Southwest Michigan Behavioral Health Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
October 14, 2022
9:30 am to 11:30 am
(d) means document provided
Draft: 10/5/22

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda**

   - September 9, 2022 SWMBH Board Meeting Minutes (d) pg.3

5. **Operations Committee**

   a. Operations Committee August 24, 2022 Meeting minutes (d) pg.6
   b. Operations Committee Quarterly Report (D. Hess) (d) pg.8

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

   a. *Home Adult Benefit Waiver (J. Gardner) (d) pg.9
   b. *Health Services Advisory Group Performance Measure Validation Results (J. Gardner and N. Spivak) (d) pg.11

7. **Board Actions to be Considered**

   a. Fiscal Year 2023 Budget (T. Dawson/G. Guidry) (d) pg.13
   b. Credentialing of Behavioral Health Practitioners (M. Todd) (d) pg.24
   c. Credentialing of Organizational Providers (M. Todd) (d) pg.32
   d. Michigan Consortium for Healthcare Excellence Membership (B. Casemore) (d)
   e. Holiday Event (B. Casemore) pg.38
   f. Voting Delegates needed for upcoming 2022 CMHA Fall Conference (d) pg.39

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

   - BG-008 Board Member Job Description (d) pg.40

9. Executive Limitations Review

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

a. BEL-002 Financial Conditions (L. Csokasy) (d) pg.42
b. BEL-008 Communication and Counsel (E. Meny) (d) pg.49
c. BEL-005 Treatment of Plan Members (R. Perino) (d) pg.54

10. Board Education

a. Fiscal Year 2022 Year to Date Financial Statements (T. Dawson/G. Guidry) (d) pg.61
b. Fiscal Year 2022 CMHSP Site Review Results (M. Todd) (d) pg.69
c. Compliance Role & Function (M. Todd) (d) pg.89
d. Michigan Consortium for Healthcare Excellence Written Report (B. Casemore) (d) pg.131
e. 7th Annual Public Policy Healthcare Forum Debrief (B. Casemore)

11. Communication and Counsel to the Board

a. Opioid Advisory Commission and Opioid Task Force (B. Casemore) (d) pg.134
b. System Transformation Legislation
c. November 11, 2022 Board Agenda (d) pg.147
d. Board Member Attendance Roster (d) pg.149
e. The Value of PIHPs (d) pg.150
f. November Direct Inspection Reports- BEL-010 501 (c) (3) Representation (T. Schmelzer); Executive Officer Evaluation (Executive Committee)

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 11, 2022
9:30 am - 11:30 am

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting Minutes
September 9, 2022
Four Points Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
9:30 am-11:30 am
Draft: 9/12/22

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

Members Absent: Sherii Sherban

Guests Present: Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Ellie DeLeon, Audit and Accreditation Specialist, SWMBH; Jeannie Goodrich, Summit Pointe; Tim Smith, Woodlands; Jon Houtz, Board Alternate for Pines Behavioral Health; Jeff Patton, ISK; Ric Compton, Riverwood Center; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Nancy Johnson, Board Alternate for Riverwood; Mike Kenny, NAMI; Rich Thiemkey, Barry County CMH

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

Public Comment
Louie Csokasy offered an apology on behalf of Woodlands Behavioral Healthcare Network (WBHN) Board of Directors regarding deficiencies identified in the Notices of Breach of Delegation MOU and Contract sent by SWMBH to WBHN. Louie Csokasy assured the SWMBH Board that WBHN Board and staff are working diligently to remediate the identified deficiencies.

Agenda Review and Adoption

Motion	Erik Krogh
Second	Tom Schmelzer
Motion Carried	

Financial Interest Disclosure (FID) Handling
None

Consent Agenda

Motion	Erik Krogh moved to approve the August 12, 2022 Board meeting minutes as presented.
Second	Susan Barnes
Motion Carried	

Operations Committee

Operations Committee Meeting Minutes

Edward Meny noted the June 22, 2022 Operations Committee meeting minutes in the packet. No questions from the Board.

Ends Metrics

Follow up after Hospitalization for Mental Illness

Jonathan Gardner reported as documented noting that the report is an update, and no motion is necessary. Discussion followed.

Board Actions to be Considered

2022-2025 Strategic Plan

Brad Casemore reported as documented noting that this plan is a first draft and asked the Board members to review and provide him any feedback.

Resolution Honoring Representative Fred Upton

Brad Casemore reported as documented.

Motion Erik Krogh moved to adopt the resolution as presented.

Second Louie Csokasy

Motion Carried

Executive Officer Evaluation and Employment Agreement Process

Edward Meny explained the Executive Officer Evaluation and Employment Agreement processes. Edward Meny noted SWMBH policy EO-002 Monitoring of Executive Officer Performance as the guiding document for the evaluation. Both will be action items at the November Board meeting.

Board Policy Review

None

Executive Limitations Review

BEL-002 Financial Conditions

Louie Csokasy stated that he is actively working on the review of the policy and corresponding documents and asked to move this review to the October Board meeting. Board agreed.

BEL-004 Treatment of Staff

Ruth Perino reported as documented.

Motion Ruth Perino moved that the Executive Officer is in compliance with Policy BEL-004 Treatment of Staff and the policy does not need revision.

Second Tom Schmelzer

Motion Carried

BEL-009 Global executive Constraint

Susan Barnes reported as documented.

Motion Susan Barnes moved that the Executive Officer is in compliance with Policy BEL-009 Global Executive Constraint and the policy does not need revision.

Second Erik Krogh
Motion Carried

Board Education

Fiscal Year 2022 Year to Date Financial Statements

Tracy Dawson reported as documented highlighting and explaining the CCBHC portion of the financials. Discussion followed.

Preview Fiscal Year 2023 Budget

Tracy Dawson reported as documented. Discussion followed.

MI Health Link Extrication

Brad Casemore shared the history and context of MI Health Link. Ellie DeLeon reported as documented.

7th Annual Healthcare Policy Forum – October 7, 2022

Brad Casemore reviewed the invitation as documented.

Communication and Counsel to the Board

SWMBH Michigan Municipal Risk Management Authority (MMRMA) Insurance Renewal

Tracy Dawson reported as documented.

System Transformation Legislation

Brad Casemore noted no formal action regarding SB 597 and 598 or HB 4925 through 4929.

October 12th SWMBH Draft Board Agenda

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

Board Member Attendance Roster

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

Public Comment

None

Adjournment

Motion Carol Naccarto moved to adjourn at 11:15 am
Second Erik Krogh
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: August 24, 2022 10:05am-11:45am

Members Present – Jeannie Goodrich, Richard Thiemkey, Sue Germann, Cameron Bullock, Tim Smith, Ric Compton, Jeff Patton, Debbie Hess

Guests present – Brad Casemore, CEO, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Beth Guisinger, Manager of Call Center, SWMBH; Garyl Guidry, Senior Financial Analyst, SWMBH; Ella Philander, CCBHC Coordinator, SWMBH; Ellie DeLeon, Audit and Accreditation Specialist, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Jeanette Bayyapuneedi, Behavioral Health and Integrated Care Manager, SWMBH; Beth Ann Meints, ISK; and Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH

Call to Order – Cameron Bullock began the meeting at 10:01 am.

Review and approve agenda – Agenda approved as presented.

Review and approve minutes from 6/22/22 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2022 Year to Date Financials – Garyl Guidry reported that financials are not ready yet but noted the Internal Savings Fund will be full for year-end financials and SWMBH is waiting on the State for guidance on CCBHC.

Fiscal Year 2023 Budget – Garyl Guidry reported as documented and noted that there will be a State reduction of 2.9% in Medicaid and Health Michigan for 2023. Discussion followed.

Conflict Free Access and Planning – Brad Casemore reported as documented.

Certified Community Behavioral Health Clinics Medicaid Demonstration Expansion CMHs – Ella Philander and Beth Ann Meints reported as documented highlighting Evidence Based Practices.

System Transformation – Group discussed at CEO only portion of meeting and no further comments were made.

Fiscal Year 2022 CMH Site Visit Review Results – Mila Todd reported as documented.

Performance Bonus Incentive Program 2022 current status – Jonathan Gardner reported as documented.

MI Health Link Extraction status/updates – Ellie DeLeon reported as documented. Brad Casemore summarized the ongoing processes. Discussion followed.

Foster Care and CPS Incentive Payment Program (DHIP) – Brad Casemore reported as documented. Discussion followed.

State Hospital Capacity – Brad Casemore reported as documented. Discussion followed.

DHHS Contract Monitoring and Oversight of PIHPs – Mila Todd reported as documented.

Medicaid Health Plans Rebid – Group discussed at CEO only portion of meeting and no further comments were made.

10/7 Healthcare Policy Forum – Brad Casemore reminded group of upcoming October 7th event.

Encounter Quality Improvement Reporting Timeline for September – Brad Casemore reported as documented and noted reporting specifics.

2022-2025 Strategic Plan – Brad Casemore reported as documented.

Physician Coordination – Jeanette Byyapuneedi shared that recent site reviews noted physician coordination is lagging and planning is being developed to address this.

Fiscal Year 2023 CMH Agreements and FY '23 DHHS-required Delegation Agreement revisions update – Mila Todd stated that red line versions were sent out with down stream and other follows up being worked on. Group requested a meeting with Mila Todd to review the Fiscal Year 2023 CMH agreements.

Michigan Crisis and Access Line (MiCAL) – Beth Guisinger reported as documented.

Adverse Benefit Determination (ABD) Letters – Anne Wickham gave an update on ABD letters and noted that November 1 will be the next file review for the 4th quarter fiscal year 2022.

Adjourned – Meeting adjourned at 11:40 am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for August, September 2022
Board Date 10/14/22

Action items:

- None

Discussion items:

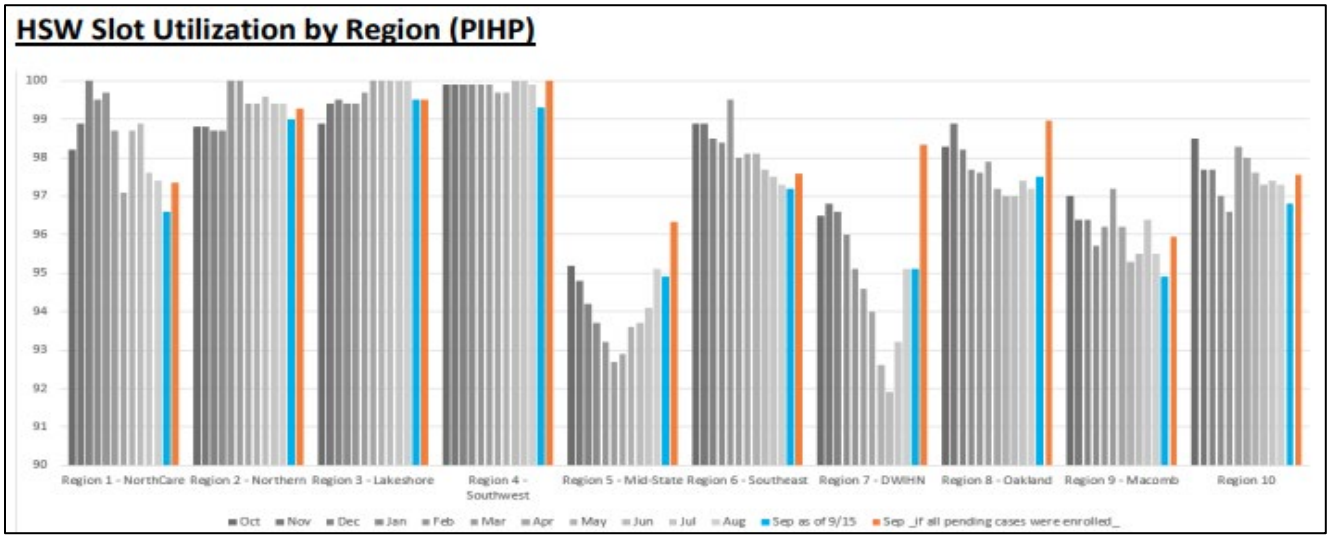
- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some recommendations are to SWMBH management, and some go to SWMBH Board. Much information and recommendations are taken by Operations members take back to their own CMH's. Some of the topics from this quarter included:
    - Reviewed year to date financial reports, actions being taken to decrease expenditures, and reviewed state level actions which impact financials
    - Reviewed Fiscal Year 2023 Budget
    - Reviewed Fiscal Year 2023 Contract Status/Updates
    - Reviewed Fiscal Year 2022 Performance Bonus Incentive Program developments
    - status and Opioid Health Homes (OHH) status
    - Reviewed Habilitation Supports Waiver Releases
    - Reviewed Grant Updates/Status (Block Grant, Opioid Health Homes)
    - Reviewed and discussed various State and Milliman rate setting documents and Cost Allocation Workgroup updates including Standard Cost Allocation
    - Reviewed Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and External Quality Review
    - Reviewed CMH Site Review schedule and processes
    - Discussed Direct Care Wage
    - Reviewed and discussed beginning Health Disparities Data
    - Reviewed MDHHS code changes
    - Discussion of Michigan Open Meetings Act
    - Discussion of Behavioral Health System Transformation proposals
    - Discussion of awarded COIVD supplemental funds
    - Discussion of Provider Network Capacity and Stability issues
    - Discussion of State's Unfunded Mandates
    - Discussion of CCBHC (Certified Community Behavioral Health Clinics) implementation and status
    - Discussion of Integrated Healthcare strategies
    - Discussion of State Hospital Capacity and Incentive Payment Program (DHIP)
    - Discussion of Conflict Free Access and Planning
    - Discussion of Adverse Benefit Determination Letters
    - Discussion of MiCAL implementation
    - Discussion of MHL extraction
    - Discussion of 2022-2025 Strategic Plan and 2023-2024 Board Ends Metrics
    - Discussion of Opioid Settlement dollars and Opioid Advisory Commission

2022 Habilitation Supports Waiver (HSW) Slot Volume and Capacity Metric

PERFORMANCE METRIC DESCRIPTION	STATUS
Regional Habilitation Supports Waiver slots are full at 98% throughout FY22. Metric Measurement Period: (10/1/21 - 9/30/22) Metric Board Report Date: October 8, 2022 (*or when MDHHS posts yearend report*). Interim Board Report with (CQD) in April 2022 **Measurement:** Results are verified and certified through the MDHHS HSW performance dashboard. (%) of waiver slots (months) filled x 12 (#) of waiver slots (months) available **Possible Points:** 1 point awarded. +1 bonus point awarded for (5) or more *new* slots awarded to SWMBH by MDHHS during FY22.	**METRIC ACHEIVED** ▪ FY22 Result: 99.7% (9.30.22) ▪ FY21 Result: 99.8% ▪ FY20 Result: 99.8% **Metric Update:** Current Status as of 9.30.22 99.7% full *SWMBH has maintained the highest filed slot capacity over the past 4 years of all PIHP's!

Results from the 2022 MDHHS HSW Score Card

PIHP Name	Fiscal Year	Utilization	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Region 4 - Southwest	2022	Owned	710	710	710	710	710	710	710	710	710	710	710	710
Region 4 - Southwest	2022	Loaned	0	0	0	0	0	0	0	0	0	0	0	0
Region 4 - Southwest	2022	Borrowed	0	0	0	0	0	0	0	0	0	0	0	0
Region 4 - Southwest	2022	Used	709	709	708	708	706	705	707	707	707	707	709	710
Region 4 - Southwest	2022	Available	1	1	2	2	4	5	3	3	3	3	1	0
Region 4 - Southwest	2022	% Used	99.9	99.9	99.7	99.7	99.4	99.3	99.6	99.6	99.6	99.6	99.9	100



Additional Notes/Highlights

***SWMBH has maintained the highest filed slot capacity over the past 4 years of all PIHP's!**
***SWMBH was awarded 30 additional HSW slots in fiscal year 2020 for maintaining good performance!**
***SWMBH manages (84) more HSW slots than the next highest performing PIHP!**

Suggested Motion:

The data has been found to be relevant and compelling, the Executive Officer is in compliance and the ends metric needs no revision at this time.

2022 Health Service Advisory Group (HSAG)
Performance Measure Validation (PMV) Audit Results

PERFORMANCE METRIC DESCRIPTION	STATUS
2022 HSAG Performance Measure Validation Audit Passed with (90% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/2022 - 6/30/22) Metric Board Report Date: September 12, 2022 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. Number of Critical Measures that achieved the status of "Met," "Achieved," or "Reportable." Total number of critical measures evaluated **Possible Points:** 1 point awarded.	**METRIC ACHIEVED** **Final report received on 9/23/22** **2022 Results: 37/37 (100%) of measures evaluated achieved full compliance.** Executive Owners: Natalie Spivak and Jonathan Gardner

HSAG PMV AUDIT RESULTS COMPARISON BY YEAR SUMMARY REPORT

The below results represent the scoring designation for each element that was reviewed during the 2021 and 2022 audit process.

Scoring designation categories include: Accepted, Reportable or Met

As you can see from the Overall performance results Table; 34/38 or 89.4% of the Total elements evaluated received a designation score of Met, Reportable or Accepted.

2021 Audit Results

Scoring Category	Performance Results
Accepted	**2/3** – 66% Data Integration, Data Control and Performance Indicator Documentation Elements Evaluated were ***"Accepted"*** and met full compliance standards.
Reportable	**10/11** – 90.9% of Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications and the percentage reported.
Met	**11/13** – 84.6% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	**11/11** – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance standards.

As you can see from the Overall performance results Table; 37/37 or 100% of the Total elements evaluated during the 2022 audit cycle received a designation score of Met, Reportable or Accepted

2022 Audit Results (***draft report received on 8/29/22***)

Scoring Category	Performance Results
Accepted	**3/3** – 100% Data Integration, Data Control and Performance Indicator Documentation Elements Evaluated were ***"Accepted"*** and met full compliance standards.
Reportable	**12/12** – 100% of Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications and the percentage reported.
Met	**13/13** – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	**9/9** – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance standards.

SWMBH achieved a 10.6% improvement over the 2021 HSAG PMV Audit Results

Special Thank you to Berrien, Calhoun and Van Buren County CMHSP representatives for assisting during the live Case Review portion of the audit

Suggested Motion:

The data has been found to be relevant and compelling, the Executive Officer is in compliance and the ends metric needs no revision at this time.

Southwest Michigan
BEHAVIORAL HEALTH

For SWMBH Board
Fiscal Year 2023 Budget
Assumptions and Targets

13 Oct 14, 2022

Environmental Context

- Medicaid/Healthy Michigan Plan Rebasing: The basis for rate development is largely unchanged from the prior year
- Michigan budget process has been concluded.

Environmental Context

- MI Health Link (Duals) sunsets for SWMBH 12/31/22, though processes related to claims and settlement will continue for at least 6 months after 1/1/23.
- Trends in Medicaid eligible continue to be high due to the states handling of the Health Emergency, (FY21 is the year the actuary plans to use for rate development) but some additional years will be utilized in the process.
- Cessation of federal Public Health Emergency (PHE) unlikely until after the November elections, and federal government will provide 60 days notice and grant states one year to do Medicaid redeterminations. This major drop off in eligibles and funding likely will have only minimal impact for FY23.

FY 23 DHHS MODEL CHANGE AND QUESTIONS FOR RATE DEVELOPMENT

- Morbidity mix of eligibles in PIHP, the regions population mix by age/gender, program code, SMI, DDI, etc. compared to state
  - Treatment prevalence - count more than one specific month of persons served (change from last year)
  - Wage and Salary data, to support concerns of staff shortage

FY 2022 PROJECTED RESULTS & EFFECTS

- Projected FY 22 Internal Service Fund Balance $22,151,004
- Projected FY 22 Medicaid Savings Funding $19,620,641
- Projected FY 22 DCW LAPSE $7,839,564
- FY 21 Medicaid Savings $17,316,482
- Total Risk Pool Projected $40,771,645
- End the year positive
- Preliminary estimate

FY 2023 Budget Assumptions

- MDHHS has developed a new method they are requiring CMH's to follow to cost allocation and reporting. It is called the SCA (Standard Cost Allocation), it has been a very elaborate and challenging change for our CMH's all CMH's will be using this method for FY23.

- Target: Aggregate Medical Loss Ratio continue to push to be to at the target of 85% which the Federal government requires of the Medicaid Plans.

- Target: Aggregate Administrative Cost Ratio 9.0% or less for Specialty Services.

- Central Operations 4.% of Net Revenues or less.

Medicaid Cost PMPM
FY21 vs FY22 (5/22 YTD)

	FY21YTD	FY22YTD	Chg $	Chg%
• Barry	$86.86	$89.06	$2.20	2%
• Berrien	$109.60	$99.17	$10.43	11%
• Branch	$88.92	$84.27	$4.65	6%
• Calhoun	$108.77	$94.83	$13.94	15%
• Cass	$88.77	$93.88	$5.11	5%
• Kalamazoo	$118.56	$94.90	$23.66	25%
• St. Joseph	$93.49	$78.38	$15.11	19%
• Van Buren	$100.94	$99.33	$1.61	2%
• SWMBH Ctl	$7.97	$6.35	$1.62	25%
• Regional	$113.88	$100.14	$13.74	14%

Medicaid Expenditures Drivers

- Population Demographics
- Severity of Illness
- Intensity of Service
- Internal CMH vs. External Provider Service Delivery
- Type, Amount, Scope, and Duration of Care
- Effectiveness & Efficiency of Central Managed Care and CMHSP Operations
- Uniformity of Benefit (Medicaid Requirement)
- Population Demands
- Aging I/DD population and aging natural supports, e.g., parents (this will become an even larger driver)

Expense Drivers

- Individual Customers' Budgets
  - Person Centered Plan
  - Medical Necessity Supported by Functional Assessment
  - Effective Service Delivery Model
  - Fidelity to EBP with Proper Client Matching
- Utilization Management Standards
- Productivity Benchmarks
- Penetration Targets
- Competitive Provider Rates (CMH & Non-CMH)

QUESTIONS?

	E	F	I	J	K	L	M
1	***Southwest Michigan Behavioral Health***						
2	For the Fiscal YTD Period Ended 9/30/2023			**FY23 Budget - DRAFT-**			
3	*(For Internal Management Purposes Only)*						
4	***INCOME STATEMENT***		**FY23 Budget Current Status**	**FY22 Budget**	**FY 22 Projection**	**Change FY22B v FY22P Fav/(Unfav)**	**Comments**
5							
6	**REVENUE**						
7	**Contract Revenue**						
8	Medicaid Capitation		241,208,483	257,489,835	244,166,137	(13,323,698.46)	*FY22 Budget - CCBHC was included in Medicaid*
9	Healthy Michigan Plan Capitation		49,181,542	44,859,735	50,860,635	6,000,900.56	
10	Autism Services Capitation		20,544,417	25,525,816	20,622,520	(4,903,295.54)	
11	Opioid Health Home Capitation		1,657,770	-	1,632,828	1,632,828.17	
12	CCBHC Supplemental		9,219,609	-	9,472,090	9,472,089.79	*As noted above with Medicaid Capitation*
13	Dual Eligibles Demonstration Project		1,228,330	3,716,984	5,089,750	1,372,766.36	*FY23 revenune budget represents months of dual eligible demonstation project*
14	Mental Health Block Grant Funding		2,372,272	-	680,198	680,197.77	
15	SA Block Grant Funding		9,642,647	7,737,915	6,208,051	(1,529,864.46)	*FY 22 projected utilization.*
16	SA PA2 Funding		1,799,627	1,925,017	2,132,627	207,610.44	
17							
18	Contract Revenue		336,854,697	341,255,301	340,864,836	(390,465.37)	
19	DHHS Incentive Payments		605,208	624,094	651,909	27,815.43	
20	Grants and Earned Contracts		-	2,575,000	-	(2,575,000.00)	
21	Interest Income - Working Capital		21,304	11,438	27,947	16,508.81	
22	Interest Income - ISF Risk Reserve		1,062	1,082	1,202	120.62	
23	Local Funds Contributions		1,289,352	1,726,192	1,289,352	(436,840.32)	
24	Other Local Income		-	-	-	-	
25							
26	**TOTAL REVENUE**		**338,771,623**	**346,193,107**	**342,835,246**	**(3,357,860.83)**	
27							
28	**EXPENSE**						
29	**Healthcare Cost**						
30	Provider Claims Cost		26,636,779	25,284,037	23,165,312	(2,118,725.33)	
31	CMHP Subcontracts, net of 1st & 3rd party		269,531,195	246,629,278	247,545,764	916,485.41	
32	Insurance Provider Assessment Withhold (IPA)		3,589,470	3,435,307	3,604,368	169,060.32	
33	Medicaid Hospital Rate Adjustments		2,067,450	3,222,501	3,165,994	(56,507.73)	
34	MHL Cost in Excess of Medicare FFS Cost		-	-	-	-	
35							
36	**Total Healthcare Cost**		**301,824,894**	**278,571,124**	**277,481,437**	**(1,089,687)**	
37	**Medical Loss Ratio (HCC % of Revenue)**		**89.4%**	**81.5%**	**81.2%**		
39	**Administrative Cost**						
40	Purchased Professional Services		644,000	712,181	439,271	(272,910.22)	
41	Administrative and Other Cost		12,005,555	10,734,399	9,042,965	(1,691,434.47)	
43	Depreciation		5,723	23,911	5,723	(18,188.52)	
44	Functional Cost Reclassification		-	-	-	-	
45	Allocated Indirect Pooled Cost		-	(0)	(0)	(0.00)	
46	Delegated Managed Care Admin		16,660,888	17,784,222	16,600,411	(1,183,810.56)	
47	Apportioned Central Mgd Care Admin		0	0	0	(0.02)	
48							
49	**Total Administrative Cost**		**29,316,166**	**29,254,713**	**26,088,369**	**(3,166,344)**	
50	**Admin Cost Ratio (MCA % of Total Cost)**		**8.9%**	**9.5%**	**8.6%**	**74.4%**	
51							
52	Local Funds Contribution		1,289,352	1,726,192	1,289,352	(436,840.32)	
54							
55	**TOTAL COST after apportionment**		**332,430,412**	**309,552,029**	**304,859,158**	**(4,692,871)**	
56							
57	**NET SURPLUS before settlement**		**6,341,212**	**36,641,078**	**37,976,088**	**1,335,011**	
58	**Net Surplus (Deficit) % of Revenue**		**1.9%**	**10.6%**	**11.1%**		
60	Prior Year Savings		17,316,482	-	17,316,482	17,316,482.00	
61	Change in PA2 Fund Balance		(549,040)	-	(684,013)	(684,012.69)	
62	ISF Risk Reserve Abatement (Funding)		(1,062)	-	(1,202)	(1,202.15)	
63	ISF Risk Reserve Deficit (Funding)		-	-	-	-	
64	Settlement Receivable / (Payable)		(7,839,568)	-	(7,839,568)	(7,839,568.00)	
65	**NET SURPLUS (DEFICIT)**		**15,268,024**	**36,641,078**	**46,767,787**	**10,126,710**	

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: **7**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: **Approved by SWMBH Board**	Date Approved: **10/14/2022**
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 (CMHSP) will ensure the credentialing and re-credentialing of behavioral health practitioners whom 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 National Council for Quality Assurance (NCQA) credentialing standards. Practitioners may not provide care for SWMBH members until they have been credentialed in accordance with this policy.

SWMBH and its participant Community Mental Health (CMH) agencies 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 Prepaid Inpatient Health Plan (PIHP) receive care from practitioners who are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network Management
Participant CMHSPs
Network Providers

Responsibilities: SWMBH Provider Network Management, Participant CMHSPs, and network providers must follow the below requirements as it relates to 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. 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

B. Credentialing Criteria and Application Process

1. Practitioners requesting inclusion in the SWMBH provider network will complete the current formal SWMBH Credentialing Application or another application approved by SWMBH. The application will be processed by designated credentialing staff.
2. SWMBH will require completed credentialing applications, with signed and dated attestations regarding accuracy and completeness of information, ability to perform duties, lack of present illegal drug use, history of loss of license and any felony convictions, and consent allowing verification of license, education, competence and any other related information.
3. Credentialing staff will verify information obtained in the credentialing application as described in section III.B.4, below. Copies of verification sources will be maintained in the practitioner credentialing file. When source documentation is not electronically dated, staff will sign and date with the current date. The verification timeframe will not exceed one-hundred-eighty (180) days.
4. 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.

Credentialing Criteria	Verification Method(s)
(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 exceeding six (6) months clarified in writing from the practitioner.	• Work history is verified through practitioner's credentialing application. • Verbal explanation from the applicant may be accepted for gaps in work history between 6 and 12 months. Gaps in work history greater than 12 months 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).
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 from within the last ten (10) 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 ten (10) 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 must not have opted out of Medicare if he/she will be providing Medicare services.	• Queries will be made to the System for Award Management (SAM) and the Office of Inspector General (OIG) to ensure that practitioners have not been suspended or debarred from participation with Medicare, Medicaid or other Federal contracts. • A query will be made at http://www.wpsmedicare.com/j8macpartb/departments/enrollment/b_opt_enroll.shtml to verify that the practitioner has not opted out of Medicare, if a Medicare provider.
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/)

C. Temporary/Provisional Credentialing Process

1. Temporary or provisional status can be granted one time to practitioners until formal credentialing is completed.
2. Providers seeking temporary or provisional status must complete a signed application with attestation.
3. A decision regarding temporary /provisional credentialing shall be made within 31 days of receipt of application.
4. In order to render a temporary / provisional credentialing decision, verification will be conducted of:
    a. Primary-source verification of a current, valid license to practice.
    b. 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.
    c. Medicare/Medicaid sanctions
5. Each factor must be verified within 180 calendar days of the provisional credentialing decision. The organization shall follow the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.

6. Temporary / Provisional credentialing status shall not exceed 60 days, after which time the credentialing process shall move forward according to this credentialing policy.

D. Re-credentialing Criteria and Application Process

1. Re-credentialing will be completed for all participating physicians and other participating practitioners at least every two (2) years for those providing Medicaid services, and every three (3) years for those providing Medicare services only. The Credentialing Committee may recommend re-credentialing for a lesser period of time.
2. Every practitioner will complete or update the current formal SWMBH 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 A.1. 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: 1) the reasons for inability to perform essential functions, 2) lack of present illegal drug use, 3) history of loss of license, 4) history of loss or limitation of privileges, 5) 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.
   e. To ensure quality and safety of care between credentialing cycles, SWMBH performs on-going monitoring of:
      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. 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 Southwest Michigan Behavioral Health by other individuals or organizations contact 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.

F. 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.

G. Reporting Requirements.

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

Procedures: None

Effectiveness Criteria: N/A

References: 42 CFR § 438.214 (a-e)
Michigan Department of Community Health / PIHP contract attachment P.7.1.1
Public Act 218 as amended by Act 59 section 400.734b
42 FR 422.204
NQCA CR 1, CR 2, CR 3, CR 4

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	10/14/22	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: **5**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: **Approved by SWMBH Board**	Date Approved: **10/14/2022**
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 (CMHSP) 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 licensed organizational providers who are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network Management
Participant 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: None

Standards and Guidelines:

A. Credentialing of Licensed Behavioral Health Facilities

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require licensed behavioral health facilities (i.e., acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities) wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application. The application will contain:
   a. A signed and dated statement from an authorized representative.
   b. Documentation collected and verified for health care facilities 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 facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization 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 information. License status and any license violations or special investigations incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license violations and nospecial 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 ten (10) years.
Verification that the providers has not been excluded from Medicare/Medicaid participation.	Is not on the OIG Sanctions list /SAM List
A copy of the facility's liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.

Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of facility.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals and recipient rights complaints are within the expected threshold given the provider size, MMBPIS and other performance indicators if applicable meet standard.

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 in writing and of their right to and process for appealing /disputing the decision in accordance with SWMBH policy 02.14.

B. Temporary/Provisional Credentialing Process

1. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed.
2. Providers seeking temporary or provisional status must complete a signed application with attestation.
3. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of application.
4. In order to render a temporary/provisional credentialing decision, verification will be conducted of:
   a. Primary-source verification of a current, valid license.
   b. 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.
   c. Medicare/Medicaid sanctions
5. Each factor must be verified within 180 calendar days of the provisional credentialing decision. The organization shall follow the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
6. Temporary / Provisional credentialing status shall not exceed 60 days, after which time the credentialing process shall move forward according to this credentialing policy.

C. Assessment of Other Behavioral Health Organizations (other than acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities)
   1. Before executing an initial contract, SWMBH and participant CMHSP will require other behavioral health organizations not listed in section A to provide:
      a. State and federal license, if applicable
      b. Current W-9
      c. Verification of liability insurance coverage
      d. Accreditation status, if applicable
   2. If the provider is not accredited and will be providing services at their place of business (ambulatory clinics), an on-site quality review must occur prior to contracting. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, CHAPS, NCQA, COA, and AOA.
   3. SWMBH or the participant CMHSP will verify that the provider has not been excluded from Medicare participation (is not on the OIG Sanctions list/SAM List).
   4. SWMBH or the participant CMH will verification that the provider has met all state and federal licensing and regulatory requirements, if applicable.

D. Organizational providers may be held responsible for credentialing and re-credentialing their direct employed and subcontracted professional service providers per SWMBH or SWMBH CMHSP contractual requirements. They shall maintain written policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements. SWMBH or a participant CMHSP shall verify through on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

E. Reporting Requirements. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.

Procedures: None

Effectiveness Criteria: N/A

References: NCQA Credentialing and Credentialing CR8
MDHHS-PIHP Contract P.7.1.1
BBA § 438.214

Attachments: None

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	10/14/22	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board

TO: SWMBH BOARD

FROM: BRAD

DATE: 10/14/22

Per Board Policy BEL-010 Regional Entity 501c3 Representation II.4 "The SWMBH Board will evaluate…in October of each year whether SWMBH will continue to hold a membership interest in MCHE or withdraw from such membership."

My recommendation is to continue to hold membership in MCHE. There have been no dues or fees this past year, we have an active beneficial group purchasing agreement for which withdrawal from MCHE would have both financial and time burdens, there is another group purchasing collective data analytics under consideration and MCHE will continue to be of some use to SWMBH and to the public behavioral health system over the coming year.

Motion requested: "SWMBH shall maintain its membership in MCHE through October 2023."

Bradley P. Casemore, *MHSA, LMSW, FACHE*

Executive Officer

Community Mental Health Association of Michigan

October 3, 2022

MEMORANDUM

To: Executive Directors
Executive Secretaries

FROM: Monique Francis

RE: Voting Delegates

Voting Delegates are Responsible for Voting at the
FALL CONFERENCE
in Traverse City on October 23, 2022
and must be present to vote.
PLEASE REMEMBER THAT MEMBER ASSEMBLY MEETINGS ARE HELD ON THE EVENING ***PRIOR*** TO THE START OF THE CONFERENCE. DELEGATES MUST BE ABLE TO ARRIVE BY 5:30PM THAT EVENING.

VOTING DELEGATES
Member Assembly Meeting

Please fill out and email this form to Monique at
mfrancis@cmham.org by ***October 14, 2022***

You may choose different voting delegates for each CMHAM Member Assembly Meeting.

Please list your board's voting delegates for the Association Member Assembly Meeting to be held on ***SUNDAY, OCTOBER 23, 2022, at 5:40PM*** at The Grand Traverse Resort, Traverse City.

Your board's 3 voting delegates (or 5 for Stand Alone PIHP's) must sign in at the conference registration to receive their voting card on October 23, 2022. ***EARLY BIRD REGISTRATION WILL OPEN AT 2:00PM TO ACCOMMODATE FOR THIS.***

Voting Privileges of CMHSPs/PIHPs: According to Association By-Laws, Article III (D): Voting privileges in the meetings of the Member Assembly shall be composed of three (3) delegates from each member CMHSP: two (2) board members and one (1) CMHSP executive director, OR, three (3) delegates from each member Regional Entity PIHP: two (2) board members and one (1) PIHP executive director, OR five (5) delegates for each member Stand Alone PIHP: four (4) board members and one (1) PIHP executive Director. *The executive director vote may* ***NOT*** *be reassigned to any other individual. Voting by proxy is expressly prohibited.*

Name of CMH/PIHP: _____	***Macomb/Oakland/Detroit Wayne PIHPs Only:***
Ex. Director _____	***Name of PIHP***: _____
Bd. Member _____	Ex. Director _____
Bd. Member _____	Bd. Member _____
	Bd. Member _____
	Bd. Member _____
	Bd. Member _____

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-008	Pages: 1
Subject: Board Member Job Description	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 03.14.2014	**Last Review Date**: 9/10/21	**Past Review Dates**: 2.13.15, 2/12/16, 1/13/17,2/9/18,9/13/19,9/11/20

I. **PURPOSE:**
To define the role and responsibility of the SWMBH Board.

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

III. **STANDARDS:**
To distinguish the Board's own unique job from the jobs of its staff, the Board will concentrate its efforts on the following job "products" or outputs:

1. The link between Southwest Michigan Behavioral Health and Participant counties.

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

3. The assurance of organizational and EO performance.

IV. **ORIENTATION:**
New Board Members shall be required to complete an initial orientation for purposes of enhancing their knowledge of the roles and responsibilities of SWMBH as an agency, and their understanding to assist in governance decision-making.

Specifically, they shall be provided the following information:

- **Governance Documents (Hierarchical)**
  o SWMBH Board Bylaws
  o SWMBH Operating Agreement
  o Michigan Consortium of Healthcare Excellence Bylaws (MCHE)

- **Ends, Proofs and Strategy**
  o Previous and Current Years' SWMBH Board Ends and Proofs

- **Context**
  o SWMBH General PowerPoint
  o Current SWMBH Board Meeting Calendar and Roster

In addition, new Board Members will be offered a live/remote briefing for each functional area leader.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Meeting: August 12, 2022

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.
This report addresses fiscal year 2021, October 1, 2020 to September 30, 2021. As expected, any material exceptions noted after September 30, 2021 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 2020, October 1, 2020 to September 30, 2021, SWMBH received gross revenues, (all types), of $322,598,890 million. Expenses during the period, (all types), were $301,353,093 million and a favorable difference of $21,245,797 million.

Please see 2021 Financial Audit as presented to the Board in May 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 and Treatment Block Grant and PA2 are not entitlements and are funded with a 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, 2020 and September 30, 2021. 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 2021 External Audit and Financial Statements (provided at the May 13, 2022 Board meeting).

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

Enclosures:

- 2021 Audited Financial Statements
- April 30, 2022 Financials

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Meeting: October 14, 2022

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 negative material deviation of actual expenditures from Board priorities established in policies and inclusive of Annual budget.
This report addresses fiscal year 2021, October 1, 2020 to September 30, 2021. As expected, any material exceptions noted after September 30, 2021 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.~~

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 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.

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 standard

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 and a termination of a contract. 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 – 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**: 07.09.21	**Past Review Dates**: 10.12.14, 02.13.15, 5.13.16,5.12.17, 6.8.18; 6.14.19,06.12.20

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 deviation of actual expenditures from board priorities established in policies.

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) unless the Board's debt guideline is met.

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

Executive Limitations
Monitoring to Assure Executive Performance
October 14, 2022

Policy Number: BEL008
Policy Name: Communication and Counsel to the Board
Assigned Reviewer: Ed Meny

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

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

Standards: The EO will not:

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

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

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

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

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

EO Response: *The EO has assured the Board has decision-making information required and has routinely briefed the Board and provided materials on relevant trends as evidenced by retrospective Board materials, Board meeting Minutes, Board retreat materials and exposure to knowledgeable others including but not limited to Alan Bolter of CMHAM and Farah Hanley of MDHHS.*

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

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

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

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

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

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

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

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

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

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

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

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

   Materials offered: Retrospective Board packets.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-008	Pages: 2
Subject: Communication and Counsel to the Board	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date: 01.10.2014	**Last Review Date**: 09.10.21	**Past Review Dates**: 10.12.14, 10.09.15, 10.14.16, 10.13.17, 10.12.18, 10.11.19,10.9.20

I. PURPOSE:

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

II. POLICY:

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

III. STANDARDS:

The EO will not;

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

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

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

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

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

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

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

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

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

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
For the period August 2021 to July 2022

Policy Number: BEL-005
Policy Name: Treatment of Plan Members
Assigned Reviewer: Ruth Perino

Policy Purpose: To clearly define the Treatment of Plan Members by Southwest Michigan Behavioral Health (SWMBH).

Policy: With respect to interactions with Plan members, the SWMBH EO shall not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy.

EO Comment: I broadly interpret "Plan Member" as any past, present, or potential future beneficiary of SWMBH-managed supports and services, including MI Health Link dual eligibles, Block Grant funded persons, etc. Enrollee Rights and Protections regulations for Medicaid are codified primarily in the federal Managed Care Regulations, in our contract with MDHHS, and in Michigan statute for persons with substance use disorders. Enrollee rights and protections for persons with Medicare, under the MI Health Link program, are similarly codified in federal statute and regulations as well as the SWMBH contract with our two Integrated Care Organizations. Additional privacy, security and confidentiality protections are codified in multiple federal and state regulations. The Treatment of Staff Policy is covered with all new employees at mandatory orientation with me and it is posted at the agency.

Standards: Accordingly, the EO may not;

1. Use forms or procedures that elicit information for which there is no clear necessity.

EO Response: SWMBH does not use any unwarranted forms or procedures to request any information for which there is no clear necessity of Members other than those required by statutory, regulatory, or contractual obligations. There are no Member complaints known to SWMBH related to this issue for the time period under consideration.

2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.

EO Response: All electronic and paper member informational files at SWMBH are appropriately and securely stored, with "need-to-know" access to Protected Health Information (PHI) that is limited by job function(s). Managed Care Information System and other electronic storage access to PHI is strictly limited, individually assigned by job functions and auditable by individual. Logins and passwords are required for network and managed care information system applications; passwords are "change-forced" every ninety (90) days. Recent efforts have enhanced security by adding Duo multifactor authentication (MFA) for the Microsoft 365 environment. MFA is also in place for our on-premises servers and financial systems.

SWMBH has a designated Privacy Officer (Mila Todd) and Security Officer (Natalie Spivak) as required under HIPAA regulations. SWMBH has a set of privacy, security, and confidentiality related policies. Staff receive, sign acknowledgements for, and undergo annual training that also includes federal regulations related to proper safeguarding and release of information rules for substance use disorder information (42 CFR Part 2). Paper records with protected health information are stored in supervised locked cabinets within sight of staff. There is a designated clinical area that is protected with a digital door lock to restrict access to the area. SWMBH has adopted a hybrid work model, therefore there are minimal clinical staff in the office. Due to the hybrid work model, SWMBH has created policy language to include security requirements for staff working remotely. This is to ensure member protected health information is secure no matter where the workstation is located. There are no known Member complaints or compliance inquiries stemming from SWMBH related to this issue in the period under consideration.

3. Fail to inform the Board of the status of uniform benefits across the region or fail to assist Participant CMHs towards compliance.

EO Response: The Board has periodically received penetration and access reports indicative of Uniform Benefit measures such as readiness of access, timeliness of care, utilization data and other measures. There is very little legitimate Michigan PIHP comparative data for benchmarking. SWMBH benefits use exists in the area of utilization, especially where assessment of functioning, level of care and outcome is concerned. We continue to work with MDHHS and counterpart Regional Entities to prepare and present comparative data. Milliman has provided an analytic tool which has more comparative data than was available in the past. SWMBH analysts create, update and circulate related reports.

Multiple evidence-based practices, (trauma informed care, seeking safety, helping men recover, cognitive behavioral therapy, dialectical behavior therapy, motivational interviewing, parent management training), and member self-support tools, such as MyStrength, have been promoted throughout the region at both

the provider and member level. Common assessment tools have been installed region wide, such as LOCUS and ASAM for adult mental health and adult co-occurring (mental health and substance use disorders). Level of Care guidelines using a statistical and clinical analysis approach to planning severity of illness/intensity of service and type, amount, scope, and duration of services are in place for most populations served. These guidelines are neither minimums not maximums but reasonably assure common delegated utilization management practices across the region.

Through various methodologies, including geo-mapping, SWMBH assesses the adequacy of our Provider Network. This allows the SWMBH region to adjust as necessary to member needs. The MHL network adequacy report has been updated for 2021. It was reviewed and approved by the SWMBH internal MHL Committee in March 2022. Provider Network is currently working with IT to develop an automated, real time Network Adequacy report. In the interim, a manual report is completed. The report was submitted to DHHS in June 2022. SWMBH also assesses any deficiencies with timeliness/access to care with our providers through the MMBPIS. Throughout the pandemic SWMBH and CMHSPs have worked with fragile providers to assure their ongoing availability by distributing millions of dollars in provider stability funds.

This year's Customer Satisfaction results had a reduction in overall scores with the largest reduction in the Youth Services Survey (YSS). An area of opportunity identified is promoting participation in the survey by identifying a different survey tool as well as alternative ways to access the survey. Another area identified is improving scores in access and outcome categories by working with CMHs to improve provider availability. Results were reviewed with the Board at the April 8, 2022, meeting. There are no Member complaints registered by or to SWMBH related to the issue of lack of uniform benefit for the period under consideration. All member grievances and appeals are tracked and trended by SWMBH. SWMBH reviews and, if warranted, defends actions on termination, reduction, suspension, or denials of services at the Fair Hearing.

4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.

EO Response: All electronic and non-electronic information transmission activities and network design and protections take place under applicable federal and state law and regulations, and established policies. An e-mail security hardening project was completed, which strengthened the electronic policies governing electronic mail forcing malicious messages to quarantine before they can be opened or acted upon. We require encryption on all outgoing e-mail messages containing protected information and scan for data such as social security numbers going out unencrypted. We have also required all staff to receive quarterly security awareness training around common threats, social engineering, and Internet security for the past two years and this year began

more effectively using a rules-based system for reporting and resolving phishing attempts. If the outside agency uses Transport Layer Security (TLS), we can instruct our email system to utilize this encryption tunneling protocol instead.

Data transmission with external trading partners occurs via encryption with passwords, inspection of technical systems and actual processes are overseen by the Security Officer and Privacy Officer.

For the period under review, fifty-seven (57) actual or potential privacy incidents were reported. They have all been investigated by the Program Integrity and Compliance Department. Fifty-Three (53) incidents were reviewed and considered by the SWMBH Breach Response Team which completed a Breach Risk Assessment Tool utilizing factors enumerated by the Federal Rules (45 CFR 164.402(2)) to assess the probability that the protected health information involved was compromised. The remaining four (4) incidents will be reviewed and considered during the next SWMBH Breach Response Team meeting. Breach incidents are reported to the Board periodically during the Program Integrity and Compliance Program updates.

Of the fifty-three (53) incidents assessed to date, zero were identified as rising to the level of a HIPAA breach and necessitating notification to the affected members and to the Office for Civil Rights (OCR).

5. Fail to establish with Plan members a clear contract of what may be expected from SWMBH including but not limited to their rights and protections.

EO Response: The SWMBH Member Handbook outlines what services are mandatory, optional, and alternative by Benefit Plan. It also states SWMBH's expectations of Providers in their Treatment of Plan Members. Ongoing Member education occurs via Newsletters and regular EO and Leadership attendance at the SWMBH Customer Advisory Council. Periodic newsletters are prepared and distributed that update changes or clarify information to educate Plan Members. At intake, members sign to acknowledge the handbook has been offered to them either in paper format or electronically on SWMBH or the CMHSP's website. There are no known Member complaints related to this topic for the period under consideration.

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

EO Response: The SWMBH Member Handbook delineates what issues are subject to Office of Recipient Rights complaints, grievance and appeals, as well as how to access the related processes. Member newsletters periodically reinforce this policy and how to file a grievance or appeal. Participant CMH Customer Services representatives have been trained in their delegated roles

and receive ongoing oversight and monitoring from SWMBH. The SWMBH Customer Services Department completes, at a minimum, an annual grievance and appeal report that is provided to each Participant CMH for review, and annually to the SWMBH Board. This Policy is available to all staff on the Shared Network Drive.

Related items offered for review upon request:

- Modified 2021 QAPI-UM Evaluation Report
- 2021 MHL Network Adequacy - Final Summary and Goals for Board
- Final- SWMBH 2021 Network Adequacy Analysis
- Customer Handbook 2022
- January 2022 and February 2022 Customer Advisory Committee Minutes
- SWMBH Customer Newsletter_Oct_2021
- SWMBH Customer Newsletter_Jan_2022

The assigned SWMBH Behavioral Health Board direct inspector, Mrs. Perino, was offered further contact with the EO, Chief Administrative Officer and Manager of Customer Services.

Policy BEL-005, Executive Limitations; Treatment of Plan Members

Assigned review by Ruth Perino

First, I note Brad Casemore's definition of "Plan Members." It is most inclusive as he broadly interprets "Plan Member" as any past, present, or potential future beneficiary of SWMBH-managed supports and services personnel. Treatment of Plan Members is carefully defined, and approach is defined by parameters that help ensure that no conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy will happen. Moreover, Plan Members have access and are coached on familiarity with the Handbook that presents their rights and ways to address concerns. Every incident of security breech is investigated, and none have reached the level of HIPAA breech. Data transmission is done with encryption and process is carefully monitored. A grievance policy is in place and the Recipient Rights division is legally bound to carefully address every complaint.

A careful and thorough response is given to each of the six standards outlined in Policy BEL-005 by Brad Casemore, CEO. A customer satisfaction response reduction among youth was reported and is being addressed with use of alternative approaches to encourage survey response. A second area addressed is access of service and outcome which is being addressed through individual CMHs. Note too, that every area is set up with a scoring system that gives reliable feedback. All responses have been updated with results to date. There is a constant attempt to ensure best practices and to keep monitoring systems upgraded and current. Newsletters to members, staff training, use of many methodologies and mapping of direct service with evidence based criterion to Plan Members' needs ensures a high level of service.

A reading of newsletters to customers shows respectful coverage of health suggestions, available services, and statistics about SWMBH that help define its role and reach towards excellent customer service. Brad Casemore writes an entry piece that helps create a sense of all staff and customers belonging. Areas of weakness are shared. Call numbers are repeatedly made available for any questions or concerns. The customers are addressed as full participants in SWMBH. Information is offered in various languages.

In addition, Customer Handbook was included in documents to review. I have read this before and am find it very comprehensive and valuable.

The Assessment of MI Health Link Network Adequacy from 2021 with particulars regarding ethnic and racial makeup was included. Language translation service utilized was recorded as well as processes for data collection. Every possible review seems included along with recommendations. The board has seen this information through metric reviews with Jonathan. Also, minutes of the Customer Advisory Committee show careful attention to surveys of customer satisfaction and ongoing issues like acquiring needed homes and issues of staff recruiting are reviewed with updates of hiring and encouragement of ideas to find and keep staff.

This review finds that the EO is in compliance and that Policy BEL-005, Executive Limitations; Treatment of Plan Members, does not need revision.

Ruth Perino, Board Member 9/29/2022

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy	Policy Number: BEL-005	Pages: 1
Subject: Treatment of Plan Members	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
12.20.2013	09/10/21	12/12/14, 1/8/16, 3/10/17, 3/18/18,8/9/19,08/14/20

I. **PURPOSE:**

To clearly define the Treatment of Plan Members by SWMBH

II. **POLICY:**

With respect to interactions with Plan members, the SWMBH EO shall not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy.

III. **STANDARDS:**

Accordingly the EO may not:

1. Use forms or procedures that elicit information for which there is no clear necessity.

2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.

3. Fail to inform the Board of the status of uniform benefits across the region or fail to assist Participant CMHs towards compliance.

4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.

5. Fail to establish with Plan members a clear contract of what may be expected from SWMBH including but not limited to their rights and protections.

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

	E	F	H	J	K	L	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2022		**P11FYTD22**	**11**									
3	*(For Internal Management Purposes Only)*												
4	***INCOME STATEMENT***		**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**Opioid Health Home Contract**	**CCBHC**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**
5													
6													
7	**REVENUE**												
18	Contract Revenue		313,442,479	224,833,179	47,336,991	18,924,537	1,469,670	8,669,263	4,372,853	-	5,810,724	2,025,263	-
19	DHHS Incentive Payments		543,258	543,258	-	-	-	-	-	-	-	-	-
20	Grants and Earned Contracts		654,297	-	-	-	-	-	-	654,297	-	-	-
21	Interest Income - Working Capital		27,799	-	-	-	-	-	-	-	-	-	27,799
22	Interest Income - ISF Risk Reserve		1,198	-	-	-	-	-	-	-	-	-	1,198
23	Local Funds Contributions		1,181,906	-	-	-	-	-	-	-	-	-	1,181,906
24	Other Local Income		-	-	-	-	-	-	-	-	-	-	-
25													
26	**TOTAL REVENUE**		**315,850,936**	**225,376,436**	**47,336,991**	**18,924,537**	**1,469,670**	**8,669,263**	**4,372,853**	**654,297**	**5,810,724**	**2,025,263**	**1,210,902**
27													
28	**EXPENSE**												
29	**Healthcare Cost**												
30	Provider Claims Cost		21,718,193	2,988,454	6,974,841	-	1,039,504	-	3,674,165	526,969	5,190,760	1,323,500	-
31	CMHP Subcontracts, net of 1st & 3rd party		234,385,208	175,004,942	18,912,874	15,153,828	-	24,385,583	493,405	-	434,575	-	-
32	Insurance Provider Assessment Withhold (IPA)		3,310,652	2,488,260	822,392	-	-	-	-	-	-	-	-
33	Medicaid Hospital Rate Adjustments		3,972,892	3,972,892	-	-	-	-	-	-	-	-	-
34	MHL Cost in Excess of Medicare FFS Cost		-	(21,073)	-	-	-	-	21,073		-	-	-
35													
36	**Total Healthcare Cost**		**263,386,945**	**184,433,475**	**26,710,107**	**15,153,828**	**1,039,504**	**24,385,583**	**4,188,643**	**526,969**	**5,625,335**	**1,323,500**	**-**
37	**Medical Loss Ratio (HCC % of Revenue)**		**83.9%**	**81.8%**	**56.4%**	**80.1%**	**70.7%**	**281.3%**	**95.8%**		**96.8%**	**65.3%**	
39	**Administrative Cost**												
40	Purchased Professional Services		389,870	-	-	-	-	-	-	-	-	-	389,870
41	Administrative and Other Cost		8,228,203	-	-	-	-	-	-	150,347	-	-	8,078,155
42	Interest Expense		-	-	-	-	-	-	-	-	-	-	-
43	Depreciation		5,246	-	-	-	-	-	-	-	-	-	5,246
44	Functional Cost Reclassification		-	-	-	-	-	-	-	-	-	-	-
45	Allocated Indirect Pooled Cost		(0)	-	-	-	-	-	-	-	-	-	(299)
46	Delegated Managed Care Admin		15,215,412	12,937,186	1,431,892	799,471	-	-	46,863	-	-	-	-
47	Apportioned Central Mgd Care Admin		(0)	5,865,957	853,156	499,410	34,258	803,652	137,347	22,322	185,389	-	(8,401,490)
48													
49	**Total Administrative Cost**		**23,838,730**	**18,803,143**	**2,285,049**	**1,298,881**	**34,258**	**803,652**	**184,210**	**172,669**	**185,389**	**-**	**71,481**
50	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**9.3%**	**7.9%**	**7.9%**	**3.2%**	**3.2%**	**4.2%**		**3.2%**	**0.0%**	**2.9%**
51													
52	Local Funds Contribution		1,181,906	-	-	-	-	-	-	-	-	-	1,181,906
53	PBIP Transferred to CMHPs		-										-
54													
55	**TOTAL COST after apportionment**		**288,407,581**	**203,236,617**	**28,995,156**	**16,452,709**	**1,073,762**	**25,189,235**	**4,372,853**	**699,638**	**5,810,724**	**1,323,500**	**1,253,386**
56													
57	**NET SURPLUS before settlement**		**27,443,355**	**22,139,819**	**18,341,835**	**2,471,828**	**395,908**	**(16,519,973)**	**-**	**(45,342)**	**0**	**701,763**	**(42,484)**
58	**Net Surplus (Deficit) % of Revenue**		**8.7%**	**9.8%**	**38.7%**	**13.1%**	**26.9%**	**-190.6%**	**0.0%**	**-6.9%**	**0.0%**	**34.7%**	**-3.5%**
60	Prior Year Savings		-	-	-	-	-	-	-		-	-	-
61	Change in PA2 Fund Balance		(701,763)	-	-	-	-	-	-		-	(701,763)	-
62	ISF Risk Reserve Abatement (Funding)		(1,198)	-	-	-	-	-	-		-	-	(1,198)
63	ISF Risk Reserve Deficit (Funding)		-	-	-	-	-	-	-		-	-	-
64	Settlement Receivable / (Payable)		(7,186,271)	(5,006,212)	(15,832,295)	(2,471,828)	(395,908)	16,519,973	-	-	(0)	-	-
65	**NET SURPLUS (DEFICIT)**		**19,554,123**	**17,133,607**	**2,509,539**	**-**	**-**	**-**	**-**	**(45,342)**	**-**	**-**	**(43,682)**
66	*HMP & Autism is settled with Medicaid*												
67													
68	**SUMMARY OF NET SURPLUS (DEFICIT)**												
69	Prior Year Unspent Savings		-	-	-	-	-	-	-		-	-	-
70	Current Year Savings		22,337,114	19,827,575	2,509,539	-	-	-	-		-	-	-
71	Current Year Public Act 2 Fund Balance		-	-	-	-	-	-	-		-	-	-
72	Local and Other Funds Surplus/(Deficit)		(2,782,991)	(2,693,967)	-	-	-	-	-	(45,342)	-	-	(43,682)
74	**NET SURPLUS (DEFICIT)**		**19,554,123**	**17,133,607**	**2,509,539**	**-**	**-**	**-**	**-**	**(45,342)**	**-**	**-**	**(43,682)**
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 8/31/2022			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%*	81.7%	79.5%	78.2%	79.8%	84.6%	80.8%	35.6%	38.4%	80.8%
7	Subcontract Revenue		233,502,441	8,795,750	224,706,691	9,327,729	40,866,370	11,460,879	38,189,398	11,982,343	70,714,974	22,223,194	19,941,804
8	Incentive Payment Revenue		543,258	224,252	319,006	15,885	52,949	82,324	112,252	-	-	31,240	24,357
9	**Contract Revenue**		**234,045,699**	**9,020,002**	**225,025,697**	**9,343,614**	**40,919,319**	**11,543,203**	**38,301,650**	**11,982,343**	**70,714,974**	**22,254,434**	**19,966,160**
10													
11	External Provider Cost		152,226,544	2,988,454	149,238,090	4,956,413	25,379,187	7,363,594	26,188,153	7,329,613	48,949,050	16,993,201	12,078,879
12	Internal Program Cost		51,968,713	-	51,968,713	3,362,729	9,672,609	2,684,164	9,013,537	3,178,884	15,598,871	991,279	7,466,640
13	SSI Reimb, 1st/3rd Party Cost Offset		(1,409,478)	-	(1,409,478)	-	(670,790)	(58,557)	(312,928)	-	(311,469)	(8,621)	(47,113)
14	Insurance Provider Assessment Withhold (IPA)		6,461,152	6,461,152	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(558,048)	(558,048)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**208,688,883**	**8,891,557**	**199,797,325**	**8,319,142**	**34,381,006**	**9,989,201**	**34,888,762**	**10,508,497**	**64,236,452**	**17,975,859**	**19,498,406**
17	**Medical Loss Ratio (HCC % of Revenue)**		**89.2%**	**98.6%**	**88.8%**	**89.0%**	**84.0%**	**86.5%**	**91.1%**	**87.7%**	**90.8%**	**80.8%**	**97.7%**
18													
19	**Managed Care Administration**		**18,850,006**	**5,865,957**	**12,984,049**	**986,772**	**3,501,503**	**362,626**	**2,500,391**	**1,138,178**	**2,432,199**	**612,641**	**1,449,738**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.6%**	**5.7%**	**10.6%**	**9.2%**	**3.5%**	**6.7%**	**9.8%**	**3.6%**	**3.3%**	**6.9%**
21													
22	**Contract Cost**		**227,538,888**	**14,757,514**	**212,781,374**	**9,305,914**	**37,882,509**	**10,351,828**	**37,389,153**	**11,646,675**	**66,668,651**	**18,588,500**	**20,948,144**
23	**Net before Settlement**		**6,506,811**	**(5,737,512)**	**12,244,323**	**37,700**	**3,036,810**	**1,191,375**	**912,497**	**335,668**	**4,046,323**	**3,665,933**	**(981,984)**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(5,006,212)	7,238,111	(12,244,323)	(37,700)	(3,036,810)	(1,191,375)	(912,497)	(335,668)	(4,046,323)	(3,665,933)	981,984
28	**Net after Settlement**		**1,500,599**	**1,500,599**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		175,240	175,240	175,240	9,507	33,191	10,332	33,779	10,273	45,787	14,396	17,975
32	Revenue PMPM		$ 121.42	$ 4.68	$ 116.74	$ 89.35	$ 112.08	$ 101.57	$ 103.08	$ 106.04	$ 140.40	$ 140.53	$ 100.98
33	Expense PMPM		$ 118.04	$ 7.66	$ 110.38	$ 88.99	$ 103.76	$ 91.08	$ 100.63	$ 103.07	$ 132.37	$ 117.38	$ 105.95
34	Margin PMPM		$ 3.38	$ (2.98)	$ 6.35	$ 0.36	$ 8.32	$ 10.48	$ 2.46	$ 2.97	$ 8.03	$ 23.15	$ (4.97)
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		175,240	175,240	175,240	9,507	33,191	10,332	33,779	10,273	45,787	14,396	17,975
41	Budget		163,943	163,943	163,943	8,753	31,438	9,460	31,147	9,837	42,899	13,498	16,911
42	Variance - Favorable / (Unfavorable)		11,297	11,297	11,297	754	1,753	872	2,632	436	2,888	898	1,064
43	% Variance - Fav / (Unfav)		6.9%	6.9%	6.9%	8.6%	5.6%	9.2%	8.5%	4.4%	6.7%	6.7%	6.3%
44													
45	**Contract Revenue before settlement**												
46	Actual		234,045,699	9,020,002	225,025,697	9,343,614	40,919,319	11,543,203	38,301,650	11,982,343	70,714,974	22,254,434	19,966,160
47	Budget		236,604,435	15,937,903	220,666,532	11,592,965	42,294,723	12,548,191	42,326,151	12,949,912	58,525,498	17,762,003	22,667,090
48	Variance - Favorable / (Unfavorable)		(2,558,736)	(6,917,901)	4,359,165	(2,249,351)	(1,375,404)	(1,004,988)	(4,024,501)	(967,569)	12,189,476	4,492,431	(2,700,930)
49	% Variance - Fav / (Unfav)		-1.1%	-43.4%	2.0%	-19.4%	-3.3%	-8.0%	-9.5%	-7.5%	20.8%	25.3%	-11.9%
50													
51	**Healthcare Cost**												
52	Actual		208,688,883	8,891,557	199,797,325	8,319,142	34,381,006	9,989,201	34,888,762	10,508,497	64,236,452	17,975,859	19,498,406
53	Budget		195,977,016	9,568,219	186,408,797	7,964,113	36,135,667	8,581,192	35,281,288	9,274,343	57,729,747	13,600,253	17,842,194
54	Variance - Favorable / (Unfavorable)		(12,711,866)	676,662	(13,388,528)	(355,029)	1,754,661	(1,408,009)	392,526	(1,234,154)	(6,506,705)	(4,375,606)	(1,656,212)
55	% Variance - Fav / (Unfav)		-6.5%	7.1%	-7.2%	-4.5%	4.9%	-16.4%	1.1%	-13.3%	-11.3%	-32.2%	-9.3%
56													
57	**Managed Care Administration**												
58	Actual		18,850,006	5,865,957	12,984,049	986,772	3,501,503	362,626	2,500,391	1,138,178	2,432,199	612,641	1,449,738
59	Budget		21,566,058	8,072,805	13,493,253	808,276	2,667,909	670,912	1,952,597	971,534	4,670,826	685,669	1,065,531
60	Variance - Favorable / (Unfavorable)		2,716,053	2,206,848	509,204	(178,496)	(833,594)	308,286	(547,794)	(166,645)	2,238,627	73,028	(384,207)
61	% Variance - Fav / (Unfav)		12.6%	27.3%	3.8%	-22.1%	-31.2%	46.0%	-28.1%	-17.2%	47.9%	10.7%	-36.1%
62													

	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 8/31/2022			**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													
63	**Total Contract Cost**												
64	Actual		227,538,888	14,757,514	212,781,374	9,305,914	37,882,509	10,351,828	37,389,153	11,646,675	66,668,651	18,588,500	20,948,144
65	Budget		217,543,075	17,641,024	199,902,050	8,772,389	38,803,576	9,252,104	37,233,885	10,245,877	62,400,573	14,285,922	18,907,725
66	Variance - Favorable / (Unfavorable)		(9,995,814)	2,883,510	(12,879,324)	(533,525)	921,067	(1,099,724)	(155,268)	(1,400,799)	(4,268,078)	(4,302,578)	(2,040,419)
67	% Variance - Fav / (Unfav)		-4.6%	16.3%	-6.4%	-6.1%	2.4%	-11.9%	-0.4%	-13.7%	-6.8%	-30.1%	-10.8%
68													
69	**Net before Settlement**												
70	Actual		6,506,811	(5,737,512)	12,244,323	37,700	3,036,810	1,191,375	912,497	335,668	4,046,323	3,665,933	(981,984)
71	Budget		19,061,360	(1,703,121)	20,764,482	2,820,576	3,491,147	3,296,087	5,092,266	2,704,035	(3,875,075)	3,476,081	3,759,365
72	Variance - Favorable / (Unfavorable)		(12,554,550)	(4,034,391)	(8,520,159)	(2,782,876)	(454,337)	(2,104,712)	(4,179,769)	(2,368,368)	7,921,398	189,853	(4,741,348)
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2022			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%*	8.8%	12.1%	8.3%	16.3%	12.6%	7.9%	2.5%	3.8%	8.3%
76	**Contract Revenue**		**47,336,991**	**10,515,328**	**36,821,662**	**1,853,855**	**7,149,159**	**1,729,861**	**6,806,166**	**2,172,176**	**10,773,746**	**2,865,872**	**3,470,828**
77													
78	External Provider Cost		17,803,377	6,974,841	10,828,536	543,089	822,163	857,236	2,928,665	443,527	3,073,363	1,141,488	1,019,006
79	Internal Program Cost		8,084,338	-	8,084,338	724,510	2,503,698	551,364	2,530,311	590,597	124,903	67,832	991,124
80	Insurance Provider Assessment Withhold (IPA)		822,392	822,392	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**26,710,107**	**7,797,234**	**18,912,874**	**1,267,599**	**3,325,861**	**1,408,599**	**5,458,976**	**1,034,123**	**3,198,266**	**1,209,320**	**2,010,130**
82	**Medical Loss Ratio (HCC % of Revenue)**		**56.4%**	**74.2%**	**51.4%**	**68.4%**	**46.5%**	**81.4%**	**80.2%**	**47.6%**	**29.7%**	**42.2%**	**57.9%**
83													
84	**Managed Care Administration**		**2,285,049**	**853,156**	**1,431,892**	**150,356**	**290,519**	**74,488**	**403,995**	**112,006**	**169,386**	**81,686**	**149,456**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**7.9%**	**2.9%**	**4.9%**	**10.6%**	**8.0%**	**5.0%**	**6.9%**	**9.8%**	**5.0%**	**6.3%**	**6.9%**
86													
87	**Contract Cost**		**28,995,156**	**8,650,390**	**20,344,766**	**1,417,955**	**3,616,380**	**1,483,088**	**5,862,971**	**1,146,129**	**3,367,652**	**1,291,006**	**2,159,586**
88	**Net before Settlement**		**18,341,835**	**1,864,938**	**16,476,896**	**435,901**	**3,532,779**	**246,773**	**943,195**	**1,026,046**	**7,406,094**	**1,574,866**	**1,311,241**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(15,832,295)	644,601	(16,476,896)	(435,901)	(3,532,779)	(246,773)	(943,195)	(1,026,046)	(7,406,094)	(1,574,866)	(1,311,241)
93	**Net after Settlement**		**2,509,539**	**2,509,539**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		75,567	75,567	75,567	3,834	14,855	3,575	13,811	4,531	21,793	5,914	7,253
97	Revenue PMPM		$ 56.95	$ 12.65	$ 44.30	$ 43.95	$ 43.75	$ 43.98	$ 44.80	$ 43.58	$ 44.94	$ 44.05	$ 43.50
98	Expense PMPM		34.88	10.41	24.48	33.62	22.13	37.71	38.59	23.00	14.05	19.85	27.07
99	Margin PMPM		$ 22.07	$ 2.24	$ 19.82	$ 10.33	$ 21.62	$ 6.27	$ 6.21	$ 20.59	$ 30.89	$ 24.21	$ 16.43
100													
101	**Healthy Michigan Plan**												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		75,567	75,567	75,567	3,834	14,855	3,575	13,811	4,531	21,793	5,914	7,253
106	Budget		67,368	67,368	67,368	3,409	13,500	3,191	12,191	4,051	19,238	5,239	6,549
107	Variance - Favorable / (Unfavorable)		8,199	8,199	8,199	425	1,354	385	1,621	480	2,555	675	704
108	% Variance - Fav / (Unfav)		12.2%	12.2%	12.2%	12.5%	10.0%	12.1%	13.3%	11.8%	13.3%	12.9%	10.8%
109													
110	**Contract Revenue before settlement**												
111	Actual		47,336,991	10,515,328	36,821,662	1,853,855	7,149,159	1,729,861	6,806,166	2,172,176	10,773,746	2,865,872	3,470,828
112	Budget		41,121,424	7,978,474	33,142,950	1,611,837	6,350,448	1,691,475	6,580,849	1,802,660	9,319,013	2,407,725	3,378,943
113	Variance - Favorable / (Unfavorable)		6,215,567	2,536,855	3,678,712	242,019	798,711	38,386	225,317	369,515	1,454,733	458,147	91,885
114	% Variance - Fav / (Unfav)		15.1%	31.8%	11.1%	15.0%	12.6%	2.3%	3.4%	20.5%	15.6%	19.0%	2.7%
115													
116	**Healthcare Cost**												
117	Actual		26,710,107	7,797,234	18,912,874	1,267,599	3,325,861	1,408,599	5,458,976	1,034,123	3,198,266	1,209,320	2,010,130
118	Budget		29,505,959	6,696,157	22,809,802	1,387,159	4,312,848	1,247,539	5,488,960	1,249,763	5,122,373	1,997,465	2,003,694
119	Variance - Favorable / (Unfavorable)		2,795,852	(1,101,077)	3,896,929	119,560	986,987	(161,060)	29,984	215,640	1,924,107	788,145	(6,436)
120	% Variance - Fav / (Unfav)		9.5%	-16.4%	17.1%	8.6%	22.9%	-12.9%	0.5%	17.3%	37.6%	39.5%	-0.3%
121													
122	**Managed Care Administration**												
123	Actual		2,285,049	853,156	1,431,892	150,356	290,519	74,488	403,995	112,006	169,386	81,686	149,456
124	Budget		2,893,024	1,266,779	1,626,245	140,782	318,419	97,538	303,779	130,919	414,443	100,704	119,660
125	Variance - Favorable / (Unfavorable)		607,975	413,623	194,353	(9,573)	27,900	23,049	(100,216)	18,913	245,058	19,018	(29,796)
126	% Variance - Fav / (Unfav)		21.0%	32.7%	12.0%	-6.8%	8.8%	23.6%	-33.0%	14.4%	59.1%	18.9%	-24.9%
127													
128	**Total Contract Cost**												
129	Actual		28,995,156	8,650,390	20,344,766	1,417,955	3,616,380	1,483,088	5,862,971	1,146,129	3,367,652	1,291,006	2,159,586
130	Budget		32,398,983	7,962,936	24,436,047	1,527,941	4,631,267	1,345,077	5,792,739	1,380,682	5,536,816	2,098,169	2,123,354
131	Variance - Favorable / (Unfavorable)		3,403,827	(687,454)	4,091,281	109,987	1,014,888	(138,010)	(70,232)	234,553	2,169,165	807,163	(36,232)

	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 8/31/2022			**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													
132	% Variance - Fav / (Unfav)		10.5%	-8.6%	16.7%	7.2%	21.9%	-10.3%	-1.2%	17.0%	39.2%	38.5%	-1.7%
133													
134	**Net before Settlement**												
135	Actual		18,341,835	1,864,938	16,476,896	435,901	3,532,779	246,773	943,195	1,026,046	7,406,094	1,574,866	1,311,241
136	Budget		8,722,441	15,538	8,706,903	83,895	1,719,181	346,398	788,110	421,978	3,782,196	309,556	1,255,589
137	Variance - Favorable / (Unfavorable)		9,619,394	1,849,400	7,769,994	352,005	1,813,598	(99,625)	155,086	604,068	3,623,898	1,265,310	55,652
138													
139													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2022			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													
140	***Autism Specialty Services***			*HCC%*	6.9%	3.4%	12.4%	0.1%	0.0%	4.2%	4.0%	0.0%	6.6%
141	**Contract Revenue**		**18,924,537**	**495,596**	**18,428,942**	**999,246**	**3,457,834**	**1,054,752**	**3,593,299**	**1,020,142**	**4,924,848**	**1,520,089**	**1,858,732**
142													
143	External Provider Cost		13,601,120	-	13,601,120	-	4,919,882	7,554	1,408,815	545,025	5,170,740	10,170	1,538,934
144	Internal Program Cost		1,552,708	-	1,552,708	351,001	6,144	341,288	806,163	-	-	-	48,113
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**15,153,828**	**-**	**15,153,828**	**351,001**	**4,926,026**	**348,842**	**2,214,978**	**545,025**	**5,170,740**	**10,170**	**1,587,047**
147	**Medical Loss Ratio (HCC % of Revenue)**		**80.1%**	**0.0%**	**82.2%**	**35.1%**	**142.5%**	**33.1%**	**61.6%**	**53.4%**	**105.0%**	**0.7%**	**85.4%**
148													
149	**Managed Care Administration**		**1,298,881**	**499,410**	**799,471**	**41,634**	**-**	**46,108**	**260,847**	**59,032**	**273,851**	**-**	**118,000**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**7.9%**	**3.0%**	**4.9%**	**10.6%**	**0.0%**	**11.7%**	**10.5%**	**9.8%**	**5.0%**	**0.0%**	**6.9%**
151													
152	**Contract Cost**		**16,452,709**	**499,410**	**15,953,299**	**392,634**	**4,926,026**	**394,949**	**2,475,825**	**604,057**	**5,444,591**	**10,170**	**1,705,046**
153	**Net before Settlement**		**2,471,828**	**(3,814)**	**2,475,643**	**606,611**	**(1,468,192)**	**659,802**	**1,117,474**	**416,085**	**(519,743)**	**1,509,919**	**153,686**
154	Contract Settlement / Redistribution		(2,471,828)	3,814	(2,475,643)	(606,611)	1,468,192	(659,802)	(1,117,474)	(416,085)	519,743	(1,509,919)	(153,686)
155	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.2%	0.2%	0.2%	0.5%	2.8%	1.6%	0.0%	0.1%	0.3%
159	**Contract Revenue**		**5,810,724**	**5,281,867**	**528,857**	**34,609**	**179,021**	**25,911**	**-**	**55,876**	**102,628**	**72,388**	**58,424**
160													
161	External Provider Cost		5,190,960	5,190,760	200	-	-	200	-	-	-	-	-
162	Internal Program Cost		434,375	-	434,375	21,775	84,349	14,665	-	206,425	-	32,818	74,343
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**5,625,335**	**5,190,760**	**434,575**	**21,775**	**84,349**	**14,865**	**-**	**206,425**	**-**	**32,818**	**74,343**
165	**Medical Loss Ratio (HCC % of Revenue)**		**96.8%**	**98.3%**	**82.2%**	**62.9%**	**47.1%**	**57.4%**	**0.0%**	**369.4%**	**0.0%**	**45.3%**	**127.2%**
166													
167	**Managed Care Administration**		**185,389**	**185,389**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**3.2%**	**3.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**5,810,724**	**5,376,149**	**434,575**	**21,775**	**84,349**	**14,865**	**-**	**206,425**	**-**	**32,818**	**74,343**
171	**Net before Settlement**		**0**	**(94,282)**	**94,282**	**12,834**	**94,672**	**11,046**	**-**	**(150,549)**	**102,628**	**39,570**	**(15,919)**
172	Contract Settlement		(0)	94,282	(94,282)	(12,834)	(94,672)	(11,046)	-	150,549	(102,628)	(39,570)	15,919
173	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2022			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													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		305,574,693	25,088,541	280,486,152	12,215,439	51,652,384	14,271,403	48,588,863	15,230,537	86,516,196	26,681,543	25,329,788
178	Incentive Payment Revenue		543,258	224,252	319,006	15,885	52,949	82,324	112,252	-	-	31,240	24,357
179	**Contract Revenue**		**306,117,951**	**25,312,792**	**280,805,159**	**12,231,324**	**51,705,333**	**14,353,726**	**48,701,115**	**15,230,537**	**86,516,196**	**26,712,783**	**25,354,144**
180													
181	External Provider Cost		188,822,001	15,154,055	173,667,946	5,499,501	31,121,233	8,228,583	30,525,633	8,318,164	57,193,153	18,144,860	14,636,819
182	Internal Program Cost		62,040,134	-	62,040,134	4,460,015	12,266,799	3,591,481	12,350,011	3,975,906	15,723,774	1,091,929	8,580,220
183	SSI Reimb, 1st/3rd Party Cost Offset		(1,409,478)	-	(1,409,478)	-	(670,790)	(58,557)	(312,928)	-	(311,469)	(8,621)	(47,113)
184	Insurance Provider Assessment Withhold (IPA)		7,283,544	7,283,544	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(558,048)	(558,048)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**256,178,153**	**21,879,551**	**234,298,602**	**9,959,516**	**42,717,241**	**11,761,507**	**42,562,716**	**12,294,070**	**72,605,458**	**19,228,168**	**23,169,925**
187	**Medical Loss Ratio (HCC % of Revenue)**		**83.7%**	**86.4%**	**83.4%**	**81.4%**	**82.6%**	**81.9%**	**87.4%**	**80.7%**	**83.9%**	**72.0%**	**91.4%**
188													
189	**Managed Care Administration**		**22,619,324**	**7,403,912**	**15,215,412**	**1,178,762**	**3,792,022**	**483,222**	**3,165,233**	**1,309,216**	**2,875,436**	**694,327**	**1,717,194**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.1%**	**2.7%**	**5.5%**	**10.6%**	**8.2%**	**3.9%**	**6.9%**	**9.6%**	**3.8%**	**3.5%**	**6.9%**
191													
192	**Contract Cost**		**278,797,477**	**29,283,463**	**249,514,014**	**11,138,278**	**46,509,263**	**12,244,730**	**45,727,949**	**13,603,287**	**75,480,893**	**19,922,495**	**24,887,119**
193	**Net before Settlement**		**27,320,474**	**(3,970,671)**	**31,291,145**	**1,093,046**	**5,196,070**	**2,108,997**	**2,973,167**	**1,627,250**	**11,035,303**	**6,790,288**	**467,025**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(23,310,336)	7,980,809	(31,291,145)	(1,093,046)	(5,196,070)	(2,108,997)	(2,973,167)	(1,627,250)	(11,035,303)	(6,790,288)	(467,025)
198	**Net after Settlement**		**4,010,138**	**4,010,138**	**(0)**	**-**	**-**	**-**	**0**	**-**	**-**	**-**	**(0)**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2022			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													
201	***State General Fund Services***			*HCC%*	2.4%	4.8%	0.8%	3.3%	0.0%	5.5%	0.5%	0.9%	4.0%
202	**Contract Revenue**				**11,261,637**	**727,535**	**1,945,198**	**748,073**	**1,754,975**	**740,190**	**3,507,672**	**818,796**	**1,019,198**
203													
204	External Provider Cost				2,017,112	140,962	217,186	99,974	155,787	397,528	667,124	164,070	174,482
205	Internal Program Cost				2,792,572	365,105	103,855	132,891	939,776	320,554	-	137,591	792,799
206	SSI Reimb, 1st/3rd Party Cost Offset				(3,241)	-	-	-	-	-	(3,241)	-	-
207	**Total Healthcare Cost**				**4,806,443**	**506,067**	**321,041**	**232,865**	**1,095,563**	**718,082**	**663,883**	**301,661**	**967,281**
208	**Medical Loss Ratio (HCC % of Revenue)**				**42.7%**	**69.6%**	**16.5%**	**31.1%**	**62.4%**	**97.0%**	**18.9%**	**36.8%**	**94.9%**
209													
210	**Managed Care Administration**				**667,583**	**66,886**	**23,136**	**17,953**	**352,063**	**85,649**	**29,847**	**12,268**	**79,781**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**12.2%**	**11.7%**	**6.7%**	**7.2%**	**24.3%**	**10.7%**	**4.3%**	**3.9%**	**7.6%**
212													
213	**Contract Cost**				**5,474,026**	**572,953**	**344,177**	**250,818**	**1,447,626**	**803,732**	**693,730**	**313,929**	**1,047,061**
214	**Net before Settlement**				**5,787,611**	**154,582**	**1,601,021**	**497,255**	**307,349**	**(63,542)**	**2,813,942**	**504,867**	**(27,863)**
215													
216	Other Redistributions of State GF				1,715,883	-	(314,774)	-	(583,216)	-	2,819,061	(205,188)	-
217	Contract Settlement				(154,562)	(154,562)	-	-	-	-	-	-	-
218	**Net after Settlement**				**7,348,931**	**20**	**1,286,247**	**497,255**	**(275,867)**	**(63,542)**	**5,633,003**	**299,679**	**(27,863)**
219	**CCBHC revenues and expenditures are currently included in Medicaid Specialty Service, Statement modifications are in progress to separate CCBHC from Medicaid Specialty Services.*												

Southwest Michigan
BEHAVIORAL HEALTH

Fiscal year 2022(October 1, 2021- September 30, 2022) SWMBH Participant Community Mental Health Site Review Summary Results

Upstream Requirements

- **Managed Care Rules require the following (42 CFR §438.230):**
  - PIHPs remain ultimately responsible for adhering to and complying with the terms of their contract with the State;
  - All contracts between the PIHP and a subcontractor must be in writing and specify:
    - Any delegated activities or obligations, and related reporting responsibilities;
    - That the subcontractor agrees to perform the delegated activities in compliance with the PIHP's contract obligations;
    - A method for revocation of the delegation of activities or obligations, or specify other remedies in instances where the PIHP determines that the subcontractor has not performed satisfactorily;
    - That the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and contract provisions.
- **MDHHS-PIHP Contract**
  - SWMBH is held "fully liable" and retains "full responsibility" for the performance and completion of all Contract requirements, regardless of whether SWMBH performs the work or subcontracts.
  - SWMBH must "monitor the performance of subcontractors on an ongoing basis" including conducting formal reviews.
  - MDHHS contracts with Health Services Advisory Group (HSAG) to perform an External Quality Review (EQR) of the PIHPs annually, to assess compliance with contractual and managed care responsibilities.

Upstream Requirements

- **Enhanced Oversight & Monitoring**
  - HSAG EQR has become increasingly more robust and rigid.
    - Includes file reviews in delegated managed care functional areas.
    - Results in Corrective Action Plans that are monitored by HSAG and reported to MDHHS
  - MDHHS reorganization has resulted in increased MDHHS staffing devoted to monitoring and oversight of PIHP contract compliance.
    - Increased data requests from the PIHP system.
    - Increased MDHHS intimate involvement in various issues.
  - MDHHS-PIHP contract has had language added increasingly PIHP reporting obligations to MDHHS when a PIHP issues a Notice of Revocation of Delegated Functions or is otherwise monitoring corrective action of a CMH as it relates to delegated managed care functions.
    - PIHPs must notify MDHHS ten (10) days in advance of issuing a Notice to Revoke a delegated function or imposing other sanctions for inadequate or deficient performance.
    - PIHPs must submit quarterly reports to MDHHS of all subcontractor (CMH) noncompliance or deficiencies as it relates to delegated functions, a brief description of the deficiency, what action the PIHP took and is taking to resolve the issue including specific monitoring, and status updates on those efforts.

Subcontractual Relationships & Delegation

PIHP-CMHSP Monitoring

- Upstream requirements and enhanced oversight and monitoring necessarily flow downstream.
- Documentation in place to satisfy managed care and MDHHS-PIHP contract requirements for written agreements:
  - Written Delegation Memorandum Of Understanding with each participant CMHSP, which include specifics around delegated functions, reporting responsibilities, and corrective action and revocation steps.
  - Written contracts that further define requirements and monitoring.
- Annual Participant CMHSP Site Reviews
  - Monitor delegated managed care functions and contractual obligations.
  - Require Corrective Action Plans for identified deficiencies.
  - Monitoring schedule provided to CMH and used to monitor the implementation and effectiveness of CMH corrective action plans.
  - Annual Site Reviews are relied on heavily to show HSAG that SWMBH is meeting its contractual obligations by ensuring they are performed through its subcontractors.

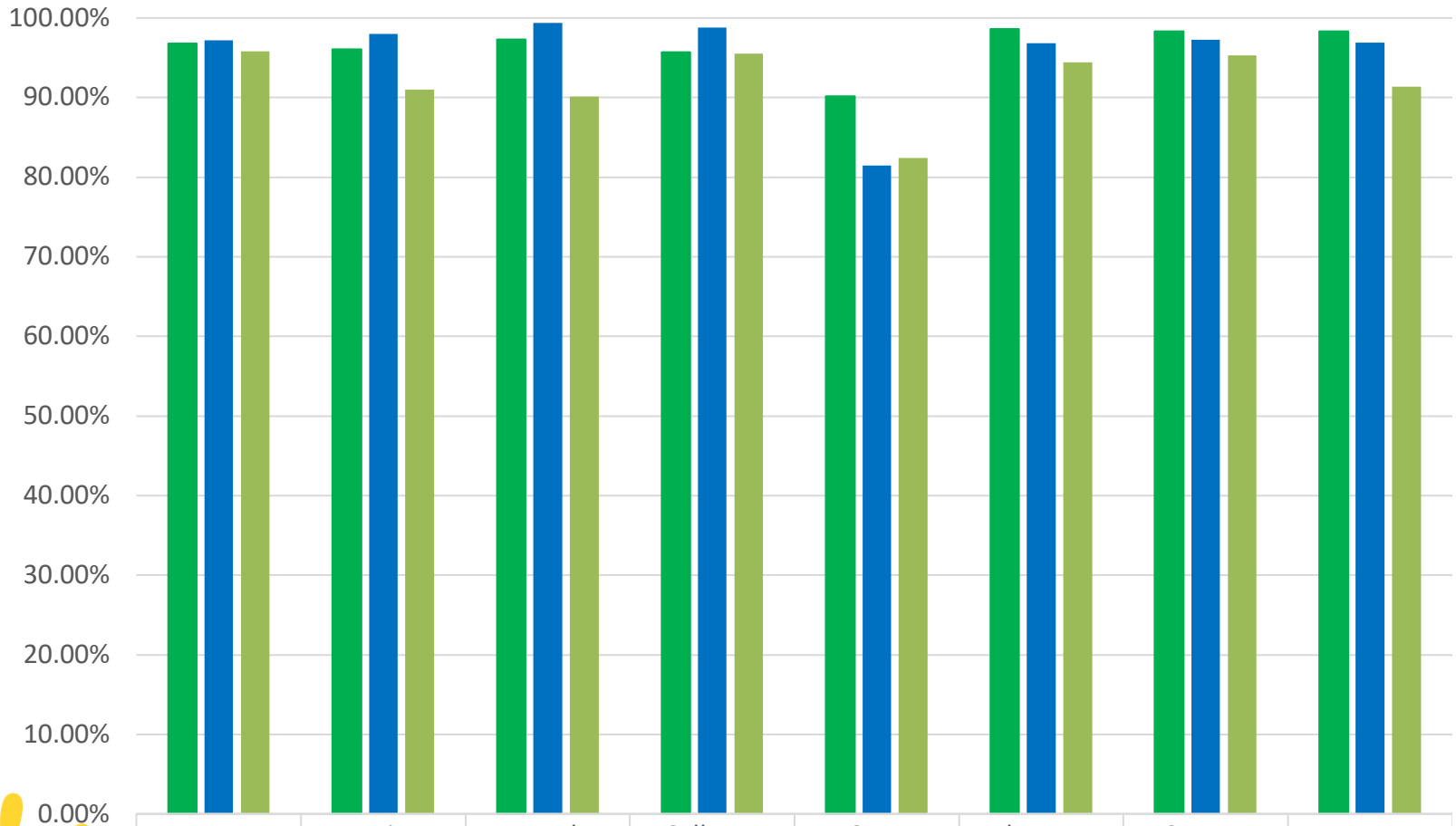
CMHSP Site Review Process

- FY21 and FY22 have been a combination of desk audit and virtual reviews
- Reviews delegated functions and contractual requirements
  - Any functions that are not in full compliance with MDHHS, 42 CFR § 438 (Managed Care), and SWMBH requirements require corrective action plans to be submitted by the participant CMHSP and approved by SWMBH
- SWMBH monitors select clinical programs each year for program and staffing fidelity, and adherence to MDHHS contractual requirements for specialty services
  - Clinical requirements not meeting 90% compliance require corrective action plans
- SWMBH monitors corrective action plan implementation at designated intervals to ensure it is occurring and assess CAP effectiveness at resolving identified deficiencies.

FY22 CMHSP Site Review Process

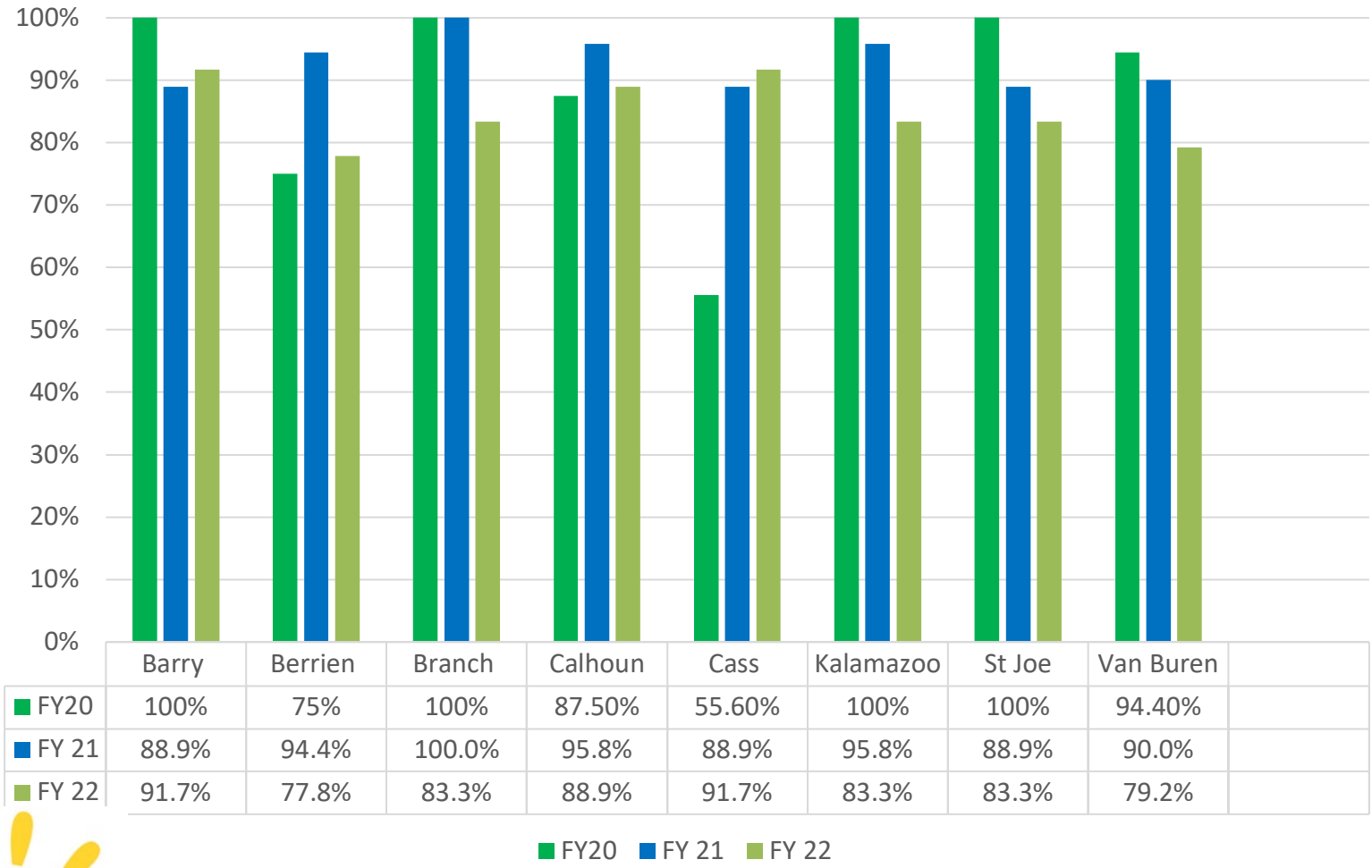
- Full Review
- Components included:
  - Administrative desk audit reviewing policies, procedures, and proof of implementation of various business processes
  - Clinical desk audit – SWMBH clinical reviewers accessed CMH EMRs remotely and reviewed clinical records
  - Denial & 2nd Opinion File Reviews completed via desk audit
  - Virtual file reviews for Grievance & Appeals, Credentialing & Staff Training
  - Virtual Site Review Day to review any deficiencies or missing items with CMH Subject Matter Experts, complete virtual file reviews, and present final findings

Delegated / Administrative Function Review Overall Scores by CMHSP



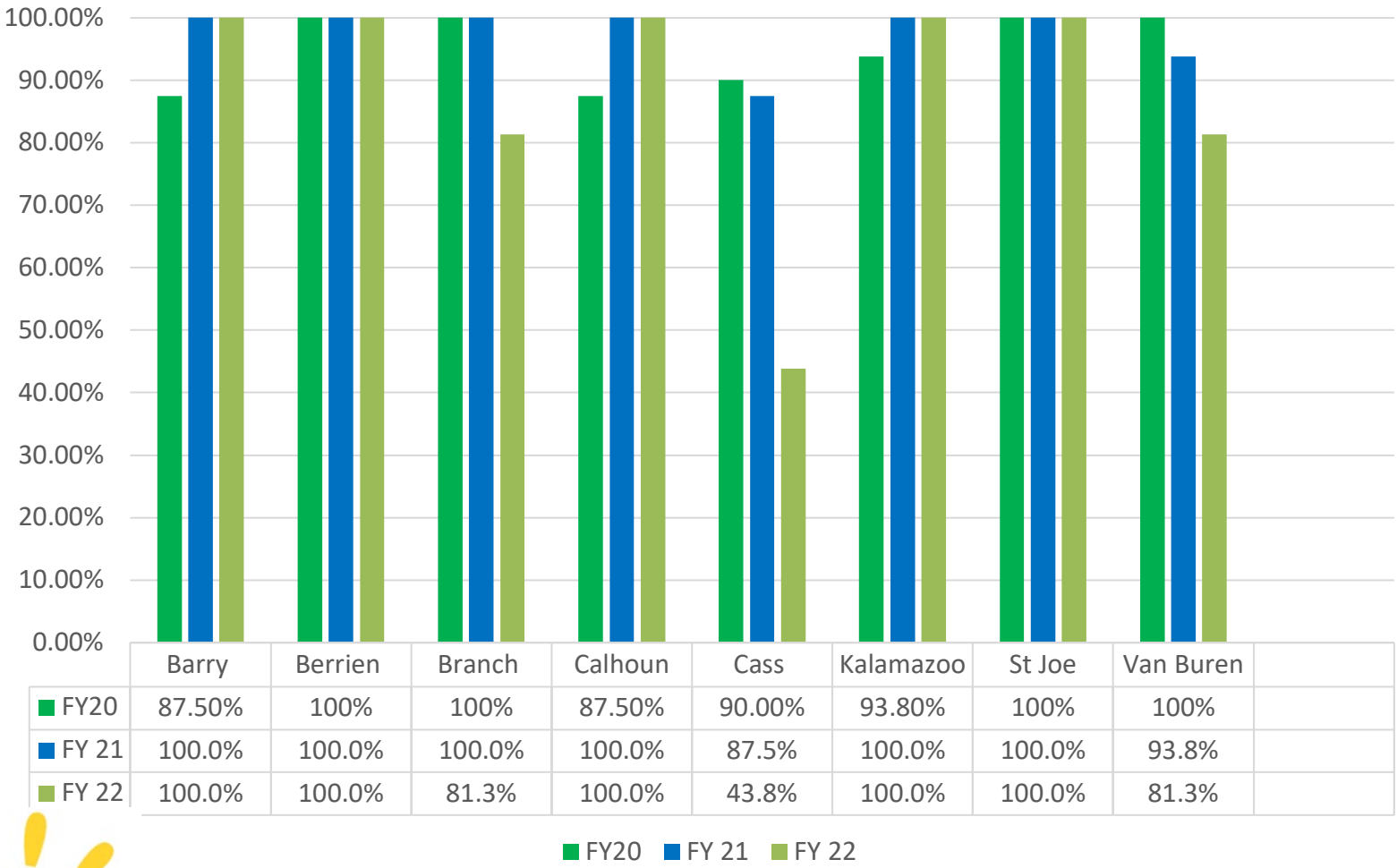
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY20	96.80%	96.10%	97.30%	95.70%	90.20%	98.60%	98.30%	98.30%
Overall Score FY21	97.2%	98.0%	99.4%	98.8%	81.5%	96.8%	97.3%	96.9%
Overall Score FY22	95.8%	91.0%	90.1%	95.5%	82.4%	94.4%	95.3%	91.4%

CMHSP Oversight and Monitoring: Utilization Management and Access



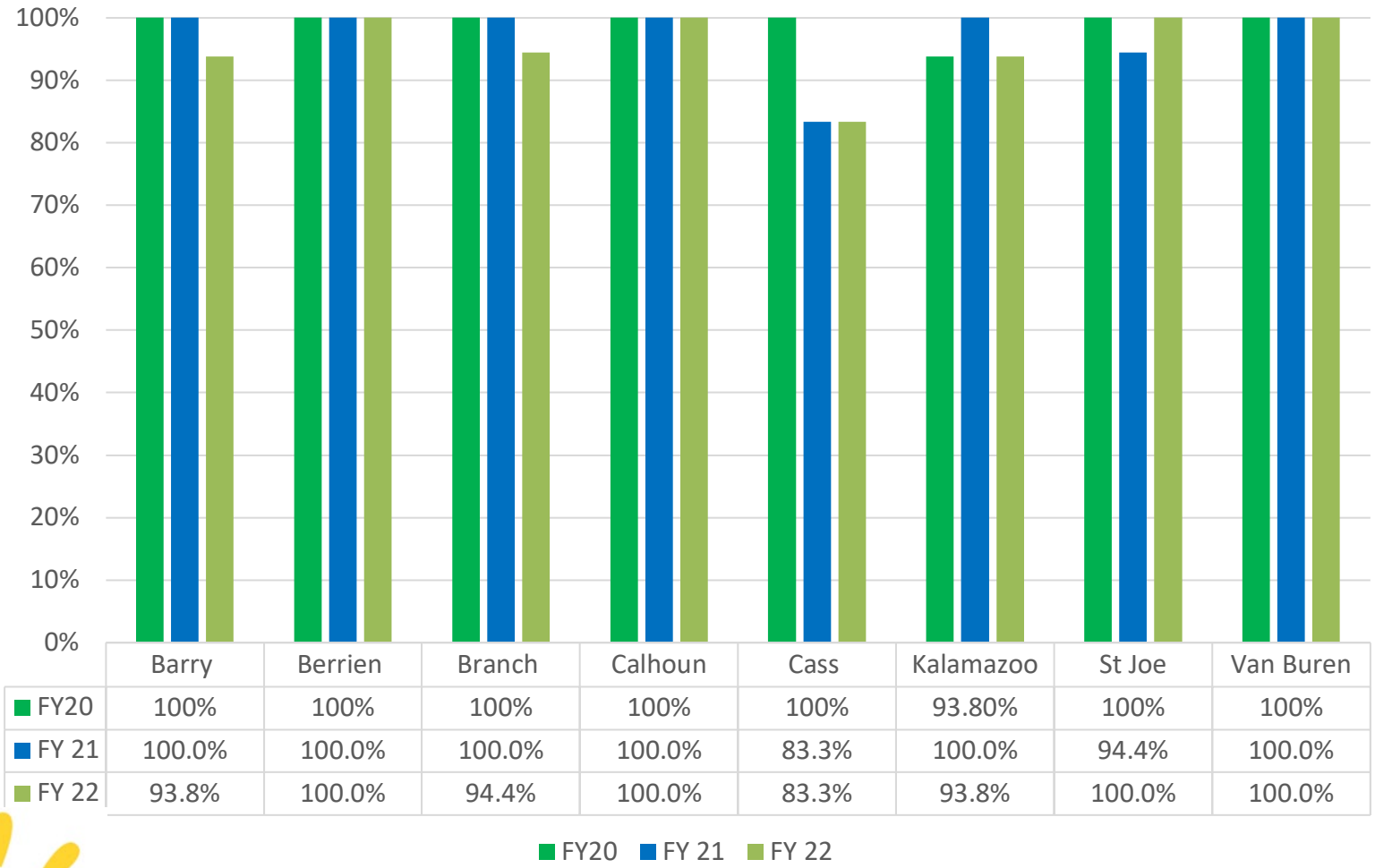
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	75%	100%	87.50%	55.60%	100%	100%	94.40%
FY 21	88.9%	94.4%	100.0%	95.8%	88.9%	95.8%	88.9%	90.0%
FY 22	91.7%	77.8%	83.3%	88.9%	91.7%	83.3%	83.3%	79.2%

CMHSP Oversight and Monitoring Claims



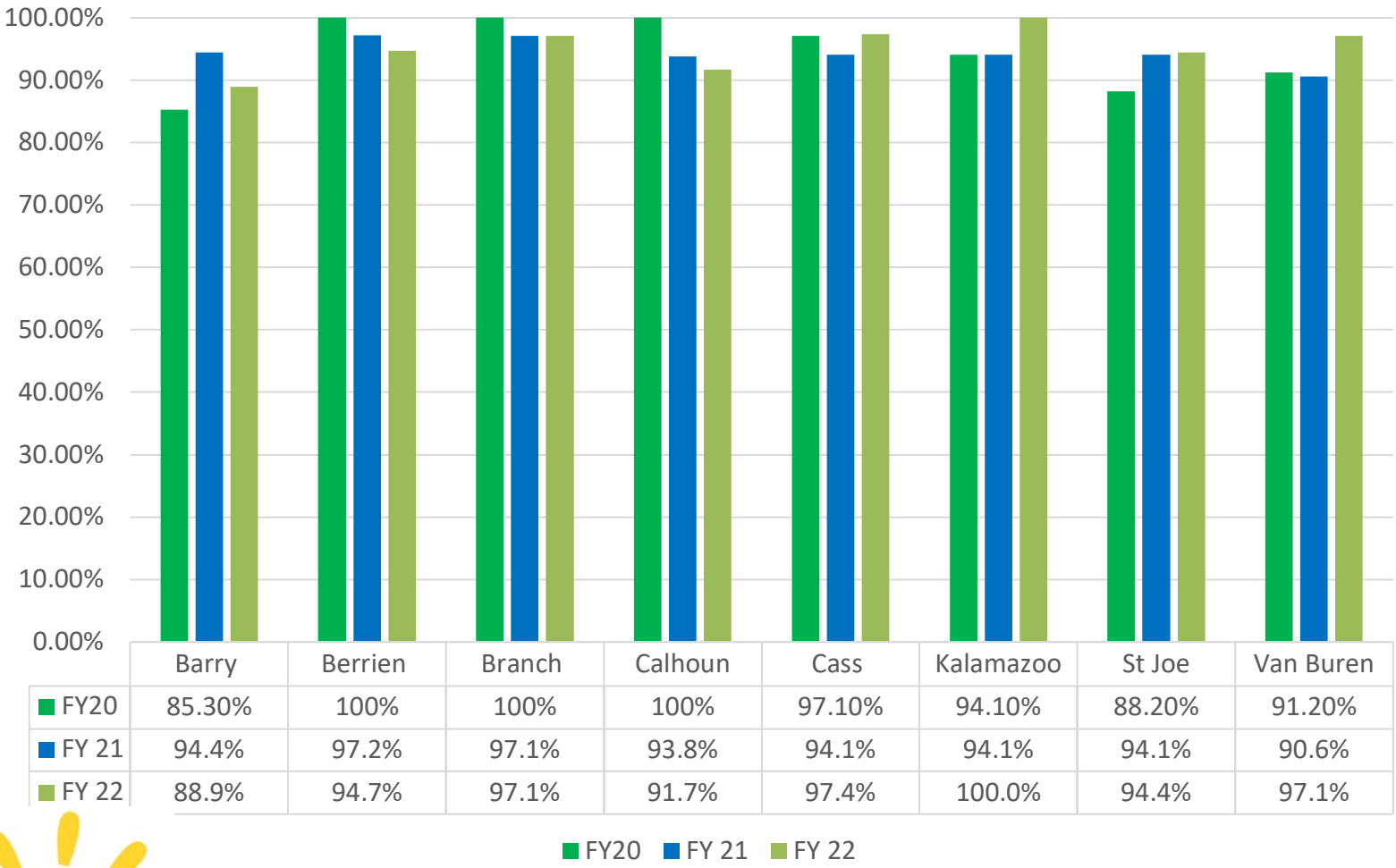
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	87.50%	100%	100%	87.50%	90.00%	93.80%	100%	100%
FY 21	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	93.8%
FY 22	100.0%	100.0%	81.3%	100.0%	43.8%	100.0%	100.0%	81.3%

CMHSP Oversight and Monitoring Compliance Program



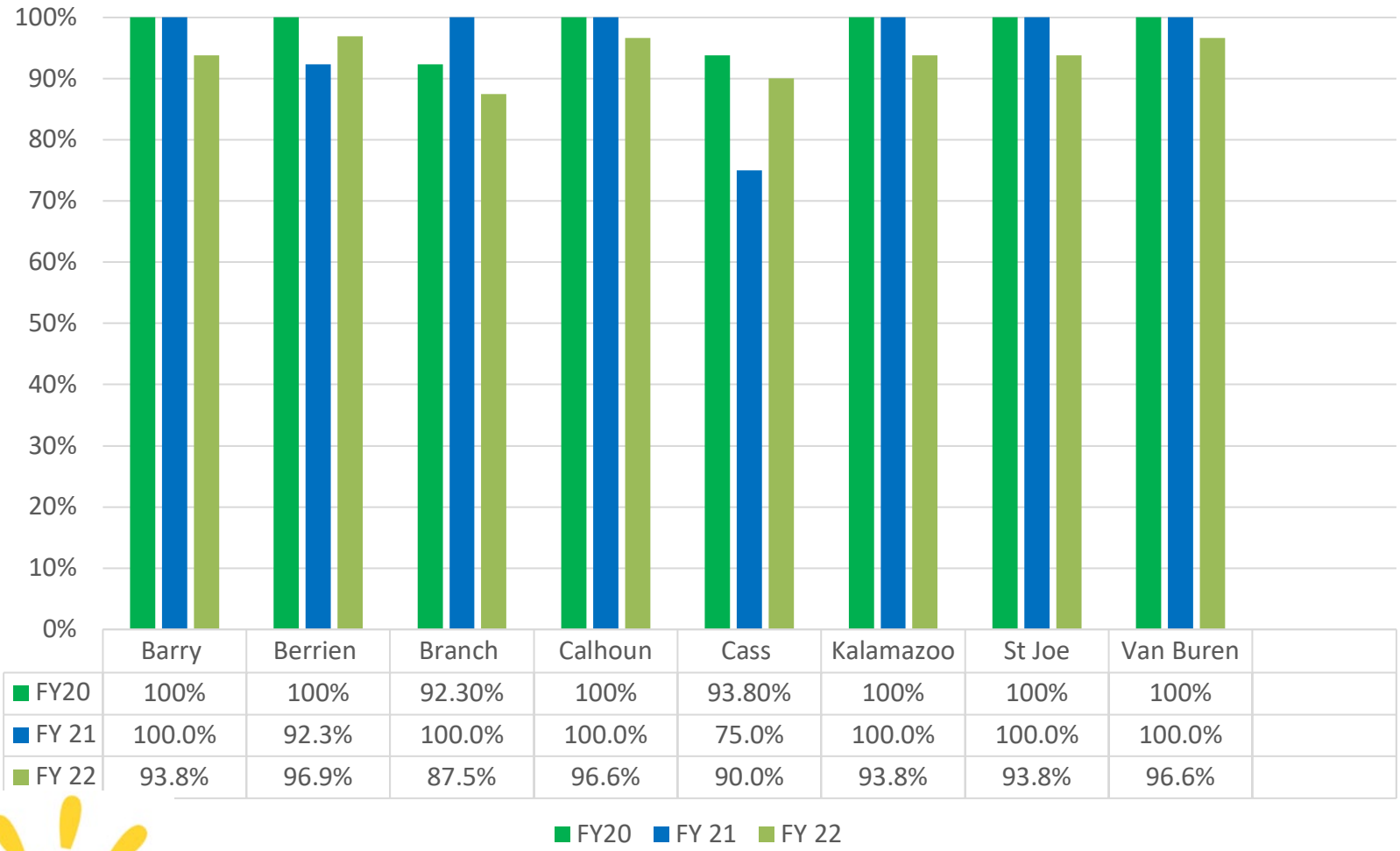
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	100%	100%	100%	100%	93.80%	100%	100%
FY 21	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	94.4%	100.0%
FY 22	93.8%	100.0%	94.4%	100.0%	83.3%	93.8%	100.0%	100.0%

CMHSP Oversight and Monitoring Credentialing



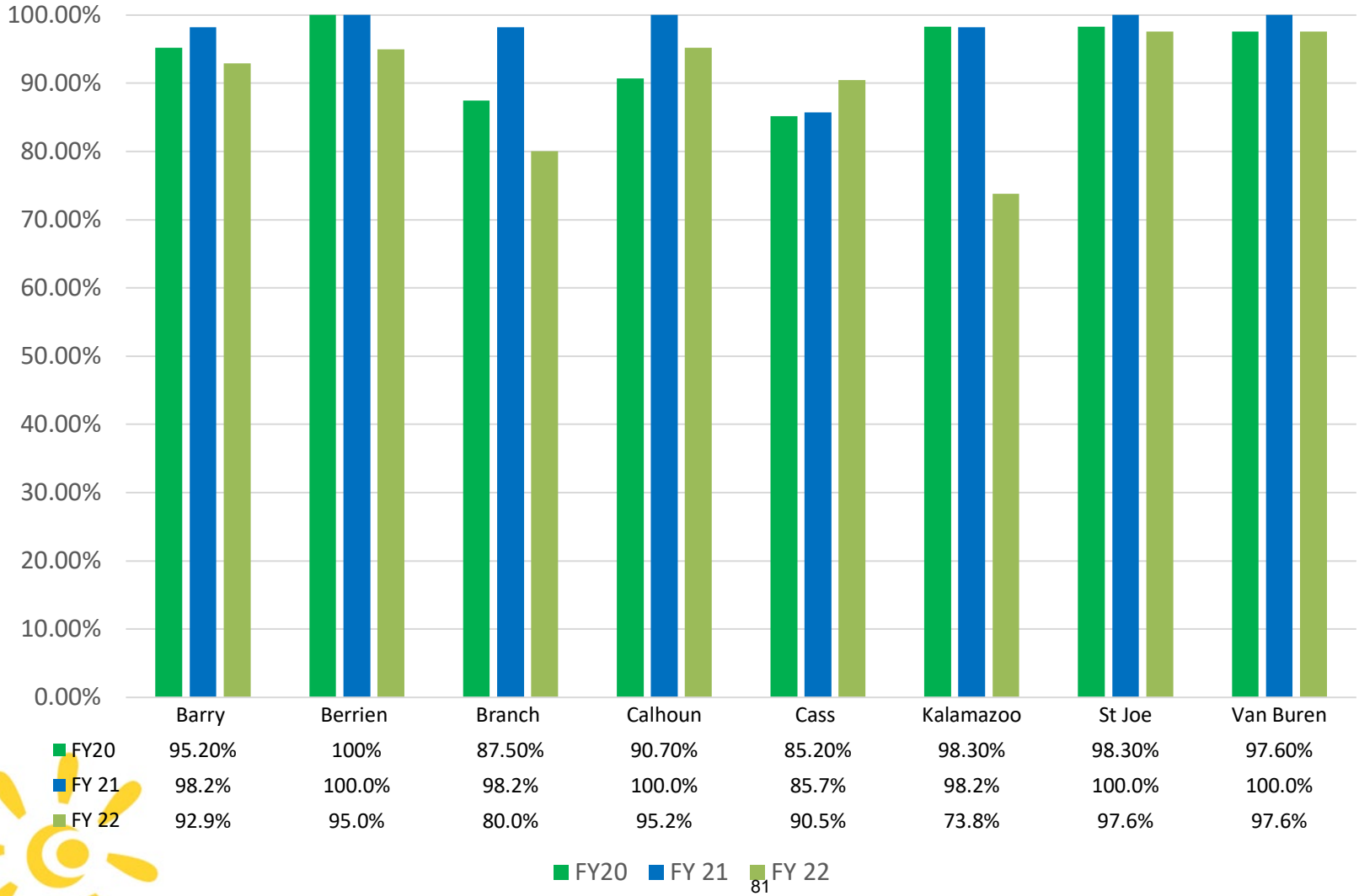
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	85.30%	100%	100%	100%	97.10%	94.10%	88.20%	91.20%
FY 21	94.4%	97.2%	97.1%	93.8%	94.1%	94.1%	94.1%	90.6%
FY 22	88.9%	94.7%	97.1%	91.7%	97.4%	100.0%	94.4%	97.1%

CMHSP Oversight and Monitoring Customer Services



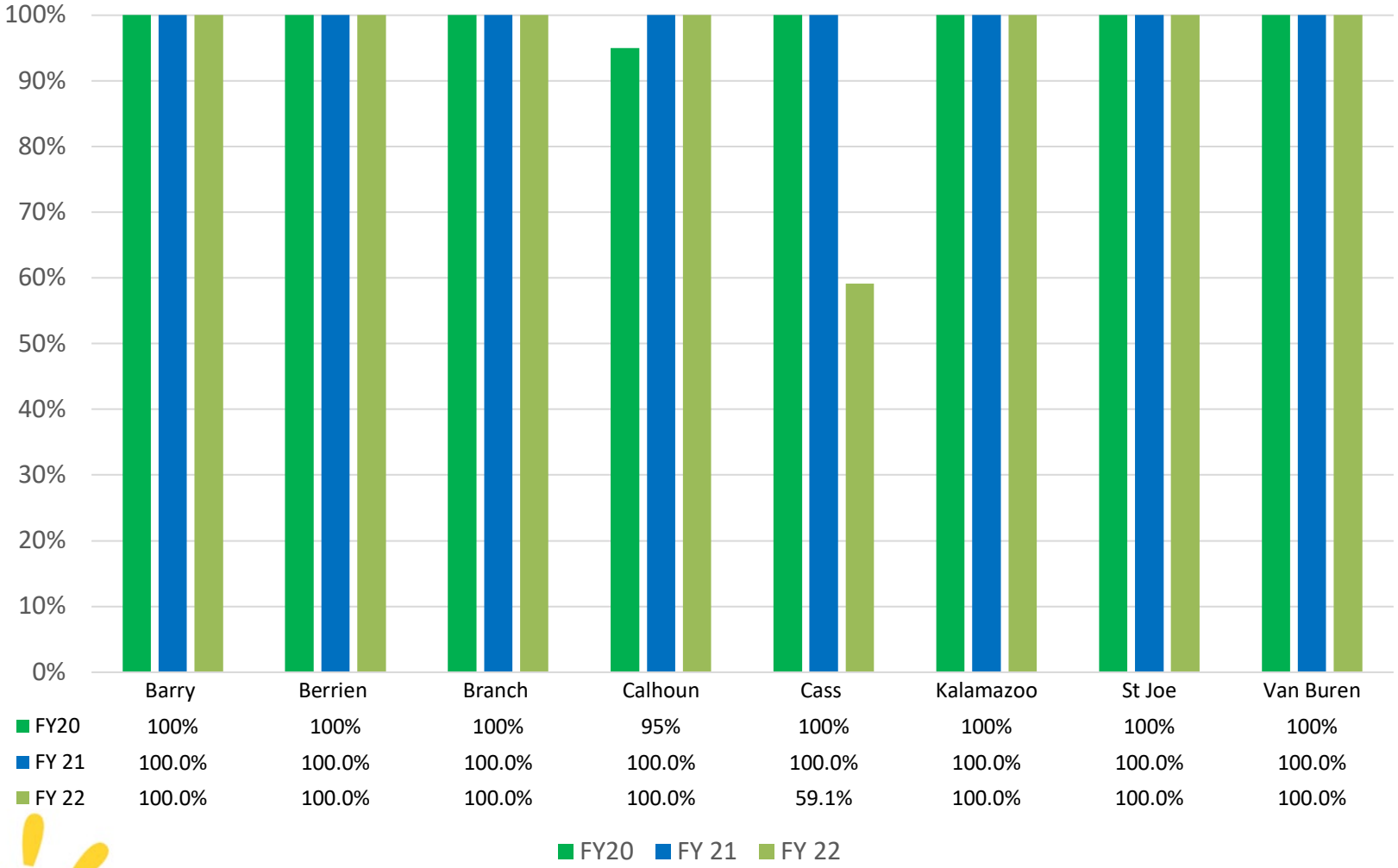
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	100%	92.30%	100%	93.80%	100%	100%	100%
FY 21	100.0%	92.3%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%
FY 22	93.8%	96.9%	87.5%	96.6%	90.0%	93.8%	93.8%	96.6%

CMHSP Oversight and Monitoring Grievances and Appeals



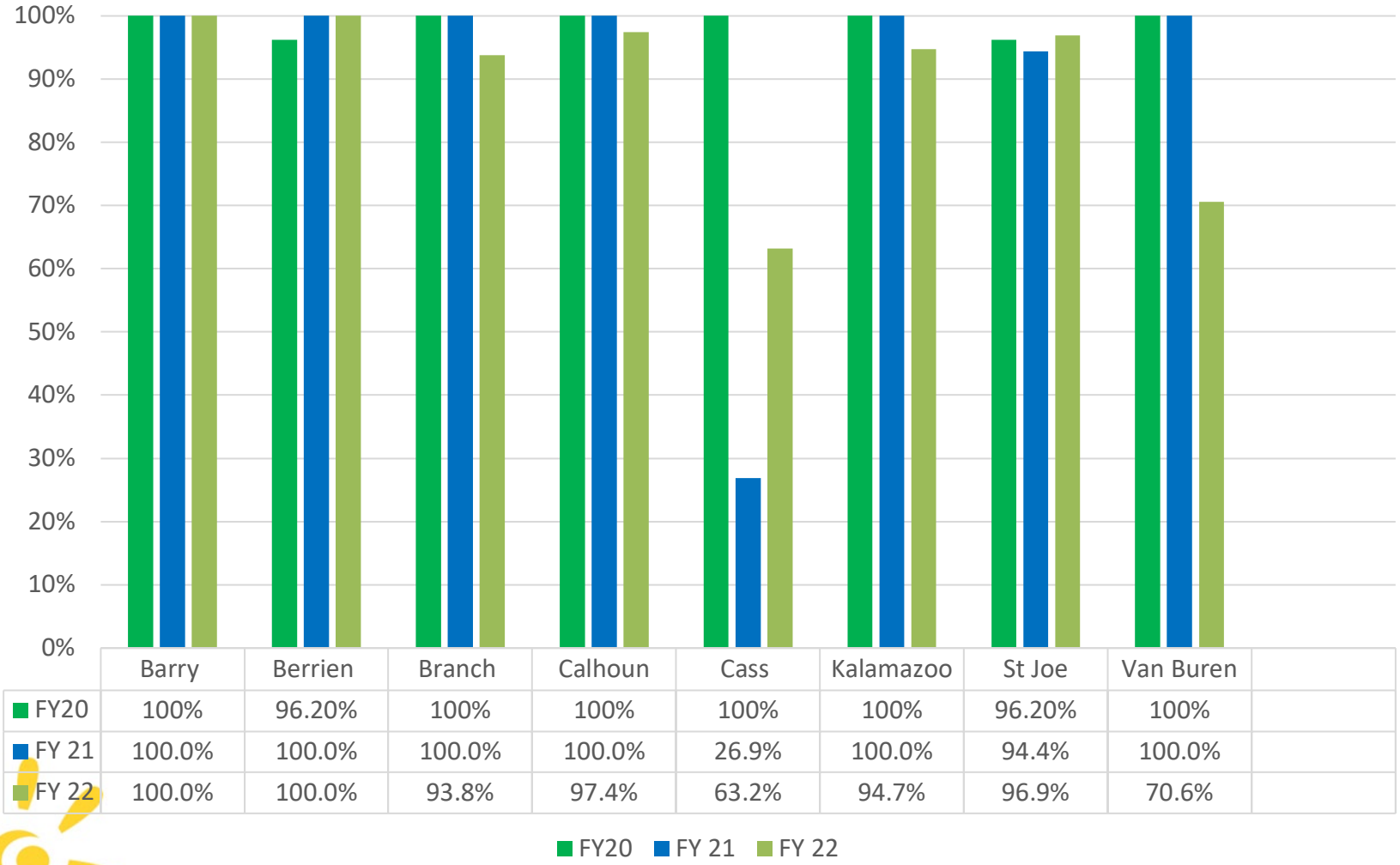
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	95.20%	100%	87.50%	90.70%	85.20%	98.30%	98.30%	97.60%
FY 21	98.2%	100.0%	98.2%	100.0%	85.7%	98.2%	100.0%	100.0%
FY 22	92.9%	95.0%	80.0%	95.2%	90.5%	73.8%	97.6%	97.6%

CMHSP Oversight and Monitoring Provider Network



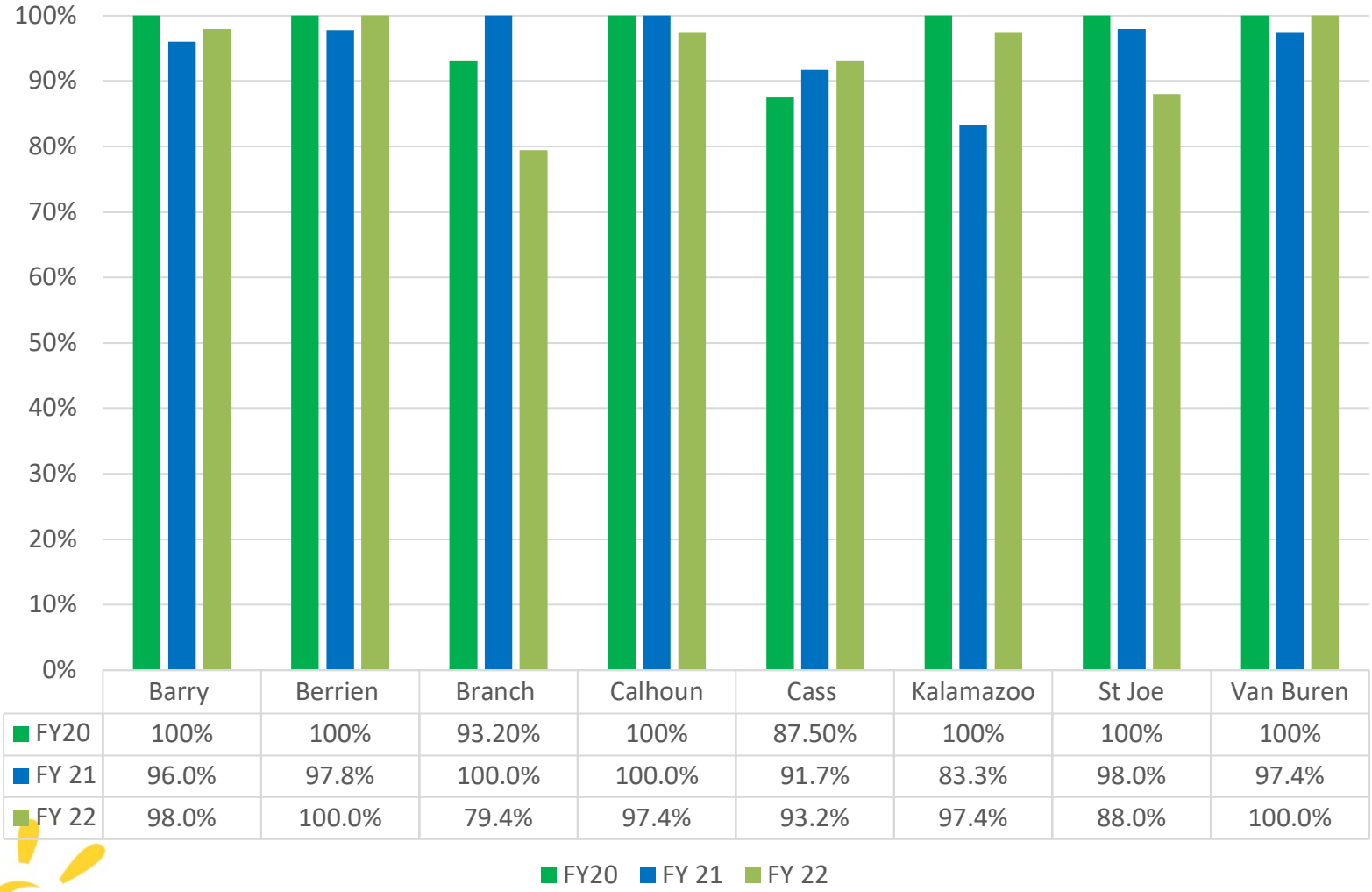
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	100%	100%	95%	100%	100%	100%	100%
FY 21	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FY 22	100.0%	100.0%	100.0%	100.0%	59.1%	100.0%	100.0%	100.0%

CMHSP Oversight and monitoring Quality Improvement



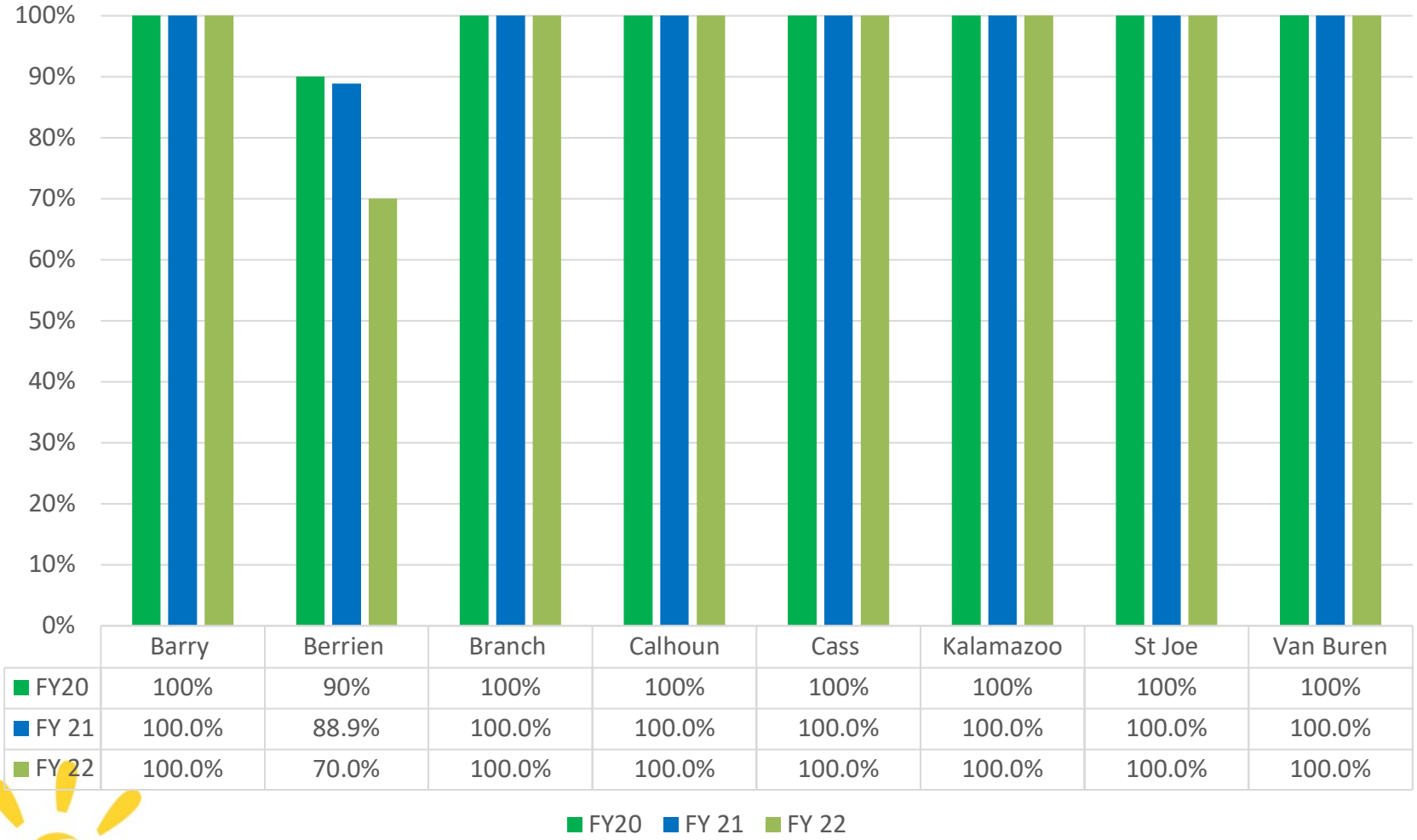
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	96.20%	100%	100%	100%	100%	96.20%	100%
FY 21	100.0%	100.0%	100.0%	100.0%	26.9%	100.0%	94.4%	100.0%
FY 22	100.0%	100.0%	93.8%	97.4%	63.2%	94.7%	96.9%	70.6%

CMHSP Oversight and Monitoring Staff Training



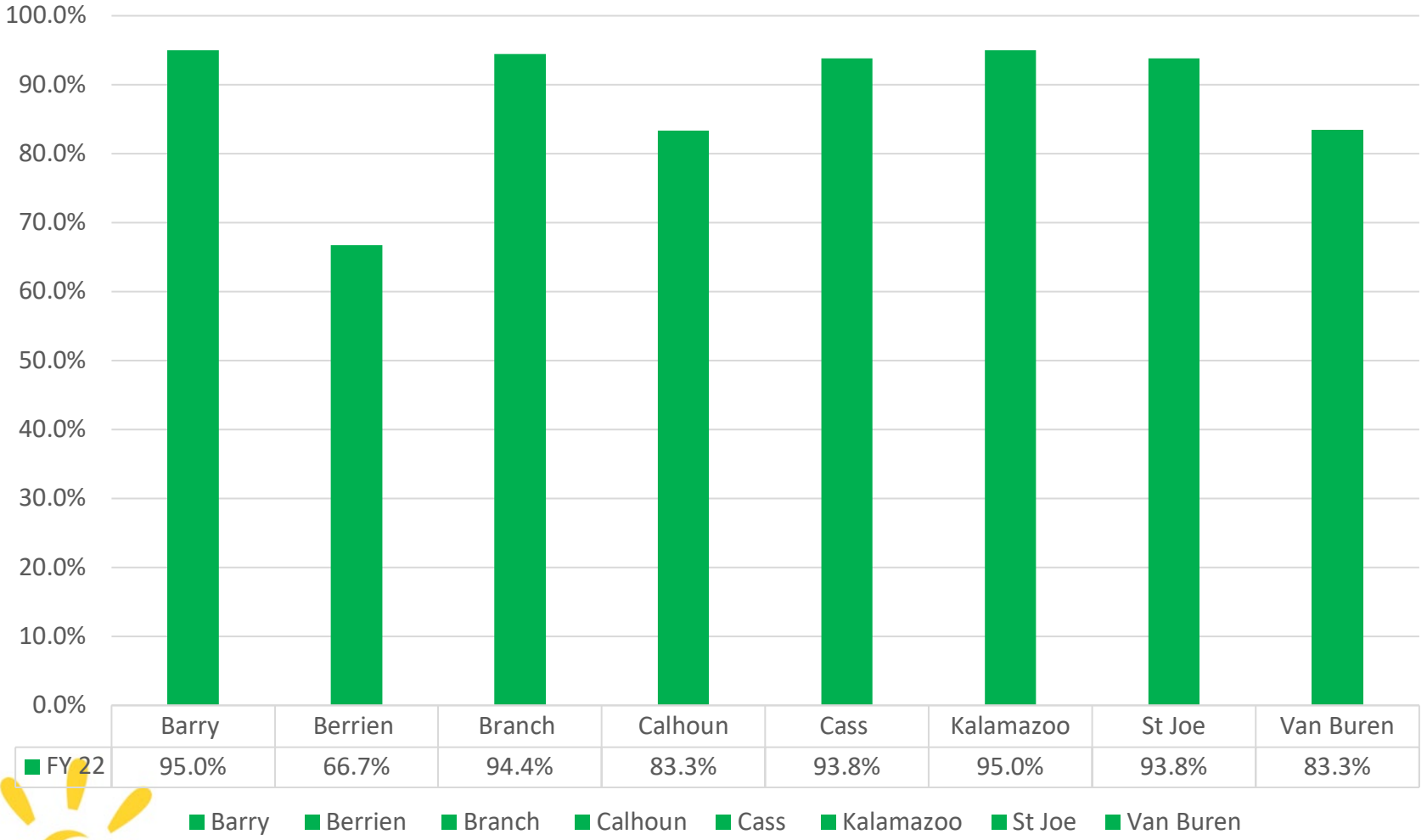
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	100%	93.20%	100%	87.50%	100%	100%	100%
FY 21	96.0%	97.8%	100.0%	100.0%	91.7%	83.3%	98.0%	97.4%
FY 22	98.0%	100.0%	79.4%	97.4%	93.2%	97.4%	88.0%	100.0%

CMHSP Oversight and Monitoring SUD Administrative –EBP Fidelity

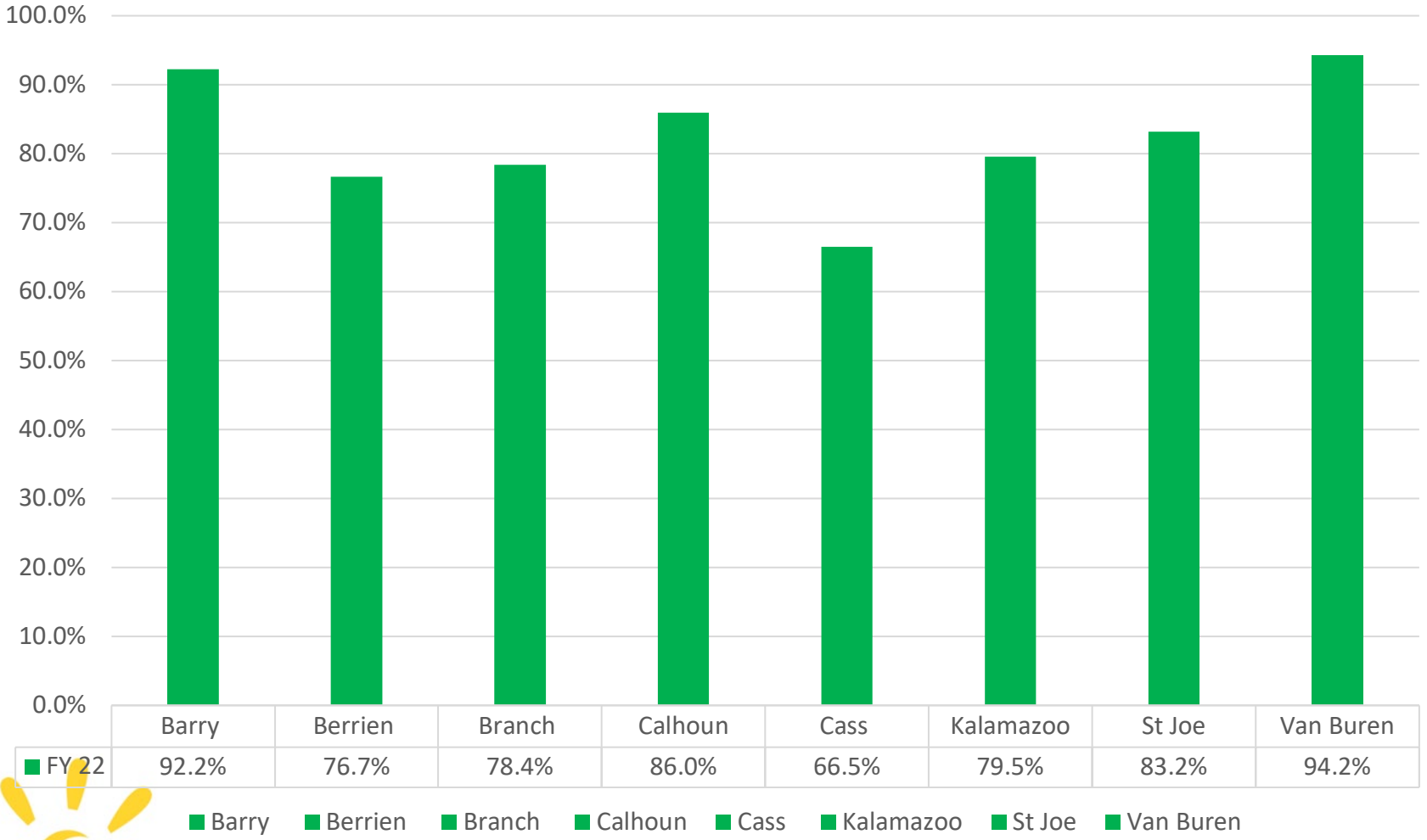


	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY20	100%	90%	100%	100%	100%	100%	100%	100%
FY 21	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FY 22	100.0%	70.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

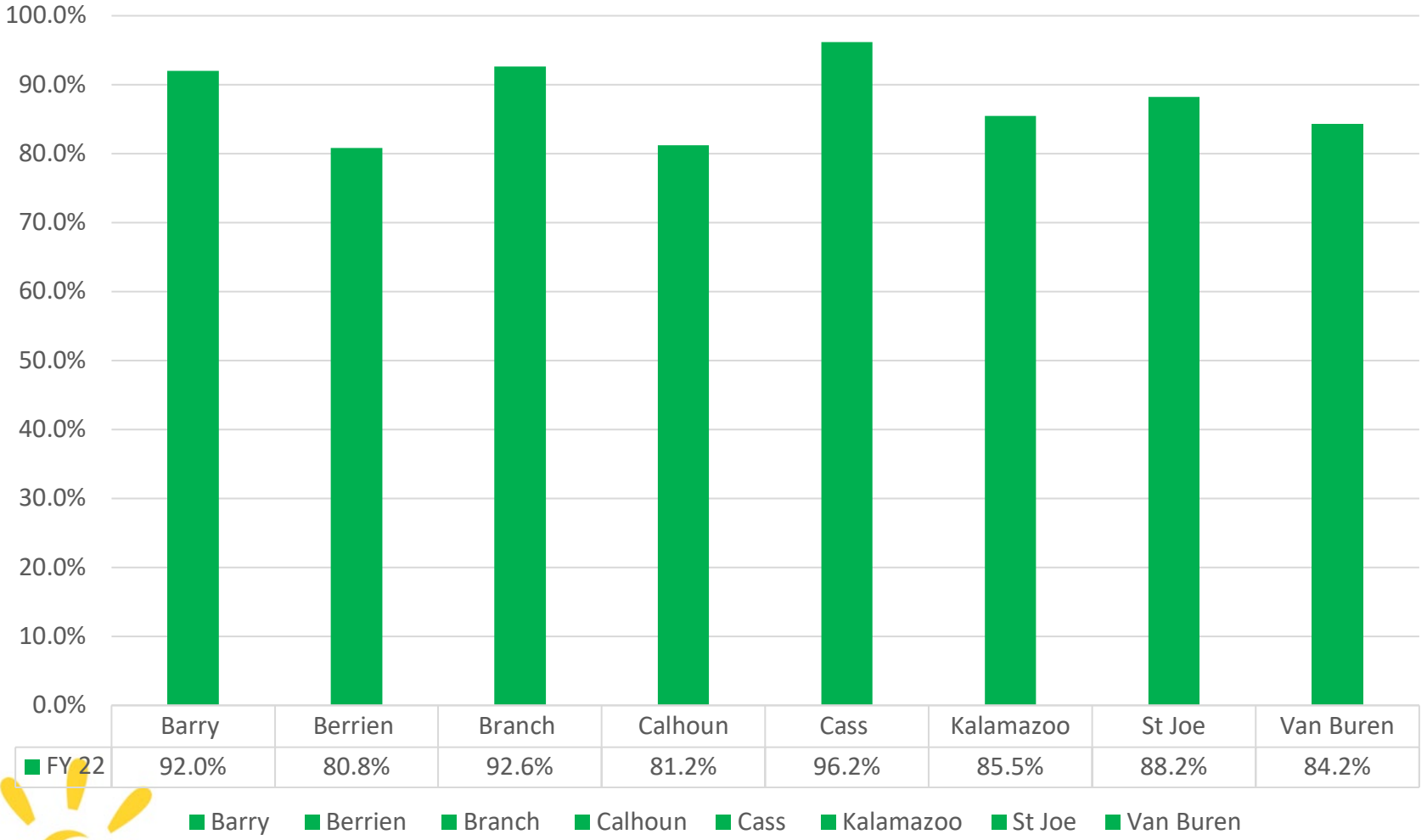
CMHSP Oversight and Monitoring Clinical Administrative

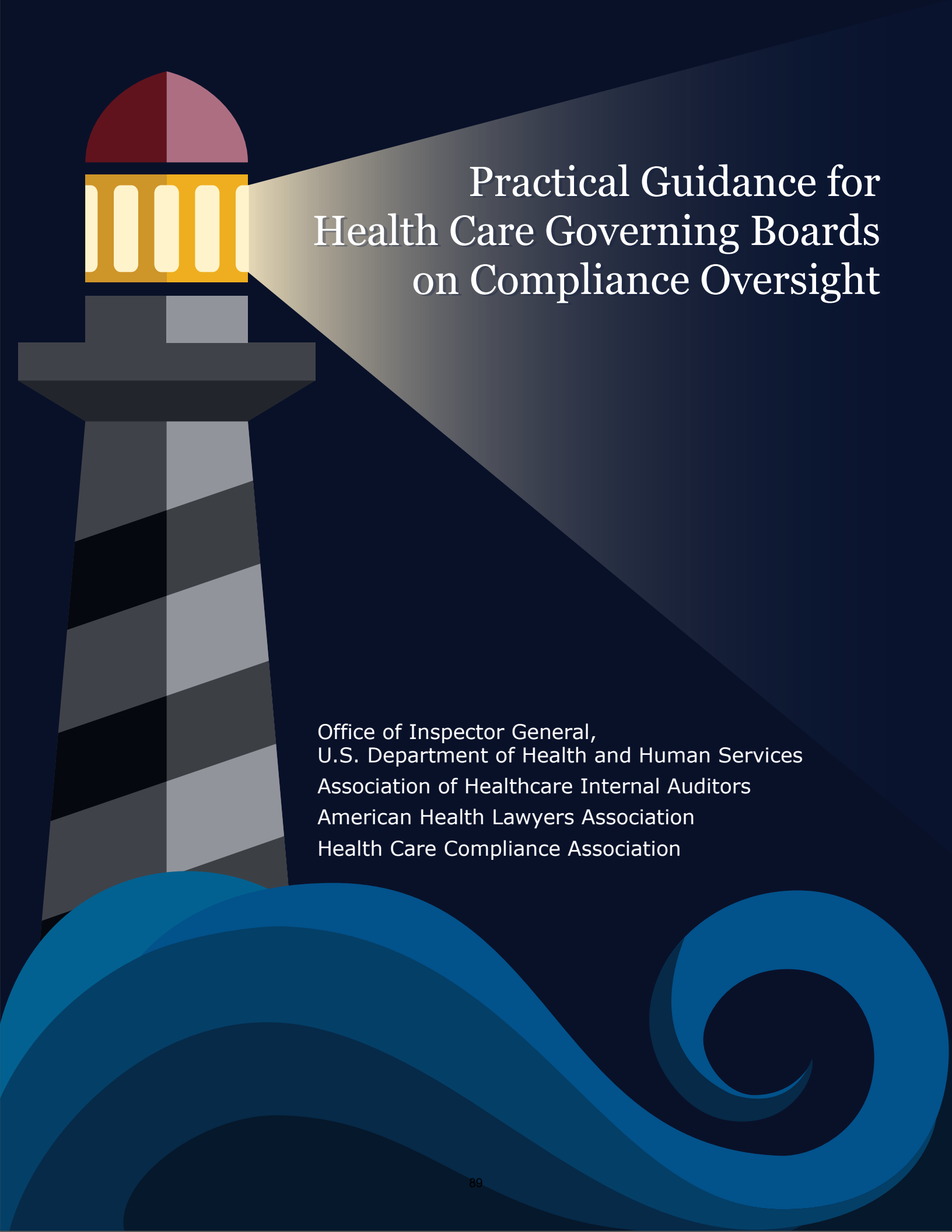


CMHSP Oversight and Monitoring Clinical Quality File Review



CMHSP Oversight and Monitoring
SUD Clinical File Review





Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services

Association of Healthcare Internal Auditors

American Health Lawyers Association

Health Care Compliance Association

About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

Table of Contents

Introduction

Previous guidance[1] has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.[2] The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),[3] OIG's voluntary compliance program guidance documents,[4] and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."[5] The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to "the size of the organization."[6] In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.[7] Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.[8] Smaller organizations may meet their compliance responsibility by "using available personnel, rather than employing separate staff, to carry out the compliance and ethics program." Board members of such organizations may wish to evaluate whether the organization is "modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations."[9] The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations' compliance and ethics efforts than their larger counterparts.[10]

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

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7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.[11] OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.[12] Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

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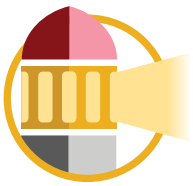
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 *See* Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:



The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,[13] and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.[14] While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;[15]

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13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

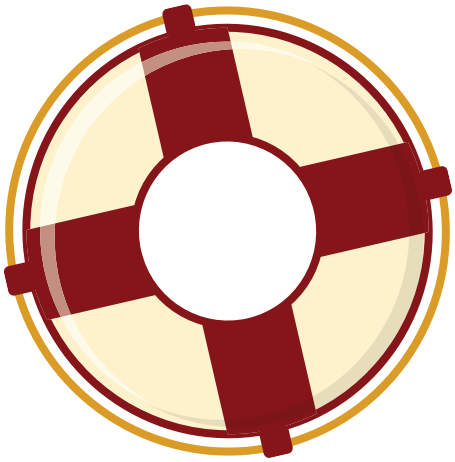
15 *See, generally, id.*

the same is true for internal audit.[16] To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is "monitoring and auditing to detect criminal conduct."[17] Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.[18]

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[19] offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

Compliance is an enterprise-wide responsiblity.

In an effort to support the concept that compliance is "a way of life," a Board may assess employee performance in promoting and adhering to compliance.[20] An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html.

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.[21] The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is "identified" or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to "identify" an overpayment.[22] However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization's compliance program may be in correcting and remediating compliance issues.

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21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is "identified" when a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.") disregard or deliberate ignorance of the overpayment."); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG's Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management's responses to identified violations of the organization's policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization's compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

23 *See* OIG, *Self-Disclosure Information*, http://oig.hhs.gov/compliance/self-disclosure-info.

24 *See id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).")

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

Bibliography

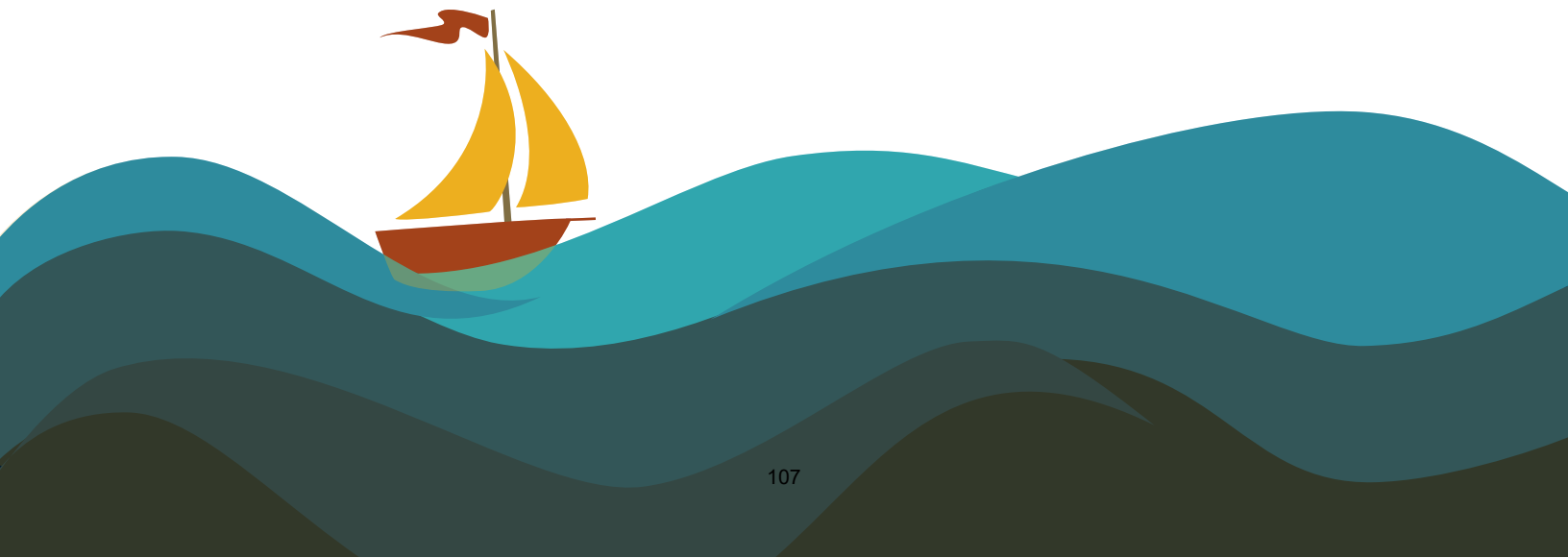
Elisabeth Belmont, et al., "Quality in Action: Paradigm for a Hospital Board-Driven Quality Program," 4 Journal of Health & Life Sciences Law. 95, 113 (Feb. 2011).

Larry Gage, *Transformational Governance: Best Practices for Public and Nonprofit Hospitals and Health Systems*, Center for Healthcare Governance (2012).

Tracy E. Miller and Valerie L. Gutmann, "Changing Expectations for Board Oversight of Healthcare Quality: The Emerging Paradigm," 2 Journal of Health & Life Sciences Law (July 2009).

Tracy E. Miller, B*oard Fiduciary Duty to Oversee Quality: New Challenges, Rising Expectations*, 3 NYSBA Health L.J. (Summer/Fall 2012).

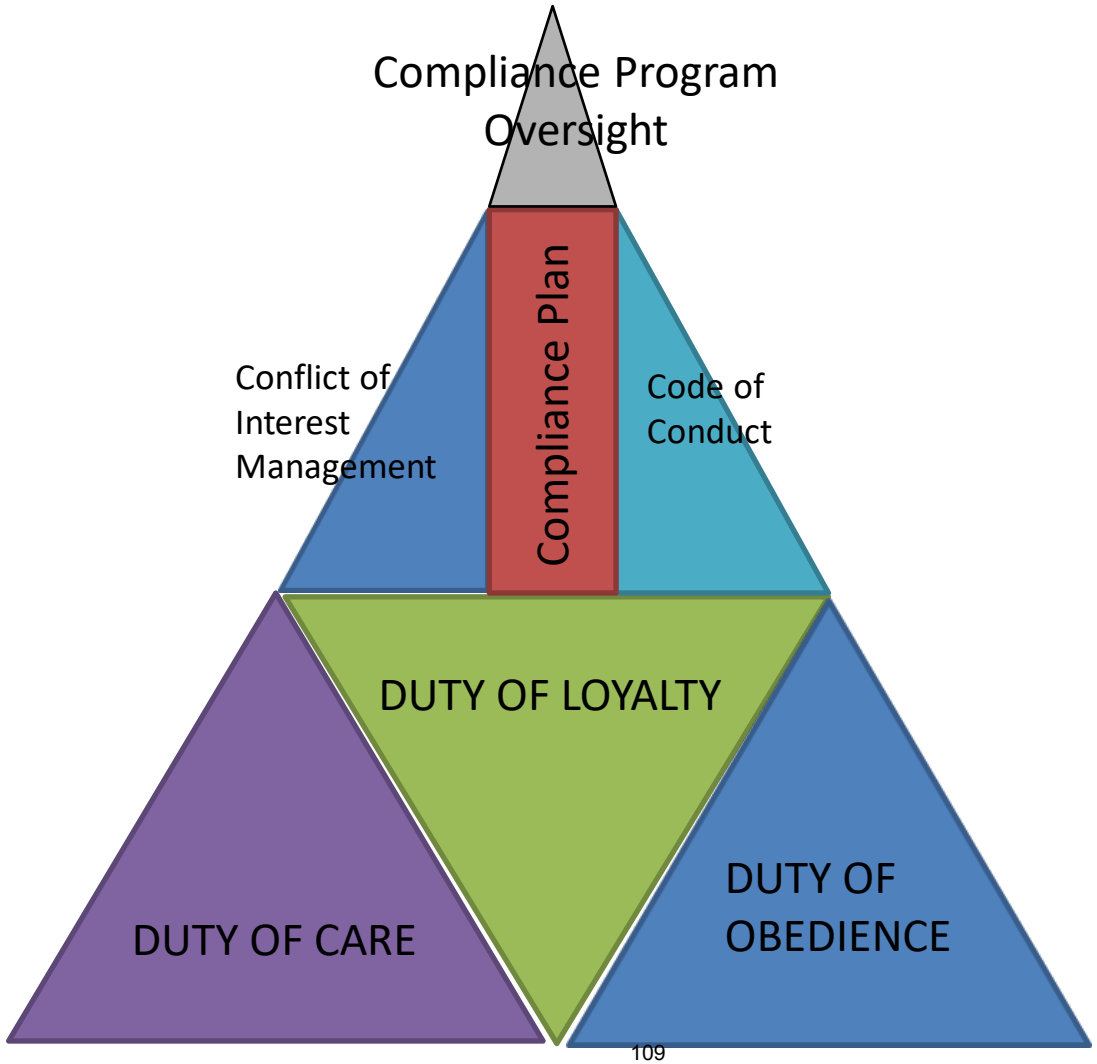
Lawrence Prybil, et al., *Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives*, Grant Thornton LLP (Feb. 2008).



Corporate Compliance Role and Function

10/14/2022

Board of Directors: Role & Function



Board of Directors: Role & Function

FIDUCIARY DUTIES OWED TO SWMBH:

- Duty of Care – requires a Board Member to exercise reasonable care that an ordinarily prudent person would use in similar circumstances.

- Duty of Loyalty – requires a Board Member to act faithfully in the best interest of the organization and never for self-benefit financially or any other personal gain.

- Duty of Obedience – requires a Board Member to serve in a manner that is faithful to and consistent with the organization's mission.

SWMBH Board Members' Compliance role flows from and compliments these fiduciary duties.

Board of Directors: Role & Function

Recognize and Avoid Conflicts of Interest

- Can I act in the best interests of the Region as a whole?
- Do I have a relationship/position that may effect my decision-making when sitting as a SWMBH Board Member?
  - Examples – spouse is employed by a provider within SWMBH's provider network; you serve as a Board member for a contracted entity; child works for a SWMBH vendor.

- Complete Financial Interest Disclosure Statements (FIDs) annually and whenever a new actual or perceived COI exists.
  - Chief Compliance Officer reviews and Board determines if an actual or perceived COI exists.
  - If not, no further action.
  - If yes, Board evaluates what restrictions can be implemented so Board Member can continue service AND continue with actual/perceived COI, OR if the two positions are mutually exclusive (very rare).

- Duty to disclose AND duty to inquire of other Board Members
- Protects the integrity of Board action and ensures that you are fulfilling your fiduciary duties owed to SWMBH.

Board of Directors: Role & Function

Comply with Corporate Compliance Plan & Code of Conduct

- Comply with SWMBH's Corporate Compliance Plan;

- Comply with SWMBH's Code of Conduct including:
  - Understanding and abiding by reporting obligations – duty to report actual/suspected fraud, waste, or abuse to the Chief Compliance Officer;
  - Cooperating fully with any Compliance investigation;
  - Remaining free of the influence of alcohol and illegal drugs while performing Board service;
  - Abstaining from harassment and discrimination in any form;
  - Remaining free from conflicts of interest;
  - Maintaining confidentiality, when appropriate (subject to OMA);
  - Not accepting or soliciting business courtesies or gifts meant to effect business decisions, nor any single gift of more than a $25 value or $300 value per year.

Board of Directors: Role & Function

Ensure Compliance Program Oversight

Compliance Program Oversight – the exercise of reasonable care to assure that SWMBH staff carry out their management responsibilities and comply with the law, and that the Compliance Program is effective.

How should Board oversight of Compliance Program functions be accomplished?

Adequate reporting systems.

Board Oversight Responsibilities

Making inquiries to ensure:

- (1) a corporate information and reporting system exists, and
- (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. *(In re Caremark Int'l, Inc. Derivative Litig. 698 A.2d 959 (Del. Ch. 1996)*).

Practical Guidance for Health Care Governing Boards on Compliance Oversight (Published April 20, 2015):

- "The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity."

Board Oversight Responsibilities

(1) a corporate information and reporting system exists…

- Designation of Chief Compliance Officer
  - Delegated day-to-day operational responsibility for the development and implementation of the compliance program
  - Direct access and accountability to the Board
  - Schedule for reporting included on the Board Calendar
- Reporting obligations, including Whistleblower protections, are well-publicized and communicated to Board members, staff, and network providers
  - Corporate Compliance Plan
  - SWMBH Code of Conduct
  - SWMBH Policy for reporting FWA

Board Oversight Responsibilities

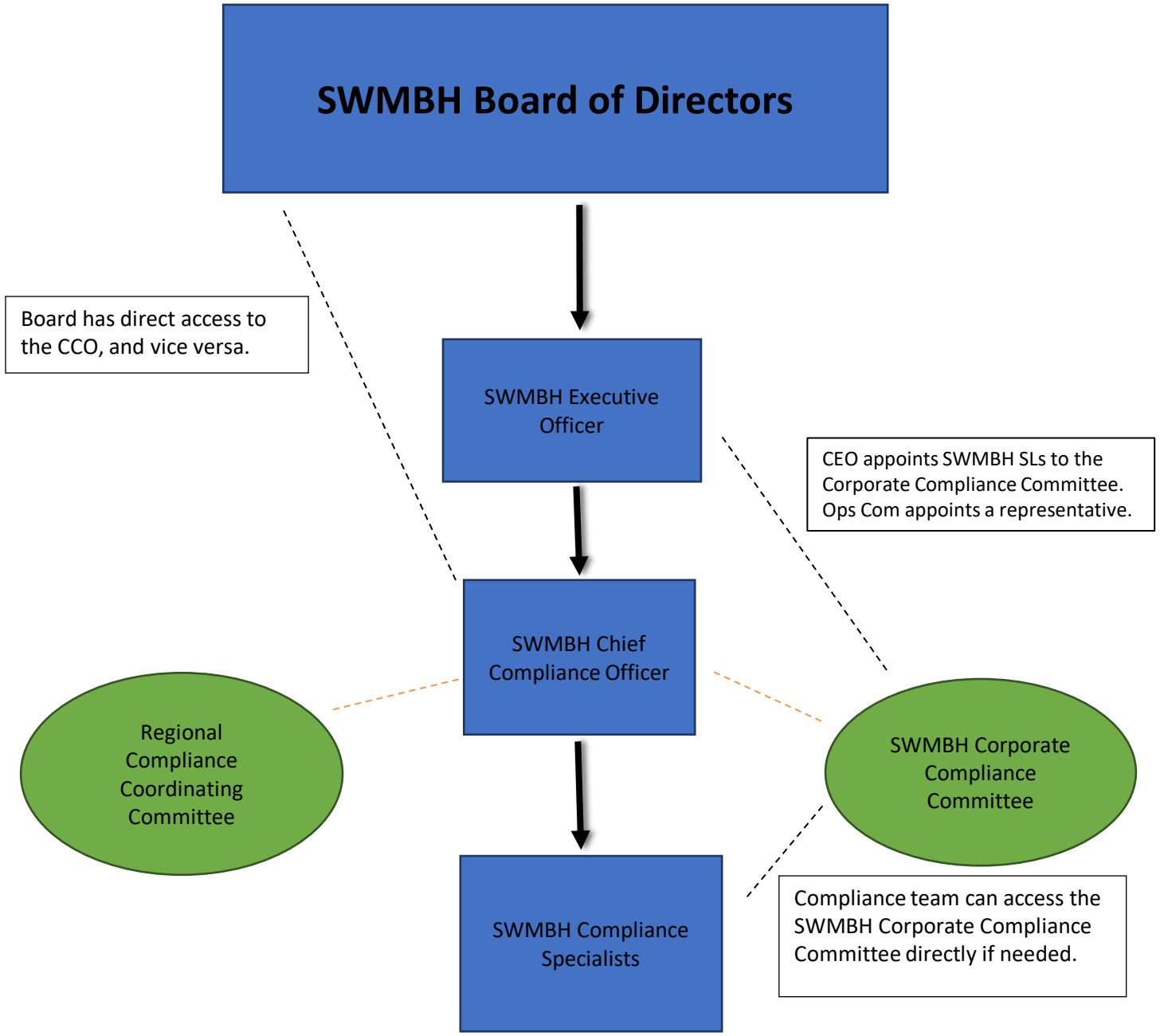
(2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.

- Annually the Board reviews and prospectively approves the PI/C Corporate Compliance Plan.
  - Includes Audit & Monitoring Plan
- Bi-annual reports to the Board regarding PI/C investigations, breaches, and audits. Includes any reporting to outside entities.
- Annual PI/C Program Evaluation submitted to the Board to review program initiatives, changes, and improvements.
- Periodic updates as necessary.

Are you satisfied with the information you receive? If not, it is your responsibility to instruct management that you want more.

SWMBH Compliance Team

- SWMBH Program Integrity & Compliance Department
  - Three Compliance Specialists – Alison Strasser, Jordan Huyser and Ramiah Johnson
  - Responsible for day-to-day operations of the Compliance Program
- SWMBH Compliance Committee
  - Comprised of SWMBH Senior leadership from varying departments, as well as a CMH CEO (presently Van Buren's Debbie Hess)
  - Responsible for oversight of Compliance Program activities
  - Meets monthly
- Regional Compliance Coordinating Committee
  - Compliance Officer from each CMHSP and SWMBH Compliance Dept.
  - Meets monthly to coordinate compliance activities across the Region
- Corporate Counsel
- PIHP Compliance Officers
  - Meet periodically to discuss compliance related issues


SWMBH Board of Directors
Board has direct access to the CCO, and vice versa.
SWMBH Executive Officer
CEO appoints SWMBH SLs to the Corporate Compliance Committee. Ops Com appoints a representative.
SWMBH Chief Compliance Officer
Regional Compliance Coordinating Committee
SWMBH Corporate Compliance Committee
SWMBH Compliance Specialists
Compliance team can access the SWMBH Corporate Compliance Committee directly if needed.

SWMBH Compliance Risks

- Fraud, Waste, and Abuse
- Appropriate and accurate coding of services
- Appropriate use of modifiers
- Proper credentials for clinicians providing service(s)
- Third Party Liability/Coordination of Benefits
- Excluded providers
- Privacy of Protected Health Information (PHI)

SWMBH Compliance Risks

- How does SWMBH manage Compliance Risks?
  - Routine audit & monitoring
    - Quarterly Medicaid claims review
    - Quarterly MHL claims review
    - SUD Reviews – Block Grant ATP, COB, and Net Cost Contracts
  - Focused audits
    - As part of investigations
    - Necessitated by concerning findings and/or poor performance on a routine audit(s)
  - Well publicized reporting system
    - SWMBH internal, CMHSPs, entire provider network
  - Excluded provider monitoring
    - Prior to hire/contracting, monthly for all staff, “Screened Persons”, provider entities, and contractors that meet statutory threshold

SWMBH Compliance Risks

- How do we manage them? (continued)
  - Data Mining
    - Developed business processes to address:
      - Overlapping billing
      - Appropriate use of specific modifiers (in response to investigation findings)
      - Third party billing reviews
  - Training/Education & Effective lines of Communication
    - At hire, electronically annually, in-person annually during Compliance Week
    - Open-door policy for entire Compliance team
  - Breach Report and Review Process
    - Staff do a wonderful job reporting actual and suspected unauthorized uses and/or disclosures of PHI
    - Reviewed by SWMBH's Breach Response Team monthly
  - Quarterly reporting to the MI Office of Inspector General (OIG)

Board Compliance Reports

- Current schedule:
  - Bi-annual reports
    - Number, type, and outcome of investigations and breaches
    - Update on on-going compliance audits
  - Annual Corporate Compliance education
    - Refresher on Board's role
    - Highlight risks and how SWMBH addresses
  - Updates as needed
    - Anytime an external agency is involved, or when disclosure is required to an authoritative body
    - Any situations that would implicate the entity's Executive Officer
  - Board prospectively reviews and approves the Corporate Compliance Plan for the coming Fiscal Year
- Do you feel this meets your needs?
- Is there additional information you feel is necessary?

Code of Conduct

Important Phone Numbers

Compliance Hotline: (800) 783-0914

Mila C. Todd, Chief Compliance & Privacy Officer: (269) 488-6794

Southwest Michigan Behavioral Health Vision, Mission, Values and Behavioral Standards

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH VISION

To ensure persons with specialty care needs reside in their own community, have a quality and healthy lifestyle and are fully accepted.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH MISSION

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. To ensure all persons receiving our services have access to the highest quality care available.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH 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

The Code of Conduct serves to function as a foundational document that details the fundamental principles, values and framework for action within Southwest Michigan Behavioral Health's (SWMBH) compliance program. The Code of Conduct articulates SWMBH's commitment to comply with all applicable Federal and State standards. The standards not only address compliance with statutes and regulations, but also set forth broad principles that guide employees in conducting business professionally and properly. The standards included in the Code of Conduct will promote integrity, support objectivity, and foster trust. Furthermore, the SWMBH standards of conduct will reflect a commitment to high quality health care delivery as evidenced by its conduct, of on-going performance assessment, improved outcomes of care, and respect for the rights of SWMBH's consumers.

SWMBH is committed to conducting its business in a manner that facilitates quality, efficiency, honesty, integrity, confidentiality, respect and full compliance with applicable laws and regulations. In order to achieve this goal, SWMBH recognizes that it must require its staff to maintain a standard of behavior that is both lawful and ethical. Accordingly,

- SWMBH will advise and train its staff about the applicable laws and requirements.
- SWMBH board members, administration, staff, participating CMHSP's and providers are expected to assume personal responsibility and accountability for understanding relevant laws, regulations and contract and grant requirements and for ensuring compliance.
- SWMBH management is committed to informing those under their supervision that they should comply with the applicable standards and, if they do not comply, appropriate disciplinary action will be taken.

Definitions

- 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.

- Fraud (per CMS): 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.

- Fraud (per Michigan Medicaid): 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.

- 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.

Reporting Violations

All staff or agents of the organization have the responsibility not only to comply with the laws and regulations but to ensure that others do as well. Any staff or agent who has firsthand knowledge of activities or omissions that may violate applicable laws and regulations is required to report such wrongdoing. Reporting suspected violations is mandatory, not optional. Staff will be informed that in some instances, failure to report a suspected violation may be the basis for disciplinary action against the staff. Corporate Compliance violations may be reported to the Chief Compliance Officer through either the hotline **(800) 783-0914**, e-mail, in person or in writing. All reports of wrongdoing shall be investigated to the extent necessary to determine their validity. No staff, provider or agent making such a report in good faith shall be retaliated against by SWMBH, staff, or agents and will be protected by the Michigan Whistleblower's Protection Act. Discipline for engaging in acts that violate applicable laws and regulations, making knowingly false reports, or discipline for any other performance–related reason unconnected to reporting potential violations is not retaliation.

Resources for Guidance

Staff or agents may seek clarification from the Compliance Program, organizational policies, or may direct questions to the Chief Compliance Officer through either the hotline, e-mail, in person or in writing.

Confidentiality

All staff or agents making reports are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigation. Nonetheless, anonymous reports are better than no report at all, and no report shall be refused or treated less seriously because the

reporter wishes to remain anonymous. Confidentiality and anonymity of the reporter/complainant and the content of the report will be preserved to the extent permitted by law and by the circumstances. Information about reports, investigations, or follow-up actions shall not be disclosed to anyone other than those individuals charged with responsibility in investigation and remedial action as well as legal counsel.

Examples of Fraud, Waste and Abuse That Should Be Reported

Examples of fraud, waste and abuse activities that should be reported include, but are not limited to, the following;

- Financial
    - Forgery or alteration of documents related to SWMBH services and/or expenditures (checks, contracts, purchase orders, invoices, etc.);
    - Misrepresentation of information on documents (financial records and medical records);
    - Theft, unauthorized removal, or willful destruction of SWMBH records or property;
    - Misappropriation of SWMBH funds or equipment, supplies or other assets purchased with Medicaid or Medicare funds; and
    - Embezzlement or theft

- Beneficiaries/Consumers:
    - Changing, forging or altering medical records;
    - Changing referral forms;
    - Letting someone else use their Medicaid or Medicare card to obtain SWMBH covered services;
    - Misrepresentation of eligibility status;
    - Identity theft;
    - Prescription diversion and inappropriate use;
    - Resale of medications on the black market;
    - Prescription stockpiling;

- Provider
    - Lying about credentials such as a college degree;
    - Billing for services that were not provided;
    - Billing a balance that is not allowed;
    - Double billing or upcoding;
    - Underutilization – not ordering or providing services that are medically necessary;
    - Overutilization – ordering or providing services in excess of what is medically necessary;

- Falsifying information (not consistent with the consumer's condition or medical record) submitted through a prior authorization or other service utilization oversight mechanism in order to justify coverage;
- Forging a signature on a contract or other document;
- Pre- or post-dating a contract or other document;
- Intentionally submitting a false claim;
- Changing, forging or altering medical records;
- Kickbacks, inducements and/or other illegal remunerations; and
- Illegal use of drug samples

Internal Investigation

All reports of wrongdoing, however received, shall be investigated and documented according to the Corporate Compliance Investigation Procedure. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within SWMBH who is not involved in the investigatory process or to anyone outside SWMBH without the prior approval of the Chief Compliance Officer. All staff and agents are expected to cooperate fully with investigation efforts.

Disciplinary Accountability and Consequences

SWMBH has formulated guidelines regarding the consequences and disciplinary action for staff who have failed to comply with SWMBH policies and procedures, Federal and State laws or the Corporate Compliance Plan. The disciplinary measures will vary depending upon the severity of the transgression. Sanctions could range from an oral warning to suspension, termination or financial penalties as appropriate.

Disciplinary actions will be taken in a fair, equitable, appropriate and consistent manner. All staff will be subject to the same disciplinary action for the commission of similar offenses.

Conflicts of Interest

In order to safeguard SWMBH's commitment to ethical and legal standards of conduct, Board Members, all officers, all senior management members, medical staff, and individuals with Board-designated powers and/or authority shall avoid any action that conflicts with the interests of the organization and refrain from being influenced by personal considerations in the performance of their duties. Unless properly disclosed and approved by SWMBH, it could be a conflict of interest to, but is not limited to:

- Have an interest in a publicly held company, vendor, customer or competitor of SWMBH;
- Work for, consult with or provide services to a competitor; and/or
- Use confidential information obtained for any person's personal gain or benefit.

Accordingly, staff/agents, officers, senior managers, and medical staff must disclose the existence and nature of any actual or potential conflict of interest on their Conflict of Interest Form or to the Chief Compliance Officer at the time of interview, orientation and annually thereafter and/or when a conflicting interest arises. All actual or potential conflicts of interest

disclosed shall be reviewed by the Chief Compliance Officer, according to previously identified criteria, to determine whether there is a conflict of interest.

Substance Abuse

To protect staff/agents and consumers, SWMBH is committed to an alcohol and drug-free environment. All staffs/agents must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drugs or alcohol, having an illegal drug in one's system, or using, possessing, or distributing/selling illegal drugs while on SWMBH's work time or property may result in immediate termination.

Harassment

Mutual respect among all staff members in the way we treat each other is expected. Each SWMBH staff/agent has the right to work in an environment free of harassment. Therefore, harassment of staff/agents in the work place by any person or in any form is prohibited by SWMBH. This includes sexual harassment; harassment based on sex, race, color, religion, national origin, citizenship, disability, age, sexual orientation, or any other protected category; or conduct such as ridicule or degrading comments to others which severely and adversely affect their work environment or interferes with their ability to perform their job. Alleged harassment should be reported to a member of the senior management team or to the Human Resources Director.

Confidentiality

SWMBH is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any consumer information to anyone other than a staff/agent or staff member involved in the care and treatment of that consumer. Any staff/agent who engages in the unauthorized disclosure of any information concerning a consumer may be subject to immediate termination. Staff/agents shall comply with the SWMBH Confidentiality Policy, the Michigan Mental Health Code, HIPAA Privacy requirements, and all other applicable laws and regulations.

To ensure that all consumer information remains confidential, staff/agents are required to comply with the following guidelines:

- Staff/agents shall not discuss any consumer in an external or internal environment where such information could be heard by unauthorized personnel or other consumer/visitors.
- If asked about a consumer by anyone other than staff/agents involved in the care or treatment of the consumer, staff/agents will disclose no information unless first obtaining the written consent of the consumer or the consumer's representative/legal guardian.
- Medical staff members and staff/agents may not have access to the records of any consumer unless they are involved in the care and treatment of the consumer, or if a legal or administrative reason exists requiring them to have access to those documents.

Political Activities and Contributions

SWMBH funds or resources are not to be used to contribute to political campaigns or for gifts or payments to any political party or any of their affiliated organizations. SWMBH resources include financial and non-financial donations of funds, products, or services to any political cause.

Staff/agents may make voluntary contributions provided they do not communicate that their contributions are from SWMBH.

At times, SWMBH may ask staff/agents to make personal contact with government officials or to write letters to present the organization's position on specific issues. In addition, it is part of the role of some SWMBH management to interface on a regular basis with government officials. Such activity is permissible provided that funds and resources are not contributed.

Marketing Practices

There are times when SWMBH directly markets services to potential consumers; however, the federal Anti-Kickback Statute 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 the Medicaid or Medicare programs.

Under no circumstances will SWMBH offer free items or services that are not related to medical or health care. Moreover, any free items offered must have no monetary value.

SWMBH staff/agents will not engage in any prohibitive marketing activities. These activities include: the giving of gifts or payments to induce enrollments, discrimination of any kind, unsolicited door-to-door marketing, and contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.

Charitable Contributions

All charitable contributions must be made for the benefit of SWMBH and for the purpose of advancing SWMBH's mission. The Executive Officer will oversee all charitable contributions to ensure that they are administered in accordance with the donor's intent. All checks and other documents must be made payable to SWMBH and given to the Finance Department to deposit into the appropriate account.

Contractual/Financial Arrangements with Health Care Professionals

SWMBH is committed to ensuring that all contractual and financial arrangements with health care professionals are structured in accordance with Federal and State laws and other regulations and are in the best interests of the organization and the consumers it serves. In order to ethically and legally meet all standards regarding referrals and enrollments, SWMBH will strictly adhere to the following:

- SWMBH does not pay for referrals. Consumer referrals and enrollments will be accepted based solely on the consumer's clinical needs and our ability to render the needed services. SWMBH does not pay or offer to pay anyone for referrals or consumers. Violation of this policy may have grave consequences for the organization and the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

- SWMBH does not accept payments for referrals. No SWMBH staff/agent 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.
- SWMBH does not use financial incentives to encourage barriers to care and services and/or decisions the result in underutilization. SWMBH does not reward practitioners, or other individuals conducting utilization review, for issuing denials of coverage or service. All utilization management decision-making is based only on the existence of coverage and appropriateness of care and service. Clinical decisions are based on the clinical features of the individual case and the medical necessity criteria.

Receiving Business Courtesies and Gifts

No staff/agent or officer shall accept or solicit any gifts, gratuities, loans (in nature of a gratuity), or favors of any kind from any individual, firm, or corporation doing business with or seeking to do business with SWMBH or any of its affiliates, if the gift is offered or appears to be offered in exchange for any type of favorable treatment or advantage. Specifically, no gifts or favors shall be accepted if valued in excess of $25, with a maximum of $300 per year, or intended to affect the recipient's business decisions with SWMBH. Perishable or consumable gifts, except for items of minimal value such as flowers, cookies or candy from consumers and/or family members given to a department or group are not subject to any specific limitation. Under no circumstances shall a direct care staff receive monetary gifts from consumers and/or family members. Consumers wishing to make a gift must follow the protocol for charitable contributions. If there are concerns regarding any staff's acceptance of gifts, the Chief Compliance Officer, in coordination with the SWMBH Compliance Committee, shall make the final decision.

There are some circumstances where staff are invited to an event at a vendor's expense to receive information about new products or services. Prior to accepting any such invitation, approval must be received from the Executive Officer. Accepting personal gifts and/or entertainment can sometimes be construed as an attempt to influence judgment concerning patient care or performance of other duties at SWMBH. It may also violate the anti-kickback statue or conflict of interest policy. To that end, no staff may accept any cash amount, or any single gift of more than $25 value with the total not to exceed $300 per year.

Michigan Consortium for Healthcare Excellence
SWMBH Executive Officer Board Report
October 14, 2022

For the period April 2022 – September 2022

MCHE Activity

Ongoing Work Groups

- **Reciprocity: Direct Care Worker Training (all PIHPs)**
- **Reciprocity: Provider Reviews and Audits (all PIHPs)**
- **Statewide implementation of MCG Utilization Management solution**

- **Emerging: Shared contracting for healthcare data analytics, comparative reports, and publishable proofs of performance**

Why Collaborate?

- **Enhance public policy influence via collective consensus views and advocacy with executive branch**
- **Enhance collective and individual relations with Advocacy groups and individuals**
- **Share scarce resources**
- **Share operational and performance information for quality improvement and benchmarking**
- **Reduce provider burdens and provider administrative costs**
- **Reduce PIHP administrative costs**
- **Identify and pursue system opportunities**

OPIOD ADVISORY COMMISSION Senate Bill No. 994 Chapter 8A Sections 850-851 (all from 851)	**OPIOIDS TASK FORCE** Executive Order 2022-12
MEMBERS & MEETINGS	
(1-7) All appointed by combination of senate majority & minority leaders, speaker & minority leaders of the house, 1 of 3 chosen from list provided by governor, and same by attorney general	1(b)(1(a-k)) 11 State departments represented by director or director's designee: DHHS, Chief Medical Executive, LARA, MSP, DOC, Environment Great Lakes and Energy, Insurance and Financial Services, Military and Veterans Affairs, Labor and Economic Opportunity, Attorney General, Superintendant of Public Instruction
(2)(b) DHHS or designee ex officio member without vote	1(b)(2)(A) **10 representatives** from each PIHP region appointed by the Governor
	1(b)(3)(A) Chief Justice MAY participate
(8) **CHAIRPERSON:** Elected by OAC Elect Other officers as necessary or appropriate	1(f) **CHAIRPERSON:** DHHS director designates; non-voting member for purposes of allocation decisions
	VICE-CHAIR: Task force selects
SECRETARY: Council administrator or designee	3(f) **SECRETARY**: Task force selects
(9) **MEETINGS:** Quarterly or more often at request of chair or 7 members	3.c&h **MEETINGS**: 4 per year; at the call of its chairperson
Quorum: Seven	**Quorum:** Majority
10-11 Open Meetings Act & Freedom of Information Act	3.e Open Meetings Act & Freedom of Information Act
	3.j **Advisory workgroups** may include other members of the public; TF may adopt, reject, or modify recommendations by workgroups
	3.l May hire contractors, sub-contractors, advisor, consultants, and agents
(13) OAC SHALL DO THE FOLLOWING	**2. CHARGE TO THE TASK FORCE**
	2(a) Act as Government Participation Mechanism for purposes of opioid bankruptcy or settlement in which gov't participation is needed to effecuate collection of the claim
b **Review** local state, state, and federal initiatives and activities related to education, prevention, treatments, and services to ind. And families affected by SUD and co-occurring MH conditions and	
Establish priorities to address sud and co-occurring MH conditions	C.8 Create measureable **goals and objectives** along an established timeline
c **Annual written report** due 3/30 to governor, attorney general, senate majority leader, speaker o fhte house of representative, and chairs of the senate and house of representatives appropriations committees	2(b) **Provide Recommendations to** the State of Michigan, Director of DHHS and heads of other departments or agencies, coordinate activities among departments and agencies

OPIOD ADVISORY COMMISSION	OPIOIDS TASK FORCE
(i) Statewide evidence-based needs assessment	C Research, Identify, Recommend, and implement response actions which may include:
A Summary of **funding**: SUD and co-occurring MH conditions	c.3 Identify **financial and other resources** are available on all levels to combat the epidemic. **Develop strategies for implementing those response actions
B Discussion of: overdose prevention, address disparities in access to health care & prevent youth substance use	
C Analysis: effects on this state of SUD & co-occurring MH conditions	
D Describe: common risk factors associated with SUD and co-occuring MH conditions	
(ii) Goals and recommendations, sustainability plans, performance indicators	
A SUD and co-occurring prevention, treatment, recovery and harm reduction efforts	
B Reduce disparity in access to prevention, treatment recovery, and harm reduction programs, services, supposrts, and resources	C.2 Identify & Evaluate: nature and scope of the impact on various locations and communities & what response actions would be most effective in each area
(iii) Assessment of prior use of money appropriated from MI opioid healing and recovery fund, extent to which expendictures abated the opioid crisis	c.1 Identify & Evaluate epidemic's root causes and contributing factors; effectiveness of response actions that have been taken or are being undertaken. **Develop strategies to support or improve efficacy of response actions
(iv) Recommend: funding for tasks, activities, projects, and initiatives &	
(v) additional legislation needed to accomplish objectives	C.9 Recommend Changes in Mi law relevant to combating epidemic
	Public Awareness / Outreach
	C.4 Public Awareness: strategies to increase, causes and effects, resources available, actions to combat it
	C.5 Routine communicating and information-sharing protocols between all members of the task force and stakeholders as defined below
	C.6 residents, community members, other partner organizations, tribal governments, local government officials, other elected officials
	C.7 Outreach to the general public regarding epidemic and task force

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GARLIN GILCHRIST II
LT. GOVERNOR

EXECUTIVE ORDER

No. 2022-12

Michigan Opioids Task Force

Department of Health and Human Services

The epidemic of opioid abuse has plagued Michigan for years. While more recent response efforts have made some headway in combating this epidemic, it remains a significant public-health crisis, afflicting Michigan residents of all backgrounds, age groups, and income levels.

Michigan has taken a coordinated and comprehensive approach to combating the opioid epidemic. Fighting an epidemic of this size and impact has required a coordinated and comprehensive approach: one that identifies and confronts the full scope of the epidemic's root causes and contributing factors in Michigan; that pools, optimizes, and augments the efforts and resources on all levels—public and private; local, state, and federal—that are available to address the epidemic; and that raises public awareness of the epidemic, its causes and effects, the resources available to those afflicted by it, and the actions that can be taken to combat it.

We have also vigorously pursued the companies and individuals who created the crisis by putting corporate profits ahead of human welfare. This strategy has resulted in several large settlements against opioid manufacturers, as well as those who distributed the drugs that created such harm in our communities.

On August 21, 2019, Executive Order 2019-18 established the Michigan Opioids Task Force to inform the state's strategy for addressing the opioid epidemic. Progress has been made, but much more remains to be done. The Task Force must be updated to optimize its work and to allow it to efficiently receive and distribute resources.

Section 51 of article 4 of the Michigan Constitution of 1963 declares the public health and general welfare of the people of the State of Michigan as matters of primary public concern.

Section 1 of article 5 of the Michigan Constitution of 1963 vests the executive power of the

State of Michigan in the governor.

Section 8 of article 5 of the Michigan Constitution of 1963 places each principal department of state government under the supervision of the governor unless otherwise provided.

Section 8 of article 5 of the Michigan Constitution of 1963 also obligates the governor to take care that the laws be faithfully executed.

Acting pursuant to the Michigan Constitution of 1963 and Michigan law, I order the following:

1. Creation of the Michigan Opioids Task Force

(a) The Michigan Opioids Task Force ("Task Force") is reconstituted as an advisory body within the Department of Health and Human Services ("Department").

(b) The Task Force shall consist of the following members:

(1) State Representatives

(A) The director of the Department, or the director's designee from within the Department.

(B) The chief medical executive of the State of Michigan.

(C) The director of the Department of Licensing and Regulatory Affairs, or the director's designee from within that department.

(D) The director of the Michigan State Police, or the director's designee from within that department.

(E) The director of the Department of Corrections, or the director's designee from within that department.

(F) The director of the Department of Environment, Great Lakes, and Energy, or the director's designee from within that department.

(G) The director of the Department of Insurance and Financial Services, or the director's designee from within that department.

(H) The director of the Department of Military and Veterans Affairs, or the director's designee from within that department.

(I) The director of the Department of Labor and Economic Opportunity, or the director's designee from within that department.

(J) The attorney general, or the attorney general's designee from

within the Department of Attorney General.

(K) The superintendent of public instruction, or the superintendent's designee from within the Department of Education.

(2) Representatives from Local Governments

(A) One representative appointed by the Governor from each of the ten regions established by the Department for specialty Prepaid Inpatient Health Plans for Medicaid mental health and substance use disorder services and supports ("PIHP Regions").

(3) Representative from the Michigan Supreme Court

(A) The chief justice of the Michigan Supreme Court, or the chief justice's designee, may also participate as a member of the Task Force.

(c) The Task Force, as a group, should possess experience, expertise, and education with respect to one or more of the following: public health, substance use, or health equity. Membership by individuals with direct lived experience in substance use and related services is a priority.

(d) Members of the Task Force appointed under section (1)(b)(1) are ex officio members and serve at the pleasure of the governor.

(e) Members of the Task Force appointed under section (1)(b)(2) shall serve for four-year terms. Of the members initially appointed, two shall serve for one-year terms, three shall serve for two-year terms, two shall serve for three-year terms, and three shall serve for four-year terms. A vacancy on the Task Force shall be filled in the same manner as the original appointment for the balance of the unexpired term.

(f) The director of the Department shall designate the chairperson of the Task Force from among the State Representatives. For purposes of allocation decisions under Section 2(a) of this Order, the chairperson will be a non-voting member.

2. Charge to the Task Force

(a) The Task Force shall act as a Government Participation Mechanism for purposes of any opioid-related bankruptcy or settlement in which a government participation mechanism is needed to effectuate Michigan's collection of the claim.

(b) The Task Force shall provide recommendations to the State of Michigan, Director of the Department, and the heads of other departments or agencies, and coordinate activities among departments and agencies.

(c) The Task Force shall research, identify, recommend, and implement response actions to the opioid epidemic in Michigan, which may include the following:

(1) Identify and evaluate the epidemic's root causes and contributing factors in Michigan, and the effectiveness of response actions on all levels that have been undertaken or are currently being undertaken. Develop strategies for supporting or otherwise improving the efficacy of those response actions.

(2) Identify and evaluate the nature and scope of the epidemic's impact on various locations and communities throughout the state and what response actions would be most effective in helping each of those impacted areas. Develop strategies for implementing those response actions.

(3) Identify and evaluate what financial and other resources are available on all levels to combat the epidemic in Michigan. Develop strategies for securing, coordinating, augmenting, and deploying those resources.

(4) Develop strategies for increasing public awareness of the epidemic in Michigan, its causes and effects, the resources available to those afflicted by it, and the actions that can be taken to combat it.

(5) Develop routine communication and information-sharing protocols between members of the Task Force and stakeholders on all levels.

(6) Perform outreach to ensure all stakeholders in impacted areas are informed, educated, and empowered. Stakeholders will include, but are not limited to, residents, community members, other partner organizations, tribal governments, local government officials, and other elected officials representing the impacted areas.

(7) Perform outreach to the general public regarding the epidemic and the work of the Task Force.

(8) Create measurable goals and objectives along an established timeline.

(9) Recommend changes in Michigan law relevant to combating the epidemic.

(10) Provide other information and advice and perform other duties as requested by the director of the Department or the governor.

(d) The Task Force shall report regularly to the governor on its activities.

3. Operations of the Task Force

(a) The Department shall assist the Task Force in the performance of its duties and provide personnel to staff the Task Force. The budgeting, procurement, and related management functions of the Task Force shall be performed under the direction and supervision of the director of the Department.

(b) The Task Force shall adopt procedures consistent with Michigan law and this order governing its organization and operations.

(c) The Task Force shall hold no fewer than four public meetings per year and shall comply at those meetings with the Open Meetings Act, MCL 15.261 *et seq*.

(d) The Task Force shall promote stakeholder participation, including from the former Opioid Task Force Stakeholders Advisory Group.

(e) The Task Force shall comply with the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231 to 15.246.

(f) The Task Force may select from among its members a vice chairperson.

(g) The Task Force may select from among its members a secretary. Task Force staff shall assist the secretary with record keeping responsibilities.

(h) The Task Force shall meet at the call of its chairperson and as otherwise provided in the procedures adopted by the Task Force.

(i) A majority of the members of the Task Force serving constitutes a quorum for the transaction of the business of the Task Force. The Task Force must act by a majority vote of its serving members.

(j) The Task Force may establish advisory workgroups composed of individuals or entities participating in Task Force activities or other members of the public as deemed necessary by the Task Force to assist it in performing its duties and responsibilities. The Task Force may adopt, reject, or modify any recommendations proposed by an advisory workgroup.

(k) The Task Force may, as appropriate, make inquiries, studies, and investigations, hold hearings, and receive comments from the public. The Task Force also may consult with outside experts in order to perform its duties, including experts in the private sector, organized labor, government agencies, and at institutions of higher education.

(l) The Task Force may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Task Force and the performance of its duties as the director of the Department deems advisable and necessary, consistent with this order and applicable law, rules and procedures, and subject to available funding.

(m) The Task Force may accept donations of labor, services, or other things of value from any public or private agency or person. Any donations shall be received and used in accordance with law.

(n) Members of the Task Force shall serve without compensation but may receive reimbursement for necessary travel and expenses consistent with applicable law, rules, and procedures, and subject to available funding.

(o) Members of the Task Force shall coordinate all legislative and media contacts that directly involve the work of the Task Force.

4. Implementation

(a) All departments, committees, commissioners, or officers of this state shall give to the Task Force, or to any member or representative of the Task Force, any necessary assistance required by the Task Force, or any member or representative of the Task Force, in the performance of the duties of the Task Force so far as is compatible with their duties and consistent with this order and applicable law. Free access also must be given to any books, records, or documents in their custody relating to matters within the scope of inquiry, study, or review of the Task Force, consistent with applicable law.

(b) Nothing in this order shall be construed to change the organization of the executive branch of state government or the assignment of functions among its units, in a manner requiring the force of law.

(c) If any portion of this order is found to be unenforceable, the unenforceable provision should be disregarded and the rest of the order should remain in effect as issued.

(d) Executive Order 2019-18 is rescinded. The Michigan Opioids Task Force established under Executive Order 2019-18 is abolished.

(e) This order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan.

Date: September 29, 2022

Time: 6:58am

GRETCHEN WHITMER
GOVERNOR

By the Governor:

SECRETARY OF STATE

EXECUTIVE ORDER

No. 2019-18

Department of Health and Human Services

Michigan Opioids Task Force

The epidemic of opioid abuse has plagued Michigan for years. While more recent response efforts have made some headway in combating this epidemic, it remains a full-blown public-health crisis, afflicting Michigan residents of all backgrounds, age groups, and income levels. Michigan remains among the states with the highest levels of both opioid prescriptions and opioid overdose deaths, and the abuse of these drugs continues to exact a heavy toll on this state's families, communities, and resources.

Combating an epidemic of this size and impact requires a coordinated and comprehensive approach: one that identifies and confronts the full scope of the epidemic's root causes and contributing factors in Michigan; that pools, optimizes, and augments the efforts and resources on all levels—public and private; local, state, and federal—that are available to address the epidemic; and that raises public awareness of the epidemic, its causes and effects, the resources available to those afflicted by it, and the actions that can be taken to combat it.

The health and well-being of this state and its residents would benefit from a task force devoted to developing and implementing such statewide response actions, and to bringing this crisis under full and lasting control.

Section 51 of article 4 of the Michigan Constitution of 1963 declares the public health and general welfare of the people of the State of Michigan as matters of primary public concern.

Section 1 of article 5 of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the governor.

Section 8 of article 5 of the Michigan Constitution of 1963 places each principal department of state government under the supervision of the governor unless otherwise provided.

Section 8 of article 5 of the Michigan Constitution of 1963 also obligates the governor to take care that the laws be faithfully executed.

Acting pursuant to the Michigan Constitution of 1963 and Michigan law, I order the following:

1. Creation of the Michigan Opioids Task Force

(a) The Michigan Opioids Task Force ("Task Force") is created as an advisory body within the Department of Health and Human Services ("Department").

(b) The Task Force shall consist of the following members:

(1) The director of the Department, or the director's designee from within the Department.

(2) The chief medical executive of the State of Michigan.

(3) The director of the Department of Licensing and Regulatory Affairs, or the director's designee from within that department.

(4) The director of the Michigan State Police, or the director's designee from within that department.

(5) The director of the Department of Corrections, or the director's designee from within that department.

(6) The director of the Department of Environment, Great Lakes, and Energy, or the director's designee from within that department.

(7) The director of the Department of Insurance and Financial Services, or the director's designee from within that department.

(8) The director of the Department of Military and Veterans Affairs, or the director's designee from within that department.

(9) The director of the Department of Labor and Economic Opportunity, or the director's designee from within that department.

(10) The attorney general, or the attorney general's designee from within the Department of Attorney General.

(11) The superintendent of public instruction, or the superintendent's designee from within the Department of Education.

(c) The chief justice of the Michigan Supreme Court, or the chief justice's designee, may also participate as a member of the Task Force.

(d) Members of the Task Force are ex officio members and serve at the pleasure of the governor.

(e) The director of the Department shall designate the chairperson of the Task Force.

2. Charge to the Task Force

(a) The Task Force shall provide recommendations to the director of the Department, and the heads of other departments or agencies, and coordinate activities among departments and agencies.

(b) The Task Force shall research, identify, recommend, and implement response actions to the opioid epidemic in Michigan, which may include the following:

(1) Identify and evaluate the epidemic's root causes and contributing factors in Michigan, and the effectiveness of response actions on all levels that have been undertaken or are currently being undertaken. Develop strategies for supporting or otherwise improving the efficacy of those response actions.

(2) Identify and evaluate the nature and scope of the epidemic's impact on various locations and communities throughout the state and what response actions would be most effective in helping each of those impacted areas. Develop strategies for implementing those response actions.

(3) Identify and evaluate what financial and other resources are available on all levels to combat the epidemic in Michigan. Develop strategies for securing, coordinating, augmenting, and deploying those resources.

(4) Develop strategies for increasing public awareness of the epidemic in Michigan, its causes and effects, the resources available to those afflicted by it, and the actions that can be taken to combat it.

(5) Develop routine communication and information-sharing protocols between members of the Task Force and stakeholders on all levels.

(6) Perform outreach to ensure all stakeholders in impacted areas are informed, educated, and empowered. Stakeholder outreach will include, but is not limited to, residents, community members, other partner organizations, tribal governments, local government officials, and other elected officials representing the impacted areas.

(7) Perform outreach to the general public regarding the epidemic and the work of the Task Force.

(8) Create measurable goals and objectives along an established timeline.

(9) Recommend changes in Michigan law relevant to combating the epidemic.

(10) Provide other information and advice and perform other duties as requested by the director of the Department or the governor.

(c) The Task Force shall report regularly to the governor on its activities.

3. Operations of the Task Force

(a) The Department shall assist the Task Force in the performance of its duties and provide personnel to staff the Task Force. The budgeting, procurement, and related management functions of the Task Force shall be performed under the direction and supervision of the director of the Department.

(b) The Task Force shall adopt procedures consistent with Michigan law and this order governing its organization and operations.

(c) The Task Force shall comply with the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231 to 15.246.

(d) The Task Force may select from among its members a vice chairperson.

(e) The Task Force may select from among its members a secretary. Task Force staff shall assist the secretary with recordkeeping responsibilities.

(f) The Task Force shall meet at the call of its chairperson and as otherwise provided in the procedures adopted by the Task Force.

(g) A majority of the members of the Task Force serving constitutes a quorum for the transaction of the business of the Task Force. The Task Force must act by a majority vote of its serving members.

(h) The Task Force may establish advisory workgroups composed of individuals or entities participating in Task Force activities or other members of the public as deemed necessary by the Task Force to assist it in performing its duties and responsibilities. The Task Force may adopt, reject, or modify any recommendations proposed by an advisory workgroup.

(i) The Task Force may, as appropriate, make inquiries, studies, and investigations, hold hearings, and receive comments from the public. The Task Force also may consult with outside experts in order to perform its duties, including experts in the private sector, organized labor, government agencies, and at institutions of higher education.

(j) The Task Force may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Task Force and the performance of its duties as the director of the Department deems advisable and necessary, consistent with this order and applicable law, rules and procedures, and subject to available funding.

(k) The Task Force may accept donations of labor, services, or other things of value from any public or private agency or person. Any donations shall be received and used in accordance with law.

(l) Members of the Task Force shall serve without compensation, but may receive reimbursement for necessary travel and expenses consistent with applicable law, rules, and procedures, and subject to available funding.

(m) Members of the Task Force shall coordinate all legislative and media contacts that directly involve the work of the Task Force.

4. Implementation

(a) All departments, committees, commissioners, or officers of this state shall give to the Task Force, or to any member or representative of the Task Force, any necessary assistance required by the Task Force, or any member or representative of the Task Force, in the performance of the duties of the Task Force so far as is compatible with their duties and consistent with this order and applicable law. Free access also must be given to any books, records, or documents in their custody relating to matters within the scope of inquiry, study, or review of the Task Force, consistent with applicable law.

(b) Nothing in this order shall be construed to change the organization of the executive branch of state government or the assignment of functions among its units, in a manner requiring the force of law.

(c) If any portion of this order is found to be unenforceable, the unenforceable provision should be disregarded and the rest of the order should remain in effect as issued.

(d) This order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan.

Date: August 21, 2019

_____
GRETCHEN WHITMER
GOVERNOR

By the Governor

_____
SECRETARY OF STATE

Southwest Michigan Behavioral Health Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
November 11, 2022
9:30 am to 11:30 am

(d) means document provided

Draft: 9/26/22

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda**

   - October 14, 2022 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   - Operations Committee September 28, 2022 Meeting minutes (d)

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

   a. Opioid Health Homes Enrollees (J. Gardner) (d)
   b. Fiscal Year 2022 Health Services Advisory Group External Quality Review (J. Gardner) (d)
   c. Certified Community Behavioral Health Clinics Demonstration Year Report (J. Gardner and E. Philander) (d)
   d. Fiscal Year 2022 Accomplishments and Successes (J. Gardner) (d)

7. **Board Actions to be Considered**

   a. Executive Officer Evaluation (Board Executive Committee) (d)
   b. Executive Officer Employment Agreement (Board Executive Committee) (d)
   c. 2022-2024 Ends Metrics (J. Gardner) (d)

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

   a. EO-002 Monitoring Executive Performance (d)
   b. EO-001 Executive Role and Job Description (d)
   c. BG-003 Unity of Control (d)

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

- BEL-010 RE 501 (c) (3) Representation (T. Schmelzer) (d)

10. Board Education

a. Fiscal Year 2023 Year to Date Financial Statements (T. Dawson) (d)
b. Fiscal Year 2023 Program Integrity Compliance Plan (M. Todd) (d)
c. Clinical Quality and Outcomes (A. Lacey, J. Smith, M. Kean) (d)

11. Communication and Counsel to the Board

a. November 8th Election Debrief
b. System Transformation Legislation
c. December 9, 2022 Board Agenda (d)
d. Board Member Attendance Roster (d)
e. December Direct Inspection Reports-BEL-003 Asset Protection (M. Starkey)

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
December 9, 2022
9:30 am - 11:30 am

Holiday Celebration (tentative)

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
December 9, 2022
11:45 am - 1:30 pm

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

as of 9/9/22

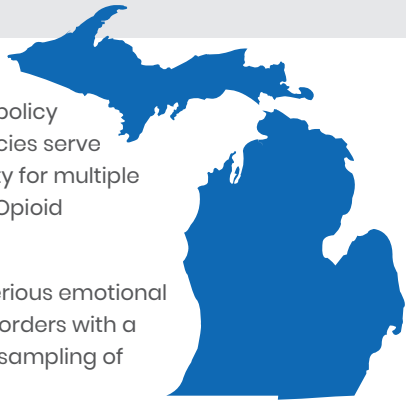
Green = present
Red = absent
Black = not a member
Gray = meeting cancelled

The Value of PIHPs

What is a PIHP?

PIHP is an acronym for Prepaid Inpatient Health Plan, a term in federal regulations from the Centers for Medicare & Medicaid Services (CMS). It means an entity that:

1. Serves as the public health plan for a region through a **shared-risk arrangement with the State of Michigan** to manage the use of Medicaid dollars to serve the behavioral/mental health needs of Michiganders enrolled in Medicaid who live within the PIHP's region
2. Serves adults with severe mental illness, youth with serious emotional disturbance, persons with intellectual & developmental disabilities or autism spectrum disorders under federal Medicaid managed care regulations.
3. Carries out the functions of a private health plan but, as a **public body**, without taking profits
4. Provides and manages the use and risk of Medicaid benefits to the state's Community Mental Health Service Providers, who use these dollars to provide and purchase the **full range of community and home based mental health services** and other providers.
5. Provides and manages the use and risk of over $100 million annually in federal mental health and substance abuse block grant funds, earmarked for **substance use disorder services**, to public and private providers in their region.
6. Receives the Medicaid funds that it manages, not through a fee-for-service, but through **capitated payments** (a given payment for each Medicaid enrollee living in the PIHP region)



Michigan's PIHPs partner with the Michigan Department of Health and Human Services (MDHHS) and the State's Community Mental Health Services Programs (CMHSPs), implementing the state vision and policy across the behavioral health system following federal regulations and CMS-approved waivers. These agencies serve as a contractor to the state while maintaining local responsiveness, access, governance, and accountability for multiple promising demonstrations including, but not limited to, Certified Community Behavioral Health Clinics and Opioid Health Homes.

In the fiscal year 2021, **PIHPs served approximately 300,000 Michigan citizens** with severe mental illness, serious emotional disturbance, intellectual and developmental disabilities, autism spectrum disorders, and substance use disorders with a $3.6 billion budget. The collective knowledge, skills, and abilities of PIHPs are without peers in the nation. The sampling of accomplishments is categorized below:

FINANCIAL

PIHPs cushion the state from financial risk as they are responsible for the first 5% of cost overruns and half of the second 5%. As governmental agencies, they do not earn a profit, do not distribute excess revenue to other parties, and invest any savings back into the public behavioral health system and the communities they serve.

QUALITY

PIHPs offer unparalleled access for persons served. PIHPs regularly meet or exceed the access and responsiveness metrics in the Michigan Mission Based Performance Indicator System while remaining public entities where the consumer's voice is at the highest levels, including their public board meetings.

PROGRAMMATIC EXPERTISE

PIHPs provide oversight and education to ensure that county-based organizations' financial strategies and fiduciary responsibility comply with applicable processes and maintain transparent accountability. PIHPs serve as state-designated Community Mental Health Entities with broad statutory roles in policy, planning and programs for substance abuse treatment and prevention.

They offer deep and broad integrated care services, leadership, and results. They work with Medicaid plans, hospitals and health systems, physician groups, and others to identify complex cases for care coordination for better health outcomes and reductions in avoidable physical health services. PIHPs lead the way in healthcare information exchange and healthcare data analytics as active in state-owned and regional data use agreements and data-driven decision-making applications of complex care management resources. They are driven by and held accountable to Michigan and national healthcare access and outcome metrics.

What PIHPs do:

- PIHPs are responsible for **enrollee rights and protections** for Medicaid-eligible persons and have a proven record of adherence to regulations and, more importantly, to beneficiary protections.

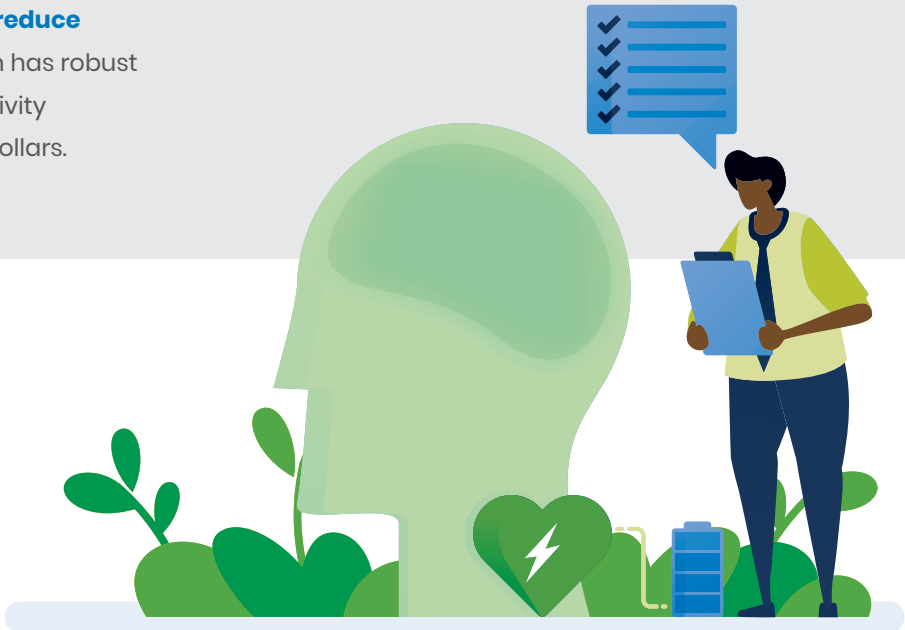
- PIHPs assure the **availability and accessibility** of all Medicaid services and have a proven record of adherence to regulations and, more importantly, to beneficiary services.

- PIHPs are designated Community Mental Health Entities in regional statutory **substance use disorder prevention and treatment planning roles** and will provide essential functions and expertise in the successful implementation of the Opioid Settlement across Michigan.

- PIHPs significantly **prevent, detect, and reduce Medicaid fraud, waste, and abuse.** Each has robust compliance programs with ongoing activity supporting the proper use of taxpayer dollars.

- PIHPs are directed through an MDHHS agreement and are **actively overseen and monitored by MDHHS and its contractors.** Including but not limited to regular audits of PIHPs, broad and frequent data reporting to MDHHS, and annual reviews of managed care regulation, performance measure validation, and performance improvement projects by a federally required External Quality Review Organization, Health Services Advisory Group.

- PIHPs provide untold **tens of thousands of staff hours** of subject matter expertise, technical assistance, and the real world know-how to every MDHHS change management process, assuring deeper and broader consistency and implementation,



CMHA
Community Mental Health Association of Michigan

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

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.