# Southwest Michigan Behavioral Health Board Meeting

**Please join the meeting from your computer, tablet or smartphone:**
**https://global.gotomeeting.com/join/515345453**
**You can also dial in using your phone:**
**1-571-317-3116 - Access Code: 515-345-453**
**October 8, 2021**
**9:30 am to 11:00 am**
**(d) means document provided**
**Draft: 9/29/21**

1. **Welcome Guests/Public Comment**

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

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

   - None

4. **Consent Agenda**

   a. September 10, 2021 SWMBH Board Meeting Minutes (d) pg.3
   b. Credentialing of Behavioral Health Practitioners (M. Todd) (d) pg.8
   c. Credentialing of Organizational Providers (M. Todd) (d) pg.15

5. **Operations Committee**

   a. Operations Committee Minutes August 25, 2021 (d) pg.20
   b. Operations Committee Quarterly Report (D. Hess) (d) pg.22

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

   - *Home Adult Benefit (HAB) Waiver (J. Gardner) (d) pg. 23

7. **Board Actions to be Considered**

   a. Fiscal Year 2022 SWMBH Budget (T. Dawson) (to be displayed)
   b. Fiscal Year 2022 Program Integrity Compliance Plan (M. Todd) (d) pg.24
   c. December Holiday Event (B. Casemore)

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

   - EO-003 Emergency Executive Officer Succession (d) pg. 59

**9. Executive Limitations Review**

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

- BEL-008 Communication and Counsel (T. Schmelzer) (d) pg.62

**10. Board Education**

a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d) pg.67
b. Michigan Municipal Risk Management Authority (MMRMA) (T. Dawson) (d) pg.75
c. Michigan Consortium for Healthcare Excellence (MCHE) (B. Casemore) (d) pg.77
d. Compliance Role & Function (M. Todd) (d) pg.80

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

a. November 12, 2021 Board Agenda (d) pg.122
b. Board Member Attendance Roster (d) pg.124
c. Mental Health Listening Tour (d) pg.125
d. Community Mental Health Association of Michigan Fiscal Year 2022 Conference Report-Final Budget (d) pg.127
e. November Executive Officer Performance Review
f. November Board Policy Direct Inspection – BEL-010 RE 501 (c) (3) Representation (E. Krogh)

**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**
**November 12, 2021**
**9:30 am - 11:00 am**

Southwest Michigan
BEHAVIORAL HEALTH

**Board Meeting Minutes**
**September 10, 2021**
**9:30 am-11:00 am**
**GoTo Webinar and Conference Call**
**Draft: 9/10/21**

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**Members Present via virtual:**
Edward Meny, Tom Schmelzer, Terry Proctor, Erik Krogh, Carol Naccarato, Susan Barnes, Ruth Perino, Marcia Starkey

**Guests Present:** Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist, Rights Advisor, SWMBH

**Guests Present via virtual:** Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance & Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Richard Thiemkey, Barry County CMH; Brad Sysol, Summit Pointe; Sue Germann, Pines BH; Kris Kirsch, St. Joseph CMH; Debb Hess, Van Buren CMH; Ric Compton, Riverwood; Jon Houtz, Pines BH Alternate; Tim Smith, Woodlands; Patricia Gunther, ISK Alternate; Mike Hoss, Veterans Navigator, SWMBH; Jonathan Gardner, Director of Quality Assurance & Performance Improvement, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH

**Welcome Guests**
Edward Meny called the meeting to order at 9:30 am.

**Public Comment**
None

**Agenda Review and Adoption**

Motion Erik Krogh moved to accept the agenda as presented.
Second Tom Schmelzer
Motion Carried

**Financial Interest Disclosure Handling**
Mila Todd reviewed financial interest disclosures for Marcia Starkey, Calhoun County appointed SWMBH Board member and Jeanne Jourdan, Cass County appointed SWMBH Board Alternate member.

Motion Erik Krogh moved that a conflict exists and that:

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

Second Tom Schmelzer
Motion Carried

Motion Tom Schmelzer moved that a conflict exists and that:

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

Second Susan Barnes
Motion Carried

**Consent Agenda**

Motion Tom Schmelzer moved to approve the July 9, 2021, Board meeting minutes as presented.
Second Susan Barnes
Motion Carried

Motion Ruth Perino moved to approve the August 13, 2021 Board meeting minutes as presented.
Second Erik Krogh
Motion Carried

Motion Tom Schmelzer moved to approve the Customer Advisory Committee nominees as presented.
Second Susan Barnes
Motion Carried

**Operations Committee**

**Operations Committee Minutes July 28, 2021**

Edward Meny reviewed the minutes as documented. There were no questions, and the minutes were accepted.

**Ends Metrics**

**Fulfillment of Contractual Obligations – State Opioid Response Grant Review Results**

Tom Schmelzer reminded the Board that the document was reviewed at the last Board meeting and only a vote is required today.

Motion Tom Schmelzer moved that the data is relevant and compelling, the Executive Officer is in compliance and the contract obligations have been fulfilled.
Second Susan Barnes
Motion Carried

**Board Actions to be Considered**

**Michigan Consortium for Healthcare Excellence (MCHE) payment for MCG Utilization Management Tool**

Brad Casemore reviewed the history of MCHE, prior payment history and current payment requests referencing SWMBH Policy BEL-010 Regional Entity 501 (c) (3) Representation. Discussion followed.

| | | |
|---|---|---|
| Motion | Erik Krogh moved to authorize the 2021 Fee payment to MCHE for MCG state-required Utilization Review Criteria and Solution in the approximate amount of $45,000.00. | |
| Second | Tom Schmelzer | |
| Roll call vote | Ruth Perino | yes |
| | Carol Naccarato | yes |
| | Tom Schmelzer | yes |
| | Terry Proctor | yes |
| | Erik Krogh | yes |
| | Edward Meny | yes |
| | Susan Barnes | yes |

Motion Carried

| | | |
|---|---|---|
| Motion | Ruth Perino moved to authorize the payment of the 2022 and 2023 MCG state-required Utilization Review Criteria and Solution Fee payments to MCHE in the approximate amounts of $45,000.00 each. | |
| Second | Susan Barnes | |
| Roll call vote | Ruth Perino | yes |
| | Carol Naccarato | yes |
| | Tom Schmelzer | yes |
| | Terry Proctor | yes |
| | Erik Krogh | yes |
| | Edward Meny | yes |
| | Susan Barnes | yes |

Motion Carried

**Board Policy Review**

**BG-008 Board Member Job Description**

Edward Meny reported as documented.

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|---|---|
| Motion | Tom Schmelzer moved that the Board is in compliance and policy BEL-008 Board Member Job Description does not need revision. |
| Second | Susan Barnes |

Motion Carried

**EO-001 Executive Role & Job Description**

Edward Meny reported as documented.

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|---|---|
| Motion | Ruth Perino moved that the Board is in compliance and policy EO-001 Executive Role & Job Description does not need revision. |
| Second | Erik Krogh |

Motion Carried

**BG-002 Management Delegation**

Edward Meny reported as documented.

Motion Erik Krogh moved that the Board is in compliance and policy BG-002 Management Delegation does not need revision.

Second Carol Naccarato

Motion Carried

**Executive Limitations Review**

**BEL-009 Global Executive Constraint**

Ruth Perino reported as documented.

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

Second Tom Schmelzer

Motion Carried

**BEL-005 Treatment of Plan Members**

Erik Krogh reported as documented.

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

Second Carol Naccarato

Motion Carried

**BEL-004 Treatment of Staff**

Edward Meny reported as documented.

Motion Edward Meny 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

**Board Education**

**Fiscal Year 2021 Year to Date Financial Statements**

Tracy Dawson reported as documented.

**Preview Fiscal Year 2022 SWMBH Budget**

Tracy Dawson reported as documented noting that the State does not have a budget yet and SWMBH does not have good rate information. The State said that rate information would be provided by September 16, 2021, and then SWMBH will begin internal budget processes.

**Veteran's Services**

Mike Hoss reported as documented. The Board thanked Mike Hoss for his service.

**Communication and Counsel to the Board**

**Provider Network Stability Report**
Mila Todd reported as documented.

**October 8, 2021, 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.

**6th Annual Regional Healthcare Policy Forum**
Brad Casemore reminded the Board of the 10/1/21 Healthcare Policy Forum, panelists, current registrants, and location.

**New Audio-Visual System in Board Room**
Brad Casemore noted today's Board meeting is utilizing new audio-visual equipment which will be conducive to future meetings and offer a hybrid option if necessary/allowed.

**President Biden's Pandemic Address**
Brad Casemore stated that SWMBH is reviewing the recent pandemic address to determine affects to SWMBH and the clients it serves.

**CMHAM Hybrid Annual Fall Conference – October 25 & 26, 2021**
Brad Casemore announced the Fall Conference and reminded Board members to register soon if they wish to attend.

**EO Annual Evaluation Process**
Michelle Jacobs reviewed SWMBH Policy EO-002 Monitoring of Executive Officer Performance, noting Standard III.5 detailing data and information that the Executive Committee will receive in their upcoming review of the Fiscal Year 2021 Executive Officer performance.

**Public Comment**

None

**Adjournment**

Motion Erik Krogh moved to adjourn at 10:45 am
Second Tom Schmelzer
Unanimous Voice Vote
Motion Carried

| 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 01/10/2020** | Date Approved: |
| Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____ | Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____ | Effective Date: **1/1/14** |

**Policy:** Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (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.<br>• 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.<br>• The American Medical Association (AMA) or American Osteopathic Association (AOA) Master Files may be used as the source for education verification for physicians.<br>• 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.<br>• 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.<br>• 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 of their 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.

**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 |
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| 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 12/14/18** | Date Approved: |
| Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____ | Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____ | Effective Date: **1/1/14** |

**Policy:** Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (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 no special state investigations in time frame (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.

**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 |
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Southwest Michigan
BEHAVIORAL HEALTH

**Operations Committee Meeting Minutes**
**Meeting: August 25, 2021 10:00am-1:00pm**

**Members Present via phone –** Brad Casemore, Jeannie Goodrich, Jeff Patton, Richard Thiemkey, Sue Germann, Kris Kirsch, Tim Smith, Ric Compton, Debbie Hess

**Guests present via phone** – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Pat Davis, ISK; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Sally Weigandt, CCBHC Coordinator, SWMBH

**Call to Order –** Sue Germann began the meeting at 10:10 am.

**Review and approve agenda –** Agenda approved and group agreed that Tim Smith would be the facilitator for the September Operations Committee Meeting.

**Review and approve minutes from 7/28/21 Operations Committee Meeting –** Minutes were approved by the Committee.

**CMH Updates –** CMHSP CEOS's shared current updates and highlighted ongoing staffing shortages and work regarding CCBHC implementation.

**Fiscal Year 2022 Draft Budget –** Tracy Dawson reported as documented, noting this is the first iteration and the State revenue is not yet known.

**Fiscal Year 2021 Year to Date Financials –** Tracy Dawson reported as documented.

**Standard Cost Allocation (SCA)/EQI/Rate Setting Workgroup Updates –** Tracy Dawson shared that the regional finance staff are working hard and collaborating well on SCA implementation.

**System Transformation Updates –** Brad Casemore noted that PIHPs and staff continue to grow anxious and if legislative proposals pass staff will exit and there will be a disruption of service.

**Fiscal Year 2022 PIHP-DHHS Contract Status –** Brad Casemore stated that he signed amendments 1 and 2 and that a State contract negotiations meeting is scheduled for August 27th.

**Fiscal Year 2022 CMH Contracts –** Brad Casemore stated that contracts are in development and reviewed email from CMHAM. Discussion followed.

**CCBHC Update –** Sally Weigandt stated that there has been quite a bit of movement with CCBHC and there is 26 business days to implementation. State gave the following updates:

- Rework of payment operations – no longer carved out of bas capitation rate, supplemental funds to be sent to PIHPS for distribution
- Workgroup meeting with National Council on DCOs. DCO networks in Michigan are much larger than in other states, incorporating all nine core CCBHC functions, including screenings and authorizations. Discussion followed.
- Subgroup work continues regarding screenings, authorizations, data processes, encounters, WSA, automation, reporting requirements, finance, budget and payments.
- Sally is reviewing CCBHC Handbook and developing maps/workflows and preliminary contract agreement language

**MI Care Open Beds –** Brad Casemore reported as documented and noted that this was referred to the Regional IT Committee.

**Audit Reviews –** Jonathan Gardner updated group on current MDHHS audits and corrective actions plans. SWMBH is reviewing the plans received.

**Fiscal Year 2021 PBIP Update –** Jonathan Gardner stated that SWMBH is collecting information for the narrative piece of the PBIP which is due to the State on 11/15/21. The narrative has been reduced from 150 page maximum to a 10-page maximum.

**Fiscal Year 2021 2nd Quarter PIHP MMBPIS Reports –** Jonathan Gardner reported as documented noting that 7 out of 7 benchmarks were met and reviewed indicators that could be bench marked soon. Group to discuss top tier metrics at September meeting.

**American Society of Addiction Medicine (ASAM) Continuum of Care Installation –** Joel Smith noted that ASAM assessment trainings have been sent out to SUD Program Directors for staff to receive the required training. There are about 60 clinical staff trained so far. SmartCare installation/testing should start the first week of September to test interface with the ASAM continuum.

**Clinical Leadership –** Brad Casemore noted that Moira Kean has stepped away from clinical leadership duties and SWMBH is reviewing resumes for open clinical position.

**October 1, 2021 Public Policy Event –** Brad Casemore noted the document in the packet for the committee's review.

**September 10, 2021 SWMBH Board Agenda –** Brad Casemore noted the draft agenda in the packet for the committee's review.

**September 29, 2021 Operations Committee Meeting Agenda –** Brad Casemore noted the draft agenda in the packet for the committee's review.

**BHDDA Jon Villasurda Visit –** Brad Casemore noted that Jon Villasurda will be joining the September Operations Committee meeting. Please send any topics for discussion to Brad. Brad also noted the KBB (My Kids Now) lawsuit has reached a final settlement.

**Adjourned –** Meeting adjourned at 11:30am

Southwest Michigan
BEHAVIORAL HEALTH

**Operations Committee Board Report**
**Quarterly Report for July, August, September 2021**
**Board Date 10/8/21**

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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-back to their own CMH's. Some of the topics from this quarter included:

- Reviewed year to date financial reports, and reviewed state level actions which impact financials
- Reviewed Fiscal Year 2022 Budget
- Reviewed Fiscal Year 2022 Contract Status/Updates
- Reviewed Fiscal Year 2021 Performance Bonus Incentive Program developments
- Reviewed State changes regarding Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI)
- Reviewed Fiscal Year 2020 Encounter Volumes
- Reviewed Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status
- Reviewed American Society of Addiction Medicine (ASAM) assessment tool implementation 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 Provider Stability Plan and MDHHS Funding (CMH General Fund and PIHP Risk Corridor)
- Reviewed MI Health Link meetings and status
- Discussed Direct Care Wage
- Reviewed MCHE/MCG Contract renewal status
- Reviewed Building Better Lives Project
- Reviewed and discussed of Unenrolled Complex Care Management Proposal
- Discussion of Center for Medicare and Medicaid Services (CMS) Certified Community Behavioral Health Clinics (CCBHC) Demonstration
- Discussion of Health Information Exchange (HIE)
- Reviewed and discussed beginning Health Disparities Data
- Reviewed MDHHS code changes
- Discussion of Unenrolled Complex Care Management Proposal
- Discussion of Behavioral Health System Transformation proposals
- Discussion of remote and face to face meetings
- Discussion of awarded COIVD supplemental funds
- Discussion of Provider Network Capacity and Stability issues
- Discussion of State's Unfunded Mandates
- Discussion of CMHSPs issues and challenges

# Board Ends Metric Updates – October 8, 2021

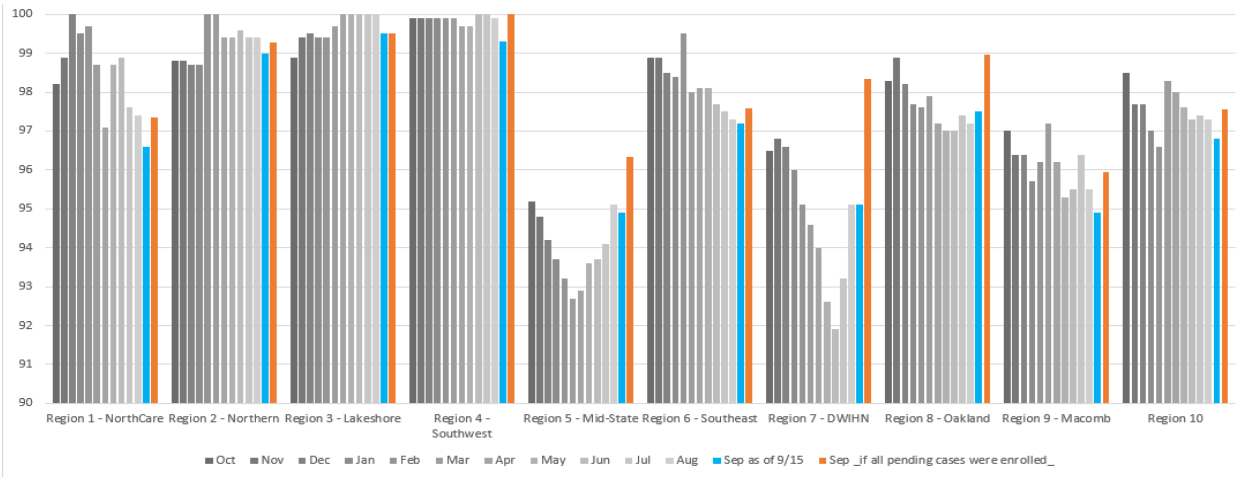
## Regional Habilitation Supports Waiver slots are full at 99% throughout FY21.

| PERFORMANCE METRIC DESCRIPTION | STATUS |
|---|---|
| **Regional Habilitation Supports Waiver slots are full at 98% throughout FY21.**<br><br>Metric Measurement Period: (10/1/21 - 9/30/21)<br>Metric Board Report Date: October 8, 2021<br>(*or when MDHHS posts yearend report*).<br>Interim Board Report with (MK or RF) in April 2021<br><br>**Measurement:** Results are verified and certified through the MDHHS HSW performance dashboard.<br>(%) of waiver slots (months) filled x 12<br>(#) of waiver slots (months) available<br><br>**Possible Points:** 1 point awarded upon official Board approval.<br>+1 bonus point awarded for (5) or more *new* slots awarded to SWMBH by MDHHS during FY21. | **Completed Successfully**<br><br>▪ FY21 Result: **99.90%**<br>▪ FY20 Result: 99.84%<br><br>Please note we have one transfer that will be backdated to the 1st of August (not recorded) and 4 new HAB Packets uploaded with a start of 9/1/21 waiting to be approved.<br><br>Executive Owners:<br>Moira Kean and<br>Rhea Freitag |

**MDHHS Dashboard:**

| PIHP Name | Fiscal Year | | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Region 4 - Southwest | 2021 | Owned | 710 | 710 | 710 | 710 | 710 | 710 | 710 | 710 | 710 | 710 | 710 | 710 |
| Region 4 - Southwest | 2021 | Loaned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Region 4 - Southwest | 2021 | Borrowed | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Region 4 - Southwest | 2021 | Used | 710 | 710 | 709 | 710 | 710 | 710 | 710 | 710 | 709 | 710 | 710 | 707 |
| Region 4 - Southwest | 2021 | Available | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 |
| Region 4 - Southwest | 2021 | % Used | 100 | 100 | 99.9 | 100 | 100 | 100 | 100 | 100 | 99.9 | 100 | 100 | 99.6 |

**HSW Slot Utilization by Region (PIHP)**



# Southwest Michigan Behavioral Health
# CORPORATE COMPLIANCE PLAN

**Approved by SWMBH Board of Directors**
**10/0~~9~~8/2021~~0~~**

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

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## ORGANIZATIONAL STRUCTURE

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

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

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

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

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

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

**SWMBH: MISSION, VISION AND VALUES**

**Philosophy:**
*"Excellence through Partnership."*

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

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

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

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

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

## OVERVIEW

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

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

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

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

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

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

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

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

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

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

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

The SWMBH Compliance Plan is subject to the following conditions:

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

## APPLICATION OF COMPLIANCE PLAN

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

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

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

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

**DEFINITIONS AND TERMS**

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

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

**SECTION I - CODE OF CONDUCT**

- SWMBH Personnel and Board of Directors Code of Conduct

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Participant CMHSP and Contracted and Subcontracted Provider Relationships

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

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

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

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

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

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

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

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

**SECTION II - CHIEF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE**

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

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

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

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

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

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

**Specific responsibilities of the Corporate Compliance Committee include:**

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

## SECTION III - COMPLIANCE TRAINING AND EDUCATION

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

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

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

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

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

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

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

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

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

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

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

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

## SECTION IV - COMPLIANCE REPORTING AND ONGOING COMMUNICATION

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

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

Whistleblower Protections for SWMBH Personnel

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

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

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

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

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

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

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

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

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

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

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

## SECTION V - COMPLIANCE AUDITING, MONITORING AND RISK EVALUATION

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

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

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

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

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

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

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

**SECTION VI - ENFORCEMENT OF COMPLIANCE POLICIES AND STANDARDS**

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

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

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

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

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

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

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

## SECTION VII - CONFIDENTIALITY AND PRIVACY

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

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

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

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

## SWMBH PERSONNEL COMPLIANCE CERTIFICATION FORM

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

_____ _____

Employee/Provider/Contractor Signature Date

**SWMBH BOARD OF DIRECTORS COMPLIANCE CERTIFICATION FORM**

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

_____ _____

Board Member Signature Date

The SWMBH FY2021 Payment Integrity Auditing and monitoring plan, monitors services delivered by CMHSPs as well as contracted service providers to assess compliance with applicable Federal and State billing rules, applicable contracts, and SWMBH policies and procedures. The reviews are also designed to monitor and detect deficiencies in business processes used for coverage determinations and claims adjudication. The Audit and Monitoring Plan focuses on review of services that fall under the following business lines: Medicaid, Healthy Michigan, SED Waiver, and MI Health Link, SAPT Block Grant and P.A.2 funds both in Fee-for-Service claims and net cost contract formats.

| | Audit Topic | Audit Mechanism | Known Risks and/or Purpose of Audit | Frequency of Audits | Responsibility |
|---|---|---|---|---|---|
| 1 | **Medicaid Services Verification Claims Review**<br>**CONTRACT REQUIREMENT:** FY21&22 1115 Demonstration Waiver, 1915(c)/(i) Waiver Program - Attachment P6.4.1. | Review Medicaid covered services using the Medicaid Services Verification Review Tool. Tool will identify those items for which scores will be reported to the State. Reviews CMHSP provided services, CMHSP subcontracted provider services, and SUD services paid for utilizing Medicaid funds, for documentation and claims/payment accuracy. | 1) Required through PIHP/MDHHS contract; 2) Procedures prescribed by MDHHS Technical Advisory; and 3) Additional elements added to address known risk areas (overlapping billing, IOP, etc.). | Quarterly audit (based on Fiscal Year Quarters consisting of a sample for CMHSPs of 15 internal services and 15 external services. CMHSP sampling universes will be stratified to remove the top external providers and top hospital providers that will be independently audited. Audit will consist of a sample of 30 dates of service from SUD providers collectively (stratified to remove any SUD provider that is also a top external provider and to include only 10 methadone dosing claims), 15 dates of service for each of the top three hospital providers (by dollar figure), 15 dates of service for each of the top three external providers (by dollar figure), and a 30 date of service sample for the remaining providers in the region. Samples pulled utilizing sampling specifications consistent with the OIG Self Reporting Protocol. | SWMBH Program Integrity & Compliance |

| | Audit Topic | Audit Mechanism | Known Risks and/or Purpose of Audit | Frequency of Audits | Responsibility |
|---|---|---|---|---|---|
| 2 | **MI Health Link (Medicare) Claims Review (Duals Demonstration)** | Review of MI Health Link provider claims. Review of supporting documentation as necessary. | Required as set forth in the contracts with Aetna and Meridian to audit for 1) financial accuracy by looking at under/over payments related to claims, 2) to maintain an acceptable level of correctly paid/denied claims, and 3) to maintain an acceptable percentage of claims that were properly coded. | Quarterly sample of 30 DOS for each CMHSP. 15 SUD 15 Mental Health as long as there enough SUD claims to monitor. 30 DOS for non-SUD service providers and 30 DOS for SUD service providers Quarterly. Total quarterly sample of 300 DOS. | SWMBH Program Integrity & Compliance |
| 3 | **Block Grant FFS Claims** | Review of Block Grant Fee-for-Service claims including ATP process. | 1) SWMBH Organizational Risk Assessment identified very minimal oversight of Block Grant funding stream; 2) Past findings concerning ATP process. | Quarterly sample of 60 DOS for SUD services paid via Block Grant funds. Audit will ensure: Customer eligibility, Block Grant used as last resort, ATP completed, client Medicaid application, Collection of ATP prior to billing SWMBH, and service documentation. | SWMBH Program Integrity & Compliance |
| 4 | **Net cost Contract Review** | Review of SUD Net Cost Contracts - review to include FSR (financial status reports) and Data Template review, SWMBH work plan included with contracts, and supporting documentation from Provider as necessary. | SWMBH Organizational Risk Assessment identified need for Funding Stream Oversite; | SWMBH Organizational Risk Assessment identified need for Funding Stream Oversite; Annual monitoring of •Staffing Costs •Supplied and Materials •Sub-Contracts •Documentation for invoicing/payments •Data Reporting | SWMBH Program Integrity & Compliance & SWMBH Finance |
| 5 | **Coordination of Benefits audit** | Audit of SUD providers to ensure that Coordination of Benefits occurs when a client has both commercial and Medicaid insurance. | Required to ensure that SWMBH is the payor of last resort when a client has commerial insurance. | Compliance Specialist does a sample size made up of 30 dates of service randomly selected on a quarterly basis | SWMBH Program Integrity & Compliance |
| 6 | **Residential personal care and community living services** | Review of personal care and community living services through the annual documentation review plan. | 1) Continued OIG review due to current and anticipated increased spending. 2) Past audit findings through SWMBH. 3) Issue again cited by OIG in 2017 Work Plan | This sample is included in the claims sample for each CMHSP as **part of the Medicaid Services Verification Audit**. Please see that audit topic for further detail. | SWMBH Program Integrity & Compliance |

| | Audit Topic | Audit Mechanism | Known Risks and/or Purpose of Audit | Frequency of Audits | Responsibility |
|---|---|---|---|---|---|
| 7 | **Business Associate/ Qualified Service Organization Agreement Annual Review** | Review of Business Associate Agreements. Internal | No current monitoring occurring on a regular basis. Risk Assessment indicated an annual audit of BAAQSOA to ensure they are current and that all applicable vendors have one as needed. | 1. Annual review of all BAA/QSOAs 2. Make sure that each BAA/QSOA is valid and current. 3. If the agreement is deemed invalid or not current, additional review is needed. 4. This is an internal audit and will not incorporate cooperation from the BA/QSO unless agreement is deemed invalid. | SWMBH Program Integrity & Compliance |
| 9 | **Business Associate and QSOA Annual Review** | Review of Business Associates. Review of supporting processes at individual locations. | Currently no oversight of compliance with BAA/QSOA terms. | 1. Biennially site review of Business associates and/or qualified service organizations 2. 100% of all locations reviewed EOY. 3. Utilize the BA Audit Tool for all sites. 4. If noncompliance is found within the audit a corrective action plan will be implemented with expectation of return of 14 days from receipt. | SWMBH Program Integrity & Compliance |
| 10 | **Data Mining** | Review of Tableau reports to monitor the following: ABA Modifiers Overlapping Per Diems Disallowed Place of Service Codes Overlapping of H0018/H0019 with H0038 | | Monthly reports are run to review any risk that has occurred within the areas of identified concern. Claim corrections, recoupments and/or CAPs can be requested when issues are discovered. *ABA modifiers-sample of 5% of paid claims (2 months prior to the month of the audit) using modifiers HN, HO, HP; Samples pulled utilizing sampling specifications consistent with the OIG Self Reporting Protocol. | SWMBH Program Integrity & Compliance |

| | Audit Topic | Audit Mechanism | Known Risks and/or Purpose of Audit | Frequency of Audits | Responsibility |
|---|---|---|---|---|---|
| 11 | **MHL Credentialing audit** | Review of MHL credentialing files to assure the process is completed per requirements | ICO requested monitoring of the process during audit process. | Monthly audits occur with a minimum of two MHL credentialing records per month or 10% of files credentialing during the month. | SWMBH Program Integrity & Compliance |
| 12 | **CCBHC Monitoring** | tbd | tbd | | SWMBH Program Integrity & Compliance |
| 13 | **Opioid Health Home audit** | tbd | tbd | | SWMBH Program Integrity & Compliance |

The SWMBH FY2021 Clinical Quality Audit and Monitoring Plan reviews services de
applicable Federal and State billing and licensing rules, applicable contracts, and S\
deficiencies in business processes, documentation, and scope of care.

| | Audit Topic | Audit Mechanism |
|---|---|---|
| 1 | **SUD Site Review** | Annual review of SUD Providers, including CMHSP SUD Providers, including an administrative review and a clincial file review of services paid for utilizing Medicaid, Healthy Michigan Plan (HMP), and Block Grant funds. |
| 2 | **Inpatient Psychiatric Hospital Services Clinical Review** | Administrative and Clinical review of inpatient psychiatric services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds. |
| 3 | **Crisis Residential Administrative Services Review** | Administrative and Clinical review of crisis residential services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds. |
| 4 | **Annual CMHSP Site Review** | Administrative and Clinical review of functions delegated to participant CMHSP related to Medicaid and Healthy Michigan Plan (HMP) funds. |

| | | |
|---|---|---|
| **5** | **Autism Provider Reviews** | Administrative review and brief clinical review for State of Michigan quality metrics. |

elivered by CMHSPs as well as contracted service providers to assess compliance with
/MBH policies and procedures. The reviews are also designed to monitor and detect

| Known Risks and/or Purpose of Audit | Frequency of Audits | Responsibility |
|---|---|---|
| 1) Past audit findings through SWMBH. | Sample size is 5% with a minimum of 8 files and a maximum of 20 records. If multiple sites, files to be reviewed from each site. SUD clinical to determine focus population(s) and review entire scope of care (not DOS specific). | SWMBH Provider Network and SWMBH Clinical Quality/SUD Department |
| 1) Services have been subject to minimal review in the past and are a high cost service; 2) Review pursuant to the PIHP Statewide Provider Monitoring - Inpatient Protocol under the Statewide Reciprocity Agreement; 3) Claims/coding/payment/COB accuracy due to past audit findings regarding coding accuracy & documentation sufficiency. | SWMBH Clinical Quality working with Statewide Reciprocity Workgroup re: Inpatient Review methodology, and working with CMHSP PNM/RR officers re: responsibility for auditing inpatient providers physically located within Region 4. Review will utilize approved Inpatient Protocol. | Coordinated by SWMBH Clinical Quality for entire Region pursuant to the PIHP Statewide Inpatient Reciprocity protocol |
| 1. Administrative oversight and monitoring as well as Clinical quality and adherence to the standards outlined in the Medicaid Provider Manual. | Annual sample size of 5% of staff for each provider with a minimum of 8 clinical files. Clinical sample size is 5% or no less than 8 files, staff file sample size is 5% or no less than 5 files. If multiple sites, files to be reviewed from each site. Provider Network with stratify within Universe to determine focus areas. Not DOS specific, rather review will focus on entire scope of care. | SWMBH Provider Network Managenet & SWMBH Clinical Quality |
| 1) Title 42: Public Health<br>PART 438—MANAGED CARE<br>Subpart D—MCO, PIHP and PAHP Standards<br><br>§438.230 Sub contractual relationships and delegation | Sample size is 5% with a minimum of 8 files and a maximum of 20 records. If multiple sites, files to be reviewed from each site. Clinical Quality/SUD determine focus population and review entire scope of care (not DOS specific). | SWMBH Provider Network, SWMBH Clinical Quality, and SWMBH SUD Departments |

| | | |
|---|---|---|
| | Annual. | SWMBH Clinical Quality |

Southwest Michigan
BEHAVIORAL HEALTH

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

I. **PURPOSE:**

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

II. **POLICY:**

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

Southwest Michigan
BEHAVIORAL HEALTH

**Executive Limitations**
**Monitoring to Assure Executive Performance**

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**Policy Number: EO-003**
**Policy Name: Emergency Executive Officer Succession**
**Board Date: October 8, 2021**

## POLICY PURPOSE:

In order to protect the board from sudden loss of Chief Executive (EO) services.

## BOARD POLICY:

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

Executive Officer Report

I previously identified, and the Board accepted, Tracy Dawson, Chief Financial Officer and Mila Todd, Chief Compliance Officer and Director of Provider Network Management as executives identified to be sufficiently familiar with Board and EO issues and processes to enable either to take over with reasonable proficiency as an interim EO if called upon by the Board to do so.

Over the past year I have continued concerted efforts with Tracy and Mila to enhance the Board directive of reasonable proficiency. Specifically,

- I have met regularly with Tracy and Mila together and separately on operational matters and have incorporated into those meetings discussions of Board and EO issues and processes. They are also those first privy to and consulted on major emerging strategic plans and major operational decisions.

- They are both regular attendees at Board and Operations Committee meetings.

- I have made a written pre-directive to applicable SWMBH Senior Leaders to free access to hard and soft version EO files immediately to the interim EO if the Board names one.

I continue to solicit and fulfill needs from Tracy and Mila in this regard.

Designated representative(s) of the Board are of course free to solicit views on this topic from Tracy and Mila.

<END>

Southwest Michigan
BEHAVIORAL HEALTH

**Executive Limitations**
**Monitoring to Assure Executive Performance**
**October 8, 2021**

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**Policy Number: BEL008**
**Policy Name: Communication and Counsel to the Board**
**Assigned Reviewer: Tom Schmelzer**

**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.*

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.

| | E | H | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | ***Southwest Michigan Behavioral Health*** | | *Mos in Period* | | | | | | | | |
| 2 | For the Fiscal YTD Period Ended 8/31/2021 | **P11FYTD21** | **11** | | | | | | | | |
| 3 | *(For Internal Management Purposes Only)* | | | | | | | | | | |
| 4 | ***INCOME STATEMENT*** | **TOTAL** | **Medicaid Contract** | **Healthy Michigan Contract** | **Autism Contract** | **MI Health Link** | **MH Block Grant Contracts** | **SA Block Grant Contract** | **SA PA2 Funds Contract** | **SWMBH Central** | **Indirect Pooled Cost** |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |
| 7 | **REVENUE** | | | | | | | | | | |
| 16 | Contract Revenue | 297,540,661 | 221,015,130 | 43,139,515 | 20,814,336 | 4,049,136 | - | 5,784,862 | 1,751,763 | 985,918 | - |
| 17 | DHHS Incentive Payments | 654,452 | 654,452 | - | - | - | - | - | - | - | - |
| 18 | Grants and Earned Contracts | 235,975 | - | - | - | - | 235,975 | - | - | - | - |
| 19 | Interest Income - Working Capital | 12,086 | - | - | - | - | - | - | - | 12,086 | - |
| 20 | Interest Income - ISF Risk Reserve | 992 | - | - | - | - | - | - | - | 992 | - |
| 21 | Local Funds Contributions | 1,582,343 | - | - | - | - | - | - | - | 1,582,343 | - |
| 22 | Other Local Income | - | - | - | - | - | - | - | - | - | - |
| 23 | | | | | | | | | | | |
| 24 | **TOTAL REVENUE** | **300,026,507** | **221,669,582** | **43,139,515** | **20,814,336** | **4,049,136** | **235,975** | **5,784,862** | **1,751,763** | **2,581,338** | **-** |
| 25 | | | | | | | | | | | |
| 26 | **EXPENSE** | | | | | | | | | | |
| 27 | **Healthcare Cost** | | | | | | | | | | |
| 28 | Provider Claims Cost | 20,979,421 | 3,361,752 | 6,965,540 | - | 3,609,899 | 74,179 | 4,989,485 | 1,281,813 | 696,752 | - |
| 29 | CMHP Subcontracts, net of 1st & 3rd party | 216,657,061 | 177,204,397 | 21,313,500 | 16,341,135 | 1,361,980 | - | 436,050 | - | - | - |
| 30 | Insurance Provider Assessment Withhold (IPA) | 3,076,926 | 3,076,926 | - | - | - | - | - | - | - | - |
| 31 | Medicaid Hospital Rate Adjustments | 4,117,344 | 4,117,344 | - | - | - | - | - | - | - | - |
| 32 | MHL Cost in Excess of Medicare FFS Cost | - | 1,202,271 | - | - | (1,202,271) | | - | - | - | |
| 33 | | | | | | | | | | | |
| 34 | **Total Healthcare Cost** | **244,830,752** | **188,962,691** | **28,279,041** | **16,341,135** | **3,769,608** | **74,179** | **5,425,535** | **1,281,813** | **696,752** | **-** |
| 35 | **Medical Loss Ratio (HCC % of Revenue)** | **82.1%** | **85.2%** | **65.6%** | **78.5%** | **93.1%** | | **93.8%** | **73.2%** | | |
| 37 | **Administrative Cost** | | | | | | | | | | |
| 38 | Purchased Professional Services | 358,258 | - | - | - | - | - | - | - | 358,258 | - |
| 39 | Administrative and Other Cost | 7,638,254 | - | - | - | - | 161,795 | 161,856 | - | 7,309,839 | 4,764 |
| 40 | Interest Expense | - | - | - | - | - | - | - | - | - | - |
| 41 | Depreciation | 21,918 | - | - | - | - | - | - | - | 21,918 | - |
| 42 | Functional Cost Reclassification | - | - | - | - | - | - | - | - | - | - |
| 43 | Allocated Indirect Pooled Cost | 0 | - | - | - | - | - | - | - | 4,764 | (4,764) |
| 44 | Delegated Managed Care Admin | 16,534,763 | 13,557,784 | 1,630,479 | 1,242,691 | 103,809 | - | - | - | - | - |
| 45 | Apportioned Central Mgd Care Admin | 0 | 6,381,649 | 999,450 | 577,536 | 175,718 | 8,340 | 197,472 | - | (8,340,166) | - |
| 46 | | | | | | | | | | | |
| 47 | **Total Administrative Cost** | **24,553,193** | **19,939,433** | **2,629,930** | **1,820,226** | **279,528** | **170,135** | **359,328** | **-** | **(645,386)** | **0** |
| 48 | **Admin Cost Ratio (MCA % of Total Cost)** | **9.1%** | **9.5%** | **8.5%** | **10.0%** | **6.9%** | | **6.2%** | **0.0%** | **3.1%** | |
| 49 | | | | | | | | | | | |
| 50 | Local Funds Contribution | 1,582,343 | - | - | - | - | - | - | - | 1,582,343 | - |
| 51 | PBIP Transferred to CMHPs | - | | | | | | | | - | |
| 52 | | | | | | | | | | | |
| 53 | **TOTAL COST after apportionment** | **270,966,288** | **208,902,124** | **30,908,970** | **18,161,361** | **4,049,136** | **244,315** | **5,784,862** | **1,281,813** | **1,633,708** | **0** |
| 54 | | | | | | | | | | | |
| 55 | **NET SURPLUS before settlement** | **29,060,219** | **12,767,458** | **12,230,545** | **2,652,976** | **-** | **(8,340)** | **-** | **469,950** | **947,630** | **(0)** |
| 56 | **Net Surplus (Deficit) % of Revenue** | **9.7%** | **5.8%** | **28.4%** | **12.7%** | **0.0%** | **-3.5%** | **0.0%** | **26.8%** | **36.7%** | |
| 58 | Prior Year Savings | - | - | - | - | - | | - | - | - | |
| 59 | Change in PA2 Fund Balance | (469,950) | - | - | - | - | | - | (469,950) | - | |
| 60 | ISF Risk Reserve Abatement (Funding) | (992) | - | - | - | - | | - | - | (992) | |
| 61 | ISF Risk Reserve Deficit (Funding) | - | - | - | - | - | | - | - | - | |
| 62 | Settlement Receivable / (Payable) | - | 12,530,456 | (9,877,480) | (2,652,976) | - | - | - | - | - | |
| 63 | **NET SURPLUS (DEFICIT)** | **28,589,277** | **25,297,914** | **2,353,064** | **-** | **-** | **(8,340)** | **-** | **-** | **946,639** | **(0)** |
| 64 | *HMP & Autism is settled with Medicaid* | | | | | | | | | | |
| 65 | | | | | | | | | | | |
| 66 | **SUMMARY OF NET SURPLUS (DEFICIT)** | | | | | | | | | | |
| 67 | Prior Year Unspent Savings | - | - | - | - | - | | - | - | - | |
| 68 | Current Year Savings | 21,615,219 | 19,262,155 | 2,353,064 | - | - | | - | - | - | |
| 69 | Current Year Public Act 2 Fund Balance | - | - | - | - | - | | - | - | - | |
| 70 | Local and Other Funds Surplus/(Deficit) | 6,974,058 | 6,035,759 | - | - | - | (8,340) | - | - | 946,639 | (0) |
| 72 | **NET SURPLUS (DEFICIT)** | **28,589,277** | **25,297,914** | **2,353,064** | **-** | **-** | **(8,340)** | **-** | **-** | **946,639** | **(0)** |
| 73 | | | | | | | | | | | |

| | F | G | H | I | J | K | L | M | N | O | P | Q | R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Southwest Michigan Behavioral Health** | | | *Mos in Period* | | | | | | | | | |
| 2 | For the Fiscal YTD Period Ended 8/31/2021 | | | 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%* | 79.5% | 76.2% | 78.3% | 78.4% | 78.3% | 78.8% | 81.8% | 79.5% | 79.8% |
| 7 | Subcontract Revenue | | 221,015,130 | 14,571,964 | 206,443,167 | 8,998,769 | 40,727,399 | 11,473,754 | 37,275,520 | 11,124,129 | 63,397,678 | 13,703,855 | 19,742,062 |
| 8 | Incentive Payment Revenue | | 654,452 | 40,241 | 614,210 | 19,062 | 56,126 | 107,487 | 153,552 | 3,706 | 217,092 | 46,595 | 10,590 |
| 9 | **Contract Revenue** | | **221,669,582** | **14,612,205** | **207,057,377** | **9,017,831** | **40,783,525** | **11,581,241** | **37,429,072** | **11,127,835** | **63,614,770** | **13,750,450** | **19,752,652** |
| 10 | | | | | | | | | | | | | |
| 11 | External Provider Cost | | 136,465,555 | 3,361,752 | 133,103,803 | 4,660,510 | 26,134,502 | 6,164,306 | 26,011,063 | 6,592,924 | 44,564,150 | 8,184,898 | 10,791,449 |
| 12 | Internal Program Cost | | 46,317,567 | - | 46,317,567 | 3,037,329 | 9,334,541 | 2,550,444 | 8,663,578 | 2,602,360 | 7,957,226 | 5,040,522 | 7,131,566 |
| 13 | SSI Reimb, 1st/3rd Party Cost Offset | | (854,993) | - | (854,993) | (8,259) | (105,604) | (50,404) | (280,551) | - | (317,857) | (26,628) | (65,690) |
| 14 | Insurance Provider Assessment Withhold (IPA) | | 7,194,270 | 7,194,270 | - | - | - | - | - | - | - | - | - |
| 15 | MHL Cost in Excess of Medicare FFS Cost | | (263,518) | (263,518) | - | - | - | - | - | - | - | - | - |
| 16 | **Total Healthcare Cost** | | **188,858,881** | **10,292,504** | **178,566,377** | **7,689,580** | **35,363,439** | **8,664,346** | **34,394,089** | **9,195,285** | **52,203,519** | **13,198,793** | **17,857,325** |
| 17 | **Medical Loss Ratio (HCC % of Revenue)** | | **85.2%** | **70.4%** | **86.2%** | **85.3%** | **86.7%** | **74.8%** | **91.9%** | **82.6%** | **82.1%** | **96.0%** | **90.4%** |
| 18 | | | | | | | | | | | | | |
| 19 | **Managed Care Administration** | | **20,043,242** | **6,381,649** | **13,661,593** | **851,097** | **2,688,518** | **745,414** | **2,412,812** | **878,010** | **4,253,236** | **673,663** | **1,158,842** |
| 20 | **Admin Cost Ratio (MCA % of Total Cost)** | | **9.6%** | **3.1%** | **6.5%** | **10.0%** | **7.1%** | **7.9%** | **6.6%** | **8.7%** | **7.5%** | **4.9%** | **6.1%** |
| 21 | | | | | | | | | | | | | |
| 22 | **Contract Cost** | | **208,902,124** | **16,674,154** | **192,227,970** | **8,540,677** | **38,051,957** | **9,409,760** | **36,806,901** | **10,073,295** | **56,456,755** | **13,872,456** | **19,016,168** |
| 23 | **Net before Settlement** | | **12,767,458** | **(2,061,948)** | **14,829,407** | **477,153** | **2,731,568** | **2,171,481** | **622,171** | **1,054,540** | **7,158,015** | **(122,006)** | **736,485** |
| 24 | | | | | | | | | | | | | |
| 25 | Prior Year Savings | | - | - | - | - | - | - | - | - | - | - | - |
| 26 | Internal Service Fund Risk Reserve | | - | - | - | - | - | - | - | - | - | - | - |
| 27 | Contract Settlement / Redistribution | | 12,530,456 | 27,359,862 | (14,829,407) | (477,153) | (2,731,568) | (2,171,481) | (622,171) | (1,054,540) | (7,158,015) | 122,006 | (736,485) |
| 28 | **Net after Settlement** | | **25,297,914** | **25,297,914** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| 29 | | | | | | | | | | | | | |
| 30 | **Eligibles and PMPM** | | | | | | | | | | | | |
| 31 | Average Eligibles | | 164,980 | 164,980 | 164,980 | 8,812 | 31,656 | 9,519 | 31,377 | 9,866 | 43,150 | 13,577 | 17,023 |
| 32 | Revenue PMPM | | $ 122.15 | $ 8.05 | $ 114.10 | $ 93.03 | $ 117.12 | $ 110.60 | $ 108.44 | $ 102.54 | $ 134.02 | $ 92.07 | $ 105.49 |
| 33 | Expense PMPM | | $ 115.11 | $ 9.19 | $ 105.92 | $ 88.11 | $ 109.28 | $ 89.87 | $ 106.64 | $ 92.82 | $ 118.94 | $ 92.89 | $ 101.55 |
| 34 | Margin PMPM | | $ 7.04 | $ (1.14) | $ 8.17 | $ 4.92 | $ 7.84 | $ 20.74 | $ 1.80 | $ 9.72 | $ 15.08 | $ (0.82) | $ 3.93 |
| 35 | | | | | | | | | | | | | |
| 36 | ***Medicaid Specialty Services*** | | | | | | | | | | | | |
| 37 | **Budget v Actual** | | | | | | | | | | | | |
| 38 | | | | | | | | | | | | | |
| 39 | **Eligible Lives (Average Eligibles)** | | | | | | | | | | | | |
| 40 | Actual | | 164,980 | 164,980 | 164,980 | 8,812 | 31,656 | 9,519 | 31,377 | 9,866 | 43,150 | 13,577 | 17,023 |
| 41 | Budget | | 150,993 | 150,993 | 150,993 | 7,748 | 29,128 | 8,480 | 28,644 | 8,958 | 39,711 | 12,462 | 15,862 |
| 42 | Variance - Favorable / (Unfavorable) | | 13,987 | 13,987 | 13,987 | 1,064 | 2,528 | 1,039 | 2,733 | 908 | 3,439 | 1,115 | 1,161 |
| 43 | % Variance - Fav / (Unfav) | | 9.3% | 9.3% | 9.3% | 13.7% | 8.7% | 12.3% | 9.5% | 10.1% | 8.7% | 8.9% | 7.3% |
| 44 | | | | | | | | | | | | | |
| 45 | **Contract Revenue before settlement** | | | | | | | | | | | | |
| 46 | Actual | | 221,669,582 | 14,612,205 | 207,057,377 | 9,017,831 | 40,783,525 | 11,581,241 | 37,429,072 | 11,127,835 | 63,614,770 | 13,750,450 | 19,752,652 |
| 47 | Budget | | 201,911,428 | 12,484,679 | 189,426,749 | 8,217,264 | 37,335,486 | 10,479,255 | 34,530,957 | 10,343,884 | 57,883,940 | 12,540,364 | 18,095,600 |
| 48 | Variance - Favorable / (Unfavorable) | | 19,758,154 | 2,127,526 | 17,630,628 | 800,567 | 3,448,039 | 1,101,986 | 2,898,116 | 783,951 | 5,730,830 | 1,210,087 | 1,657,052 |
| 49 | % Variance - Fav / (Unfav) | | 9.8% | 17.0% | 9.3% | 9.7% | 9.2% | 10.5% | 8.4% | 7.6% | 9.9% | 9.6% | 9.2% |
| 50 | | | | | | | | | | | | | |
| 51 | **Healthcare Cost** | | | | | | | | | | | | |
| 52 | Actual | | 188,858,881 | 10,292,504 | 178,566,377 | 7,689,580 | 35,363,439 | 8,664,346 | 34,394,089 | 9,195,285 | 52,203,519 | 13,198,793 | 17,857,325 |
| 53 | Budget | | 183,887,968 | 10,181,875 | 173,706,093 | 7,275,640 | 33,276,531 | 9,405,693 | 31,517,542 | 8,676,501 | 54,303,887 | 13,171,743 | 16,078,556 |
| 54 | Variance - Favorable / (Unfavorable) | | (4,970,913) | (110,630) | (4,860,284) | (413,940) | (2,086,908) | 741,347 | (2,876,547) | (518,784) | 2,100,368 | (27,050) | (1,778,770) |
| 55 | % Variance - Fav / (Unfav) | | -2.7% | -1.1% | -2.8% | -5.7% | -6.3% | 7.9% | -9.1% | -6.0% | 3.9% | -0.2% | -11.1% |
| 56 | | | | | | | | | | | | | |
| 57 | **Managed Care Administration** | | | | | | | | | | | | |
| 58 | Actual | | 20,043,242 | 6,381,649 | 13,661,593 | 851,097 | 2,688,518 | 745,414 | 2,412,812 | 878,010 | 4,253,236 | 673,663 | 1,158,842 |
| 59 | Budget | | 19,670,263 | 6,828,478 | 12,841,785 | 542,598 | 2,451,391 | 794,731 | 2,156,304 | 789,376 | 4,327,421 | 824,814 | 955,150 |
| 60 | Variance - Favorable / (Unfavorable) | | (372,979) | 446,829 | (819,808) | (308,498) | (237,127) | 49,317 | (256,507) | (88,635) | 74,185 | 151,150 | (203,693) |
| 61 | % Variance - Fav / (Unfav) | | -1.9% | 6.5% | -6.4% | -56.9% | -9.7% | 6.2% | -11.9% | -11.2% | 1.7% | 18.3% | -21.3% |

| | 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 8/31/2021 | | | **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 | | | | | | | | | | | | | |
| 62 | | | | | | | | | | | | | |
| 63 | **Total Contract Cost** | | | | | | | | | | | | |
| 64 | Actual | | 208,902,124 | 16,674,154 | 192,227,970 | 8,540,677 | 38,051,957 | 9,409,760 | 36,806,901 | 10,073,295 | 56,456,755 | 13,872,456 | 19,016,168 |
| 65 | Budget | | 203,558,231 | 17,010,352 | 186,547,878 | 7,818,239 | 35,727,923 | 10,200,424 | 33,673,847 | 9,465,876 | 58,631,308 | 13,996,556 | 17,033,705 |
| 66 | Variance - Favorable / (Unfavorable) | | (5,343,893) | 336,199 | (5,680,092) | (722,439) | (2,324,035) | 790,664 | (3,133,054) | (607,419) | 2,174,553 | 124,100 | (1,982,462) |
| 67 | % Variance - Fav / (Unfav) | | -2.6% | 2.0% | -3.0% | -9.2% | -6.5% | 7.8% | -9.3% | -6.4% | 3.7% | 0.9% | -11.6% |
| 68 | | | | | | | | | | | | | |
| 69 | **Net before Settlement** | | | | | | | | | | | | |
| 70 | Actual | | 12,767,458 | (2,061,948) | 14,829,407 | 477,153 | 2,731,568 | 2,171,481 | 622,171 | 1,054,540 | 7,158,015 | (122,006) | 736,485 |
| 71 | Budget | | (1,646,803) | (4,525,674) | 2,878,870 | 399,025 | 1,607,563 | 278,831 | 857,110 | 878,008 | (747,369) | (1,456,193) | 1,061,895 |
| 72 | Variance - Favorable / (Unfavorable) | | 14,414,262 | 2,463,725 | 11,950,536 | 78,128 | 1,124,004 | 1,892,650 | (234,939) | 176,532 | 7,905,383 | 1,334,187 | (325,410) |
| 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 8/31/2021 | | | 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%* | 9.5% | 13.5% | 8.6% | 11.5% | 10.8% | 10.3% | 7.6% | 11.9% | 9.0% |
| 76 | **Contract Revenue** | | **43,139,515** | **9,696,636** | **33,442,879** | **1,692,676** | **6,676,962** | **1,580,064** | **6,154,739** | **1,810,410** | **9,702,395** | **2,607,876** | **3,217,756** |
| 77 | | | | | | | | | | | | | |
| 78 | External Provider Cost | | 18,734,891 | 6,965,540 | 11,769,351 | 631,532 | 2,095,579 | 687,680 | 2,048,289 | 454,824 | 3,940,608 | 834,043 | 1,076,797 |
| 79 | Internal Program Cost | | 9,544,149 | - | 9,544,149 | 732,790 | 1,790,095 | 585,123 | 2,708,993 | 747,443 | 906,299 | 1,145,227 | 928,179 |
| 80 | Insurance Provider Assessment Withhold (IPA) | | - | - | - | - | - | - | - | - | - | - | - |
| 81 | **Total Healthcare Cost** | | **28,279,041** | **6,965,540** | **21,313,500** | **1,364,322** | **3,885,674** | **1,272,803** | **4,757,282** | **1,202,267** | **4,846,907** | **1,979,269** | **2,004,976** |
| 82 | **Medical Loss Ratio (HCC % of Revenue)** | | **65.6%** | **71.8%** | **63.7%** | **80.6%** | **58.2%** | **80.6%** | **77.3%** | **66.4%** | **50.0%** | **75.9%** | **62.3%** |
| 83 | | | | | | | | | | | | | |
| 84 | **Managed Care Administration** | | **2,629,930** | **999,450** | **1,630,479** | **151,005** | **295,410** | **109,502** | **333,732** | **114,798** | **394,898** | **101,021** | **130,112** |
| 85 | **Admin Cost Ratio (MCA % of Total Cost)** | | **8.5%** | **3.2%** | **5.3%** | **10.0%** | **7.1%** | **7.9%** | **6.6%** | **8.7%** | **7.5%** | **4.9%** | **6.1%** |
| 86 | | | | | | | | | | | | | |
| 87 | **Contract Cost** | | **30,908,970** | **7,964,991** | **22,943,979** | **1,515,327** | **4,181,084** | **1,382,306** | **5,091,014** | **1,317,065** | **5,241,804** | **2,080,291** | **2,135,088** |
| 88 | **Net before Settlement** | | **12,230,545** | **1,731,645** | **10,498,900** | **177,349** | **2,495,878** | **197,759** | **1,063,725** | **493,345** | **4,460,590** | **527,586** | **1,082,668** |
| 89 | | | | | | | | | | | | | |
| 90 | Prior Year Savings | | - | - | - | - | - | - | - | - | - | - | - |
| 91 | Internal Service Fund Risk Reserve | | - | - | - | - | - | - | - | - | - | - | - |
| 92 | Contract Settlement / Redistribution | | (9,877,480) | 621,420 | (10,498,900) | (177,349) | (2,495,878) | (197,759) | (1,063,725) | (493,345) | (4,460,590) | (527,586) | (1,082,668) |
| 93 | **Net after Settlement** | | **2,353,064** | **2,353,064** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| 94 | | | | | | | | | | | | | |
| 95 | **Eligibles and PMPM** | | | | | | | | | | | | |
| 96 | Average Eligibles | | 68,120 | 68,120 | 68,120 | 3,448 | 13,628 | 3,226 | 12,355 | 4,096 | 19,454 | 5,298 | 6,615 |
| 97 | Revenue PMPM | | $ 57.57 | $ 12.94 | $ 44.63 | $ 44.63 | $ 44.54 | $ 44.52 | $ 45.29 | $ 40.18 | $ 45.34 | $ 44.75 | $ 44.22 |
| 98 | Expense PMPM | | 41.25 | 10.63 | 30.62 | 39.95 | 27.89 | 38.95 | 37.46 | 29.23 | 24.50 | 35.70 | 29.34 |
| 99 | Margin PMPM | | $ 16.32 | $ 2.31 | $ 14.01 | $ 4.68 | $ 16.65 | $ 5.57 | $ 7.83 | $ 10.95 | $ 20.84 | $ 9.05 | $ 14.88 |
| 100 | | | | | | | | | | | | | |
| 101 | ***Healthy Michigan Plan*** | | | | | | | | | | | | |
| 102 | **Budget v Actual** | | | | | | | | | | | | |
| 103 | | | | | | | | | | | | | |
| 104 | **Eligible Lives (Average Eligibles)** | | | | | | | | | | | | |
| 105 | Actual | | 68,120 | 68,120 | 68,120 | 3,448 | 13,628 | 3,226 | 12,355 | 4,096 | 19,454 | 5,298 | 6,615 |
| 106 | Budget | | 52,365 | 52,365 | 52,365 | 2,543 | 10,834 | 2,465 | 9,345 | 3,201 | 14,696 | 4,100 | 5,182 |
| 107 | Variance - Favorable / (Unfavorable) | | 15,755 | 15,755 | 15,755 | 905 | 2,794 | 761 | 3,010 | 895 | 4,757 | 1,198 | 1,434 |
| 108 | % Variance - Fav / (Unfav) | | 30.1% | 30.1% | 30.1% | 35.6% | 25.8% | 30.9% | 32.2% | 28.0% | 32.4% | 29.2% | 27.7% |
| 109 | | | | | | | | | | | | | |
| 110 | **Contract Revenue before settlement** | | | | | | | | | | | | |
| 111 | Actual | | 43,139,515 | 9,696,636 | 33,442,879 | 1,692,676 | 6,676,962 | 1,580,064 | 6,154,739 | 1,810,410 | 9,702,395 | 2,607,876 | 3,217,756 |
| 112 | Budget | | 38,219,421 | 7,188,580 | 31,030,841 | 1,539,972 | 6,235,955 | 1,491,599 | 5,656,783 | 1,873,152 | 8,854,366 | 2,409,343 | 2,969,670 |
| 113 | Variance - Favorable / (Unfavorable) | | 4,920,094 | 2,508,055 | 2,412,038 | 152,703 | 441,007 | 88,465 | 497,956 | (62,742) | 848,029 | 198,533 | 248,086 |
| 114 | % Variance - Fav / (Unfav) | | 12.9% | 34.9% | 7.8% | 9.9% | 7.1% | 5.9% | 8.8% | -3.3% | 9.6% | 8.2% | 8.4% |
| 115 | | | | | | | | | | | | | |
| 116 | **Healthcare Cost** | | | | | | | | | | | | |
| 117 | Actual | | 28,279,041 | 6,965,540 | 21,313,500 | 1,364,322 | 3,885,674 | 1,272,803 | 4,757,282 | 1,202,267 | 4,846,907 | 1,979,269 | 2,004,976 |
| 118 | Budget | | 25,144,123 | 5,673,102 | 19,471,021 | 1,048,107 | 3,261,443 | 966,315 | 5,029,759 | 791,531 | 5,115,021 | 1,277,064 | 1,981,781 |
| 119 | Variance - Favorable / (Unfavorable) | | (3,134,917) | (1,292,438) | (1,842,479) | (316,215) | (624,231) | (306,488) | 272,478 | (410,736) | 268,114 | (702,205) | (23,196) |
| 120 | % Variance - Fav / (Unfav) | | -12.5% | -22.8% | -9.5% | -30.2% | -19.1% | -31.7% | 5.4% | -51.9% | 5.2% | -55.0% | -1.2% |
| 121 | | | | | | | | | | | | | |
| 122 | **Managed Care Administration** | | | | | | | | | | | | |
| 123 | Actual | | 2,629,930 | 999,450 | 1,630,479 | 151,005 | 295,410 | 109,502 | 333,732 | 114,798 | 394,898 | 101,021 | 130,112 |
| 124 | Budget | | 2,399,551 | 978,038 | 1,421,512 | 78,165 | 240,262 | 81,648 | 344,116 | 72,012 | 407,611 | 79,970 | 117,728 |
| 125 | Variance - Favorable / (Unfavorable) | | (230,379) | (21,412) | (208,967) | (72,840) | (55,148) | (27,854) | 10,384 | (42,786) | 12,713 | (21,052) | (12,384) |
| 126 | % Variance - Fav / (Unfav) | | -9.6% | -2.2% | -14.7% | -93.2% | -23.0% | -34.1% | 3.0% | -59.4% | 3.1% | -26.3% | -10.5% |
| 127 | | | | | | | | | | | | | |
| 128 | **Total Contract Cost** | | | | | | | | | | | | |
| 129 | Actual | | 30,908,970 | 7,964,991 | 22,943,979 | 1,515,327 | 4,181,084 | 1,382,306 | 5,091,014 | 1,317,065 | 5,241,804 | 2,080,291 | 2,135,088 |
| 130 | Budget | | 27,543,674 | 6,651,140 | 20,892,534 | 1,126,272 | 3,501,705 | 1,047,964 | 5,373,875 | 863,544 | 5,522,631 | 1,357,034 | 2,099,509 |

| | 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 8/31/2021 | | | **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 | | | | | | | | | | | | | |
| 131 | Variance - Favorable / (Unfavorable) | | (3,365,296) | (1,313,850) | (2,051,446) | (389,055) | (679,379) | (334,342) | 282,861 | (453,522) | 280,827 | (723,257) | (35,580) |
| 132 | % Variance - Fav / (Unfav) | | -12.2% | -19.8% | -9.8% | -34.5% | -19.4% | -31.9% | 5.3% | -52.5% | 5.1% | -53.3% | -1.7% |
| 133 | | | | | | | | | | | | | |
| 134 | **Net before Settlement** | | | | | | | | | | | | |
| 135 | Actual | | 12,230,545 | 1,731,645 | 10,498,900 | 177,349 | 2,495,878 | 197,759 | 1,063,725 | 493,345 | 4,460,590 | 527,586 | 1,082,668 |
| 136 | Budget | | 10,675,747 | 537,440 | 10,138,307 | 413,700 | 2,734,251 | 443,635 | 282,908 | 1,009,609 | 3,331,735 | 1,052,309 | 870,161 |
| 137 | Variance - Favorable / (Unfavorable) | | 1,554,798 | 1,194,205 | 360,593 | (236,352) | (238,372) | (245,877) | 780,817 | (516,264) | 1,128,856 | (524,723) | 212,507 |
| 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 8/31/2021 | | | 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%* | 7.3% | 5.2% | 9.9% | 4.0% | 6.7% | 6.0% | 7.4% | 6.7% | 6.7% |
| 141 | **Contract Revenue** | | **20,814,336** | **198,601** | **20,615,735** | **1,080,705** | **3,884,521** | **1,096,716** | **3,821,657** | **974,077** | **5,996,127** | **1,678,708** | **2,083,225** |
| 142 | | | | | | | | | | | | | |
| 143 | External Provider Cost | | 14,429,917 | - | 14,429,917 | - | 4,455,510 | 440,145 | 1,612,383 | 691,915 | 4,697,306 | 1,089,693 | 1,442,965 |
| 144 | Internal Program Cost | | 1,911,217 | - | 1,911,217 | 526,718 | 1,264 | 3,832 | 1,309,292 | 3,097 | - | 19,633 | 47,381 |
| 145 | Insurance Provider Assessment Withhold (IPA) | | - | - | - | - | - | - | - | - | - | - | - |
| 146 | **Total Healthcare Cost** | | **16,341,135** | **-** | **16,341,135** | **526,718** | **4,456,774** | **443,978** | **2,921,675** | **695,012** | **4,697,306** | **1,109,326** | **1,490,346** |
| 147 | **Medical Loss Ratio (HCC % of Revenue)** | | **78.5%** | **0.0%** | **79.3%** | **48.7%** | **114.7%** | **40.5%** | **76.5%** | **71.4%** | **78.3%** | **66.1%** | **71.5%** |
| 148 | | | | | | | | | | | | | |
| 149 | **Managed Care Administration** | | **1,820,226** | **577,536** | **1,242,691** | **58,298** | **338,828** | **38,196** | **204,961** | **66,363** | **382,709** | **56,620** | **96,715** |
| 150 | **Admin Cost Ratio (MCA % of Total Cost)** | | **10.0%** | **3.2%** | **6.8%** | **10.0%** | **7.1%** | **7.9%** | **6.6%** | **8.7%** | **7.5%** | **4.9%** | **6.1%** |
| 151 | | | | | | | | | | | | | |
| 152 | **Contract Cost** | | **18,161,361** | **577,536** | **17,583,825** | **585,016** | **4,795,602** | **482,174** | **3,126,636** | **761,375** | **5,080,015** | **1,165,946** | **1,587,061** |
| 153 | **Net before Settlement** | | **2,652,976** | **(378,935)** | **3,031,910** | **495,689** | **(911,081)** | **614,542** | **695,020** | **212,702** | **916,112** | **512,762** | **496,164** |
| 154 | Contract Settlement / Redistribution | | (2,652,976) | 378,935 | (3,031,910) | (495,689) | 911,081 | (614,542) | (695,020) | (212,702) | (916,112) | (512,762) | (496,164) |
| 155 | **Net after Settlement** | | **(0)** | **(0)** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| 156 | | | | | | | | | | | | | |
| 157 | | | | | | | | | | | | | |
| 158 | ***SUD Block Grant Treatment*** | | | *HCC%* | 0.2% | 1.1% | 0.2% | 0.2% | 0.0% | 0.8% | 0.0% | 0.2% | 0.3% |
| 159 | **Contract Revenue** | | **5,784,862** | **5,258,361** | **526,501** | **34,609** | **179,021** | **23,556** | **-** | **55,876** | **102,628** | **72,388** | **58,424** |
| 160 | | | | | | | | | | | | | |
| 161 | External Provider Cost | | 4,989,665 | 4,989,485 | 180 | 180 | - | - | - | - | - | - | - |
| 162 | Internal Program Cost | | 435,870 | - | 435,870 | 108,247 | 108,716 | 17,732 | - | 92,438 | 1,049 | 35,842 | 71,846 |
| 163 | Insurance Provider Assessment Withhold (IPA) | | - | - | - | - | - | - | - | - | - | - | - |
| 164 | **Total Healthcare Cost** | | **5,425,535** | **4,989,485** | **436,050** | **108,427** | **108,716** | **17,732** | **-** | **92,438** | **1,049** | **35,842** | **71,846** |
| 165 | **Medical Loss Ratio (HCC % of Revenue)** | | **93.8%** | **94.9%** | **82.8%** | **313.3%** | **60.7%** | **75.3%** | **0.0%** | **165.4%** | **1.0%** | **49.5%** | **123.0%** |
| 166 | | | | | | | | | | | | | |
| 167 | **Managed Care Administration** | | **197,472** | **197,472** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| 168 | **Admin Cost Ratio (MCA % of Total Cost)** | | **3.5%** | **3.5%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| 169 | | | | | | | | | | | | | |
| 170 | **Contract Cost** | | **5,623,007** | **5,186,957** | **436,050** | **108,427** | **108,716** | **17,732** | **-** | **92,438** | **1,049** | **35,842** | **71,846** |
| 171 | **Net before Settlement** | | **161,856** | **71,404** | **90,452** | **(73,818)** | **70,305** | **5,824** | **-** | **(36,562)** | **101,579** | **36,546** | **(13,422)** |
| 172 | Contract Settlement | | - | 90,452 | (90,452) | 73,818 | (70,305) | (5,824) | - | 36,562 | (101,579) | (36,546) | 13,422 |
| 173 | **Net after Settlement** | | **161,856** | **161,856** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| 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 8/31/2021 | | | 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 | | 290,753,844 | 29,725,561 | 261,028,282 | 11,806,758 | 51,467,903 | 14,174,090 | 47,251,916 | 13,964,492 | 79,198,827 | 18,062,827 | 25,101,468 |
| 178 | Incentive Payment Revenue | | 654,452 | 40,241 | 614,210 | 19,062 | 56,126 | 107,487 | 153,552 | 3,706 | 217,092 | 46,595 | 10,590 |
| 179 | **Contract Revenue** | | **291,408,295** | **29,765,803** | **261,642,493** | **11,825,820** | **51,524,030** | **14,281,577** | **47,405,468** | **13,968,199** | **79,415,919** | **18,109,423** | **25,112,058** |
| 180 | | | | | | | | | | | | | |
| 181 | External Provider Cost | | 174,620,029 | 15,316,778 | 159,303,251 | 5,292,222 | 32,685,591 | 7,292,131 | 29,671,735 | 7,739,663 | 53,202,064 | 10,108,634 | 13,311,211 |
| 182 | Internal Program Cost | | 58,208,803 | - | 58,208,803 | 4,405,084 | 11,234,616 | 3,157,131 | 12,681,863 | 3,445,338 | 8,864,573 | 6,241,224 | 8,178,973 |
| 183 | SSI Reimb, 1st/3rd Party Cost Offset | | (854,993) | - | (854,993) | (8,259) | (105,604) | (50,404) | (280,551) | - | (317,857) | (26,628) | (65,690) |
| 184 | Insurance Provider Assessment Withhold (IPA) | | 7,194,270 | 7,194,270 | - | - | - | - | - | - | - | - | - |
| 185 | MHL Cost in Excess of Medicare FFS Cost | | (263,518) | (263,518) | - | - | - | - | - | - | - | - | - |
| 186 | **Total Healthcare Cost** | | **238,904,591** | **22,247,530** | **216,657,061** | **9,689,047** | **43,814,604** | **10,398,858** | **42,073,046** | **11,185,002** | **61,748,780** | **16,323,230** | **21,424,494** |
| 187 | **Medical Loss Ratio (HCC % of Revenue)** | | **82.0%** | **74.7%** | **82.8%** | **81.9%** | **85.0%** | **72.8%** | **88.8%** | **80.1%** | **77.8%** | **90.1%** | **85.3%** |
| 188 | | | | | | | | | | | | | |
| 189 | **Managed Care Administration** | | **24,690,870** | **8,156,107** | **16,534,763** | **1,060,400** | **3,322,756** | **893,113** | **2,951,505** | **1,059,172** | **5,030,843** | **831,304** | **1,385,670** |
| 190 | **Admin Cost Ratio (MCA % of Total Cost)** | | **9.4%** | **3.1%** | **6.3%** | **9.9%** | **7.0%** | **7.9%** | **6.6%** | **8.7%** | **7.5%** | **4.8%** | **6.1%** |
| 191 | | | | | | | | | | | | | |
| 192 | **Contract Cost** | | **263,595,461** | **30,403,637** | **233,191,824** | **10,749,448** | **47,137,359** | **11,291,971** | **45,024,552** | **12,244,173** | **66,779,623** | **17,154,535** | **22,810,164** |
| 193 | **Net before Settlement** | | **27,812,834** | **(637,834)** | **28,450,668** | **1,076,372** | **4,386,670** | **2,989,606** | **2,380,917** | **1,724,025** | **12,636,296** | **954,888** | **2,301,894** |
| 194 | | | | | | | | | | | | | |
| 195 | Prior Year Savings | | - | - | - | - | - | - | - | - | - | - | - |
| 196 | Internal Service Fund Risk Reserve | | - | - | - | - | - | - | - | - | - | - | - |
| 197 | Contract Settlement | | - | 28,450,668 | (28,450,668) | (1,076,372) | (4,386,670) | (2,989,606) | (2,380,917) | (1,724,025) | (12,636,296) | (954,888) | (2,301,894) |
| 198 | **Net after Settlement** | | **27,812,834** | **27,812,834** | **-** | **-** | **-** | **-** | **(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 8/31/2021 | | | 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%* | 3.6% | 3.9% | 3.0% | 5.9% | 4.2% | 4.2% | 3.2% | 1.7% | 4.2% |
| 202 | **Contract Revenue** | | | | **10,925,109** | **727,148** | **1,851,008** | **688,914** | **1,805,894** | **825,547** | **3,439,871** | **681,911** | **904,816** |
| 203 | | | | | | | | | | | | | |
| 204 | External Provider Cost | | | | 2,138,157 | 141,726 | 278,203 | 144,308 | 274,341 | 299,636 | 744,321 | 137,003 | 118,620 |
| 205 | Internal Program Cost | | | | 6,004,862 | 254,149 | 1,070,801 | 507,212 | 1,570,208 | 188,847 | 1,451,942 | 140,248 | 821,454 |
| 206 | SSI Reimb, 1st/3rd Party Cost Offset | | | | (136,283) | - | - | - | - | - | (136,283) | - | - |
| 207 | **Total Healthcare Cost** | | | | **8,006,736** | **395,875** | **1,349,004** | **651,520** | **1,844,550** | **488,483** | **2,059,980** | **277,251** | **940,074** |
| 208 | **Medical Loss Ratio (HCC % of Revenue)** | | | | **73.3%** | **54.4%** | **72.9%** | **94.6%** | **102.1%** | **59.2%** | **59.9%** | **40.7%** | **103.9%** |
| 209 | | | | | | | | | | | | | |
| 210 | **Managed Care Administration** | | | | **692,470** | **48,467** | **114,789** | **62,881** | **145,038** | **50,815** | **186,836** | **15,813** | **67,832** |
| 211 | **Admin Cost Ratio (MCA % of Total Cost)** | | | | **8.0%** | **10.9%** | **7.8%** | **8.8%** | **7.3%** | **9.4%** | **8.3%** | **5.4%** | **6.7%** |
| 212 | | | | | | | | | | | | | |
| 213 | **Contract Cost** | | | | **8,699,206** | **444,341** | **1,463,793** | **714,401** | **1,989,588** | **539,298** | **2,246,815** | **293,064** | **1,007,906** |
| 214 | **Net before Settlement** | | | | **2,225,902** | **282,807** | **387,215** | **(25,487)** | **(183,694)** | **286,249** | **1,193,056** | **388,847** | **(103,090)** |
| 215 | | | | | | | | | | | | | |
| 216 | Other Redistributions of State GF | | | | - | - | - | - | - | - | - | - | - |
| 217 | Contract Settlement | | | | (2,447,075) | (275,610) | (371,745) | - | - | (244,972) | (1,180,498) | (374,249) | - |
| 218 | **Net after Settlement** | | | | **(221,172)** | **7,197** | **15,470** | **(25,487)** | **(183,694)** | **41,277** | **12,557** | **14,598** | **(103,090)** |
| 219 | | | | | | | | | | | | | |

RISK

MICHIGAN MUNICIPAL
RISK MANAGEMENT
AUTHORITY

# CERTIFICATE OF COVERAGE

This certificate is issued as a matter of information only and confers no rights upon the certificate holder except to the extent shown below. This certificate does not amend, extend, or alter the coverage contained in the Authority's Joint Powers Agreement and coverage attachments thereto.

This is to certify that a Self-Insured Program has been undertaken by the member listed below through the Authority pursuant to Act 138 P.A. 1982.

The coverage provided by the Authority is as follows:

1. Liability coverage for general liability, automobile (including Michigan No-Fault), law enforcement, and public officials liability; in the sum of $10,000,000 each occurrence inclusive of loss adjustment and defense costs.
2. Property Coverage including loss to real & personal property, to amounts stipulated in coverage documents and overview for this member.
3. Motor Vehicle Physical Damage Coverage for the vehicles stipulated in the Coverage Document.
4. X Information only.
5. _ The entity named below is included in the scope of protection as respects claims arising from a COVERED CONTRACT as defined in the MMRMA Liability and Motor Vehicle Physical Damage Coverage Document.
6. X Other (as described here): **COVERAGE ABOVE INCLUDES MEDICAL MALPRACTICE FOR NURSES; PUBLIC AND MENTAL HEALTH OPERATIONS AND FACILITIES; AND PARAMEDICS, EMERGENCY MEDICAL SERVICE TECHNICIANS, POLICE OR FIRE PERSONNEL ONLY FOR IMMEDIATE MEDICAL ASSISTANCE OR TREATMENT IN AN EMERGENCY SITUATION. COVERAGE EXCLUDES THE RENDERING OR FAILURE TO RENDER PROFESSIONAL SERVICES BY A DENTIST OR PHYSICIAN EXCEPT FOR A CORONER OR MEDICAL EXAMINER OR THEIR DEPUTIES BY THOSE TITLES.**

This certificate is issued in accordance with and is subject to all provisions of the Joint Powers Agreement, Coverage Documents, reinsurance agreements, MMRMA rules, regulation and administrative procedures. Should the member identified below withdraw from the Authority, or its Authority Membership be otherwise terminated, the Authority shall endeavor to notify the certificate holder in writing thirty (30) days in advance thereof, but failure to furnish such notice shall impose no obligation or liability of any kind upon the Authority, or its representatives.

**Certificate Holder:**
**TO WHOM IT MAY CONCERN**

**Member:**
**SOUTHWEST MI BEHAVIORAL HEALTH**
**5250 LOVERS LANE, SUITE 200**
**PORTAGE, MI 49002**

**Certificate Expiration Date: October 1, 2022**
**Date Issued: October 1, 2021**

**Member Number: # M0001669**
**Effective Date of Membership: October 1, 2013**

**Distribution:**
**Ms. Tracy Dawson, Southwest MI Behavioral Health**
**MMRMA Underwriting**

**Authorized Representative**

IBEX
INSURANCE AGENCY

P.O. Box 3355
Farmington Hills, Michigan 48333-3355
877-888-IBEX (4239) 248-538-0470 Fax 248-538-0471 www.ibexagency.com

Community: **SW MI Bahavioral Health**
Renewal period: Oct 1, 2021 to Oct 1, 2022

| | Total Contribution | Property Totals |
|---|---|---|
| Last Year | $46,624 | $550,543 |
| This Year | $47,083 | $567,059 |
| Total Change | $459 | $16,516 |
| % Change (+ -) | **1.0%** | **3.0%** |

**Notes:** New MMRMA property adjuster, Tracey Cool, tcool@mmrma.org

**RAP Grants:**

| | Net Asset Distribution | Loss Fund Distribution | Total | |
|---|---|---|---|---|
| **MMRMA Coverage 2013-14** | | | | **LZ** |
| **MMRMA Coverage 2014-15** | | | | **KD** |
| **2015 MMRMA Distribution:** | $3,911 | $2,149 | $6,060 | **KD** |
| **2016 MMRMA Distribution:** | $3,196 | $1,511 | $4,707 | **KE** |
| **2017 MMRMA Distribution:** | $4,463 | $2,095 | $6,558 | **MR** |
| **2018 MMRMA Distribution:** | $6,785 | $3,802 | $10,587 | **KE** |
| **2019 MMRMA Distribution:** | $10,544 | $4,950 | $15,494 | **KE** |
| **2020 MMRMA Distribution:** | $14,400 | $4,187 | $18,587 | **MR** |
| **2021 MMRMA Distribution:** | $9,697 | $2,726 | $12,423 | **LZ** |
| | **$52,996** | **$21,420** | **$74,416** | |


# Michigan Consortium for Healthcare Excellence SWMBH Executive Officer Board Report

For the period April 2021 – September 2021

October 8, 2021

# MCHE Activity April 2021 - September 2021

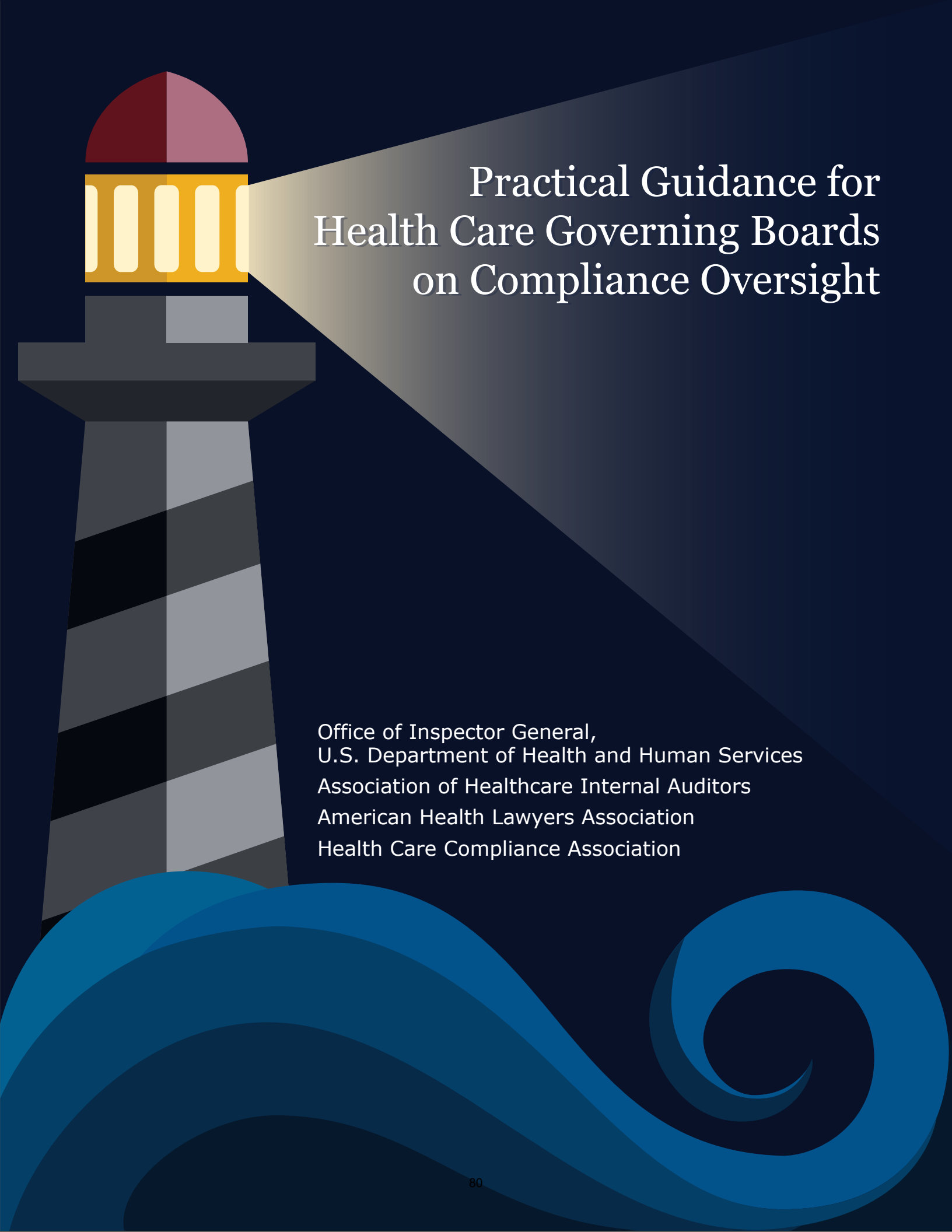
**Initiatives**

**Ongoing Work Groups**

- **Reciprocity: Direct Care Worker Training (all PIHPs)**
- **Reciprocity: Provider Reviews and Audits (all PIHPs)**
- **Statewide implementation of MCG Utilization Management solution**
  - **MCHE MCG Master Licensing Agreement Renewal Team finalizing renewal**

# 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**



# 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.

The following individuals, representing these organizations, served on the drafting task force for this document:


**Katherine Matos**, Senior Counsel, OIG, HHS

**Felicia E. Heimer**, Senior Counsel, OIG, HHS

**Catherine A. Martin**, Principal, Ober | Kaler (AHLA)

**Robert R. Michalski**, Chief Compliance Officer, Baylor Scott & White Health (AHIA)

**Daniel Roach**, General Counsel and Chief Compliance Officer, Optum360 (HCCA)

**Sanford V. Teplitzky**, Principal, Ober | Kaler (AHLA)


Published on April 20, 2015.

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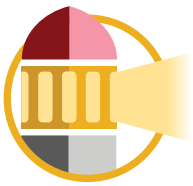
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

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)).

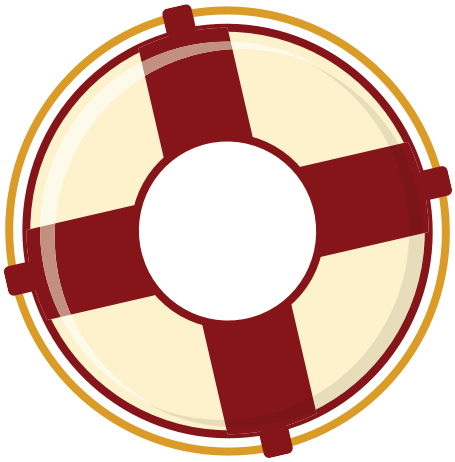
15 *See, generally, id.*

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.

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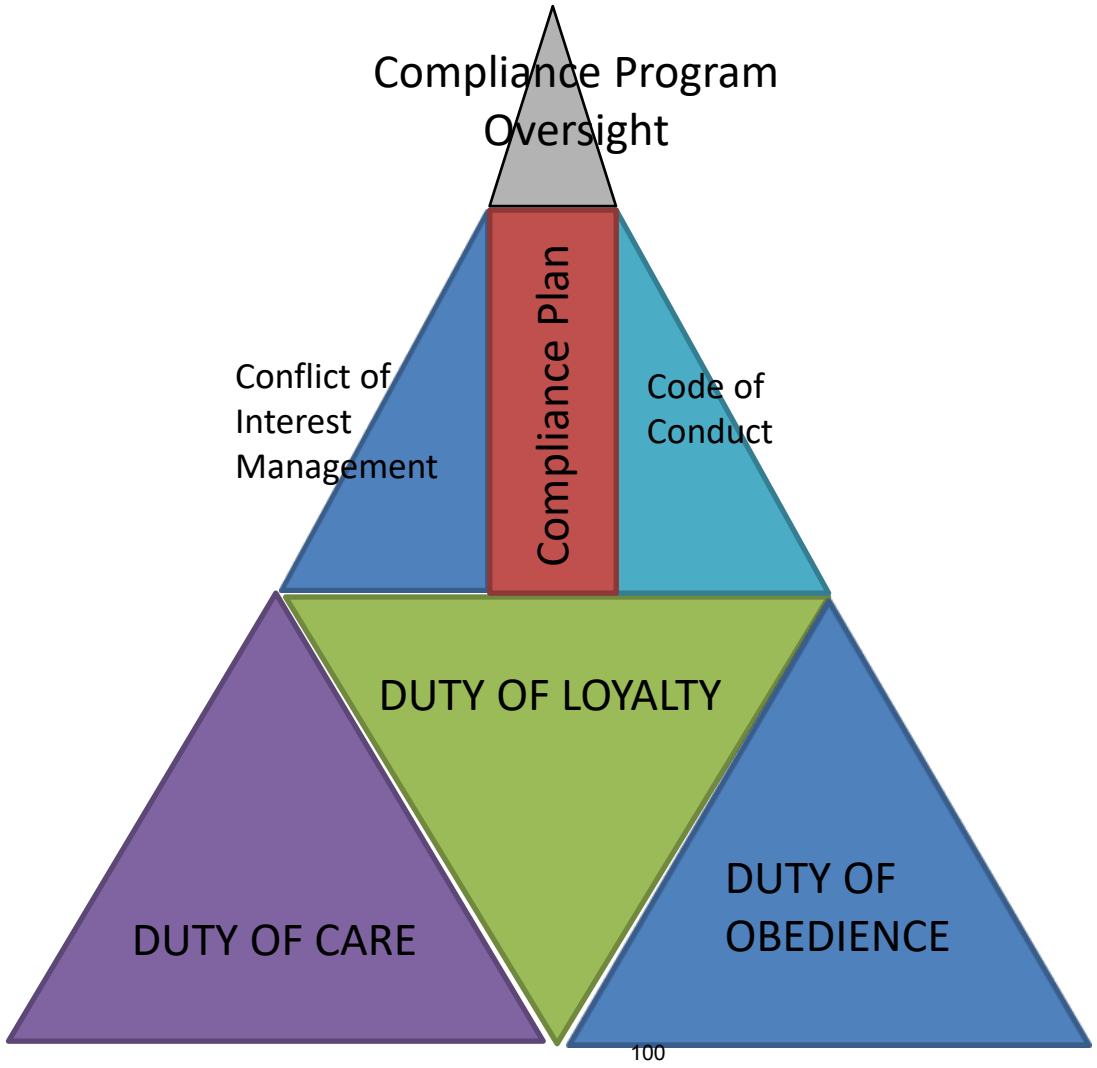
# Corporate Compliance Role and Function



10/08/2021

# 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 of a real or perceived COI exists.
  - If no, 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?**

# 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

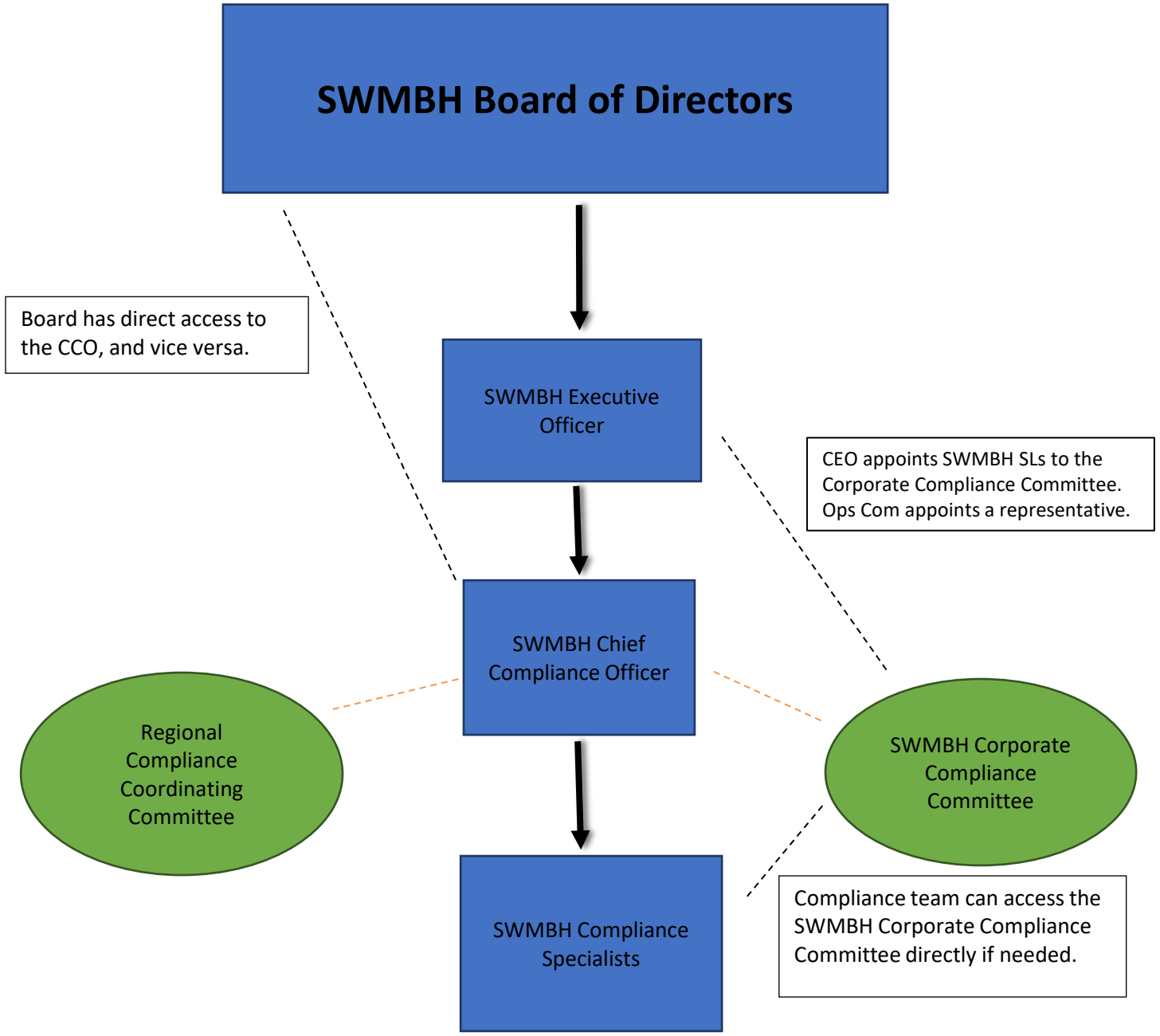
(2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.

- 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
  - Four Compliance Specialists – Alison Strasser, Jordan Huyser, Shelley Cizio 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 as part of department goals this year, now ready for implementation 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.

# Southwest Michigan Behavioral Health Board Meeting

**Please join the meeting from your computer, tablet or smartphone:**
**https://global.gotomeeting.com/join/515345453**
**You can also dial in using your phone:**
**1-571-317-3116 - Access Code: 515-345-453**
**November 12, 2021**
**9:30 am to 11:00 am**
**(d) means document provided**
**Draft: 9/28/21**

1. **Welcome Guests/Public Comment**

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

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

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

4. **Consent Agenda**

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

5. **Operations Committee**

   - Operations Committee Minutes September 29, 2021 (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. * Integrated Care (S. Green) (d)
   b. * Fiscal Year 2021 Health Services Advisory Group (HSAG) External Quality Compliance Results (J. Gardner)
   c. Ends Reporting (J. Gardner)
   d. *Fiscal Year 2021 Health Services Advisory Group Medicaid Managed Care Regulations Compliance Report (J. Gardner) (d)
   e. * Fiscal Year 2021 Health Services Advisory Group (HSAG) Performance Measure Validation Audit (J. Gardner) (d)

7. **Board Actions to be Considered**

   - Executive Officer Performance Evaluation (Executive Committee)

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

   a. BG-003 Unity of Control (d)
   b. EO-002 Monitoring Executive Performance (d)

**9. Executive Limitations Review**

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

- BEL-010 RE 501 (c) (3) Representation (E. Krogh) (d)

**10. Board Education**

a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d)
b. Information Systems Update (N. Spivak) (d)
c. Certified Community Behavioral Health Clinics (CCBHC) (S. Weigandt) (d)
d. Annual Program Integrity - Compliance Program Effectiveness Evaluation (M. Todd)
e. Fiscal Year 2021 CMHSP Site Review Results (M. Todd) (d)
f. SWMBH Tele-Commuting Hybrid (B. Casemore & A. Wickham)
g. Calendar Year 2022 Live Meeting Requirements (B. Casemore)

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

a. December 10, 2021 Board Agenda (d)
b. Board Member Attendance Roster (d)
c. December Board Policy Direct Inspection – BEL-003 Asset Protection (S. Barnes)
d. December Holiday Event

**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**
**December 10, 2021**
**9:30 am - 11:00 am**

| 2021 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) | | | | | | | | | | | | |
| Marcia Starkey (Calhoun) | | | | | | | | | | | | |
| Terry Proctor (Cass) | | | | | | | | | | | | |
| Erik Krogh (Kalamazoo) | | | | | | | | | | | | |
| Carole Naccarto (St. Joe) | | | | | | | | | | | | |
| Susan Barnes (Van Buren) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| **Alternates:** | | | | | | | | | | | | |
| Robert Becker (Barry) | | | | | | | | | | | | |
| Randy Hyrns (Berrien) | | | | | | | | | | | | |
| Jon Houtz (Branch) | | | | | | | | | | | | |
| Kathy-Sue Vette (Calhoun) | | | | | | | | | | | | |
| Jeanne Jourdan (Cass) | | | | | | | | | | | | |
| Patricia Guenther (Kalamazoo) | | | | | | | | | | | | |
| Cathi Abbs (St. Joe) | | | | | | | | | | | | |
| Angie Dickerson (Van Buren) | | | | | | | | | | | | |

as of 8/13/21

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patrick Garrett (Calhoun) | | | | | | | | | | | | |
| Mary Middelton (Cass) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

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

**Mental Health Listening Tour**

**Mission**: To facilitate a guided discussion among local mental health stakeholders and constituents around the state in order to create legislation and recommendations. Recommendations could include revising departmental policies, establishing new programs, or continuing discussions through workgroups.

**Structure**: The listening tour will take place throughout October and November, with recommendations and legislation being produced by late November. Interested stakeholders and consumers will be invited to a roundtable discussion on the current state of our mental health system in Michigan, existing barriers, and ideas for improvement. All regions will use the same questions to guide the discussion, with the questions provided to all panelists prior to the discussion. Given rising cases of COVID and the tight timeframe, the tours will be a mix of in-person and virtual depending on the preference of the Representative hosting. Once the tour is complete, the recommendations and data will be used to pursue legislation.

**Duration**: Each stop will be for 90 minutes, with the last 15 minutes open for public comment. All attendees will be sent a follow-up survey to capture any comments not mentioned because of time constraints.

**Potential Participants**:

- Representative Brabec (moderator)
- District State Representative
- District State Senator
- Regional FQHC
- Regional CMH
- Regional PIHP
- Regional CCBHC (if applicable)
- Regional representative from MHA
- Regional representative from Health Plans
- Consumer or secondary consumer
- Other interested stakeholders

**Regions**:

- Oakland
- Wayne
- Macomb
- Detroit
- Grand Rapids
- Kalamazoo
- Battle Creek
- Flint/Saginaw
- Marquette
- Ingham
- Washtenaw

**Guided Questions**

A series of guided questions will be created prior to the listening tour. The questions will be workshopped to ensure we can capture all the information we need given the time constraints.

**Tentative Schedule**

| Region | Date | Location | Time |
|---|---|---|---|
| **Wayne** | Mon. Oct. 4th | Virtual | 5:00- 6:30 PM |
| **Battle Creek** | Thurs. Oct. 7th | in-person; Location TBD | 5:00-6:30 |
| **Marquette** | Mon. Oct 11th | Virtual | 5:00 - 6:30 PM |
| **Oakland** | Thurs. Oct. 14th | Virtual | 5:00-6:30 PM |
| **Kalamazoo** | Mon. Oct. 18th | In-person; Location TBD | 5:00-6:30 PM |
| **Grand Rapids** | Thurs. Oct. 21st | TBD | 5:00 - 6:30 PM |
| **Detroit** | Mon. Oct. 25th | Virtual | 5:00 - 6:30 PM |
| **Macomb** | Thurs. Oct. 28th | Virtual | 6:00-7:30 PM |
| **Saginaw/Flint** | Mon. Nov. 1st | In-person; Location TBD | 5:00-6:30 PM |
| **Ingham** | Thurs. Nov. 4th | In-person; Location TBD | 5:00 – 6:30 PM |

* These are the tentative dates of the listening tour. An email will be sent out with the final dates and locations. If you are interested in participating in a certain region, please reach out to Brooke in my office (bhansen@house.mi.gov) and we will make sure you are added to the participant list.

# FY22 Conference Report – Final Budget

## Specific Mental Health/Substance Abuse Services Line items

| | FY'20 (Final) | FY'21 (Final) | FY'22 (Final) |
|---|---|---|---|
| -CMH Non-Medicaid services | $125,578,200 | $125,578,200 | $125,578,200 |
| -Medicaid Mental Health Services | $2,487,345,800 | $2,653,305,500 | $3,124,618,700 |
| -Medicaid Substance Abuse services | $68,281,100 | $87,663,200 | $83,067,100 |
| -State disability assistance program | $0 | $2,018,800 | $2,018,800 |
| -Community substance abuse (Prevention, education, and treatment programs) | $108,754,700 | $108,333,400 | $79,705,200 |
| -Health Homes Program | $3,369,000 | $26,769,700 | $33,005,400 |
| -Autism services | $230,679,600 | $271,721,000 | $339,141,600 |
| -Healthy MI Plan (Behavioral health) | $371,843,300 | $589,941,900 | $603,614,300 |
| -CCBHC | $0 | $0 | $25,597,300 |
| -Total Local Dollars | $20,380,700 | $20,380,700 | $15,285,600 |

## Other Highlights of the FY22 Final Budget:

**Direct Care Worker Wage Increase**

Conference concurs with the Senate budget and reflects a full year implementation of a **$2.35/hour direct care worker wage increase** on an ongoing basis after revising annual costs cost estimates to $414.5 million Gross ($146.1 million GF/GP), Sec. 231 is related boilerplate.

**CCBHC Implementation**

**CCBHC Implementation**

**Conference report concurs with the FY22 Executive Budget and includes $26.5million gross, $5.0million general fund(6.0FTEs) to support a two-year implementation of the Centers for Medicare and Medicaid (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration program.** Proposed funding will be used to:

- **Establish 14 CCBHC sites**, through 11 Community Mental Health Programs and 3 non-profit behavioral health entities, to provide comprehensive access to behavioral health services to vulnerable individuals.

- Create a new Behavioral Health Policy and Operations Office to oversee the implementation of the CCBHC demonstration, Medicaid Health Homes, and other behavioral health integration initiatives The new office will comprise 6 new FTE positions and 9 reassigned FTE positions responsible for policy, operations, technical assistance, and quality monitoring support.

**KB vs. Lyon lawsuit**

**Conference report concurs with the FY22 Executive budget and includes $91 million gross ($30 million general fund) to recognize new costs related to the implementation of policy changes associated with the KB v. Lyon lawsuit settlement.** These caseload costs will come from program changes aimed at increasing consistency in access to behavioral health services for Medicaid enrollees and those served through the child welfare system.

**Local Match Draw Down**

Conference report includes funding for the second year of a five-year phase-out of the use of Local CMH Local Match funding to support the Medicaid Restricted Mental Health Services line. **$5,095,100 GF/GP**

**Five-Year Inpatient Psychiatric Plan**

Conference includes $300,000 GF/GP for DHHS to create a 5-year plan to address adult and children inpatient psychiatric bed needs using both public and public-private partnership beds. Sec. 1062 is related boilerplate.

**Federal State Opioid Response (SOR) Grant**

Conference report concurs with the Executive budget and includes $36.4 million in federal SOR grant funding to increase access to medication-assisted treatments, addressing unmet treatment needs, and reducing opioid overdose deaths. Federal opioid grant funding also separated out into a separate opioid response activity line item.

**Behavioral Health Community Supports and Services**

Conference report concurs with the House budget and adds $2.3 million Gross ($138,500 GF/GP) and directs these community supports to crisis stabilization units and psychiatric residential treatment facilities and authorizes 2.0 FTE positions. Sec. 1010 is related boilerplate.

**Specialty Medicaid Managed Care Health Plan for Foster Children**

Conference report concurs with the House budget and includes $500,000 Gross ($250,000 GF/GP) to complete an actuarial analysis and any necessary federal approvals to create a specialty Medicaid managed care health plan for children in foster care to provide comprehensive medical, behavioral, and dental services

**Key Boilerplate Sections:**

Sec. 239 NEW. Medicaid Reimbursement for Telemedicine – New Senate language requires DHHS to reimburse Medicaid telemedicine services the same as if the serve involved face-to-face contact between the provider and patient. House Omnibus concurs with the Senate with revisions to apply the language to the non-facility component of the reimbursement rate. Conference concurs with the House Omnibus.

**Sec. 908.** NEW Senate – Uniform credentialing , As a condition of their contracts with the department, PIHPs and CMHSPs, in consultation with the Community Mental Health Association of Michigan, shall work with the department to implement section 206b of the mental health code, MCL 330.1206b, to establish a uniform community mental health services credentialing program.

**Sec. 927.** Uniform Behavioral Health Service Provider Audit. Existing boilerplate requires DHHS to create a uniform community mental health services auditing process for CMHPs and PIHPs, outlines auditing process requirements, and requires a report.

**Sec. 928. (FULL LANGUAGE)** (1) Each PIHP shall provide, from internal resources, local funds to be used as a part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

(2) It is the intent of the legislature that any funds that lapse from the funds appropriated in part 1 for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds on a proportional basis to those CMHSPs whose local funds were used as state Medicaid match. By April 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the lapse by PIHP from the previous fiscal year and the projected lapse by PIHP in the current fiscal year.

(3) It is the intent of the legislature that the amount of local funds used in subsection (1) be phased out and offset with state general fund/general purpose revenue in equal amounts over a 5-year period.

(4) Until the local funds are phased out as described in subsection (3), each PIHP shall not be required to provide local funds, used as part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs, at an amount greater than what each PIHP received from local units of government, either directly or indirectly, during the fiscal year ending September 30, 2018 for this purpose.

**Sec. 940.** Transferring and Withdrawing CMHSP Allocations - Requires DHHS to review CMHSP expenditures to identify projected lapses and surpluses, to encourage the board of the CMHSP with a projected lapse to concur with the recommendation to reallocate the lapse to other CMHSPs, and to withdraw funds from a CMHSP if those funds were not expended in a manner approved by DHHS, including for services and programs provided to individuals residing outside of the CMHSP's geographic region; prohibits a CMHSP from receiving additional funding if the CMHSP transferred out or withdrew funds during current fiscal year; requires CMHSPs to report any proposed reallocations prior to going into effect; requires legislative notification and report. *Conference report concurs with Executive and House revision by removing the requirement to withdraw unspent funds if funds were not expended in a manner approved by DHHS*

**Sec. 964.** Behavioral Health Fee Schedule. Requires the department to provide a report with the standardized fee schedule for Medicaid behavioral health services and supports to the Legislature by July 1 and must include the adequacy standards to be used in all contracts with PIHPs and CMHSPs. In developing the fee schedule the Department must prioritize and support essential service providers and develop a standardized fee schedule for revenue code 0204.

**Sec. 965.** Medication Assisted Treatment - Requires DHHS to explore requiring CMHSPs to reimburse medication assisted treatment at not less than $12.00 per dose and drug screen collection at not less than $12.00 per screen. Executive deletes. *Conference report concurs with House revision to require the Medicaid behavioral health fee schedule to offer bundled medication assisted treatment billing and prioritizes federal state opioid response funds to assist in providing efficient and effective billing*

**Sec. 970.** Skill Building Assistance Services – RETAINED Requires DHHS to maintain skill building assistance services policies in effect on October 1, 2018, and requires DHHS to continue to seek federal matching funds for skill building assistance services.

**Sec. 1005.** Health Home Program Expansion – REVISED Requires DHHS to maintain and expand the number of behavioral health homes in PIHP regions 1, 2, and 8 and to expand the number of opioid health homes in PIHP regions 1, 2, 4, and 9. *Conference revises to maintain the current behavioral health and substance use disorder health homes and permits DHHS to expand into additional PIHP regions.*

**Sec. 1010.** Behavioral Health Community Supports and Services – REVISED Requires the funds appropriated for behavioral health community supports and services be used to expand assertive community treatment (ACT), forensic assertive community treatment, and supportive housing for the purpose of reducing waiting lists at state psychiatric hospitals. House revises to allocate funding for crisis stabilization units and psychiatric residential treatment facilities. *Conference adds crisis stabilization units and psychiatric residential treatment facilities to list of uses of the line.*

**Sec. 1062**. Inpatient Psychiatric Plan – By July 1 of the current fiscal year, the department shall provide a 5-year plan to address the need for adult and children's inpatient psychiatric beds to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office. The report shall include recommendations for utilizing both public and public private partnership beds.

**Sec. 1151.** Opioid Addiction Treatment Education Collaboration – current boilerplate requires DHHS to coordinate with other departments, law enforcement, and Medicaid health plans to work with substance use disorder providers to inform Medicaid beneficiaries of medically appropriate opioid addiction treatment options when an opioid prescription is ended, and address other opioid abuse issues; requires report.

**Sec. 1517.** Specialty Medicaid Managed Care Health Plan for Foster Children – (1) From the funds appropriated in part 1 for medical services administration, the department shall allocate $500,000.00 to complete an actuarial analysis and any necessary federal approvals to create a specialty Medicaid managed care health plan for children in foster care. The specialty Medicaid managed care health plan must be responsible for comprehensive medical, behavioral, and dental services, including EPSDT exams, as well as case management, specialty supports and services, home- and community-based waiver services, and any other medically necessary value-added services.

(2) By July 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the implementation status of this section.

**Sec. 1846.** Graduate Medical Education Priorities - Requires DHHS to distribute GME funds with an emphasis on encouragement of the training of physicians in specialties, including primary care, that are necessary to meet future needs of this state, and training of physicians in settings that include ambulatory sites and rural locations. *Conference report concurs with House to also emphasize training of pediatric psychiatrists.*