Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
October 9, 2020
9:30 am to 11:00 am
Draft: 10/1/20

1. **Welcome Guests/Public Comment**

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

4. **Consent Agenda**

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5. **Operations Committee**

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   b. Operations Committee Quarterly Report (d) p. 11

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

   a. * Behavioral Health (BH) Treatment Episode Data Set (TEDS) (J. Gardner) (d) p. 12
   b. *Habilitation Supports Waiver (R. Freitag) (d) p. 14
   c. *Integrated Care Organization (ICO) Quality Withhold Bonus Performance Measures (J. Gardner) (d) p. 15
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7. **Board Actions to be Considered**

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   Is the Board in Compliance? Does the Policy Need Revision?

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

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b. Michigan Consortium for Healthcare Excellence (MCHE) Update and the Annual MCHE Member Meeting is November 6, 2020 11:30 am to 12:00 pm (B. Casemore) (d) p. 139
c. SWMBH Award (A. Malta) (d) p. 143
d. Community Mental Health Association of Michigan Fiscal Year 2021 Conference Committee Report (B. Casemore) (d) p. 144
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j. November Board Policies: BEL-010 Regional Entity 501 (c) (3) Representation (J. Bermingham)

12. Public Comment

13. Adjournment

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

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

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

Next SWMBH Board Meeting
November 13, 2020
9:30 am - 11:00 am

and

SWMBH Board Planning Retreat
November 13, 2020
11:15 am – 1:15 pm

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Draft Board Meeting Minutes
September 11, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 9/11/20

Members Present via phone: Edward Meny, Tom Schmelzer, Susan Barnes, Michael McShane, Patrick Garrett, Erik Krogh, and Janet Bermingham

Guests Present via phone: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Alternate; Mary Middleton, Woodlands Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH, Brad Sysol, Summit Pointe; Jeannie Goodrich, Summit Pointe; Jeff Patton, ISK, Pat Guenther, ISK Board Alternate, Paul Yeager

Welcome Guests
Edward Meny called the meeting to order at 9:30 am, introductions were made, Edward welcomed the group and spent a moment remembering 9/11 and honoring the lives lost and the lives of those still impacted.

Agenda Review and Adoption

Motion	Erik Krogh moved to accept the agenda as presented with additions noted by Brad Casemore.	
Second	Tom Schmelzer	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes
Motion Carried		

Financial Interest Disclosure Handling
None

Consent Agenda

Motion	Erik Krogh moved to approve the August 14, 2020 Board meeting minutes as presented.
Second	Susan Barnes

Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Operations Committee

Operations Committee Minutes July 22, 2020

Edward Meny noted the minutes as documented and Deb Hess asked if there were any questions. Edward Meny asked about the Provider Network Stability Plan and Mila Todd updated the Board on the recent Provider Stability report that was sent to the State. Minutes accepted.

Ends Metrics

Health Services Advisory Group – Performance Measure Validation

Jonathan Gardner reported as documented. Discussion followed.

Motion	Tom Schmelzer moved that the data is relevant and compelling, the executive officer is in compliance and the Board Ends Metric does not need revision.	
Second	Susan Barnes	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Health Services Advisory Group – Performance Improvement Project

Moira Kean reported as documented. No motion was needed as the motion was made and carried last month. This was an additional update. Discussion followed.

Michigan Health Endowment Fund (MHEF) Grant Update

Moira Kean reviewed the history, award and purpose of the MHEF grant which started October 1, 2019. As the end of the first year of the grant approached and analysis was completed SWMBH decided to end the grant after the 10/1/2020 due to the COVID-19 Pandemic that effected enrollment trends. Brad Casemore reviewed finances and shared that two SWMBH staff were laid off and the decision was a difficult one to make. Discussion followed.

Board Actions to be Considered

None Scheduled

Board Policy Review

BG-008 Board Member Job Description

Edward Meny reviewed the policy as documented.

Motion	Tom Schmelzer Barnes moved that the Board is in compliance and the Policy BG-008 Board Member Job Description does not need revision.	
Second	Patrick Garrett	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

EO-001 Executive Role & Job Description

Edward Meny reviewed the policy as documented.

Motion	Susan Barnes moved that the Board is in compliance and the Policy EO-001 Executive Role & Job Description does not need revision.	
Second	Janet Bermingham	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Executive Limitations Review

BEL-009 Global Executive Constraints

Edward Meny reviewed the policy as documented.

Motion	Edward Meny moved that the executive officer is in compliance and policy BEL-009 Global Executive Constraints does not need revision.	
Second	Patrick Garrett	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Board Education

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented noting the positive position of the region as of 7/31/2020.

Fiscal Year 2021 Budget Preview

Tracy Dawson reported as documented noting several errors and revisions by Milliman (the State's Actuary) which resulted in projections that went from a 5% increase to a 3.1% decrease. Brad Casemore shared possible budget considerations for the Board's review for a possible motion to incorporate into the final 2021 SWMBH Budget development for presentation at October's Board meeting. Discussion followed and the Board determined to use the information as education and wait to see what the State will do within the next month.

Compliance Role and Function

Mila Todd reported as documented highlighting fiduciary duties, code of conduct and insurance of compliance oversight processes and reporting systems.

Michigan Department of Civil Rights (MDCR) Notice of Disposition and Order of Dismissal

Mila Todd reported that a recipient of SWMBH services filed a complaint with the Michigan Department of Civil Rights. SWMBH received a notice of dismissal from MDCR on September 4, 2020 noting insufficient evidence to proceed.

Communication and Counsel to the Board

Asset Protection: Michigan Municipal Risk Management Authority (MMRMA)

Tracy Dawson reported as documented. Discussion followed.

Consensus Revenue Estimating Conference (CREC)

Brad Casemore reported as documented.

Strategic Business Plan Meeting Schedule

Mary Ann Bush reported as documented noting dates, times, and draft agendas for upcoming Board strategic planning sessions. Mary Ann Bush also noted the October 16, 2020 5th Annual Regional Healthcare Policy Forum, which is being held virtually.

October 9, 2020 Board Agenda

Brad Casemore noted the document is in the meeting materials for the Board's review.

Board Member Attendance Roster

Brad Casemore noted the document is in the meeting materials for the Board's review.

Next Month's Policy Reviews

Brad Casemore noted policies for review next month including the Executive Officer Performance Evaluation policy and process.

Community Mental Health Association of Michigan (CMHAM)

Brad Casemore reviewed an email from CMHAM in which they announced an opening on their Board of Directors. Brad Casemore asked if any SWMBH Board member was interested in applying for the open position to please let him know by September 25, 2020.

Adjournment

Motion Erik Krogh moved to adjourn at 11:10am

Second Patrick Garrett

Unanimous Voice Vote

Motion Carried

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BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: August 26, 2020 9:00am-11:00am

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

Guests present via phone – Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Sarah Ameter, Customer Services Manager, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Mary Ann Bush, Senior Operations Specialist-Project Coordinator, SWMBH; Brad Sysol, Summit Pointe, Pat Davis, Integrated Services of Kalamazoo

Call to Order – Brad Casemore began the meeting at 8:59 am.

Review and approve agenda – Agenda approved.

Review and approve minutes from 7/22/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Brad Casemore reported as documented. Discussion followed.

Cost Allocation and Rate Development Workgroup – Pat Davis highlighted CMH cost centers, allocation of fringe benefits, review of Tier 1 codes and significant changes that could be coming.

Milliman Behavioral Health Fee Schedule Development – Brad Casemore reported as documented.

Encounter Quality Improvement (EQI) – Pat Davis reported as documented noting that EQI is scheduling meetings with IT vendors to discuss issues and needs.

Racial/Ethnic Health Disparities Report – Moira Kean reported as documented and reviewed ERACCE (Eliminating Racism & Creating/Celebrating Equity) quote for training facilitation in health equity workshop for the region. Several counties expressed interest in participation. Discussion followed.

Mental Health Block Grant Transition Navigators – Moira Kean reported that Summit Pointe and ISK are not participating, Riverwood and Pines are using their own staff. The other CMHSPs will contact Moira with their decisions on this grant.

SWMBH/Meridian/Centene Integrated Care 8/18/20 Meeting – Brad Casemore reviewed history and call on 8/18/2020. Meridian and Centene to develop plans and processes for another call and/or

SWMBH review. Discussion followed with a recommendation to invite Allen Jansen to the October Operations Committee meeting. Brad Casemore will contact Allen Jansen.

Medicare 99441, 99442, 99443 and Billing to Medicare – Mila Todd reported as documented noting the difficulties in competing definitions and interpretations. Discussion followed. Mila Todd to ask for additional guidance from State and Federal levels.

Lisa Grost, Behavioral Health Policy and Strategic Initiatives State Administrator – Brad Casemore shared with the group that he has contacted Lisa Grost to join the Operations Committee and will reconnect with her to see if she is available to join the September meeting.

Direct Care Wage (DCW) – Brad Casemore reviewed State's position on DCW after September 30th with group. Discussion followed. Brad Casemore stated that for budget development to assume that DCW will not be available.

SWMBH/PCE Memorandum of Understanding (MOU) – Brad Casemore reported as documented.

Autism Spectrum Disorder (ASD) Tech Fee $50 Region Wide for Providers – Mila Todd stated that SWMBH is paying State Autism rates for services. Discussion followed.

Provider Stability Plan – Mila Todd reported as documented noting the plan was submitted and approved by MDHHS. SWMBH must submit monthly reports and ask each CHMSP to submit their provider stability efforts to her for compiling one report for MDHHS.

Behavioral Health and Developmental Disabilities Administration (BHDDA) Encounter Data Integrity Team (EDIT) Charter – Brad Casemore

Fiscal Year 2021 Preview Budget – Brad Casemore reported as documented noting that this is a draft and does not included the 2.9% increase and asked each CMHSP to clarify if their budget submission included DCW.

Health Services Advisory Group (HSAG) Performance Improvement Project (PIP) Diabetes – Moira Kean reported as documented.

Primary Care Physicians (PCP) Survey – Moira Kean reported as documented and noted that a report would be presented to the Board at the October meeting.

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd shared that the Attorney General was actively listening to PIHPs issues and concerns during the last meeting. Two meetings are schedule on August 28th.

Fiscal Year 2021 CMH Contract Review – Mila Todd reported as documented, reviewing revisions in the Fiscal Year 2021 CMH contract. All CMHSPs agreed to revisions presented.

Managed Care Functional Review (MCFR) Provider Network Management (PNM) – Mila Todd stated that work is underway with IT to development tracking methods for implemented changes to PNM processes.

Building Better Lives Project – Sarah Ameter reported as documented highlighting purpose of project, charter, plans, goals and deliverables.

Opioid Health Homes (OHH) Update – Brad Casemore shared that SWMBH is participating in a two-day virtual OHH training. OHH start date is 10/01/2020.

SWMBH September Board Agenda – Brad Casemore noted the draft Board agenda in the packet for the group's review.

Michigan Health Endowment Fund (MHEF) Grant – Moira Kean reported that due to COVID-19 and difficulties with enrollment into the MHEF – Kalamazoo Connections program grant SWMBH has decided to end the grant on 10/01/2020.

Direct Community Placement Program (DCPP) – Jeannie Goodrich reported as documented and noted that feedback on this should be sent to Robert Sheehan by 8/28/2020. Discussion followed.

Adjourned – Meeting adjourned at 11:38am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for July, August, September 2020
Board Date 10/09/20

Action items:

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

Discussion items:

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

Board Ends Metric Updates – October 9, 2020

6a. 2020 MDHHS Behavioral Health Treatment Episode Data Set (BH TEDS) Metric Update:

A. 97% of applicable MH served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** **B. 97% of applicable SUD** served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** Metric Measurement Period: (1/1/20 - 7/1/20) Board Report Date: October 9, 2020 **Measurement:** (#) of reportable MH/SUD encounters (#) of MH/SUD encounters with BH TEDS matching record	Metric Data Source: MDHHS Monthly Status Reports Current Baseline: 2/16/19 • MH = 87.12% • SUD = 85.63% Current Status: 7/24/20 • **MH = 98.53%** • **SUD = 97.21%** 95% puts SWMBH in the **green (compliance)** on the MDHHS report. SWMBH established a target Regional Compliance rate of 97%. Matching rules as defined by MDHHS. Must have a matching and accepted BH TEDS record completed within one year of the encounter. For MH, this means that SWMBH minimally need an annual update record completed by the provider/CMHSP.

Overall Results Per the MDHHS Completion Dashboard:

- This meets *successful completion of our 2020 Board Ends Metric*, which indicates: ***97% of applicable MH/SUD served clients will have an accepted encounter, with a matching BH TEDS record confirmed by the MDHHS status report.***

- Please find the attached MDHHS status reports for your review and as evidence of Board Ends Metric Completion.

- Suggested Board Motion:
  The data is relevant and compelling, the Executive Officer is in Compliance and the Ends Metric needs no Revision.

FY20 MH Encounters w/BH-TEDS records

Encounters: 10/01/2019 - 05/31/2020*			BH-TEDS: 07/01/2018 - 07/23/2020	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-H0002 & Non-Crisis Encounters	Non-H0002, Non-Crisis, & Non-OBRA Assessment Encounters But NO BH-TEDS Record Since 07/01/2018	Current Completion Rate
CMH Partnership of SE MI	00XT	8,798	127	98.56%
Detroit/Wayne	00XH	53,089	2,913	94.51%
Lakeshore Regional Entity	00ZI	15,771	636	95.97%
Macomb	00GX	9,785	227	97.68%
Mid-State Health Network	0107	34,949	634	98.19%
NorthCare Network	0101	5,285	23	99.56%
Northern MI Regional Entity	0108	10,365	90	99.13%
Oakland	0058	15,870	403	97.46%
Region 10	0109	14,495	13	99.91%
Southwest MI Behavioral Health	0102	16,173	238	98.53%
Statewide		184,580	5,304	97.13%

Key

95.00+ = Compliant
90.00-94.99
85.00-89.99
<85.00

*Encounters = All MH encounters **excluding**: H0002, H2011, S9484, T1023, 90834, 90840, 99304-99310

FY20 SUD Encounters w/BH-TEDS records

SUD Encounters from 10/01/20019-05/31/2020			Does Not Have Open Admission at Time of Encounter	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Encounters	Encounters But NO BH-TEDS Record	Completion Rate
CMH Partnership of SE MI	00XT	2,467	70	97.16%
Detroit/Wayne	00XH	8,292	3	99.96%
Lakeshore Regional Entity	00ZI	4,819	127	97.36%
Macomb	00GX	3,955	22	99.44%
Mid-State Health Network	0107	9,055	6	99.93%
NorthCare Network	0101	1,304	4	99.69%
Northern MI Regional Entity	0108	3,121	127	95.93%
Oakland	0058	3,287	0	100.00%
Region 10	0109	4,467	24	99.46%
Salvation Army	002Y	484	71	85.33%
Southwest MI Behavioral Health	0102	4,510	126	97.21%
Statewide		45,761	580	98.73%

Key

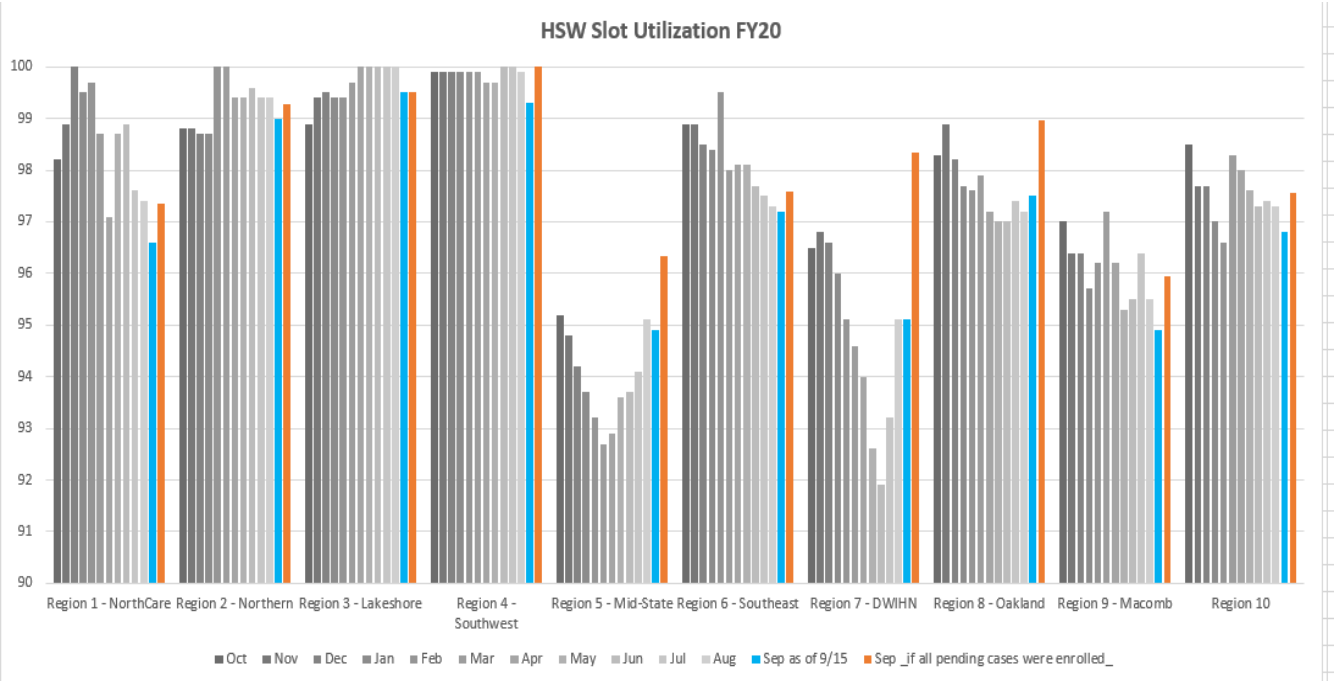
95.00+ = Compliant
90.00-94.99
85.00-89.99
<85.00

6b. Regional Habilitation Supports Waiver slots are full at 98% throughout FY20.

Regional Habilitation Supports Waiver slots are full at 99% throughout FY19. Metric Measurement Period: (10/1/19 - 9/30/20) Board Report Date: October 9, 2020 **Measurement:** (%) of waiver slot filled x 12 (#) of waiver slots (months) available *+1-point bonus credit will be awarded for (5) or more *new* HSW Slots SWMBH receives from MDHHS during FY20.	**Metric Achieved** ***99.84%*** of available HSW slots have been filled during FY 20 SWMBH has been the best performing PIHP, over the past 3 years for HSW slot maintenance!

MDHHS Dashboard:

PIHP Name	Fiscal Year		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Region 4 - Southwest	2020	Owned	710	710	710	710	710	710	710	710	710	710	710	710
Region 4 - Southwest	2020	Loaned	0	0	0	0	0	0	0	0	0	0	0	0
Region 4 - Southwest	2020	Borrowed	0	1	1	0	0	0	0	0	0	0	0	0
Region 4 - Southwest	2020	Used	709	710	710	709	709	709	708	708	710	710	709	706
Region 4 - Southwest	2020	Available	1	1	1	1	1	1	2	2	0	0	1	4
Region 4 - Southwest	2020	% Used	99.9	99.9	99.9	99.9	99.9	99.9	99.7	99.7	100	100	99.9	99.4



6c. SWMBH Achievement of Quality Withhold Measures Identified in MHL Integrated Care Organization Contracts Update:

SWMBH will achieve 90% of available monetary bonus award for achievement of quality withhold performance measures identified in the (2018-DY3) MHL Integrated Care Organization (ICO) contracts including:

Metric Measurement Period: (1/1/18 - 12/31/18)
Board Report Date: October 9, 2020

a. 90% of paid claim encounters are submitted by the 15th of the month following payment.
b. 95% CMS initial acceptance rate of PIHP encounters are received monthly.
c. 95% of enrollees have a level II assessment completed within 15 days of their level I assessment.
d. 80% of enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within (24 hours) of discharge to the facility or BH professional designated for follow-up care.
e. 95% of enrollees have documented discussions regarding care goals.
f. The PIHP will designate (2) members to serve on the MHL advisory board.

*SWMBH achieves 1-point credit for:
achievement of (*90% of total possible points - each contract*)
+1pt. Aetna Quality Withhold Measures
+1pt. Meridian Quality Withhold Measures

- **Data and reporting represent DY 3 (CY2018).**
- **DY 4-5 are currently being settled.**
- **Meridian Performance: 100pts. earned with withhold bonus earnings of $70, 240.**
- **Aetna Performance: 55 pts. Earned with withhold earnings of $26,624.**

Overall Results Per the MDHHS Completion Dashboard:

- The Meridian Metric was achieved, earning over 90% of available monetary bonus award.
- +1 pt. bonus for exceeding the 90% on the Meridian settlement.
- The Aetna Metric was not achieved, earning 55% of available monetary bonus award.

- Please find the attached Quality Withhold settlement breakdowns for your review and as evidence of Board Ends Metric Completion.

- Suggested Board Motion: The data is relevant and compelling; the Executive Officer is in Compliance and the Ends Metric needs no Revision.

Meridian Health Plan Performance:

Performance Measure	Benchmark	Total Point Value	Withhold Allocation	Points Earned	Withhold Return	Result
Encounter Data submitted timely, accurately, and completely in compliance with requirements in Agreement	90% of claims processed submitted by 15th of the following month	5-Timely	$ 3,512	5	$ 3,512	90.08% 7031/7738
	95% of claims per final reconciliation were timely received	5-Complete	$ 3,512	5	$ 3,512	97.33% 7557/7738 within 30 days
	95% CMS initial acceptance rate	5-Accurate	$ 3,512	5	$ 3,512	Acceptance Transactions not provided from MHP until 2018
Assessments	Percenter of Enrollees with Level II assessments completed within 15 days of the Level I assessment	50-96%+ 40-91% to 95% 30-86% to 90% 20-81% to 85% 10-76% to 80%	$ 35,120	50	$ 35,120	99.77% 974/977 (within 15 days or less)
Care Transition Record Transmitted to Health Care Professional	Percentage of Enrollees with an inpatient psychiatric admissions for whom a transition record was transmitted within 24 hours of discharge	10-80%+	$ 7,024	10	$ 7,024	82.30% 158/192
Documentation of Care Goals	Percentage of Enrollees with documented discussions of care goals	20-95%+ 10-90% to 94%	$ 14,048	20	$ 14,048	95% Per Joint Care Meeting and Care Bridge Records
Governance Board	2 participating members appointed by PIHP on the ICO's advisory board	5	$ 3,512	5	$ 3,512	Nancy Wallace and Bethany Vail
GRAND TOTAL		**100**	**$ 70,240**	**100**	**$ 70,240**	

Aetna Health Plan Performance:

Performance Measure	Benchmark	Total Point Value	Status	Withhold Allocation	Points Earned	Withhold Return
Encounter Data submitted timely, accurately, and completely in compliance with requirements in Agreement	90% of paid claim encounters submitted by 15th of the month following payment	5-Timely	96%	$ 2,420	0	$ -
	80% of paid claim encounters submitted within 180 days of the date of service	5-Complete	93%	$ 2,420	5	$ 2,420
	95% CMS initial acceptance rate	5-Accurate	91%	$ 2,420	0	$ -
Assessments	Percenter of Enrollees with Level II assessments completed within 15 days of the Plan referral of Level II assessment	30-95%+ 25-90% to 94% 20-85% to 89% 10-80% to 84% 5-75% to 79%	76.20%	$ 14,522	5	$ 2,420
Care Transition Record Transmitted to Health Care Professional	Percentage of Enrollees with an inpatient psychiatric admissions for whom a transition record was transmitted within 24 hours of discharge	10-80%+	42.90%	$ 4,841	0	$ -
Documentation of Care Goals	Percentage of Enrollees with documented discussions of care goals	20-95%+ 10-90% to 94%	99%	$ 9,681	20	$ 9,681
Follow-up after Inpatient Admission	Percentage of Enrollees with a follow-up visit with a BH practitioner within 30 days of BH inpatient discharge	20-56%+	61%	$ 9,681	20	$ 9,681
Governance Board	2 participating members appointed by PIHP on the ICO's advisory board	5	Met	$ 2,420	5	$ 2,420
GRAND TOTAL		**100**		**$ 48,407**	**55**	**$ 26,624**

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

September 16, 2020

Mr. Bradley Casemore, CEO
Southwest MI Behavioral Health – Region 4
5250 Lovers Lane Ste. 200
Portage, MI 49002

Dear Mr. Casemore:

Thank you for the cooperation extended to the Office of Recovery Oriented Systems of Care (OROSC) staff during the June 3, 2020 virtual site visit.

PRESENT AT THE SITE VISIT

Southwest MI Behavioral Health:	Joel Smith, SAPT Director Achilles Malta, Prevention Coordinator Cathy Hart, SOR Grant Coordinator Anastasia Miliadi, Treatment Coordinator
OROSC:	Logan O'Neil, Project Coordinator – *State Opioid Response (SOR)* David Havens, Project Support Technician – *SOR Supplemental* Choua Gonzalez-Medina, State Opioid Coordinator- *SOR* Jamie Meister, Project Assistant – *State Opioid Response (SOR)* Ricky Kent, Opioid Care Liaison – *State Opioid Response (SOR)*
Wayne State University:	Elizabeth Agius, Lead Evaluator – *SOR* Rachel Kollin, Project Manager – *SOR*

The purpose of the grant year two site visit was to verify that Southwest Michigan Behavioral Health's State Opioid Response (SOR) grant activities and funds for opioid use disorder are in compliance with federal and state requirements to support prevention, treatment and recovery activities.

After careful consideration and review of the requirements and documentation submitted, we have determined that Southwest Michigan Behavioral Health's activities are in compliance.

SOR REQUIREMENTS

Prepaid Inpatient Health Plans must utilize funds within programs for individuals with opioid use disorder in order to fulfill federal and state funding requirements. SOR funds are distributed to increase

the availability of prevention, treatment and recovery services designed for individuals with an opioid use disorder (OUD).

The State Opioid Response grant requirements state that the following services must be included:

1. Implement the required prevention, treatment, and recovery initiatives as outlined in the SOR Funding Opportunity Announcement.

2. Complete GPRA Surveys on eligible individuals with an OUD.

SITE VISIT FINDINGS

Currently, Southwest Michigan Behavioral Health has all the necessary tools in place to manage, maintain and report on the SOR activities and data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an opioid use disorder.

We greatly appreciate Southwest Michigan Behavioral Health's preparation for the site visit and their commitment to provide our staff with the necessary documentation.

If you have any further questions, please contact Logan O'Neil, SOR Project Coordinator at ONeilL@michigan.gov.

Sincerely,

Larry P. Scott, Director
Office of Recovery Oriented Systems of Care

LPS/lo

Enclosure (if applicable)

c: Angie Smith-Butterwick
Logan O'Neil
David Havens
Joel Smith

Southwest Michigan Behavioral Health

For the Fiscal YTD Period Ended 9/30/2021

(For Internal Management Purposes Only)

Mos in Period 12

FY21 Budget — DRAFT

INCOME STATEMENT

	For Board Consideration	FY21 Budget Current Status	Variance	FY20 Projection	Change FY21B v FY20P Fav / (Unfav)	FY20 Budget	Proposed Cost Reductions	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central
REVENUE														
Contract Revenue														
Contract Revenue	283,336,567	283,336,567	-	289,732,704	(6,396,137)	267,536,498		213,594,312	39,412,095	17,250,441	3,480,161	7,801,586	1,797,973	-
DHHS Incentive Payments	629,741	629,741	-	669,469	(39,728)	650,920		629,741	-	-	-	-	-	-
Grants and Earned Contracts	1,521,294	1,521,294	-	1,985,226	(463,932)	461,128		-	-	-	-	1,521,294	-	-
Interest Income - Working Capital	101,227	101,227	-	87,680	13,547	198,574		-	-	-	-	-	-	101,227
Interest Income - ISF Risk Reserve	5,123	5,123	-	4,422	702	48,015		-	-	-	-	-	-	5,123
Local Funds Contributions	1,726,192	1,726,192	-	1,726,192	-	2,163,020		-	-	-	-	-	-	1,726,192
Other Local Income	-	-	-	252,587	(252,587)	243,099		-	-	-	-	-	-	-
	-	-	-											
TOTAL REVENUE	**287,320,144**	**287,320,144**	**-**	**294,458,279**	**(7,138,135)**	**271,301,256**		**214,224,053**	**39,412,095**	**17,250,441**	**3,480,161**	**9,322,880**	**1,797,973**	**1,832,542**
EXPENSE														
Healthcare Cost														
Provider Claims Cost	22,233,468	22,233,468	-	23,258,499	(1,025,031)	22,415,051		3,593,555	6,188,839	-	4,258,071	6,650,990	1,542,014	-
CMHP Subcontracts, net of 1st & 3rd party	230,237,545	230,237,545	-	219,161,394	11,076,151	216,125,411		187,917,138	21,241,114	17,716,900	1,580,418	1,781,975	-	-
Insurance Provider Assessment Withhold (IPA)	2,894,655	2,894,655	-	2,931,271	(36,616)	2,590,858		2,894,655	-	-	-	-	-	-
Medicaid Hospital Rate Adjustments	3,614,277	3,614,277	-	3,931,156	(316,878)	139,821		3,614,277	-	-	-	-	-	-
Provider Stability and DCW Payments	-	-	-	6,500,000	(6,500,000)	-								
Total Healthcare Cost	**258,979,946**	**258,979,946**	**-**	**255,782,320**	**3,197,626**	**241,271,141**		**200,714,015**	**27,429,953**	**17,716,900**	**3,144,100**	**8,432,965**	**1,542,014**	**-**
Medical Loss Ratio (HCC % of Revenue)	**91.2%**	**91.2%**	**0.0%**	**88.1%**	**-49.7%**	**90.0%**		**93.7%**	**69.6%**	**102.7%**	**90.3%**	**108.1%**	**85.8%**	
Administrative Cost														
Purchased Professional Services	697,240	697,240	-	379,200	318,040	623,000		-	-	-	-	-	-	697,240
Administrative and Other Cost	9,313,774	9,313,774	-	7,328,591	1,985,183	8,293,670		-	-	-	-	-	-	9,313,774
Depreciation	89,172	89,172	-	89,095	77	109,640		-	-	-	-	-	-	89,172
Functional Cost Reclassification	-	-	-	-	-	-		-	-	-	-	551,037	-	(551,037)
Allocated Indirect Pooled Cost	-	-	-	0	(0)	-		-	-	-	-	-	-	-
Delegated Managed Care Admin	15,620,489	16,870,489	(1,250,000)	16,790,512	79,977	14,585,702	(1,250,000)	13,893,388	1,550,741	1,310,528	115,832	-	-	-
Apportioned Central Mgd Care Admin	0	0	-	(0)	0	0		7,223,800	1,034,660	668,283	220,228	338,877	-	(9,485,849)
Total Administrative Cost	**25,720,674**	**26,970,674**	**(1,250,000)**	**24,587,397**	**2,383,277**	**23,612,012**		**21,117,188**	**2,585,401**	**1,978,811**	**336,061**	**889,914**	**-**	**63,300**
Admin Cost Ratio (MCA % of Total Cost)	**9.0%**	**9.4%**	**100.0%**	**8.8%**	**42.7%**	**9.0%**	**9.0%**	**9.5%**	**8.6%**	**10.0%**	**9.7%**	**9.5%**	**0.0%**	**3.3%**
			-											
Local Funds Contribution	1,726,192	1,726,192	-	1,726,192	-	2,163,020		-	-	-	-	-	-	1,726,192
TOTAL COST after apportionment	**286,426,813**	**287,676,813**	**(1,250,000)**	**282,095,910**	**5,580,903**	**267,046,173**		**221,831,203**	**30,015,354**	**19,695,711**	**3,480,161**	**9,322,879**	**1,542,014**	**1,789,492**
NET SURPLUS before settlement	**893,331**	**(356,669)**	**1,250,000**	**12,362,370**	**(12,719,039)**	**4,255,082**		**(7,607,150)**	**9,396,742**	**(2,445,270)**	**-**	**0**	**255,959**	**43,050**
Net Surplus (Deficit) % of Revenue	**0.3%**	**-0.1%**	**#DIV/0!**	**4.2%**	**178.2%**	**1.6%**		**-3.6%**	**23.8%**	**-14.2%**	**0.0%**	**0.0%**	**14.2%**	**2.3%**
Prior Year Savings	-	-	-	-	-			-	-	-	-	-	-	-
Change in PA2 Fund Balance	(255,959)	(255,959)	-	(21,125)	(234,834)	(30,389)		-	-	-	-	-	(255,959)	-
ISF Risk Reserve Abatement (Funding)	(5,123)	(5,123)	-	(4,422)	(702)	(48,015)		-	-	-	-	-	-	(5,123)
ISF Risk Reserve Deficit (Funding)	655,678	655,678	-	-	655,678	-		655,678	-	-	-	-	-	-
Settlement Receivable / (Payable)	(0)	(0)	-	(67,738)	67,738	(17,147)		6,951,472	(9,396,742)	2,445,270	-	(0)	-	-
NET SURPLUS (DEFICIT)	**1,287,927**	**37,927**	**1,250,000**	**12,269,085**	**(12,231,158)**	**4,159,531**		**-**	**-**	**-**	**-**	**-**	**-**	**37,927**

HMP & Autism is settled with Medicaid

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			*Mos in Period*									
5	**FY21 Budget**			12									
6	*(For Internal Management Purposes Only)*			*ok*	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
9	***Medicaid Specialty Services***			*HCC%*	78.5%	72.1%	78.1%	77.9%	75.3%	80.5%	80.4%	85.4%	76.7%
10	Subcontract Revenue		213,594,312	13,419,262	200,175,050	8,549,071	38,730,831	11,044,336	36,429,720	10,829,685	62,074,802	13,371,837	19,144,768
11	Incentive Payment Revenue		629,741	252,180	377,560	36,005	45,385	36,308	120,000	4,862	115,000	20,000	-
12	**Contract Revenue**		**214,224,053**	**13,671,442**	**200,552,610**	**8,585,077**	**38,776,216**	**11,080,644**	**36,549,720**	**10,834,547**	**62,189,802**	**13,391,837**	**19,144,768**
13													
14	External Provider Cost		141,416,151	3,593,555	137,822,596	4,575,537	26,351,920	7,123,979	24,170,868	6,150,144	50,121,263	9,257,527	10,071,357
15	Internal Program Cost		52,535,213	-	52,535,213	3,374,849	10,105,695	3,180,420	10,402,452	3,358,145	9,427,321	5,141,647	7,544,686
16	SSI Reimb, 1st/3rd Party Cost Offset		(860,253)	-	(860,253)	(13,323)	(155,945)	(43,642)	(190,547)	(43,016)	(307,980)	(30,000)	(75,800)
17	Insurance Provider Assessment Withhold (IPA)		6,508,933	6,508,933	-	-	-	-	-	-	-	-	-
18	MHL Cost in Excess of Medicare FFS Cost		998,139	998,139	-	-	-	-	-	-	-	-	-
19	**Total Healthcare Cost**		**200,598,183**	**11,100,626**	**189,497,556**	**7,937,062**	**36,301,670**	**10,260,756**	**34,382,774**	**9,465,273**	**59,240,604**	**14,369,174**	**17,540,243**
20	**Medical Loss Ratio (HCC % of Revenue)**		**93.6%**	**81.2%**	**94.5%**	**92.5%**	**93.6%**	**92.6%**	**94.1%**	**87.4%**	**95.3%**	**107.3%**	**91.6%**
21													
22	**Managed Care Administration**		**21,233,020**	**7,223,800**	**14,009,220**	**591,926**	**2,674,245**	**866,979**	**2,352,332**	**861,137**	**4,720,823**	**899,797**	**1,041,981**
23	**Admin Cost Ratio (MCA % of Total Cost)**		**9.6%**	**3.3%**	**6.3%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
24													
25	**Contract Cost**		**221,831,203**	**18,324,426**	**203,506,777**	**8,528,988**	**38,975,916**	**11,127,736**	**36,735,106**	**10,326,410**	**63,961,427**	**15,268,971**	**18,582,224**
26	**Net before Settlement**		**(7,607,150)**	**(4,652,984)**	**(2,954,166)**	**56,089**	**(199,699)**	**(47,092)**	**(185,386)**	**508,136**	**(1,771,625)**	**(1,877,133)**	**562,544**
27													
28	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
29	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
30	Contract Settlement / Redistribution		6,951,472	3,997,306	2,954,166	(56,089)	199,699	47,092	185,386	(508,136)	1,771,625	1,877,133	(562,544)
31	**Net after Settlement**		**(655,678)**	**(655,678)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
32													
33	**Eligibles and PMPM**												
34	Average Eligibles		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
35	Revenue PMPM		$ 118.23	$ 7.55	$ 110.69	$ 92.34	$ 110.94	$ 108.89	$ 106.33	$ 100.79	$ 130.50	$ 89.55	$ 100.58
36	Expense PMPM		$ 122.43	$ 10.11	$ 112.32	$ 91.73	$ 111.51	$ 109.35	$ 106.87	$ 96.06	$ 134.22	$ 102.10	$ 97.62
37	Margin PMPM		$ (4.20)	$ (2.57)	$ (1.63)	$ 0.60	$ (0.57)	$ (0.46)	$ (0.54)	$ 4.73	$ (3.72)	$ (12.55)	$ 2.96
38													
39	***Medicaid Specialty Services***												
40	**Budget v Actual**												
41													
42	**Eligible Lives (Average Eligibles)**												
43	Actual		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
44	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
45	Variance - Favorable / (Unfavorable)		2,586	2,586	2,586	227	156	43	731	408	588	240	193
46	% Variance - Fav / (Unfav)		1.7%	1.7%	1.7%	3.0%	0.5%	0.5%	2.6%	4.8%	1.5%	2.0%	1.2%
47													
48	**Contract Revenue before settlement**												
49	Actual		214,224,053	13,671,442	200,552,610	8,585,077	38,776,216	11,080,644	36,549,720	10,834,547	62,189,802	13,391,837	19,144,768
50	Budget		204,068,849	17,242,038	186,826,811	7,396,377	37,196,138	9,989,229	34,283,103	9,752,361	57,765,210	12,540,970	17,903,422
51	Variance - Favorable / (Unfavorable)		10,155,203	(3,570,596)	13,725,800	1,188,700	1,580,078	1,091,415	2,266,617	1,082,185	4,424,592	850,867	1,241,345
52	% Variance - Fav / (Unfav)		5.0%	-20.7%	7.3%	16.1%	4.2%	10.9%	6.6%	11.1%	7.7%	6.8%	6.9%
53													
54	**Healthcare Cost**												
55	Actual		200,598,183	11,100,626	189,497,556	7,937,062	36,301,670	10,260,756	34,382,774	9,465,273	59,240,604	14,369,174	17,540,243
56	Budget		190,649,234	10,330,043	180,319,192	7,776,176	36,453,063	9,559,212	32,144,756	9,256,775	54,655,508	12,971,760	17,501,941
57	Variance - Favorable / (Unfavorable)		(9,948,948)	(770,584)	(9,178,364)	(160,886)	151,392	(701,544)	(2,238,017)	(208,498)	(4,585,096)	(1,397,414)	(38,301)
58	% Variance - Fav / (Unfav)		-5.2%	-7.5%	-5.1%	-2.1%	0.4%	-7.3%	-7.0%	-2.3%	-8.4%	-10.8%	-0.2%
59													
60	**Managed Care Administration**												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			***Mos in Period***									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
61	Actual		21,233,020	7,223,800	14,009,220	591,926	2,674,245	866,979	2,352,332	861,137	4,720,823	899,797	1,041,981
62	Budget		20,585,764	6,967,929	13,617,834	579,053	2,717,287	798,312	2,319,936	709,287	4,594,528	809,923	1,089,510
63	Variance - Favorable / (Unfavorable)		(647,256)	(255,870)	(391,386)	(12,873)	43,041	(68,668)	(32,396)	(151,850)	(126,295)	(89,873)	47,528
64	% Variance - Fav / (Unfav)		-3.1%	-3.7%	-2.9%	-2.2%	1.6%	-8.6%	-1.4%	-21.4%	-2.7%	-11.1%	4.4%
65													
66	**Total Contract Cost**												
67	Actual		221,831,203	18,324,426	203,506,777	8,528,988	38,975,916	11,127,736	36,735,106	10,326,410	63,961,427	15,268,971	18,582,224
68	Budget		211,234,998	17,297,972	193,937,026	8,355,229	39,170,349	10,357,524	34,464,692	9,966,062	59,250,036	13,781,683	18,591,451
69	Variance - Favorable / (Unfavorable)		(10,596,205)	(1,026,454)	(9,569,750)	(173,759)	194,434	(770,212)	(2,270,414)	(360,348)	(4,711,391)	(1,487,287)	9,227
70	% Variance - Fav / (Unfav)		-5.0%	-5.9%	-4.9%	-2.1%	0.5%	-7.4%	-6.6%	-3.6%	-8.0%	-10.8%	0.0%
71													
72	**Net before Settlement**												
73	Actual		(7,607,150)	(4,652,984)	(2,954,166)	56,089	(199,699)	(47,092)	(185,386)	508,136	(1,771,625)	(1,877,133)	562,544
74	Budget		(7,166,149)	(55,933)	(7,110,215)	(958,852)	(1,974,211)	(368,295)	(181,589)	(213,701)	(1,484,826)	(1,240,713)	(688,029)
75	Variance - Favorable / (Unfavorable)		(441,001)	(4,597,051)	4,156,049	1,014,941	1,774,512	321,203	(3,797)	721,837	(286,799)	(636,420)	1,250,572
76													
77													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			***Mos in Period***									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
78	***Healthy Michigan Plan***			*HCC%*	8.8%	10.4%	7.7%	8.0%	12.0%	7.3%	7.6%	8.3%	9.5%
79	**Contract Revenue**		**39,412,095**	**7,813,602**	**31,598,494**	**1,504,575**	**6,435,654**	**1,522,394**	**5,699,415**	**1,903,163**	**9,038,821**	**2,419,745**	**3,074,727**
80													
81	External Provider Cost		17,825,967	6,188,839	11,637,128	459,183	1,948,944	413,499	2,829,775	169,085	4,042,548	519,493	1,254,600
82	Internal Program Cost		9,603,986	-	9,603,986	684,206	1,608,993	640,663	2,657,235	694,404	1,537,475	873,668	907,342
83	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
84	**Total Healthcare Cost**		**27,429,953**	**6,188,839**	**21,241,114**	**1,143,389**	**3,557,938**	**1,054,162**	**5,487,010**	**863,489**	**5,580,023**	**1,393,161**	**2,161,942**
85	**Medical Loss Ratio (HCC % of Revenue)**		**69.6%**	**79.2%**	**67.2%**	**76.0%**	**55.3%**	**69.2%**	**96.3%**	**45.4%**	**61.7%**	**57.6%**	**70.3%**
86													
87	**Managed Care Administration**		**2,585,401**	**1,034,660**	**1,550,741**	**85,271**	**262,104**	**89,071**	**375,399**	**78,559**	**444,666**	**87,240**	**128,431**
88	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**3.4%**	**5.2%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
89													
90	**Contract Cost**		**30,015,354**	**7,223,499**	**22,791,855**	**1,228,660**	**3,820,041**	**1,143,233**	**5,862,409**	**942,048**	**6,024,689**	**1,480,401**	**2,290,373**
91	**Net before Settlement**		**9,396,742**	**590,103**	**8,806,639**	**275,915**	**2,615,612**	**379,160**	**(162,995)**	**961,116**	**3,014,132**	**939,344**	**784,354**
92													
93	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
94	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
95	Contract Settlement / Redistribution		(9,396,742)	(590,103)	(8,806,639)	(275,915)	(2,615,612)	(379,160)	162,995	(961,116)	(3,014,132)	(939,344)	(784,354)
96	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
97													
98	**Eligibles and PMPM**												
99	Average Eligibles		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
100	Revenue PMPM		$ 62.72	$ 12.43	$ 50.29	$ 49.30	$ 49.50	$ 51.47	$ 50.83	$ 49.55	$ 51.25	$ 49.19	$ 49.45
101	Expense PMPM		47.77	11.50	36.27	40.26	29.38	38.65	52.28	24.52	34.16	30.09	36.84
102	Margin PMPM		$ 14.95	$ 0.94	$ 14.01	$ 9.04	$ 20.12	$ 12.82	$ (1.45)	$ 25.02	$ 17.09	$ 19.09	$ 12.61
103													
104	***Healthy Michigan Plan***												
105	**Budget v Actual**												
106													
107	**Eligible Lives (Average Eligibles)**												
108	Actual		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
109	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
110	Variance - Favorable / (Unfavorable)		796	796	796	31	424	34	176	226	(356)	183	78
111	% Variance - Fav / (Unfav)		1.5%	1.5%	1.5%	1.2%	4.1%	1.4%	1.9%	7.6%	-2.4%	4.7%	1.5%
112													
113	**Contract Revenue before settlement**												
114	Actual		39,412,095	7,813,602	31,598,494	1,504,575	6,435,654	1,522,394	5,699,415	1,903,163	9,038,821	2,419,745	3,074,727
115	Budget		29,027,015	5,016,199	24,010,816	1,159,255	4,844,554	1,125,228	4,296,564	1,368,310	7,049,612	1,816,861	2,350,433
116	Variance - Favorable / (Unfavorable)		10,385,080	2,797,402	7,587,678	345,320	1,591,100	397,166	1,402,851	534,853	1,989,209	602,884	724,295
117	% Variance - Fav / (Unfav)		35.8%	55.8%	31.6%	29.8%	32.8%	35.3%	32.7%	39.1%	28.2%	33.2%	30.8%
118													
119	**Healthcare Cost**												
120	Actual		27,429,953	6,188,839	21,241,114	1,143,389	3,557,938	1,054,162	5,487,010	863,489	5,580,023	1,393,161	2,161,942
121	Budget		25,127,724	5,813,027	19,314,697	1,380,754	2,888,453	1,265,829	4,763,800	982,435	5,128,279	1,165,313	1,739,834
122	Variance - Favorable / (Unfavorable)		(2,302,229)	(375,812)	(1,926,417)	237,364	(669,484)	211,667	(723,210)	118,946	(451,744)	(227,848)	(422,108)
123	% Variance - Fav / (Unfav)		-9.2%	-6.5%	-10.0%	17.2%	-23.2%	16.7%	-15.2%	12.1%	-8.8%	-19.6%	-24.3%
124													
125	**Managed Care Administration**												
126	Actual		2,585,401	1,034,660	1,550,741	85,271	262,104	89,071	375,399	78,559	444,666	87,240	128,431
127	Budget		2,405,657	950,562	1,455,095	102,818	215,311	105,712	343,811	75,278	431,101	72,759	108,306
128	Variance - Favorable / (Unfavorable)		(179,744)	(84,099)	(95,645)	17,547	(46,792)	16,641	(31,589)	(3,281)	(13,566)	(14,481)	(20,125)
129	% Variance - Fav / (Unfav)		-7.5%	-8.8%	-6.6%	17.1%	-21.7%	15.7%	-9.2%	-4.4%	-3.1%	-19.9%	-18.6%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			***Mos in Period***									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
130													
131	**Total Contract Cost**												
132	Actual		30,015,354	7,223,499	22,791,855	1,228,660	3,820,041	1,143,233	5,862,409	942,048	6,024,689	1,480,401	2,290,373
133	Budget		27,533,381	6,763,588	20,769,793	1,483,571	3,103,765	1,371,542	5,107,611	1,057,712	5,559,379	1,238,072	1,848,141
134	Variance - Favorable / (Unfavorable)		(2,481,972)	(459,911)	(2,022,062)	254,911	(716,277)	228,309	(754,798)	115,665	(465,309)	(242,329)	(442,233)
135	% Variance - Fav / (Unfav)		-9.0%	-6.8%	-9.7%	17.2%	-23.1%	16.6%	-14.8%	10.9%	-8.4%	-19.6%	-23.9%
136													
137	**Net before Settlement**												
138	Actual		9,396,742	590,103	8,806,639	275,915	2,615,612	379,160	(162,995)	961,116	3,014,132	939,344	784,354
139	Budget		1,493,634	(1,747,389)	3,241,023	(324,316)	1,740,789	(246,314)	(811,047)	310,598	1,490,232	578,789	502,292
140	Variance - Favorable / (Unfavorable)		7,903,107	2,337,492	5,565,616	600,231	874,823	625,474	648,052	650,518	1,523,900	360,555	282,062
141													
142		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			*Mos in Period*									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
143	***Autism Specialty Services***			*HCC%*	7.3%	5.6%	9.6%	8.9%	6.9%	4.9%	7.2%	2.6%	8.8%
144	**Contract Revenue**		**17,250,441**	**0**	**17,250,441**	**894,284**	**3,241,112**	**982,461**	**3,127,220**	**887,761**	**5,006,136**	**1,396,849**	**1,714,619**
145													
146	External Provider Cost		15,283,003	-	15,283,003	-	4,463,446	1,175,846	1,459,963	574,439	5,302,991	424,994	1,881,325
147	Internal Program Cost		2,433,896	-	2,433,896	618,164	3,404	-	1,679,419	2,586	-	8,461	121,863
148	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
149	**Total Healthcare Cost**		**17,716,900**	**-**	**17,716,900**	**618,164**	**4,466,850**	**1,175,846**	**3,139,382**	**577,025**	**5,302,991**	**433,455**	**2,003,188**
150	**Medical Loss Ratio (HCC % of Revenue)**		**102.7%**	**0.0%**	**102.7%**	**69.1%**	**137.8%**	**119.7%**	**100.4%**	**65.0%**	**105.9%**	**31.0%**	**116.8%**
151													
152	**Managed Care Administration**		**1,978,811**	**668,283**	**1,310,528**	**46,101**	**329,061**	**99,353**	**214,784**	**52,497**	**422,590**	**27,143**	**119,000**
153	**Admin Cost Ratio (MCA % of Total Cost)**		**10.0%**	**3.4%**	**6.7%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
154													
155	**Contract Cost**		**19,695,711**	**668,283**	**19,027,428**	**664,265**	**4,795,910**	**1,275,199**	**3,354,166**	**629,522**	**5,725,581**	**460,598**	**2,122,187**
156	**Net before Settlement**		**(2,445,270)**	**(668,283)**	**(1,776,987)**	**230,018**	**(1,554,799)**	**(292,738)**	**(226,945)**	**258,239**	**(719,445)**	**936,251**	**(407,569)**
157	Contract Settlement / Redistribution		2,445,270	668,282	1,776,987	(230,018)	1,554,799	292,738	226,945	(258,239)	719,445	(936,251)	407,569
158	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
159													
160		x											
161	***SUD Block Grant Treatment***			*HCC%*	0.7%	7.6%	1.0%	0.4%	0.0%	0.9%	0.0%	1.5%	0.3%
162	**Contract Revenue**		**7,801,586**	**6,468,777**	**1,332,809**	**91,443**	**473,006**	**37,629**	**-**	**147,634**	**271,161**	**192,262**	**119,674**
163													
164	External Provider Cost		6,650,990	6,650,990	-	-	-	-	-	-	-	-	-
165	Internal Program Cost		1,781,975	-	1,781,975	831,811	476,306	52,350	-	100,195	13,373	244,844	63,097
166	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
167	**Total Healthcare Cost**		**8,432,965**	**6,650,990**	**1,781,975**	**831,811**	**476,306**	**52,350**	**-**	**100,195**	**13,373**	**244,844**	**63,097**
168	**Medical Loss Ratio (HCC % of Revenue)**		**108.1%**	**102.8%**	**133.7%**	**909.6%**	**100.7%**	**139.1%**	**0.0%**	**67.9%**	**4.9%**	**127.3%**	**52.7%**
169													
170	**Managed Care Administration**		**(631,379)**	**(631,379)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
171	**Admin Cost Ratio (MCA % of Total Cost)**		**-8.1%**	**-8.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
172													
173	**Contract Cost**		**7,801,586**	**6,019,610**	**1,781,975**	**831,811**	**476,306**	**52,350**	**-**	**100,195**	**13,373**	**244,844**	**63,097**
174	**Net before Settlement**		**0**	**449,166**	**(449,166)**	**(740,368)**	**(3,300)**	**(14,721)**	**-**	**47,439**	**257,788**	**(52,582)**	**56,577**
175	Contract Settlement		(0)	(449,166)	449,166	740,368	3,300	14,721	-	(47,439)	(257,788)	52,582	(56,577)
176	**Net after Settlement**		**-**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
177													
178		x	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			*Mos in Period*									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
179	***SWMBH CMHP Subcontracts***												
180	Subcontract Revenue		278,058,434	27,701,640	250,356,793	11,039,373	48,880,602	13,586,819	45,256,355	13,768,243	76,390,920	17,380,693	24,053,788
181	Incentive Payment Revenue		629,741	252,180	377,560	36,005	45,385	36,308	120,000	4,862	115,000	20,000	-
182	**Contract Revenue**		**278,688,174**	**27,953,821**	**250,734,354**	**11,075,379**	**48,925,987**	**13,623,127**	**45,376,355**	**13,773,105**	**76,505,920**	**17,400,693**	**24,053,788**
183													
184	External Provider Cost		181,176,110	16,433,383	164,742,727	5,034,720	32,764,310	8,713,324	28,460,607	6,893,668	59,466,802	10,202,014	13,207,282
185	Internal Program Cost		66,355,071	-	66,355,071	5,509,030	12,194,398	3,873,433	14,739,105	4,155,330	10,978,168	6,268,619	8,636,988
186	SSI Reimb, 1st/3rd Party Cost Offset		(860,253)	-	(860,253)	(13,323)	(155,945)	(43,642)	(190,547)	(43,016)	(307,980)	(30,000)	(75,800)
187	Insurance Provider Assessment Withhold (IPA)		6,508,933	6,508,933	-	-	-	-	-	-	-	-	-
188	MHL Cost in Excess of Medicare FFS Cost		998,139	998,139	-	-	-	-	-	-	-	-	-
189	**Total Healthcare Cost**		**254,178,000**	**23,940,455**	**230,237,545**	**10,530,427**	**44,802,763**	**12,543,115**	**43,009,165**	**11,005,982**	**70,136,990**	**16,440,634**	**21,768,470**
190	**Medical Loss Ratio (HCC % of Revenue)**		**91.2%**	**85.6%**	**91.8%**	**95.1%**	**91.6%**	**92.1%**	**94.8%**	**79.9%**	**91.7%**	**94.5%**	**90.5%**
191													
192	**Managed Care Administration**		**25,165,852**	**8,295,364**	**16,870,489**	**723,298**	**3,265,410**	**1,055,403**	**2,942,515**	**992,193**	**5,588,079**	**1,014,179**	**1,289,412**
193	**Admin Cost Ratio (MCA % of Total Cost)**		**9.0%**	**3.0%**	**6.0%**	**6.4%**	**6.8%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.8%**	**5.6%**
194													
195	**Contract Cost**		**279,343,852**	**32,235,818**	**247,108,034**	**11,253,724**	**48,068,173**	**13,598,518**	**45,951,681**	**11,998,174**	**75,725,070**	**17,454,813**	**23,057,881**
196	**Net before Settlement**		**(655,678)**	**(4,281,998)**	**3,626,320**	**(178,346)**	**857,814**	**24,609**	**(575,326)**	**1,774,930**	**780,851**	**(54,120)**	**995,906**
197													
198	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
199	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
200	Contract Settlement		(0)	3,626,319	(3,626,320)	178,346	(857,814)	(24,609)	575,326	(1,774,930)	(780,851)	54,120	(995,906)
201	**Net after Settlement**		**(655,678)**	**(655,678)**	**0**	**0**	**0**	**(0)**	**-**	**-**	**(0)**	**0**	**(0)**
202													
203													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	***Southwest Michigan Behavioral Health***			***Mos in Period***									
5	**FY21 Budget**			**12**									
6	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
7	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
8													
204	***State General Fund Services***			*HCC%*	4.7%	4.4%	3.6%	4.8%	5.8%	6.4%	4.8%	2.2%	4.8%
205	**Contract Revenue**				**11,582,725**	**793,253**	**2,019,282**	**751,543**	**1,969,536**	**611,785**	**3,752,587**	**743,903**	**940,836**
206													
207	External Provider Cost				4,090,313	203,272	320,492	117,403	515,437	488,587	2,079,770	183,851	181,500
208	Internal Program Cost				7,314,666	278,709	1,367,260	515,334	2,134,405	267,389	1,636,790	193,631	921,148
209	SSI Reimb, 1st/3rd Party Cost Offset				(181,000)	-	-	-	-	-	(181,000)	-	-
210	**Total Healthcare Cost**				**11,223,979**	**481,981**	**1,687,752**	**632,737**	**2,649,842**	**755,976**	**3,535,560**	**377,482**	**1,102,648**
211	**Medical Loss Ratio (HCC % of Revenue)**				**96.9%**	**60.8%**	**83.6%**	**84.2%**	**134.5%**	**123.6%**	**94.2%**	**50.7%**	**117.2%**
212													
213	**Managed Care Administration**				**923,554**	**39,585**	**139,230**	**59,777**	**201,410**	**75,128**	**309,308**	**26,448**	**72,667**
214	**Admin Cost Ratio (MCA % of Total Cost)**				**7.6%**	**7.6%**	**7.6%**	**8.6%**	**7.1%**	**9.0%**	**8.0%**	**6.5%**	**6.2%**
215													
216	**Contract Cost**				**12,147,532**	**521,566**	**1,826,982**	**692,514**	**2,851,253**	**831,105**	**3,844,868**	**403,930**	**1,175,315**
217	**Net before Settlement**				**(564,807)**	**271,687**	**192,300**	**59,029**	**(881,717)**	**(219,319)**	**(92,281)**	**339,973**	**(234,479)**
218													
219	Other Redistributions of State GF				(97,584)	-	-	-	-	-	-	-	(97,584)
220	Contract Settlement				(727,591)	(258,833)	(91,336)	(52,575)	-	-	-	(324,847)	-
221	**Net after Settlement**				**(1,389,982)**	**12,854**	**100,964**	**6,454**	**(881,717)**	**(219,319)**	**(92,281)**	**15,126**	**(332,063)**
222													

Southwest Michigan Behavioral Health
CORPORATE COMPLIANCE PLAN

Approved by SWMBH Board of Directors
[INSERT DATE]

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. First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Termination of subcontract or provider contract. All related remuneration and/or funds will be recouped by SWMBH.
Unknowingly violating federal or state billing or documentation practice(s).	First Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon CCO/human resources judgment up to and including: written reprimand for personnel file, mandatory compliance refresher training, individual counseling with manager and Chief Compliance Officer, probation, etc. Second Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon EO. First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Written notice of noncompliance for contract file, mandatory compliance

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

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

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

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

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

SECTION VII - CONFIDENTIALITY AND PRIVACY

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

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

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

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

SWMBH PERSONNEL COMPLIANCE CERTIFICATION FORM

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

_____ _____

Employee/Provider/Contractor Signature Date

SWMBH BOARD OF DIRECTORS COMPLIANCE CERTIFICATION FORM

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

_____ _____

Board Member Signature Date

The SWMBH FY2021 Payment Integrity and Clinical Quality Audit and Monitoring Plan reviews services delivered by CMHSPs as well as contracted service providers to assess compliance with applicable Federal and State billing and licensing 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** **CONTRACT REQUIREMENT:** FY21 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 beginning 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), 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 unit volume), 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

SWMBH FY2021 Payment Integrity and Clinical Quality Audit and Monitoring Plan
October 1, 2020 - September 30, 2021

	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 and Net cost Contract Review**	Review of Block Grant Fee-for-Service claims including ATP process. 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.	1) SWMBH Organizational Risk Assessment identified very minimal oversight of Block Grant funding stream; 2) Past findings concerning ATP process.	Annual review of each provider during PNM site review. Providers that only hold a Net Cost Contract and do not undergo an annual site review - review to be scheduled by SWMBH PI/C. Further methodology to be developed.	Program Integrity & Compliance - to be coordinated with PNM and SUD site reviews to reduce provider burden and improve efficiency.
4	**a. 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
5	**c. 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.	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
6	**e. Inpatient Psychiatric Hospital Services Clinical Review**	Administrative and Clinical review of inpatient psychiatric services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds.	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

Prepared By: Petra Morey Compliance Specialist III

	Audit Topic	Audit Mechanism	Known Risks and/or Purpose of Audit	Frequency of Audits	Responsibility
7	**Crisis Residential Administrative Services Review**	Administrative and Clinical review of crisis residential services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds.	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
7	**Annual CMHSP Site Review**	Administrative and Clinical review of functions delegated to participant CMHSP related to Medicaid and Healthy Michigan Plan (HMP) funds.	1) Title 42: Public Health PART 438—MANAGED CARE Subpart D—MCO, PIHP and PAHP Standards §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
8	**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	**Autism Provider Reviews**	Administrative review and brief clinical review for State of Michigan quality metrics.		Annual.	SWMBH Clinical Quality

	Audit Topic	Audit Mechanism	Known Risks and/or Purpose of Audit	Frequency of Audits	Responsibility
10	**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

Prioritization of Audit Items:

Red: These audit items are of highest priority based upon known risks identified through prior compliance analysis or investigations and/or they are contractual requirements. Compliance resources will be allocated to these items in such a way as to complete the audits before the end of the calendar year 2021 and/or pursuant to contractual requirements.

Orange: These audit items are moderate priority based upon known risks identified through prior compliance analysis or investigations and State/Federal audits. Compliance resources will be allocated to these audits in such a way as to complete the audits before the end of the calendar year 2021.

Yellow: These audit items are of lowest priority. At a minimum, these audits will be started during calendar year 2021.

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**: 11.8.19	**Past Review Dates**: 11.14.14, 9.11.15, 9.9.16, 11.11.16, 11.10.17,10.12.18

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

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

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	F	G	H	J	K	L	M	N	O	P	Q	R	S
1	**Southwest Michigan Behavioral Health**				*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2020			P11FYTD20	11									
3	*(For Internal Management Purposes Only)*													
4	**INCOME STATEMENT**			TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ASO Activities	Indirect Pooled Cost	
5														
7	**REVENUE**													
16	Contract Revenue			263,638,433	202,090,811	34,956,385	15,712,963	3,175,195	6,273,214	1,429,866	-	-	-	
17	DHHS Incentive Payments			613,680	613,680	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			1,819,791	-	-	-	-	1,819,791	-	-	-	-	
19	Interest Income - Working Capital			80,373	-	-	-	-	-	-	80,373	-	-	
20	Interest Income - ISF Risk Reserve			4,053	-	-	-	-	-	-	4,053	-	-	
21	Local Funds Contributions			1,582,343	-	-	-	-	-	-	1,582,343	-	-	
22	Other Local Income			231,538	-	-	-	-	-	-	231,538	-	-	
24	**TOTAL REVENUE**			**267,970,211**	**202,704,490**	**34,956,385**	**15,712,963**	**3,175,195**	**8,093,004**	**1,429,866**	**1,898,307**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			21,320,291	3,288,574	5,856,235	-	3,789,424	6,975,556	1,410,501	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			200,860,215	165,252,386	19,218,910	14,364,348	1,396,241	628,331	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			2,686,999	2,686,999	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			3,603,559	3,603,559	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	2,277,248	-	-	(2,277,248)	-	-	-			
34	**Total Healthcare Cost**			**228,471,064**	**177,108,765**	**25,075,145**	**14,364,348**	**2,908,417**	**7,603,887**	**1,410,501**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**86.5%**	**87.4%**	**71.7%**	**91.4%**	**91.6%**	**121.2%**	**98.6%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			347,600	-	-	-	-	-	-	347,600	-	-	
39	Administrative and Other Cost			6,717,875	-	-	-	-	-	-	6,714,751	-	3,124	
41	Depreciation			81,671	-	-	-	-	-	-	81,671	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	245,003	-	(245,003)	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	3,124	-	(3,124)	
44	Delegated Managed Care Admin			15,380,204	12,716,070	1,467,646	1,090,994	105,494	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	5,241,926	779,882	446,757	161,283	244,115	-	(6,873,963)	-	-	
46														
47	**Total Administrative Cost**			**22,527,349**	**17,957,996**	**2,247,528**	**1,537,750**	**266,778**	**489,117**	**-**	**28,180**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.2%**	**8.2%**	**9.7%**	**8.4%**	**6.0%**	**0.0%**	**2.7%**			
49														
50	Local Funds Contribution			1,582,343	-	-	-	-	-	-	1,582,343	-	-	
51														
52	**TOTAL COST after apportionment**			**252,580,756**	**195,066,761**	**27,322,673**	**15,902,099**	**3,175,195**	**8,093,004**	**1,410,501**	**1,610,523**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**15,389,455**	**7,637,730**	**7,633,712**	**(189,136)**	**-**	**-**	**19,365**	**287,785**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**5.7%**	**3.8%**	**21.8%**	**-1.2%**	**0.0%**	**0.0%**	**1.4%**	**15.2%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(19,365)	-	-	-	-	-	(19,365)	-			
59	ISF Risk Reserve Abatement (Funding)			(4,053)	-	-	-	-	-	-	(4,053)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	4,584,508	(4,773,644)	189,136	-	-	-	-			
62	**NET SURPLUS (DEFICIT)**			**15,366,037**	**12,222,238**	**2,860,068**	**-**	**-**	**-**	**-**	**283,732**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			14,451,348	11,591,280	2,860,068	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			914,689	630,957	-	-	-	-	-	283,732	-	-	
71	**NET SURPLUS (DEFICIT)**			**15,366,037**	**12,222,238**	**2,860,068**	**-**	**-**	**-**	**-**	**283,732**	**-**	**-**	
72														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2020			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			*HCC%*	79.4%	77.3%	78.1%	79.6%	75.4%	79.6%	82.3%	84.5%	78.2%
7	Subcontract Revenue		202,090,811	14,574,582	187,516,229	7,944,147	36,611,673	10,233,481	34,207,913	10,229,024	57,612,569	12,703,315	17,974,106
8	Incentive Payment Revenue		613,680	178,498	435,182	34,946	28,593	33,887	118,606	3,646	183,733	26,475	5,295
9	**Contract Revenue**		**202,704,490**	**14,753,080**	**187,951,410**	**7,979,094**	**36,640,266**	**10,267,369**	**34,326,519**	**10,232,671**	**57,796,302**	**12,729,789**	**17,979,401**
10													
11	External Provider Cost		125,377,423	3,288,574	122,088,849	4,026,110	24,153,139	5,500,079	22,381,896	5,793,153	42,743,711	8,502,784	8,987,978
12	Internal Program Cost		45,298,199	-	45,298,199	2,564,715	9,076,184	2,470,047	9,654,496	2,613,635	7,954,237	4,149,462	6,815,422
13	SSI Reimb, 1st/3rd Party Cost Offset		(746,306)	-	(746,306)	(12,231)	(177,717)	(34,010)	(123,682)	(32,262)	(267,313)	(26,021)	(73,070)
14	Insurance Provider Assessment Withhold (IPA)		6,290,558	6,290,558	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		775,513	775,513	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**176,995,387**	**10,354,645**	**166,640,742**	**6,578,594**	**33,051,606**	**7,936,116**	**31,912,710**	**8,374,526**	**50,430,635**	**12,626,225**	**15,730,330**
17	**Medical Loss Ratio (HCC % of Revenue)**		**87.3%**	**70.2%**	**88.7%**	**82.4%**	**90.2%**	**77.3%**	**93.0%**	**81.8%**	**87.3%**	**99.2%**	**87.5%**
18													
19	**Managed Care Administration**		**18,063,490**	**5,241,926**	**12,821,564**	**712,616**	**2,342,760**	**692,554**	**2,182,646**	**709,544**	**4,274,935**	**846,099**	**1,060,409**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**2.7%**	**6.6%**	**9.8%**	**6.6%**	**8.0%**	**6.4%**	**7.8%**	**7.8%**	**6.3%**	**6.3%**
21													
22	**Contract Cost**		**195,058,877**	**15,596,571**	**179,462,306**	**7,291,210**	**35,394,367**	**8,628,670**	**34,095,356**	**9,084,070**	**54,705,570**	**13,472,324**	**16,790,739**
23	**Net before Settlement**		**7,645,613**	**(843,491)**	**8,489,104**	**687,883**	**1,245,899**	**1,638,699**	**231,162**	**1,148,601**	**3,090,733**	**(742,535)**	**1,188,662**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		4,584,508	13,073,612	(8,489,104)	(687,883)	(1,245,899)	(1,638,699)	(231,162)	(1,148,601)	(3,090,733)	742,535	(1,188,662)
28	**Net after Settlement**		**12,230,121**	**12,230,121**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		152,051	152,051	152,051	7,832	29,304	8,572	28,828	9,011	39,985	12,543	15,976
32	Revenue PMPM		$ 121.19	$ 8.82	$ 112.37	$ 92.62	$ 113.67	$ 108.89	$ 108.25	$ 103.23	$ 131.40	$ 92.26	$ 102.31
33	Expense PMPM		$ 116.62	$ 9.32	$ 107.30	$ 84.63	$ 109.80	$ 91.51	$ 107.52	$ 91.65	$ 124.38	$ 97.64	$ 95.55
34	Margin PMPM		$ 4.57	$ (0.50)	$ 5.08	$ 7.98	$ 3.87	$ 17.38	$ 0.73	$ 11.59	$ 7.03	$ (5.38)	$ 6.76
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		152,051	152,051	152,051	7,832	29,304	8,572	28,828	9,011	39,985	12,543	15,976
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		3,644	3,644	3,644	311	332	135	915	461	862	321	307
43	% Variance - Fav / (Unfav)		2.5%	2.5%	2.5%	4.1%	1.1%	1.6%	3.3%	5.4%	2.2%	2.6%	2.0%
44													
45	**Contract Revenue before settlement**												
46	Actual		202,704,490	14,753,080	187,951,410	7,979,094	36,640,266	10,267,369	34,326,519	10,232,671	57,796,302	12,729,789	17,979,401
47	Budget		187,063,112	15,805,202	171,257,910	6,780,012	34,096,460	9,156,793	31,426,178	8,939,664	52,951,442	11,495,889	16,411,470
48	Variance - Favorable / (Unfavorable)		15,641,379	(1,052,122)	16,693,501	1,199,081	2,543,806	1,110,575	2,900,341	1,293,006	4,844,860	1,233,900	1,567,931
49	% Variance - Fav / (Unfav)		8.4%	-6.7%	9.7%	17.7%	7.5%	12.1%	9.2%	14.5%	9.1%	10.7%	9.6%
50													
51	**Healthcare Cost**												
52	Actual		176,995,387	10,354,645	166,640,742	6,578,594	33,051,606	7,936,116	31,912,710	8,374,526	50,430,635	12,626,225	15,730,330
53	Budget		174,761,798	9,469,206	165,292,592	7,128,162	33,415,307	8,762,611	29,466,027	8,485,377	50,100,882	11,890,780	16,043,446
54	Variance - Favorable / (Unfavorable)		(2,233,589)	(885,439)	(1,348,150)	549,567	363,701	826,495	(2,446,683)	110,851	(329,752)	(735,445)	313,116
55	% Variance - Fav / (Unfav)		-1.3%	-9.4%	-0.8%	7.7%	1.1%	9.4%	-8.3%	1.3%	-0.7%	-6.2%	2.0%
56													
57	**Managed Care Administration**												

	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 8/31/2020			**11**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
58	Actual		18,063,490	5,241,926	12,821,564	712,616	2,342,760	692,554	2,182,646	709,544	4,274,935	846,099	1,060,409
59	Budget		18,870,283	6,387,269	12,483,015	530,799	2,490,846	731,786	2,126,608	650,179	4,211,651	742,430	998,717
60	Variance - Favorable / (Unfavorable)		806,794	1,145,343	(338,549)	(181,817)	148,086	39,231	(56,039)	(59,364)	(63,285)	(103,669)	(61,692)
61	% Variance - Fav / (Unfav)		4.3%	17.9%	-2.7%	-34.3%	5.9%	5.4%	-2.6%	-9.1%	-1.5%	-14.0%	-6.2%
62													
63	**Total Contract Cost**												
64	Actual		195,058,877	15,596,571	179,462,306	7,291,210	35,394,367	8,628,670	34,095,356	9,084,070	54,705,570	13,472,324	16,790,739
65	Budget		193,632,082	15,856,474	177,775,607	7,658,960	35,906,153	9,494,397	31,592,634	9,135,557	54,312,533	12,633,210	17,042,163
66	Variance - Favorable / (Unfavorable)		(1,426,795)	259,904	(1,686,699)	367,750	511,787	865,727	(2,502,722)	51,487	(393,037)	(839,115)	251,424
67	% Variance - Fav / (Unfav)		-0.7%	1.6%	-0.9%	4.8%	1.4%	9.1%	-7.9%	0.6%	-0.7%	-6.6%	1.5%
68													
69	**Net before Settlement**												
70	Actual		7,645,613	(843,491)	8,489,104	687,883	1,245,899	1,638,699	231,162	1,148,601	3,090,733	(742,535)	1,188,662
71	Budget		(6,568,970)	(51,272)	(6,517,697)	(878,948)	(1,809,693)	(337,603)	(166,457)	(195,892)	(1,361,091)	(1,137,320)	(630,693)
72	Variance - Favorable / (Unfavorable)		14,214,583	(792,218)	15,006,802	1,566,831	3,055,593	1,976,302	397,619	1,344,493	4,451,823	394,785	1,819,355
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 8/31/2020			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	**Healthy Michigan Plan**			*HCC%*	9.1%	12.7%	9.4%	8.7%	11.4%	7.8%	7.4%	9.1%	8.8%
76	**Contract Revenue**		**34,956,385**	**7,724,953**	**27,231,432**	**1,300,182**	**5,565,716**	**1,299,557**	**4,845,966**	**1,644,768**	**7,830,732**	**2,109,161**	**2,635,352**
77													
78	External Provider Cost		16,473,533	5,856,235	10,617,298	444,362	2,241,612	384,626	2,310,654	249,210	3,437,205	591,530	958,099
79	Internal Program Cost		8,601,612	-	8,601,612	637,267	1,736,434	479,280	2,517,783	566,736	1,087,211	766,426	810,475
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**25,075,145**	**5,856,235**	**19,218,910**	**1,081,629**	**3,978,046**	**863,907**	**4,828,437**	**815,946**	**4,524,416**	**1,357,956**	**1,768,573**
82	**Medical Loss Ratio (HCC % of Revenue)**		**71.7%**	**75.8%**	**70.6%**	**83.2%**	**71.5%**	**66.5%**	**99.6%**	**49.6%**	**57.8%**	**64.4%**	**67.1%**
83													
84	**Managed Care Administration**		**2,247,528**	**779,882**	**1,467,646**	**117,166**	**281,971**	**75,390**	**330,237**	**69,132**	**383,528**	**90,998**	**119,223**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.2%**	**2.9%**	**5.4%**	**9.8%**	**6.6%**	**8.0%**	**6.4%**	**7.8%**	**7.8%**	**6.3%**	**6.3%**
86													
87	**Contract Cost**		**27,322,673**	**6,636,117**	**20,686,556**	**1,198,795**	**4,260,018**	**939,296**	**5,158,675**	**885,078**	**4,907,944**	**1,448,954**	**1,887,796**
88	**Net before Settlement**		**7,633,712**	**1,088,835**	**6,544,876**	**101,387**	**1,305,698**	**360,261**	**(312,709)**	**759,690**	**2,922,787**	**660,206**	**747,556**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(4,773,644)	1,771,232	(6,544,876)	(101,387)	(1,305,698)	(360,261)	312,709	(759,690)	(2,922,787)	(660,206)	(747,556)
93	**Net after Settlement**		**2,860,068**	**2,860,068**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		53,424	53,424	53,424	2,598	11,032	2,530	9,525	3,263	15,027	4,167	5,281
97	Revenue PMPM		$ 59.48	$ 13.15	$ 46.34	$ 45.50	$ 45.86	$ 46.70	$ 46.25	$ 45.82	$ 47.37	$ 46.01	$ 45.37
98	Expense PMPM		46.49	11.29	35.20	41.95	35.10	33.75	49.23	24.66	29.69	31.61	32.50
99	Margin PMPM		$ 12.99	$ 1.85	$ 11.14	$ 3.55	$ 10.76	$ 12.95	$ (2.98)	$ 21.16	$ 17.68	$ 14.40	$ 12.87
100													
101	**Healthy Michigan Plan**												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		53,424	53,424	53,424	2,598	11,032	2,530	9,525	3,263	15,027	4,167	5,281
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		1,854	1,854	1,854	85	622	99	357	289	(25)	250	178
108	% Variance - Fav / (Unfav)		3.6%	3.6%	3.6%	3.4%	6.0%	4.1%	3.9%	9.7%	-0.2%	6.4%	3.5%
109													
110	**Contract Revenue before settlement**												
111	Actual		34,956,385	7,724,953	27,231,432	1,300,182	5,565,716	1,299,557	4,845,966	1,644,768	7,830,732	2,109,161	2,635,352
112	Budget		26,608,097	4,598,183	22,009,915	1,062,650	4,440,841	1,031,459	3,938,517	1,254,284	6,462,144	1,665,456	2,154,563
113	Variance - Favorable / (Unfavorable)		8,348,288	3,126,770	5,221,518	237,531	1,124,874	268,098	907,448	390,484	1,368,588	443,705	480,788
114	% Variance - Fav / (Unfav)		31.4%	68.0%	23.7%	22.4%	25.3%	26.0%	23.0%	31.1%	21.2%	26.6%	22.3%
115													
116	**Healthcare Cost**												
117	Actual		25,075,145	5,856,235	19,218,910	1,081,629	3,978,046	863,907	4,828,437	815,946	4,524,416	1,357,956	1,768,573
118	Budget		23,033,747	5,328,608	17,705,139	1,265,691	2,647,749	1,160,344	4,366,817	900,565	4,700,922	1,068,204	1,594,848
119	Variance - Favorable / (Unfavorable)		(2,041,398)	(527,627)	(1,513,771)	184,062	(1,330,297)	296,437	(461,620)	84,619	176,506	(289,753)	(173,725)
120	% Variance - Fav / (Unfav)		-8.9%	-9.9%	-8.5%	14.5%	-50.2%	25.5%	-10.6%	9.4%	3.8%	-27.1%	-10.9%
121													
122	**Managed Care Administration**												
123	Actual		2,247,528	779,882	1,467,646	117,166	281,971	75,390	330,237	69,132	383,528	90,998	119,223
124	Budget		2,205,186	871,348	1,333,837	94,250	197,369	96,903	315,160	69,004	395,176	66,696	99,281
125	Variance - Favorable / (Unfavorable)		(42,342)	91,466	(133,809)	(22,916)	(84,603)	21,513	(15,078)	(128)	11,647	(24,302)	(19,942)
126	% Variance - Fav / (Unfav)		-1.9%	10.5%	-10.0%	-24.3%	-42.9%	22.2%	-4.8%	-0.2%	2.9%	-36.4%	-20.1%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 8/31/2020			**11**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
127													
128	**Total Contract Cost**												
129	Actual		27,322,673	6,636,117	20,686,556	1,198,795	4,260,018	939,296	5,158,675	885,078	4,907,944	1,448,954	1,887,796
130	Budget		25,238,933	6,199,956	19,038,977	1,359,940	2,845,118	1,257,247	4,681,977	969,570	5,096,098	1,134,899	1,694,129
131	Variance - Favorable / (Unfavorable)		(2,083,740)	(436,161)	(1,647,579)	161,146	(1,414,900)	317,950	(476,698)	84,492	188,154	(314,055)	(193,667)
132	% Variance - Fav / (Unfav)		-8.3%	-7.0%	-8.7%	11.8%	-49.7%	25.3%	-10.2%	8.7%	3.7%	-27.7%	-11.4%
133													
134	**Net before Settlement**												
135	Actual		7,633,712	1,088,835	6,544,876	101,387	1,305,698	360,261	(312,709)	759,690	2,922,787	660,206	747,556
136	Budget		1,369,165	(1,601,773)	2,970,938	(297,290)	1,595,724	(225,788)	(743,460)	284,715	1,366,046	530,557	460,434
137	Variance - Favorable / (Unfavorable)		6,264,547	2,690,609	3,573,938	398,677	(290,026)	586,049	430,751	474,976	1,556,741	129,650	287,121
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 8/31/2020			**11**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
140	***Autism Specialty Services***			*HCC%*	6.8%	5.2%	9.2%	7.6%	7.1%	5.8%	5.9%	2.9%	7.9%
141	**Contract Revenue**		**15,712,963**	**19,450**	**15,693,513**	**779,207**	**2,960,974**	**877,054**	**2,846,742**	**793,808**	**4,620,714**	**1,269,470**	**1,545,544**
142													
143	External Provider Cost		12,478,790	-	12,478,790	-	3,896,170	751,781	1,677,105	609,437	3,611,006	424,979	1,508,312
144	Internal Program Cost		1,885,558	-	1,885,558	442,361	4,831	2,495	1,343,144	2,006	-	6,828	83,892
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**14,364,348**	**-**	**14,364,348**	**442,361**	**3,901,001**	**754,276**	**3,020,249**	**611,443**	**3,611,006**	**431,807**	**1,592,205**
147	**Medical Loss Ratio (HCC % of Revenue)**		**91.4%**	**0.0%**	**91.5%**	**56.8%**	**131.7%**	**86.0%**	**106.1%**	**77.0%**	**78.1%**	**34.0%**	**103.0%**
148													
149	**Managed Care Administration**		**1,537,750**	**446,757**	**1,090,994**	**47,918**	**276,510**	**65,823**	**206,568**	**51,805**	**306,100**	**28,936**	**107,333**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.7%**	**2.8%**	**6.9%**	**9.8%**	**6.6%**	**8.0%**	**6.4%**	**7.8%**	**7.8%**	**6.3%**	**6.3%**
151													
152	**Contract Cost**		**15,902,099**	**446,757**	**15,455,342**	**490,279**	**4,177,511**	**820,098**	**3,226,817**	**663,249**	**3,917,106**	**460,743**	**1,699,538**
153	**Net before Settlement**		**(189,136)**	**(427,307)**	**238,171**	**288,928**	**(1,216,537)**	**56,956**	**(380,075)**	**130,559**	**703,608**	**808,727**	**(153,994)**
154	Contract Settlement / Redistribution		189,136	427,307	(238,171)	(288,928)	1,216,537	(56,956)	380,075	(130,559)	(703,608)	(808,727)	153,994
155	**Net after Settlement**		**-**	**(0)**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.3%	0.7%	0.4%	0.6%	0.0%	0.9%	0.0%	1.2%	0.4%
159	**Contract Revenue**		**6,273,214**	**5,020,142**	**1,253,072**	**83,823**	**433,589**	**32,047**	**-**	**135,331**	**248,564**	**175,324**	**144,395**
160													
161	External Provider Cost		6,975,736	6,975,556	180	180	-	-	-	-	-	-	-
162	Internal Program Cost		628,151	-	628,151	62,304	150,796	58,161	-	92,678	2,829	172,739	88,645
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**7,603,887**	**6,975,556**	**628,331**	**62,484**	**150,796**	**58,161**	**-**	**92,678**	**2,829**	**172,739**	**88,645**
165	**Medical Loss Ratio (HCC % of Revenue)**		**121.2%**	**139.0%**	**50.1%**	**74.5%**	**34.8%**	**181.5%**	**0.0%**	**68.5%**	**1.1%**	**98.5%**	**61.4%**
166													
167	**Managed Care Administration**		**(1,330,673)**	**(1,330,673)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-21.2%**	**-21.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**6,273,214**	**5,644,883**	**628,331**	**62,484**	**150,796**	**58,161**	**-**	**92,678**	**2,829**	**172,739**	**88,645**
171	**Net before Settlement**		**-**	**(624,741)**	**624,741**	**21,339**	**282,793**	**(26,115)**	**-**	**42,654**	**245,735**	**2,585**	**55,750**
172	Contract Settlement		-	624,741	(624,741)	(21,339)	(282,793)	26,115	-	(42,654)	(245,735)	(2,585)	(55,750)
173	**Net after Settlement**		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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 8/31/2020			**11**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		259,033,372	27,339,126	231,694,246	10,107,359	45,571,951	12,442,139	41,900,621	12,802,931	70,312,579	16,257,269	22,299,397
178	Incentive Payment Revenue		613,680	178,498	435,182	34,946	28,593	33,887	118,606	3,646	183,733	26,475	5,295
179	**Contract Revenue**		**259,647,052**	**27,517,625**	**232,129,427**	**10,142,306**	**45,600,544**	**12,476,026**	**42,019,227**	**12,806,578**	**70,496,312**	**16,283,744**	**22,304,692**
180													
181	External Provider Cost		161,305,483	16,120,365	145,185,118	4,470,652	30,290,921	6,636,485	26,369,656	6,651,800	49,791,922	9,519,293	11,454,389
182	Internal Program Cost		56,413,519	-	56,413,519	3,706,647	10,968,245	3,009,983	13,515,423	3,275,055	9,044,277	5,095,455	7,798,434
183	SSI Reimb, 1st/3rd Party Cost Offset		(746,306)	-	(746,306)	(12,231)	(177,717)	(34,010)	(123,682)	(32,262)	(267,313)	(26,021)	(73,070)
184	Insurance Provider Assessment Withhold (IPA)		6,290,558	6,290,558	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		775,513	775,513	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**224,038,768**	**23,186,436**	**200,852,331**	**8,165,069**	**41,081,449**	**9,612,459**	**39,761,397**	**9,894,592**	**58,568,885**	**14,588,727**	**19,179,753**
187	**Medical Loss Ratio (HCC % of Revenue)**		**86.3%**	**84.3%**	**86.5%**	**80.5%**	**90.1%**	**77.0%**	**94.6%**	**77.3%**	**83.1%**	**89.6%**	**86.0%**
188													
189	**Managed Care Administration**		**20,518,095**	**5,137,891**	**15,380,204**	**877,700**	**2,901,242**	**833,767**	**2,719,451**	**830,481**	**4,964,564**	**966,033**	**1,286,965**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.4%**	**2.1%**	**6.3%**	**9.7%**	**6.6%**	**8.0%**	**6.4%**	**7.7%**	**7.8%**	**6.2%**	**6.3%**
191													
192	**Contract Cost**		**244,556,863**	**28,324,328**	**216,232,535**	**9,042,768**	**43,982,692**	**10,446,226**	**42,480,848**	**10,725,074**	**63,533,449**	**15,554,760**	**20,466,718**
193	**Net before Settlement**		**15,090,189**	**(806,703)**	**15,896,892**	**1,099,537**	**1,617,852**	**2,029,800**	**(461,621)**	**2,081,504**	**6,962,863**	**728,983**	**1,837,974**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		-	15,896,892	(15,896,892)	(1,099,537)	(1,617,852)	(2,029,800)	461,621	(2,081,504)	(6,962,863)	(728,983)	(1,837,974)
198	**Net after Settlement**		**15,090,189**	**15,090,189**	**0**	**-**	**-**	**-**	**(0)**	**0**	**0**	**-**	**0**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 8/31/2020			11									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	4.4%	4.0%	2.9%	3.6%	6.0%	6.0%	4.4%	2.3%	4.6%
202	**Contract Revenue**				**10,350,696**	**662,031**	**1,764,335**	**630,421**	**1,854,312**	**573,549**	**3,372,070**	**545,026**	**948,952**
203													
204	External Provider Cost				3,303,551	109,322	131,940	79,549	713,198	408,611	1,593,564	142,363	125,005
205	Internal Program Cost				5,973,948	231,029	1,095,343	276,371	1,839,700	221,878	1,300,172	205,778	803,677
206	SSI Reimb, 1st/3rd Party Cost Offset				(177,111)	-	-	-	-	-	(177,111)	-	-
207	**Total Healthcare Cost**				**9,100,388**	**340,351**	**1,227,283**	**355,920**	**2,552,897**	**630,489**	**2,716,624**	**348,141**	**928,682**
208	**Medical Loss Ratio (HCC % of Revenue)**				**87.9%**	**51.4%**	**69.6%**	**56.5%**	**137.7%**	**109.9%**	**80.6%**	**63.9%**	**97.9%**
209													
210	**Managed Care Administration**				**774,461**	**41,055**	**97,843**	**34,806**	**192,656**	**58,112**	**253,971**	**26,116**	**69,903**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.8%**	**7.4%**	**8.9%**	**7.0%**	**8.4%**	**8.5%**	**7.0%**	**7.0%**
212													
213	**Contract Cost**				**9,874,849**	**381,406**	**1,325,126**	**390,726**	**2,745,553**	**688,601**	**2,970,595**	**374,257**	**998,585**
214	**Net before Settlement**				**475,847**	**280,625**	**439,209**	**239,696**	**(891,241)**	**(115,052)**	**401,475**	**170,769**	**(49,633)**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(1,256,413)	(272,098)	(350,992)	(236,704)	-	-	(232,871)	(163,748)	-
218	**Net after Settlement**				**(780,566)**	**8,527**	**88,217**	**2,992**	**(891,241)**	**(115,052)**	**168,604**	**7,021**	**(49,633)**
219													

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Summary: Conference Report
Article 6, House Bill 5396 (S-1) CR-1

Analysts: Kent Dell, Susan Frey, Kevin Koorstra, and Viola Wild

	FY 2019-20 YTD as of 2/6/20	FY 2020-21 Conference	*Difference: Conference From FY 2019-20 YTD* *Amount*	*%*
IDG/IDT	$13,819,300	$13,829,900	$10,600	0.1%
Federal	18,306,958,900	20,066,172,200	1,759,213,300	9.6%
Local	146,246,000	161,422,800	15,176,800	10.4%
Private	142,959,500	177,172,500	34,213,000	23.9%
Restricted	2,978,783,900	2,989,480,100	10,696,200	0.4%
GF/GP	4,769,278,700	5,090,371,100	321,092,400	6.7%
Gross	**$26,358,046,300**	**$28,498,448,600**	***$2,140,402,300***	**8.1%**
FTEs	15,438.0	15,487.0	*49.0*	0.3%

Notes:
(1) FY 2019-20 year-to-date figures are as of release of the executive budget on February 6, 2020 and do not include mid-year budget adjustments.
(2) Appropriation figures include all proposed appropriation amounts and amounts designated as "one-time."
(3) Because of revenue uncertainty due to the COVID-19 pandemic, separate FY 2020-21 budget bills were not passed by the House or the Senate.

Overview

The Department of Health and Human Services (DHHS) includes programs and services to assist Michigan's most vulnerable families, including public assistance programs, protecting children and assisting families by administering foster care, adoption, and family preservation programs and by enforcing child support laws, and funding for behavioral health (mental health and substance use disorder), population health, aging, crime victim, and medical services programs, including Medicaid and the Healthy Michigan Plan.

Major Budget Changes From FY 2019-20 YTD Appropriations		FY 2019-20 Year-to-Date (as of 2/6/20)	FY 2020-21 Conference Change
MEDICAID AND BEHAVIORAL HEALTH – GENERAL			
1. Traditional Medicaid Cost Adjustment Increases $895.9 million Gross ($100.0 million GF/GP) for traditional Medicaid program caseload, utilization, inflation, and financing adjustments based on the August caseload consensus between the State Budget Office, Senate Fiscal Agency, and House Fiscal Agency. Amount includes GF/GP offsets from federal FMAP and SCHIP match rates adjustments from 64.06% to 64.08% and 86.34% to 74.86%, respectively, plus an additional 6.2 percentage point increase to the state FMAP provided under the federal Families First Coronavirus Response Act for 1 quarter. Primary source of cost increases is from additional caseloads as a result of the COVID-19 pandemic.	**Gross**	**$14,654,187,100**	**$895,928,200**
	Federal	9,340,804,400	796,114,100
	Local	52,140,400	(70,900)
	Private	2,100,000	0
	Restricted	2,351,951,200	(79,100)
	GF/GP	$2,907,191,100	$99,964,100
2. Healthy Michigan Plan Cost Adjustment Increases $994.3 million Gross ($121.9 million GF/GP) for Healthy Michigan Plan caseload, utilization, inflation, and financing adjustments based on the August caseload consensus. Primary source of cost increases is from additional caseloads as a result of the COVID-19 pandemic.	**Gross**	**$4,116,287,200**	**$994,327,400**
	Federal	3,741,823,200	864,252,100
	Local	1,754,800	240,800
	Restricted	338,849,100	7,911,900
	GF/GP	$33,860,100	$121,922,600

Major Budget Changes From FY 2019-20 YTD Appropriations		FY 2019-20 Year-to-Date (as of 2/6/20)	FY 2020-21 Conference Change
3. Actuarial Soundness	**Gross**	**NA**	**$207,813,000**
Includes $207.8 million Gross ($61.6 million GF/GP) to support an estimated 2.0% actuarial soundness adjustment for prepaid inpatient health plans (PIHPs), Medicaid Health plans, home- and community-based services, and Healthy Kids Dental, and an estimated 6.0% increase for PIHP autism services.	Federal	NA	146,197,100
	GF/GP	NA	$61,615,900
DEPARTMENTAL ADMINISTRATION			
	FTE	0.0	6.0
4. MiSACWIS Replacement	**Gross**	**$0**	**$4,389,400**
Includes $4.4 million Gross ($2.6 million GF/GP) and authorizes 6.0 FTE positions to begin the replacement of MiSACWIS with a new Comprehensive Child Welfare Information System (CCWIS). Replacement will include the introduction of 9 cloud-based modules over the course of approximately 5 to 6 years.	Federal	0	1,789,400
	GF/GP	$0	$2,600,000
	FTE	207.0	(10.0)
5. Office of Inspector General – Vacant FTE Positions	**Gross**	**$25,961,600**	**($1,303,100)**
Includes a reduction of $1.3 million Gross ($671,900 GF/GP) and 10.0 FTE positions due to currently vacant positions. SBO has indicated that the department does not intend to fill these positions in the current fiscal year.	IDG/IDT	198,200	0
	TANF	874,800	0
	Federal	13,421,100	(631,200)
	GF/GP	$11,467,500	($671,900)
6. Lease Cancellations and Staff Relocation	**Gross**	**NA**	**($2,788,100)**
Includes a reduction of $2.8 million Gross ($1.5 million GF/GP) resulting from the transfer of the Victor building to the Department of Labor and Economic Opportunity and the cancellation of multiple leases.	Federal	NA	(1,296,800)
	GF/GP	NA	($1,491,300)
7. Information Technology Consolidation	FTE	43.0	(30.0)
Includes a net-zero transfer of $40.0 million Gross ($10.0 million GF/GP) from one-time appropriations, as well as $6.0 million GF/GP from various line items across the department budget to the Information Technology appropriation unit to ameliorate the identified information technology GF/GP funding shortfall. Also adjusts FTE positions and distributes appropriations from the Information Technology Contingency line item to the major IT programs.	**Gross**	**$504,698,900**	**$6,000,000**
	IDG/IDT	1,067,000	0
	TANF	24,854,500	0
	Federal	345,760,400	0
	Private	25,000,000	0
	Restricted	1,999,800	0
	GF/GP	$106,017,200	$6,000,000
8. Property Management – Non-State-Owned Building Leases	**Gross**	**$65,809,800**	**$866,300**
Includes $866,300 Gross ($671,400 GF/GP) to account for adjustments in lease costs for non-state-owned buildings utilized by the department.	IDG/IDT	593,500	0
	TANF	10,698,900	0
	Federal	23,921,000	194,900
	Private	36,400	0
	Restricted	494,900	0
	GF/GP	$30,065,100	$671,400
9. Economic Adjustments	**Gross**	**NA**	**$53,898,000**
Reflects increased costs of $53.9 million Gross ($34.7 million GF/GP) for negotiated salary and wage increases (2.0% on October 1, 2020 and 1.0% on April 1, 2021), actuarially required retirement contributions, worker's compensation, building occupancy charges, and other economic adjustments.	IDG/IDT	NA	10,600
	TANF	NA	(13,400)
	Federal	NA	18,172,100
	Local	NA	101,300
	Private	NA	239,200
	Restricted	NA	699,900
	GF/GP	NA	$34,688,300

Major Budget Changes From FY 2019-20 YTD Appropriations		FY 2019-20 Year-to-Date (as of 2/6/20)	FY 2020-21 Conference Change
CHILD SUPPORT ENFORCEMENT			
10. Child Support Operations Reduction	FTE	179.7	0.0
Includes a $3.9 million Gross ($1.3 million GF/GP) reduction for the Office of Child Support based on costs and administrative efficiencies.	**Gross**	**$23,464,900**	**($3,900,000)**
	Federal	14,810,400	(2,574,000)
	GF/GP	$8,654,500	($1,326,000)
COMMUNITY SERVICES AND OUTREACH			
11. Homeless Programs	**Gross**	**$22,632,700**	**$649,800**
Includes $649,800 GF/GP to increase funding for homeless programs that provide emergency shelter and services to homeless individuals. Increase is to provide additional funding to current providers for additional services at current per diem rates.	Federal	3,613,900	0
	TANF	6,162,600	0
	GF/GP	$12,856,200	$649,800
12. Runaway and Homeless Youth Grants	**Gross**	**$7,384,000**	**$400,000**
Includes an increase of $400,000 GF/GP for Runaway and Homeless Youth programs.	Federal	3,103,000	0
	TANF	3,424,800	0
	GF/GP	$856,200	$400,000
13. School Success Partnership Program	**Gross**	**$0**	**$525,000**
Includes $525,000 federal funding for state grant to Northeast Michigan Community Service Agency for School Success Partnership Program.	TANF	0	525,000
	GF/GP	$0	$0
14. Child Advocacy Centers	FTE	0.5	0.0
Includes an increase of $999,900 GF/GP for child advocacy centers. Sec. 459 is related boilerplate.	**Gross**	**$1,407,100**	**$999,900**
	Restricted	1,407,000	0
	GF/GP	$100	$999,900
15. Unified Clinics Resiliency Center for Families and Children – One-Time Funding	**Gross**	**$100**	**$1,499,900**
	GF/GP	$100	$1,499,900
Includes $1.5 million GF/GP for the development and operation of a Resiliency Center for Families and Children to provide services to families and children experiencing trauma, toxic stress, chronic disability, neurodevelopmental disorders, or addictions. Sec. 1919 is related boilerplate.			
16. Washtenaw County Youth Programs- One-Time Funding	**Gross**	**NA**	**$250,000**
Includes $250,000 GF/GP for a grant to a provider network for services to youth in Washtenaw County during the COVID-19 crisis. Sec. 1914 is related boilerplate.	GF/GP	NA	$250,000
CHILDREN'S SERVICES AGENCY – CHILD WELFARE			
17. Child Welfare Caseload Adjustments	**Gross**	**$696,118,600**	**$27,799,500**
Increases funding for child welfare programs by $27.8 million Gross ($39.4 million GF/GP) as follows:	Federal	198,373,900	(1,889,400)
	TANF	94,280,100	(14,310,500)
	Local	40,914,500	5,166,900
	Private	1,770,700	(562,700)
	GF/GP	$360,779,400	$39,395,200
• Foster care payments are increased by $9.1 million Gross ($9.0 million GF/GP) from 6,124 cases at $37,100 per year to 8,152 cases at $32,415 per year.			
• Adoption subsidies are reduced by $1.1 million Gross ($178,700 GF/GP) from 22,062 cases at $730.41 per month to 22,061 cases at $728.48 per month.			
• The Child Care Fund is increased by $19.8 million Gross ($30.9 million GF/GP).			
• Guardianship assistance payments are decreased by $103,200 Gross ($250,900 GF/GP) from 1,188 cases at $709.26 per month to 1,201 cases at $694.42 per month.			
Caseload estimates based on August caseload consensus.			

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18. Child Welfare FMAP Savings	**Gross**	**NA**	**$0**
Includes $3.6 million GF/GP savings from enhanced FMAP rates in the first quarter of FY 2020-21 during the COVID-19 crisis.	Federal	NA	3,600,000
	GF/GP	NA	($3,600,000)
19. Qualified Residential Treatment Program (QRTP) Child Assessments	**Gross**	**$259,974,400**	**$3,410,600**
	Federal	105,645,300	910,600
Includes an increase of $3.4 million Gross ($2.5 million GF/GP) for assessments of children in private foster care institutions. Third-party treatment assessments are mandated by the federal Family First Prevention Services Act (FFPSA) to be completed within 30 days of placement in a QRTP.	TANF	9,248,000	0
	Local	18,102,700	0
	Private	1,770,700	0
	GF/GP	$125,207,700	$2,500,000
20. Foster Care Prevention Programming	FTE	NA	5.0
	Gross	**NA**	**$716,300**
Includes an increase of $716,300 Gross ($524,500 GF/GP) and authorization for 5.0 FTE positions for community analysts/liaisons to provide services to help families avoid entry into foster care and prevent children from being placed into residential care.	Federal	NA	191,800
	GF/GP	NA	$524,500
21. Foster Care Congregate Care Pilot	**Gross**	**NA**	**$501,500**
Adds $501,500 GF/GP to fund the first year of a congregate care pilot that will use an evidence-based program with focused cognitive behavioral therapy for foster children.	GF/GP	NA	$501,500
22. Residential Foster Care Facility Rate Increase	**Gross**	**$259,974,400**	**$7,086,100**
Includes an increase of $7.1 million Gross ($4.6 million GF/GP) to fund a residential rate increase for private agencies to meet new residential treatment requirements, such as additional staffing, programming, and accreditation, under the federal FFPSA.	Federal	105,645,300	2,486,100
	TANF	9,248,000	0
	Local	18,102,700	0
	Private	1,770,700	0
	GF/GP	$125,207,700	$4,600,000
23. Family Preservation Program Private Agency Rate Increase	FTE	15.0	0.0
	Gross	**$46,820,900**	**$1,750,000**
Adds $1.8 million GF/GP to fund an increase to private agency rates for family preservation program services. Sec. 523(3) is related boilerplate and states any eligible federal matching funds may be allocated as well.	Federal	609,100	0
	GF/GP	43,235,600	0
		$2,976,200	$1,750,000
24. Adoption Provider Rate Increase	**Gross**	**NA**	**$1,500,000**
Includes $1.5 million Gross ($1.0 million GF/GP) to fund an increase to private agency rates for adoption support services. Sec. 509 is related boilerplate.	Federal	NA	500,000
	GF/GP	NA	$1,000,000
25. West Michigan Partnership for Children Rate Increase	**Gross**	**$29,320,700**	**$8,777,700**
Includes $8.8 million Gross ($4.7 million GF/GP) to fund a prospective case rate increase based on updated program costs, transition to a global capitated payment model, and the establishment of a risk reserve fund. Sec. 504 is related boilerplate.	Federal	8,773,800	4,037,700
	TANF	3,690,100	0
	Local	4,500,000	0
	GF/GP	$12,356,800	$4,740,000
26. Relative Licensure Incentive Payments	**Gross**	**$2,250,000**	**($2,250,000)**
Eliminates $2.3 million Gross ($800,000 GF/GP) for incentive payments concerning the licensure of relative caregivers as foster parents, including $2.0 million Gross ($550,000 GF/GP) to child placing agencies and $250,000 GF/GP to relative caregivers.	Federal	1,450,000	(1,450,000)
	GF/GP	$800,000	($800,000)
27. Court-Appointed Special Advocates	**Gross**	**$100**	**$499,900**
Adds $499,900 GF/GP for court-appointed special advocates that advocate in the legal system for children who have been abused or neglected. Sec. 526 is related boilerplate.	GF/GP	$100	$499,900

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28. Kinship Caregiver Advisory Council Includes $200,000 GF/GP to provide support and coordinated services to the Kinship Caregiver Advisory Council within DHHS. Sec. 575 is related boilerplate.	**Gross**	**$0**	**$200,000**
	GF/GP	$0	$200,000
29. Parent-to Parent Mentoring Program Includes $250,000 GF/GP to Adoptive Family Support Network for the Parent-to-Parent mentoring program. Sec. 559 is related boilerplate.	**Gross**	**$0**	**$250,000**
	GF/GP	$0	$250,000
30. Children Protective Services Legal Representation Program Includes $4.3 million federal grant funding for a new program to provide children and parents legal representation in child protective hearings.	**Gross**	**$0**	**$4,263,300**
	Federal	0	4,263,300
	GF/GP	$0	$0
PUBLIC ASSISTANCE			
31. Public Assistance Caseload Adjustments Recognizes a $43.2 million Gross ($40.4 million GF/GP) increase resulting from adjustments in expected public assistance caseloads in accordance with the August 2020 Consensus Revenue Estimating Conference. Increased caseloads are correlated with the COVID-19 pandemic and resulting emergency response. • Family Independence Program: increase of $39.4 million Gross ($35.2 million GF/GP) • Food Assistance Program: no change from YTD • State Supplementation: increase of $1.7 million GF/GP • State Disability Assistance: increase of $2.1 million Gross ($3.6 million GF/GP)	**Gross**	**NA**	**$43,171,300**
	TANF	NA	5,213,600
	Federal	NA	0
	Restricted	NA	(2,452,300)
	GF/GP	NA	$40,410,000
32. Food Assistance Program Reinvestment Includes $11.0 million GF/GP and authorizes 6.0 FTE positions to support both penalty payments to the federal government and a federally-required corrective action plan. Penalties are related to multi-year higher than national average error rates in food assistance over/under payments.	FTE	0.0	6.0
	Gross	**$0**	**$10,991,200**
	GF/GP	$0	$10,991,200
33. Field Operations – Administrative Reductions Includes $850,000 GF/GP in administrative reductions across multiple line items. Reductions include $500,000 GF/GP from Pathways to Potential; $150,000 from Volunteer Services and Reimbursements; $100,000 GF/GP from Public Assistance Field Staff; and $100,000 from Contractual Services, Supplies, and Materials.	**Gross**	**NA**	**($850,000)**
	GF/GP	NA	($850,000)
34 Public Assistance Fund Source Transfers Shifts $2.0 million TANF to offset $2.0 million GF/GP from the Family Independence Program and includes $700,000 GF/GP to replace a shortfall in restricted Supplemental Security Income recoveries revenue.	**Gross**	**NA**	**$0**
	TANF	NA	2,000,000
	Restricted	NA	(700,000)
	GF/GP	NA	($1,300,000)
35. Kids' Food Basket – One-Time Funding Includes $250,000 GF/GP in one-time funding for a grant to a West Michigan non-profit that provides free meals to children of low-income families.	**Gross**	**NA**	**$250,000**
	GF/GP	NA	$250,000
36. Legal Assistance – One-Time Funding Includes $60,000 GF/GP in one-time funding for a grant to the Allegan County Legal Assistance Center, which provides free civil-law legal assistance to low-income individuals.	**Gross**	**NA**	**$60,000**
	GF/GP	NA	$60,000

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BEHAVIORAL HEALTH SERVICES			
37. K.B. v. Lyon	FTE	NA	9.0
Includes $19.1 million Gross ($2.7 million GF/GP) and authorization for 9.0 FTE positions for behavioral health services and supports monitoring, system improvement, and performance monitoring for children related to the legal settlement K.B. v. Lyon. Amount includes $17.7 million Gross ($1.8 million GF/GP) for IT system upgrades.	**Gross**	**NA**	**$19,102,000**
	Federal	NA	16,435,300
	GF/GP	NA	$2,666,700
38. Nursing Home Pre-Admission Screening (PAS)/ Annual Resident Reviews (ARR) Cost Increase	FTE	7.0	0.0
Adds $1.6 million Gross ($407,700 GF/GP) for increased clinical evaluations for individuals with mental illnesses for developmental disabilities who are requesting to or are residing in a nursing home.	**Gross**	**$12,291,300**	**$1,631,100**
	Federal	9,218,600	1,223,400
	GF/GP	$3,072,700	$407,700
39. Behavioral Health Homes	**Gross**	**$3,369,000**	**$23,400,700**
Includes $23.4 million Gross ($2.5 million GF/GP) to expand the number of behavioral health homes, including opioid health homes, by a prospective 9,245 enrollees.	Federal	3,032,100	20,934,400
	Local	246,900	0
	GF/GP	$90,000	$2,466,300
40. State Psychiatric Hospital Direct Care Staffing	FTE	1,838.3	60.0
Includes $5.0 million GF/GP and authorization for 60.0 FTE positions to increase direct care staffing levels at 4 of the state's psychiatric hospitals and centers: Kalamazoo, Walter P. Reuther, Hawthorn, and the Center for Forensic Psychiatry.	**Gross**	**$239,384,600**	**$5,000,000**
	Federal	35,551,100	0
	Local	19,288,000	0
	Restricted	10,275,000	0
	GF/GP	$174,270,500	$5,000,000
41. State Psychiatric Hospital Coronavirus Relief Funds	FTE	1,838.3	0.0
Replaces $22.5 million GF/GP with a like amount of federal Coronavirus Relief Funds (CRF), which can be used to cover certain personnel costs through December 30, 2020.	**Gross**	**$239,384,600**	**$0**
	Federal	35,551,100	22,500,000
	Local	19,288,000	0
	Restricted	10,275,000	0
	GF/GP	$174,270,500	($22,500,000)
42. Behavioral Health Facility Contingency Transfer	**Gross**	**$20,000,000**	**$0**
Transfers $20.0 million GF/GP from the new Behavioral Health Facility Contingency line item into the state hospitals and centers line items. Sec. 1053 is related deleted boilerplate.	GF/GP	$20,000,000	$0
43. Behavioral Health Program Reductions	**Gross**	**NA**	**($3,299,600)**
Includes reductions totaling $3.3 million GF/GP for various behavioral health programs including in-sourcing Children's Transition Support Team, court-ordered assisted treatment, jail diversion, applied behavioral treatment, and psychiatric bed database.	GF/GP	NA	($3,299,600)
44. Direct Care Worker Wage Increase – One-Time Funding	**Gross**	**$0**	**$150,000,000**
Adds $150.0 million Gross ($40.0 million GF/GP) to provide a temporary $2.00 per hour wage increase for direct care workers for 3 months. Funding would be available for the same direct care workers that were eligible for COVID-19 direct care worker hazard pay included in 2020 PA 123, including Medicaid-eligible behavioral health direct care workers, skilled nursing facility employees, and area agency on aging direct care employees.	Federal	0	110,000,000
	GF/GP	$0	$40,000,000

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45. Other Behavioral Health Funding – One-Time Funding	**Gross**	**$1,125,000**	**$4,394,800**
Adds $4.4 million GF/GP in one-time funding for the following behavioral health programs: $2.5 million for first responder post-traumatic stress syndrome and other mental health conditions, $1.0 million for Special Olympics, $250,000 for Great Lakes Recovery Center, $200,000 for nonprofit mental health clinics, $200,000 for The Children's Center, $100,000 for Safe Substance Abuse Coalition, and maintains the $1.0 million GF/GP for autism navigators and adds $144,800 GF/GP to Autism Train-the-Trainer, which was both funded in FY 2019-20.	GF/GP	$1,125,000	$4,394,800
POPULATION HEALTH			
46. Expand Programs for Healthy Moms and Healthy Babies	**Gross**	**NA**	**$23,531,900**
Increases funding by $23.5 million Gross ($12.6 million GF/GP) for expansion of maternal and infant health and support programs, including lengthening Medicaid coverage for new mothers and infants to 12 months from 2 months, enhancing access to behavioral health care, and expanding and other home visiting programs for pregnant women, new mothers, and at-risk families.	Federal	NA	10,900,400
	GF/GP	NA	$12,631,500
47. State Innovation Model Grant Completion	**Gross**	**$10,002,700**	**($10,002,700)**
Removes $10.0 million excess federal authorization for the completed federal State Innovation Model (SIM) grant, first funded in FY 2014-15, and revises related boilerplate Sec. 1144 to provide certain reporting.	Federal	10,002,700	(10,002,700)
	GF/GP	$0	$0
48. Michigan Essential Health Provider	**Gross**	**$4,519,600**	**($1,000,000)**
Reduces Michigan Essential Health Provider program by $1.0 million GF/GP, the amount of a FY 2019-20 program increase, and eliminates related boilerplate Sec. 1141.	Federal	1,236,300	0
	Private	855,000	0
	GF/GP	$2,428,300	($1,000,000)
49. Laboratory Equipment for Newborn Screening Testing	**Gross**	**$23,774,500**	**$1,500,000**
Provides $1.5 million of state restricted newborn screening fee revenue for laboratory information technology and testing instruments for new approved newborn screening tests.	IDG	1,004,600	0
	Federal	4,338,600	0
	Restricted	12,147,200	1,500,000
	GF/GP	$6,284,100	$0
50. Lead Abatement Grant SCHIP Adjustment	**Gross**	**$33,768,000**	**$0**
Includes a net $0 Gross ($2.8 million GF/GP) federal to GF/GP fund shift to recognize reduction of the federal share for lead abatement grant from 86.34% to 74.86%. YTD includes $20.9 million of federal Children's Health Insurance Program (SCHIP) funds approved for use for lead abatement in Flint and other high-risk communities for up to five years, since FY 2016-17. Revises related Sec. 1182 boilerplate.	Federal	22,349,600	(2,785,500)
	Private	77,800	0
	Restricted	723,700	0
	GF/GP	$10,616,900	$2,785,500
51. Lead Poisoning Prevention Fund – One-Time Funding	**Gross**	**$0**	**$2,000,000**
Includes new one-time funding of $2.0 million GF/GP to establish a Lead Poisoning Prevention Fund to be administered by an independent third-party as a public-private loan loss reserve fund for private lenders; fund would support low-cost loans to homeowners and landlords for lead remediation projects. Sec. 1913 is related boilerplate.	GF/GP	$0	$2,000,000
52. Flint Drinking Water and Lead Exposure	**Gross**	**$4,621,100**	**($100)**
Continues funding of $4.6 million GF/GP for assistance to residents exposed to lead in the City of Flint but moves appropriation from one-time to ongoing. Related Sec. 1910 boilerplate is moved to Sec. 1306.	GF/GP	$4,621,100	($100)

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53. Bone Marrow Donor and Blood Bank Programs	**Gross**	**$0**	**$750,000**
Includes $250,000 GF/GP for Be the Match marrow donor registry program and $500,000 GF/GP for cord blood bank programs, both through the Versiti Blood Center. Sections 1146 and 1147 are related boilerplate.	GF/GP	$0	$750,000
54. Family Readiness Events	**Gross**	**$0**	**$25,000**
Includes $25,000 GF/GP for free family emergency readiness public events. Sec. 1185 is related boilerplate.	GF/GP	$0	**$25,000**
55. Rare Disease Review Committee	**Gross**	**$0**	**$70,000**
Includes $70,000 GF/GP to support the establishment of a rare disease review committee within DHHS. Sec. 1240 is related boilerplate. HB 5465 is similar proposed legislation.	GF/GP	$0	$70,000
56. School Children's Healthy Exercise Program	**Gross**	**$1,000,000**	**($500,000)**
Reduces funding by $500,000 GF/GP for an ongoing school children's healthy exercise program first funded in FY 2012-13 to address childhood obesity. Sec. 1226 related boilerplate is revised to direct remaining funding only to before- and after-school programming.	GF/GP	$1,000,000	($500,000)
57. Population Health Reductions for GF/GP Savings	**Gross**	**NA**	**($2,621,800)**
Includes additional reductions for GF/GP savings including:	Private	NA	136,500
• PFAS $500,000 as an offset to $1.0 million new federal funds	Restricted	NA	45,500
• PFAS $581,800 drinking well laboratory test cost savings	GF/GP	NA	($2,803,800)
• Revised lead and copper rule local support $1.0 million			
• HIV program shift $182,000 cost for 3 positions to non-GF/GP			
• Prenatal care home visit program $40,000 contract savings			
• $500,000 savings for various projects contracted with the Michigan Public Health Institute			
58. Population Health Non-GF/GP Funds Adjustments	**Gross**	**NA**	**$52,104,000**
Recognizes a net increase of $52.1 million Gross for federal, local, private, and state restricted funding, including:	Federal	NA	13,445,100
	Local	NA	8,442,700
• $13.4 million net federal grant funds increase for opioid overdose data to action, biomonitoring assessments, lead poisoning prevention, PFAS health studies, epidemiology and laboratory capacity, family planning Title X, and completion of oral health workforce grant;	Private	NA	30,200,000
	Restricted	NA	16,200
	GF/GP	NA	$0
• $32.8 million federal and private funds to AIDS program primarily reflecting increased drug assistance program rebates;			
• $200,000 private funds from Amanda's Fund for Breast Cancer Prevention and Treatment;			
• $16,200 increase for annual inflationary fee adjustment for screening of newborns for genetic conditions; and			
• $8.4 million local funds for expanded child and adolescent health center care and emotional health services in schools, originating from the state School Aid Fund and included as a new line item.			
59. Healthy Communities Grant – One-Time Funding	**Gross**	**$300,100**	**($100)**
Continues one-time funding of $300,000 GF/GP for healthy living, obesity prevention, and substance abuse prevention programs of Leaders Advancing and Helping Communities. Sec. 1915 is related boilerplate.	GF/GP	$300,100	($100)
60. Infant Genome Testing for Treatment – One-Time Funding	**Gross**	**$0**	**$1,000,000**
Includes $1.0 million Gross ($250,000 GF/GP) for rapid whole genome sequencing testing for critically ill infants and children, through Project Baby Deer with Spectrum Children's Hospital. Sec. 1917 is related boilerplate.	Federal	0	650,000
	Private	0	100,000
	GF/GP	$0	$250,000

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61. Vision Clinic – One-Time Funding	**Gross**	**$0**	**$100,000**
Includes $100,000 GF/GP for vision services to special needs individuals through a nonprofit vision clinic. Sec. 1927 is related boilerplate.	GF/GP	$0	$100,000
AGING AND ADULT SERVICES			
62. Senior Programs - Non-GF/GP Funds Adjustments	**Gross**	**$111,781,900**	**$2,000,000**
Recognizes $2.0 million increase of federal and private funds for senior programs including $700,000 for community supportive services, $800,000 for congregate and home-delivered meals, and $500,000 to improve health of individuals receiving public long-term care support services.	Federal	59,343,900	1,500,000
	Private	520,000	500,000
	Restricted	6,068,700	0
	GF/GP	$45,849,300	$0
63. Senior Call Check Pilot Program	**Gross**	**$0**	**$40,000**
Includes $40,000 GF/GP for a senior call check pilot program for voluntary regular contact with participating seniors. Sec. 1426 is related boilerplate. HB 6236 is similar proposed legislation.	GF/GP	$0	$40,000
64. Senior Citizen Center Grants – One-Time Funding	**Gross**	**$500,000**	**($350,000)**
Continues one-time funding for a small grants program for health-related senior programs at multipurpose senior citizen centers at a reduced appropriation of $150,000 GF/GP. Sec. 1923 is related boilerplate.	GF/GP	$500,000	($350,000)
MEDICAL SERVICES			
65. Healthy Michigan Plan Administration	FTE	36.0	0.0
Removes $20.7 million Gross ($15.2 million GF/GP) in Healthy Michigan Plan administration related to a federal judge ruling the new workforce engagement requirements were unlawful and the resulting delay in implementing the new workforce engagement requirements.	**Gross**	**$55,629,700**	**($20,721,400)**
	GF/GP	26,549,200	(5,541,300)
		$29,080,500	($15,180,100)
66. Claimsure	**Gross**	**NA**	**$1,200,000**
Adds $1.2 million Gross ($300,000 GF/GP) for a predictive modeling tool for provider billing accuracy by identifying outlier claims.	Federal	NA	900,000
	GF/GP	NA	$300,000
67. Healthy Kids Dental Risk Corridor	**Gross**	**NA**	**($33,686,000)**
Assumes $33.7 million Gross ($12.1 million GF/GP) in savings from a 2-way risk corridor for the Healthy Kids Dental managed care program.	Federal	NA	(21,586,000)
	GF/GP	NA	($12,100,000)
68. Medicaid Managed Care Organization Risk Corridor	**Gross**	**NA**	**($141,360,000)**
Assumes $141.4 million Gross ($36.0 million GF/GP) in savings from cost settling the FY 2019-20 2-way risk corridor for Medicaid Managed Care Organizations. Sec. 1881 is related boilerplate and states legislative intent that a 2-way risk corridor is not included in the managed care capitation rates in the next fiscal year.	Federal	NA	(105,360,000)
	GF/GP	NA	($36,000,000)
69. Medicaid Managed Care Organization Single Preferred Drug List	**Gross**	**NA**	**($190,762,800)**
Assumes $190.8 million Gross ($47.7 million GF/GP) in net savings from establishing a single preferred drug list to be utilized by all Medicaid managed care organizations and increasing Medicaid managed care independent pharmacy dispensing fees. Amount includes $322.3 million Gross ($80.7 million GF/GP) in additional pharmaceutical rebate savings, $86.2 million Gross ($21.6 million GF/GP) in additional pharmaceutical ingredient costs, and $45.3 million Gross ($11.3 million GF/GP) in dispensing fee increases. Sections 1625, 1879, and 1880 are related boilerplate.	Federal	NA	(143,020,200)
	GF/GP	NA	($47,742,600)

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70. Medicaid Managed Care Organization Rate Reduction – Third Party Liabilities	**Gross**	**$5,384,831,800**	**($30,623,600)**
	Federal	3,532,282,900	(19,623,600)
Assumes a savings of $30.6 million Gross ($11.0 million GF/GP) from Medicaid health plans recouping a greater amount of third-party liability collections.	Local	25,140,900	0
	Restricted	1,625,099,700	0
	GF/GP	$202,308,300	($11,000,000)
71. Medicaid Hospital Outpatient Rate Increase	**Gross**	**NA**	**$352,646,000**
Includes $352.6 million Gross ($0 GF/GP) to provide a 21.37% rate increase in Medicaid outpatient hospital reimbursements utilizing provider tax revenue. The corresponding HRA increase and MACI decrease would result in assumed GF/GP savings of $15.7 million.	Federal	NA	253,480,300
	Restricted	NA	114,881,800
	GF/GP	NA	($15,716,100)
72. MiDocs	**Gross**	**$17,500,000**	**$5,400,000**
Includes $5.4 million Gross ($1.4 million GF/GP) to support the new MiDocs class during the current fiscal year over the course of 5 years.	Federal	8,750,000	2,700,000
	Restricted	5,000,000	1,350,000
	GF/GP	$3,750,000	$1,350,000
73. Private Duty Nursing	**Gross**	**NA**	**$3,780,600**
Includes $8.7 million Gross ($3.1 million GF/GP) to provide a 10% rate increase for private duty nursing services for Medicaid recipients under the age of 21.	Federal	NA	2,481,200
	GF/GP	NA	$1,299,400
74. Tribal Pharmacy Reimbursement Increase	**Gross**	**NA**	**$17,000,000**
Includes $17.0 million federal to provide tribal health centers with a pharmacy reimbursement rate increase. The intent is to reimburse Native Americans' drug costs at the federal all-inclusive rate.	Federal	NA	17,000,000
	GF/GP	NA	$0
75. Nonemergency Medical Transportation (NEMT)	**Gross**	**$18,686,800**	**($1,165,800)**
Reflects a $1.2 million Gross ($400,700 GF/GP) reduction in NEMT contract costs. Contract with LogistiCare – which provides NEMT services to Macomb, Oakland, and Wayne Counties – was re-bid at a lower cost.	Federal	10,458,800	(765,100)
	GF/GP	$8,228,000	($400,700)
76. Skilled Nursing Facility PPE Grants – One-Time Funding	**Gross**	**$0**	**$20,000,000**
Includes $20.0 million of federal Coronavirus Relief Funds (CRF) for personal protection equipment (PPE) grants to be allocated to skilled nursing facilities on a per licensed bed basis. Sec. 1928 is related boilerplate.	Federal	0	20,000,000
	GF/GP	$0	$0
77. Michigan Health Information Network (MiHIN) – One-Time Funding	**Gross**	**$0**	**$2,750,000**
	GF/GP	$0	$2,750,000
Includes $2.8 million GF/GP to MiHIN for health information technology strategies for data management, data clean-up, and data governance.			
78. Access Health Actuarial Study – One-Time Funding	**Gross**	**$0**	**$275,000**
Includes $275,000 GF/GP to complete a federal section 1332 state innovation waiver actuarial analysis for community-based coverage entities to provide health coverage and educational and occupational training to individuals who qualify.	GF/GP	$0	$275,000
79. State Restricted Revenue Adjustments	**Gross**	**NA**	**$0**
Revises restricted revenues based on projected available revenue for a net reduction of $53.4 million, which is offset by a like amount of GF/GP. Revisions include:	Restricted	NA	(53,445,300)
	GF/GP	NA	$53,445,300
• Reducing Medicaid Benefits Trust Fund $33.0 million.			
• Reducing Merit Award Trust Fund $8.5 million.			
• Reducing Healthy Michigan Fund $4.7 million.			
• Removing Health Insurance Claims Assessment (HICA) fund balance $7.2 million.			

Major Budget Changes From FY 2019-20 YTD Appropriations		FY 2019-20 Year-to-Date (as of 2/6/20)	FY 2020-21 Conference Change
ONE-TIME APPROPRIATIONS			
80. Remove FY 2019-20 One-Time Appropriations	FTE	10.0	(10.0)
Removes one-time appropriations included in FY 2019-20. Any funding retained into FY 2020-21 is noted elsewhere.	**Gross**	**$253,882,900**	**($253,882,900)**
	Federal	166,790,800	(166,790,800)
	Restricted	100	(100)
	GF/GP	$87,092,000	($87,092,000)

Boilerplate Changes From FY 2019-20

GENERAL SECTIONS

Sec. 208. Legal Services of Attorney General – **NEW**
Prohibits the use of funds to hire a person to provide legal services that are the responsibility of the Attorney General, except for bonding activities and outside services authorized by the Attorney General.

Sec. 210. Contingency Fund Appropriations – **REVISED**
Appropriates federal, state restricted, local, and private contingency funds of up to $132 million total, available for expenditure when transferred to a line item through the legislative transfer process. Revises to reduce maximum amounts for federal and state restricted contingency appropriations for a total amount of up to $47 million.

Sec. 222. Notification and Report of Policy Changes – **REVISED**
Requires policy manual to be available on the DHHS website; and requires a report by April 1 on policy changes made to implement new acts. Revises to also require written notification to the legislature of any major policy changes at least 30 days before implementation.

Sec. 234. Receipt and Retention of Reports – **NEW**
Requires DHHS to receive and retain copies of all reports funded from the appropriations in part 1 and to follow federal and state guidelines for short-term and long-term retention of records.

Sec. 235. Reappropriation of Unexpended Federal Coronavirus Relief Funds – **NEW**
Requires that as of December 30, 2020 any unexpended coronavirus relief funds appropriated in part 1 be unappropriated and immediately reappropriated to the unemployment compensation fund to support 2020 costs.

Sec. 240. Use of Existing Work Project Authorization – **REVISED**
Prohibits expenditure of appropriations in cases where existing work project authorization is available for the same expenditures. Revises to add "to the extent possible by the department".

Sec. 253. Information Technology Investment Management and Board/Agile Software Development Plan – **REVISED**
Requires establishment of an information technology investment board within DHHS, provides guidance and policy for establishing management practices, and requires reports. Revises to require DHHS to implement an agile software development plan funded with a time and materials contract, and to establish the state or the public domain as the software owner. Software design shall be user centered. Requires report at commencement of project, and updates to the legislature upon request. Includes definitions of terms.

Sec. 257. Revise Education Modules Regarding Suicide and Depression Prevention – **DELETED**
Directs DHHS, if funds are available, to collaboratively revise education health modules to include age-appropriate and medically accurate information about depression and suicide and protective factors to prevent suicide.

Sec. 258. Education Initiatives Regarding Trauma, Human Trafficking, and Sexual Abuse Prevention – **NEW**
Directs DHHS to collaboratively promote and support school and education initiatives including training regarding use of trauma-informed practices and age-appropriate information about human trafficking and sexual abuse prevention.

Sec. 281. Certification of Destruction of Information from Canceled Contract – **NEW**
Requires DHHS by November 1 to provide certifications and affidavits of destruction of data related to an April 2020 contract with Great Lakes Community Engagement for coronavirus pandemic contact tracing, now canceled. Establishes that all Sec. 102 departmental administration appropriations are contingent on compliance with this section.

HEALTH AND HUMAN SERVICES

Boilerplate Changes From FY 2019-20

Sec. 293. Savings from Behavioral Health Integration Pilot Projects **– DELETED**
Requires that any savings from pilots to integrate Medicaid behavioral health and Medicaid physical health services systems shall only be used for reinvestment in the pilot sites where savings occurred; authorizes shared savings between a PIHP or CMHSP and a Medicaid health plan shall be carried forward for expenditures in future years.

DEPARTMENTAL ADMINISTRATION AND MANAGEMENT

Sec. 309. Health Literacy Pilot **– NEW**
Requires department to design and implement a web-based intensive information therapy within Medicaid managed care in order to mitigate deficiencies in health literacy through connections between health care providers, beneficiaries and health plans.

COMMUNITY SERVICES AND OUTREACH

Sec. 462. Trauma Recovery Center Pilots **– NEW**
Requires that if federal funding from Crime Victim Justice Assistance Grants becomes available, four trauma recovery center program pilot projects shall be funded; requires report.

CHILDREN'S SERVICES - CHILD WELFARE

Sec. 506. Juvenile Justice Data Report **– NEW**
Requires a report on containing juvenile justice data from Wayne County, including the number of youth referred for care or supervision and type of setting for referred youth.

Sec. 514. Child Protective Services (CPS) Report **– REVISED**
Requires report on CPS; lists specific information and statistics to be included in the report. Revised by including new subsection (d) requiring report to include statistical information on effectiveness of the category III open/close policy.

Sec. 532. Licensing and Contract Compliance Review **– DELETED**
Requires collaboration between DHHS and representatives of private child and family agencies to revise and improve contract compliance and licensing review processes; requires report.

Sec. 592. Child Protective Services Data **– NEW**
Requires DHHS to provide quarterly reports that include certain CPS data from the most recent 30-day period.

Sec. 593. County Child Abuse and Child Neglect Investigation and Interview Protocols **– NEW**
Requires DHHS to conduct an annual review in each county of whether the standard child abuse and child neglect investigation and interview protocols required by the Child Protection Law have been adopted; requires report.

JUVENILE JUSTICE

Sec. 710. Juvenile Justice Diversion Programs **– NEW**
Requires DHHS to create a workgroup on the use of juvenile justice diversion programs; requires report.

PUBLIC ASSISTANCE

Sec. 613. Indigent Burial Grants **– REVISED**
Provides for state emergency relief grants for indigent burials and the schedule of grant amounts. Revised to increase each payment classification by $40.00.

Sec. 619. Title IV-A and Food Assistance Exemption **– REVISED**
Exempts individuals convicted of a single drug felony after August 22, 1996 from the federal prohibition on receiving TANF and food assistance benefits; requires FIP benefits to be paid in restricted payments, or through a protective payee if possible, if the individual is the head of household; prohibits individuals convicted of 2 or more separate drug felonies from receiving assistance, subject to federal approval of this additional condition; and requires that FIP benefits be paid to the grantee if the grantee was not the individual with the conviction. Revises to remove the prohibition on individuals convicted of 2 or more separate drug felonies from receiving assistance.

Boilerplate Changes From FY 2019-20

FIELD OPERATIONS AND SUPPORT SERVICES

Sec. 801. Food Assistance Program Error Rate **– NEW**
Requires the department to report monthly to the Legislature on the active case FAP payment error rate as provided to the U.S. Department of Agriculture – Food and Nutrition Services; requires the department to report to the Legislature by March 1 on the corrective actions taken to mitigate FAP payment error rates and prevent federal penalties.

Sec. 825. Vehicle Repair Grants **– REVISED**
Prohibits the department from providing employment and training support services grants for vehicle repairs to not more than $500 to an individual in a 1-year period; allows to the department the discretion to provide grants of up to $900 in certain circumstances. Revises to require the department to report to the Legislature by November 30 on the total number of repairs; total repairs over $500; total repairs costing exactly $500; and total repairs costing exactly $900 in the previous fiscal year.

BEHAVIORAL HEALTH SERVICES

Sec. 924. Autism Services Fee Schedule **– REVISED**
Requires DHHS to maintain a fee schedule for autism services by not allowing expenditures used for actuarially sound rate certification to exceed the identified fee schedule, also sets behavioral technician fee schedule at not more than $55.00 per hour. Revises to also prohibit behavioral technician fee schedule to not be less than $50.00 per hour.

Sec. 927. Behavior Health Service Provider Audits **– REVISED**
Requires DHHS to determine the steps necessary to allow behavioral health service providers that operate in multiple counties to utilize a single audit rather than multiple audits, requires report. Revises to require DHHS to create a uniform community mental health services auditing process for CMHSPs and PIHPs, outlines auditing process requirements, and requires a report.

Sec. 960. Autism Services Cost Containment **– REVISED**
Requires DHHS to continue to cover all autism services that were covered on January 1, 2019; to restrain costs required DHHS to develop written guidance for standardization; and permits DHHS to require 6-month consultation if costs are above a monthly threshold, limits practitioners who can perform a diagnostic evaluation; provide fidelity reviews and secondary approvals, and prohibit specific providers from providing both evaluation and treatment; requires a report. Revises to require 3-year reevaluations, unless a clinician recommended an earlier reevaluation, requires evaluations performed by a master's level practitioner to be reviewed by a second practitioner, and require maintenance of statewide provider trainings.

Sec. 964. Behavioral Health Fee Schedule **– REVISED**
Requires DHHS to develop and implement a standardized fee schedule for Medicaid behavioral health services by January 1, and to develop and implement adequacy standards for all contracts with PIHPs and CMHSPs. Revises date to July 1 and requires development of fee schedule to prioritize and support essential service providers and to include a fee schedule for psychiatric intensive care (revenue code 0204).

Sec. 972. Michigan Crisis and Access Line (MiCAL) **– REVISED**
Allocates $2.0 million for the development, operation, and maintenance of a hotline consistent with section 165 of the Mental Health Code, MCL 330.1165. Revises to allocate up to $1.5 million and requires the psychiatric bed registry to be integrated into MiCAL.

Sec. 974. Intellectual or Developmental Disability Service Delivery **– REVISED**
Allows an individual with an intellectual or developmental disability who receives supports and services from a CMHSP to choose to instead receive supports and services from another provider. Revises to require instead of allow.

Sec. 994. National Accreditation Review Criteria for Behavioral Health Services **– DELETED**
Requires DHHS to seek, if necessary, a federal waiver to allow a CMHSP, PIHP, or subcontracting provider agency that is reviewed and accredited by a national accrediting entity for behavioral health care services to be in compliance with state program review and audit requirements; requires a report that lists each CMHSP, PIHP, and subcontracting provider agency that is considered in compliance with state requirements; requires DHHS to continue to comply with state and federal law to not initiate an action by negatively impacts beneficiary safety; defines "national accrediting entity."

Sec. 1006. Intellectual or Developmental Disability Health Homes **– NEW**
Requires DHHS to explore implementing Medicaid health homes for individuals with intellectual or developmental disabilities, and requires a report.

Boilerplate Changes From FY 2019-20

Sec. 1007. Standalone Intellectual or Developmental Disability Medicaid Delivery System **– NEW**
Requires DHHS to explore the feasibility of implementing a standalone Medicaid delivery system for individuals with intellectual or developmental disabilities, and requires a report.

Sec. 1011. Out-of-State Crisis Resolution and Outpatient Services **– NEW**
Allows a CMHSP to reimburse out-of-state providers of crisis resolution and outpatient services if the out-of-state provider is enrolled as a state Medicaid provider and the out-of-state provider is located closer to the client's home than an in-state provider.

Sec. 1013. Transportation to Preadmission Screening Units **– NEW**
Allows a CMHSP to permit a sheriff's office to use a qualified contracted entity to transport an individual for preadmission screening.

POPULATION HEALTH

Sec. 1144. State Innovation Model Federal Grant and CHIR Reporting **– REVISED**
Guidance for allocation of federal state innovation model grant, outcomes, performance measures, aggregated claims data, and reports. Strikes current language and revises to require DHHS to report trended cost and utilization claims data by Medicaid health plan and by community health innovation region (CHIR) from FY 2014-15 to date.

Sec. 1150. Opioid Fraud Collaboration **– DELETED**
Requires DHHS to coordinate with other state departments, law enforcement, and Medicaid health plans to reduce fraud related to opioid prescribing within Medicaid, and to address other drug and opioid abuse issues; requires a report.

Sec. ~~1350~~. 1183. Emergency Medical Services Data Exemption **– REVISED**
Prohibits DHHS from requiring a life support agency that does not charge for services to submit data to the Michigan emergency medical services information system or any other quality improvement program. Revises to limit the exemption from data submittal to medical first response services located in counties with less than 85,000 population, and outlines written reporting required by medical first responders to others arriving at a site of emergency services in those counties.

Sec. 1184. Emergency Medical Services - Process for Change in Guidance **– NEW**
Requires DHHS to review its process for consideration and implementation of changes proposed for EMS guidance or protocols; states improvements to be included; requires public website weekly updates of proposed changes including any proposed administrative rule changes, and requires a report.

Sec. 1319. Oral Health Screening and Assessment for School Children **– NEW**
States legislative intent that DHHS develop an oral health screening and assessment program for children entering school, and pursue alternative funding sources to aid in financing the program.

Sec. 1322. State Immunization Policy and Practices Report **– NEW**
Requires DHHS to report to the legislature on state immunization policy and practices including a list of recommended vaccinations, and basis, rationale, and improvement in human health documented for each listed vaccination.

Sec. 1340. National Brand Food Options as Approved WIC Food Items **– DELETED**
Requires the Women, Infants, and Children Special Supplemental Food and Nutrition program (WIC) to include national brand options for all food categories on the list of approved food basket items for WIC participant purchase.

MEDICAL SERVICES

Sec. 1501. Electronic Health Records Incentive Program **– REVISED**
Establishes unexpended funds for the electronic health records incentive program as a work project appropriation with the tentative completion date to be September 30, 2025. Revised to include intent that dental providers be included in the incentive program.

Sec. 1502. Nursing Facility Cost Report Policies **– DELETED**
Requires DHHS to use prospective effective dates if DHHS issues new policies affecting nursing facility cost reports, and allows a retroactive date if required by state law, federal law, or judicial ruling. Deleted.

Sec. 1512. Medicaid Utilization Report **– NEW**
Requires the department to update the Medicaid utilization and net cost report to separate nonclinical administrative costs from actual claims and encounters.

Boilerplate Changes From FY 2019-20

***Sec. 1513. Medicaid Inpatient Psychiatric Hospital Workgroup* – REVISED**
Requires DHHS to create a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care, list participating workgroup members, require a report from the workgroup. Revises to include workgroup recommendations being implemented as well as not implemented with identified implementation barriers.

***Sec. 1615. Encounter Claims Data Integrity* – NEW**
Requires the department to provide oversight of Medicaid claims encounter data to insure the integrity of actuarial rates; allows the department to request certain information from Medicaid health plans; and provides for the intent that the department conduct annual audits of Medicaid claims and provide for remedial actions to mitigate errors in actuarial rates.

***Sec. 1625. Medicaid Managed Care Pharmacy Benefits Managers* – REVISED**
Prohibits DHHS, beginning February 1, 2020, from entering into any contracts with a Medicaid managed care organization that relies on a pharmacy benefits manager that does not: 1) utilize a pharmacy reimbursement methodology of the National Average Drug Acquisition Cost plus a professional dispensing fee comparable to the Medicaid fee-for-service dispensing fees for pharmacies with not more than 7 retail outlets (and lists reimbursements when an ingredient does not have a National Average Drug Acquisition Cost listed); 2) reimburse for valid claims at the rate in effect at the time of original claim; 3) agree to transparent "pass-through" pricing, 4) agree to not create new fees or increase fees above inflation, and 5) agree to not terminate existing contracts for the sole reason of the additional professional dispensing fee. Revises to update beginning date to February 1, 2021.

***Sec. 1626. Pharmacy Benefits Manager Reimbursements Report* – NEW**
Requires all pharmacy benefits managers that receive reimbursements from Medicaid health plans to report to the department on total prescriptions dispensed; wholesale acquisition cost of each drug in the state formulary; aggregate rebates, discounts, and concessions; aggregate administrative fees; aggregate amounts that did not pass through Medicaid health plans; aggregate reimbursements paid to contracting pharmacies; requires the department to report the consolidated information to the Legislature by March 1; and requires non-aggregate information provided to the department to remain confidential.

***Sec. 1793. Medicaid Overpayment Standard of Promptness* – DELETED**
Prohibits DHHS from recovering an overpayment if DHHS notifies the provider more than 180 days after receipt of the overpayment. Deleted.

***Sec. 1803. Portable X-Ray and Ultrasound Provider Type* – REVISED**
Requires DHHS to establish Medicaid rules to allow for billing and reimbursement for transportation charges related to portable x-ray services and requires policies be effective October 1 of the current fiscal year. Revises to require the department to set payment rates for portable X-ray services by October 1.

***Sec. 1805. Graduate Medical Education Quality Data* – DELETED**
Requires hospitals receiving GME payments to submit quality data utilizing consensus-based nationally endorsed standards to be posted on a public website, lists specific quality reporting information, requires hospitals to also post quality data on the hospital's website, and requires DHHS to withhold 25% of a hospital's GME payment if data is not submitted by January 1. Deleted.

***Sec. 1870. MiDOCS Consortium* – REVISED**
Appropriates $3.75 million GF/GP and any restricted and any associated federal match to the MiDocs consortium to create new primary care residency slots in underserved communities, lists qualifying specialties; requires DHHS to seek any necessary federal CMS approvals; requires medical education loan repayments be contingent on 2-year commitment to practice in an underserved community post-residency; requires MiDocs to work with DHHS to, when possible, prioritize training opportunities in state psychiatric hospitals and CMHSPs; reserves at least 3 slots for the Michigan early primary care incentive program; reports report; creates an advisory council; establishes outcome and performance measures; and designates unexpended funds as work project appropriation. Revises to increase GF/GP appropriation from $3.75 million to $5.1 million; creates an exception for child and adolescent psychiatry fellowships; allow for local match from accredited organizations; allow for administration at the local-level for areas impacted by COVID-19 and a for a focus on psychiatric and child and maternal health disparities; and provide for the legislative intent of creating 5 additional slots for underserved areas.

HEALTH AND HUMAN SERVICES

Boilerplate Changes From FY 2019-20

Sec. 1875. Prior Authorization for Certain Drugs **– REVISED**
Applies prior authorization prohibition to DHHS and its contractual agents for psychotropic medications, drugs for the treatment of HIV or AIDS, epilepsy/seizure disorder, or drugs for organ transplant therapy, if those drugs were either carved out or not subject to prior authorization procedures as of May 9, 2016, defines "prior authorization". Revises to require the department to explore the inclusion of drugs to treat Duchenne Muscular Dystrophy.

Sec. 1876. Common Formulary **– NEW**
Requires DHHS to include the corticosteroid deflazacort on the Medicaid health plan common formulary.

Sec. 1879. Single Preferred Drug List **– NEW**
Requires DHHS to maintain a standard preferred drug list for Medicaid manage care, requires any changes in the preferred drug list to made in consultation with the Medicaid managed care organizations and the Pharmacy and Therapeutics Committee. Requires a report.

Sec. 1880. Single Preferred Drug List Report and Rate Setting **– NEW**
Requires DHHS to submit a report on estimated and actual expenditures and savings incurred from the single preferred drug list, requires DHHS to make any relevant adjustments to the rates to Medicaid managed care organizations to occur outside of the May caseload consensus.

Sec. 1881. Risk Corridor Financial Reconciliation **– NEW**
Identifies savings assumptions from the 2-way risk corridor for Medicaid managed care organizations, requires a report and requires DHHS to make any relevant adjustments to the rates to Medicaid managed care organizations to occur outside of the May caseload consensus, and states intent that a 2-way risk corridor will not be in effect next fiscal year.

INFORMATION TECHNOLOGY

Sec. 1909. Information Technology Spending Restrictions **– REVISED**
Restricts the department from expending funds appropriated for major information technology programs on any other program or project and requires a legislative transfer of appropriations from the Information Technology Contingency and One-Time Information Technology Contingency line items to another line item before those funds may be expended. Revises to remove Information Technology Contingency restrictions; and provides for the requirements on replacing MiSACWIS with the new CCWIS information technology system, and requires the department to use the agile development methodology of IT development and comply with the Enterprise Portfolio Management Office process and quality assurance.

Fiscal year 2020(October 1, 2019- September 30, 2020) SWMBH Participant Community Mental Health Site Review Summary Results

Subcontractual Relationships & Delegation

- PIHPs remain ultimately responsible for adhering to and complying with the terms of their contract with the State;
- All contracts between the PIHP and a subcontractor must be in writing and specify:
  - Any delegated activities or obligations, and related reporting responsibilities;
  - That the subcontractor agrees to perform the delegated activities in compliance with the PIHP's contract obligations;
  - A method for revocation of the delegation of activities or obligations, or specify other remedies in instances where the PIHP determines that the subcontractor has not performed satisfactorily;
  - That the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and contract provisions.

- XV. The PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which is has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of it subcontractors.

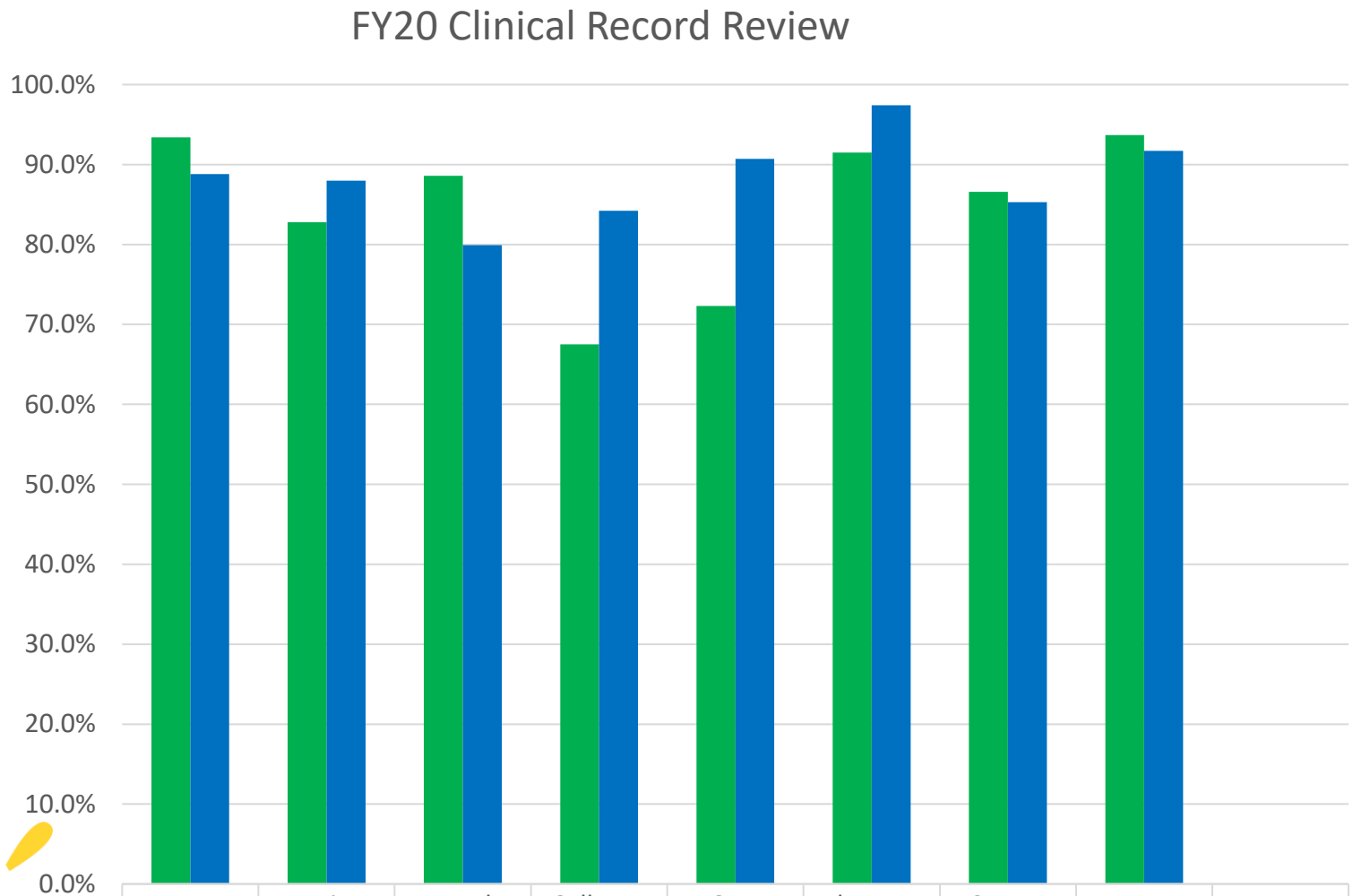
Subcontractual Relationships & Delegation

CMHSP Site Review Process

- Any functions that are not in full compliance with MDHHS, 42 CFR § 438 (Managed Care), and SWMBH requirements require corrective action plans to be submitted by the participant CMHSP and approved by SWMBH

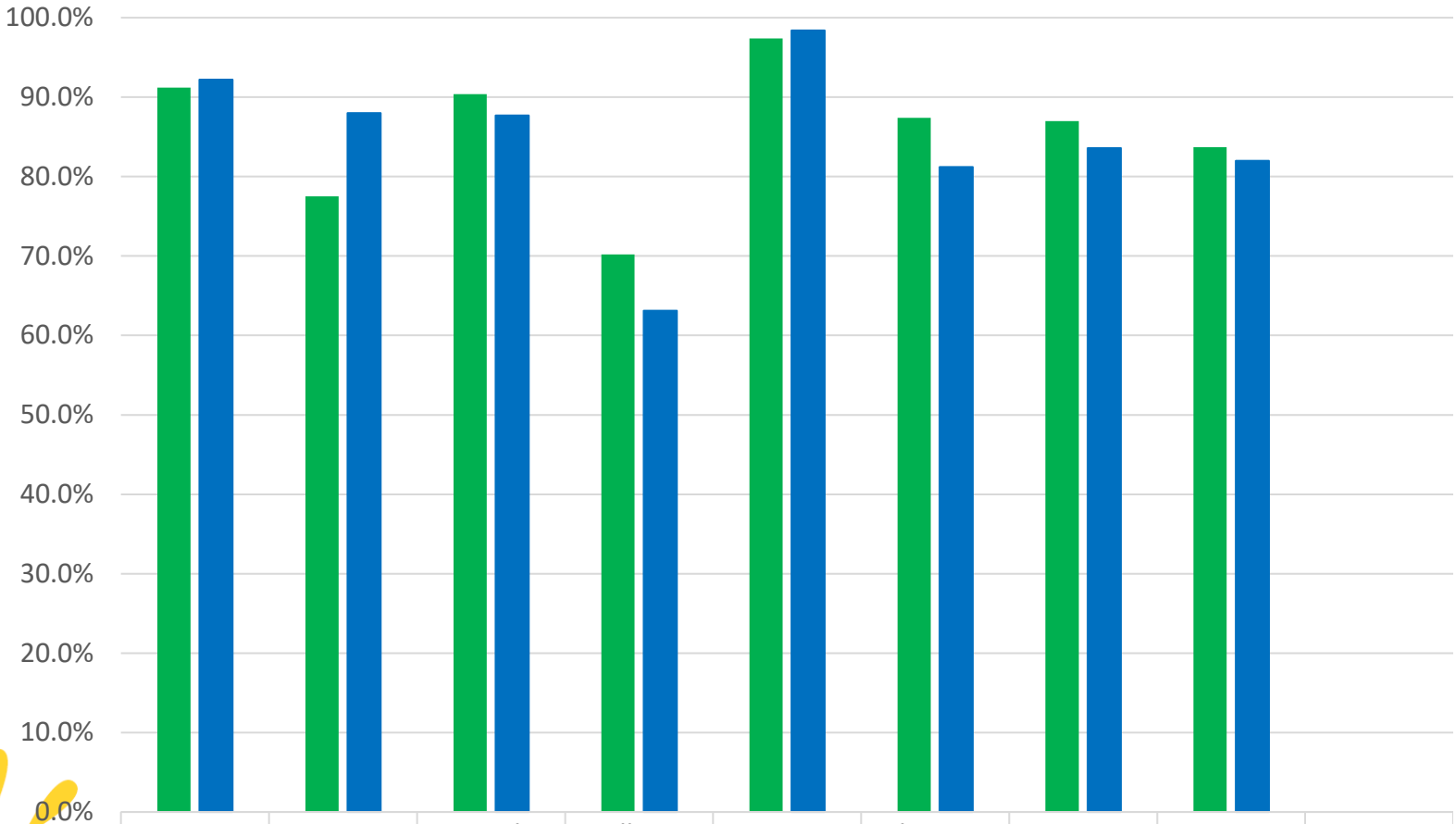
- Clinical requirements not meeting 90% compliance require corrective action plans

Clinical Record Review
Overall Scores by CMHSP



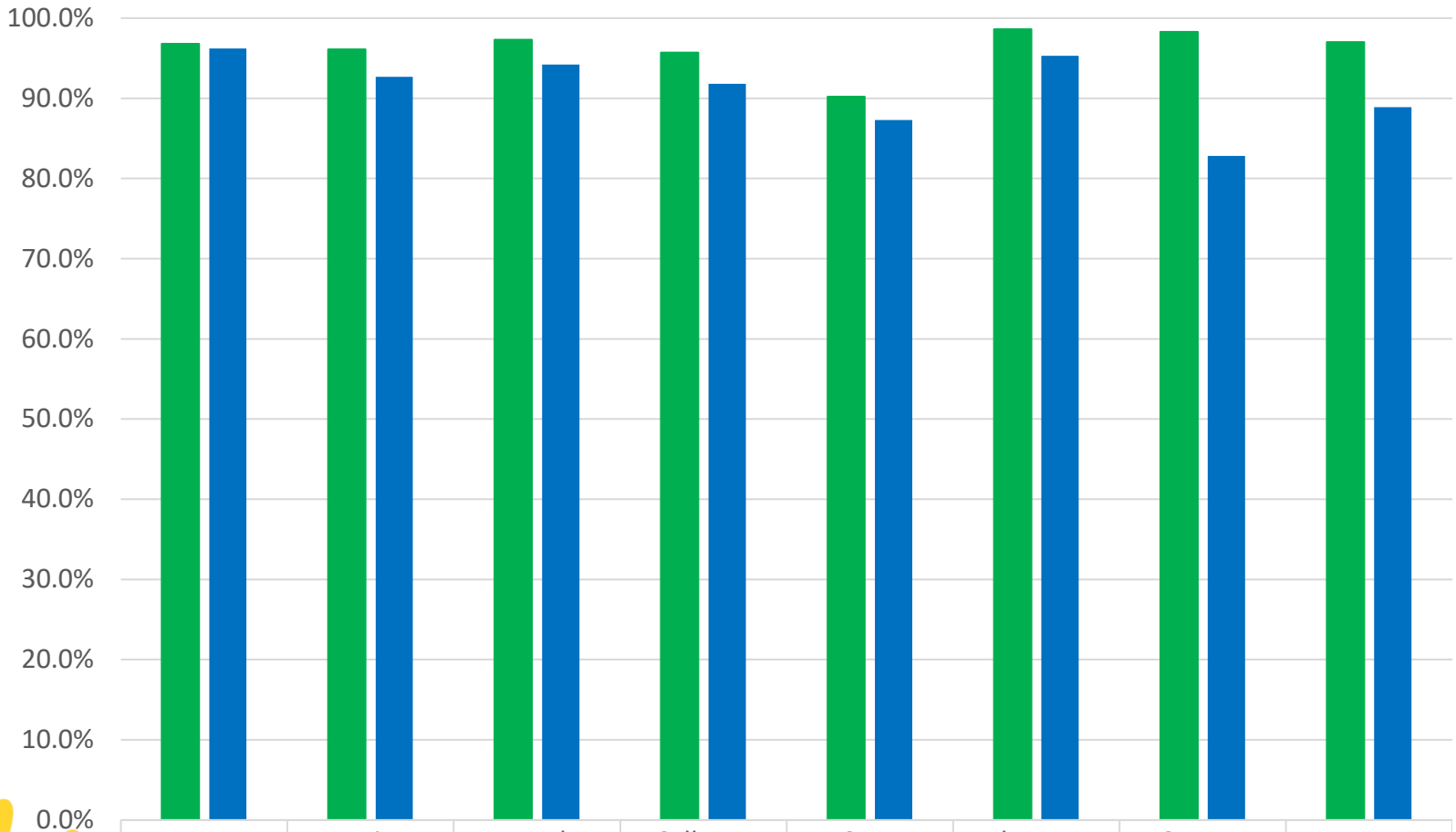
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY20	93.4%	82.8%	88.6%	67.5%	72.3%	91.5%	86.6%	93.7%
Overall Score FY19	88.8%	88.0%	79.9%	84.2%	90.7%	97.4%	85.3%	91.7%

SUD Clinical Record Review Overall Scores by CMHSP



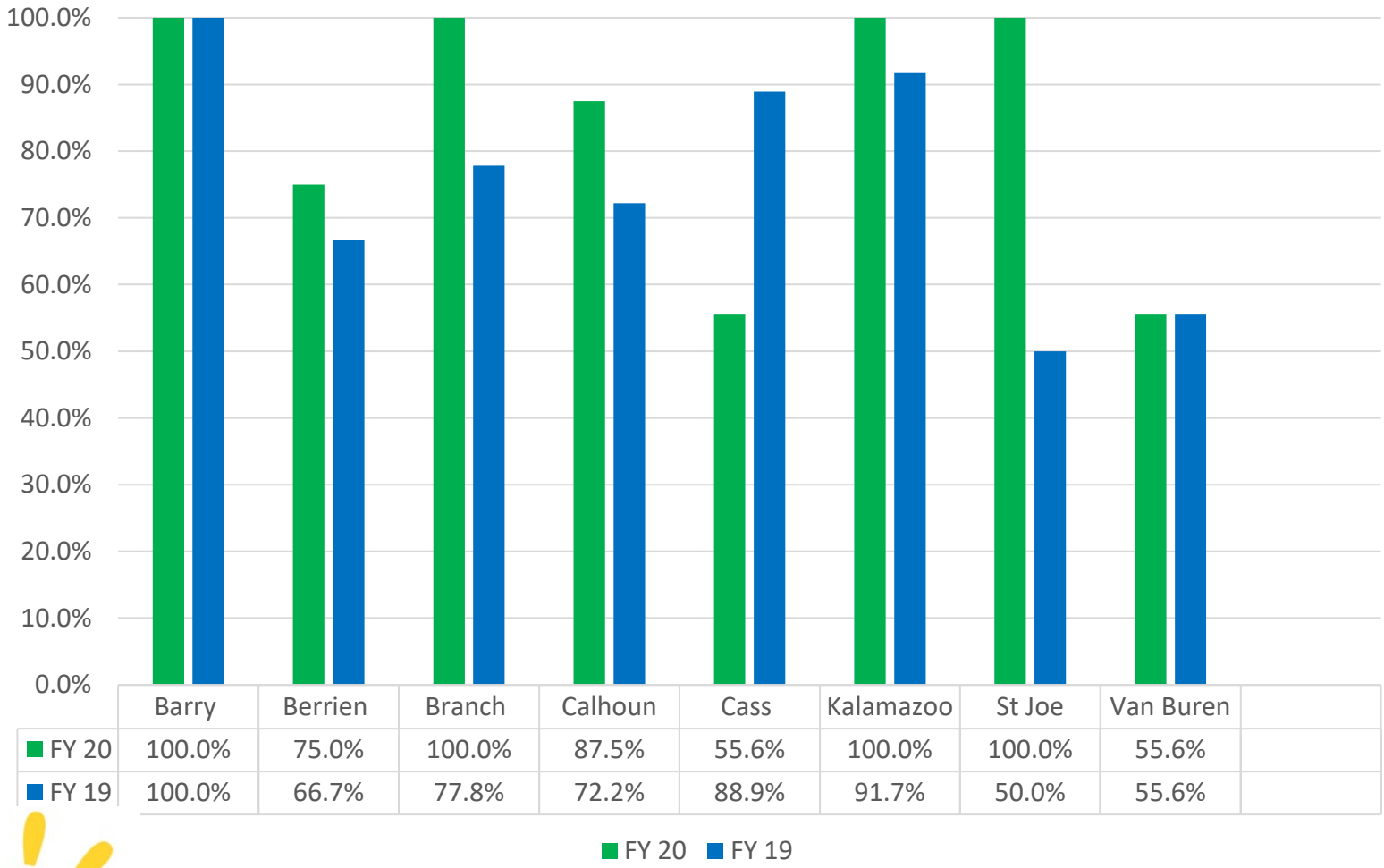
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY20	91.2%	77.5%	90.4%	70.2%	97.4%	87.4%	87.0%	83.7%
Overall Score FY19	92.2%	88.0%	87.7%	63.1%	98.4%	81.2%	83.6%	82.0%

Delegated / Administrative Function Review Overall Scores by CMHSP



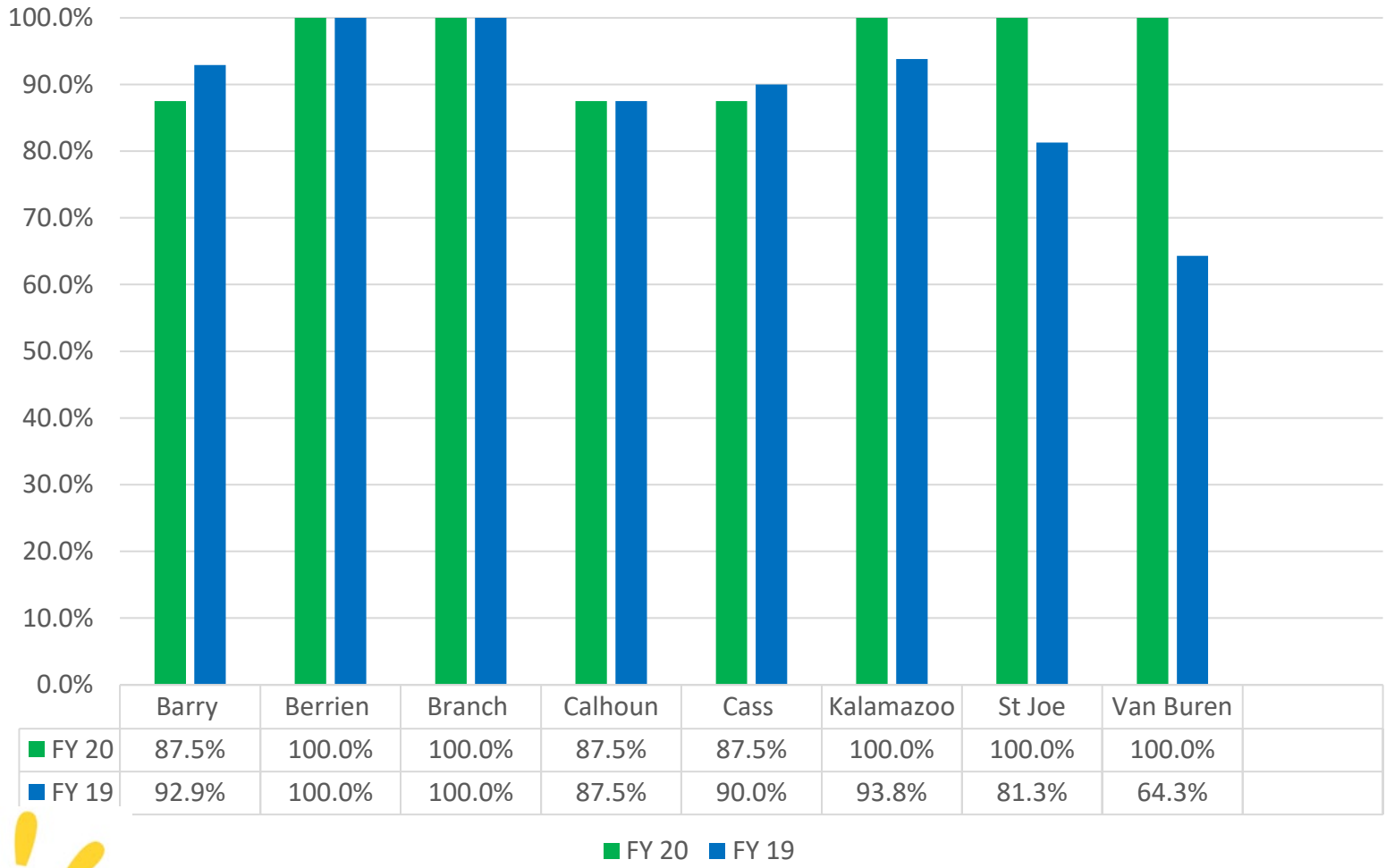
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY20	96.8%	96.1%	97.3%	95.7%	90.2%	98.6%	98.3%	97.0%
Overall Score FY19	96.2%	92.7%	94.2%	91.8%	87.3%	95.3%	82.8%	88.9%

CMHSP Oversight and Monitoring: Utilization Management and Access



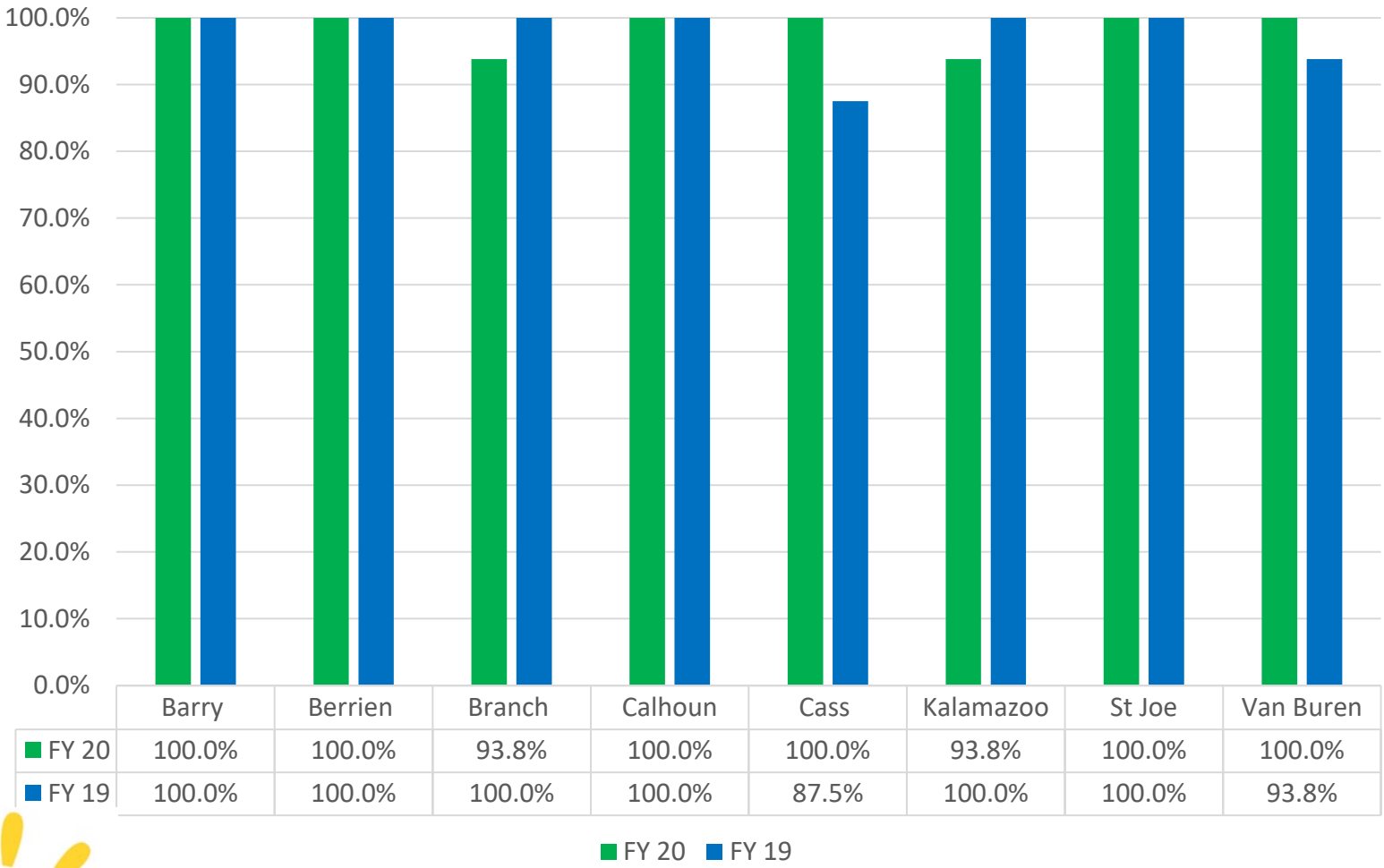
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	75.0%	100.0%	87.5%	55.6%	100.0%	100.0%	55.6%
FY 19	100.0%	66.7%	77.8%	72.2%	88.9%	91.7%	50.0%	55.6%

CMHSP Oversight and Monitoring Claims



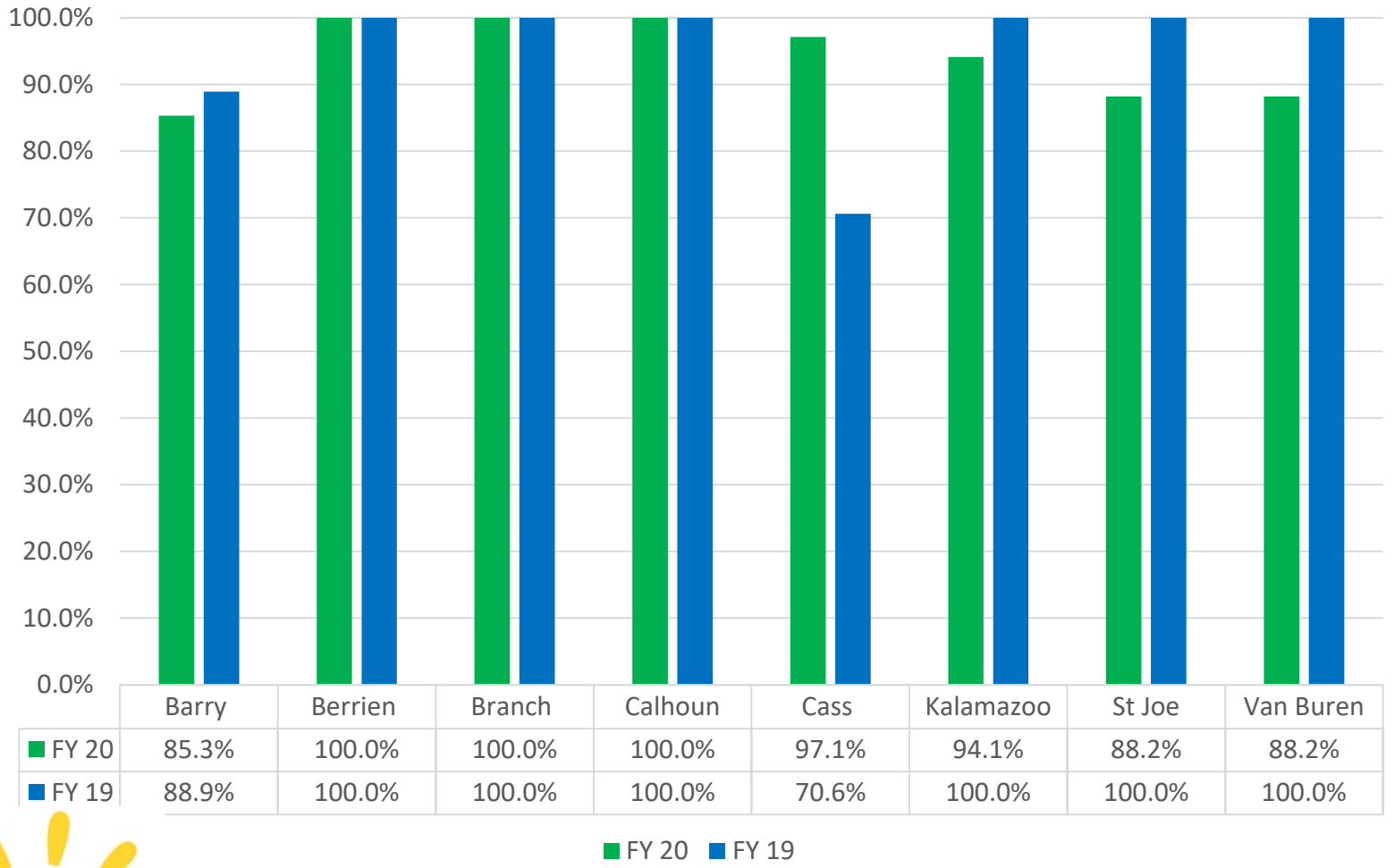
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	87.5%	100.0%	100.0%	87.5%	87.5%	100.0%	100.0%	100.0%
FY 19	92.9%	100.0%	100.0%	87.5%	90.0%	93.8%	81.3%	64.3%

CMHSP Oversight and Monitoring Compliance Program



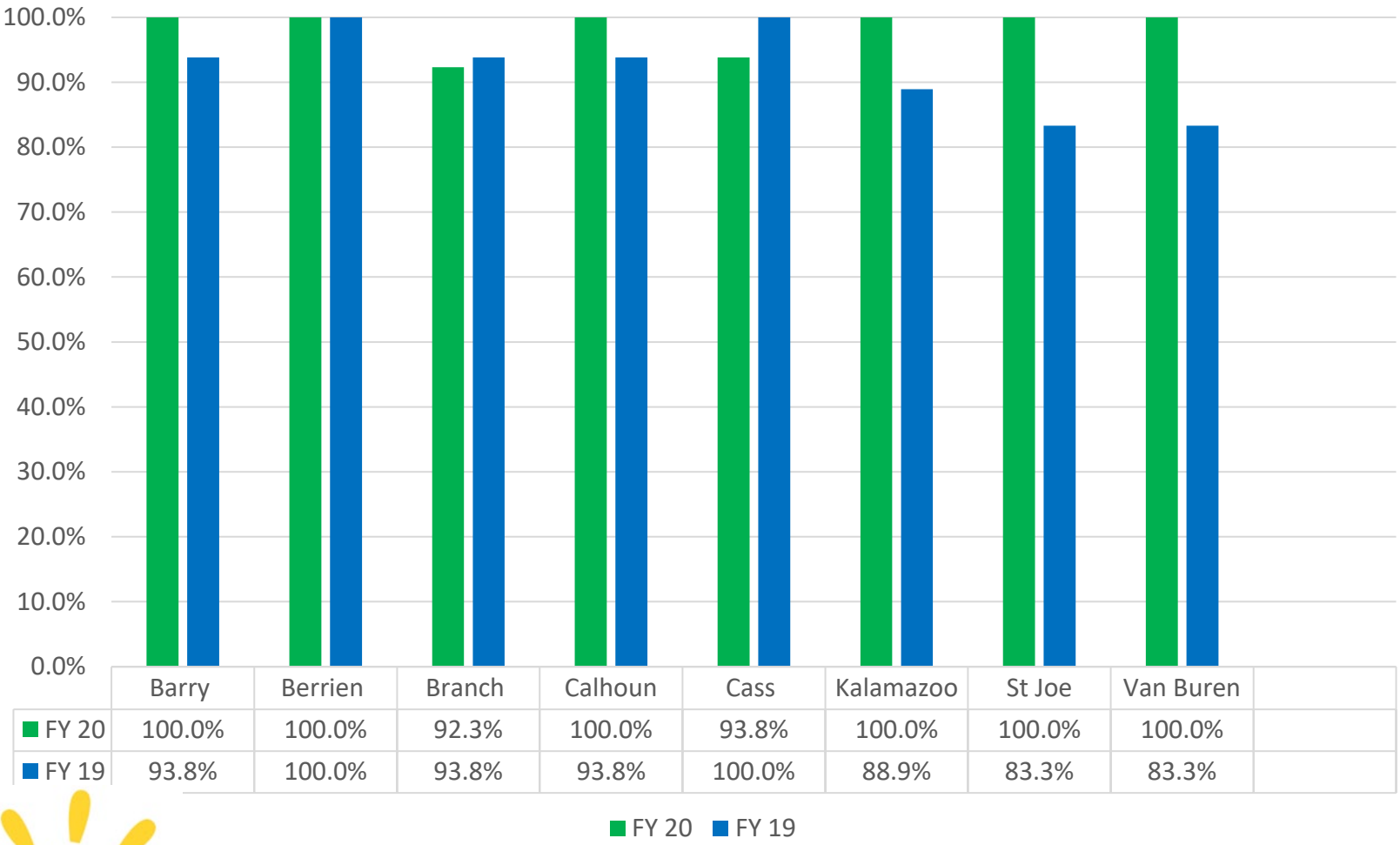
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	100.0%	93.8%	100.0%	100.0%	93.8%	100.0%	100.0%
FY 19	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	93.8%

CMHSP Oversight and Monitoring Credentialing



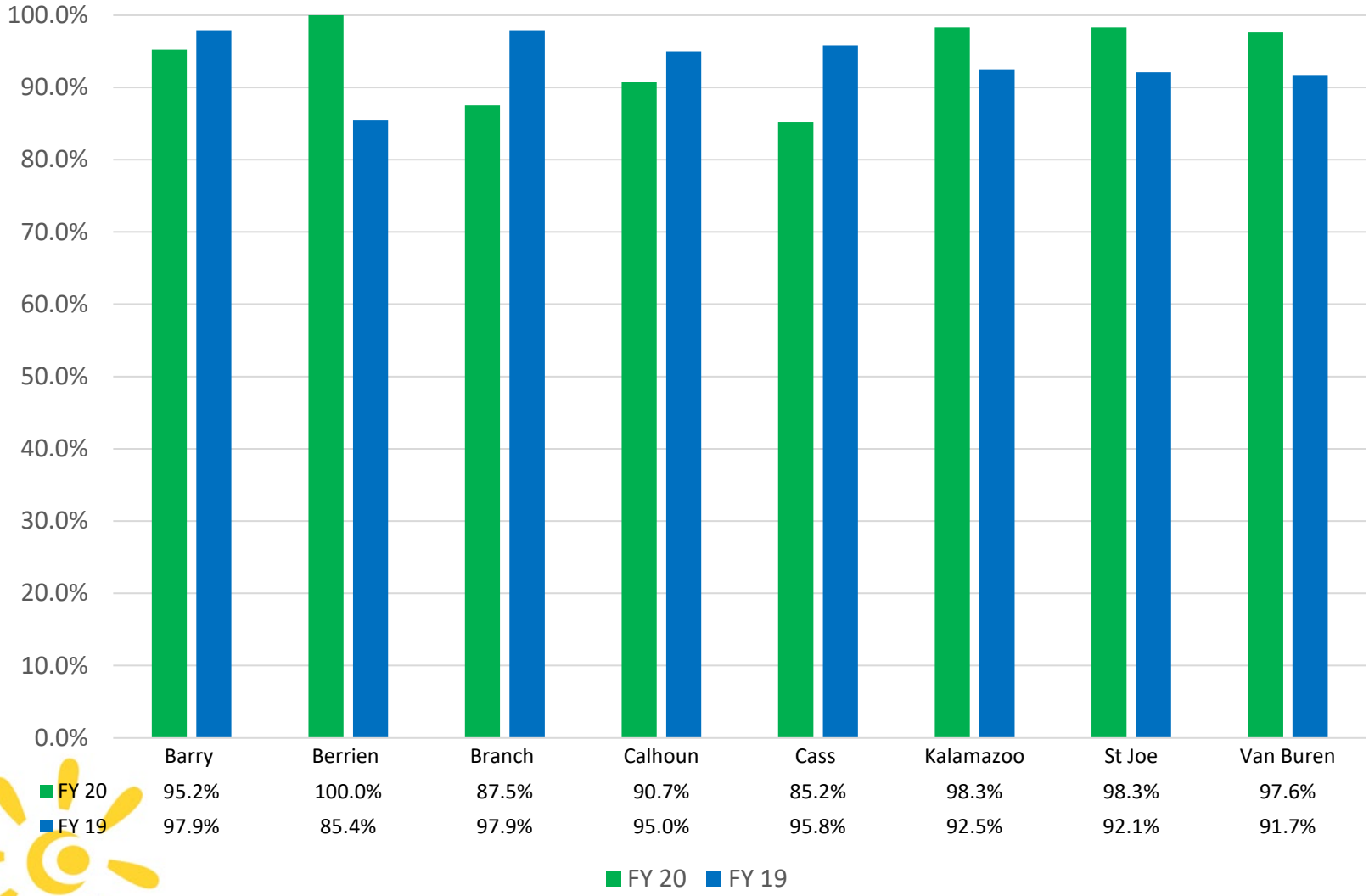
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	85.3%	100.0%	100.0%	100.0%	97.1%	94.1%	88.2%	88.2%
FY 19	88.9%	100.0%	100.0%	100.0%	70.6%	100.0%	100.0%	100.0%

CMHSP Oversight and Monitoring Customer Services

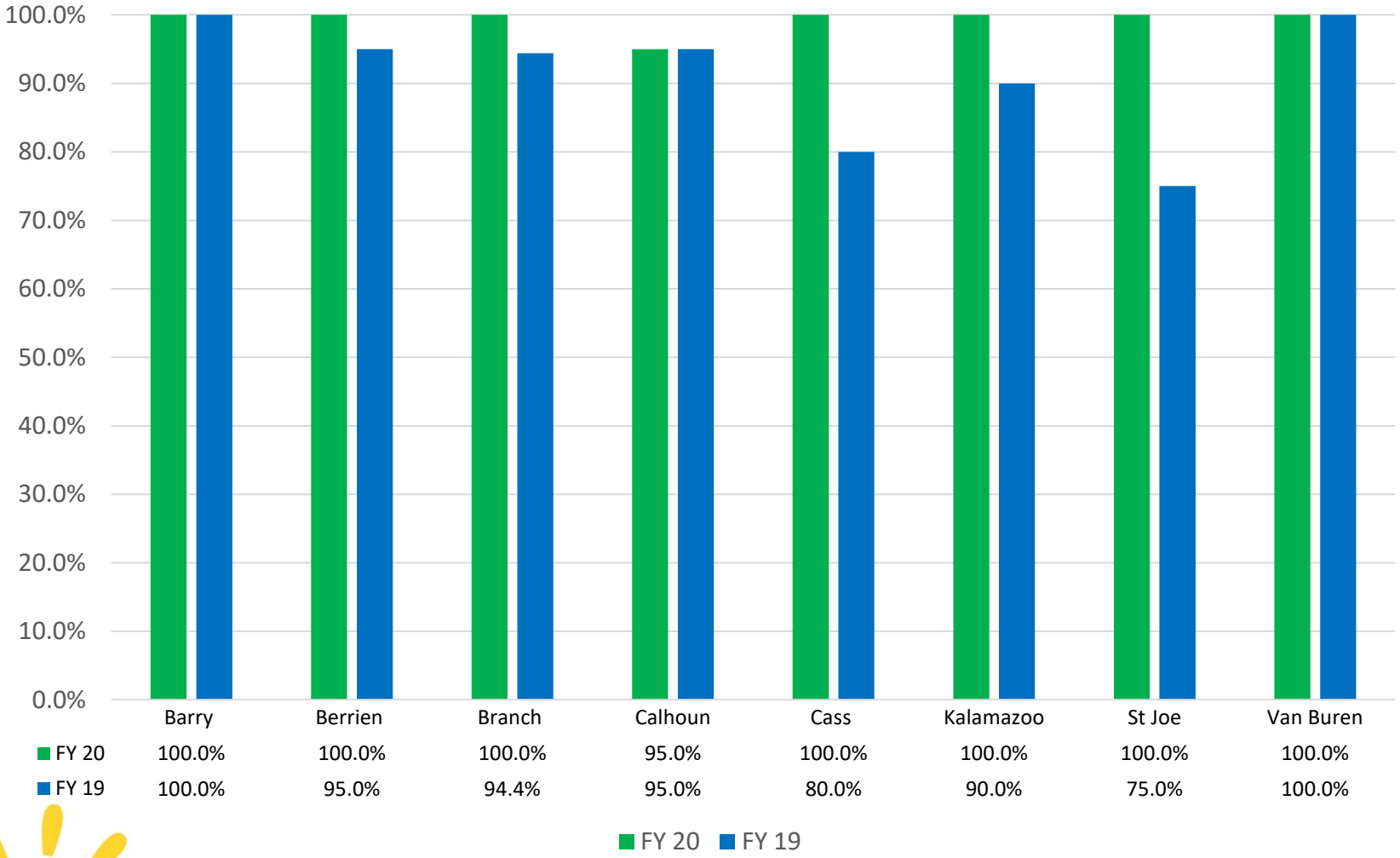


	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	100.0%	92.3%	100.0%	93.8%	100.0%	100.0%	100.0%
FY 19	93.8%	100.0%	93.8%	93.8%	100.0%	88.9%	83.3%	83.3%

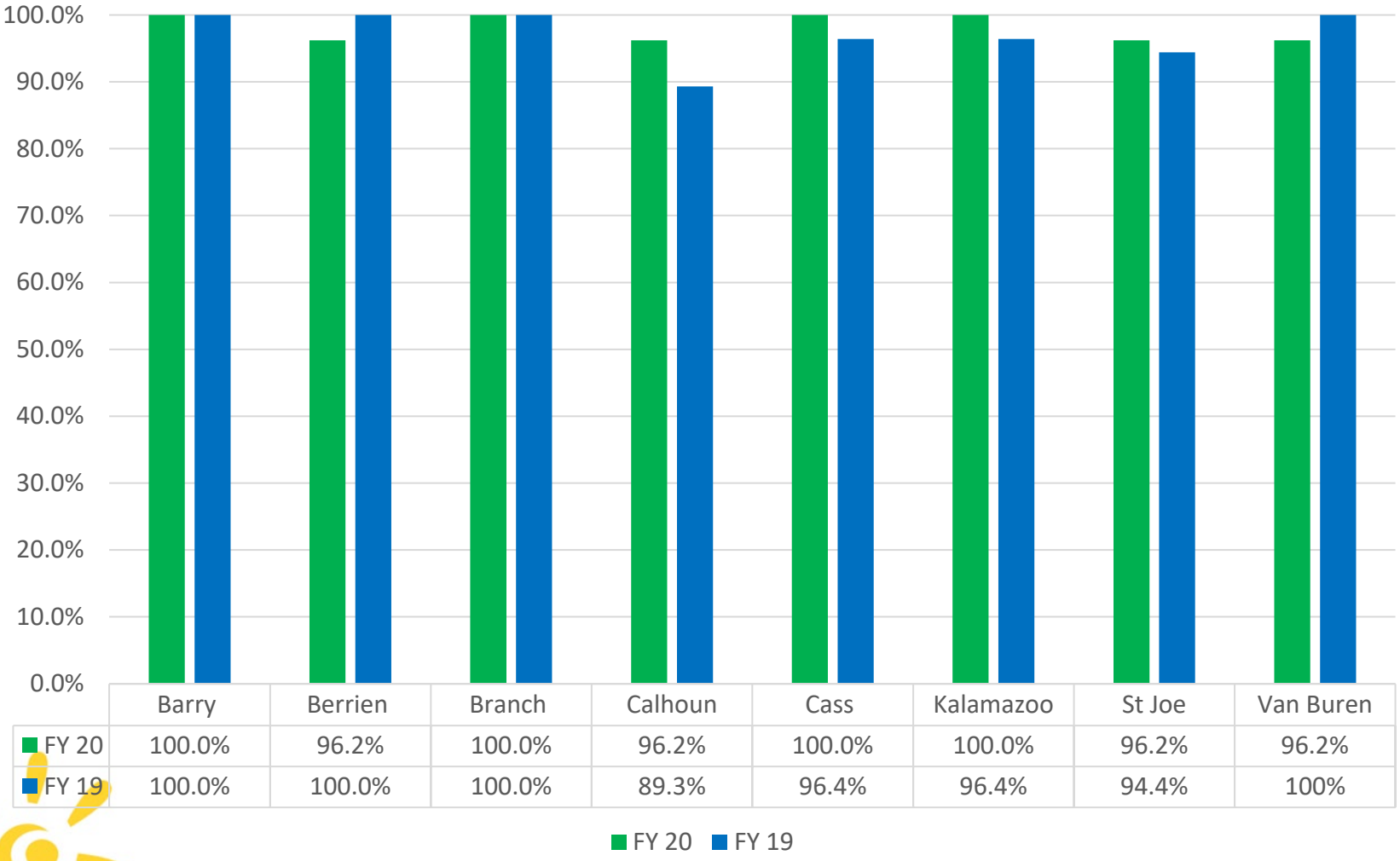
CMHSP Oversight and Monitoring Grievances and Appeals



CMHSP Oversight and Monitoring Provider Network

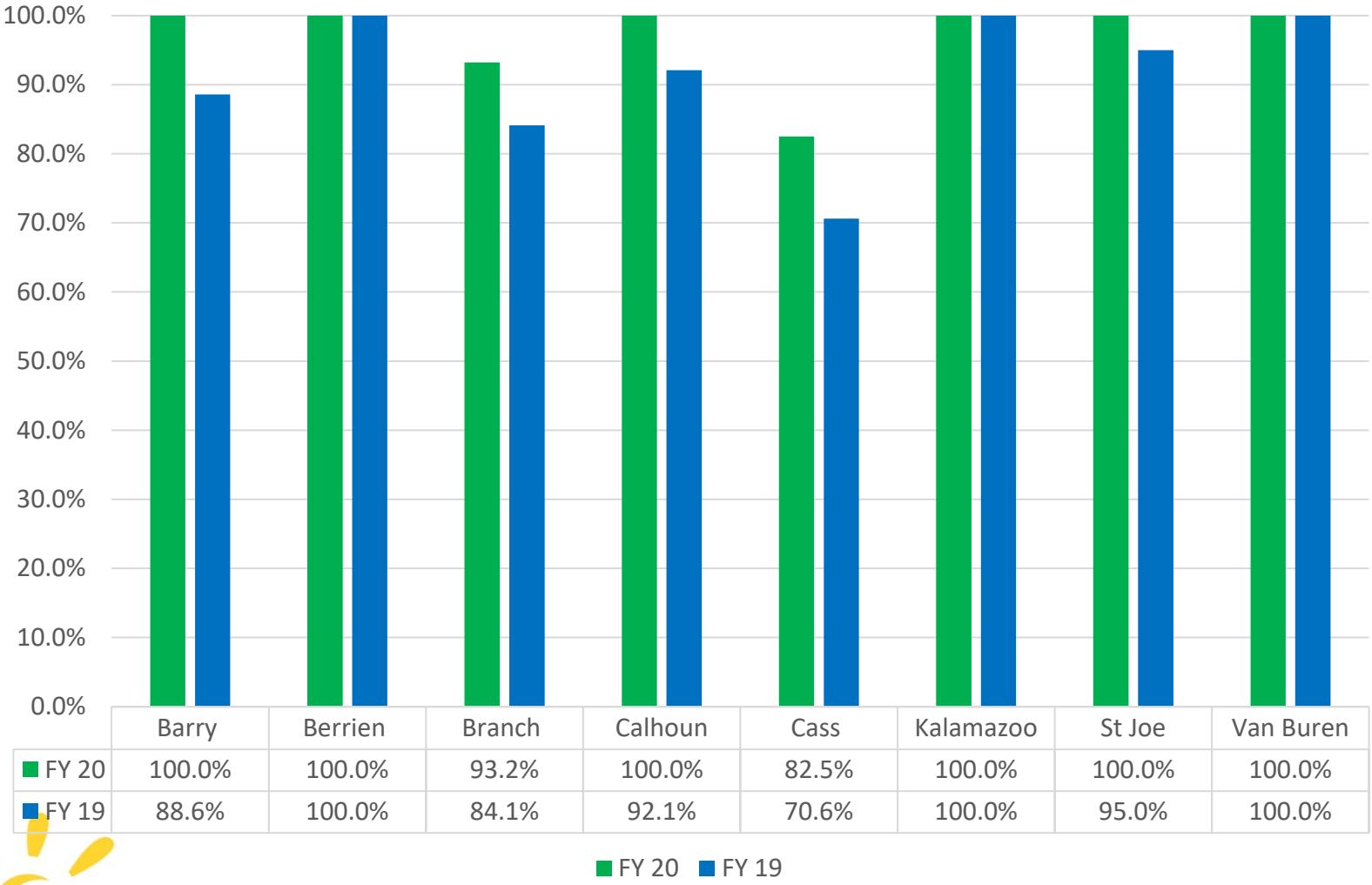


CMHSP Oversight and monitoring Quality Improvement



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	96.2%	100.0%	96.2%	100.0%	100.0%	96.2%	96.2%
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100%

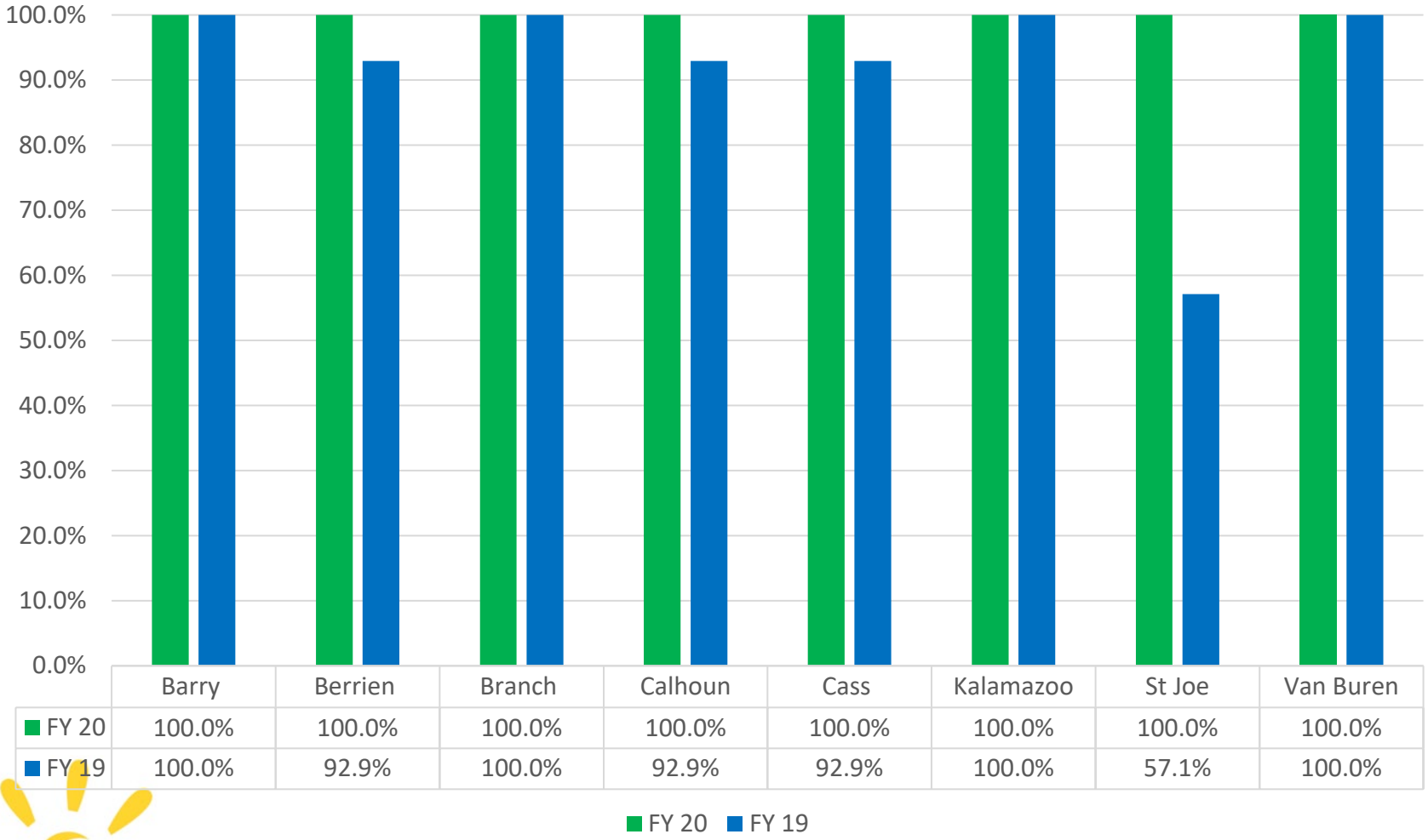
CMHSP Oversight and Monitoring Staff Training



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	100.0%	93.2%	100.0%	82.5%	100.0%	100.0%	100.0%
FY 19	88.6%	100.0%	84.1%	92.1%	70.6%	100.0%	95.0%	100.0%

100

CMHSP Oversight and Monitoring SUD Administrative



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FY 19	100.0%	92.9%	100.0%	92.9%	92.9%	100.0%	57.1%	100.0%

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

BOARD OF DIRECTORS REPORT
JUNE 2020

PROVIDED BY:

OPEN SYSTEMS TECHNOLOGIES

An Information Technology Security Assessment was conducted for Southwest Michigan Behavioral Health on the 17th of June 2020. This report summarizes the ratings and recommendations related to this assessment.

Seventy-Eight (78) network devices were comprehensively scanned using a variety of tools. The team has determined that 0 high/critical vulnerabilities exist within the SWMBH network environment. A weighted vulnerability index of 0.000 has been assigned and a determination has been made that the exploitability related to the reported vulnerabilities is “Elevated”.

OST has provided the organization with detailed recommendations and information on how to reduce the risks that were identified from this assessment process.

Overall, SWMBH has been assigned a security rating of 7.3. A potential rating of 8.5 is possible. Improvements to the Final Security Rating will occur as IT related risk is removed from the organization.

A Periodic Security Assessment is scheduled for June 2021.

Sincerely,

W. Scott Montgomery
Security Practice Manager
Open Systems Technologies

INFORMATION TECHNOLOGY SECURITY ASSESSMENT

JUNE 2020

FINDINGS AND RECOMMENDATIONS

1

Southwest Michigan Behavioral Health

Presentation Agenda

- Findings and Recommendations
- Discussion
- Information Technology Security Assessment Project Sign-off

2

Findings and Recommendations

This presentation provides a summary of the activity that was performed as part of the Information Technology Security Assessment.

Specific technical details have purposely been left out of this presentation.

Please refer to the accompanying USB Flash Drive for all detail related to the information presented here.

3

Acknowledgements

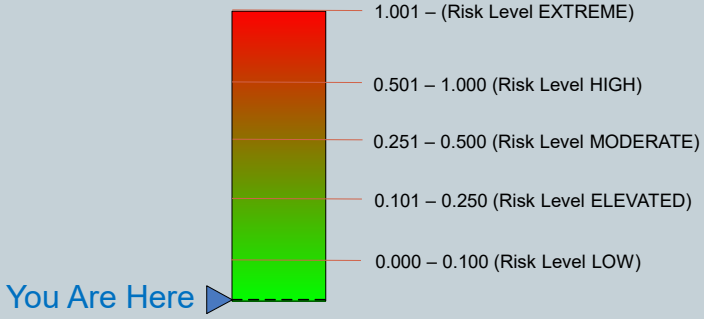
- Solid firewall protection.
- Low vulnerability index.

4

Findings and Recommendations

0 High/Critical Vulnerabilities identified on 70 IP Addresses

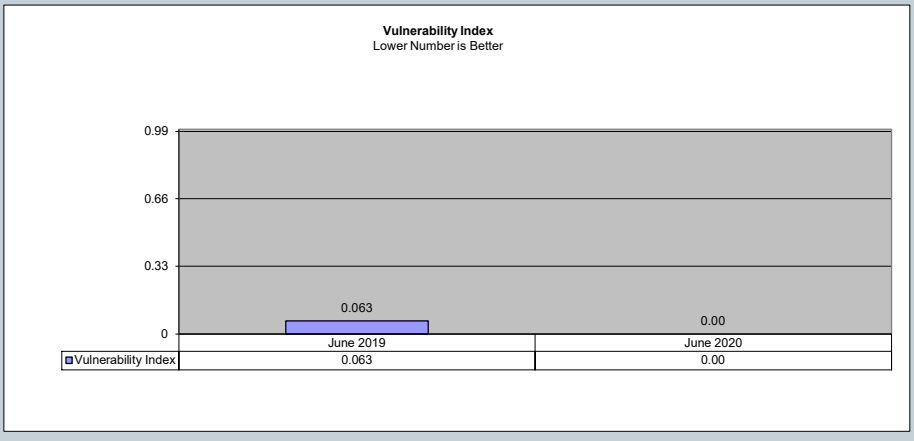
Vulnerability Index = 0.000



5

Findings and Recommendations

Vulnerability Index History



6

Findings and Recommendations

Security Issues

- Guest wifi network is not isolated from the production network environment.
- Authenticated scanning reports some missing updates (Oracle Java, Adobe Flash, etc.)

7

Findings and Recommendations

Physical Security Issues

Physical security is risk has been assigned a rating of Low.

8

Findings and Recommendations

Virus Protection

Antivirus was detected and up-to-date on each system.

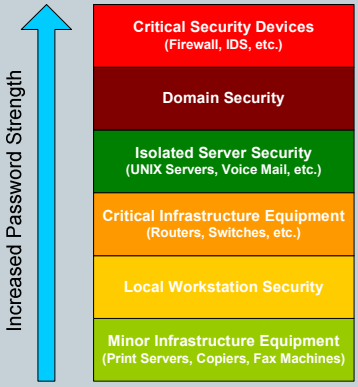
9

Findings and Recommendations

Classification

Provide unique passwords at all security levels within an enterprise.

Strong passwords should be used at all levels, but should also increase in complexity as the device(s) becomes more critical to overall security.



10

Findings and Recommendations

SpyWare

Spyware (Malware) protection: Workstations with internet access are prone to spyware infection. Spyware is quickly becoming a serious issue and is difficult to block. Spyware detection and removal tools are necessary to reduce the risk from this new threat.

Spyware can cause a wide variety of issues from slow, sluggish computer operation to key-logging.

Antivirus installation is working to reduce this security threat by blocking and detecting many SpyWare variants.

11

Findings and Recommendations

External Exposure

The external vulnerability scanning and penetration testing processes did not identify any high or critical security issues.

12

Findings and Recommendations

System/Software Updates

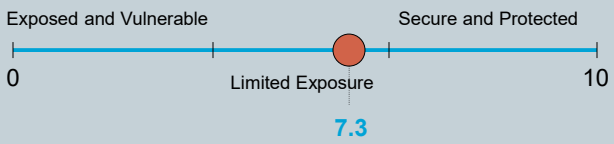
Organizations should ensure that all operating systems, applications, and network devices are up-to-date and supported by the vendor.

100% of reviewed workstations and servers are running supported versions of their operating systems.

13

Final Security Rating

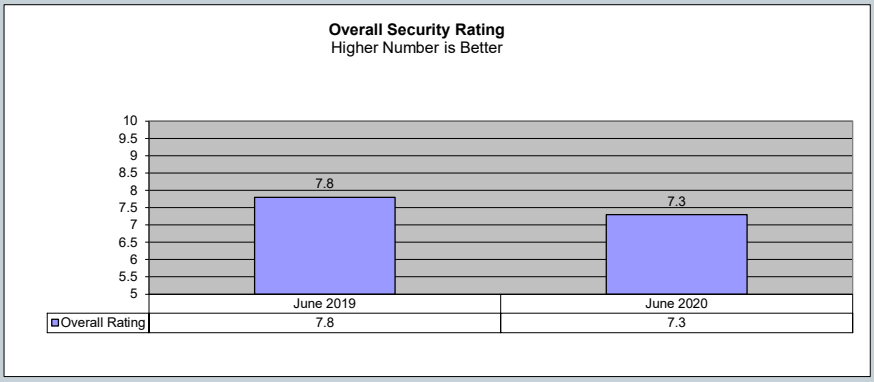
Final Security Rating



14

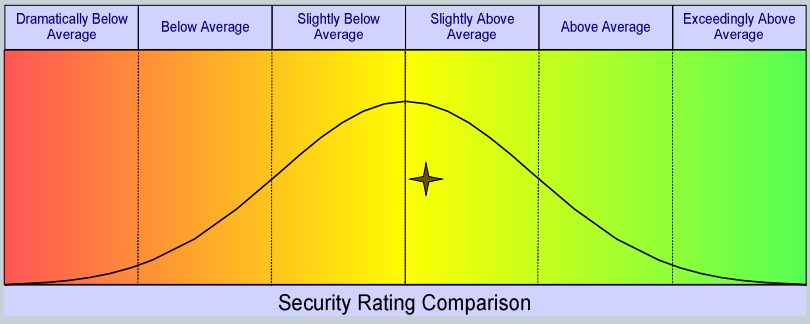
Final Security Rating

Final Security Rating History



15

Statistical Distribution



When compared to the overall security of similar organizations, you are rated Slightly Above Average.

16

Potential Security Rating

Final Network Security Rating can be increased upon implementation of recommendations shown on the next slide.

17

Recommendations (Prioritized)

- Isolate the Guest wifi network from the production network environment. Provide access to the internet only.
- Implement content filtering for all networks.
- Harden Microsoft Servers by removing un-necessary application software. Specifically software reporting vulnerabilities and missing updates/patches (Oracle Java, Adobe, etc.)
- Update third party application software on workstations. Primarily Adobe Flash and Oracle Java. Review detailed scanning reports for all update requirements.

18

Recommendations (Advisable)

- A Periodic Security Assessment is scheduled for June 2021.

Optimum security can be achieved by implementing these recommendations.

19

Discussion

20

Project Sign-Off

- Sign-Off document provides authorization for OST to close this project.
- Communicates satisfaction with project deliverables.

21

Conclusion

- Next steps?....

Thank You

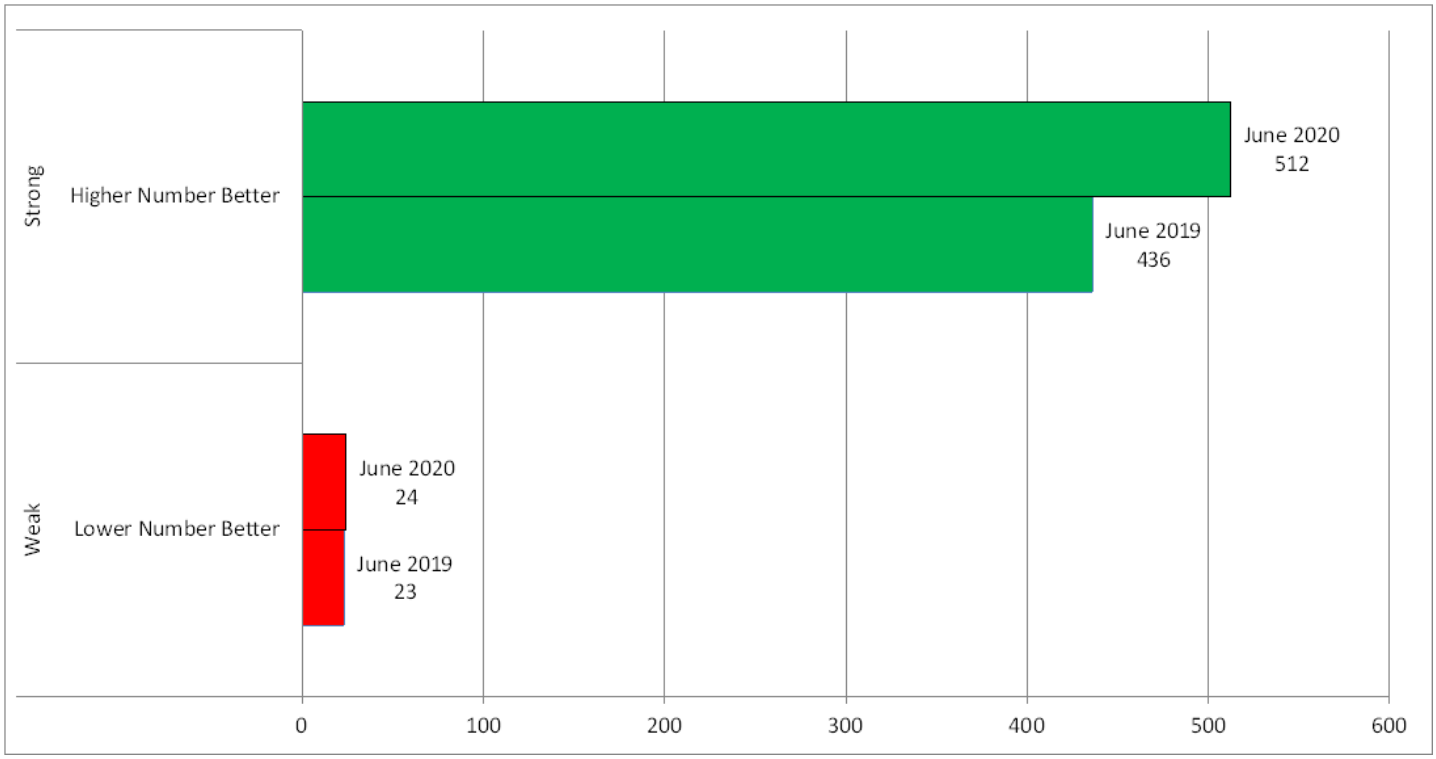
22

The following ratings have been assigned to the organization based on the information gathered and analyzed during this assessment process.

Domain Password Strength

Security Risk Level Low

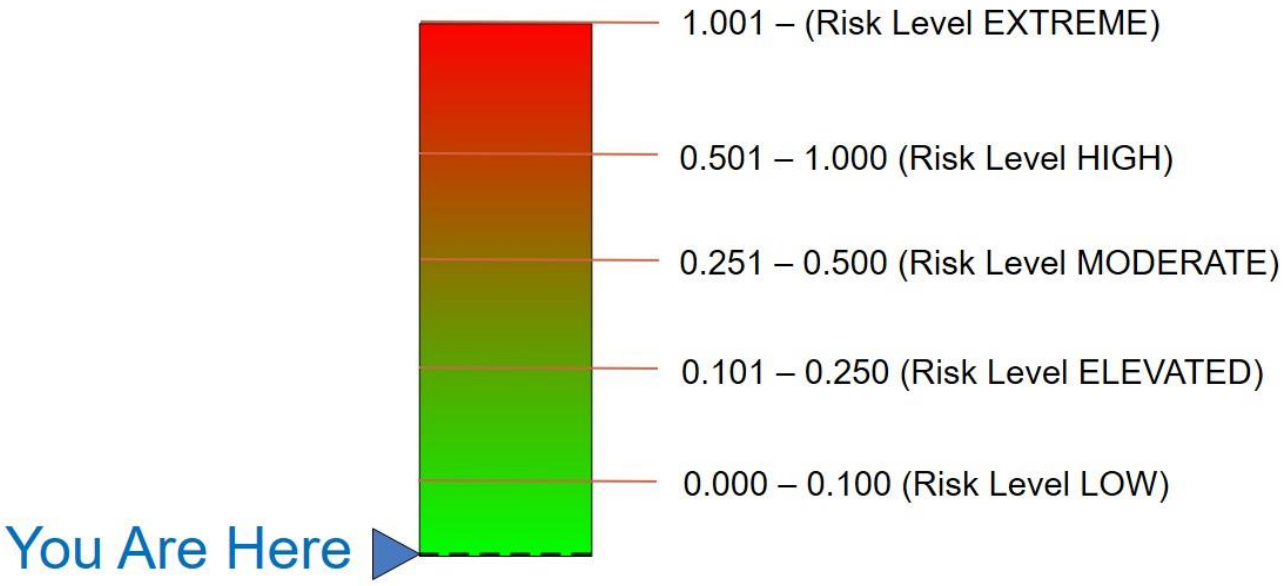
Password Strength History



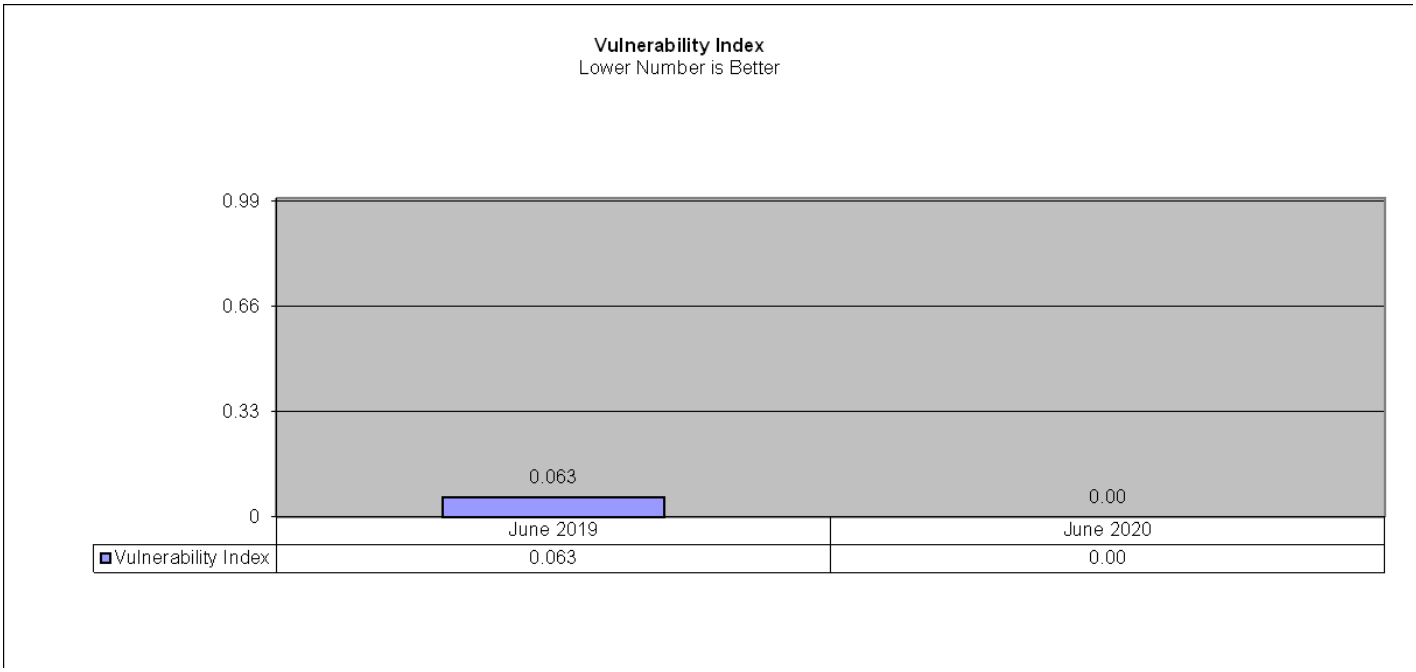
Physical Security

Security Risk Level Low

System Vulnerability Index (Current 0.000)



System Vulnerability Index History



Exploitability

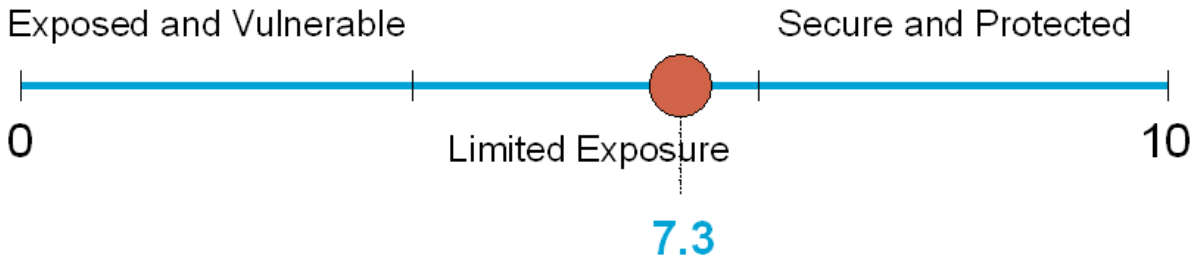
Wireless Networking Risk

Security Risk Level Moderate

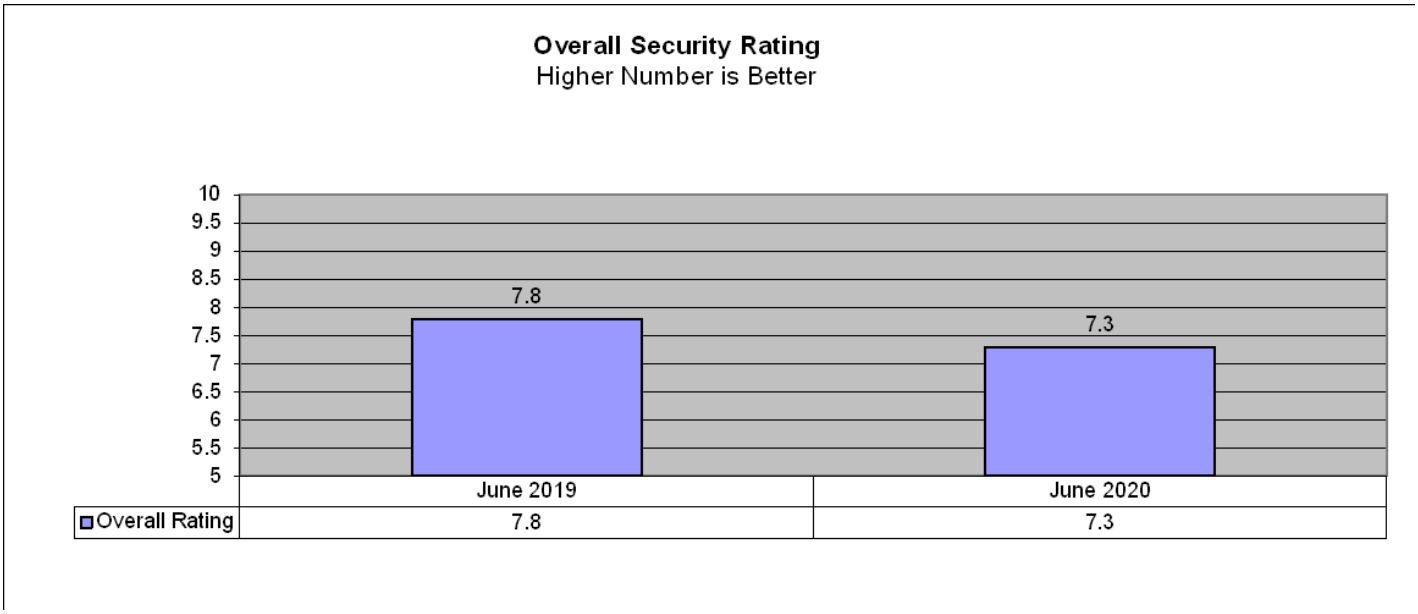
MalWare/Zero Day Virus Risk

Security Risk Level Elevated

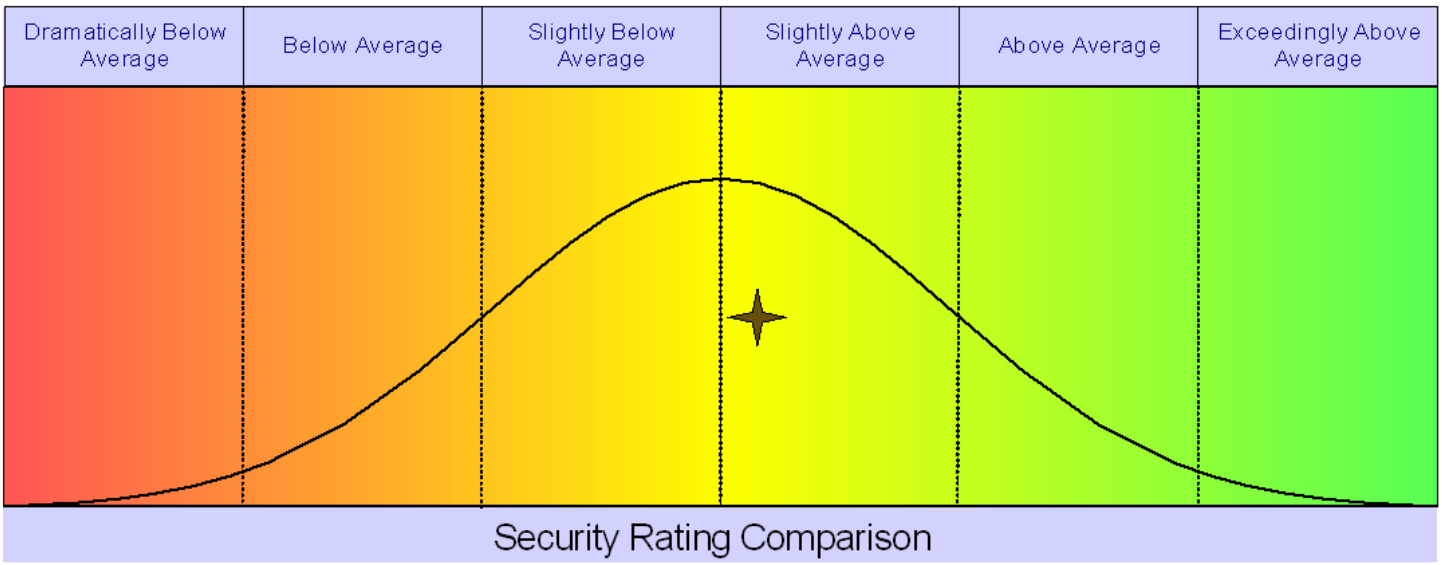
Final Security Rating (Possible Maximum Rating of 8.5)



Final Security Rating History



Comparative Results by Industry



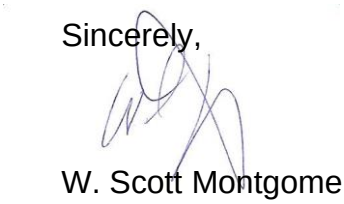
On the 24th of August 2020, OST conducted independent verification that the Guest Wifi Network at Southwest Michigan Behavioral Health was configured to be isolated from the organizations production network environment.

While parked in the public parking lot, in front of the office building, OST connected to the Guest WiFi network using the password provided.

Attempts to connect to network elements within the production network failed. This results in confirmation that at the point of testing, the Guest WiFi network is properly configured.

If multiple wireless access points are used throughout the building for the Guest network, only the device that was connected to from the parking lot was tested.

Sincerely,



W. Scott Montgomery
Security Practice Manager
Open Systems Technologies

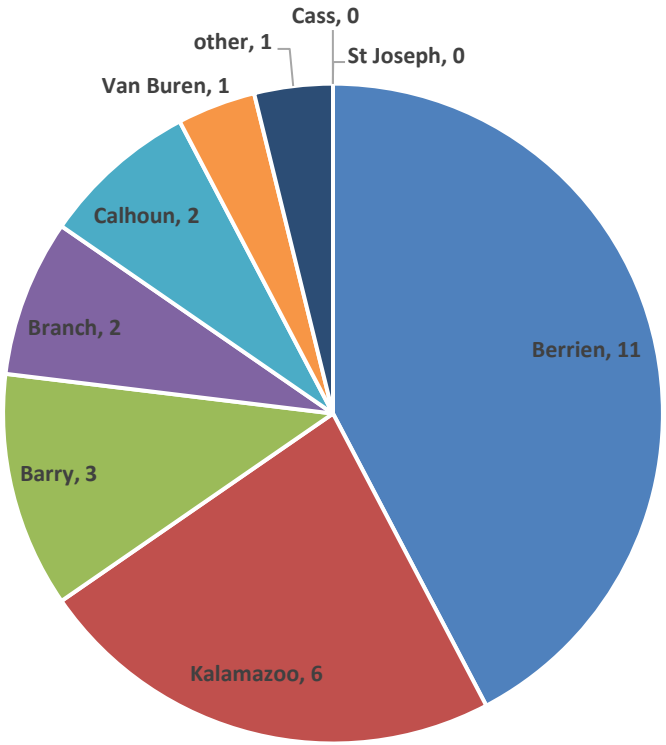
Integrated Care Board Education

SWMBH Board Meeting October 9, 2020

Primary Care Collaboration Survey

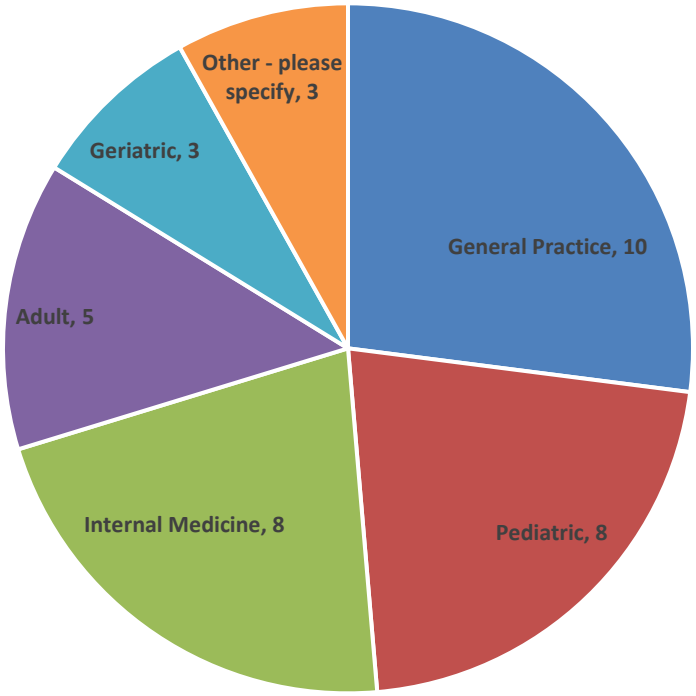
- For NCQA accreditation requirement
- Survey conducted in June 2020
- 150 Primary care offices in all 8 counties contacted for survey
- 22 Responded

Survey Respondents

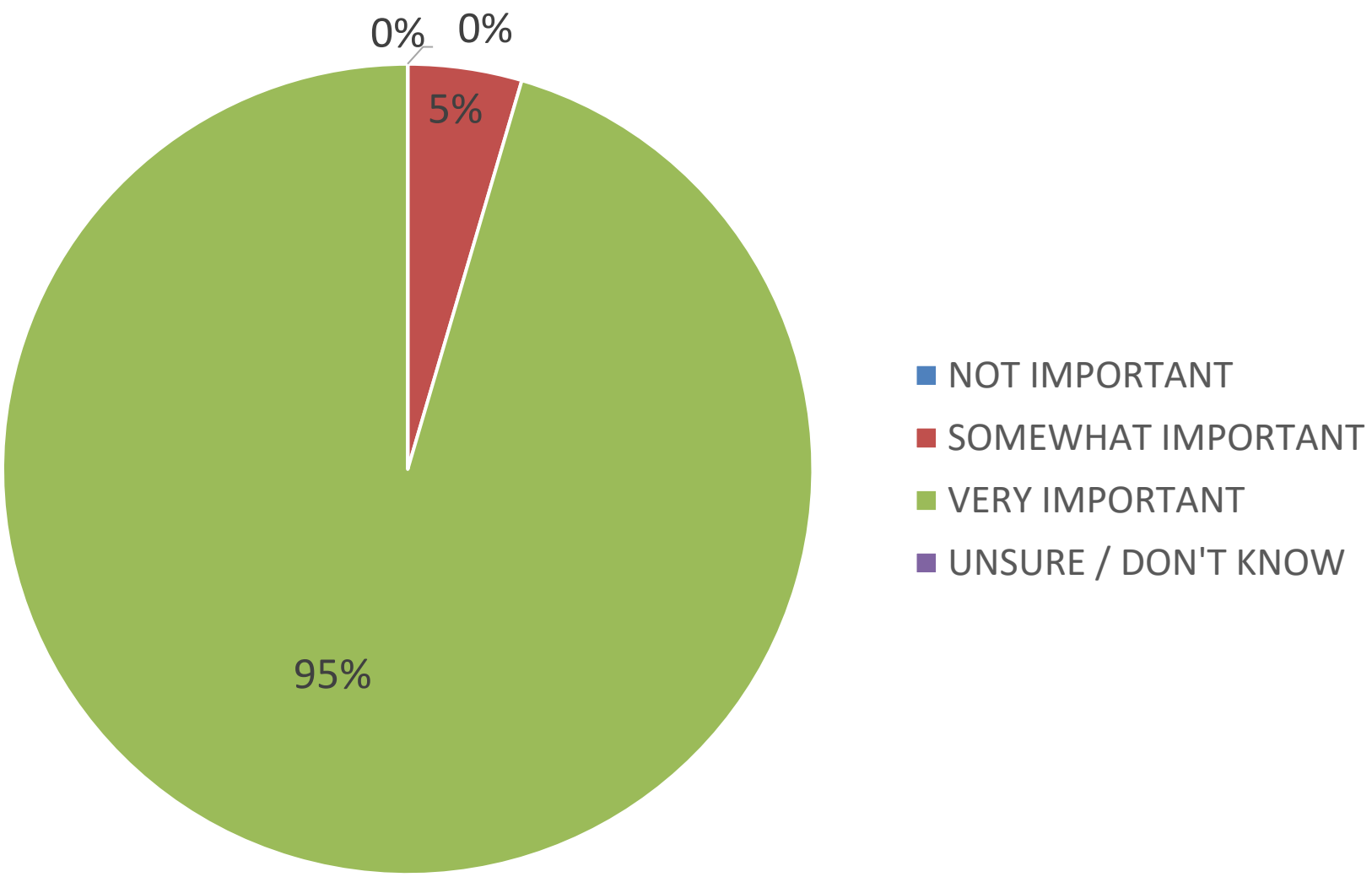


Respondents by County

Respondents by Practice Area (multiple possible)

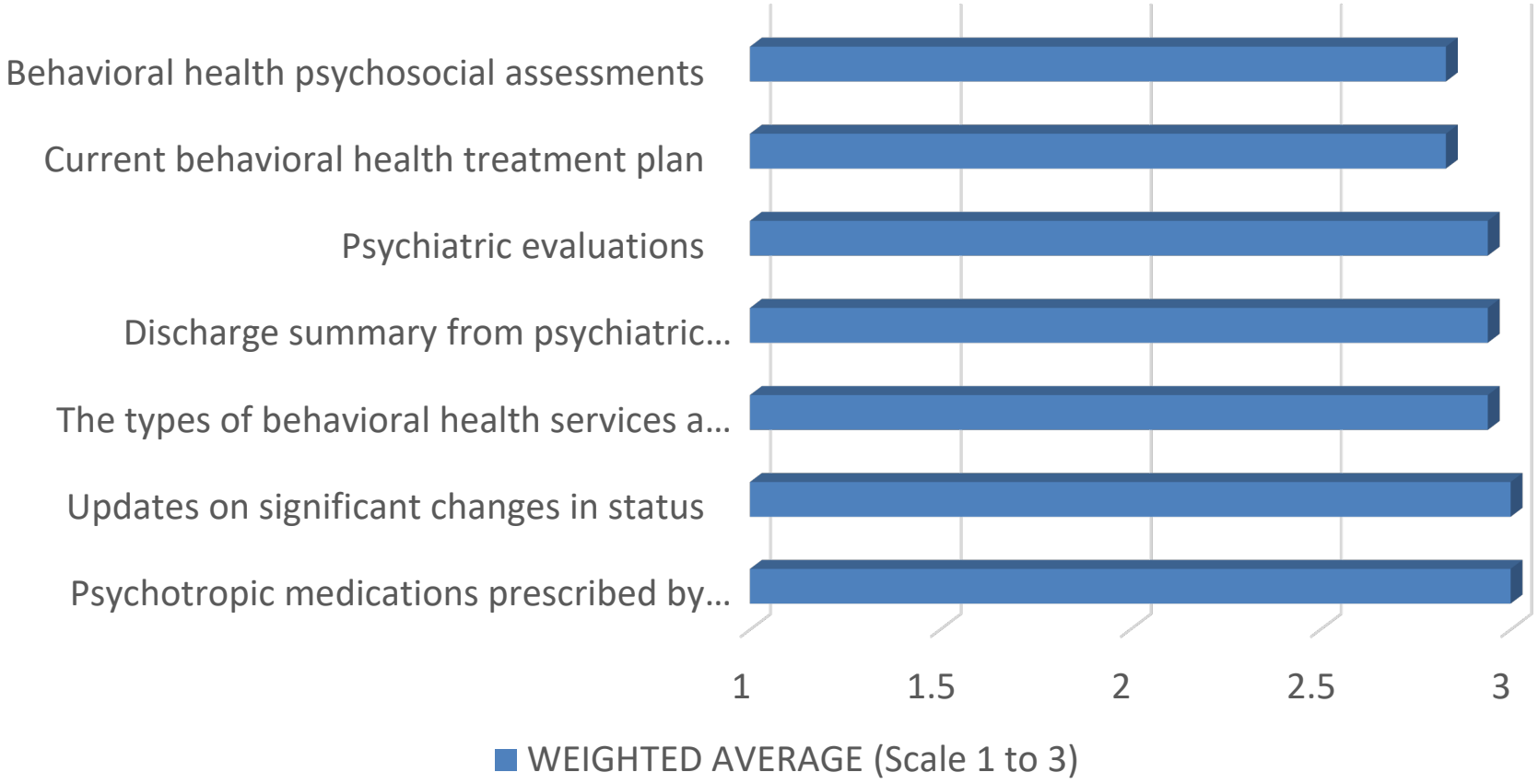


How important is it to you that patients' behavioral health and physical health care be coordinated?

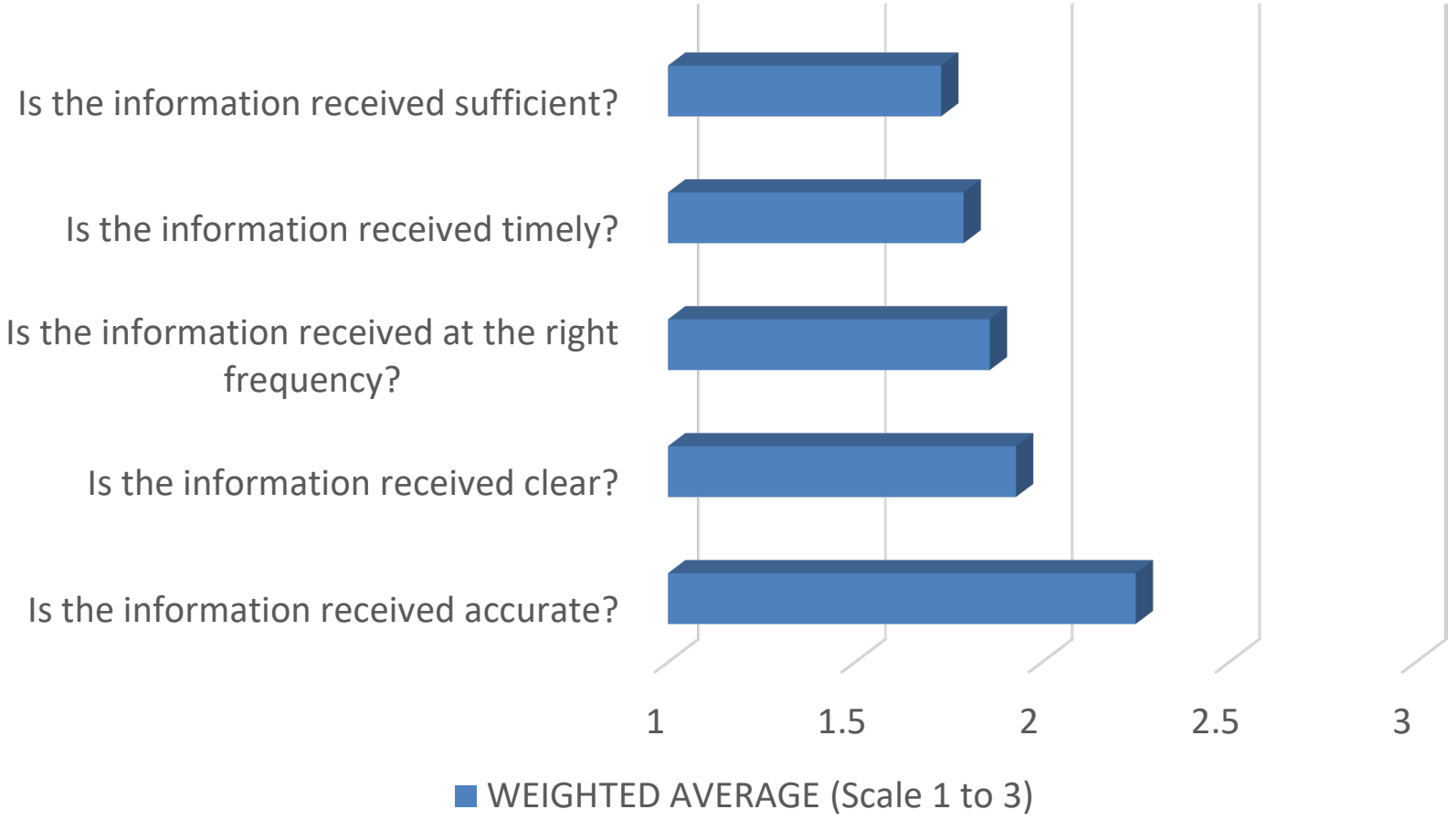


123

What type of behavioral health documentation helps your decision making in treating your patients?



Please rate the quality of behavioral health care information you've received about your patients in the last 6 months



Observations

- Information is frequently shared by CMHs with PCP offices.
- Large packets and PDFs of information can be cumbersome to review
- Often this information is annual, not necessarily real-time notices of changes in status, treatment, or diagnosis

Suggestions for Follow Up

- Encourage BH providers to involve primary care providers in developing processes for effective information sharing
- Support use of Health Information Exchange for coordination of care
- Acknowledge cultural differences in social work vs physician styles. Keep verbal communications concise and to the point.

Thank you

- Questions or comments?

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep
Revenue:				
Prior Year(s) Carryover	4,575,621	4,314,042	4,593,957	4,712,916
PA2 Revenue	1,827,172	1,522,643	1,827,172	1,827,172
Total Revenue	**6,402,793**	**5,836,686**	**6,421,129**	**6,540,088**
Expenses:				
RESIDENTIAL TREATMENT SERVICES	141,972	114,938	137,926	179,303
OUTPATIENT TREATMENT SERVICES	1,763,074	1,044,569	1,354,287	1,581,800
PREVENTION SERVICES	216,000	171,520	216,000	206,000
Total Expenses	**2,121,046**	**1,331,027**	**1,708,213**	**1,967,103**
Total Carryover	**4,281,747**	**4,505,658**	**4,712,916**	**4,572,985**

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Expense FY 20 Oct - Jun	Proposed Budget FY 21 Oct - Sep
Barry			
OUTPATIENT TREATMENT SERVICES	51,650.00	27,502.00	54,500.00
PREVENTION SERVICES	-	-	-
Total	51,650.00	27,502.00	54,500.00
Berrien			
OUTPATIENT TREATMENT SERVICES	306,339.93	172,775.00	283,033.60
PREVENTION SERVICES	110,000.00	82,520.00	100,000.00
Total	416,339.93	255,295.00	383,033.60
Branch			
OUTPATIENT TREATMENT SERVICES	72,820.00	31,962.65	36,430.00
PREVENTION SERVICES	-	-	-
Total	72,820.00	31,962.65	36,430.00
Calhoun			
OUTPATIENT TREATMENT SERVICES	418,378.51	341,035.25	393,699.17
PREVENTION SERVICES	-	-	-
Total	418,378.51	341,035.25	393,699.17
Cass			
OUTPATIENT TREATMENT SERVICES	82,500.00	24,983.20	82,500.00
PREVENTION SERVICES	-	-	-
Total	82,500.00	24,983.20	82,500.00
Kalamazoo			
RESIDENTIAL TREATMENT SERVICES	111,627.00	89,989.00	158,303.00
OUTPATIENT TREATMENT SERVICES	597,463.19	357,248.87	535,238.50
PREVENTION SERVICES	106,000.00	89,000.00	106,000.00
Total	815,090.19	536,237.87	799,541.50
St Joseph			
RESIDENTIAL TREATMENT SERVICES	30,344.85	24,949.00	21,000.00
OUTPATIENT TREATMENT SERVICES	106,040.00	30,346.04	62,040.00
PREVENTION SERVICES	-	-	-
Total	136,384.85	55,295.04	83,040.00
Van Buren			
OUTPATIENT TREATMENT SERVICES	127,882.40	58,716.38	134,359.10
PREVENTION SERVICES	-	-	-
Total	127,882.40	58,716.38	134,359.10
All Counties			
RESIDENTIAL TREATMENT SERVICES	141,972	114,938	179,303
OUTPATIENT TREATMENT SERVICES	1,763,074	1,044,569	1,581,800
PREVENTION SERVICES	216,000	171,520	206,000
	2,121,046	1,331,027	1,967,103

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
BARRY COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	511,814	469,938	508,676	549,320	568,467	587,614	606,761
PA2 Revenue	73,647	61,373	73,647	73,647	73,647	73,647	73,647
Total Revenue	**585,461**	**531,311**	**582,323**	**622,967**	**642,114**	**661,261**	**680,408**
Expenses:							
OUTPATIENT TREATMENT SERVICE	51,650	27,502	33,002	54,500	54,500	54,500	54,500
PREVENTION SERVICES	-	-	-	-	-	-	-
Total Expenses	**51,650**	**27,502**	**33,002**	**54,500**	**54,500**	**54,500**	**54,500**
Total Carryover	**533,811**	**503,809**	**549,320**	**568,467**	**587,614**	**606,761**	**625,908**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
BERRIEN COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	523,056	485,403	522,065	577,471	569,451	561,432	521,715
PA2 Revenue	375,014	312,512	375,014	375,014	375,014	375,014	375,014
Total Revenue	**898,070**	**797,915**	**897,079**	**952,485**	**944,465**	**936,446**	**896,729**
Expenses:							
OUTPATIENT TREATMENT SERVICES							
Abundant Life - Healthy Start	70,200	58,761	70,200	74,000	74,000	74,000	74,000
Berrien MHA - Riverwood	-	-	-	-	-	-	-
Berrien MHA - Riverwood Jail Based Asses	18,058			18,058	18,058	18,058	18,058
Berrien County - DTC	15,000	4,895	5,874	15,000	15,000	15,000	15,000
Berrien County - Trial courts (Intake Coor	44,755	36,224	43,469	48,610	48,610	48,610	48,610
CHC - Niles Family & Friends	5,739	2,713	3,256	5,739	5,739	5,739	5,739
CHC - Jail	31,697	21,907	26,288	-	-	31,697	31,697
CHC - Wellness Grp	9,328	1,097	1,316	9,328	9,328	9,328	9,328
CHC - Star of Hope Recovery House	37,730	27,741	33,289	37,730	37,730	37,730	37,730
Harbortown - Juvenile and Detention Ctr	-	-	-	-	-	-	-
Sacred Heart	73,834	19,437	25,916	74,569	74,569	74,569	74,569
PREVENTION SERVICES	110,000	82,520	110,000	100,000	100,000	100,000	100,000
Total Expenses	**416,340**	**255,295**	**319,608**	**383,034**	**383,034**	**414,730**	**414,730**
Total Carryover	**481,730**	**542,620**	**577,471**	**569,451**	**561,432**	**521,715**	**481,999**

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
BRANCH COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	327,040	334,094	356,324	379,353	408,568	437,784	466,999
PA2 Revenue	65,646	54,705	65,646	65,646	65,646	65,646	65,646
Total Revenue	**392,686**	**388,798**	**421,970**	**444,998**	**474,214**	**503,429**	**532,645**
Expenses:							
OUTPATIENT TREATMENT SERVICES							
Jail Case Management	36,190	21,901	29,201	-	-	-	-
Outpatient Treatment	34,430	9,971	13,295	34,430	34,430	34,430	34,430
WSS	2,200	91	121	2,000	2,000	2,000	2,000
PREVENTION SERVICES	-						
Total Expenses	**72,820**	**31,963**	**42,617**	**36,430**	**36,430**	**36,430**	**36,430**
Total Carryover	**319,866**	**356,836**	**379,353**	**408,568**	**437,784**	**466,999**	**496,215**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
CALHOUN COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	422,444	406,584	429,770	346,538	285,253	284,344	262,552
PA2 Revenue	332,415	277,013	332,415	332,415	332,415	332,415	332,415
Total Revenue	**754,859**	**683,597**	**762,185**	**678,953**	**617,668**	**616,759**	**594,967**
Expense:							
OUTPATIENT TREATMENT SERVICES							
10th Dist Drug Sobriety Court	127,807	110,068	127,807	124,929	104,107	104,107	104,107
10th Dist Veteran's Court	6,510	3,149	3,778	6,450	6,450	6,450	6,450
37th Circuit Drug Treatment Court	168,742	149,733	168,742	175,225	146,021	146,021	146,021
Haven of Rest	40,320	33,600	40,320	37,095	30,913	30,913	30,913
MRS	25,000	20,833	25,000	25,000	25,000	25,000	25,000
Summit Pointe - Jail	25,000	12,360	25,000	-	-	20,833	20,833
Summit Pointe - Juvenile Home	25,000	11,292	25,000	25,000	20,833	20,883	20,883
Total Expenses	**418,379**	**341,035**	**415,647**	**393,699**	**333,324**	**354,207**	**354,207**
Total Carryover	**336,481**	**342,562**	**346,538**	**285,253**	**284,344**	**262,552**	**240,760**
Note(s)							
PREVENTION SERVICES							
Substance Abuse Council	239,120			204,574	204,574	204,574	204,574
Substance Abuse Prevention Services	155,343			160,436	160,436	160,436	160,436
Total Expenses	**394,463**	**-**	**-**	**365,009**	**365,009**	**365,009**	**365,009**

Prevention services are funded through block grant

Notes:
FY 22 projections include a 20% reduction based on FY 21 approved budget except Veteran's Court and MRS
FY 23 SOR Grant for Jail will end and Jail program will need to be considered.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
CASS COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expens FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	366,250	354,756	381,039	412,240	403,769	395,298	386,827
PA2 Revenue	74,029	61,691	74,029	74,029	74,029	74,029	74,029
Total Revenue	**440,279**	**416,447**	**455,068**	**486,269**	**477,798**	**469,327**	**460,856**
Expense:							
OUTPATIENT TREATMENT SERVICES	82,500	24,983	42,828	82,500	82,500	82,500	82,500
PREVENTION SERVICES	-	-	-	-	-	-	-
Total Expenses	**82,500**	**24,983**	**42,828**	**82,500**	**82,500**	**82,500**	**82,500**
Total Carryover	**357,779**	**391,464**	**412,240**	**403,769**	**395,298**	**386,827**	**378,356**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
KALAMAZOO COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	1,739,053	1,797,121	1,840,140	1,833,387	1,694,574	1,555,761	1,349,723
PA2 Revenue	660,729	550,607	660,729	660,729	660,729	660,729	660,729
Total Revenue	**2,399,781**	**2,347,728**	**2,500,868**	**2,494,115**	**2,355,302**	**2,216,489**	**2,010,451**
Expenses:							
RESIDENTIAL TREATMENT SERVICES							
CHC - New Beginnings	77,627	61,656	73,987	77,627	77,627	77,627	77,627
CHC - Bethany House	-	-	-	27,200	27,200	27,200	27,200
CHC - Healing House	-	-	-	19,476	19,476	19,476	19,476
ISK - Oakland Drive Shelter	34,000	28,333	34,000	34,000	34,000	34,000	34,000
OUTPATIENT TREATMENT SERVICES							
8th District Sobriety Court	28,000	7,344	9,793	26,500	26,500	26,500	26,500
8th District Young Adult Diversion Court	5,000	1,859	2,479	5,000	5,000	5,000	5,000
8th District Probation Court	7,000	2,463	3,285	8,500	8,500	8,500	8,500
9th Circuit Drug Court	60,000	41,921	55,895	60,000	60,000	60,000	60,000
CHC - Adolescent Services	19,619	16,025	19,230	19,619	19,619	19,619	19,619
Interact - IDDT	26,600	16,473	19,768	26,600	26,600	26,600	26,600
KCHCS Healthy Babies	87,000	53,804	71,739	87,000	87,000	87,000	87,000
ISK - EMH	56,400	47,000	56,400	56,400	56,400	56,400	56,400
ISK - FUSE	25,000	20,833	25,000	25,000	25,000	25,000	25,000
ISK - MH Court	65,000	54,167	65,000	65,000	65,000	65,000	65,000
KPEP Social Detox	20,000	5,500	11,000	20,000	20,000	20,000	20,000
MRS	17,250	14,375	17,250	17,250	17,250	17,250	17,250
Recovery Institute - Recovery Coach	60,623	39,918	53,224	60,623	60,623	60,623	60,623
WMU - Jail Groups	67,225	31,285	37,542	-	-	67,225	67,225
WMU - BHS SBIRT	46,747	629	1,510	51,747	51,747	51,747	51,747
WMU - BHS Text Messaging	6,000	3,652	4,382	6,000	6,000	6,000	6,000
PREVENTION SERVICES							
Gryphon Gatekeeper - Suicide Prevention	20,000	18,000	20,000	20,000	20,000	20,000	20,000
Gryphon Helpline/Crisis Response	36,000	30,000	36,000	36,000	36,000	36,000	36,000
Prevention Works - Task Force	50,000	41,000	50,000	50,000	50,000	50,000	50,000
Total Expenses	**815,090**	**536,238**	**667,482**	**799,542**	**799,542**	**866,767**	**866,767**
Total Carryover	**1,584,691**	**1,811,490**	**1,833,387**	**1,694,574**	**1,555,761**	**1,349,723**	**1,143,685**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
ST. JOSEPH COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 20 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected Revenue/Expense FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	213,309	232,944	260,110	278,032	296,003	313,973	331,944
PA2 Revenue	101,011	84,175	101,011	101,011	101,011	101,011	101,011
Total Revenue	**314,319**	**317,119**	**361,120**	**379,043**	**397,013**	**414,984**	**432,954**
Expenses:							
RESIDENTIAL TREATMENT SERVICES							
Hope House	30,345	24,949	29,939	21,000	21,000	21,000	21,000
OUTPATIENT TREATMENT SERVICES							
3B District - Sobriety Courts	2,200	790	1,053	2,200	2,200	2,200	2,200
3B District - Drug/Alcohol Testing	16,640	5,910	7,880	16,640	16,640	16,640	16,640
CMH Drug Testing	53,200	19,801	39,602	43,200	43,200	43,200	43,200
CMH Jail Program	34,000	3,845	4,614	-	-	-	-
PREVENTION SERVICES							
3B District - Sobriety Courts	-	-	-	-	-	-	-
Total Expenses	**136,385**	**55,295**	**83,088**	**83,040**	**83,040**	**83,040**	**83,040**
Total Carryover	**177,934**	**261,824**	**278,032**	**296,003**	**313,973**	**331,944**	**349,914**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
VAN BUREN COUNTY
ALCOHOL TAX PLAN - FY21

	Approved Budget FY 19 Oct - Sep	Actual Rev/Exp FY 20 Oct - Jul	Projected evenue/Expens FY 20 Oct - Sep	Proposed Budget FY 21 Oct - Sep	Estimate FY22 Oct - Sep	Estimate FY23 Oct - Sep	Estimate FY24 Oct - Sep
Revenue:							
Prior Year(s) Carryover	260,438	233,202	295,833	336,576	346,900	357,223	367,546
PA2 Revenue	144,683	120,569	144,683	144,683	144,683	144,683	144,683
Total Revenue	**405,121**	**353,771**	**440,516**	**481,259**	**491,582**	**501,906**	**512,229**
Expenses:							
OUTPATIENT TREATMENT SERVICES							
Van Buren CMHA	97,882	38,476	76,953	94,359	94,359	94,359	94,359
Van Buren Circuit Court	30,000	20,240	26,987	40,000	40,000	40,000	40,000
Total Expenses	**127,882**	**58,716**	**103,939**	**134,359**	**134,359**	**134,359**	**134,359**
Total Carryover	**277,238**	**295,054**	**336,576**	**346,900**	**357,223**	**367,546**	**377,870**

Note(s)

MCHE

MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE

2020 ANNUAL MEETING

11:30 AM NOVEMBER 5, 2020

Attend via Zoom on your device:
https://us02web.zoom.us/j/84563406891?pwd=WWNmTnVjeFZjQURicW50Z05rWGl6dz09

or dial: 470-250-9358 or 646-518-9805

Meeting ID: 845 6340 6891

Passcode: 042209

Invitees are MCHE Board Members and Regional Entity and Stand-alone CMH/PIHP Board Members

Meeting Materials: MCHE.MemberMeeting2020-21 DRAFT.pptx

Michigan Consortium for Healthcare Excellence
SWMBH Executive Officer Board Report

For the period April 2020 through September 2020

MCHE Activity April 2020 – September 2020

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

STATE OF MICHIGAN

SPECIAL TRIBUTE

To

ACHILLES MALTA

LET IT BE KNOWN, That it is a great pleasure to congratulate Achilles Malta on being honored during the 2020 Recovery Month "Salute to Excellence" Awards Program of the Substance Abuse and Mental Health Task Force Assembly.

Achilles Malta, Substance Use Disorder Regional Coordinator of Southwest Michigan Behavioral Health, is honored for conducting excellent work in preventing and intervening in treatment and recovery services and for collaborating with Network Perinti and Substance Abuse Prevention Services, Inc.

During Recovery Month, we commend the Substance Abuse and Mental Health Services Administration in Michigan and globally for educating Americans that substance use treatment and mental health services can enable those with mental and substance use disorders to live healthy and rewarding lives. Now in its 31st year, Recovery Month celebrates the gains made by those living in recovery.

IN SPECIAL TRIBUTE, Therefore, This document is signed and dedicated to commend and acknowledge Achilles Malta for his outstanding commitment to the community in the area of substance abuse and mental health services.

John Bizon
John Bizon, M.D., State Senator
The Nineteenth District

Gavin Gilchrist II
Gavin Gilchrist II
Lieutenant Governor

Gretchen Whitmer
Governor

The One Hundredth Legislature
At Lansing
Tuesday, September 8, 2020

FY21 Conference Committee Report

Specific Mental Health/Substance Abuse Services Line items

	FY'19 (Final)	FY'20 (Final)	FY'21 (Final)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,386,669,800	$2,487,345,800	$2,653,305,500
-Medicaid Substance Abuse services	$67,640,500	$68,281,100	$87,663,200
-State disability assistance program	$2,018,800	$0	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,956,200	$108,754,700	$108,333,400
-Health Homes Program			$26,769,700
-Autism services	$192,890,700	$230,679,600	$271,721,000
-Healthy MI Plan (Behavioral health)	$299,439,000	$371,843,300	$589,941,900

FY21 Conference Report Decisions:

- Estimated 2% actuarial soundness increase for Medicaid and HMP behavioral health services and a 6% increase for autism services

- K.B. v. Lyon Includes $19.1 million Gross ($2.7 million GF/GP) and authorization for 9.0 FTE positions for behavioral health services and supports monitoring, system improvement, and performance monitoring for children related to the legal settlement K.B. v. Lyon. Amount includes $17.7 million Gross ($1.8 million GF/GP) for IT system upgrades.

- Behavioral Health Homes – Includes $23.4 million Gross ($2.5 million GF/GP) to expand the number of behavioral health homes, including opioid health homes, by a prospective 9,245 enrollees.

- Behavioral Health Program Reductions – Includes reductions totaling $3.3 million GF/GP for various behavioral health programs including in-sourcing Children's Transition Support Team, court-ordered assisted treatment, jail diversion, applied behavioral treatment, and psychiatric bed database.

- Direct Care Worker Wage Increase – One-Time Funding Adds $150.0 million Gross ($40.0 million GF/GP) to provide a temporary $2.00 per hour wage increase for direct care workers for 3 months. Funding would be available for the same direct care workers that were eligible for COVID-19 direct care worker hazard pay included in 2020 PA 123, including Medicaid-eligible behavioral health direct care workers, skilled nursing facility employees, and area agency on aging direct care employees.

- $1.0 million GF/GP for autism navigators and adds $144,800 GF/GP to Autism

- $8.4 million local funds for expanded child and adolescent health center care and emotional health services in schools

- Includes $5.4 million Gross ($1.4 million GF/GP) to support the MiDocs class during the current fiscal the course of 5 years.

Conference Report Boilerplate Sections:

- NOT INCLUDED – **Sec. 293. Savings from Behavioral Health Integration Pilot Projects** – Deleted language requiring that any savings from pilots to integrate Medicaid behavioral health and Medicaid physical health services systems shall only be used for reinvestment in the pilot sites where savings occurred; authorizes shared savings between a PIHP or CMHSP and a Medicaid health plan shall be carried forward for expenditures in future years;

- NOT INCLUDED – **Section 294** – Adds a new Care Coordination Pilot. (1) Allows the department to work with PIHPs and CMHSPs to create a service level integration pilot. (2) Contracts under this pilot shall require the use of the department's Care Connect 360 platform to achieve shared care coordination between PIHPs and Medicaid HMOs.

- NOT INCLUDED – **Sec. 298**

- **Sec. 927. Uniform community mental health services auditing process for use by CMHSPs and PIHPs.** Full language below:

Sec. 927. (1) The department shall, in consultation with the Community Mental Health Association of Michigan, establish, maintain, and review as necessary, a uniform community mental health services auditing process for use by CMHSPs and PIHPs.

(2) The uniform auditing process required under this section must do all of the following:

(a) Create uniformity in the collection of data and consistent measurement of the quality, efficacy, and cost effectiveness of provided services and supports. (b) Establish a uniform audit tool that contains information

necessary for the uniform community mental health services auditing process and adheres to national standards.
(c) Strive to meet the needs of community mental health service beneficiaries and meet all statewide audit requirements.
(d) Maintain audit responsibility at the local agency level.

(3) By March 1 of the current fiscal year, the department shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the senate and house policy offices on the implementation status of the uniform auditing process and any barriers to implementation.

(4) A state department or agency that provides, either directly or through a contract, community mental health services and supports must comply with the uniform auditing process and utilize the audit tool maintained by the department. All forms, processes, and contracts used by the state that relate to the provision of community mental health services and supports must comply with the uniform auditing process.

- **Sec. 928. CMH Funding Using Local Funds as State Match.** The Governor modified language directing the use of local funds as State match for Medicaid mental health funding to remove language stating legislative intent that local funding used to pull down match be phased out over five years and replaced with GF/GP. Conference maintained current year language with clarification on the source of funds used for local match. Full budget language below:

Sec. 928. (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.

- **Section 964** – Language requiring the department to develop and implement a Medicaid behavioral health fee schedule by July 1 and create network adequacy standards to be used in all contracts.

- **Sec. 974. Intellectual or Developmental Disability Service Delivery** – REVISED Allows an individual with an intellectual or developmental disability who receives supports and services from a CMHSP to choose to instead receive supports and services from another provider. Revises to require instead of allow.

- **Sec. 1006. Intellectual or Developmental Disability Health Homes** – NEW Requires DHHS to explore implementing Medicaid health homes for individuals with intellectual or developmental disabilities, and requires a report.

- **Sec. 1007. Standalone Intellectual or Developmental Disability Medicaid Delivery System** – NEW Requires DHHS to explore the feasibility of implementing a standalone Medicaid delivery system for individuals with intellectual or developmental disabilities, and requires a report.

- **Sec. 1013. Transportation to PSU.** Full language below:

Sec. 1013. CMHSPs that operate preadmission screening units, or that have designated a hospital as a preadmission screening unit, may permit a sheriff's office to use a qualified contracted entity to transport an individual for preadmission screening.

- **Section 1513 Medicaid Inpatient Psychiatric Hospital Workgroup** – Requires DHHS to create a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care, lists participating workgroup members, requires a report from the workgroup.

- **Section1696 – Traditional Medicaid to HMP Migration Restriction** – It is the intent of the legislature that, beginning in the fiscal year beginning October 1, 2019, if an applicant for Medicaid coverage through the Healthy Michigan Plan received medical coverage in the previous fiscal year through traditional Medicaid, and is still eligible for coverage through traditional Medicaid, the applicant is not eligible to receive coverage through the Healthy Michigan Plan.

Southwest Michigan Behavioral Health Feedback on Michigan Department of Health and Human Services 2020-2021 Strategic Pillars of Health

Drive improved outcomes and more funding to the front lines through streamlined oversight PIHP/CMHP accountability reforms

- Promote and reward PIHP's/CMHSP's who routinly achieve MDHHS quality metric benchmarks and acheive exceptional performance on MDHHS sponsored audits
- The Medicaid Provider Manual has not kept up with changes to waivers and benefits. This has caused inconsistencies and confusion on how services can or should be managed and the rules or requirements around them
- Promote and acknowledge PIHP's/CMHSP's who have achieved (full) NCQA or other gold standard Program Accreditation
- Publish more comparison reports, to highlight each of the Michigan PIHP's performance; in comparison to National quality, clinical and financial Benchmarks
- Develop PIHP/CMHSP comparative performance public reporting across the public behavioral health system
- Develop Medicaid Health Plan comparative performance public reporting across the specialty services populations and mild to moderate populations
- Develop FQHC comparative performance public reporting across the specialty services populations and mild to moderate populations
- Invest in clinical evidence-based and promising practices development, fidelity monitoring and outcomes reporting across the public behavioral health system
- Develop, RFP competitively and fund clinical evidence-based and promising practices Centers of Excellence at several PIHPs/CMHs
- Grant deemed status to PIHPs and CMHSPs for exemption from MDHHS reviews where National accreditation exists and overlaps

Southwest Michigan Behavioral Health Feedback on Michigan Department of Health and Human Services 2020-2021 Strategic Pillars of Health

Integrate physical and behavioral health care at the point of service with a person-centered approach

- Promote and add additional resources towards improving the MHL Demonstration Project
- Help to improve the 3-way contract language between PIHP's/ICO's and MDHHS, with clear and realistic metrics, benchmarks and bonus awards for acheivement
- Acknowledge PIHP's/ICO's with a proven success in high consumer satisfaction results and consistent program enrollment volume
- Convene MHPs, PIHPs, CMHSPs and FQHCs and deliver a clear and specific DHHS vision, population health expectations, goals and objectives
- Convene MHL ICOs and PIHPs for best practice sharing and troubleshooting
- Provide leadership and support for social determinants of health best practices including but not limited to more flexible funding
- Expand CC360 and uses of state data warehouse information to plans, providers and patients
- Expand Medicaid Benefits Monitoring Program
  https://www.michigan.gov/documents/mdch/changes for BMP 11242014 484735 7.pdf
- Revisit, prioritize and implement the policy recommendations from the 298 Pilot efforts
- Develop and institute true bonus incentives with shared metrics for behavioral and physical health morbidity and mortality improvements for MHPs, PIHPs and FQHCs

Ensure all Michiganders have access to behavioral health, mental health and substance use prevention and treatment services and follow up services for the best quality life.

- Access would be increased if the MHPs were more flexible in their fee rates. Many CMH's do not contract with the MHP's because of the low and inflexible fee rates
- No longer require the WSA for children enrolling in the Autism Benefit. The WSA is applying unnecesary requirements and standards on a benefit; potentially delaying treatment and cuasing access and billing issues
- Look into reducing the cost and administrative burden for Autism Services throughout the State. Highlight Best Practice Programs and recognize those PIHP's and Service providers who have operated efficently and met quality benchmarks
- Remove the requirement that services must be provided within a 25% variance of a childs approved direct ABA hours, in alignment with other Medicaid policy. This has resulted in excessive unnecesary administrative cost tracking down each case to determine the cause of the variance
- Consider carefully the emerging PIHP unenrolled SMI Complex Care Management Proposal
- Implement Medicaid Care Coordination service codes for PIHPs and CMHSPs https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Assess and hold inpatient psychiatric providers to access metrics
- Review and revise statutory and regulatory barriers to subacute psychiatric secure facilities
- Announce the MHP rebid schedule and provide MHP specific mild to moderate BH services access, utilization and outcomes information to Medicaid eligibles

Provide people with outreach, service delivery, and access to behavioral health services at their preferred locations and mechanisms. Consider telehealth and telephone services utilized during COVID-19.

- Expand the Medicaid prevention models to include local community assessed prevention choices. For example, if the community needs assessment indicates prevention is needed in a specific area, the CMH should be able to choose an evidenced based model to meet that need; not be limited to the 5 chosen by the state
- Promote and create Partnerships with other safety net providers, improving access to care
- Expanision of Telehealth services to include phone services. Lack of access to internet or computers or lack of technicial abilities to access "telehealth" with video
- Build on best practice models and promote entities who have experience with specialty populations
- Expansion of the use of telehealth services, even beyond the COVID-19 emergency authorization period
- Improve funding and capacity for broadband coverage in rural areas, to provide access to telehealth and improve communications with primary care and BH/MH/SUD specialty providers
- Extend telehealth service codes beyond pandemic period
- Support telehealth equipment and service investments
- Assure MHP fulfillment of transportation role and service
- Circulate publicly and widely all external review reports of MHPs and PIHPs especially those of HSAG and for the MHL Demonstration

Provide quality and time efficient patient care flow from community to resedential treatment or institution (hospital, juvenile detention centers, jail) to community with individualized clinical treatment

- Promote and add additional resources towards improving Jail Diversion programs, metrics and reporting
- Create visibility and creditibity at legislative level
- Provide additional guidance, resources, policy and incentives on streamlining Transfer or Care (TOC) and transition of services for consumers
- Incentive counties (city government, specifically) to encourage the training of officers in CIT which will assist in jail diversion, as well as incentive the creation and use of specialty courts
- Assure Medicaid enrollment and referrals immediately upon release from county jails
- Develop and publicly report transition metrics
- Expand eligible Michigan Automated Prescription System (MAPS) user types

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

September 29, 2020

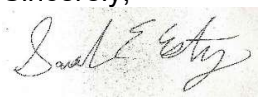
Dear behavioral health stakeholders:

We are writing with an update on the behavioral health system transformation efforts and the plan announced earlier this year to establish Specialty Integrated Plans starting in fall 2022. Given the unprecedented challenges around COVID-19 and the economy, we have to pause on comprehensive system change right now. We appreciate the enormous efforts all of you have made over the last several years to help us envision and design the future of behavioral health in Michigan. That time was not wasted. When the current situation has stabilized and we are all able to again devote our attention and resources to system transformation, we are excited to resume work on this effort. In addition, we see many current opportunities to advance and continue working on aspects of system improvement that were identified during our last few years of conversations and planning.

Under Al Jansen's leadership, the Behavioral Health and Developmental Disabilities Administration is developing a robust agenda that balances crisis response with ongoing improvement. In the coming months, our department will remain focused on addressing immediate challenges: making sure people have the mental health and SUD resources they need in the COVID crisis; continuing to support the outstanding network of behavioral health providers that Michigan has built over decades; investing in prevention, early intervention, and integrated physical and behavioral health care; and increasing accountability and oversight across the system. We will also be ramping up our proactive efforts to improve the system. Even with the pandemic, we are moving forward with creating MiCAL – a centralized crisis and access system that will make it easier for families in crisis to locate the resources they need. We have set up new service delivery structures, like text-based counselling and a crisis warmline. We are developing a comprehensive set of initiatives to better coordinate and deliver mental health services for children.

We are committed to continue strengthening Michigan's behavioral health system, and we look forward to working together with people served, providers, advocates, CMHs and PIHPs, and other stakeholders to achieve our shared goals.

Sincerely,



Sarah Esty, Senior Deputy Director
Policy and Planning Administration

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
November 13, 2020
9:30 am to 11:00 am
Draft: 9/1/20

1. **Welcome Guests/Public Comment**

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

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

4. **Consent Agenda**

   - October 9, 2020 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   - Operations Committee Minutes September 23, 2020 (d)

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

   a. HSAG PIP Diabetes (d) (M. Kean)
   b. 2021-2022 Board Ends Metrics (d) (J. Gardner)

7. **Board Actions to be Considered**

   a. Executive Officer Evaluation
   b. December Board Luncheon

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 of Executive Officer Performance (Board Executive Committee) (d)

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

   - BEL-010 Regional Entity 501 (c) (3) Representation (d) (J. Bermingham)

10. Board Education

a. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson)
b. Fiscal Year 2020 Contract Vendor Summary (T. Dawson)
c. Information Systems Update (N. Spivak)
d. Fiscal Year 2020 Compliance Plan Approval (d) (M. Todd)
e. CMH Review Results (d) (J. Gardner)

11. Communication and Counsel to the Board

a. MCG Fees (B. Casemore)
b. December 11, 2020 Board Agenda (d)
c. Board Member Attendance Roster (d)
d. December Board Policies: BEL-003 Asset Protection (S. Barnes); BG-005 Chairperson's Role

12. Public Comment

13. Adjournment

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

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

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

Next SWMBH Board Meeting
December 11, 2020
9:30 am - 11:00 am

2020 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Robert Nelson (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Michael McShane (Cass)												
Erik Krogh (Kalamazoo)												
Janet Bermingham (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Randy Hyrns (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Mary Middleton (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 9/11/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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