Board of Directors.
B. This document is not intended to, nor should be construed as, a contract or agreement and does not grant any individual or entity employment or contract rights.

APPLICATION OF COMPLIANCE PLAN

SWMBH is a regional PIHP and as such, this Plan is intended to address SWMBH's function as a PIHP. It is the intent of SWMBH that the scope of all its compliance policies and procedures should promote integrity, support objectivity and foster trust throughout the service region. This Plan applies to all SWMBH operational activities and administrative actions, and includes those activities that come within federal and state regulations relating to PIHPs. SWMBH personnel are subject to the requirements of this plan as a condition of employment. All SWMBH personnel are required to fulfill their duties in accordance with SWMBH's Compliance Plan, human resource and operational policies, and to promote and protect the integrity of SWMBH. Failure to do so by SWMBH personnel will result in discipline, up to and including termination of employment depending on the egregiousness of the offense. Disciplinary action may also be taken against a supervisory employee who directs or approves an employee's improper conduct, is aware of the improper conduct and does not act appropriately to correct it, or who fails to properly exercise appropriate supervision over an employee.

SWMBH directly and indirectly, through its Participant CMHSPs, contracts services for adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders within its eight counties (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren counties).

The PIHP Compliance Plan applies to all contracted and subcontracted providers receiving payment through SWMBH and/or through the PIHP managed care functions. All Participant CMHSPs and contracted and subcontracted providers, including their officers, employees, servants and agents, are subject to the requirements of this Plan as applicable to them and as stated within the applicable contracts. Failure to follow the SWMBH Compliance Plan and cooperate with the compliance program will result in remediation effort attempts and/or contract action, if needed. SWMBH has the responsibility of regulating, overseeing and monitoring the Medicare funds it receives specific to its participation in the dual eligibles demonstration project, and the Medicaid processes of business conducted throughout its service area. SWMBH also has the responsibility to support business practices conducted with integrity and in compliance with the requirements of applicable laws and sound business practices.

The SWMBH Corporate Compliance Plan standards and policies included or referenced herein are not exhaustive or all inclusive. All SWMBH personnel, Participant CMHSPs and providers are required to comply with all applicable laws, rules and regulations including those that are not specifically addressed in the Corporate Compliance Plan.

DEFINITIONS AND TERMS

- Compliance investigation: the observation or study of suspected fraud, abuse, waste, or reported violations of applicable laws and regulations for all SWMBH-administered funding streams by close examination and systematic inquiry.
- Abuse: means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)
- Fraud (Federal False Claims Act): means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2)
- Fraud (MI Medicaid False Claims Act): Michigan law permits a finding of Medicaid fraud based upon "constructive knowledge." This means that if the course of conduct reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake. (Public Act 421 of 2008, effective 1/6/2009)
- Waste: means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

- Participant CMHSPs**:** Participant CMHSPs hold a subcontract with SWMBH to provide supports and services to adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders to Plan Members and to perform various delegated managed care functions consistent with SWMBH policy. "Participant CMHSPs" includes the agency itself as well as those acting on its behalf, regardless of the employment or contractual relationship.
- Contracted Providers: substance abuse, MI Health Link and other Providers throughout the SWMBH region with which SWMBH directly holds a contract to provide Medicaid covered mental health and substance abuse services.
- Subcontracted Providers: various Providers throughout the SWMBH region that contract directly with one or more of the Participant CMHSPs to provide covered mental health and substance abuse services.
- Medicare Funds: when Medicare or Medicare funds are referenced in this Compliance Plan, the related activities are limited to services covered by SWMBH Medicare funds received due to its participation in the dual eligibles demonstration project.

SECTION I - CODE OF CONDUCT

- SWMBH Personnel and Board of Directors Code of Conduct

  In order to safeguard the ethical and legal standards of conduct, SWMBH will enforce policies and procedures that address behaviors and activities within the work setting, including but not limited to the following:

  1) Confidentiality: SWMBH is committed to protecting the privacy of its consumers. Board members and SWMBH personnel are to comply with the Michigan Mental Health Code, Section 330.1748, 42 CFR Part 2 relative to substance abuse services, and all other privacy laws as specified under the Confidentiality section of this document.
  2) Harassment: SWMBH is committed to an environment free of harassment for Board members and SWMBH personnel. SWMBH will not tolerate harassment based on sex, race, color, religion, national origin, citizenship, chronological age, sexual orientation, or any other condition, which adversely affects their work environment. SWMBH has a strict non-retaliation policy prohibiting retaliation against anyone reporting suspected or known compliance violations.
  3) Conflict of Interest: SWMBH Board members and personnel will avoid any action that conflicts with the interest of the organization. All Board members and personnel must disclose any potential conflict of interest situations that may arise or exist. SWMBH will maintain standards establishing a clear separation of any supplemental employment in terms of private practice and outside employment from activities performed for SWMBH.
  4) Reporting Suspected Fraud: SWMBH Board members and personnel must report any suspected or actual "fraud, abuse or waste" (consistent with the

definitions as set forth in this Plan) of any SWMBH funds to the organization.

5) Culture: SWMBH Board members, Executive Officer and management personnel will establish at SWMBH, and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations. SWMBH will assist Participant CMHSPs, contracted and subcontracted providers in adopting practices that promote compliance with Medicare and Medicaid fraud, abuse and waste program requirements. The SWMBH Compliance Plan and program will be enforced consistently.
6) Delegation of Authority: SWMBH Board members, Executive Officer and management personnel will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.
7) Excluded Individuals: SWMBH will perform or cause to be performed criminal records checks on potential SWMBH personnel, and shall avoid placing untrustworthy or unreliable employees in key positions. In addition, SWMBH will consult the OIG Cumulative Sanctions List, the System for Award Management, and the Michigan Department of Health and Human Services List of Sanctioned Providers to determine whether any current or prospective SWMBH Board members or personnel have been excluded from participation in federal health care programs.
8) SWMBH Board members and SWMBH personnel are expected to participate in compliance training and education programs.
9) SWMBH Board members and SWMBH personnel are expected to cooperate fully in any investigation.
10) Reporting: All SWMBH Board members and SWMBH personnel have the responsibility of ensuring the effectiveness of the organization's Compliance Program efforts by actively participating in the reporting of suspected violations of the Compliance Plan or policies, and the standards stated in this Code of Conduct.
11) Gifts From Consumers/Members: SWMBH personnel are prohibited from soliciting tips, personal gratuities or gifts from members or member families. Additionally, SWMBH personnel are prohibited from accepting gifts or gratuities of more than nominal value. SWMBH generally defines "nominal" value as $25.00 per gift or less. If a member or other individual wishes to present a monetary gift of more than nominal value, he or she should be referred to the Executive Officer.
12) Gifts Influencing Decision-Making: SWMBH personnel will not accept from anyone gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting SWMBH might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, customer/member, government official or other person by any SWMBH personnel or

SWMBH is absolutely prohibited. Any such conduct should be reported immediately to the CCO, or through the SWMBH corporate compliance hotline at (800) 783-0914.

13) Gifts from Existing Vendors: SWMBH personnel may accept gifts from vendors, suppliers, contractors or other persons that have nominal values as defined in SWMBH financial and compliance policies. SWMBH expects SWMBH personnel to exercise good judgment and discretion in accepting gifts. If any SWMBH personnel have any concerns regarding whether a gift should be accepted, the person should consult with his or her supervisor. SWMBH personnel will not accept excessive gifts, meals, expensive entertainment or other offers of goods or services, which has a more than a nominal value as defined in SWMBH financial and compliance policies.
14) Vendor Sponsored Entertainment: At a vendor's invitation, SWMBH personnel may accept meals or refreshments of nominal value at the vendor's expense. Occasional attendance at local theater or sporting events, or similar activity at a vendor's expense may also be accepted provided that, a business representative of the vendor attends with SWMBH personnel. Such activities are to be reported to the Chief Compliance Officer by SWMBH personnel.
15) Purchasing and Supplies: It is the policy of SWMBH to ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

    All subcontractor and supplier arrangements will be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors will be selected based on objective criteria including quality, technical excellence, price, delivery, and adherence to schedules, services and maintenance of adequate sources of supply. Purchasing decisions will be made on the supplier's ability to meet needs and not on personal relationships or friendships. SWMBH will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of purchasing activities.
16) Marketing: Marketing and advertising practices are defined as those activities used by SWMBH to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. SWMBH will present only truthful, fully informative and non-deceptive information in any materials or announcements. All marketing materials will reflect available services.

    The federal Anti-kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay,

solicit, or receive "remuneration" as an inducement to generate business compensated by Medicare and Medicaid programs. Therefore, all direct- to-consumer marketing activities require advance review by the Compliance Committee or designee if the activity involves giving anything of value directly to a consumer.

17) Financial Reporting: SWMBH shall ensure integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law, and shall be recorded in conformity with generally accepted accounting principles or any other applicable criteria.

    All financial reports, accounting records, research reports, expense accounts, time sheets and other documents will accurately and clearly represent the relevant facts or the true nature of a transaction. No undisclosed or unrecorded funds or assets will be established for any purpose.

    SWMBH will not tolerate improper or fraudulent accounting, documentation, or financial reporting. SWMBH personnel have a duty to make reasonable inquiry into the validity of financial information reporting. In addition to employee discipline and termination, SWMBH may terminate the contractual arrangement involving any contracted provider due to fraudulent accounting, documentation, or financial reporting.

    SWMBH shall develop internal controls and obtain an annual independent audit of financial records; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete documentation; and shall maintain accountability of assets.

18) Third Party Billing and Governmental Payers: SWMBH is committed to truthful billing that is supported by complete and accurate documentation. SWMBH personnel may not misrepresent charges to, or on behalf of, a consumer or payer.

    SWMBH must comply with all payment requirements for government-sponsored programs. All SWMBH personnel must exercise care in any written or oral statement made to any government agency. *SWMBH will not tolerate false statements by SWMBH personnel to a governmental agency.* Deliberate misstatements to governmental agencies or to other payers will expose the individual to potential criminal penalties and termination.

19) Responding to Government Investigations: SWMBH will fully comply with the law and cooperate with any reasonable demand made in a governmental investigation as outlined and specified in the SWMBH Compliance and Program Integrity Operating Policy 19.9, *Response To Government Investigations*. SWMBH personnel may not conceal, destroy,

or alter any documents, lie or make misleading statements to governmental representatives. SWMBH personnel may not aid in any attempt to provide inaccurate or misleading information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of the law.

It is crucial that the legal rights of SWMBH personnel and SWMBH are protected. If any SWMBH personnel receives an inquiry, a subpoena, or other legal documents requiring information about SWMBH business or operation, whether at home or in the workplace, from any government agency, SWMBH requests that the person notify SWMBH's Executive Officer or the Chief Compliance Officer immediately.

SWMBH will distribute the Code of Conduct to all SWMBH personnel upon hire who shall certify in writing that they have received, read, and will abide by the organization's Code of Conduct. In addition to the Code of Conduct, all SWMBH personnel will be familiar with and agree to abide by all SWMBH operational and human resources policies and procedures as well as the employee handbook. All operational and human resources policies and procedures and the employee handbook are available to SWMBH personnel through the SWMBH intranet and the shared drive.

- Participant CMHSP and Contracted and Subcontracted Provider Relationships

  It is the policy of SWMBH to ensure that all direct and subcontracted provider contractual arrangements are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers we serve. In order to ethically and legally meet all standards, SWMBH will strictly adhere to the following:

  1) SWMBH does not receive or provide any inducement for referrals. Consumer referrals and intakes will be accepted based on the consumer's needs, eligibility, and SWMBH's ability to provide the services needed.
  2) No employee, Participant CMHSP, or contracted or subcontracted provider, or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers.
  3) SWMBH does not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician's ability to provide services to state and federal health care program beneficiaries.
  4) SWMBH does not enter into contractual relationships with individuals or agents/agencies that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs. Reasonable and prudent background investigations will be completed prior to entering into contractual relationships with all individuals and agents/agencies. SWMBH will consult the National Practitioner Data

Bank and the OIG Cumulative Sanctions List to determine whether any current or prospective Participant CMHSPs or contracted or subcontracted Providers have been excluded from participation in federal health care programs.

5) All Participant CMHSP, contracted and subcontracted provider personnel have the responsibility of ensuring the effectiveness of SWMBH's Compliance Program efforts by actively participating in the reporting of suspected violations of the Compliance Plan or policies, and the standards stated in this Code of Conduct consistent with SWMBH compliance policies.

Participant CMHSPs and contracted and subcontracted providers will be required to comply with the SWMBH Code of Conduct or provide evidence of a sufficient Code of Conduct of their own. If complying with the SWMBH Code of Conduct, Participant CMHSPs and contractual providers will receive a copy of the Code of Conduct at the time of the initial contract and will be required to certify in writing that they have received, read, and will abide by SWMBH's Code of Conduct for inclusion in the contractor file. Participant CMHSPs and contracted or subcontracted providers having developed their own Code of Conduct will be required to provide evidence of such for inclusion in the contractor file. Participant CMHSPs and contracted and subcontracted providers will be familiar with and agree to abide by the SWMBH Compliance Plan and all applicable policies and procedures as incorporated into relevant contracts. All policies and procedures are available to the Participant CMHSPs, contracted, and subcontracted providers via the SWMBH Internet Website at www.swmbh.org. Participant CMHSPs and contracted and subcontracted providers are responsible for monitoring and staying informed of regulatory developments independent of SWMBH Compliance Program efforts.

- All SWMBH personnel, Participant CMHSPs, contracted and subcontracted providers will refrain from conduct that may violate the Medicare and Medicaid anti-kickback, false claims or physician self-referral laws and regulations. A false claim includes the following: billing for services not rendered; misrepresenting services actually rendered; falsely certifying that certain services were medically necessary; or submitting a claim for payment that is inconsistent with or contrary to Medicaid payment requirements. In general, these laws prohibit:

  - Submission of false, fraudulent or misleading claims for payment, the knowing use of a false record or statement to obtain payment on false or fraudulent claims paid by the United States government, or the conspiracy to defraud the United States government by getting a false or fraudulent claim allowed or paid. If the claims submitted are knowingly false or fraudulent then the False Claims Act has been violated;
  - Knowingly and willfully making false representation to any person or entity in order to gain or retain participation in the Medicaid program or to obtain payment for any service from the United States government;

- A physician (or immediate family member of the physician) who has a financial relationship with an entity from referring a Medicaid patient to the entity for the provision of certain "designated health services" unless an exception applies; or an entity from billing an individual, third party payer, or other entity for any designated health services provided pursuant to a prohibited referral; and
- Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application (claim) for benefits or payments under a Federal health care program.

SECTION II - CHIEF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

SWMBH EO will designate a Chief Compliance Officer (CCO), who will be given sufficient authority to oversee and monitor the Compliance Plan, including but not limited to the following:

- Recommending revisions/updates to the Compliance Plan, policies, and procedures to reflect organizational, regulatory, contractual and statutory changes.
- Reporting on a regular basis the status of the implementation of the Compliance Plan and related compliance activities.
- Assuring and/or coordinating compliance training and education efforts for SWMBH personnel, Participant CMHSPs and contracted and subcontracted providers.
- Assuring continuing analysis, technical expertise and knowledge transmission of corporate compliance requirements and prepaid health plan performance in keeping with evolving federal requirements and MDHHS contractual obligations and standards.
- Coordinating internal audits and monitoring activities outlined in the compliance work plan.
- Performing or causing to be performed risk assessments, verification audits, and on-site monitoring consistent with the approved annual PIHP compliance work plan(s) intended to reduce the risk of criminal conduct at SWMBH, Participant CMHSPs, contracted and subcontracted providers.
- Ensure coordinating efforts with Human Resources, Provider Network Management, and other relevant departments regarding employee certifications/licensures, background checks, and privileging and credentialing.
- Developing and modifying policy and programs that encourage the reporting of suspected fraud and other potential problems without fear of retaliation.
- Independently investigating and acting on matters related to compliance.
- Drafting and maintaining SWMBH Board and executive reports including annual Compliance Program Evaluation and bi-annual Board compliance reports.

The authority given the CCO will include the ability to review all SWMBH, Participant CMHSP, contracted and subcontracted provider Medicare (specific to the Medicare funds received for participation in the dual eligible demonstration project), Medicaid and ABW

documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records and contracts and obligations of SWMBH, consistent with applicable contract provisions.

SWMBH maintains and charters a Corporate Compliance Committee that oversees the implementation and operation of the SWMBH Compliance Plan. The Corporate Compliance Committee reviews reports and recommendations made by the SWMBH CCO regarding compliance activities. This includes data regarding compliance generated through audits, monitoring, and individual reporting. Based on these reports, the Chief Compliance Officer will make recommendations to the Executive Officer regarding the efficiency of the SWMBH Compliance Plan and program**.** The Corporate Compliance Committee will be chaired by the CCO and will consist of members appointed by the EO of SWMBH, which can include:

- Executive Officer (EO) of SWMBH or his/her designee;
- Chief Compliance Officer/Privacy Officer;
- Chief Information Officer;
- Member Services Coordinator;
- Director of Performance Improvement Program;
- Directors of Clinical functional areas;
- Chief Administrative Officer;
- Provider Network Manager;
- Chief Financial Officer; and
- Participant CMHSP CEO

Specific responsibilities of the Corporate Compliance Committee include:

- Regularly reviewing compliance program policies to ensure they adequately address legal requirements and address identified risk areas;
- Assisting the CCO with developing standards of conduct and policies and procedures to promote compliance with the Compliance Plan;
- Analyzing the effectiveness of compliance education and training programs;
- Reviewing the compliance log for adequate and timely resolution of issues and/or inquiries;
- Assisting the CCO in identifying potential risk areas, advising and assisting the CCO with compliance initiatives, identifying areas of potential violations, and recommending periodic monitoring/audit programs ;
- Assisting in the development of policies to address the remediation of identified problems;
- Receiving, interpreting, and acting upon reports and recommendations from the CCO;
- Evaluating the overall performance of the Compliance Program and making recommendations accordingly; and
- Providing a forum for the discussion of ethical issues related to entity business functions.

SECTION III - COMPLIANCE TRAINING AND EDUCATION

Proper and continuous training and education of SWMBH personnel at all levels is a significant element of an effective compliance program. Therefore, SWMBH will establish a regular training program consistent with applicable compliance policies that covers the provisions of the Code of Conduct, as well as the processes for obtaining advice and reporting misconduct. Training is provided upon hire for new employees; annual and periodic retraining is provided to existing SWMBH personnel and, as applicable, independent contractors.

SWMBH Board members and personnel will be scheduled to receive SWMBH's compliance program training on the Compliance Plan and Code of Conduct at orientation or within thirty (30) days of employment. Tailored training may be required for employees involved in specific areas of risk and the CCO will coordinate and schedule this as needed and will supplement with training and/or newsletters, e-mails and in- services. Records will be maintained on all formal training and educational activities. Training is considered a condition of employment and failure to comply will result in appropriate disciplinary action.

Upon employment, all SWMBH personnel will be provided a written copy of the Plan; staff signature (Compliance Certification Form Attachment A) acknowledges that the staff received:

- Corporate Compliance Orientation
- A copy of the Code of Conduct
- A copy of the SWMBH Corporate Compliance Plan

The Compliance Certification Forms will be maintained in the Program Integrity and Compliance Office. Modifications to the Plan will be distributed to all personnel after revisions have been approved by the SWMBH Compliance Committee and accepted by the Board of Directors.

A copy of the Plan will be kept on file by the CCO and maintained at SWMBH's corporate office. The SWMBH Corporate Compliance Plan can also be accessed on the shared drive of SWMBH's network, and on the SWMBH Internet Website at www.swmbh.org.

- Initial training: The Chief Compliance Officer shall ensure the scheduling and documentation of initial trainings for all SWMBH personnel regarding SWMBH's Corporate Compliance Plan. Training sessions may include, but are not limited to face-to-face educational presentations or videotapes. Subsequent compliance instruction will occur annually.

- Continuing Education: The CCO shall review and circulate periodic information to the Corporate Compliance Committee regarding any health care fraud issues as received from the Office of Inspector General (OIG), the Department of Health and Human Services (DHHS), and other updated compliance materials. The CCO shall ensure current mandates are instituted in both initial and refresher

education/training that will assist in answering personnel questions related to modifications in either federal or state edicts. Continued compliance training will be documented in electronic format. These training sessions are obligatory, personnel initiated, or instituted upon request of the supervisor. Failure to participate in mandatory training session(s) will result in verbal/written reprimand, suspension, or termination of employment as deemed appropriate by SWMBH's EO. The CCO will be available to all personnel to answer questions regarding modifications of governmental guidelines.

- Regulations: It is the responsibility of SWMBH personnel to maintain job specific certifications and/or licensing requirements, proficiencies, and competencies set forth by the State of Michigan licensing body.

  Training and educational opportunities related to compliance may be made available by SWMBH to Participant CMHSPs, contracted and subcontracted provider staff, as well as consumers and others as appropriate. Participant CMHSPs, contracted and subcontracted providers are expected to provide the following minimum compliance training annually to all staff and agents working on their behalf:
  - Establish and review policies and procedures that provide detailed information about the Federal False Claims Act;
  - Establish and review policies and procedures that provide detailed information about the MI State False Claims Act;
  - Review administrative, civil and criminal remedies for false claims and statements under both the Federal and State False Claims Act;
  - Establish and review agency policies/procedures relating to prevention of fraud, waste and abuse; and
  - Establish and review agency policies and procedures relating to whistleblower provisions and non-retaliation protections.

  SWMBH reserves the right to review all compliance related training materials used by Participant CMHSPs covering the elements noted above in order to ensure compliance with contractual requirements.

SECTION IV - COMPLIANCE REPORTING AND ONGOING COMMUNICATION

All SWMBH Board members and personnel must be familiar with applicable federal and state laws and regulations as well as SWMBH policies and procedures. Any SWMBH Board member and personnel that know, or has reason to believe, that an employee of, or independent professional providing services to, SWMBH is not acting in compliance with federal and state laws and regulations should report such matters to the CCO consistent with the applicable compliance policy. Reporting of suspected violations may be accomplished through a verbal, written, or anonymous report using the following mechanisms:

- SWMBH Telephone Hot Line – Suspected compliance violations or questions can be made to a toll-free hot line. The number is (800) 783-0914 and includes confidential voice mail.
- SWMBH Electronic Mail (E-Mail) – Suspected compliance violations or questions can be sent electronically via e-mail to the mila.todd@swmbh.org or swmbhcompliance@swmbh.org.
- Mail Delivery – Suspected compliance violations or questions can be mailed to:
  Southwest Michigan Behavioral Health
  Attn: Chief Compliance Officer
  5250 Lovers Lane, Suite 200
  Portage, MI 49002
- In Person - Suspected compliance violations or questions can be made in person to SWMBH's CCO at the above address.

Whistleblower Protections for SWMBH Personnel

Employees who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, as more fully described below.

Under the *Federal False Claims Act* and the *Michigan Medicaid False Claims Act*, employees who report violations in good faith are entitled to protection from disciplinary actions taken by their employer.

The *Federal False Claims Act*, 31 USC §§3729 through 3731, provides for administrative remedies, encourages enactment of parallel State laws pertaining to civil and criminal penalties for false claims and statements, and provides "whistle-blower" protection for those making good faith reports of statutory violations.

Under the *Michigan Medicaid False Claims Act*, an employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding or court action under this act or because the employee cooperates with or assists in an investigation under this act. This prohibition does not apply to an employment action against an employee who the court finds: (i) brought
a frivolous claim, as defined in section 2591 of the revised judicature act of 1961, 1961 PA 236, MCL §600.2591; or, (ii) planned, initiated, or participated in the conduct upon

which the action is brought; or, (iii) is convicted of criminal conduct arising from a violation of that act.

An employer who takes action against an employee in violation of the *Michigan Medicaid False Claims Act* is liable to the employee for all of the following:
1. Reinstatement to the employee's position without loss of seniority;
2. Two times the amount of lost back pay;
3. Interest on the back pay;
4, Compensation for any special damages; and,
5. Any other relief necessary to make the employee whole.

Under the *Federal False Claims Act*, any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

Partly because of their status as primary contracted agents performing delegated managed care functions and in order to minimize regional risk and harm, Participant CMHSPs will report suspected compliance issues within three business days or less to the SWMBH Chief Compliance Officer when one or more of the following criteria are met:

1) During an inquiry by the Participant CMHSP compliance officer there is determined to be (reasonable person standard) Medicare (for a Duals Demonstration beneficiary) or Medicaid fraud, abuse, or waste as defined by federal statute, CMS, HHS OIG and applicable Michigan statute or regulation; or
2) Prior to any self-disclosure to any federal or state of Michigan Medicare (for a Duals Demonstration beneficiary) or Medicaid authority. In no way is this intended to nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations; or
3) When a Participant CMHSP knows or (reasonable person standard) suspects that an action or failure to take action in the organization or its contractors would result in the improper application or improper retention of Medicaid funds.

   Participant CMHPs shall undertake fraud, waste and abuse prevention, detection, and surveillance measures per contractual obligations and industry standards.

They are encouraged to independently assure that claims, encounters, other data and financial submissions to SWMBH are complete, accurate and timely on an ongoing basis. They are encouraged to update financial reports and encounter submissions consistent with this approach.

SECTION V - COMPLIANCE AUDITING, MONITORING AND RISK EVALUATION

The SWMBH CCO is responsible for monitoring compliance activities and operations within SWMBH. The CCO must then report any determinations of noncompliance to the Executive Officer, the Corporate Compliance Committee, and SWMBH's Board of Directors. The CCO will identify, interpret and determine standards of compliance through internal audit and monitoring functions and external audits. The CCO shall prepare an Annual Auditing and Monitoring Plan for EO and Corporate Compliance Committee review and input.

Monitoring and Auditing: SWMBH believes that a thorough and ongoing evaluation of the various aspects of SWMBH's Compliance Plan is crucial to its success. In order to evaluate the effectiveness of the Plan, SWMBH will employ a variety of monitoring and auditing techniques, including but not limited to, the following:

- Periodic interviews with personnel within SWMBH, Participant CMHSPs, and contracted and subcontracted providers regarding their perceived levels of compliance within their departments or areas of responsibilities;
- Questionnaires developed to poll personnel within SWMBH, Participant CMHSPs, contracted and subcontracted providers regarding compliance matters including the effectiveness of training/education;
- Information gained from written reports from SWMBH compliance staff utilizing audit and assessment tools developed to track all areas of compliance;
- Audits designed and performed by internal and/or external auditors utilizing specific compliance guidelines;
- Investigations of alleged noncompliance reports as described in SWMBH Compliance Operating Policy 10.8 – *Compliance Reviews and Investigations for Reporting*; and
- Exit interviews with departing SWMBH employees.
- Participant CMHSPs, contracted and subcontracted providers are encouraged to perform auditing and monitoring functions involving Medicare and Medicaid covered services through their own compliance program efforts.

The SWMBH CCO, legal counsel, Corporate Compliance Committee, and as appropriate, other SWMBH personnel will take actions to ensure the following:

- Access to and familiarity with the latest HHS OIG compliance guidelines and current enforcement priorities; and

- Assessment of the baseline risk of any significant issues regarding non- compliance with laws or regulations in accordance with SWMBH's Compliance Plan.

The CCO is also responsible to ensure a risk assessment is performed annually with the results integrated into the daily operations of the organization.

SECTION VI - ENFORCEMENT OF COMPLIANCE POLICIES AND STANDARDS

Corrective action shall be imposed as a means of facilitating the overall SWMBH Compliance Plan goal of full compliance. Corrective action plans should assist SWMBH personnel, Participant CMHSPs, contracted and subcontracted providers to understand specific issues and reduce the likelihood of future noncompliance. Corrective action, however, shall be sufficient to address the particular instance of noncompliance and should reflect the severity of the noncompliance. The following Corrective Action Plan Guidelines are to be used with SWMBH Personnel, Participant CMHSPs, contracted and subcontracted providers:

Violation	Possible Disciplinary Action
Knowingly and willfully committing fraud and/or violation of a federal or state billing or documentation practice(s). Knowingly and willfully providing false or misleading information in a compliance context to SWMBH, governmental agency, consumer or MDHHS. [E.g. billing for services not performed, forging documentation or signatures, upcoding, kickbacks, bribes]	First Offense for SWMBH Personnel: Immediate termination of employment. First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Termination of subcontract or provider contract. All related remuneration and/or funds will be recouped by SWMBH.
Unknowingly violating federal or state billing or documentation practice(s).	First Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon CCO/human resources judgment up to and including: written reprimand for personnel file, mandatory compliance refresher training, individual counseling with manager and Chief Compliance Officer, probation, etc. Second Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon EO. First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Written notice of noncompliance for contract file, mandatory compliance

	training approved by SWMBH Corporate Compliance Committee or provided by SWMBH CCO, Corrective Action Plan to be submitted to the SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from Medicare and Medicaid service provision or administrative activity. All related remuneration and/or funds will be recouped by SWMBH. Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.
Knowingly violating policies and/or procedures as set forth in the Compliance Plan.	First Offense for SWMBH Personnel: Written reprimand for personnel file, individual counseling with manager and Chief Compliance Officer, and placed on 60-day probation. Second Offense for SWMBH Personnel: Unpaid suspension and possible termination. First Offense for Participant CMHSP, Contracted and Subcontracted Providers: Written notice of noncompliance for contract file, Corrective Action Plan to be submitted to SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from Medicare and Medicaid service provision or administrative activity. Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.
Detection of, but, failure to report or failure to detect substantive violations of federal and state mandates in duties where a	First Offense for SWMBH Personnel: Written reprimand for personnel file, mandatory compliance refresher training,

reasonable person could be expected to detect violation(s).	individual counseling with manager and Chief Compliance Officer, and placed on 60-day probation. Second Offense for SWMBH Personnel: Suspension and possible termination. First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Written notice of noncompliance for contract file, mandatory compliance training approved by SWMBH Corporate Compliance Committee or provided by SWMBH CCO, Corrective Action Plan to be submitted to SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from Medicare and Medicaid service provision or administrative activity. Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.

Basis for Participant CMHSP, Contracted or Subcontracted Provider Corrective Action: Monitoring and auditing, and reports of questionable practices may form the basis for imposing corrective action.

Elements of a Participant CMHSP, Contracted or Subcontracted Provider Corrective Action Plan: As appropriate given the nature of the noncompliance, a corrective action plan submitted to SWMBH for approval shall include:

- A description of how the issue(s) identified was immediately corrected OR the reason the issue(s) cannot be immediately corrected (i.e. the consumer has been discharged).
- A description of the steps to be put into place to prevent the issue(s), or a similar issue(s), from occurring again (i.e. staff training, process redesign, etc.)
- A description of the quality assurance program put into place for monitoring purposes to ensure the corrective action plan is effective and/or similar issues do not occur.

SECTION VII - CONFIDENTIALITY AND PRIVACY

SWMBH is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in the current published Privacy Notice. Any Board member, SWMBH personnel, or contracted or subcontracted provider who engages in unauthorized disclosure of consumer information is subject to disciplinary action which may result in removal from the Board, termination of employment, or termination of the contract.

To ensure that all consumer information remains confidential, SWMBH personnel and contracted and subcontracted providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA privacy regulations outlined below:

- Privacy Notice - SWMBH will have a Notice of Privacy Practices to be given to each consumer at intake and to be further available upon request.
- Consent - Prior to treatment, Participant CMHSPs and contracted and subcontracted providers will obtain a signed consumer consent for permission to treat, bill for and carry out health care operations described in the Privacy Notice.
- Authorization - If consumer Protected Health Information is disclosed to an individual or entity outside of SWMBH, a signed authorization will be obtained from the consumer consistent with the HIPAA Privacy Rule, MI Mental Health Code, and 42 CFR Part 2 requirements.
- Business Associate Agreement – SWMBH will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements..
- SWMBH shall investigate any reports of suspected violations and respond to findings of the investigations in compliance with the HIPAA Privacy and Security regulations.
- SWMBH will perform any necessary risk analyses or assessments to ensure compliance.

All SWMBH Board members, SWMBH personnel, Participant CMHSPs, and contracted and subcontracted providers must conduct themselves in accord with the principle of maintaining the confidentiality of consumers' information in accordance with all applicable laws and regulations, including but not limited to the Michigan Mental Health Code, the Privacy and Security Regulations issued pursuant to HIPAA and recent updated HITECH revisions, and 42 CFR Part 2 as it relates to substance abuse records. All will refrain from disclosing any personal or confidential information concerning members unless authorized by laws relating to confidentiality of records and protected health information. If specific questions arise regarding the obligation to maintain the confidentiality of information or the appropriateness of releasing information, SWMBH Board members, SWMBH personnel, and Participant CMHSPs should seek guidance from the Chief Compliance Officer/Chief Privacy Officer (the Chief Compliance Officer also fulfills the role of Chief Privacy Officer), or anonymously through the SWMBH corporate compliance hotline at (800) 783-0914.

SWMBH PERSONNEL COMPLIANCE CERTIFICATION FORM

1) I have received, read and understand the SWMBH Compliance Plan, Code of Conduct, and related policies and procedures.
2) I pledge to act in compliance with and abide by the Code of Conduct and SWMBH Compliance Plan during the entire term of my employment and/or contract.
3) I acknowledge that I have a duty to report to the Chief Compliance Officer any alleged or suspected violation of the Code of Conduct, agency policy, or applicable laws and regulations.
4) I will seek advice from my supervisor or the Chief Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct or Compliance Plan.
5) I understand that failure to comply with this certification or failure to report any alleged or suspected violation of the Code of Conduct or Compliance Plan may result in disciplinary action up to and including termination of employment or contract.
6) I agree to participate in any future compliance trainings as required and acknowledge my attendance at such trainings as a condition of my continued employment/contract.
7) I agree to disclose the existence and nature of any actual or potential conflict of interest to the Chief Compliance Officer. Further, I certify that I am not aware of any current, undisclosed conflicts of interest.

_____ _____

Employee/Provider/Contractor Signature Date

SWMBH BOARD OF DIRECTORS COMPLIANCE CERTIFICATION FORM

1) I have received, read and understand the SWMBH Compliance Plan and Code of Conduct.
2) I pledge to act in compliance with and abide by the Code of Conduct and SWMBH Compliance Plan during the entire term of my Board service.
3) I acknowledge that I have a duty to report to the SWMBH Chief Compliance Officer any alleged or suspected violation of the Code of Conduct or related laws and regulations by myself, another Board Member or any other person.
4) I will seek advice from the SWMBH Board Chairman or the SWMBH Chief Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct or Compliance Plan.
5) I understand that failure to comply with any part of this certification may result in my removal from the Board of Directors.
6) I agree to participate in future Board compliance trainings as required
7) I agree to disclose the existence and nature of any actual or potential conflict of interest to the Board Chairman and Chief Compliance Officer. Further, I certify that I am not aware of any current, undisclosed conflicts of interest.

_____ _____

Board Member Signature Date

Table 7—Indicator-Specific Review Findings and Designations for Southwest Michigan

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs.	The PIHPs were not required to report a rate for this indicator.	NA
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#6	The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R

Performance Indicator		Key Review Findings	Indicator Designation
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Southwest Michigan Behavioral Health
PMV Date:	July 12, 2023
Reviewers:	Emily Redman and Tiffany Gardiner

Data Integration and Control Element	Met	Not Met	NA	Comments
Accuracy of data transfers to assigned performance indicator data repository				
The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance indicator data repository used to keep the data until the calculations of the performance indicators have been completed and validated.	☒	☐	☐	
Samples of data from performance indicator data repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations				
The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate.	☒	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	☒	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database.	☒	☐	☐	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer.	☒	☐	☐	
If the PIHP uses a performance indicator data repository, its structure and format facilitates any required programming necessary to calculate and report required performance indicators.				
The performance indicator data repository's design, program flow charts, and source code enables analyses and reports.	☒	☐	☐	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	NA	Comments
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate.	☒	☐	☐	
Prescribed data cutoff dates are followed.	☒	☐	☐	
The PIHP retains copies of files or databases used for performance indicator reporting in case results need to be reproduced.	☒	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance indicator data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix B. Denominator and Numerator Validation Findings

Reviewer Worksheet

PIHP Name:	Southwest Michigan Behavioral Health
PMV Date:	July 12, 2023
Reviewers:	Emily Redman and Tiffany Gardiner

Denominator Validation Findings for Southwest Michigan				
Audit Element	**Met**	**Not Met**	**NA**	**Comments**
For each of the performance indicators, all members of the relevant populations identified in the specifications are included in the population from which the denominator is produced.	☒	☐	☐	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance indicators.	☒	☐	☐	
The PIHP correctly calculates member months and member years if applicable to the performance indicator.	☐	☐	☒	Member month and member year calculations were not applicable to the indicators under the scope of the audit.
The PIHP properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and applied as specified in each performance indicator.	☒	☐	☐	
If any time parameters are required by the specifications for the performance indicator, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
Exclusion criteria included in the performance indicator specifications are followed.	☒	☐	☐	
Systems or methods used by the PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not applicable to the indicators under the scope of the audit.

Numerator Validation Findings for Southwest Michigan				
Audit Element	**Met**	**Not Met**	**NA**	**Comments**
The PIHP uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
The PIHP avoids or eliminates all double-counted members or numerator events.	☒	☐	☐	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☒	☐	☐	
If any time parameters are required by the specifications for the performance indicator, they are followed (i.e., the indicator event occurred during the period specified or defined in the specifications).	☒	☐	☐	

Board Ends Metric 8: Motion Requested – The Ends Metric is Met

2023 CCBHC Program Customer Satisfaction Surveys collected by SWMBH represent an 85% First Year *"in agreement"* Satisfaction rate average across all categories measured.

July 14, 2023, Board meeting inaccurately stated SWMBH had not met the metric.

Statement made: We did not achieve 85% across all categories measured, the metric reads "average across all categories measured."

The rated average across all categories measured is above 85%.

Mental Health Statistics Improvement Program	
Satisfaction	89.0%
Access	87.0%
Quality-Appropriateness and Participation	92.0%
Outcomes and Functioning	78.0%
Social Connectedness	84.0%
Average	**86.0%**

Youth Services Survey	
Satisfaction & Apporpriateness	87.0%
Access	89.0%
Participation in Treatment	92.0%
Outcomes	83.0%
Social Connectedness	89.0%
Cultural Sensitivity	98.0%
Average	**89.7%**

Average of Both MHSIP & YSS	**88.0%**

Board Ends Metric 10: Motion Requested – The Ends Metric is Met

2023 HSAG Performance Measure Validation (PMV) Audit Results and Improvement Strategies

Deliverable/Goal: All standards or corrective action plans reviewed, will receive a score of 90% compliance, or designation that the standard has been “Met” or “Accepted” or SWMBH will be within the *top 2* scoring Michigan PIHP’s

Board Ends Metric 11: Motion Requested
The Ends Metric is Partially Met

SWMBH will achieve CCBHC Demonstration Year 1 Quality Bonus Payment Metrics (QBP's), against the States FY23 indicated Benchmarks.

.5 points for each metric achieved
5 of 6 points earned

For CCBHC's that did not meet all benchmarks for QBP measures, the potential distribution amount was added to a QBP Redistribution pool.

A CCBHC was eligible for equal distribution from the pool if they submitted their clinic reported metric templates by the due date.

Metrics	Benchmark	ISK	Pivotal
Child and Adolescent Major Depressive Disorder; Suicide Risk Assessment *(SRA-BHC)*	23.90%	36.12%	74.90%
Major Depressive Disorder, Suicide Risk Assessment *(SRA-A)*	12.50%	71.02%	68.89%
Adherence to Antipsychotic Meds for Individuals with Schizophrenia *(SAA-*	58.50%	53.61%	52.70%
Follow-up after Hosp. for mental illness, ages 18+ *(FUH-AD)*	58.00%	73.29%	79.27%
Follow-up after Hospitalization for Children *(FUH-CH)*	70.00%	82.35%	80.77% *
Initiation and Engagement of Alcohol and other drugs *(IET-BH1)*	25.00%	43.25%	39.46%

* Pivotal's denominator for FUH-CH was 26 – minimum is 30

	ISK	Pivotal
Redistribution Award Amount	$ 940,606.33	$940,606.33
QBP Potential Award (5% of CCBHC Medicaid Costs)	$1,986,685.47	$288,640.37

	E	F	I	J	K	L
1	***Southwest Michigan Behavioral Health***					
2	For the Fiscal YTD Period Ended 9/30/2024			**FY24 Budget - DRAFT-**		
3	*(For Internal Management Purposes Only)*					
4	***INCOME STATEMENT***		**FY24 Budget Current Status**	**FY23 Budget**	**FY 23 Projection**	**Change FY23B v FY23P Fav/(Unfav)**
5						
6	**REVENUE**					
18	Contract Revenue		379,638,294	336,854,697	350,212,151	13,357,454
19	DHHS Incentive Payments		501,957	605,208	530,550	(74,658)
20	Grants and Earned Contracts		-	-	-	-
21	Interest Income - Working Capital		573,177	21,304	603,428	582,123
22	Interest Income - ISF Risk Reserve		102,887	1,062	188,293	187,230
23	Local Funds Contributions		1,289,352	1,289,352	1,289,352	-
24	Other Local Income		-	-		-
25						
26	**TOTAL REVENUE**		**382,105,668**	**338,771,623**	**352,823,773**	**14,052,149**
27						
28	**EXPENSE**					
29	**Healthcare Cost**					
30	Provider Claims Cost		24,396,146	26,636,779	28,131,874	1,495,094
31	CMHP Subcontracts, net of 1st & 3rd party		316,381,585	269,531,195	289,852,078	20,320,883
32	Insurance Provider Assessment Withhold (IPA)		3,790,852	3,589,470	3,806,202	216,732
33	Medicaid Hospital Rate Adjustments		5,963,797	2,067,450	4,893,504	2,826,054
35						
36	**Total Healthcare Cost**		**350,532,380**	**301,824,894**	**326,683,658**	**24,858,764**
37	**Medical Loss Ratio (HCC % of Revenue)**		**92.2%**	**89.4%**	**93.1%**	
38						
40	Purchased Professional Services		538,500	644,000	367,419	(276,581)
41	Administrative and Other Cost		11,033,143	12,005,555	9,294,859	(2,710,696)
43	Depreciation		5,723	5,723	5,150	(572)
44	Functional Cost Reclassification		-	-	-	-
45	Allocated Indirect Pooled Cost		-	-	0	0
46	Delegated Managed Care Admin		22,429,220	16,660,888	21,885,174	5,224,286
47	Apportioned Central Mgd Care Admin		(0)	0	(0)	(0)
48						
49	**Total Administrative Cost**		**34,006,586**	**29,316,166**	**31,552,602**	**2,236,436**
50	**Admin Cost Ratio (MCA % of Total Cost)**		**8.8%**	**8.9%**	**8.8%**	
51						
52	Local Funds Contribution		1,289,352	1,289,352	1,289,352	-
54						
55	**TOTAL COST after apportionment**		**385,828,318**	**332,430,412**	**359,525,611**	**27,095,200**
56						
57	**NET SURPLUS before settlement**		**(3,722,650)**	**6,341,212**	**(6,701,839)**	**(13,043,051)**
58	**Net Surplus (Deficit) % of Revenue**		**-1.0%**	**1.9%**	**101.9%**	**201.9%**
60	Prior Year Savings		9,769,410	17,316,482	22,226,918	4,910,436
61	Change in PA2 Fund Balance		(123,852)	(549,040)	(317,817)	231,222
62	ISF Risk Reserve Abatement (Funding)		(102,887)	(1,062)	(188,293)	(187,230)
63	ISF Risk Reserve Deficit (Funding)		-	-		-
64	CCBHC Supplemental Reciveable (Payable)		6,592	0	(471,530)	(471,530)
65	Settlement Receivable / (Payable)		0	(7,839,568.00)	0	7,839,568
66	**NET SURPLUS (DEFICIT)**		**5,826,612**	**15,268,024**	**14,547,439**	**(720,585)**
67	*HMP & Autism is settled with Medicaid*					

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			*Mos in Period*									
5	**FY24 Budget**			12									
6	*(For Internal Management Purposes Only)*			*ok*									
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**Pivotal**	**Van Buren MHA**
8													
9	***Medicaid Specialty Services***			*HCC%*		56.9%	73.8%	60.5%	53.9%	87.1%	87.2%	74.6%	86.0%
10	Subcontract Revenue		236,657,617	26,822,317	209,835,300	**8,580,145**	**41,092,052**	**10,368,906**	**37,461,297**	**14,196,903**	**61,112,443**	**12,842,726**	**24,180,829**
11	Incentive Payment Revenue		501,957	255,563	246,394	-	-	96,394	150,000	-	-	-	-
12	**Contract Revenue**		**237,159,575**	**27,077,881**	**210,081,694**	**8,580,145**	**41,092,052**	**10,465,300**	**37,611,297**	**14,196,903**	**61,112,443**	**12,842,726**	**24,180,829**
13													
14	External Provider Cost		196,041,340	5,291,664	190,749,676	5,826,478	39,568,219	9,569,735	33,846,018	12,092,631	64,463,463	9,027,585	16,355,546
15	CMHSP Internal Cost		21,800,064	-	21,800,064	621,050	2,540,524	655,054	(2,165,669)	4,937,344	3,729,970	3,561,603	7,920,188
16	SSI Reimb, 1st/3rd Party Cost Offset		(604,710)	-	(604,710)	-	(443,210)	-	-	-	-	-	(161,500)
17	Insurance Provider Assessment Withhold (IPA)		5,838,653	5,838,653	-	-	-	-	-	-	-	-	-
19	**Total Healthcare Cost**		**223,075,347**	**11,130,317**	**211,945,030**	**6,447,528**	**41,665,533**	**10,224,790**	**31,680,349**	**17,029,975**	**68,193,433**	**12,589,188**	**24,114,234**
20	**Medical Loss Ratio (HCC % of Revenue)**		**94.1%**	**41.1%**	**100.9%**	**75.1%**	**101.4%**	**97.7%**	**84.2%**	**120.0%**	**111.6%**	**98.0%**	**99.7%**
21													
22	**Managed Care Administration**		**26,928,434**	**6,757,659**	**20,170,775**	**1,259,766**	**3,412,270**	**1,169,903**	**4,841,772**	**1,370,133**	**4,656,059**	**910,563**	**2,550,309**
23	**Admin Cost Ratio (MCA % of Total Cost)**		**10.8%**	**2.7%**	**8.1%**	**16.3%**	**7.6%**	**10.3%**	**13.3%**	**7.4%**	**6.4%**	**6.7%**	**9.6%**
24													
25	**Contract Cost**		**250,003,781**	**17,887,976**	**232,115,805**	**7,707,294**	**45,077,803**	**11,394,693**	**36,522,121**	**18,400,108**	**72,849,492**	**13,499,751**	**26,664,543**
26	**Net before Settlement**		**(12,844,206)**	**9,189,905**	**(22,034,111)**	**872,851**	**(3,985,751)**	**(929,393)**	**1,089,176**	**(4,203,205)**	**(11,737,049)**	**(657,025)**	**(2,483,714)**
27													
28	Prior Year Savings		7,133,727	7,133,727	-	-	-	-	-	-	-	-	-
29	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
30	Contract Settlement / Redistribution		6,915,923	(15,118,188)	22,034,111	(872,851)	3,985,751	929,393	(1,089,176)	4,203,205	11,737,049	657,025	2,483,714
31	**Net after Settlement**		**1,205,444**	**1,205,444**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
32													
33	**Eligibles and PMPM**												
34	Average Eligibles		182,355	182,355	182,355	10,091	34,298	10,758	35,395	10,670	47,729	15,030	18,384
35	Revenue PMPM		$ 108.38	$ 12.37	$ 96.00	$ 70.86	$ 99.84	$ 81.07	$ 88.55	$ 110.88	$ 106.70	$ 71.21	$ 109.61
36	Expense PMPM		$ 114.25	$ 8.17	$ 106.07	$ 63.65	$ 109.52	$ 88.27	$ 85.99	$ 143.71	$ 127.19	$ 74.85	$ 120.87
37	Margin PMPM		$ (5.87)	$ 4.20	$ (10.07)	$ 7.21	$ (9.68)	$ (7.20)	$ 2.56	$ (32.83)	$ (20.49)	$ (3.64)	$ (11.26)
38													
39	***Medicaid Specialty Services***												
40	**Budget v Actual**												
41													
42	**Eligible Lives (Average Eligibles)**												
43	Actual		182,355	182,355	182,355	10,091	34,298	10,758	35,395	10,670	47,729	15,030	18,384
44	Budget		174,379	174,379	174,379	9,423	33,008	10,297	33,586	10,237	45,533	14,354	17,941
45	Variance - Favorable / (Unfavorable)		7,976	7,976	7,976	668	1,290	461	1,809	433	2,196	676	443
46	% Variance - Fav / (Unfav)		4.6%	4.6%	4.6%	7.1%	3.9%	4.5%	5.4%	4.2%	4.8%	4.7%	2.5%
47													
48	**Contract Revenue before settlement**												
49	Actual		237,159,575	27,077,881	210,081,694	8,580,145	41,092,052	10,465,300	37,611,297	14,196,903	61,112,443	12,842,726	24,180,829
50	Budget		262,358,108	25,505,868	236,852,241	10,118,446	44,344,688	12,691,642	41,492,811	12,923,279	76,597,273	17,119,834	21,564,267
51	Variance - Favorable / (Unfavorable)		(25,198,534)	1,572,013	(26,770,547)	(1,538,301)	(3,252,636)	(2,226,342)	(3,881,514)	1,273,623	(15,484,830)	(4,277,108)	2,616,561
52	% Variance - Fav / (Unfav)		-9.6%	6.2%	-11.3%	-15.2%	-7.3%	-17.5%	-9.4%	9.9%	-20.2%	-25.0%	12.1%
53													
54	**Healthcare Cost**												
55	Actual		223,075,347	11,130,317	211,945,030	6,447,528	41,665,533	10,224,790	31,680,349	17,029,975	68,193,433	12,589,188	24,114,234
56	Budget		211,956,823	10,578,775	201,378,049	8,936,709	38,875,474	12,482,820	40,879,137	12,334,873	53,057,860	14,458,335	20,352,841
57	Variance - Favorable / (Unfavorable)		(11,118,524)	(551,542)	(10,566,982)	2,489,181	(2,790,059)	2,258,030	9,198,787	(4,695,102)	(15,135,573)	1,869,147	(3,761,393)
58	% Variance - Fav / (Unfav)		-5.2%	-5.2%	-5.2%	27.9%	-7.2%	18.1%	22.5%	-38.1%	-28.5%	12.9%	-18.5%
59													
60	**Managed Care Administration**												
61	Actual		26,928,434	6,757,659	20,170,775	1,259,766	3,412,270	1,169,903	4,841,772	1,370,133	4,656,059	910,563	2,550,309
62	Budget		22,674,019	8,572,774	14,101,244	1,128,039	3,011,327	461,035	3,133,061	1,675,271	2,680,686	571,906	1,439,920
63	Variance - Favorable / (Unfavorable)		(4,254,415)	1,815,116	(6,069,530)	(131,727)	(400,943)	(708,868)	(1,708,711)	305,138	(1,975,373)	(338,657)	(1,110,389)
64	% Variance - Fav / (Unfav)		-18.8%	21.2%	-43.0%	-11.7%	-13.3%	-153.8%	-54.5%	18.2%	-73.7%	-59.2%	-77.1%
65													
66	**Total Contract Cost**												
67	Actual		250,003,781	17,887,976	232,115,805	7,707,294	45,077,803	11,394,693	36,522,121	18,400,108	72,849,492	13,499,751	26,664,543
68	Budget		234,630,842	19,151,549	215,479,293	10,064,748	41,886,801	12,943,855	44,012,197	14,010,144	55,738,546	15,030,241	21,792,761
69	Variance - Favorable / (Unfavorable)		(15,372,939)	1,263,573	(16,636,512)	2,357,454	(3,191,002)	1,549,162	7,490,076	(4,389,964)	(17,110,946)	1,530,490	(4,871,782)
70	% Variance - Fav / (Unfav)		-6.6%	6.6%	-7.7%	23.4%	-7.6%	12.0%	17.0%	-31.3%	-30.7%	10.2%	-22.4%
71													
72	**Net before Settlement**												
73	Actual		(12,844,206)	9,189,905	(22,034,111)	872,851	(3,985,751)	(929,393)	1,089,176	(4,203,205)	(11,737,049)	(657,025)	(2,483,714)
74	Budget		27,727,266	6,354,319	21,372,948	53,698	2,457,887	(252,213)	(2,519,386)	(1,086,864)	20,858,727	2,089,593	(228,494)
75	Variance - Favorable / (Unfavorable)		(40,571,473)	2,835,586	(43,407,059)	819,153	(6,443,638)	(677,180)	3,608,562	(3,116,341)	(32,595,776)	(2,746,618)	(2,255,220)
76			-146.3%	44.6%	-203.1%	1525.5%	-262.2%	268.5%	-143.2%	286.7%	-156.3%	-131.4%	987.0%
77													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	**Southwest Michigan Behavioral Health**			*Mos in Period*									
5	**FY24 Budget**			12									
6	*(For Internal Management Purposes Only)*			*ok*									
7	**INCOME STATEMENT**		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**Pivotal**	**Van Buren MHA**
8													
78	***Healthy Michigan Plan***			*HCC%*		9.6%	4.8%	5.1%	9.5%	5.4%	9.6%	21.4%	10.8%
79	**Contract Revenue**		**48,606,904**	**3,816,412**	**44,790,492**	**2,112,999**	**9,152,971**	**1,821,578**	**8,359,346**	**3,277,600**	**12,782,455**	**2,917,132**	**4,366,411**
80													
81	External Provider Cost		25,334,482	9,901,933	15,432,549	978,989	2,308,586	805,318	4,155,989	210,740	3,742,222	1,299,518	1,931,187
82	CMHSP Internal Cost		5,600,944	-	5,600,944	49,834	407,888	52,071	1,409,321	844,980	259,637	1,465,025	1,112,188
83	SSI Reimb, 1st/3rd Party Cost Offset		-	-	-	-	-	-	-	-	-	-	-
84	Insurance Provider Assessment Withhold (IPA)		3,915,997	3,915,997	-	-	-	-	-	-	-	-	-
85	**Total Healthcare Cost**		**34,851,423**	**13,817,930**	**21,033,493**	**1,028,823**	**2,716,474**	**857,389**	**5,565,310**	**1,055,720**	**4,001,859**	**2,764,543**	**3,043,375**
86	**Medical Loss Ratio (HCC % of Revenue)**		**71.7%**	**362.1%**	**47.0%**	**48.7%**	**29.7%**	**47.1%**	**66.6%**	**32.2%**	**31.3%**	**94.8%**	**69.7%**
87													
88	**Managed Care Administration**		**3,230,311**	**971,866**	**2,258,446**	**216,280**	**154,591**	**186,793**	**766,967**	**160,966**	**273,236**	**159,667**	**339,945**
89	**Admin Cost Ratio (MCA % of Total Cost)**		**8.5%**	**2.6%**	**5.9%**	**17.4%**	**5.4%**	**17.9%**	**12.1%**	**13.2%**	**6.4%**	**5.5%**	**10.0%**
90													
91	**Contract Cost**		**38,081,734**	**14,789,796**	**23,291,938**	**1,245,103**	**2,871,065**	**1,044,182**	**6,332,277**	**1,216,686**	**4,275,095**	**2,924,210**	**3,383,320**
92	**Net before Settlement**		**10,525,170**	**(10,973,384)**	**21,498,553**	**867,896**	**6,281,906**	**777,396**	**2,027,069**	**2,060,914**	**8,507,360**	**(7,078)**	**983,091**
93													
94	Prior Year Savings		2,635,683	2,635,683	-	-	-	-	-	-	-	-	-
95	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
96	Contract Settlement / Redistribution		(9,049,669)	12,448,885	(21,498,553)	(867,896)	(6,281,906)	(777,396)	(2,027,069)	(2,060,914)	(8,507,360)	7,078	(983,091)
97	**Net after Settlement**		**4,111,184**	**4,111,184**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
98													
99	**Eligibles and PMPM**												
100	Average Eligibles		80,899	80,899	80,899	4,135	15,777	3,853	14,800	4,923	23,446	6,225	7,740
101	Revenue PMPM		$ 50.07	$ 3.93	$ 46.14	$ 42.59	$ 48.35	$ 39.40	$ 47.07	$ 55.49	$ 45.43	$ 39.05	$ 47.01
102	Expense PMPM		39.23	15.23	23.99	25.09	15.16	22.58	35.65	20.60	15.19	39.14	36.43
103	Margin PMPM		$ 10.84	$ (11.30)	$ 22.15	$ 17.49	$ 33.18	$ 16.81	$ 11.41	$ 34.89	$ 30.24	$ (0.09)	$ 10.58
104													
105	***Healthy Michigan Plan***												
106	**Budget v Actual**												
107													
108	**Eligible Lives (Average Eligibles)**												
109	Actual		80,899	80,899	80,899	4,135	15,777	3,853	14,800	4,923	23,446	6,225	7,740
110	Budget		74,889	74,889	74,889	3,793	14,729	3,546	13,688	4,485	21,571	5,873	7,204
111	Variance - Favorable / (Unfavorable)		6,010	6,010	6,010	342	1,048	307	1,112	437	1,875	352	536
112	% Variance - Fav / (Unfav)		8.0%	8.0%	8.0%	9.0%	7.1%	8.7%	8.1%	9.8%	8.7%	6.0%	7.4%
113													
114	**Contract Revenue before settlement**												
115	Actual		48,606,904	3,816,412	44,790,492	2,112,999	9,152,971	1,821,578	8,359,346	3,277,600	12,782,455	2,917,132	4,366,411
116	Budget		49,181,542	9,432,884	39,748,658	1,998,525	7,721,263	1,867,822	7,345,997	2,343,801	11,618,151	3,100,060	3,753,039
117	Variance - Favorable / (Unfavorable)		(574,638)	(5,616,472)	5,041,834	114,474	1,431,708	(46,244)	1,013,350	933,799	1,164,304	(182,928)	613,372
118	% Variance - Fav / (Unfav)		-1.2%	-59.5%	12.7%	5.7%	18.5%	-2.5%	13.8%	39.8%	10.0%	-5.9%	16.3%
119													
120	**Healthcare Cost**												
121	Actual		34,851,423	13,817,930	21,033,493	1,028,823	2,716,474	857,389	5,565,310	1,055,720	4,001,859	2,764,543	3,043,375
122	Budget		33,937,309	8,331,144	25,606,165	1,348,195	3,808,905	2,561,662	6,048,565	998,094	5,563,993	3,012,074	2,264,678
123	Variance - Favorable / (Unfavorable)		(914,114)	(5,486,786)	4,572,673	319,372	1,092,431	1,704,273	483,255	(57,626)	1,562,134	247,531	(778,697)
124	% Variance - Fav / (Unfav)		-2.7%	-65.9%	17.9%	23.7%	28.7%	66.5%	8.0%	-5.8%	28.1%	8.2%	-34.4%
125													
126	**Managed Care Administration**												
127	Actual		3,230,311	971,866	2,258,446	216,280	154,591	186,793	766,967	160,966	273,236	159,667	339,945
128	Budget		2,960,987	1,302,471	1,658,516	170,176	293,285	137,569	487,157	135,557	197,263	77,288	160,221
129	Variance - Favorable / (Unfavorable)		(269,324)	330,605	(599,930)	(46,104)	138,694	(49,224)	(279,810)	(25,409)	(75,973)	(82,379)	(179,724)
130	% Variance - Fav / (Unfav)		-9.1%	25.4%	-36.2%	-27.1%	47.3%	-35.8%	-57.4%	-18.7%	-38.5%	-106.6%	-112.2%
131													
132	**Total Contract Cost**												
133	Actual		38,081,734	14,789,796	23,291,938	1,245,103	2,871,065	1,044,182	6,332,277	1,216,686	4,275,095	2,924,210	3,383,320
134	Budget		36,898,297	9,633,615	27,264,681	1,518,371	4,102,190	2,699,230	6,535,723	1,133,651	5,761,256	3,089,362	2,424,899
135	Variance - Favorable / (Unfavorable)		(1,183,438)	(5,156,181)	3,972,743	273,267	1,231,125	1,655,049	203,446	(83,035)	1,486,161	165,152	(958,421)
136	% Variance - Fav / (Unfav)		-3.2%	-53.5%	14.6%	18.0%	30.0%	61.3%	3.1%	-7.3%	25.8%	5.3%	-39.5%
137													
138	**Net before Settlement**												
139	Actual		10,525,170	(10,973,384)	21,498,553	867,896	6,281,906	777,396	2,027,069	2,060,914	8,507,360	(7,078)	983,091
140	Budget		12,283,245	(200,731)	12,483,976	480,154	3,619,073	(831,409)	810,274	1,210,150	5,856,896	10,698	1,328,140
141	Variance - Favorable / (Unfavorable)		(1,758,075)	(10,772,653)	9,014,577	387,742	2,662,833	1,608,805	1,216,795	850,764	2,650,464	(17,776)	(345,049)
142			-14.3%	5366.7%	72.2%	80.8%	73.6%	-193.5%	150.2%	70.3%	45.3%	-166.2%	-26.0%
143													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			*Mos in Period*									
5	**FY24 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***									
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**Pivotal**	**Van Buren MHA**
8													
163	***Certified Community Behavioral Health Clin***			*HCC%*		0.0%	0.0%	0.0%	0.0%		28.6%	23.0%	
164	**Contract Revenue**		**82,331,710**	**815,165**	**81,516,544**	**8,211,618**	**11,150,736**	**6,856,400**	**18,133,214**		**27,297,101**	**9,867,475**	
165													
166	External Provider Cost		8,642,546	-	8,642,546	-	-	-	-		-	8,642,546	
167	CCBHC Internal Cost		72,539,630	-	72,539,630	7,610,231	10,646,094	5,119,093	18,838,284		30,325,928	-	
168	SSI Reimb, 1st/3rd Party Cost Offset		-	-	-	-	-	-	-		-	-	
169	**Total Healthcare Cost**		**81,182,177**	**-**	**81,182,177**	**7,610,231**	**10,646,094**	**5,119,093**	**18,838,284**		**30,325,928**	**8,642,546**	
170	**Medical Loss Ratio (HCC % of Revenue)**		**98.6%**	**0.0%**	**99.6%**	**92.7%**	**95.5%**	**74.7%**	**103.9%**		**111.1%**	**87.6%**	
171													
172	**Managed Care Administration**		**3,820,969**	**2,550,415**	**1,270,554**	**-**	**1,270,554**	**-**	**-**		**-**	**-**	
173	**Admin Cost Ratio (MCA % of Total Cost)**		**4.5%**	**3.0%**	**1.5%**	**0.0%**	**10.7%**	**0.0%**	**0.0%**		**0.0%**	**0.0%**	
174													
175	**Contract Cost**		**85,003,146**	**2,550,415**	**82,452,731**	**7,610,231**	**11,916,648**	**5,119,093**	**18,838,284**		**30,325,928**	**8,642,546**	
176	**Net before Settlement**		**(2,671,436)**	**(1,735,249)**	**(936,186)**	**601,387**	**(765,912)**	**1,737,307**	**(705,070)**		**(3,028,827)**	**1,224,929**	
177	PPS-1 Supplemental Payment Difference		-	6,592	(6,592)	-	(6,592)	-	-		0	(0)	
178	Contract Settlement / Redistribution		-	929,594	(929,594)	601,387	(759,320)	1,737,307	(705,070)		(3,028,827)	1,224,929	
179	**Net after Settlement**		**-**	**929,594**	**(929,594)**	**601,387**	**(759,320)**	**1,737,307**	**(705,070)**		**(3,028,827)**	**1,224,929**	
180													

Recommended for Board review and approval at the October 2023 SWMBH Board Meeting

BEL-006 Investments

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

~~With respect to the actual, ongoing financial condition and activities, the EO will not cause or allow the development of fiscal jeopardy in investment activity of operational funds.~~

Further, the EO shall not:

1. Investment decisions shall not be made without consultation and guidance with an independent qualified investment advisor.
2. Ignore these priority values in investment decisions
    1. Preservation of principal.
    2. Income generation.
    3. Long term growth of principal.
    4. Protected from bank failures.
3. ~~i~~invest or hold capital in insecure instruments except where necessary to facilitate ease in operational transactions
4. invest without establishing a comparative benchmark to demonstrate investment performance.

Add to Communication and support to the Board

Annually, in conjunction with the audit report, the independent investment advisor will present an investment performance report ~~*to the Audit Committee* and then~~ the Board.

~~Add to Job Description of Audit Committee Deliverables.~~
(No audit committee exists.)

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-006	Pages: 2
Subject: Investments	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.2014	**Last Review Date**: 6.10.22 June 9, 2023	**Past Review Dates**: 2.13.15, 2.12.16, 2.10.17, 2.9.18, 6.14.19,6.12.20,7/09/21, 6/10/22

I. **PURPOSE:**

To establish a Board policy guiding investment of operational funds. This Policy does noy apply to retirement plan accounts as participants select their own investments.

II. **POLICY:**

It is the policy of SWMBH to invest public funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all ~~State~~ statutes governing investment of public funds.

To achieve this balance the Executive Officer shall consider the following objectives in rank order:

- Adherence to statutory, regulatory, and contractual requirements.
- Preservation of principal.
- Income generation.
- Long term growth of principal.

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III. **STANDARDS:**

Accordingly the Executive Officer may not:

1. Fail to comply at least with the requirements of Public Act 20 of 1943, as amended. The following types of securities are authorized by Public Act 20 of 1943, as amended:

   - Bonds, securities, and other obligations of the United Sates or an agency or instrumentality of the United States.
   - Certificates of deposit, savings accounts, deposit accounts or depository receipts of a financial institution as defined in Public Act 20 of 1943 as amended, where no more than 60% of the total investment portfolio is ~~will be~~ invested in a single security type or with a single financial institution. ~~with the exception of funds held in a CDARS account.~~
   - Commercial paper rated at the time of purchase at the highest classification established by not less than ~~2 standard~~two standard rating services and that matures not more than 270 days after the date of purchase.
   - Repurchase agreements consisting of bonds, securities and other obligations of the United States or an agency or instrumentality of the United States. ~~instruments in subdivision V.,~~

~~(A).~~

- Banker's acceptances of United States banks.
- Obligations of this state or any of its political subdivisions that at the time of purchase are rated as investment grade by at least one ~~not less than 1~~ standard rating service.
- Mutual funds registered under the Investment Company Act of 1940, 15 USC, sections 80a-1 to 80a-64, with authority to purchase only investment vehicles that are legal for direct investment by a public corporation.
- Obligations described in the above ~~subdivision 6.1 through 6.6~~ if purchased through an interlocal agreement under the Urban Cooperation Act of 1967. 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512.
- Investment pools organized under the Surplus Funds Investment Pool Act, 1982 PA 367, MCL 129.111 to 129.118.
- Investment pools organized under the Local Government Investment Pool Act, 1985 PA 121, MCL 129.141 to 129.150.

2. Neglect to diversify investment portfolio with ~~. With the exception of U.S. Treasury securities and authorized investment pools as defined in Public Act 20 of 1943 as amended,~~ no more than 60% of the total investment portfolio ~~will be~~ invested in a single security type or with a single financial institution with the exception of funds held in a Certificate of Deposit Account Registry Service (CDARS) account.

3. Fail to meet the standard of prudence. Investments shall be made with judgment and care, under circumstances then prevailing, which persons of prudence, discretion and intelligence exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of their capital as well as the probable income to be derived.

4. Endanger safekeeping of securities.

5. Avoid providing timely and accurate investment reports.

NOTES:

This Policy was reviewed by Varnum Law and their technical revisions adopted.

~~5.~~ CDARS is an acronym for the **C**ertificate of **D**eposit **A**ccount **R**egistry **S**ervice. In short, CDARS allows a business to invest in Certificates of Deposit [CDs] held by many different FDIC insured banking institutions, so it can achieve full FDIC coverage for the total sum.

Commented [SR2]: If we have the Els in proper order, there is NO need to repeat the law. The Global EL constraint should prohibit any unlawful conditions, actions, or decisions by anyone in the organization.

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Commented [SR3]: Not proscriptive. The board's policy identifies what is imprudent.

Commented [SR4]: Does SWMBH buy securities? If so, this is a reasonable policy.

Commented [SR5]: This policy belongs in the Communication and Support to the Board policy.

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Commented [SR6]: Varnum Law does not understand Policy Governance. IF the board would prefer to create an actual investment policy in its traditional format, we can attach that as an appendix, but then create a simple investment proscription in proper format.

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Sue's Commentary: Executive Limitations focuses on what would be imprudent or unethical regarding investments…if they are prescriptive, that would not be in alignment with the PG framework.

There is no need to repeat anything that is in the law regarding investments, because we have already said that the EO shall not do anything that is unlawful in the most global policy (theoretically).

Example 1:

With respect to the actual, ongoing financial condition and activities, the EO will not cause or allow the development of fiscal jeopardy in investment activity.

Further, the EO shall not:

2.5.1. Fail to invest in guaranteed financial instruments that reflect the following composition:

A. 85% to 100% are held in low risk, type of instruments, that would be covered by the CDIC or by a Provincial or Federal Government issuer with a term to maturity of no more than five years.
B. 0% to 15% are held in moderate/medium risk rated instruments, such as Large Cap, type Mutual Funds, Exchange Traded (ETF) Funds or individual equities that trade with a minimum market capitalization of $500 million.

2.5.13.1 Investment decisions shall not be made without consultation and guidance with a qualified investment advisor.

Example 2:

The EO shall not cause or allow situations that would jeopardize the Association's fiscal health or alignment with the Shared Vision (ENDS).

1. Fail to follow the Board "INVESTMENT POLICY, as established by the Board, and shown in Appendix 2.B.

Example 3:

The EO shall not:

2.6.7 Invest or hold capital in insecure instruments, including bonds of less than AA rating, or in non-interest bearing accounts except where necessary to facilitate ease in operational transactions.

2.6.7.1 All monies of CDHA which are not immediately required to meet operating expenses of CDHA shall be invested in:

i) Fixed Income: Any bond, debenture or strip coupon issued or guaranteed by the governments of Canada, Canadian provinces, municipalities of

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Canada, or any Canadian corporation. All of the above securities must have a minimum rating of A as measured by a recognized bond rating agency.

ii) Guaranteed Investment Certificates or High Interest Savings Accounts issued by banks or trust companies which are fully protected by the Canada Deposit Insurance Corporation (maximum of $100,000 per institution);

iii) Equities consisting of mutual funds or exchange-traded funds. Mutual funds may be diversified by: management investment styles, geography, and/or Fund Company.

Example 4:

Sample Executive Limitations Policy

Investments

The EO will not pursue or allow investment or investment strategy that deviates from a risk-averse orientation or that emphasizes current income at the expense of total return.

The EO shall not allow:

1. Liabilities to be unmatched for the forward three years at any given time.

2. The duration of the fixed income portfolio to be unmatched by that of the liabilities plus or minus one year.

3. Asset allocations that are not primarily fixed income in nature.

A. Asset allocations outside ranges of 90% to 100% for fixed income securities; 0% to 5% for private placements, short term securities, and real estate; and 0% to 10% for stocks whether common, preferred, or convertible.

B. Fixed income investment greater than 33% of admitted assets in the total of utilities, industrial and miscellaneous, financial services, and transportation.

C. Equity investment greater than 50% of unassigned funds.

4. Purchases of fixed income instruments that are not readily marketable and in no event in amounts greater than $500,000 from any one issuer of corporate securities.

5. Bond purchases that are not either (a) rated at least at Baa3/BBB by Moody's or S&P, (b) the equivalent of investment grade, or (c) issued by the U.S. Treasury or other government agencies.

6. Short term investment purchases that are rated less than P-1 by Moody's or S&P.

7. Purchase of foreign securities where interest and principal are paid in other than U.S. dollars.

8. Purchase of equities other than large cap U. S. entities, preferred stocks, convertible bonds, listed American depositary receipt (ADR) issues and mutual funds.

9. Purchase of mortgage backed securities including CMOs unless issued by agencies of the U.S. government or rated BBB by S&P or BAA3 by Moody's.

10. Investment transactions unidentifiable by the specific identification method of accounting.

11. Use of brokerage companies that are not licensed by the National Association of Security Dealers or that fail to demonstrate a track record of safety and soundness.

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Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Meeting: October 13, 2023

Policy Number: BEL-002
Policy Name: Financial Conditions
Assigned Reviewer: Louie Csokasy

Purpose: The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the Board's Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

Policy: With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from Board priorities established in policies.

> EO Response: This report addresses fiscal year 2022, October 1, 2021 to September 30, 2022. As expected, any material exceptions noted after September 30, 2022 to close of current year would be provided to the Board regardless of the reporting period.

Standards: Accordingly, the EO may not;

1. Expend more funds than have been received in the fiscal year to date, (including carry forward funds from prior year), unless the Board's debt guideline is met.

   > EO Response: *SWMBH has not expended more funds than have been received for the reviewed fiscal year.*
   >
   > *In fiscal year 2022, October 1, 2021 to September 30, 2022, SWMBH received gross revenues, (all types), of $343,068,875 million. Expenses during the period, (all types), were $333,100,058 million and a favorable difference of $9,968,817 million.*

Please see 2022 Financial Audit as presented to the Board in April for a detailed breakdown by contract/business line/funding streams. Recall that Medicaid and Medicaid-Healthy Michigan are entitlements with cost settled risk contracts with MDHHS. Substance Abuse Prevention, Treatment Block Grant and PA2 are not entitlements and are funded on a reimbursement basis and do-not-exceed grant contract from MDHHS.

2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.

   EO Response: *SWMBH has incurred no debt obligations.*

3. Use any designated reserves other than for established purposes.

   EO Response: *No designated reserve funds, (Internal Service Fund), have been used for any purpose other than that mentioned above. SWMBH has no other contractual or Board-designated reserves.*

4. Conduct interfund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.

   EO Response: *No interfund shifting has occurred outside these parameters.*

5. Fail to settle payroll and debts in a timely manner.

   EO Response: *Payroll has been paid in a timely manner as evidenced by payroll run reports and absence of staff complaints related thereto. Accounts Payable payment policy is 30 days. All invoices received and deemed accurate for payment were paid within this timeframe, on average 1200 invoices a year.*

6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.

   EO Response: *Tax payments and other government-ordered payments tax returns have been timely and accurately filed. Tax filings are available upon request.*

7. Fail to adhere to applicable Generally Acceptable Accounting standards.

   EO Response: *Per CFO all monthly financial statements were prepared and presented in accordance with generally accepted accounting principles. This was verified by external auditors via their clean opinion.*

8. Make a single purchase or commitment of greater than $100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.

   EO Response: *No single purchase or commitment of greater than $100,000 has occurred between October 1, 2021 and September 30,*

2022. The EO interprets "purchase or commitment" as acquisition of a product or service which excludes a termination clause.

9. Purchase or sell real estate in any amount absent Board authorization.

   EO Response: *No real estate has been purchased. No real estate is owned.*

10. Fail to aggressively pursue receivables after a reasonable grace period.

    EO Response: *Receivables largely include payments from MDHHS which are routine transmissions to us on a regular MDHHS-defined schedule. Immaterial receivables stem from contracts with other agencies who are invoiced promptly and pay promptly.*

Materials available for Review: Fiscal Year 2022 External Audit and Financial Statements (provided at the September 8, 2023 Board meeting).

Mr. Csokasy was invited to contact the CEO and/or CFO, to request additional materials, or set a phone or live meeting to discuss.

Enclosures:

- 2022 Audited Financial Statements
- April 30, 2023 Financials

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitation	Policy Number: BEL-002	Pages: 2
Subject: Financial Conditions	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.14	**Last Review Date**: 11.11.22	**Past Review Dates**: 10.12.14, 02.13.15, 5.13.16,5.12.17, 6.8.18; 6.14.19,06.12.20, 7.9.21

I. **PURPOSE:**

The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the board's Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

II. **POLICY:**

With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material negative deviation of actual expenditures from board priorities established in policies and inclusive of annual budget.

III. **STANDARDS:**

Accordingly, the Executive Officer may not:

1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year).

2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.

3. Use any designated reserves other than for established purposes.

4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.

5. Fail to settle payroll and debts in a timely manner.

6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.

7. Fail to adhere to applicable generally acceptable accounting standards.

8. Make a single purchase or commitment of greater than $100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.

9. Purchase or sell real estate in any amount absent Board authorization.

10. Fail to aggressively pursue receivables after a reasonable grace period.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy	Policy Number: EO-003	Pages: 1
Subject: Emergency EO Succession	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 06.13.2014	Last Review Date: 10.8.21	Past Review Dates: 11.14.14, 9.11.15, 9.9.16, 11.11.16, 11.10.17,10.12.18, 11.8.19, 11.13.20

I. **PURPOSE:**

In order to protect the Board from sudden loss of Executive Officer services.

II. **POLICY:**

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

Southwest Michigan Behavioral Health

Summary Income Statement

For the Fiscal YTD Period Ended 8/31/2023

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
Medicaid Specialty Services											
Contract Revenue	$ 229,528,840	$ 16,334,532	$ 213,194,308	$ 10,559,276	$ 44,426,801	$ 12,491,519	$ 42,126,574	$ 13,493,966	$ 56,574,973	$ 11,509,673	$ 22,011,526
Budget v Actual	$ (10,966,093)	$ (7,045,847)	$ (3,920,246)	$ 1,284,034	$ 3,777,504	$ 857,514	$ 4,091,497	$ 1,647,627	$ (13,639,193)	$ (4,183,509)	$ 2,244,281
% Variance - Fav / (Unfav)	-4.6%	-30.1%	-1.8%	13.8%	9.3%	7.4%	10.8%	13.9%	-19.4%	-26.7%	11.4%
Healthcare Cost	$ 226,629,314	$ 11,512,620	$ 215,116,694	$ 9,112,866	$ 45,106,591	$ 10,822,547	$ 41,344,926	$ 14,537,315	$ 57,595,293	$ 13,592,154	$ 23,005,000
Budget v Actual	$ (32,335,559)	$ (1,815,410)	$ (30,520,149)	$ (920,883)	$ (9,470,740)	$ 620,038	$ (3,872,384)	$ (3,230,349)	$ (8,958,922)	$ (338,681)	$ (4,348,229)
% Variance - Fav / (Unfav)	-16.6%	-18.7%	-16.5%	-11.2%	-26.6%	5.4%	-10.3%	-28.6%	-18.4%	-2.6%	-23.3%
MLR	98.7%	70.5%	100.9%	86.3%	101.5%	86.6%	98.1%	107.7%	101.8%	118.1%	104.5%
Managed Care Administration	$ 24,221,617	$ 6,129,325	$ 18,092,292	$ 1,178,515	$ 3,993,329	$ 1,082,031	$ 3,577,106	$ 1,221,672	$ 3,398,645	$ 1,346,443	$ 2,294,550
Budget v Actual	$ (3,437,100)	$ 1,729,052	$ (5,166,151)	$ (144,479)	$ (1,232,946)	$ (659,416)	$ (705,134)	$ 313,993	$ (941,350)	$ (822,196)	$ (974,624)
% Variance - Fav / (Unfav)	-16.5%	22.0%	-40.0%	-14.0%	-44.7%	-156.0%	-24.6%	20.4%	-38.3%	-156.8%	-73.8%
ACR	9.7%	2.4%	7.2%	11.5%	8.1%	9.1%	8.0%	7.8%	5.6%	9.0%	9.1%
Total Contract Cost	$ 250,850,931	$ 17,641,945	$ 233,208,986	$ 10,291,381	$ 49,099,920	$ 11,904,578	$ 44,922,033	$ 15,758,988	$ 60,993,938	$ 14,938,597	$ 25,299,550
Budget v Actual	$ (35,772,659)	$ (86,358)	$ (35,686,301)	$ (1,065,362)	$ (10,703,686)	$ (39,378)	$ (4,577,518)	$ (2,916,356)	$ (9,900,271)	$ (1,160,876)	$ (5,322,852)
Variance - Favorable / (Unfavorable)	-16.6%	-0.5%	-18.1%	-11.5%	-27.9%	-0.3%	-11.3%	-22.7%	-19.4%	-8.4%	-26.6%
Net before Settlement	$ (21,322,091)	$ (1,307,413)	$ (20,014,678)	$ 267,895	$ (4,673,119)	$ 586,941	$ (2,795,459)	$ (2,265,022)	$ (4,418,965)	$ (3,428,925)	$ (3,288,025)
Budget v Actual	$ (46,738,752)	$ (7,132,205)	$ (39,606,547)	$ 218,672	$ (6,926,182)	$ 818,136	$ (486,022)	$ (1,268,730)	$ (23,539,465)	$ (5,344,385)	$ (3,078,572)
Variance - Favorable / (Unfavorable)	-183.9%	-122.4%	-202.2%	444.2%	-307.4%	-353.9%	21.0%	127.3%	-123.1%	-279.0%	1469.8%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 9/26/2023

Southwest Michigan Behavioral Health

Summary Income Statement

For the Fiscal YTD Period Ended 8/31/2023

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
Healthy Michigan Plan (HMP)											
Contract Revenue	$ 48,772,241	$ 12,042,791	$ 36,729,449	$ 2,036,262	$ 7,902,498	$ 1,902,471	$ 7,469,453	$ 2,441,685	$ 9,316,374	$ 1,835,693	$ 3,825,014
Budget v Actual	$ 3,689,161	$ 3,395,981	$ 293,180	$ 204,281	$ 824,673	$ 190,301	$ 735,622	$ 293,201	$ (1,333,598)	$ (1,006,029)	$ 384,728
% Variance - Fav / (Unfav)	8.2%	39.3%	0.8%	11.2%	11.7%	11.1%	10.9%	13.6%	-12.5%	-35.4%	11.2%
Healthcare Cost	$ 36,669,149	$ 13,069,760	$ 23,599,389	$ 1,459,824	$ 5,029,278	$ 1,610,040	$ 6,351,816	$ 1,443,632	$ 3,625,465	$ 1,428,238	$ 2,651,095
Budget v Actual	$ (5,559,948)	$ (5,432,878)	$ (127,071)	$ (223,979)	$ (1,537,782)	$ 738,150	$ (807,298)	$ (528,713)	$ 1,474,862	$ 1,332,830	$ (575,141)
% Variance - Fav / (Unfav)	-17.9%	-71.1%	-0.5%	-18.1%	-44.0%	31.4%	-14.6%	-57.8%	28.9%	48.3%	-27.7%
MLR	75.2%	108.5%	64.3%	71.7%	63.6%	84.6%	85.0%	59.1%	38.9%	77.8%	69.3%
Managed Care Administration	$ 3,074,083	$ 917,763	$ 2,156,320	$ 188,791	$ 443,561	$ 136,297	$ 546,916	$ 143,525	$ 212,017	$ 199,401	$ 285,812
Budget v Actual	$ (359,845)	$ 276,168	$ (636,014)	$ (32,796)	$ (174,716)	$ (10,193)	$ (100,355)	$ (19,264)	$ (31,193)	$ (128,554)	$ (138,943)
% Variance - Fav / (Unfav)	-13.3%	23.1%	-41.8%	-21.0%	-65.0%	-8.1%	-22.5%	-15.5%	-17.3%	-181.5%	-94.6%
ACR	7.7%	2.3%	5.4%	11.5%	8.1%	7.8%	7.9%	9.0%	5.5%	12.3%	9.7%
Total Contract Cost	$ 39,743,232	$ 13,987,523	$ 25,755,709	$ 1,648,615	$ 5,472,839	$ 1,746,337	$ 6,898,731	$ 1,587,157	$ 3,837,482	$ 1,627,639	$ 2,936,907
Budget v Actual	$ 33,823,439	$ 8,830,814	$ 24,992,625	$ 1,391,840	$ 3,760,341	$ 2,474,295	$ 5,991,079	$ 1,039,180	$ 5,281,151	$ 2,831,915	$ 2,222,824
% Variance - Fav / (Unfav)	-17.5%	-58.4%	-3.1%	-18.4%	-45.5%	29.4%	-15.2%	-52.7%	27.3%	42.5%	-32.1%
Net before Settlement	$ 9,029,009	$ (1,944,732)	$ 10,973,741	$ 387,647	$ 2,429,659	$ 156,133	$ 570,721	$ 854,528	$ 5,478,892	$ 208,054	$ 888,107
Budget v Actual	$ (2,230,633)	$ (1,760,729)	$ (469,904)	$ (52,494)	$ (887,825)	$ 918,258	$ (172,030)	$ (254,776)	$ 110,071	$ 198,247	$ (329,355)
% Variance - Fav / (Unfav)	-19.8%	956.9%	-4.1%	-11.9%	-26.8%	-120.5%	-23.2%	-23.0%	2.1%	2021.6%	-27.1%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 9/26/2023

	E	F	H	J	K	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***			*Mos in Period*								
2	For the Fiscal YTD Period Ended 8/31/2023		P11FYTD22	11								
3	*(For Internal Management Purposes Only)*											
4	***INCOME STATEMENT***		TOTAL	Medicaid Contract	Healthy Michigan Contract	Opioid Health Home Contract	CCBHC	MI Health Link	MH Block Grant Contracts	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central
5												
6	**REVENUE**											
17	Contract Revenue		323,960,804	229,086,715	48,772,241	1,838,617	32,869,752	1,447,631	833,767	7,404,936	1,707,145	-
18	DHHS Incentive Payments		442,125	442,125	-	-	-	-	-	-	-	-
19	Grants and Earned Contracts		-	-	-	-	-	-		-	-	-
20	Interest Income - Working Capital		577,543	-	-	-	-	-	-	-	-	577,543
21	Interest Income - ISF Risk Reserve		201,921	-	-	-	-	-	-	-	-	201,921
22	Local Funds Contributions		1,181,906	-	-	-	-	-	-	-	-	1,181,906
23	Other Local Income		3,194	-	-	-	-	-	-	-	-	3,194
24												
25	**TOTAL REVENUE**		**326,367,492**	**229,528,840**	**48,772,241**	**1,838,617**	**32,869,752**	**1,447,631**	**833,767**	**7,404,936**	**1,707,145**	**1,964,564**
26												
27	**EXPENSE**											
28	**Healthcare Cost**											
29	Provider Claims Cost		25,986,338	4,952,636	9,263,835	1,284,920	-	2,356,661	572,342	6,161,266	1,394,679	-
30	CMHP Subcontracts, net of 1st & 3rd party		269,061,383	215,014,767	23,599,389	-	29,390,277	101,926	-	955,023	-	-
31	Insurance Provider Assessment Withhold (IPA)		3,487,450	2,414,408	1,073,041	-	-	-	-	-	-	-
32	Medicaid Hospital Rate Adjustments		5,818,428	3,085,544	2,732,884	-	-	-	-	-	-	-
33	MHL Cost in Excess of Medicare FFS Cost		-	1,082,198	-	-	-	(1,082,198)		-	-	-
34												
35	**Total Healthcare Cost**		**304,353,599**	**226,549,554**	**36,669,149**	**1,284,920**	**29,390,277**	**1,376,389**	**572,342**	**7,116,289**	**1,394,679**	**-**
36	**Medical Loss Ratio (HCC % of Revenue)**		**93.8%**	**98.7%**	**75.2%**	**69.9%**	**89.4%**	**95.1%**		**96.1%**	**81.7%**	
37												
39	Purchased Professional Services		327,232	-	-	-	-	-	-	-	-	327,232
40	Administrative and Other Cost		8,530,193	-	-	-	-	-	261,425	88,102	-	8,194,812
42	Depreciation		4,292	-	-	-	-	-	-	-	-	4,292
43	Functional Cost Reclassification		-	-	-	-	-	-	-	-	-	-
44	Allocated Indirect Pooled Cost		0	-	-	-	-	-	-	-	-	(14,145)
45	Delegated Managed Care Admin		20,248,612	18,089,711	2,156,320	-	-	2,581	-	-	-	-
46	Apportioned Central Mgd Care Admin		0	6,129,325	917,763	35,884	820,775	68,660	23,284	214,848	-	(8,210,539)
47												
48	**Total Administrative Cost**		**29,110,329**	**24,219,035**	**3,074,083**	**35,884**	**820,775**	**71,242**	**284,709**	**302,949.78**	**-**	**301,651**
49	**Admin Cost Ratio (MCA % of Total Cost)**		**8.7%**	**9.7%**	**7.7%**	**2.7%**	**2.7%**	**4.9%**		**4.1%**	**0.0%**	**2.5%**
50												
51	Local Funds Contribution		1,181,906	-	-	-	-	-	-	-	-	1,181,906
53												
54	**TOTAL COST after apportionment**		**334,645,834**	**250,768,590**	**39,743,232**	**1,320,803**	**30,211,052**	**1,447,631**	**857,051**	**7,419,239**	**1,394,679**	**1,483,557**
55												
56	**NET SURPLUS before settlement**		**(8,278,341)**	**(21,239,750)**	**9,029,009**	**517,814**	**2,658,700**	**-**	**(23,284)**	**(14,303)**	**312,466**	**481,007**
57	**Net Surplus (Deficit) % of Revenue**		**-2.5%**	**-9.3%**	**18.5%**	**28.2%**	**8.1%**	**0.0%**	**-2.8%**	**-0.2%**	**18.3%**	**24.5%**
59	Prior Year Savings		22,226,918	21,215,616	1,011,302	-	-	-		-	-	-
60	Change in PA2 Fund Balance		(298,163)	-	-	-	-	-		-	(298,163)	-
61	ISF Risk Reserve Abatement (Funding)		(201,921)	-	-	-	-	-		-	-	(201,921)
62	ISF Risk Reserve Deficit (Funding)		-	-	-	-	-	-		-	-	-
63	CCBHC Supplemental Reciveable (Payable)		(881,421)				(881,421)					
64	Settlement Receivable / (Payable)		(0)	9,286,323	(6,991,230)	(517,814)	(1,777,279)	-	-	14,303	(14,303)	-
65	**NET SURPLUS (DEFICIT)**		**12,567,072**	**9,262,189**	**3,049,081**	**-**	**-**	**-**	**(23,284)**	**-**	**-**	**279,086**
66	*HMP & Autism is settled with Medicaid*											
67												
68	**SUMMARY OF NET SURPLUS (DEFICIT)**											
69	Prior Year Unspent Savings		1,852,243	1,767,968	84,275	-	-	-		-	-	-
70	Current Year Savings		8,163,934	5,199,128	2,964,806	-	-	-		-	-	-
71	Current Year Public Act 2 Fund Balance		-	-	-	-	-	-		-	-	-
72	Local and Other Funds Surplus/(Deficit)		2,550,895	2,295,093	-	-	-	-	(23,284)	-	-	279,086
73												
74	**NET SURPLUS (DEFICIT)**		**12,567,072**	**9,262,189**	**3,049,081**	**-**	**-**	**-**	**(23,284)**	**-**	**-**	**279,086**
75												

	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 8/31/2023			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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
6	***Medicaid Specialty Services***			*HCC%*		80.9%	87.5%	83.5%	82.6%	83.3%	87.1%	86.4%	87.1%
7	Subcontract Revenue		229,086,715	16,055,491	213,031,224	10,555,570	44,384,971	12,491,519	42,031,265	13,493,966	56,574,973	11,487,434	22,011,526
8	Incentive Payment Revenue		442,125	279,042	163,083	3,706	41,830	-	95,308	-	-	22,239	-
9	**Contract Revenue**		**229,528,840**	**16,334,532**	**213,194,308**	**10,559,276**	**44,426,801**	**12,491,519**	**42,126,574**	**13,493,966**	**56,574,973**	**11,509,673**	**22,011,526**
10													
11	External Provider Cost		179,624,992	4,952,636	174,672,355	4,929,060	36,339,660	8,024,437	30,616,098	10,446,014	55,810,475	12,722,485	15,784,127
12	Internal Program Cost		41,747,593	-	41,747,593	4,196,602	9,322,081	2,798,110	10,827,675	4,091,302	2,305,868	870,497	7,335,456
13	SSI Reimb, 1st/3rd Party Cost Offset		(1,303,254)	-	(1,303,254)	(12,796)	(555,150)	-	(98,847)	-	(521,050)	(828)	(114,583)
14	Insurance Provider Assessment Withhold (IPA)		5,499,952	5,499,952	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		1,060,032	1,060,032	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**226,629,314**	**11,512,620**	**215,116,694**	**9,112,866**	**45,106,591**	**10,822,547**	**41,344,926**	**14,537,315**	**57,595,293**	**13,592,154**	**23,005,000**
17	**Medical Loss Ratio (HCC % of Revenue)**		**98.7%**	**70.5%**	**100.9%**	**86.3%**	**101.5%**	**86.6%**	**98.1%**	**107.7%**	**101.8%**	**118.1%**	**104.5%**
18													
19	**Managed Care Administration**		**24,221,617**	**6,129,325**	**18,092,292**	**1,178,515**	**3,993,329**	**1,082,031**	**3,577,106**	**1,221,672**	**3,398,645**	**1,346,443**	**2,294,550**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.7%**	**2.4%**	**7.2%**	**11.5%**	**8.1%**	**9.1%**	**8.0%**	**7.8%**	**5.6%**	**9.0%**	**9.1%**
21													
22	**Contract Cost**		**250,850,931**	**17,641,945**	**233,208,986**	**10,291,381**	**49,099,920**	**11,904,578**	**44,922,033**	**15,758,988**	**60,993,938**	**14,938,597**	**25,299,550**
23	**Net before Settlement**		**(21,322,091)**	**(1,307,413)**	**(20,014,678)**	**267,895**	**(4,673,119)**	**586,941**	**(2,795,459)**	**(2,265,022)**	**(4,418,965)**	**(3,428,925)**	**(3,288,025)**
24													
25	Prior Year Savings		21,215,616	21,215,616	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		9,286,323	(10,728,355)	20,014,678	(267,895)	4,673,119	(586,941)	2,795,459	2,265,022	4,418,965	3,428,925	3,288,025
28	**Net after Settlement**		**9,179,848**	**9,179,848**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		182,910	182,910	182,910	10,130	34,383	10,790	35,503	10,705	47,911	15,093	18,395
32	Revenue PMPM		$ 114.08	$ 8.12	$ 105.96	$ 94.76	$ 117.47	$ 105.24	$ 107.87	$ 114.59	$ 107.35	$ 69.33	$ 108.78
33	Expense PMPM		$ 124.68	$ 8.77	$ 115.91	$ 92.36	$ 129.82	$ 100.30	$ 115.03	$ 133.83	$ 115.73	$ 89.98	$ 125.03
34	Margin PMPM		$ (10.60)	$ (0.65)	$ (9.95)	$ 2.40	$ (12.36)	$ 4.95	$ (7.16)	$ (19.24)	$ (8.38)	$ (20.65)	$ (16.25)
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		182,910	182,910	182,910	10,130	34,383	10,790	35,503	10,705	47,911	15,093	18,395
41	Budget		174,379	174,379	174,379	9,423	33,008	10,297	33,586	10,237	45,533	14,354	17,941
42	Variance - Favorable / (Unfavorable)		8,531	8,531	8,531	707	1,375	493	1,917	468	2,378	739	454
43	% Variance - Fav / (Unfav)		4.9%	4.9%	4.9%	7.5%	4.2%	4.8%	5.7%	4.6%	5.2%	5.1%	2.5%
44													
45	**Contract Revenue before settlement**												
46	Actual		229,528,840	16,334,532	213,194,308	10,559,276	44,426,801	12,491,519	42,126,574	13,493,966	56,574,973	11,509,673	22,011,526
47	Budget		240,494,933	23,380,379	217,114,554	9,275,242	40,649,297	11,634,005	38,035,077	11,846,339	70,214,167	15,693,181	19,767,245
48	Variance - Favorable / (Unfavorable)		(10,966,093)	(7,045,847)	(3,920,246)	1,284,034	3,777,504	857,514	4,091,497	1,647,627	(13,639,193)	(4,183,509)	2,244,281
49	% Variance - Fav / (Unfav)		-4.6%	-30.1%	-1.8%	13.8%	9.3%	7.4%	10.8%	13.9%	-19.4%	-26.7%	11.4%
50													
51	**Healthcare Cost**												
52	Actual		226,629,314	11,512,620	215,116,694	9,112,866	45,106,591	10,822,547	41,344,926	14,537,315	57,595,293	13,592,154	23,005,000
53	Budget		194,293,755	9,697,210	184,596,544	8,191,984	35,635,851	11,442,585	37,472,542	11,306,967	48,636,372	13,253,474	18,656,771
54	Variance - Favorable / (Unfavorable)		(32,335,559)	(1,815,410)	(30,520,149)	(920,883)	(9,470,740)	620,038	(3,872,384)	(3,230,349)	(8,958,922)	(338,681)	(4,348,229)
55	% Variance - Fav / (Unfav)		-16.6%	-18.7%	-16.5%	-11.2%	-26.6%	5.4%	-10.3%	-28.6%	-18.4%	-2.6%	-23.3%
56													
57	**Managed Care Administration**												
58	Actual		24,221,617	6,129,325	18,092,292	1,178,515	3,993,329	1,082,031	3,577,106	1,221,672	3,398,645	1,346,443	2,294,550
59	Budget		20,784,517	7,858,376	12,926,141	1,034,035	2,760,383	422,616	2,871,972	1,535,665	2,457,295	524,247	1,319,927
60	Variance - Favorable / (Unfavorable)		(3,437,100)	1,729,052	(5,166,151)	(144,479)	(1,232,946)	(659,416)	(705,134)	313,993	(941,350)	(822,196)	(974,624)
61	% Variance - Fav / (Unfav)		-16.5%	22.0%	-40.0%	-14.0%	-44.7%	-156.0%	-24.6%	20.4%	-38.3%	-156.8%	-73.8%
62													
63	**Total Contract Cost**												
64	Actual		250,850,931	17,641,945	233,208,986	10,291,381	49,099,920	11,904,578	44,922,033	15,758,988	60,993,938	14,938,597	25,299,550
65	Budget		215,078,272	17,555,587	197,522,685	9,226,019	38,396,234	11,865,200	40,344,514	12,842,632	51,093,667	13,777,721	19,976,698
66	Variance - Favorable / (Unfavorable)		(35,772,659)	(86,358)	(35,686,301)	(1,065,362)	(10,703,686)	(39,378)	(4,577,518)	(2,916,356)	(9,900,271)	(1,160,876)	(5,322,852)
67	% Variance - Fav / (Unfav)		-16.6%	-0.5%	-18.1%	-11.5%	-27.9%	-0.3%	-11.3%	-22.7%	-19.4%	-8.4%	-26.6%
68													
69	**Net before Settlement**												
70	Actual		(21,322,091)	(1,307,413)	(20,014,678)	267,895	(4,673,119)	586,941	(2,795,459)	(2,265,022)	(4,418,965)	(3,428,925)	(3,288,025)
71	Budget		25,416,661	5,824,792	19,591,869	49,223	2,253,063	(231,195)	(2,309,437)	(996,292)	19,120,500	1,915,460	(209,453)
72	Variance - Favorable / (Unfavorable)		(46,738,752)	(7,132,205)	(39,606,547)	218,672	(6,926,182)	818,136	(486,022)	(1,268,730)	(23,539,465)	(5,344,385)	(3,078,572)
73			-183.9%	-122.4%	-202.2%	444.2%	-307.4%	-353.9%	21.0%	127.3%	-123.1%	-279.0%	1469.8%
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 8/31/2023			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	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
75	***Healthy Michigan Plan***			*HCC%*		13.0%	9.6%	12.4%	12.7%	8.3%	9.4%	12.6%	10.0%
76	**Contract Revenue**		**48,772,241**	**12,042,791**	**36,729,449**	**2,036,262**	**7,902,498**	**1,902,471**	**7,469,453**	**2,441,685**	**9,316,374**	**1,835,693**	**3,825,014**
77													
78	External Provider Cost		23,195,000	9,263,835	13,931,166	503,169	2,180,109	564,176	3,727,573	590,918	3,463,757	1,377,869	1,523,594
79	Internal Program Cost		9,668,223	-	9,668,223	956,655	2,849,169	1,045,863	2,624,243	852,715	161,708	50,369	1,127,501
80	SSI Reimb, 1st/3rd Party Cost Offset		-	-	-	-	-	-	-	-	-	-	-
81	Insurance Provider Assessment Withhold (IPA)		3,805,925	3,805,925	-	-	-	-	-	-	-	-	-
82	**Total Healthcare Cost**		**36,669,149**	**13,069,760**	**23,599,389**	**1,459,824**	**5,029,278**	**1,610,040**	**6,351,816**	**1,443,632**	**3,625,465**	**1,428,238**	**2,651,095**
83	**Medical Loss Ratio (HCC % of Revenue)**		**75.2%**	**108.5%**	**64.3%**	**71.7%**	**63.6%**	**84.6%**	**85.0%**	**59.1%**	**38.9%**	**77.8%**	**69.3%**
84													
85	**Managed Care Administration**		**3,074,083**	**917,763**	**2,156,320**	**188,791**	**443,561**	**136,297**	**546,916**	**143,525**	**212,017**	**199,401**	**285,812**
86	**Admin Cost Ratio (MCA % of Total Cost)**		**7.7%**	**2.3%**	**5.4%**	**11.5%**	**8.1%**	**7.8%**	**7.9%**	**9.0%**	**5.5%**	**12.3%**	**9.7%**
87													
88	**Contract Cost**		**39,743,232**	**13,987,523**	**25,755,709**	**1,648,615**	**5,472,839**	**1,746,337**	**6,898,731**	**1,587,157**	**3,837,482**	**1,627,639**	**2,936,907**
89	**Net before Settlement**		**9,029,009**	**(1,944,732)**	**10,973,741**	**387,647**	**2,429,659**	**156,133**	**570,721**	**854,528**	**5,478,892**	**208,054**	**888,107**
90													
91	Prior Year Savings		1,011,302	1,011,302	-	-	-	-	-	-	-	-	-
92	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
93	Contract Settlement / Redistribution		(6,991,230)	3,982,511	(10,973,741)	(387,647)	(2,429,659)	(156,133)	(570,721)	(854,528)	(5,478,892)	(208,054)	(888,107)
94	**Net after Settlement**		**3,049,081**	**3,049,081**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
95													
96	**Eligibles and PMPM**												
97	Average Eligibles		81,291	81,291	81,291	4,160	15,842	3,876	14,870	4,939	23,585	6,245	7,774
98	Revenue PMPM		$ 54.54	$ 13.47	$ 41.08	$ 44.50	$ 45.35	$ 44.62	$ 45.66	$ 44.95	$ 35.91	$ 26.72	$ 44.73
99	Expense PMPM		44.45	15.64	28.80	36.03	31.41	40.96	42.18	29.22	14.79	23.70	34.34
100	Margin PMPM		$ 10.10	$ (2.17)	$ 12.27	$ 8.47	$ 13.94	$ 3.66	$ 3.49	$ 15.73	$ 21.12	$ 3.03	$ 10.38
101													
102	***Healthy Michigan Plan***												
103	**Budget v Actual**												
104													
105	**Eligible Lives (Average Eligibles)**												
106	Actual		81,291	81,291	81,291	4,160	15,842	3,876	14,870	4,939	23,585	6,245	7,774
107	Budget		74,889	74,889	74,889	3,793	14,729	3,546	13,688	4,485	21,571	5,873	7,204
108	Variance - Favorable / (Unfavorable)		6,402	6,402	6,402	367	1,113	330	1,182	454	2,014	372	571
109	% Variance - Fav / (Unfav)		8.5%	8.5%	8.5%	9.7%	7.6%	9.3%	8.6%	10.1%	9.3%	6.3%	7.9%
110													
111	**Contract Revenue before settlement**												
112	Actual		48,772,241	12,042,791	36,729,449	2,036,262	7,902,498	1,902,471	7,469,453	2,441,685	9,316,374	1,835,693	3,825,014
113	Budget		45,083,080	8,646,811	36,436,269	1,831,981	7,077,825	1,712,170	6,733,831	2,148,484	10,649,972	2,841,722	3,440,286
114	Variance - Favorable / (Unfavorable)		3,689,161	3,395,981	293,180	204,281	824,673	190,301	735,622	293,201	(1,333,598)	(1,006,029)	384,728
115	% Variance - Fav / (Unfav)		8.2%	39.3%	0.8%	11.2%	11.7%	11.1%	10.9%	13.6%	-12.5%	-35.4%	11.2%
116													
117	**Healthcare Cost**												
118	Actual		36,669,149	13,069,760	23,599,389	1,459,824	5,029,278	1,610,040	6,351,816	1,443,632	3,625,465	1,428,238	2,651,095
119	Budget		31,109,200	7,636,882	23,472,318	1,235,845	3,491,496	2,348,190	5,544,518	914,919	5,100,327	2,761,068	2,075,955
120	Variance - Favorable / (Unfavorable)		(5,559,948)	(5,432,878)	(127,071)	(223,979)	(1,537,782)	738,150	(807,298)	(528,713)	1,474,862	1,332,830	(575,141)
121	% Variance - Fav / (Unfav)		-17.9%	-71.1%	-0.5%	-18.1%	-44.0%	31.4%	-14.6%	-57.8%	28.9%	48.3%	-27.7%
122													
123	**Managed Care Administration**												
124	Actual		3,074,083	917,763	2,156,320	188,791	443,561	136,297	546,916	143,525	212,017	199,401	285,812
125	Budget		2,714,238	1,193,932	1,520,306	155,995	268,845	126,105	446,561	124,261	180,824	70,847	146,869
126	Variance - Favorable / (Unfavorable)		(359,845)	276,168	(636,014)	(32,796)	(174,716)	(10,193)	(100,355)	(19,264)	(31,193)	(128,554)	(138,943)
127	% Variance - Fav / (Unfav)		-13.3%	23.1%	-41.8%	-21.0%	-65.0%	-8.1%	-22.5%	-15.5%	-17.3%	-181.5%	-94.6%
128													
129	**Total Contract Cost**												
130	Actual		39,743,232	13,987,523	25,755,709	1,648,615	5,472,839	1,746,337	6,898,731	1,587,157	3,837,482	1,627,639	2,936,907
131	Budget		33,823,439	8,830,814	24,992,625	1,391,840	3,760,341	2,474,295	5,991,079	1,039,180	5,281,151	2,831,915	2,222,824
132	Variance - Favorable / (Unfavorable)		(5,919,794)	(5,156,709)	(763,084)	(256,775)	(1,712,498)	727,957	(907,652)	(547,977)	1,443,669	1,204,276	(714,083)
133	% Variance - Fav / (Unfav)		-17.5%	-58.4%	-3.1%	-18.4%	-45.5%	29.4%	-15.2%	-52.7%	27.3%	42.5%	-32.1%
134													
135	**Net before Settlement**												
136	Actual		9,029,009	(1,944,732)	10,973,741	387,647	2,429,659	156,133	570,721	854,528	5,478,892	208,054	888,107
137	Budget		11,259,641	(184,003)	11,443,645	440,141	3,317,484	(762,125)	742,751	1,109,304	5,368,821	9,806	1,217,462
138	Variance - Favorable / (Unfavorable)		(2,230,633)	(1,760,729)	(469,904)	(52,494)	(887,825)	918,258	(172,030)	(254,776)	110,071	198,247	(329,355)
139			-19.8%	956.9%	-4.1%	-11.9%	-26.8%	-120.5%	-23.2%	-23.0%	2.1%	2021.6%	-27.1%

	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 8/31/2023			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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
159													
160	***Certified Community Behavioral Health Clin***			*HCC%*		0.0%	0.0%	0.0%	0.0%	0.0%	27.2%	25.3%	0.0%
161	**Contract Revenue**		**32,869,752**	**1,962,317**	**30,907,435**	**-**	**-**	**-**	**-**	**-**	**22,582,743**	**8,324,692**	**-**
162													
163	External Provider Cost		10,639,378	-	10,639,378	-	-	-	-	-	5,493,424	5,145,955	-
164	Internal Program Cost		18,750,899	-	18,750,899	-	-	-	-	-	18,750,899	-	-
165	SSI Reimb, 1st/3rd Party Cost Offset		-	-	-	-	-	-	-	-	-	-	-
166	**Total Healthcare Cost**		**29,390,277**	**-**	**29,390,277**	**-**	**-**	**-**	**-**	**-**	**24,244,322**	**5,145,955**	**-**
167	**Medical Loss Ratio (HCC % of Revenue)**		**89.4%**	**0.0%**	**95.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**107.4%**	**61.8%**	**0.0%**
168													
169	**Managed Care Administration**		**820,775**	**820,775**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
170	**Admin Cost Ratio (MCA % of Total Cost)**		**2.7%**	**2.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
171													
172	**Contract Cost**		**30,211,052**	**820,775**	**29,390,277**	**-**	**-**	**-**	**-**	**-**	**24,244,322**	**5,145,955**	**-**
173	**Net before Settlement**		**2,658,700**	**1,141,542**	**1,517,158**	**-**	**-**	**-**	**-**	**-**	**(1,661,580)**	**3,178,737**	**-**
174	PPS-1 Supplemental Payment Difference		-	(881,421)	881,421	-	-	-	-	-	(830,402)	1,711,823	-
175	Contract Settlement / Redistribution		-	(635,737)	635,737	-	-	-	-	-	(831,178)	1,466,915	-
176	**Net after Settlement**		**-**	**(635,737)**	**635,737**	**-**	**-**	**-**	**-**	**-**	**(831,178)**	**1,466,915**	**-**
177													
178													
179	***SUD Block Grant Treatment***			*HCC%*		0.4%	0.4%	0.3%	0.0%	2.7%	0.0%	0.1%	0.5%
180	**Contract Revenue**		**7,404,936**	**6,857,115**	**547,821**	**34,609**	**179,021**	**25,911**	**-**	**74,840**	**102,628**	**72,388**	**58,424**
181													
182	External Provider Cost		6,161,266	6,161,266	-	-	-	-	-	-	-	-	-
183	Internal Program Cost		960,364	-	960,364	44,712	224,167	40,919	13,483	484,863	-	21,342	130,878
184	SSI Reimb, 1st/3rd Party Cost Offset		(5,341)	-	(5,341)	-	-	-	-	-	-	-	(5,341)
185	**Total Healthcare Cost**		**7,116,289**	**6,161,266**	**955,023**	**44,712**	**224,167**	**40,919**	**13,483**	**484,863**	**-**	**21,342**	**125,537**
186	**Medical Loss Ratio (HCC % of Revenue)**		**96.1%**	**89.9%**	**174.3%**	**129.2%**	**125.2%**	**157.9%**	**0.0%**	**647.9%**	**0.0%**	**29.5%**	**214.9%**
187													
188	**Managed Care Administration**		**302,950**	**302,950**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
189	**Admin Cost Ratio (MCA % of Total Cost)**		**4.1%**	**4.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
190													
191	**Contract Cost**		**7,419,239**	**6,464,216**	**955,023**	**44,712**	**224,167**	**40,919**	**13,483**	**484,863**	**-**	**21,342**	**125,537**
192	**Net before Settlement**		**(14,303)**	**392,900**	**(407,202)**	**(10,103)**	**(45,146)**	**(15,008)**	**(13,483)**	**(410,023)**	**102,628**	**51,046**	**(67,113)**
193	Contract Settlement		14,303	(392,900)	407,202	10,103	45,146	15,008	13,483	410,023	(102,628)	(51,046)	67,113
194	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
195													
196													

	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 8/31/2023			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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
197	***SWMBH CMHP Subcontracts***												
198	Subcontract Revenue		318,133,644	36,917,714	281,215,930	12,626,441	52,466,490	14,419,901	49,500,718	16,010,491	88,576,718	21,720,207	25,894,964
199	Incentive Payment Revenue		442,125	279,042	163,083	3,706	41,830	-	95,308	-	-	22,239	-
200	**Contract Revenue**		**318,575,769**	**37,196,756**	**281,379,013**	**12,630,147**	**52,508,320**	**14,419,901**	**49,596,026**	**16,010,491**	**88,576,718**	**21,742,446**	**25,894,964**
201													
202	External Provider Cost		219,620,636	20,377,737	199,242,899	5,432,229	38,519,769	8,588,613	34,343,671	11,036,932	64,767,656	19,246,309	17,307,721
203	Internal Program Cost		71,127,079	-	71,127,079	5,197,969	12,395,417	3,884,893	13,465,402	5,428,879	21,218,475	942,209	8,593,835
204	SSI Reimb, 1st/3rd Party Cost Offset		(1,303,254)	-	(1,303,254)	(12,796)	(555,150)	-	(98,847)	-	(521,050)	(828)	(114,583)
205	Insurance Provider Assessment Withhold (IPA)		9,300,537	9,305,878	(5,341)	-	-	-	-	-	-	-	(5,341)
206	MHL Cost in Excess of Medicare FFS Cost		1,060,032	1,060,032	-	-	-	-	-	-	-	-	-
207	**Total Healthcare Cost**		**299,805,029**	**30,743,646**	**269,061,383**	**10,617,402**	**50,360,036**	**12,473,506**	**47,710,226**	**16,465,811**	**85,465,081**	**20,187,689**	**25,781,632**
208	**Medical Loss Ratio (HCC % of Revenue)**		**94.1%**	**82.7%**	**95.6%**	**84.1%**	**95.9%**	**86.5%**	**96.2%**	**102.8%**	**96.5%**	**92.8%**	**99.6%**
209													
210	**Managed Care Administration**		**28,419,425**	**8,170,813**	**20,248,612**	**1,367,306**	**4,436,890**	**1,218,329**	**4,124,022**	**1,365,197**	**3,610,662**	**1,545,844**	**2,580,362**
211	**Admin Cost Ratio (MCA % of Total Cost)**		**8.7%**	**2.5%**	**6.2%**	**11.4%**	**8.1%**	**8.9%**	**8.0%**	**7.7%**	**4.1%**	**7.1%**	**9.1%**
212													
213	**Contract Cost**		**328,224,454**	**38,914,459**	**289,309,995**	**11,984,708**	**54,796,926**	**13,691,835**	**51,834,248**	**17,831,008**	**89,075,743**	**21,733,533**	**28,361,995**
214	**Net before Settlement**		**(9,648,685)**	**(1,717,703)**	**(7,930,982)**	**645,440**	**(2,288,606)**	**728,066**	**(2,238,221)**	**(1,820,517)**	**(499,025)**	**8,913**	**(2,467,031)**
215													
216	Prior Year Savings		22,226,918	22,226,918	-	-	-	-	-	-	-	-	-
217	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
218	Contract Settlement		2,309,396	(6,257,324)	8,566,719	(645,440)	2,288,606	(728,066)	2,238,221	1,820,517	(332,153)	1,458,002	2,467,031
219	**Net after Settlement**		**14,887,629**	**14,251,892**	**635,737**	**(0)**	**-**	**-**	**0**	**(0)**	**(831,178)**	**1,466,915**	**-**
220													
221													

	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 8/31/2023			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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
222	***State General Fund Services***			*HCC%*	2.9%	5.7%	2.4%	3.7%	4.7%	5.7%	1.6%	0.9%	2.5%
223	**Contract Revenue**				**11,724,745**	**860,984**	**2,024,353**	**848,036**	**1,549,020**	**813,616**	**3,575,473**	**955,680**	**1,097,583**
224													
225	External Provider Cost				962,283	85,246	149,356	36,033	132,461	428,344	-	-	130,843
226	Internal Program Cost				5,448,448	557,762	1,119,607	449,217	2,217,814	575,298	-	-	528,750
227	SSI Reimb, 1st/3rd Party Cost Offset				-	-	-	-	-	-	-	-	-
228	**Total Healthcare Cost**				**6,410,731**	**643,008**	**1,268,963**	**485,251**	**2,350,275**	**1,003,642**	**-**	**-**	**659,592**
229	**Medical Loss Ratio (HCC % of Revenue)**				**54.7%**	**74.7%**	**62.7%**	**57.2%**	**151.7%**	**123.4%**	**0.0%**	**0.0%**	**60.1%**
230													
231	**Managed Care Administration**				**484,158**	**93,719**	**100,786**	**69,628**	**91,601**	**51,811**	**-**	**-**	**76,613**
232	**Admin Cost Ratio (MCA % of Total Cost)**				**7.0%**	**12.7%**	**7.4%**	**12.5%**	**3.8%**	**4.9%**	**0.0%**	**0.0%**	**10.4%**
233													
234	**Contract Cost**				**6,894,889**	**736,727**	**1,369,749**	**554,879**	**2,441,876**	**1,055,453**	**-**	**-**	**736,205**
235	**Net before Settlement**				**4,829,856**	**124,257**	**654,604**	**293,157**	**(892,856)**	**(241,837)**	**3,575,473**	**955,680**	**361,377**
236													
237	Other Redistributions of State GF				614,917	-	(87,004)	(359,035)	244,092	105,545	601,008	36,690	73,620
238	Contract Settlement				(121,002)	(121,002)	-	-	-	-	-	-	-
239	**Net after Settlement**				**5,323,771**	**3,256**	**567,600**	**(65,877)**	**(648,764)**	**(136,292)**	**4,176,481**	**992,370**	**434,997**
240													

Michigan Consortium for Healthcare Excellence
2023 Annual Member Meeting
Date: September 7, 2023
Time: 12:00 PM

Please join the meeting from your computer, tablet or smartphone.

***Invitees are Regional Entity and Stand-Alone CMH/PIHP Board Members**

Michigan Consortium for Healthcare Excellence

Meeting AGENDA

- Convene the Annual Meeting of the Members (Dave Pankotai)
- Welcome and Introductions
- Review of MCHE Purpose
- MCHE Preceding Year Activities (Dave Pankotai)
- Value Statement (Dave Pankotai)
- Strategic Plan Overview (Dave Pankotai)
- MCHE Year-to-Date Finance Report (James Colaianne)
- Questions/Discussion (All)
- Adjournment
- Please Note: MCHE Bylaws are included in the packet

Meeting PURPOSE

- To fulfill Bylaws obligation Article IV, Section 1 and Article VIII, Section 5.5 (Activities for the preceding year and recommendations for ensuing year)
- To make acquaintance with colleagues
- To review recent MCHE activities, pursuits and plans
- To solicit conversation about the future purposes and roles of MCHE

MCHE Purpose: Bylaws Article II

- To improve the health and welfare of Michigan youth, adults, families and communities facing problems associated with behavioral health and related issues;
- To interpret to the community, the Legislature, the Governor and relevant executive departments and regulatory agencies, including, but not limited to, the Michigan Department of Health and Human Services, the problems and needs of individuals and communities resulting from behavioral health needs and related issues to assist in mobilizing necessary resources to meet these needs;
- To monitor and influence public policy-making related to individuals and communities facing problems resulting from behavioral health and related issues;
- To promote prevention, treatment, and recovery services for behavioral health and related needs in Michigan recognizing the value of local service delivery;
- To seek and secure alliances, initiatives, and partnerships with similarly focused organizations for the purpose of improving population health in Michigan;
- To collect, analyze, utilize and disseminate data and other information including but not limited to operational and outcomes data regarding prevention, treatment and recovery services within behavioral health programs and related issues in Michigan;

Preceding Year Activities

- Continued to support of a state-wide, federal managed care regulatory change management work group.
- Continued subscription of web-based Team Portal service
  - Administrative Agreement with a Member for support
- Amendment of utilization management solution - “MCG” contract to include “Indicia” system as preferred platform at no additional cost to MCHE.
- Maintenance of Provider Review Reciprocity Policy, Procedures and Portal
- Maintenance of Direct Care Worker (and others) training: Records Reciprocity and Portal
- Added the PIHP/MDHHS CCBHC demonstration project updates

Preceding Year Activities

- Contracted with TBD Solutions to meet this CHARGE:
  - The membership of the Michigan Consortium for Healthcare Excellence (MCHE), has agreed to collaborate in a strategic initiative to improve their ability to communicate value and impact that the member Prepaid Inpatient Health Plans (PIHPs) bring to their management of Michigan's public behavioral health Medicaid benefit. To this end, members have agreed to take steps to develop business intelligence reports and information to communicate this to all stakeholders.
- Contracted with HMA/Wakely for actuarial support

Value to Whom?

- Our primary duty is to our Regional Entity - PIHP Board (The MCHE Members); to our PIHP Agencies; PIHP Communities; CMHSP Boards; and Substance Use Disorder Oversight Policy Boards
- Duty to constituent CMHSPs and counties for affiliated PIHPs
- Duty to PIHP funder MDHHS
- Duty to state legislators as the people's elected representatives
- Duty to Advocate Group Representatives

Strategic Plans - Overview

- Provide Visible Value
- Remain Person and Community Focused
- Enhance System Knowledge, Benchmarking and Performance Improvement
- Expand Business Lines
- Reduce unnecessary or duplicative System Administrative Expenses
- Provide Public Policy Leadership, Legislative Education and Advocacy

Strategic Plans – 2023

- Parity & Utilization Management – Assure (prove) statewide parity compliance amongst and between behavioral health and physical health services and across PIHPs/CMHSPs/Providers. Adopt statewide common Utilization Level of Care Guidelines, Service Selection Guidelines, and Functional Assessment Tools.
- Pursue Related Public Business – Identify, pursue and provide benefits management and related functions for health and human services and social determinants of health public agencies.
- Proofs of Performance – Establish and maintain a statewide effort for data, information, reports and briefings on the performance, outcomes and value of the PIHPs and public behavioral health system.
- Public Policy, Legislative Education and Advocacy – Develop and maintain a credible, visible and effective public policy/legislative education and lobbying effort, primarily for state legislators and secondarily for federal legislators for prioritized issues in behavioral health and related, including but not limited to SAPT.
- Reduce Overall Administrative Expenses – Identify and implement group efforts, group purchases and shared services to reduce system administrative expenses

Strategic Plans – 2023

- Administrative Service Organization – Incorporate one or more PIHP roles or functions into MCHE to perform state – wide to reduce costs and enhance efficiency. Examples include credentialing, provider site reviews, Member Services, provider training reciprocity, communication portal. Application purchase and maintenance, provider rate analysis and modification, software services group purchasing, value-based purchasing, subject matter expert engagement and sharing, Fair Hearing legal support, etc. Develop and host technical assistance subject matter expert meetings/seminars for PIHPs, CMHSPs, Providers. e.g., NCQA, Healthcare Data Analytics, managed care operations best practices, ED Diversion practices, Value Based Purchasing and Incentives in Medicaid, offer management of Medicaid FFS population, etc.
- Policy Recommendations Support – Develop policy recommendations on behalf of the PIHPs related to re-design, transformation or other efforts which would significantly impact the structure of the PIHP/CMHSP system, or the scope of behavioral health services delivered through the PIHP system.

Finance Report

Please see the Financial information attached to this presentation

Feedback & Thoughts????