Southwest Michigan
BEHAVIORAL HEALTH

Per PA 228 of 2020:

- For calendar year 2020 Board meetings will be held remotely due to the COVID-19 pandemic.
- Members of the public may attend electronically by https://global.gotomeeting.com/join/515345453 or by dialing 1-571-317-3116 access code: 515 345 453.
- Members of the public may contact members of the Board to provide input or ask questions on any business that will come before the Board by contacting Michelle Jacobs at michelle.jacobs@swmbh.org prior to the meeting, or by commenting during the Board meeting Public Comment section as identified by the Board Chairman.
- Members of the public with disabilities who require special accommodations should contact Anne Wickham at anne.wickham@swmbh.org well before the meeting occurs.
- Members of the public are not required register or otherwise provide their name or other information as a condition of participation, other than mechanisms to permit participation in the public comment period.
- Members of the public are to be excluded from participation in a properly convened and held closed session of the Board.

Southwest Michigan Behavioral Health Board Meeting

December 11, 2020
9:30 am to 11:30 am

(d) means document provided

Draft: 12/2/20

1. **Welcome Guests/Public Comment**

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

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

    - Carole Naccarto – St. Joseph CMH

4. **Consent Agenda**

    - November 13, 2020 SWMBH Board Meeting Minutes (d) p. 3

5. **Operations Committee**

    - Operations Committee Minutes October 28, 2020 (d) p. 8

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

    - None Scheduled

7. **Board Actions to be Considered**

    a. 2021 - 2022 Ends Metrics (J. Gardner) (d) p. 11
    b. PA 228 of 2020 (B. Casemore) (to be displayed)
    c. Membership in Michigan Consortium for Healthcare Excellence (B. Casemore) (d) p. 21
    d. Calendar Year 2021 Board Policy Direct Inspection Assignments and Events Calendars (M. Jacobs) (d) p. 22
    e. BG-012 Open Meetings Act and Freedom of Information Act (B. Casemore) (d) p. 26
    f. Financial Risk Management Plan (T. Dawson) (d) p. 28
    g. Financial Management Plan (T. Dawson) (d) p. 31
    h. Cost Allocation Plan (T. Dawson) (d) p. 37
    i. *Motion to go into closed session
    j. **10:45 -11:00am** Pending Litigation (Roz Parmenter)
    k. *Motion to return to open session

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

- BG-005 Chairperson's Role (d) p. 47

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

a. BEL-003 Asset Protection (S. Barnes) (d) p. 49
b. BEL-010 RE 501c3 Representation (M. Middleton) (d) p. 51

10. Board Education

a. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 54
b. Information Systems Update (N. Spivak) (d) p. 62

11. Communication and Counsel to the Board

a. PIHP Complex Care Management Proposal (B. Casemore) (d) p. 79
b. Intergovernmental Contract Status (B. Casemore) (d) p. 100
c. PA 2 Outcomes Report (J. Smith) (d) p. 101
d. 2020 Filonow Award of Excellence (B. Casemore) (d) p. 108
e. January 8, 2021 Board Agenda (d) p. 109
f. Board Member Attendance Roster (d) p. 111
g. January Board Policy Direct Inspection – BEL-001 Budgeting (S. Barnes)

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
January 8, 2021
9:30 am - 11:00 am

SWMBH Board Strategic Planning Session
January 8, 2021
11:15 am – 1:15 pm

Draft Board Meeting Minutes
November 13, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 11/16/20

Members Present via phone: Edward Meny, Tom Schmelzer, Susan Barnes, Mary Middleton, Patrick Garrett, Erik Krogh, and Ruth Perino

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; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Joel Smith, Director of SUD Treatment and Prevention Services, SWMBH; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Kris Kirsch, St. Joseph CMH; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Jeannie Goodrich, Summit Pointe; Brad Sysol, Summit Pointe; Jeff Patton, ISK, Pat Guenther, ISK Board Alternate

Welcome Guests
Edward Meny called the meeting to order at 9:30 am, introductions were made. Edward Meny commented on the passing of Robert Nelson, Barry County Board Member and the resignation of Michael McShane, Cass County Board Member.

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to accept the agenda with the additions of Notice of Intent – Lawsuit and no closed session for the EO Evaluation.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes
Motion Carried		

Financial Interest Disclosure Handling
None

Consent Agenda

Motion	Erik Krogh moved to approve the October 09, 2020 Board meeting minutes as presented.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes
Motion Carried		

Operations Committee

Operations Committee Minutes September 23, 2020

Edward Meny noted the minutes as documented. Minutes accepted.

Ends Metrics

None

Board Actions to be Considered

Executive Officer Evaluation

Tom Schmelzer reported as documented.

Motion	Tom Schmelzer moved that the executive committee would like to commend Brad and his team at Southwest Michigan Behavioral Health for a job well done. Your performance during this COVID pandemic has been exceptional and deserving of the highest praise. With faith in Brad as an executive officer, the executive committee wishes to retain Brad's services in the capacity of executive officer and compliment him for a job well done. We recommend a motion to the board that the executive officer is in compliance with policy E0 - 002 and the policy does not need revision and I so move.	
Second	Erik Krogh	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Susan Barnes	yes
Motion Carried		

BG-012 Open Meetings Act and Freedom of Information Act

Brad Casemore reported as documented. Discussion followed. Board agreed to bring the policy back to the December 11, 2020.

Calendar Year 2021 Board Meeting Calendar – Live versus Remote Meetings

Brad Casemore reviewed PA228 of 2020 and discussed 2021 Board meetings. Board agreed on meetings dates only with a determination of location later when more information is known regarding COVID-19 and State regulations involving Open Meetings.

Motion	Patrick Garrett moved to approve the Board meeting dates for 2021 as presented.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes

Motion Carried

December Board Luncheon

Board agreed to cancel the December Board luncheon.

Board Policy Review

BG-003 Unity of Control

Edward Meny reported as documented.

Motion	Patrick Garrett moved the Board is in compliance and the Policy BG-003 Unity of Control does not need revision.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes

Motion Carried

EO-003 Emergency Executive Officer Succession

Brad Casemore reported as documented.

Motion	Erik Krogh moved the Board is in compliance and the Policy EO-003 Emergency Executive Officer Succession does not need revision.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes

	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes

Motion Carried

EO-002 Monitoring of Executive Officer Performance

Edward Meny reported as documented.

Motion	Tom Schmelzer moved the Board is in compliance and the Policy EO-002 Monitoring of Executive Officer Performance does not need revision.	
Second	Mary Middleton	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Susan Barnes	yes

Motion Carried

BEL-010 Regional Entity 501 (c) (3) Representation

Brad Casemore stated that this policy was assigned to a Board member who has resigned and asked the Board to consider reassigning the policy to another Board member for review at the December Board meeting. Edward Meny asked Mary Middleton to review Policy BEL-010. Mary Middleton agreed.

Executive Limitations Review

None

Board Education

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Fiscal Year 2020 Contract Vendor Summary

Tracy Dawson reported as documented.

Fiscal Year 2021 Substance Use Disorder Block Grant

Joel Smith reported as documented. Discussion followed.

2020 SWMBH Successes and Accomplishments

Edward Meny reported as documented and stated the following, “The SWMBH Board hereby acknowledges the entire SWMBH staff for the impressive and important 2020 Success and Accomplishments. These efforts and results are particularly compelling and valued given the extreme pressures on professional and personal lives brought about by the COVID-19 pandemic. Let it

be known that the SWMBH Board expresses our highest commendation and gratitude to SWMBH Staff and greatly appreciate their ongoing commitment and dedication which improves the lives of those they serve."

Motion Patrick Garrett moved to approve the statement as read by Edward Meny.
Second Mary Middleton
Motion Carried

Communication and Counsel to the Board

MCG Fees
Brad Casemore reported as documented.

Monica Donofrio, COO of Behavioral Care Solutions Email
Mila Todd noted Behavioral Care Solutions (BCS) is a provider that provides mental health services to residents in nursing facilities, under arrangements with the nursing facilities. BCS contacted SWMBH to request payment for these services delivered to MI Health Link beneficiaries. SWMBH researched the matter, as well as checked with one of our MHL ICOs and its contract manager at MDHHS and takes the position that SWMBH is not the entity responsible for reimbursement for the services delivered by BCS. This was relayed to BCS in a phone call on Wednesday 11/11/2020. BCS was also provided a written summary of SWMBH's position. SWMBH committed to notifying BCS if and when we receive any additional information from MDHHS, and BCS committed to following up with its legal department on pursuing the matter further.

Letter of Intent
Brad Casemore stated that SWMBH received a letter of intent on a lawsuit being filed. Details and conversation to be discussion in December during a closed session.

Next Month's Policy Reviews
Edward Meny noted policies for review next month.

Public Comment
None

Adjournment

Motion Erik Krogh moved to adjourn at 11:01am
Second Susan Barnes
Unanimous Voice Vote
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: October 28, 2020 9:00am-12:00pm

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 – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Joel Smith, Substance Use Treatment & Prevention Director, Applications & Systems Analyst, SWMBH; Andy Aardema, 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 9:00 am.

Allen Jansen, Senior Deputy Director, Behavioral Health and Developmental Disability Services Administration (BHDDA) – Brad Casemore introduced Allen Jansen. Allen Jansen welcomed everyone and summarized the following topics at BHDDA and MDHHS:

- State is busy with and anxious about current skyrocketing numbers of COVID positive people – pressures on hospitals, AFCs, and residential settings and State working on alternative placements
- State Budget numbers for 2021 are holding
- Concerns with the Lame Duck session and future behavioral health transformation
- Both MDHHS and legislators pre-occupied with COVID responses
- Focus on modest but important areas already existing in the PIHP and CMH systems such as:
    - Public Dashboard (access to care, timeliness, impact on recipients)
    - Stability Plans
- Certified Community Behavioral Health Clinics – State is committed to wide application with verification on if limited to including only those who were part of the application in 2016
- Opioid Health Homes and Behavioral Health Homes – early phases of next expansion steps
- KB Lawsuit – created an opportunity for State to create a model of delivery that moves outside the four departments that currently provides services for kids – design robust delivery system with Medicaid health plans and child welfare system - possibility of an alternate managed care solution (SIP)
- Fiscal Year 2021 Substance Use Disorder Block Grant decrease – State is meeting on this issue

Dr. George Mellos, Senior Executive Psychiatrist Director, Senior Deputy Director State Hospitals Administration – Brad Casemore introduced Dr. Mellos. Dr. Mellos welcomed the group and

summarized the past Direct Community Placement Program developments and ongoing efforts to address specific individuals placed long term at inpatient psychiatric hospitals. Discussion followed. **Review and approve agenda –** Agenda approved with additions of Intergovernmental Contract and Substance Use Disorder Block Grant Funding.

Review and approve minutes from 9/23/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported that financials will be done by the end of the week and she will send them out to the group. Discussion followed.

Fiscal Year 2021 Draft Budget – Tracy Dawson reported as documented.

Fiscal Year 2021 Rate Setting Files Analysis – Andy Aardema reported as documented. Discussion followed. Group agreed to place on monthly meeting agenda and consider this a high priority.

Fiscal Year 2020 Encounters – Tracy Dawson reported as documented noting that the encounter reports are available on Tableau.

Cost Allocation and Rate Development Workgroup – Pat Davis shared that the State is moving toward standardized cost centers.

Milliman Behavioral Health Fee Schedule Development – Pat Davis reported as documented. Discussion followed.

Non-Disclosure Agreement – Brad Casemore reviewed history of previous non-disclosure agreement. Due to time constraints this topic will be put on the November meeting agenda.

Access to CAFAS and PECFAS System, Data and Scores – Brad Casemore noted the memo from the State in the meeting packet. Natalie Spivak shared that SWMBH collects and reports this data.

Provider Network Stability (Fiscal Year 2020 and 2021) – Mila Todd noted that she is completing the summary report today for submission to the State.

Direct Care Wage (DCW) October – December – Tracy Dawson thanked the CMHSPs for their work on the DCW and noted that SWMBH putting this in the rates was the right thing to do and now the State is advising other PIHPs to do this.

Confirm November 18th and December 16th Operations Committee Meetings – Brad Casemore asked group about November and December meetings. Group agreed to keep both meetings.

5th Annual SWMBH Legislative Event Debrief – Mary Ann Bush reported as documented noting that this event was the largest attended event that SWMBH has hosted.

Community Mental Health Association of Michigan Regional Meetings – Brad Casemore reported as documented.

Community Mental Health Association of Michigan Systems Transformation Call – Brad Casemore

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd stated that PIHPs are reviewing amendment #1 for approval in early 2021.

Managed Care Functional Review (MCFR) Provider Network Management (PNM) – Mila Todd stated there are no updates at this time.

2021-2022 Board Ends Metrics – Jonathan Gardner reported as documented.

Intergovernmental Contract Update – Brad Casemore reviewed the history of the Intergovernmental Contract regarding PA2 funding and shared that of the eight counties in the region SWMBH is waiting for signed contracts from Berrien, Cass and Kalamazoo counties. Discussion followed.

Opioid Health Homes (OHH) Update – Joel Smith reported that our region currently has 138 participants enrolled in the OHH program. Emily Flory, SWMBH OHH Coordinator, is overseeing the program and working with providers in Kalamazoo and Calhoun counties.

Substance Use Disorder Block Grant – Joel Smith reported as documented. Discussion followed.

SWMBH – Meridian Meetings – Brad Casemore reviewed recent meetings between SWMBH and Meridian which have been productive and effective on care coordination efforts.

Adjourned – Meeting adjourned at 12:15pm

2021 – 2022 SWMBH Board Ends Metrics
(Final draft v6. 12.1.20)
Fiscal and Calendar Year Metrics
Board Approval Target: *December 11, 2020*

2021-2022 Board Ends Metrics Review and Approval Schedule:

- *Operations Committee Review and Endorsement: 11/18/20*
- *Utilization Management and Clinical Practices Committee Review and Endorsement: 11/9/20*
- *Quality Management Committee Review and Endorsement: 10/22/20*
- *Board Review: 12/11/2020*

Strategic Imperative Category: Quality of Life

Persons with Intellectual Developmental Disabilities (I/DD);
Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD), and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery
and family preservation.

PERFORMANCE METRIC DESCRIPTION	STATUS
1. Achieve 95% of Veteran's Metric Performance-Based Incentive Program monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/20 - 3/1/21) Metric Board Report Date: August 13, 2021 A. **Identification of beneficiaries who may be eligible for services through the Veteran's Administration**: **i.** Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. *Deliverables:* The VSN Data Collection form will be submitted to BHDDA by the last day of the month following the end of each quarter. **ii.** Improve and maintain data quality on BH-TEDS military and veteran fields. *Deliverables:* BH TEDS quality monitoring reports delivered (10/1/20 through 3/31/21). **iii.** Monitor and analyze data discrepancies between VSN and BH TEDS data. *Deliverables:* By July 1, 2021, Plans will submit a 1-2-page narrative report on findings and any actions to improve data quality. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point will be awarded upon official Board approval.	This Metric has been modified to align with 2021 MDHHS approved PBIP Narrative Language section P.1. PA 107 of 2013 Sec. 105d (18) (50 points) Executive Owners: Anne Wickham and Natalie Spivak

PERFORMANCE METRIC DESCRIPTION	STATUS
2. Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 Interim report to the Board in August 2021 A. **Increased data sharing with other providers**: i. Send ADT messages for purposes of care coordination through the health information exchange. *Deliverable 1*: At least one CMHSP within a contractor's service area (or the contractor) will be submitting ADT messages to the MIHIN EDI pipeline by the end of FY21. ii. *Deliverable 2:* By July 31, 2021, the contractor must submit, to BHDDA, a report no longer than 2 pages listing the CMHSPs sending ADT messages, barriers for those who are not, along with remediation efforts and plans. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. If MIHIN cannot accept or process the contractor's ADT submissions, this shall not constitute a failure of the metric and will be communicated to the Board and updated appropriately. **Possible Points:** 1 point awarded upon official Board approval.	This Metric has been modified to align with 2021 MDHHS approved PBIP Narrative Language section P.2. PA 107 of 2013 Sec. 105d (18) (50 points) Executive Owner: Natalie Spivak

PERFORMANCE METRIC DESCRIPTION	STATUS
3. SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2021, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to the following areas: 1. Comprehensive Care 2. Patient-Centered Medical Homes 3. Coordination of Care 4. Accessibility to Services 5. Quality and Safety Metric Measurement Period: (10/1/20 - 11/15/21) Metric Board Report Date: January 8, 2022 **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval.	This Metric has been modified to align with 2021 MDHHS approved PBIP Narrative Language section P.1. PA 107 of 2013 Sec. 105d (18) (40 points) and 40% of the total withhold amount Report not to exceed 10 pages Executive Owners: Mila Todd, Jonathan Gardner and Moira Kean

PERFORMANCE METRIC DESCRIPTION	STATUS
4. Achieve 95% of possible points on collaboration between entities for the ongoing coordination and integration of services for shared MHL consumers. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 Interim report to the Board in March 2021 A. Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk, who have been identified as receiving services from both entities. B. Risk stratification criteria are determined in writing by the contractor in consultation with the State. MDHHS will select beneficiaries quarterly at random and review their care plans in CC360 for accuracy and compliance. **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval.	This Metric has been modified to align with 2021 MDHHS approved PBIP Narrative Language section P.1. PA 107 of 2013 Sec. 105d (18) (35 points) This metric is largely based on combination calculations between the MHP and PIHP in CC360. Executive Owner: Moira Kean

PERFORMANCE METRIC DESCRIPTION	STATUS
5. Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) and show a reduction in disparity with one minority group. Metric Measurement Period: 7/1/20 - 6/20/21) Metric Board Report Date: August 13, 2021 Interim report presented to the Board on B. In January 2021 A. Plans will meet set standard for follow-up within 30 days for each rate (ages 6-17) and (18 and older). Plans will be measured against the adult minimum standard of 58% and child minimum standard of 70%. B. Data will be stratified by race/ethnicity by MDHHS and delivered to PIHP's. PIHP's will be incentivized to reduce a disparity between the index population and at least one minority group. (7/1/20 – 6/30/21) **Measurement:** Confirmation via MDHHS written report that each identified measure has been completed successfully. **Possible Points:** 1 point awarded upon official Board approval. ½ point each, child and adult.	This Metric has been modified to align with 2021 MDHHS approved PBIP Narrative Language section P.1. PA 107 of 2013 Sec. 105d (18) (40 points) **Current SWMBH Rates:** • Adult: 67.13% • Child: 77.51% Link to FUH and Disparity Specifications Executive Owner: Moira Kean and Jonathan

Strategic Imperative Category: Exceptional Care

Persons and families served are highly satisfied with the services they receive.

PERFORMANCE METRIC DESCRIPTION	STATUS
6. 2021 Customer Satisfaction Surveys collected by SWMBH are at or above the 2020 results for the following categories: Metric Measurement Period: (1/1/21 - 9/30/21) Metric Board Report Date: December 10, 2021 A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning – baseline: 85.1%) ½ point.* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes – baseline 81.3%) ½ point.* C. A complete study exploring other survey distribution methods and automation of results collection process (*By August 31, 2021*) 1 point. **Measurement:** Confirmation via selected survey vender of a valid process, survey data, and results report. **Possible Points:** 2 points awarded upon official Board approval.	Surveys scheduled to begin in October of 2021 Improved Functioning and Improved Outcomes Categories have been the lowest-scoring categories over the past 4 years. Executive Owners: Jonathan Gardner, Sarah Ameter and Anne Wickham

PERFORMANCE METRIC DESCRIPTION	STATUS
7. Implementation of the "*MDHHS approved SUD Standardized Assessment Tool*" for FY21 by 10/1/2021 Per MDHHS Contract. Metric Measurement Period: (9/1/20 - 10/1/21) Metric Board Report Date: February 11, 2022 Interim Report Presented to Board in September 2021. A. Training and certifying all relevant clinicians to administer the approved SUD Assessment (By 8/1/21). ½ point. B. Full system implementation and integration by CMHSP's and Provider sites (By 10/1/21). ½ point. C. SWMBH to implement reporting standards, validation, accuracy and targets in FY21 for FY22 metrics/targets reporting process via MDHHS calendar. ½ point. **Measurement:** Confirmation via selected survey vender of a valid process, survey data, and results report. **Possible Points:** ½ point for each component awarded upon official Board approval. Total of 1 ½ points possible.	Possibility that this could change to the ASAM Continuum Tool Per Jeff Weiferich on 9.28.20, both the GAIN and ASAM Continuum tools are on hold, until they have a clearer picture of the SAPT Block Grant funding will look like. The Departments goal is to have an answer by: 12/16/20. Executive Owners: Joel Smith and Natalie Spivak Waiting to finalize metric after 12.16.20 mtg with MDHHS

Strategic Imperative Category: Improved Health

Individual mental health, physical health, and functionality are measured and improved.

PERFORMANCE METRIC DESCRIPTION	STATUS
8. Each quarter, at least 53% of parents and/or caregivers of youth and young adults receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Guidance. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: December 10, 2021 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter / # of youth/young adults receiving ABA services **Possible Points:** 1 point awarded upon official Board approval.	Metric Benchmark Provided by MDHHS specifications Executive Owners: Moira Kean and Mila Todd

PERFORMANCE METRIC DESCRIPTION	STATUS
9. SWMBH will achieve 225 enrollees for the Opioid Health Homes Program (OHH) during year 1 of implementation. Metric Measurement Period: (1/1/21 - 9/30/21) Metric Board Report Date: October 8, 2021 and August 12, 2022 A. Target: 225 total enrollees 1/1/21 – 9/30/21. ½ point B. Based on 2021 baseline enrollment data, SWMBH will establish a retention value for enrollees starting 1/1/22 who remain in OHH program for six months or more. ½ point. **Possible Points:** ½ point awarded for each component upon official Board approval. Total of 1 point possible.	Executive Owners: Joel Smith and supporting SL's Metric Specifications www.michigan.gov/OHH. **Measurement Year 1**: 10/1/2020 through 9/30/2021 **Performance Year 1**: 10/1/2021 through 9/30/2022 **Performance Year 2**: 10/1/2021 through 9/30/2022

Strategic Imperative Category: Mission and Value Driven

CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.

PERFORMANCE METRIC DESCRIPTION	STATUS
10. 24/28 or 85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 21. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: January 14, 2022 **Measurement:** Results are verified and certified through the quarterly consultative draft report produced by MDHHS. Total number of indicators that met State Benchmark / Total number of indicators measured **Possible Points:** 1 point awarded upon official Board approval.	▪ Metric Benchmarks Provided by MDHHS. 7/16 indicators currently have benchmarks. ▪ Performance Indicators are reviewed, approved, and validated by HSAG's annual Performance Measure Validation audit. Executive Owners: Jonathan Gardner and Joel Smith

PERFORMANCE METRIC DESCRIPTION	STATUS
11. Regional Habilitation Supports Waiver slots are full at 98% throughout FY21. Metric Measurement Period: (10/1/21 - 9/30/21) Metric Board Report Date: October 8, 2021 (*or when MDHHS posts year end report*). Interim Board Report with (MK or RF) in April 2021 **Measurement:** Results are verified and certified through the MDHHS HSW performance dashboard. (%) of waiver slots (months) filled x 12 / (#) of waiver slots (months) available **Possible Points:** 1 point awarded upon official Board approval. +1 bonus point awarded for (5) or more *new* slots awarded to SWMBH by MDHHS during FY21.	▪ FY20 Result: 99.86% Executive Owners: Moira Kean and Rhea Freitag

Strategic Imperative Category: Quality and Efficiency

The SWMBH region is a learning region where quality and cost are measured, improved, and reported.

PERFORMANCE METRIC DESCRIPTION	STATUS
12. 2021 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and corrective action plans evaluated will receive a score of 90% or designation that the standard has been "Met." Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: November 12, 2021 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. The number of standards/elements identified as "Met." / Total number of standards/elements evaluated **Possible Points:** 1 point awarded upon official Board approval.	HSAG and MDHHS are currently working out a contract and evaluation plan for 2021-2022 annual audits. Current Status: SWMBH received a 90% compliance rate on the 2019 review, which was the highest amongst all Michigan PIHP's. SWMBH recently received a compliance score of 99% on the 2019-2020 review. Executive Owners: All SL's

PERFORMANCE METRIC DESCRIPTION	STATUS
13. 2021 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/2021 - 6/30/21) Metric Board Report Date: September 12, 2021 *(dependent on the final completion date of the annual audit report)* **Measurement:** Results are verified, certified by the MDHHS/HSAG annual audit report. Number of Critical Measures that achieved the status of "Met," "Achieved," or "Reportable." Total number of critical measures evaluated **Possible Points:** 1 point awarded upon official Board approval.	HSAG and MDHHS are currently working out a contract and evaluation plan for 2021-2022 annual audits. 2020 Results: 47/47 measures evaluated achieved full compliance. Executive Owners: Natalie Spivak and Jonathan Gardner

PERFORMANCE METRIC DESCRIPTION	STATUS
14. SWMBH will meet and exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY21. Metric Measurement Period: (1/1/2021 - 12/31/21) Metric Board Report Date: January 14, 2022 Interim Board report with (NS) in June 2021 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. ½ point 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. ½ point **Measurement:** Results are verified, certified by the MDHHS quarterly BH TEDS Regional compliance reports. Number of reportable MH/SUD encounters Number of MH/SUD encounters with a matching BH TEDS record **Possible Points:** ½ point each awarded upon official Board approval.	MDHHS's current benchmark is a 95% compliance rate. 2020 Status: MH: 94.63% SUD: 97.03% Regional Impact: BH TEDS compliance rates and other metrics are factored into the annual rate-setting calculations by Milliman/MDHHS. Executive Owners: Natalie Spivak

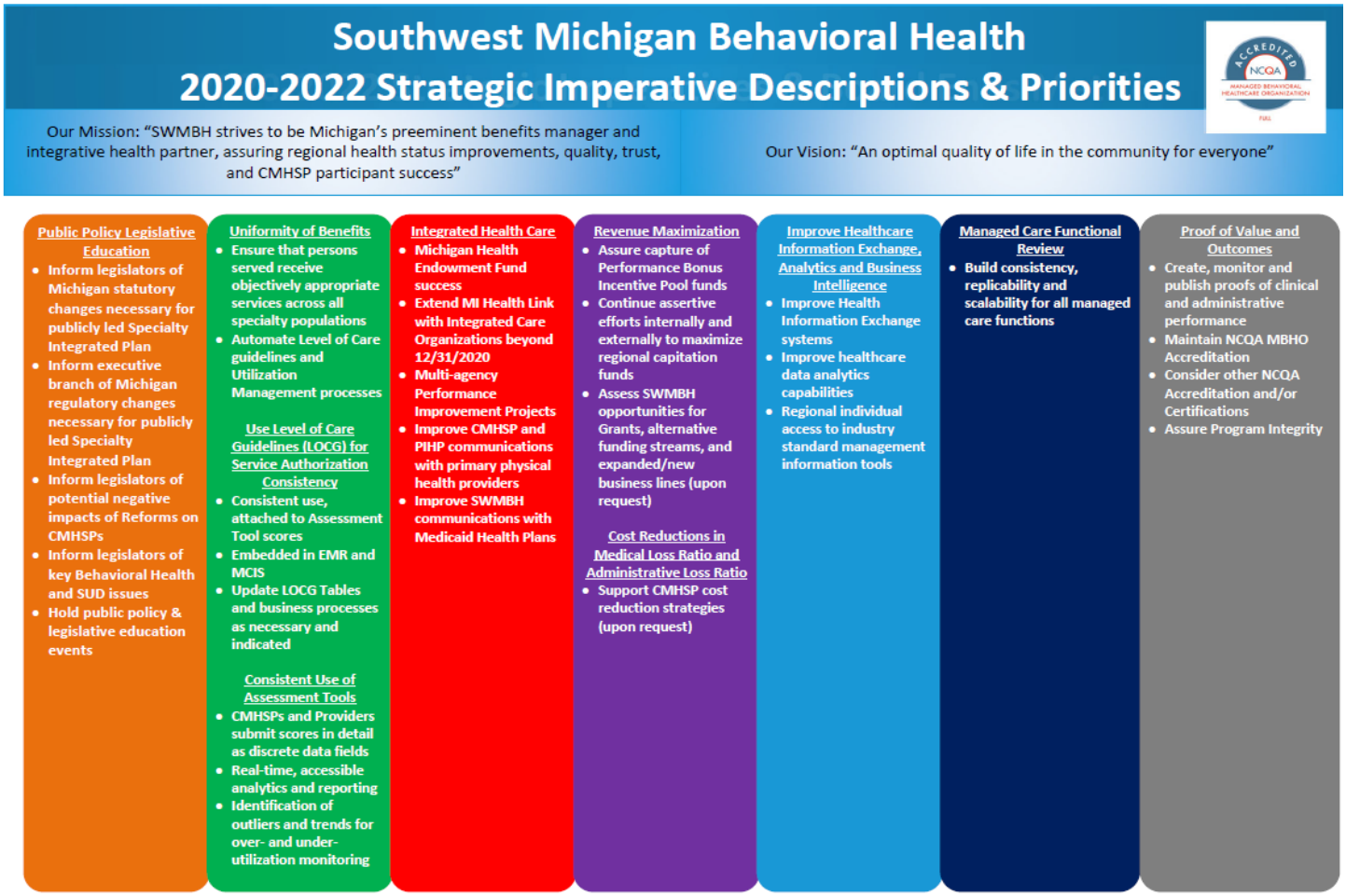
PERFORMANCE METRIC DESCRIPTION	STATUS
15. SWMBH will achieve 90% of the available CY21 monetary bonus award to achieve (*contractually specified*) quality withhold performance measures, agreed upon by the Integrated Care Organizations (ICO's). Metric Measurement Period: (1/1/2021 - 12/31/21) Metric Board Report Date: January 14, 2022 or upon finalization with ICO's A. 90% of claims processed submitted by the 15th of the following month. B. 80% of claims per final reconciliation were timely received. C. 95% CMS initial acceptance rate. D. 95% of enrollees will have a completed level II assessment within 15 days of ICO referral unless previously completed within 12 months. E. 80% of enrollees with an inpatient psychiatric admission for whom a transition record was transmitted within 24 hours of discharge. F. 95% of enrollees will have documented discussions of care goals documented in the ICBR system. G. 56% of enrollees will have a follow-up visit with a behavioral health practitioner within 30 days of release from an inpatient setting. **Measurement:** Results will be verified through the SWMBH/ICO settlement agreement. **Possible Bonus Points:** 1 point awarded upon official Board approval. ½ point each for Aetna and Meridian.	This would be for MIHL Demonstration Year 5 settlement. 2019-2020 Rates: • Meridian: 75% • Aetna 65% Executive Owners: Natalie Spivak, Anne Wickham, Sara Ameter, Moira Kean, Beth Guisinger and Jonathan Gardner

PERFORMANCE METRIC DESCRIPTION	STATUS
16. SWMBH will achieve Recertification of National Committee for Quality Assurance (NCQA) – Managed Behavioral Healthcare Organization Medicare Service Line. Metric Measurement Period: (12/1/2020 - 3/31/21) Metric Board Report Date: June 11, 2021 A. SWMBH will prepare all required evidence for each standard/element and submit through the IRT tool to NCQA by 12/15/20. B. SWMBH will prepare and complete the on-site survey review process by 3/31/21. **Measurement:** Results are verified, certified by the NCQA final compliance report to be received by June 2021. **Possible Points:** • 1 point awarded upon official Board approval. • +1/2 bonus points awarded for achievement of (Full – 3 years) Accreditation.	Current Accreditation is through March 2021 Executive Owners: All SL's

PERFORMANCE METRIC DESCRIPTION	STATUS
17. SWMBH will pursue and apply for a Substance Abuse and Mental Health Services Administration (SAMHSA) Grant by 9/30/21 ***Stretch Goal - Bonus Metric not to be counted in denominator*** Metric Measurement Period: (1/1/2021 - 12/31/21) Metric Board Report Date: January 8 , 2021 A. SWMBH will prepare all documents/evidence/communication required for application submission. **Measurement:** Results are verified through the SAMHSA website and official notification from SAMHSA. **Possible Points:** • 1 point awarded upon official Board approval. • +1 bonus points awarded for a successful Grant award (above $500,000 for duration of Grant).	Executive Owners: TBD

All 2021-2022 Board Ends Metrics are in alignment with the Board Approved Strategic Imperatives & Priorities

Used as guidance document in the formulation of the 2021-2022 Board Ends Metrics



Each Board End Metric current status will be placed into one of (3) categories.

LEGEND: **COMPLETED GOAL/ON TARGET: GREEN** **GOAL NOT MET/BEHIND SCHEDULE: RED** **PENDING: BLUE**

Pending: could represent that;

- More information is needed.
- The event/program/intervention has been scheduled, but not taken place (i.e., audits or final data submissions).
- Data has not been completed yet (i.e., due quarterly or different time table/schedule).
- The Metric is on hold until further information is received.

Not Met: could represent that;

- The proof is behind its established timeline for being completed.
- Reports or evidence for that proof have not been identified.
- The identified metric proof has passed its established timeline target.

Achieved:

- Evidence/proof exists that the Metric has been successfully completed.
- The Metric has been presented and approved by the SWMBH Board.

SWMBH

Memo

To: SWMBH Board

From: Bradley P. Casemore

cc:

Date: December 11, 2020

Re: Michigan Consortium for Healthcare Excellence (MCHE) Membership

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Board Policy BEL-010 requires annual Board consideration of our Membership in Michigan Consortium for Healthcare Excellence (MCHE).

Management strongly recommends the following Motion: *Given the past, present and potential future benefits to our Region and our Regional Entity the Board commits to MCHE membership through December 31, 2021.*

Our participation in MCHE has supported information-sharing, benchmarking, policy analyses and group purchasing opportunities and savings over the years. It is without material current expense.

Southwest Michigan Behavioral Health CY 2020 Board Calendar						
	January-21	**February-21**	**March-21**	**April-21**	**May-21**	**June-21**
Events	•Board Member Attendance to CMHSPs (July-December)	• Nothing scheduled	•Nothing scheduled	• Election of Officers •External Auditor Report Fiscal Year 2020	• Board Retreat	•Nothing scheduled
Required Operational Plans/ Policies Review	•FY 2021 Quality Assurance and Performance Improvement Plan	•Nothing scheduled	• Operating Agreement Review	•Operations Committee Self Evaluation	•Environmental Scan and Strategic Imperatives	• Nothing scheduled.
Board Education	•FY 2020 Program Integrity Compliance Evaluation • Operations Committee Written Report •FY 2020 Member Services Report	•FY 2020 Quality Assurance and Performance Improvement Program Evaluation •2021 Utilization Management Plan •FY2021 Budget Update	•Integrated Care •Consider Alternate Board Meeting Locations •FY20 Performance Incentive Program Revenue •FY 2020 HIPAA Privacy/Security Report	•Written MCHE Update • Operations Committee Written Report • Public Policy Committee Update/Events	•MI Health Link Update •FY 2021 Mid-Year Contract Vendor Summary	•Management Information & Business Intelligence (MIBI) •Information Systems Update •FY 2022 Budget Assumptions •Mid-Year Program Integrity Compliance Report

Southwest Michigan Behavioral Health Board Policy Review Calendar Year 2021

Policy Number	Policy Name	Board Review	Reviewer
Board Governance (Policy Review)			
BG004	Board Ends and Accomplishments	January	Board
BG006	Annual Board Planning	April	Board
BG007	Code of Conduct	January	Board
BG001	Committee Structure	January	Board
BG010	Board Committee Principles	April	Board
BG011	Governing Style	May	Board
BG012	Open Meetings Act and Freedom of Information Act	June	Board
BG002	Management Delegation	August	Board
BG008	Board Member Job Description	September	Board
BG003	Unity of Control	November	Board
BG005	Chairperson's Role	December	Board
Direct Inspection (Reports)			
BEL001	Budgeting	January	Barnes
BEL007	Compensation and Benefits	June	Perino
BEL002	Financial Conditions	June	Cass County
BEL006	Investments	June	St. Joseph County
BEL004	Treatment of Staff	May	Garrett
BEL005	Treatment of Plan Members	August	Krogh
BEL009	Global Executive Constraints	September	Meny
BEL008	Communication and Counsel	October	Schmelzer
BEL010	RE 501 (c) (3) Representation	November	Krogh
BEL003	Asset Protection	December	Barnes
Board-Staff Relationship (Policy Review)			
EO002	Monitoring Executive Performance	November	Board
EO001	Executive Role & Job Description	September	Board
EO003	Emergency Executive Officer Succession	October	Board

Board Approved

Per Operating Agreement Operations Committee must review "prior to presentation and approval by the SWMBH Board"

	Items not date specific	December-20	January-21	August-21
Finance	• Reviews Committee work plans and goals annually • Reviews functional consolidation and administrative efficiencies before submission to the SWMBH Board • Reviews Committee Charter if requested	•2021 Financial Management Plan •2021 Cost Allocation Plan •2021 Financial Risk Management Plan		•Reviews Annual Operating and Capital Budget
QAPI	• Reviews Committee work plans and goals annually • Reviews Committee Charter if requested	•2021 Quality Assurance and Performance Improvement Plan		
Utilization Management, Compliance and Information Technology	• Reviews Committee work plans and goals annually • Reviews Committee Charter if requested		•2021 UM Plan	

Provider Network	•Reviews Committee work plans and goals annually •Advises the EO and provides a recommendation to the Board regarding any additional contractual arragements that involve Participants and/or other vendors • Reviews Committee Charter if requested • Consulted regarding significant contract arrangements that involve SWMBH and CMHSPs			
Human Resources	• The SWMBH Employee Handbook must be made available upon request • May make recommendations to the EO on the use of hired staff or the use of contract staff to secure other established positions as required			
SUD	•Review all Grant applications prior to submission			
Customer Services	• Reviews Committee work plans and goals annually • Reviews unresolved dispute resolutions • Reviews Committee Charter if requested			
Clinical	• Reviews Committee work plans and goals annually • Reviews Clinical Practices Programs prior to implementation and/or presentation to the Board • Reviews Committee Charter if requested			

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	**Policy Number:** BG-012	**Pages:** 1
Subject: Open Meetings Act and Freedom ~~O~~of Information Act	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 6.12.15	**Last Review Date**: 6/12/20 12/11/20	**Past Review Dates**: 6/9/17; 6/10/16; 6/8/18; 6/14/19

I. **PURPOSE:**

To provide the SWMBH Board the specific requirements for operating in compliance with Michigan's Open Meetings Act, 1976 PA 267, PA 228 of 220, and the Freedom of Information Act, 1976 PA 422.

II. **POLICY:**

The Regional Entity ~~and its Participant CMHSP Boards,~~ and members of the Regional Entity SWMBH Board, officers, and staff ~~and other employees~~ shall fully comply with all applicable laws, regulations and rules, including without limitation 1976 PA 267 (the "Open Meetings Act"), PA 228 of 2020 and 1976 PA 422 (the "Freedom of Information Act"). ~~The Regional Entity~~ SWMBH shall develop ~~such~~ related compliance policies and procedures. ~~In the event that~~If ~~any such~~ noncompliance is found, immediate corrective action ~~as defined in the Operating Agreement~~ shall be taken by the appropriate ~~source~~ persons to ensure compliance. ~~Compliance policies and procedures will be defined in the Operating Agreement.~~

~~*SWMBH Bylaws 04.13 Compliance with Laws*~~

III. **STANDARDS:**

SWMBH shall operate in compliance with the procedures prescribed in Michigan's Open Meetings Act, 1976 PA 247, PA 228 of 2020 and the procedures prescribed in Michigan's Freedom of Information Act, 1976 PA 442.

~~References~~

- ~~SWMBH Operating Policy 10.12: Freedom of Information Request Policy~~

~~Attachments:~~

- Michigan's Open Meetings Act, 1976 PA 267.
  - http://www.michigan.gov/ag/OMA_handbook_287134_7.pdf
- Michigan's Freedom of Information Act, 1976 PA 442
  - http://www.michigan.gov/documents/ag/FOIA_pamphlet_380084_7.pdf
- PA 228 of 2020
  - http://blogs.mml.org/wp/coronavirus/files/2020/11/2020-PA-0228.pdf

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Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

SWMBH December 202019

1115 Demonstration waiver, 1915 (c)/(i), Healthy Michigan Plan and Autism Program

SWMBH is solely responsible for Medicaid and Healthy Michigan Plan supports and services and any cost overruns at participating CMHSPs or in the aggregate. SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) or purchase risk reinsurance, at levels appropriate for this purpose. SWMBH will maintain a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on state maximums and actuarially determined risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10) and the Medicaid Contract.

Beyond this and in further protection of SWMBH, participating CMHSPs will submit timely, complete and accurate financial information, results of operations and apportioned regional contract cost compared to sub-contract revenues which balance to actual confirmed claims and encounters. This shall be in a form and format determined by SWMBH.

This reporting will be inclusive of all of the activities of the CMHSP. While SWMBH has responsibility for only the regional contract activities and cost, SWMBH has to assure that it is being charged for only those costs that are ordinary and necessary, properly assigned, allocated and apportioned, for appropriate, medically necessary, covered services provided or arranged for contracted eligible beneficiaries. It is also in SWMBH's best interest to assure itself of the financial stability and viability of participating CMHSPs. Should a participating CMHSP exceed, or project to exceed, its sub-contract revenue amount, that CMHSP will be provided additional technical support and oversight from SWMBH and/or its agents. This could include:

- Enhanced management and financial review by SWMBH Chief Executive Officer, Chief Financial Officer, or their designees.
- Provision of special technical assistance off-site and on-site to the CMHSP
- Development and implementation of a Corrective Action Plan.
- Presentation to SWMBH Board for approval of the need for a sub-contract budget adjustment and funding increase.

Should SWMBH be imposed any contractual remedies, sanctions or penalties by a regulatory body or contractual payer that is a direct result of participating CMHSP failure to perform or rectify the participating CMHSP shall hold SWMBH harmless and make whole SWMBH for cost incurred or revenues lost as a result, with non-Medicaid funds.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

Healthy Michigan Plan

SWMBH is solely responsible for Healthy Michigan supports and services and any cost overruns at participating CMHSPs or in the aggregate. To this end, SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) and/or to purchase risk reinsurance, at levels appropriate for this purpose. SWMBH maintains a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on actuarially determined risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10)

MI Health Link- Medicare Medicaid Dual Eligible (MME) Demonstration Participating CMHSPs are paid FFS for MI Link participants. There are no risk sharing arrangements with the CMHSP's. SWMBH PIHP and Integrated Care Organizations (ICO) have specific risk sharing arrangements according to their respective contracts.

Substance Abuse Prevention and Treatment Block Grant/PA2

Allocation of substance use prevention and treatment Block Grant and PA2 revenues among participating CMHSPs are determined by eligibles within the region, allocations based on the 2010 Census and regional county board request. PA2 funds and budgets are reserved to the sole authority of the Substance Use Disorder Oversight Policy Board. These are not entitled services and these services maybe reduced/suspended or terminated by SWMBH for lack of funding.

Other Revenues

SWMBH management and/or Board considers recommendations for other contracts and thus revenues and expense allocation on a case by case basis. SWMBH Board may allocate other contracts and revenues among participating CMHSPs and SWMBH based on a number of beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

Investment Management

It is the business practice of SWMBH to invest remaining funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds. Further information is provided on investment management in the Region Entity Investment Policy and ISF policy.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

Supervision of External Audits, Internal Audits, and Internal Controls

Independent Annual Audit - SWMBH and each participating CMHSP shall ensure the completion of an annual financial audit performed by an independent certified public accountant. A copy of the audit report, audited financial statements, footnotes and supplementary schedules, along with the management letter and management's response to the management letter, shall be submitted to SWMBH within five (5) business days of the presentation to the CMHSP Board.

Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH within 10 days of its completion by the audit firm.

Internal Audits – SWMBH will perform internal audits on as needed basis

Internal Controls - SWMBH shall maintain appropriate written policies, and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

Southwest Michigan Behavioral Health (SWMBH) Financial Management Plan

This Financial Management Plan is prepared as an integral part of the annual operational and fiscal budget planning process. The Financial Management Plan shall be approved by SWMBH Board on an annual basis. Material revisions not directly a result of change in federal or state statute or regulation or SWMBH – Michigan Department of Health and Human Services MDHHS Contract terms shall also be approved by SWMBH Board before implementation. The Bylaws of SWMBH refer to the annual Financial Management Plan approved by SWMBH Board as the means to satisfy the legal requirements of the Michigan Mental Health Code, MCL 330.1204b.

SWMBH Financial Management Plan on a consolidated basis shall include:

- A Consolidated Executive Summary of the most significant operational proposals, changes or initiatives of SWMBH or a participating CMHSP, including the financial impacts thereof.
- A Consolidated Summary of Key Statistical Information, Projections and Assumptions.
- A Consolidated Summary Statement of Budgeted Income and Expense by payor and business segment.
- A description and *pro forma* computation of the manner for equitably providing for, obtaining, and allocating revenues between SWMBH and participating CMHSPs in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(i).
- A description and *pro forma* computation of the method or formula for equitably allocating and financing SWMBH's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(ii).
- A description and *pro forma* computation of the method for allocating any of SWMBH's other assets if applicable and in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iii).
- A description and *pro forma* computation of the manner in which, after the completion of its purpose as specified in SWMBH's bylaws, any surplus funds shall be returned to the DHHS in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iv).
- A description of the process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all SWMBH's receipts and disbursements, shall be prepared and presented. This will be in sufficient detail to satisfy

the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(e).

- A *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH Consolidated Financial Management Plan will be reviewed annually by participating CMHSPs. At the participating CMHSP level, the CMH proposed budget shall constitute a request for funding by SWMBH for its applicable allocated and apportioned cost. Each participating CMHSP submits to SWMBH a *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH and participating CMHSPs will comply with The Mental Health Code, the MDHHS Rules, the MDHHS/PIHP Master Contracts, and applicable State and federal laws, regulations, rules, policies and procedures, including but not limited to Balanced Budget Act (BBA) of 1997 as amended and OMB Super Circular.

Financial Management Functions

SWMBH will be responsible for its own financial management functions. Financial management functions for SWMBH include at least the following:

1) Budgeting
2) General accounting
3) Financial reporting, analysis, and monitoring,
4) Financial risk management
5) Investments management
6) Supervision of external audits, internal audits, and internal controls
7) Payments for SUD-, Financial Status Reports (FSR's) and invoices.
8) Cost allocation process

These functions will be performed by SWMBH finance staff under the management direction of SWMBH Chief Financial Officer.

Similar functions will continue to be performed at the participating CMHSPs because they are independent legal entities and have local responsibilities and independent contractual obligations outside of the business relationships with SWMBH.

1. Budgeting – Annual Projections of Revenues and Expenditures

The primary purpose of SWMBH is to contract with the State of Michigan and other payers for services and supports to be delivered to or arranged for covered eligible populations in the region. These services and supports for the regional service area will be provided or arranged for by SWMBH, its participating CMHSPs or others as agreed upon in writing.

Medicaid 1915 (b) / (c) Waiver

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The annual budget shall be prepared and presented as an integral part of the annual financial

management plan to be reviewed and approved by SWMBH Board.

SWMBH CFO will provide revenue projections for each participating CMHSP. Assuming the Medicaid contract continues as a per eligible per month (PEPM) regional rate capitation for eligible populations (from MDHHS to SWMBH), the allocation of SWMBH capitation revenue to the CMHSP of financial responsibility will continue to use the same funding allocation methodology as its starting point for interim payments and annual net cost budget limitations.

This methodology would follow the demographic, coverage levels, rate cells and regional PEPM rates inherent in the regional capitation determination and would fluctuate from month to month based on actual and confirmed eligibility fluctuations. Since the contractual relationship would not be a risk-sharing capitation between SWMBH and CMHSP's, the need for actuarial determinations or findings of "actuarial soundness" of CMH sub-capitation style payments is not required. This funding methodology is best referred to as a sub-capitation style interim payment with an annual net cost budget limitation and net cost settlement.

Recognizing that a regional rate may not be equivalent to the true, appropriate and medically necessary cost of services and supports for the entire eligible population in a specific participating CMHSP's service area, "needs based" funding adjustments for benefit stabilization could be made in the annual prospective funding allocation developed by SWMBH and as approved by SWMBH Board.

SWMBH is the sole party at- risk with the MDHHS. SWMBH will cost settle with the MDHHS. SWMBH would retain any year end contract savings (Medicaid savings), risk reserves and other funds consistent with MDHHS/PIHP contract. For participating CMHSPs the annual net cost budget limitation will be established in the budget and financial management planning process and adjust for changes in eligible covered lives. SWMBH Board may approve prospective performance incentives and sanctions for participating CMHSPs upon SWMBH management request.

Participating CMHSPs shall provide to PIHP on a quarterly basis, the obligation for local funds as a bona fide source of match for Medicaid. The payments shall be submitted to SWMBH in accordance with the schedule established by the MDHHS. SWMBH and participating CMHSPs shall establish mechanisms to assure that the local match of each participating CMHSP is funded at the adequate level. Any participating CMHSP that projects a problem or issue with local match funding shall immediately notify SWMBH. A plan of correction must be completed and sent to SWMBH within ten (10) business days of the identification of the problem.

Capitation revenues by participating CMHSP will be used as the basis of allocation of regional cost and other regional financial considerations applicable to SWMBH expense. This percentage will be established annually during the budget setting process.

The net result would constitute the sub-contract annual net cost budget limitation amount for each participating CMHSP. This initial sub-contract amount would be a "costs not to exceed" and would be subject to cost settlement to be described in the subcontract between SWMBH and the participating CMHSP. Participating CMHSPs are required to provide all medically necessary services to Medicaid beneficiaries, subject to SWMBH utilization management, evidence-based practice guidelines and other relevant policy.

Healthy Michigan Plan

Allocation of Healthy Michigan Plan revenues to SWMBH is determined by the State based on participants in the plan in our region.

Autism is now included as part of the regions capitated funding. The PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual.

MI Health Link Duals Demonstration

Demonstration Participating CMHSPs are paid FFS for MI HealthLink participants. SWMBH and Integrated Care Organizations (ICO) according to their specific agreements pay a PEPM rate for participants enrolled in the demonstration project in our region.

MiChild

A health insurance program for uninsured children of Michigan's working families. MiChild services are provided by many HMOs and other health care plans throughout Michigan, the payment for the program is now included in the Medicaid Capitation payment amount.

Substance Abuse Prevention and Treatment Block Grant/PA2

Allocation of substance use prevention and treatment Block Grant and PA2 revenues among participating CMHSPs are determined by eligibles within the region, allocations based on the 2010 Census and regional county board request. PA2 funds and budgets are reserved to the sole authority of the Substance Use Disorder Oversight Policy Board.

Other Revenues

SWMBH Board considers recommendations for other contracts and thus revenues and expense allocation on a case by case basis. SWMBH Board may allocate other contracts and revenues among participating CMHSPs and SWMBH based on a number of beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

1. Budget Preparation

SWMBH CFO will prepare annual budget for centralized operations that include:

- An Executive Summary of significant operational proposals, changes or initiatives including the financial impacts thereof.
- A Summary of Key Statistical Information, Projections and Assumptions.
- A Summary Statement of Budgeted Income and Expense by payor and segment.

- A detail Operating Budget including revenue and expense at the account and cost center level, with a staffing table at the position and cost center level.
- A Capital Budget showing anticipated replacement or new investment in capital assets.

Annual budget for SWMBH centralized operations will be approved by SWMBH Board.

2. General Accounting

SWMBH maintains accounting and financial reporting system in accordance with Generally Accepted Accounting Principles (GAAP). The accounting procedures and internal financial controls of SWMBH shall conform to Generally Accepted Accounting Principles (GAAP) for governmental units. SWMBH shall maintain accounts and source records in which any and all revenues received and expenses incurred are ascertainable and verifiable and include date of receipt / payment and sources of funds. SWMBH shall have a certified public accounting firm perform an annual independent audit of it in substantial conformance with the American Institute of Certified Public Accountants Guide to assess compliance with the appropriate standard accounting practices and procedures and MDHHS contract requirements.

3. Financial Reporting, Analysis, and Monitoring

SWMBH shall review its Financial Management Plan not less than annually and revise the plan as necessary to maintain an adequate and acceptable level of financial management. To ensure the financial stability of SWMBH, financial activities shall be performed in accordance with applicable federal and state guidelines, rules and regulations as may apply.
Financial management reports for SWMBH and each participating CMHSP shall be prepared monthly and presented to the respective boards of directors and administrative management. SWMBH shall establish the timing and content for required submission of financial management reports and other data from participating CMHSPs.

4.Financial Risk Management: See 8.2 Financial Risk Management Plan Investment Management

It is the business practice of SWMBH to invest remaining funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds Public Act 20 of 1943 as amended. Further information is provided on investment management in the Region Entity Investment Policy and ISF policy.

5. Supervision of External Audits, Internal Audits, and Internal Controls

Independent Annual Audit - SWMBH and each participating CMHSP shall ensure the completion of an annual financial audit performed by an independent certified public accountant. A copy of the audit report, audited financial statements, footnotes and supplementary schedules, along

with the management letter and management's response to the management letter, shall be submitted to SWMBH within 5 business days of CMH Board receipt of the audit.

Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH at the close of the audit, received from the PIHP commissioned auditors within 10 business days of its completion by the audit firm.

Internal Audits – SWMBH will perform internal audits on as needed basis.

Internal Controls - SWMBH shall maintain appropriate written policies, and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

6. Claims Adjudication and Payment

For consistency of policy, process and reporting, SWMBH will utilize a regional claims processing system/process for adjudication of all provider claims and service encounters for which it is the contract holder. Participating CMHSPs may utilize this system/process to adjudicate its external provider claims as needed or the CMHSP will adopt uniform claims adjudication and payment policies that adhere to those utilized at SWMBH or prior approved by SWMBH. This process is managed and monitored by the Operations and Compliance programs of SWMBH.

7. Cost Allocation Process

With respect to the MDHHS capitated funding SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSPs. It shall be the policy of SWMBH that SWMBH will prepare a Cost Allocation Plan as an integral part of their annual budget process and is suggested that each participating CMHSP prepare the same but must adhere to GAAP and the OMB Super Circular.

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Southwest Michigan Behavioral Health (SWMBH) Cost Allocation Plan for CMHSP's

POLICY

SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSP's for those funds received by the PIHP under the contract with MDHHS. It shall be the policy of SWMBH that SWMBH and each of the participating CMHSPs prepare a Cost Allocation Plan as an integral part of their annual budget process. Further, the Cost Allocation Plan methodologies will be used to determine actual allowable cost subject to cost settlement between SWMBH and participating CMHSPs.

The Cost Allocation Plan shall, at a minimum:

1. Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the organization.
2. Conform to the accounting principles and standards prescribed in pertinent contractual agreements, regulations and other authoritative literature (i.e., GAAP, GASB, OMB Super Circular).
3. Contain sufficient information in such detail to permit making an informed judgment on the correctness and fairness of the procedures for identifying, measuring, and allocating all costs to each of the programs operated by the organization.

The cost allocation plan shall contain the following information:

1. An organizational chart showing the placement of each unit or program within the organization.
2. A listing of revenue and costs for all programs performed, administered, or serviced by these organizational units.
3. A description of the activities performed by each organizational unit and, where not self-explanatory an explanation of the benefits provided to other programs performed, administered, or serviced by the organization.
4. The procedures used to identify, measure, and allocate all costs to each benefiting program and activity.
5. The estimated cost impact resulting from changes to a previously approved plan.

TABLE OF CONTENTS

POLICY 1
AUTHORITATIVE GUIDANCE 2
ADEQUACY OF COST INFORMATION 3
ADEQUATE COST DATA AND COST FINDING 3
PRINCIPLE 3
DEFINITIONS 3
Accrual Basis of Accounting 3
Allocable Costs 3
Directly Allocable Costs 3
Indirectly Allocable Costs 4
Applicable Credits 4
Charges 4
Cost Finding 4
Cost Center 4
General Service Costs Centers (Nonrevenue Producing) 4
Revenue Producing Cost Centers 5
RUUAC 5
DETERMINATION OF COST OF SERVICES 5
PRINCIPLE OF COST APPORTIONMENT 5
Departmental Method 5
COST APPORTIONMENT FOR COST-BASED CMHs 5
OBJECTIVES OF APPORTIONMENT 5
COST APPORTIONMENT FOR COST BASED CMHs 6
PROVIDER SERVICES FURNISHED UNDER ARRANGEMENTS 6
APPORTIONMENT OF ADMINISTRATIVE AND GENERAL COSTS NOT DIRECTLY ASSOCIATED WITH PROVIDING SUPPORTS AND SERVICES 6
ALLOCATION AND DISTRIBUTION OF OTHER ADMINISTRATIVE AND GENERAL COSTS 6
COST CENTER FUNCTIONAL DEFINITION 6
GENERAL AND BOARD ADMINISTRATIVE FUNCTIONS 7
PROGRAM ADMINISTRATIVE FUNCTIONS 7
MANAGED CARE ADMINISTRATIVE FUNCTIONS 8
COST ALLOCATION PLAN 8
COST FINDING 8
COST ALLOCATION 9
COST APPORTIONMENT to Payors 9
CONTRACT AND SUBCONTRACT COST SETTLEMENT 10

AUTHORITATIVE GUIDANCE

Authoritative guidance for this policy can be found in the following:

1. The Michigan Department of Community Health contract and other state and federal law, regulation and promulgation.
2. Office of Management and Budget, Super Circular, (formally OMB A-87, Cost Principles for State, Local, and Indian Tribal Governments, with particular reference to Attachment D and the referenced 45 CFR Part 95, Subpart E.
3. Generally Accepted Accounting Principles (GAAP), with particular reference to Governmental Accounting Standards Board (GASB) Statement #34, Basic Financial

Statements and Management's Discussion and Analysis for State and Local Governments (June 1999), and GASB Statement #10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues (November 1989).

ADEQUACY OF COST INFORMATION

Cost information must be current, accurate, and in sufficient detail to support payments made for services rendered. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made.

ADEQUATE COST DATA AND COST FINDING

PRINCIPLE

Organizations receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records, which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

DEFINITIONS

Accrual Basis of Accounting

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Allocable Costs

An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

Directly Allocable Costs

Directly allocable costs are chargeable based on actual usage (e.g., metered electricity) rather than a statistical surrogate.

Indirectly Allocable Costs

Indirectly allocable costs are not chargeable based on actual usage, and thus, must be allocated on the basis of a prospectively documented statistical surrogate (e.g., square feet).

Applicable Credits

Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs *(i.e., COBRA receipts)*.

Charges

The regular rates established by the provider for services rendered eligible individuals and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients. *(i.e., Gross Standard Charge Rate.)*

Cost Finding

Cost Finding is a determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the assignment of direct costs and the allocation of indirect costs.

Cost Center

An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications may be accumulated in separate cost centers created to accumulate these indirectly allocable costs such as depreciation, facilities, and fringe benefits. These cost centers also fall under this definition so as to facilitate cost finding and cost allocation.

General Service Costs Centers (Nonrevenue Producing)

General Service (or Nonrevenue Producing) Costs Centers are those organizational units that are operated for the benefit of the organization as a whole. Each of these may render services to other general service areas as well as to Revenue Producing Cost Centers.

For the CMHSP and PIHP environment, General Service Cost Centers can be further differentiated and grouped by function into:

- General and Board Administrative functions
- Managed Care Administrative functions
- Program Administrative functions

Revenue Producing Cost Centers

Revenue Producing Cost Centers are those that usually provide direct identifiable services to individual consumers.

For the CMHSP and PIHP environment, Revenue Producing Cost Centers can be further differentiated and grouped by similar business activity into:

- Managed Care Risk Contracts (Medicaid, , Healthy Michigan, MI Health Link)
- Service and Support Programs (direct-operated programs)
- Grants and Other Earned Contracts

Ratio of Units to total Units of Service Applied to Cost (RUUAC)

A ratio that may be expressed as follows:

- The ratio of total beneficiary units of service to total units of service applied to total costs on a departmental basis; or
- The ratio of total cost to total units of service applied to total beneficiary units of service on a departmental basis.

DETERMINATION OF COST OF SERVICES

PRINCIPLE OF COST APPORTIONMENT

Total allowable costs of an organization are apportioned between contract eligible individuals and other individuals so that the share borne by the contract is based upon actual services received by contract eligible individuals.

Departmental Method

This method of apportionment is the ratio of covered services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals, applied to the cost of the department.

COST APPORTIONMENT FOR COST-BASED CMH'S

The term apportionment, as used here, refers to the process of distributing allowable costs among various groups of cost-based eligible individuals and other non-eligible individuals.

OBJECTIVES OF APPORTIONMENT

The objectives of the apportionment process are to assure that:

- Costs of covered supports and services provided to eligible individuals under contract will not be borne by other contracts or other individuals.

- Costs of supports and services to non-contract and other non-eligible individuals will not be borne by the contract.

COST APPORTIONMENT FOR COST BASED CMH's

The total allowable cost of supports and services furnished to contract eligible individuals shall be apportioned to the contract on the basis of the ratio of covered supports and services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals. For purposes of this apportionment, the preferred methods are based on RUUAC as defined above.

The PIHP must use a method for reporting costs and statistics that results in an accurate and equitable allocation of allowable ~~costs, and~~costs and is justifiable from an administrative and cost efficiency standpoint.

PROVIDER SERVICES FURNISHED UNDER ARRANGEMENTS

Costs of covered services furnished to contract eligible individuals through arrangements with non-plan providers will, in most cases, are the amount the CMH/PIHP pays the provider under its financial arrangement, to the extent it is found reasonable.

APPORTIONMENT OF ADMINISTRATIVE AND GENERAL COSTS NOT DIRECTLY ASSOCIATED WITH PROVIDING SUPPORTS AND SERVICES

Enrollment and membership costs, as well as other administrative and general costs of the CMH that benefit the total eligible population of the CMH which are not directly associated with providing supports and services, are apportioned on the basis of a ratio of contract eligible population to total PIHP eligible population. These costs are classified as Plan Administration costs. *(i.e., Managed Care Administrative Costs.)*

ALLOCATION AND DISTRIBUTION OF OTHER ADMINISTRATIVE AND GENERAL COSTS

Administrative and General (A&G) costs, other than those described immediately above, which bear a significant relationship to the services rendered are not apportioned to risk contracts directly. Instead, these costs are allocated or distributed to the components of the CMH, which, in turn, are then apportioned to risk contracts.

COST CENTER FUNCTIONAL DEFINITION

The cost allocation plan process recognizes that the organization of cost centers for internal accounting and management responsibility in the formal accounting system may not adequately segregate costs by functional activity for the purpose of reimbursable cost computation. This is particularly critical within non-revenue producing administrative and general service cost centers.

For cost allocation plan purposes, segregation of costs by functional area is required if the

costs are material, the effect of not segregating the costs is significant and if an appropriate basis for cost allocation is available. The functional areas are described below.

For example, if the above conditions are met, the cost of Billing and Accounts Receivable, and Claims and Financial Risk Management would be segregated from General Financial Management and Accounting. However, if not material, not significant or not appropriate, these would not be segregated but allocated together with General and Board Administrative Functions.

The same would apply to such functions as Quality Improvement and Recipient Rights, as similar examples.

GENERAL AND BOARD ADMINISTRATIVE FUNCTIONS

General and Board Administrative functions are those that support the entire organization and are typically allocated to all other revenue and non-revenue producing cost centers typically on the basis of accumulated cost. These costs will be allocated first.

General and Board Administrative functions typically include:

- Board and Executive Administration
- Financial Management and Accounting
- Human Resources and Employee Benefit Management
- Information Systems and Data Processing
- Other functions that benefit the entire organization as a whole

General and Board Administrative costs may also include costs that would otherwise be costs of other functional areas but where the cost of these other functions is immaterial, the effect of segregation is insignificant or an appropriate basis for separate cost finding is not available. Costs associated with other functional areas must be segregated and reclassified prior to allocation, if they are material, their effect is significant, and an appropriate basis exists.

PROGRAM ADMINISTRATIVE FUNCTIONS

Program Administrative functions are those that support the direct-operated Service and Support Programs of the organization. These are typically allocated to all Service Program revenue and non-revenue producing cost centers on the basis of accumulated cost. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Program Administrative functions typically include:

- Program Management and Supervision
- Reception and Appointment Scheduling
- Records Maintenance

- Billing and Accounts Receivable
- Quality Improvement of direct-operated programs
- Recipient Rights, as a direct-operated program
- Other functions that benefit only direct-operated programs

MANAGED CARE ADMINISTRATIVE FUNCTIONS

Managed Care Administrative functions are those that support the Pre-paid Inpatient Health Plan responsibilities under risk contracts for eligible individuals and are typically apportioned to risk contracts on the basis of eligible lives. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Managed Care Administrative functions typically include the following:

- General Managed Care Administration and Governance
- Member Services, including information and referral, and eligibility maintenance, recipient rights advocacy, grievance and appeal management
- Utilization Management, including access to supports and services, provider referral and authorization, and utilization review
- Provider Network Management, including network development and provider contracting
- Claims
- Financial Risk Management
- Quality Improvement of the PIHP
- Regulatory Compliance
- Other functions that benefit the eligible population under contract

COST ALLOCATION PLAN

The Cost Allocation Plan is to be developed and review by SWMBH and the participating CMHSPs as part of the annual budget process. This planning process, in general, involves the following steps:

COST FINDING

Matching of related revenue and costs, identification of functional activities and associated costs, and, if necessary (and allowable), cost reclassifications to segregate:

- Capital-Related Cost, if not already properly assigned
- Employee Benefit Cost, if not already properly assigned
- General and Board Administrative Cost

- Program Administrative Cost
- Service Program direct and assigned indirect costs
- Grants and Earned Contract direct and assigned indirect costs
- Managed Care Administrative Cost
- Contract Provider and CMHSP Subcontract Program cost for supports and services provided to eligible individuals and segregated by risk contract responsibility.

COST ALLOCATION

Allocation of functional indirect costs to revenue/cost centers based on a priority of allocation and statistical allocation proxies.

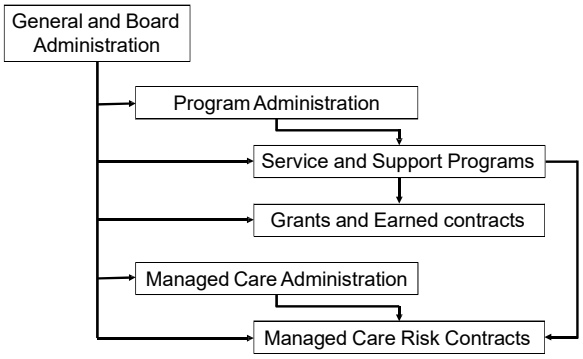
- Capital-Related Cost (depreciation and amortization, etc.) and Building Occupancy Costs, based on square feet operated for building and occupancy costs and actual depreciation for equipment and furnishings in use.
- Employee Benefit Costs, based on the dollar value of Salaries and Wages.
- General and Board Administrative Cost to all revenue / cost centers based on accumulated cost.
- Program Administrative Cost to all applicable Service Programs based on accumulated cost.

COST APPORTIONMENT to Payors

- Managed Care Administrative Costs, including previously allocated costs, apportioned to Managed Care Risk Contracts or Subcontracts based on accumulated cost.

A schematic of cost allocation process is as follows:

Cost Allocation Plan Schema



CONTRACT AND SUBCONTRACT COST SETTLEMENT

Contract and Subcontract Cost Settlement including identification of sufficient local matching fund revenues to meet matching fund requirements takes place annually.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy- Board Governance/ Management	Policy Number: BG-005	Pages: 2
Subject: Board Chair Role	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 12.20.2013	**Last Review Date**: 12.13.19	**Past Review Dates**: 11.14.14, 12.11.15, 12.9.16, 12.8.17,12.14.18

I. **PURPOSE:**
To establish the role of the Chair of the SWMBH Board.

II. **POLICY:**
It shall be the policy of the SWMBH Board to abide by its bylaws in the management of its business affairs. The Chair shall preside at all SWMBH Board meetings.

The Chair shall have the power to perform duties as may be assigned by the Regional Entity Board. If the Chair is absent or unable to perform his or her duties, the Vice Chair shall perform the Chair's duties until the Regional Entity Board directs otherwise.

III. **STANDARDS:**
The Chair shall be a specially empowered member of the Board who shall be responsible for ensuring the integrity of the Board's process and represents the Board to outside parties.

a. The result of the Chair's job is that the Board acts consistently with its own rules and those legitimately imposed upon it from outside the organization.
   1. Meeting discussion content will consist of issues that clearly belong to the Board to decide or to monitor according to Board policy.
   2. Information that is neither for monitoring Board or enterprise performance nor for Board decisions will be avoided or minimized.
   3. Deliberation will be fair, open, and thorough, but also timely and orderly.

b. The authority of the Chair consists in making decisions that fall within topics covered by Board policies on Governance Process and Board-Management Delegation, with the exception of (i) employment or termination of the EO and (ii) areas where the Board specifically delegates portions of this authority to others. The Chair is authorized to use any reasonable interpretation of the provision in these policies.

c. The Chair is empowered to preside over all SWMBH Board meetings with all the commonly accepted power of that position, such as agenda review, ruling, and recognizing.

d. The Chair has no authority to make decisions about policies created by the Board within *Ends* and *Executive Limitations* policy areas. Therefore, the Chair has no authority to supervise or direct the EO.

e. The Chair may represent the Board to outside parties in announcing Board-stated positions and in stating Chair decisions and interpretations within the area delegated to that role. The Chair may delegate this authority but remains accountable for its use.

* Verbatim from the Bylaws:

4.9 Special Meetings. Special meetings of the Regional Entity Board may be held at the call of the Chair of the Regional Entity Board or, in the Chair's absence, the Secretary, or by a simple majority of the Regional Entity Board members.

6.1 Officers. The Officers of the Regional Entity Board shall be the Chairperson, the Vice Chairperson, and the Secretary. Only Officers of the Regional Entity Board can speak to the press as representatives of the Regional Entity.

6.2 Appointment. Officers will be elected by a majority vote of the Regional Entity Board members, and must be a representative of the Participant's Board.

6.3 Term of Office. The term of office of Officers elected in 2013 shall be through March 30, 2014. Thereafter the term of office of Officers shall be annual April to March with annual April Officer elections. Election of Officers of the Regional Entity Board shall occur annually, or in case of vacancy.

6.5 Removal. The Regional Entity Board will be able to remove any Regional Entity Board Officer by a super majority (75% of attendees) vote of Regional Entity Board members present at a meeting where a quorum is present and shall constitute an authorized action of the Regional Entity Board.

6.6 Chair. The Chair shall preside at all Regional Entity Board meetings. The Chair shall have the power to perform duties as may be assigned by the Regional Entity Board. The Chair shall perform all duties incident to the office.

6.7 Vice Chair. The Vice Chair shall have the power to perform duties that may be assigned by the Chair or the Regional Entity Board. If the Chair is absent or unable to perform his or her duties, the Vice Chair shall perform the Chair's duties until the Regional Entity Board directs otherwise. The Vice Chair shall perform all duties incident to the office.

6.8 Secretary. The Secretary shall: (a) ensure that minutes of Regional Entity Board meetings are recorded; (b) be responsible for providing notice to each Regional Entity Board Member as required by law or these Bylaws; (c) be the custodian of the Regional Entity records; (d) keep a register of the names and addresses of each Officer and Regional Entity Board Member; (e) complete all required administrative filings required by the Regional Entity's legal structure; and (f) perform all duties incident to the office and other duties assigned by the Regional Entity Board.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy- Executive Limitation	Policy Number: BEL-003	Pages: 2
Subject: Asset Protection	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.2014	**Last Review Date**: 12.13.19	**Past Review Dates**: 11.14.14, 12.11.15, 12.9.16, 12.8.17,12.14.18

I. **PURPOSE:**
To establish a policy for asset protection, and financial risk management.

II. **POLICY:**
The Executive Officer shall not cause or allow corporate assets to be unprotected, inadequately maintained, or unnecessarily risked.

III. **STANDARDS:**
Additionally, the Executive Officer shall not;

1. Subject facilities and equipment to improper wear and tear or insufficient maintenance.

2. Fail to protect intellectual property, information and files from loss or significant damage.

3. Fail to insure adequately against theft and casualty and against liability losses to Board Members, Staff, and the Organization itself.

4. Compromise the independence of the Board's audit or other external monitoring or advice, such as by engaging parties already chosen by the Board as consultants or advisers.

5. Endanger the Organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission.

6. Change the organization's name or substantially alter its identity in the community.

7. Allow un-bonded personnel access to material amounts of funds.

8. Unnecessarily expose the Organization, its Board, or Staff to claims of liability.

9. Make any purchases:
   i. Wherein normally prudent protection has not been given against conflict of interest
   ii. Inconsistent with federal and state regulations related to procurement using SWMBH funds.

iii. Of more than $100,000 without having obtained comparative prices and quality
iv. Of more than $100,000 without a stringent method of assuring the balance of long-term quality and cost.
v. Of split orders to avoid these criteria.

10. Receive, process, or disburse under controls that are insufficient to meet the Board-appointed auditor's standards.

11. Invest or hold operating capital and risk reserve funds in instruments that are not compliant with the requirements of Michigan Public Act 20.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Date December 11, 2020

Policy Number: BEL-010
Policy Name: Regional Entity 501 (c) 3 Representation
Assigned Reviewer: Mary Middleton

PURPOSE:

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership. On August 12, 2016, the SWMBH Board approved the revised Bylaws presented by the MASACA Board including the fact that the name will be changed to the Michigan Consortium for Healthcare Excellence (MCHE) and on October 5, 2016, the MASACA/MCHE Board accepted the revised MCHE Bylaws. On October 11, 2019 the SWMBH Board reaffirmed its support to continue as a Member of MCHE.

II. **POLICY:**

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

III. **STANDARDS:**

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

1. Provide semi-annual written MCHE status reports to the SWMBH Board in April and October; and
   EO Response: The EO presented written reports to the Board in April and October 2020.
2. Provide verbal reports to the SWMBH Board if there are items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy or finances; and
   EO Response: There were no topics for verbal report during this Policy review period.

3. Present MCHE Articles of Incorporation revisions to the Board prior to voting on them; and

   EO Response: There were no MCHE Articles of Incorporation revisions during this Policy review period.

4. Present MCHE Bylaws revisions to the Board prior to voting on them and after the adoption of them by MCHE Board;

   EO Response: There were no MCHE Bylaws revisions during this Policy review period.

5. Adhere to the Board standard that total direct fiscal year annual costs payable to MCHE shall not exceed $5,000, absent prior official approval of the Board.

   EO Response: There was not total direct fiscal year annual costs payable to MCHE exceeding $5,000, absent prior official approval of the Board.

Motion Requested:

- The Executive Officer is in compliance with this Policy and no revisions are necessary.

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Policy – Executive Limitations	BEL-010	1
Subject:	**Required By**:	**Accountability:**
Regional Entity 501 (c)(3) Representation	Policy Governance	SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
02.13.2015	11/8/19	2.13.15, 3.11.16, 10.14.16, 10.13.17, 10.12.18

I. **PURPOSE:**

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership. On August 12, 2016, the SWMBH Board approved the revised Bylaws presented by the MASACA Board including the fact that the name will be changed to the Michigan Consortium for Healthcare Excellence (MCHE) and on October 5, 2016, the MASACA/MCHE Board accepted the revised MCHE Bylaws. On October 11, 2019 the SWMBH Board reaffirmed its support to continue as a Member of MCHE.

II. **POLICY:**

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

III. **STANDARDS:**

Accordingly, the Executive Officer as SWMBH representative to MCHE shall

1. Provide semi-annual written MCHE status reports to the SWMBH Board in April and October; and
2. Provide verbal reports to the SWMBH Board if there are items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy or finances; and
3. Present MCHE Articles of Incorporation revisions to the Board prior to voting on them; and
4. Present MCHE Bylaws revisions to the Board prior to voting on them and also after the adoption of them by MCHE Board;
5. Adhere to the Board standard that total direct fiscal year annual costs payable to MCHE shall not exceed $5,000, absent prior official approval of the Board. In the event of an urgent payment required, EO shall contact SWMBH Board Chair for guidance.

	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 10/31/2020			**P01FYTD21**	**1**									
3	*(For Internal Management Purposes Only)*													
4	***INCOME STATEMENT***			**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**	**Indirect Pooled Cost**	
5														
6														
7	**REVENUE**													
16	Contract Revenue			24,407,349	18,316,971	3,414,525	1,860,443	289,140	-	376,439	149,831	-	-	
17	DHHS Incentive Payments			101,662	101,662	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			16,218	-	-	-	-	16,218	-	-	-	-	
19	Interest Income - Working Capital			832	-	-	-	-	-	-	-	832	-	
20	Interest Income - ISF Risk Reserve			105	-	-	-	-	-	-	-	105	-	
21	Local Funds Contributions			143,849	-	-	-	-	-	-	-	143,849	-	
22	Other Local Income			-	-	-	-	-	-	-	-	-	-	
23														
24	**TOTAL REVENUE**			**24,670,017**	**18,418,633**	**3,414,525**	**1,860,443**	**289,140**	**16,218**	**376,439**	**149,831**	**144,787**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			1,685,821	361,546	719,103	-	251,954	3,035	309,851	40,332	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			19,363,431	16,111,462	1,689,086	1,376,973	128,241	-	57,669	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			268,973	268,973	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			-	-	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	115,748	-	-	(115,748)		-	-	-		
33														
34	**Total Healthcare Cost**			**21,318,225**	**16,857,729**	**2,408,189**	**1,376,973**	**264,447**	**3,035**	**367,520**	**40,332**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**87.0%**	**91.5%**	**70.5%**	**74.0%**	**91.5%**		**97.6%**	**26.9%**			
37	**Administrative Cost**													
38	Purchased Professional Services			41,007	-	-	-	-	-	-	-	41,007	-	
39	Administrative and Other Cost			808,212	-	-	-	-	13,183	16,611	-	778,894	(477)	
40	Interest Expense			-	-	-	-	-	-	-	-	-	-	
41	Depreciation			7,396	-	-	-	-	-	-	-	7,396	-	
42	Functional Cost Reclassification			-	-	-	-	-	-	-	-	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	-	(477)	477	
44	Delegated Managed Care Admin			1,451,265	1,209,832	127,477	104,170	9,786	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	645,883	94,422	53,989	14,907	636	15,061	-	(824,898)	-	
46														
47	**Total Administrative Cost**			**2,307,880**	**1,855,715**	**221,899**	**158,159**	**24,693**	**13,819**	**31,672**	**-**	**1,923**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.8%**	**9.9%**	**8.4%**	**10.3%**	**8.5%**		**7.9%**	**0.0%**	**3.5%**		
49														
50	Local Funds Contribution			143,849	-	-	-	-	-	-	-	143,849	-	
51	PBIP Transferred to CMHPs			-								-		
52														
53	**TOTAL COST after apportionment**			**23,769,954**	**18,713,444**	**2,630,088**	**1,535,132**	**289,140**	**16,854**	**399,193**	**40,332**	**145,772**	**-**	
54														
55	**NET SURPLUS before settlement**			**900,063**	**(294,811)**	**784,438**	**325,311**	**-**	**(636)**	**(22,753)**	**109,499**	**(985)**	**-**	
56	**Net Surplus (Deficit) % of Revenue**			**3.6%**	**-1.6%**	**23.0%**	**17.5%**	**0.0%**	**-3.9%**	**-6.0%**	**73.1%**	**-0.7%**		
58	Prior Year Savings			-	-	-	-	-		-	-	-		
59	Change in PA2 Fund Balance			(86,746)	-	-	-	-		-	(86,746)	-		
60	ISF Risk Reserve Abatement (Funding)			(105)	-	-	-	-		-	-	(105)		
61	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-		-	-	-		
62	Settlement Receivable / (Payable)			-	294,811	30,500	(325,311)	-	-	22,753	(22,753)	-		
63	**NET SURPLUS (DEFICIT)**			**813,211**	**-**	**814,937**	**-**	**-**	**(636)**	**-**	**-**	**(1,090)**	**-**	
64	*HMP & Autism is settled with Medicaid*													
65														
66	**SUMMARY OF NET SURPLUS (DEFICIT)**													
67	Prior Year Unspent Savings			-	-	-	-	-		-	-	-		
68	Current Year Savings			814,937	-	814,937	-	-		-	-	-		
69	Current Year Public Act 2 Fund Balance			-	-	-	-	-		-	-	-		
70	Local and Other Funds Surplus/(Deficit)			(1,726)	-	-	-	-	(636)	-	-	(1,090)	-	
72	**NET SURPLUS (DEFICIT)**			**813,211**	**-**	**814,937**	**-**	**-**	**(636)**	**-**	**-**	**(1,090)**	**-**	
73														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 10/31/2020			1									
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										**P01 projected by SWMBH**			
6	***Medicaid Specialty Services***			*HCC%*	80.3%	75.3%	80.3%	79.8%	76.3%	80.5%	82.4%	84.8%	80.8%
7	Subcontract Revenue		18,316,971	1,086,824	17,230,147	753,322	3,412,704	947,955	3,155,727	946,015	5,242,077	1,129,733	1,642,614
8	Incentive Payment Revenue		101,662	47,779	53,884	4,765	-	15,885	28,063	405	-	4,765	-
9	**Contract Revenue**		**18,418,633**	**1,134,603**	**17,284,030**	**758,087**	**3,412,704**	**963,840**	**3,183,789**	**946,420**	**5,242,077**	**1,134,499**	**1,642,614**
10													
11	External Provider Cost		12,509,427	361,546	12,147,881	390,736	2,546,794	526,637	2,103,930	512,512	4,308,614	864,564	894,095
12	Internal Program Cost		4,169,657	-	4,169,657	236,797	802,362	228,553	864,385	279,845	710,164	397,814	649,735
13	SSI Reimb, 1st/3rd Party Cost Offset		(77,834)	-	(77,834)	(722)	(33,949)	(2,235)	(6,436)	(3,585)	(21,606)	(5,241)	(4,060)
14	Insurance Provider Assessment Withhold (IPA)		268,973	268,973	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(22,279)	(22,279)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**16,847,943**	**608,240**	**16,239,703**	**626,811**	**3,315,207**	**752,955**	**2,961,879**	**788,773**	**4,997,172**	**1,257,137**	**1,539,771**
17	**Medical Loss Ratio (HCC % of Revenue)**		**91.5%**	**53.6%**	**94.0%**	**82.7%**	**97.1%**	**78.1%**	**93.0%**	**83.3%**	**95.3%**	**110.8%**	**93.7%**
18													
19	**Managed Care Administration**		**1,865,501**	**645,883**	**1,219,618**	**65,109**	**259,427**	**62,942**	**202,832**	**71,761**	**392,017**	**70,303**	**95,226**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**10.0%**	**3.5%**	**6.5%**	**9.4%**	**7.3%**	**7.7%**	**6.4%**	**8.3%**	**7.3%**	**5.3%**	**5.8%**
21													
22	**Contract Cost**		**18,713,444**	**1,254,123**	**17,459,321**	**691,920**	**3,574,633**	**815,898**	**3,164,710**	**860,534**	**5,389,189**	**1,327,440**	**1,634,997**
23	**Net before Settlement**		**(294,811)**	**(119,520)**	**(175,291)**	**66,167**	**(161,930)**	**147,942**	**19,079**	**85,886**	**(147,112)**	**(192,941)**	**7,617**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		294,811	119,520	175,291	(66,167)	161,930	(147,942)	(19,079)	(85,886)	147,112	192,941	(7,617)
28	**Net after Settlement**		**0**	**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		161,242	161,242	161,242	8,573	30,971	9,145	30,632	9,541	42,123	13,349	16,908
32	Revenue PMPM		$ 114.23	$ 7.04	$ 107.19	$ 88.43	$ 110.19	$ 105.40	$ 103.94	$ 99.20	$ 124.45	$ 84.99	$ 97.15
33	Expense PMPM		$ 116.06	$ 7.78	$ 108.28	$ 80.71	$ 115.42	$ 89.22	$ 103.31	$ 90.19	$ 127.94	$ 99.44	$ 96.70
34	Margin PMPM		$ (1.83)	$ (0.74)	$ (1.09)	$ 7.72	$ (5.23)	$ 16.18	$ 0.62	$ 9.00	$ (3.49)	$ (14.45)	$ 0.45
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		161,242	161,242	161,242	8,573	30,971	9,145	30,632	9,541	42,123	13,349	16,908
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)		12,835	12,835	12,835	1,052	1,999	708	2,719	991	3,000	1,127	1,239
43	% Variance - Fav / (Unfav)		8.6%	8.6%	8.6%	14.0%	6.9%	8.4%	9.7%	11.6%	7.7%	9.2%	7.9%
44													
45	**Contract Revenue before settlement**												
46	Actual		18,418,633	1,134,603	17,284,030	758,087	3,412,704	963,840	3,183,789	946,420	5,242,077	1,134,499	1,642,614
47	Budget		17,005,737	1,436,837	15,568,901	616,365	3,099,678	832,436	2,856,925	812,697	4,813,767	1,045,081	1,491,952
48	Variance - Favorable / (Unfavorable)		1,412,896	(302,234)	1,715,129	141,723	313,025	131,404	326,864	133,723	428,310	89,418	150,662
49	% Variance - Fav / (Unfav)		8.3%	-21.0%	11.0%	23.0%	10.1%	15.8%	11.4%	16.5%	8.9%	8.6%	10.1%
50													
51	**Healthcare Cost**												
52	Actual		16,847,943	608,240	16,239,703	626,811	3,315,207	752,955	2,961,879	788,773	4,997,172	1,257,137	1,539,771
53	Budget		15,887,436	860,837	15,026,599	648,015	3,037,755	796,601	2,678,730	771,398	4,554,626	1,080,980	1,458,495
54	Variance - Favorable / (Unfavorable)		(960,507)	252,597	(1,213,104)	21,204	(277,452)	43,646	(283,149)	(17,375)	(442,546)	(176,157)	(81,275)
55	% Variance - Fav / (Unfav)		-6.0%	29.3%	-8.1%	3.3%	-9.1%	5.5%	-10.6%	-2.3%	-9.7%	-16.3%	-5.6%
56													
57	**Managed Care Administration**												
58	Actual		1,865,501	645,883	1,219,618	65,109	259,427	62,942	202,832	71,761	392,017	70,303	95,226
59	Budget		1,715,480	580,661	1,134,820	48,254	226,441	66,526	193,328	59,107	382,877	67,494	90,792
60	Variance - Favorable / (Unfavorable)		(150,021)	(65,222)	(84,798)	(16,855)	(32,986)	3,583	(9,504)	(12,654)	(9,140)	(2,810)	(4,434)
61	% Variance - Fav / (Unfav)		-8.7%	-11.2%	-7.5%	-34.9%	-14.6%	5.4%	-4.9%	-21.4%	-2.4%	-4.2%	-4.9%

	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 10/31/2020			**1**									
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										**P01 projected by SWMBH**			
62													
63	**Total Contract Cost**												
64	Actual		18,713,444	1,254,123	17,459,321	691,920	3,574,633	815,898	3,164,710	860,534	5,389,189	1,327,440	1,634,997
65	Budget		17,602,917	1,441,498	16,161,419	696,269	3,264,196	863,127	2,872,058	830,505	4,937,503	1,148,474	1,549,288
66	Variance - Favorable / (Unfavorable)		(1,110,528)	187,375	(1,297,902)	4,349	(310,438)	47,229	(292,652)	(30,029)	(451,686)	(178,966)	(85,709)
67	% Variance - Fav / (Unfav)		-6.3%	13.0%	-8.0%	0.6%	-9.5%	5.5%	-10.2%	-3.6%	-9.1%	-15.6%	-5.5%
68													
69	**Net before Settlement**												
70	Actual		(294,811)	(119,520)	(175,291)	66,167	(161,930)	147,942	19,079	85,886	(147,112)	(192,941)	7,617
71	Budget		(597,179)	(4,661)	(592,518)	(79,904)	(164,518)	(30,691)	(15,132)	(17,808)	(123,736)	(103,393)	(57,336)
72	Variance - Favorable / (Unfavorable)		302,368	(114,859)	417,227	146,072	2,588	178,633	34,212	103,694	(23,376)	(89,548)	64,953
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 10/31/2020			1									
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										**P01 projected by SWMBH**			
75	***Healthy Michigan Plan***			*HCC%*	8.4%	15.0%	6.9%	10.6%	10.9%	7.3%	6.7%	8.3%	8.2%
76	**Contract Revenue**		**3,414,525**	**653,205**	**2,761,320**	**138,825**	**559,426**	**134,215**	**504,867**	**157,942**	**782,716**	**215,324**	**268,006**
77													
78	External Provider Cost		1,621,553	719,103	902,450	60,669	134,867	57,732	184,179	14,090	331,733	38,391	80,790
79	Internal Program Cost		786,636	-	786,636	64,325	148,696	42,548	238,644	57,867	75,019	84,370	75,166
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**2,408,189**	**719,103**	**1,689,086**	**124,994**	**283,562**	**100,281**	**422,823**	**71,957**	**406,752**	**122,760**	**155,956**
82	**Medical Loss Ratio (HCC % of Revenue)**		**70.5%**	**110.1%**	**61.2%**	**90.0%**	**50.7%**	**74.7%**	**83.7%**	**45.6%**	**52.0%**	**57.0%**	**58.2%**
83													
84	**Managed Care Administration**		**221,899**	**94,422**	**127,477**	**12,984**	**22,190**	**8,383**	**28,955**	**6,547**	**31,909**	**6,865**	**9,645**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.4%**	**3.6%**	**4.8%**	**9.4%**	**7.3%**	**7.7%**	**6.4%**	**8.3%**	**7.3%**	**5.3%**	**5.8%**
86													
87	**Contract Cost**		**2,630,088**	**813,525**	**1,816,563**	**137,978**	**305,752**	**108,664**	**451,778**	**78,504**	**438,660**	**129,626**	**165,601**
88	**Net before Settlement**		**784,438**	**(160,320)**	**944,757**	**847**	**253,674**	**25,551**	**53,088**	**79,438**	**344,056**	**85,698**	**102,405**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		30,500	975,257	(944,757)	(847)	(253,674)	(25,551)	(53,088)	(79,438)	(344,056)	(85,698)	(102,405)
93	**Net after Settlement**		**814,937**	**814,937**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		62,902	62,902	62,902	3,176	12,762	3,033	11,354	3,821	17,694	4,916	6,146
97	Revenue PMPM		$ 54.28	$ 10.38	$ 43.90	$ 43.71	$ 43.84	$ 44.25	$ 44.47	$ 41.34	$ 44.24	$ 43.80	$ 43.61
98	Expense PMPM		41.81	12.93	28.88	43.44	23.96	35.83	39.79	20.55	24.79	26.37	26.94
99	Margin PMPM		$ 12.47	$ (2.55)	$ 15.02	$ 0.27	$ 19.88	$ 8.42	$ 4.68	$ 20.79	$ 19.44	$ 17.43	$ 16.66
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		62,902	62,902	62,902	3,176	12,762	3,033	11,354	3,821	17,694	4,916	6,146
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)		11,333	11,333	11,333	664	2,352	602	2,186	846	2,642	999	1,043
108	% Variance - Fav / (Unfav)		22.0%	22.0%	22.0%	26.4%	22.6%	24.8%	23.8%	28.4%	17.5%	25.5%	20.4%
109													
110	**Contract Revenue before settlement**												
111	Actual		3,414,525	653,205	2,761,320	138,825	559,426	134,215	504,867	157,942	782,716	215,324	268,006
112	Budget		2,418,918	418,017	2,000,901	96,605	403,713	93,769	358,047	114,026	587,468	151,405	195,869
113	Variance - Favorable / (Unfavorable)		995,607	235,189	760,419	42,220	155,713	40,446	146,820	43,916	195,249	63,919	72,137
114	% Variance - Fav / (Unfav)		41.2%	56.3%	38.0%	43.7%	38.6%	43.1%	41.0%	38.5%	33.2%	42.2%	36.8%
115													
116	**Healthcare Cost**												
117	Actual		2,408,189	719,103	1,689,086	124,994	283,562	100,281	422,823	71,957	406,752	122,760	155,956
118	Budget		2,093,977	484,419	1,609,558	115,063	240,704	105,486	396,983	81,870	427,357	97,109	144,986
119	Variance - Favorable / (Unfavorable)		(314,212)	(234,684)	(79,528)	(9,931)	(42,858)	5,205	(25,840)	9,912	20,605	(25,651)	(10,970)
120	% Variance - Fav / (Unfav)		-15.0%	-48.4%	-4.9%	-8.6%	-17.8%	4.9%	-6.5%	12.1%	4.8%	-26.4%	-7.6%
121													
122	**Managed Care Administration**												
123	Actual		221,899	94,422	127,477	12,984	22,190	8,383	28,955	6,547	31,909	6,865	9,645
124	Budget		200,471	79,213	121,258	8,568	17,943	8,809	28,651	6,273	35,925	6,063	9,026
125	Variance - Favorable / (Unfavorable)		(21,427)	(15,208)	(6,219)	(4,415)	(4,247)	426	(304)	(273)	4,016	(802)	(620)
126	% Variance - Fav / (Unfav)		-10.7%	-19.2%	-5.1%	-51.5%	-23.7%	4.8%	-1.1%	-4.4%	11.2%	-13.2%	-6.9%
127													
128	**Total Contract Cost**												
129	Actual		2,630,088	813,525	1,816,563	137,978	305,752	108,664	451,778	78,504	438,660	129,626	165,601
130	Budget		2,294,448	563,632	1,730,816	123,631	258,647	114,295	425,634	88,143	463,282	103,173	154,012
131	Variance - Favorable / (Unfavorable)		(335,639)	(249,893)	(85,747)	(14,347)	(47,105)	5,631	(26,144)	9,639	24,621	(26,453)	(11,589)

	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 10/31/2020			**1**									
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										**P01 projected by SWMBH**			
132	% Variance - Fav / (Unfav)		-14.6%	-44.3%	-5.0%	-11.6%	-18.2%	4.9%	-6.1%	10.9%	5.3%	-25.6%	-7.5%
133													
134	**Net before Settlement**												
135	Actual		784,438	(160,320)	944,757	847	253,674	25,551	53,088	79,438	344,056	85,698	102,405
136	Budget		124,470	(145,616)	270,085	(27,026)	145,066	(20,526)	(67,587)	25,883	124,186	48,232	41,858
137	Variance - Favorable / (Unfavorable)		659,968	(14,704)	674,672	27,873	108,608	46,077	120,676	53,555	219,870	37,466	60,547
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 10/31/2020			**1**									
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										**P01 projected by SWMBH**			
140	***Autism Specialty Services***			*HCC%*	6.8%	5.5%	9.5%	4.7%	7.1%	4.9%	6.8%	3.8%	5.5%
141	**Contract Revenue**		**1,860,443**	**24,660**	**1,835,783**	**97,024**	**349,618**	**106,589**	**339,009**	**71,734**	**534,037**	**150,694**	**187,077**
142													
143	External Provider Cost		1,209,179	-	1,209,179	-	390,456	43,967	154,487	47,870	412,202	56,773	103,423
144	Internal Program Cost		167,794	-	167,794	45,416	614	-	120,204	216	-	325	1,020
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**1,376,973**	**-**	**1,376,973**	**45,416**	**391,071**	**43,967**	**274,691**	**48,085**	**412,202**	**57,098**	**104,443**
147	**Medical Loss Ratio (HCC % of Revenue)**		**74.0%**	**0.0%**	**75.0%**	**46.8%**	**111.9%**	**41.2%**	**81.0%**	**67.0%**	**77.2%**	**37.9%**	**55.8%**
148													
149	**Managed Care Administration**		**158,159**	**53,989**	**104,170**	**4,718**	**30,603**	**3,675**	**18,811**	**4,375**	**32,336**	**3,193**	**6,459**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**10.3%**	**3.5%**	**6.8%**	**9.4%**	**7.3%**	**7.7%**	**6.4%**	**8.3%**	**7.3%**	**5.3%**	**5.8%**
151													
152	**Contract Cost**		**1,535,132**	**53,989**	**1,481,143**	**50,133**	**421,674**	**47,642**	**293,502**	**52,460**	**444,538**	**60,292**	**110,902**
153	**Net before Settlement**		**325,311**	**(29,329)**	**354,640**	**46,891**	**(72,055)**	**58,947**	**45,506**	**19,274**	**89,499**	**90,403**	**76,175**
154	Contract Settlement / Redistribution		(325,311)	29,329	(354,640)	(46,891)	72,055	(58,947)	(45,506)	(19,274)	(89,499)	(90,403)	(76,175)
155	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.3%	0.2%	0.6%	0.6%	0.0%	0.9%	0.0%	0.6%	0.5%
159	**Contract Revenue**		**376,439**	**354,636**	**21,803**	**-**	**-**	**-**	**-**	**12,303**	**-**	**-**	**9,500**
160													
161	External Provider Cost		309,851	309,851	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		57,669	-	57,669	1,458	23,436	5,362	-	8,350	923	9,318	8,822
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**367,520**	**309,851**	**57,669**	**1,458**	**23,436**	**5,362**	**-**	**8,350**	**923**	**9,318**	**8,822**
165	**Medical Loss Ratio (HCC % of Revenue)**		**97.6%**	**87.4%**	**264.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**67.9%**	**0.0%**	**0.0%**	**92.9%**
166													
167	**Managed Care Administration**		**15,061**	**15,061**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**3.9%**	**3.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**382,582**	**324,913**	**57,669**	**1,458**	**23,436**	**5,362**	**-**	**8,350**	**923**	**9,318**	**8,822**
171	**Net before Settlement**		**(6,142)**	**29,724**	**(35,866)**	**(1,458)**	**(23,436)**	**(5,362)**	**-**	**3,953**	**(923)**	**(9,318)**	**678**
172	Contract Settlement		22,753	(13,113)	35,866	1,458	23,436	5,362	-	(3,953)	923	9,318	(678)
173	**Net after Settlement**		**16,611**	**16,611**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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 10/31/2020			**1**									
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										**P01 projected by SWMBH**			
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		23,968,378	2,119,326	21,849,052	989,170	4,321,748	1,188,759	3,999,602	1,187,993	6,558,831	1,495,752	2,107,197
178	Incentive Payment Revenue		101,662	47,779	53,884	4,765	-	15,885	28,063	405	-	4,765	-
179	**Contract Revenue**		**24,070,041**	**2,167,105**	**21,902,936**	**993,936**	**4,321,748**	**1,204,643**	**4,027,665**	**1,188,398**	**6,558,831**	**1,500,517**	**2,107,197**
180													
181	External Provider Cost		15,650,011	1,390,501	14,259,510	451,405	3,072,117	628,336	2,442,596	574,472	5,052,548	959,728	1,078,308
182	Internal Program Cost		5,181,756	-	5,181,756	347,996	975,108	276,464	1,223,234	346,278	786,106	491,826	734,744
183	SSI Reimb, 1st/3rd Party Cost Offset		(77,834)	-	(77,834)	(722)	(33,949)	(2,235)	(6,436)	(3,585)	(21,606)	(5,241)	(4,060)
184	Insurance Provider Assessment Withhold (IPA)		268,973	268,973	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(22,279)	(22,279)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**21,000,626**	**1,637,195**	**19,363,431**	**798,679**	**4,013,276**	**902,564**	**3,659,393**	**917,165**	**5,817,048**	**1,446,313**	**1,808,992**
187	**Medical Loss Ratio (HCC % of Revenue)**		**87.2%**	**75.5%**	**88.4%**	**80.4%**	**92.9%**	**74.9%**	**90.9%**	**77.2%**	**88.7%**	**96.4%**	**85.8%**
188													
189	**Managed Care Administration**		**2,260,620**	**809,355**	**1,451,265**	**82,810**	**312,219**	**75,001**	**250,598**	**82,683**	**456,262**	**80,362**	**111,331**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.7%**	**3.5%**	**6.2%**	**9.4%**	**7.2%**	**7.7%**	**6.4%**	**8.3%**	**7.3%**	**5.3%**	**5.8%**
191													
192	**Contract Cost**		**23,261,246**	**2,446,550**	**20,814,696**	**881,489**	**4,325,495**	**977,565**	**3,909,991**	**999,848**	**6,273,310**	**1,526,675**	**1,920,323**
193	**Net before Settlement**		**808,795**	**(279,445)**	**1,088,240**	**112,447**	**(3,747)**	**227,078**	**117,674**	**188,551**	**285,521**	**(26,158)**	**186,875**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		22,753	1,110,994	(1,088,240)	(112,447)	3,747	(227,078)	(117,674)	(188,551)	(285,521)	26,158	(186,875)
198	**Net after Settlement**		**831,548**	**831,548**	**-**	**0**	**0**	**(0)**	**(0)**	**-**	**-**	**0**	**-**
199													
200													

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1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 10/31/2020			**1**									
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										**P01 projected by SWMBH**			
201	***State General Fund Services***			*HCC%*	4.3%	4.0%	2.8%	4.4%	5.8%	6.4%	4.0%	2.5%	5.1%
202	**Contract Revenue**				**972,349**	**66,104**	**168,273**	**62,628**	**164,128**	**50,982**	**312,715**	**61,991**	**85,528**
203													
204	External Provider Cost				332,854	25,976	22,641	-	56,478	40,716	144,206	19,263	23,575
205	Internal Program Cost				538,333	7,497	94,466	41,400	168,380	22,282	112,489	17,734	74,085
206	SSI Reimb, 1st/3rd Party Cost Offset				(12,673)	-	-	-	-	-	(12,673)	-	-
207	**Total Healthcare Cost**				**858,515**	**33,473**	**117,106**	**41,400**	**224,859**	**62,998**	**244,022**	**36,997**	**97,660**
208	**Medical Loss Ratio (HCC % of Revenue)**				**88.3%**	**50.6%**	**69.6%**	**66.1%**	**137.0%**	**123.6%**	**78.0%**	**59.7%**	**114.2%**
209													
210	**Managed Care Administration**				**71,431**	**3,908**	**10,271**	**3,881**	**17,055**	**6,261**	**20,979**	**2,313**	**6,763**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.7%**	**10.5%**	**8.1%**	**8.6%**	**7.1%**	**9.0%**	**7.9%**	**5.9%**	**6.5%**
212													
213	**Contract Cost**				**929,946**	**37,381**	**127,377**	**45,281**	**241,914**	**69,259**	**265,001**	**39,310**	**104,423**
214	**Net before Settlement**				**42,403**	**28,723**	**40,896**	**17,347**	**(77,786)**	**(18,277)**	**47,714**	**22,681**	**(18,895)**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(129,508)	(27,652)	(32,482)	(16,331)	-	-	(32,078)	(20,965)	-
218	**Net after Settlement**				**(87,104)**	**1,071**	**8,414**	**1,016**	**(77,786)**	**(18,277)**	**15,636**	**1,716**	**(18,895)**
219													

Southwest Michigan
BEHAVIORAL HEALTH

Information Technology Services

Board Update

December 11, 2020

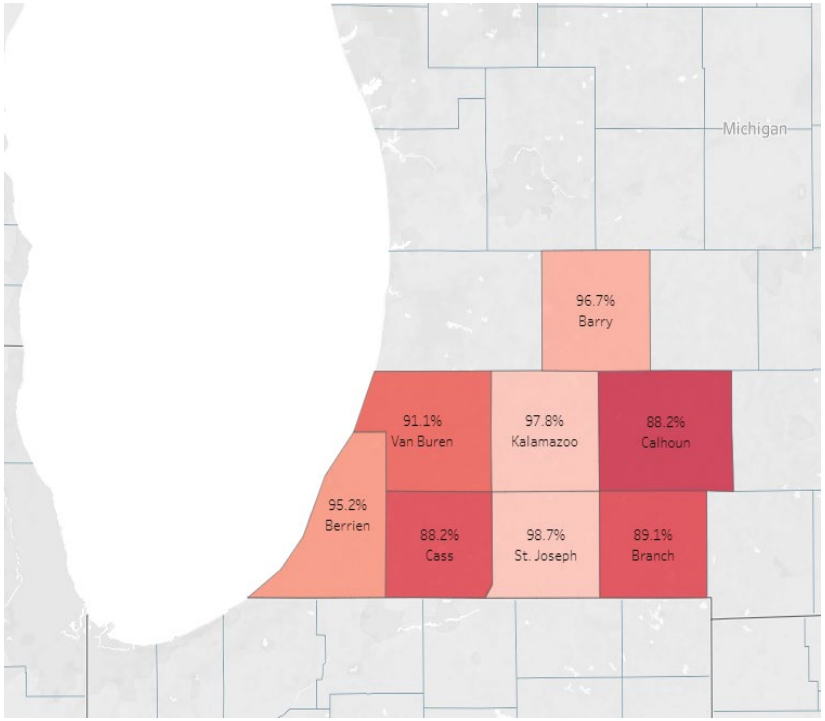
Information Technology Services

- ITS Strategic Imperatives
  - Improve Health Information Exchange systems
    - Work with MIHIN on ADT and CCDA
  - Improve healthcare data analytics capabilities
    - Tableau
    - Report Requests
    - Metrics
  - Regional individual access to industry standard management information tools
    - Complete implementation of new Relias population performance tool and share access with CMHs

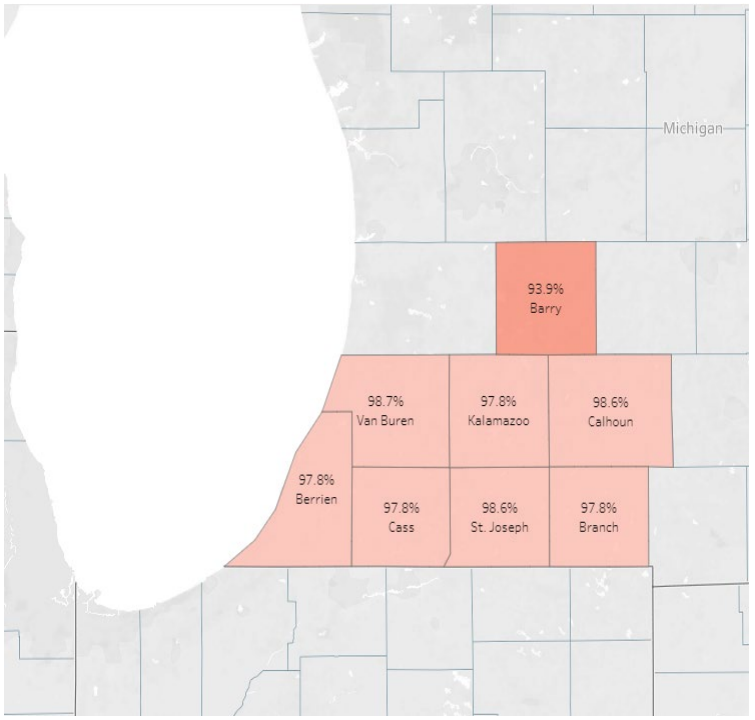
Information Technology Services

- BH-TEDS – Board Ends Metric, 97% Goal - MDHHS Goal 95%

  - FY2020 MH



  - FY2020 SUD-CMH



Information Technology Services

➢Support for Covid -19 Transition to Remote Work

- Deployed smartphones, headsets and other equipment needed to support remote work
- Made website changes to comply with governor's orders
- Added file structure to house upstream guidance
- Contracted for teleconferencing applications
- Added electronic version of Consent to Share Behavioral Health Information to SWMBH website to facilitate access for consumers and providers
- Encounter Analysis – Impact of Covid- 19 on Service Delivery

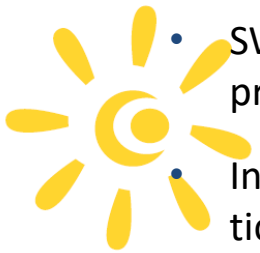
Information Technology Services

- Top 10 ITS Responsibilities
  - Data collection, management and exchange with CMHs, MDHHS and ICOs
  - Database administration
  - Systems engineering, management and technical support
  - Process automation
  - Network and Data security
  - Help Desk and preventative maintenance
  - IT procurement and deployment
  - Projects and Upgrades
  - IT strategic planning
  - IT Governance

Information Technology Services

➢ Managed Services

- Secant merged with three other entities to become Aunalytics
- Call quality jitter resolved by removing an unnecessary feature from the call manager server
- Replaced end of life conference room phones
- Moved Expressway Edge phone VPN server to Aunalytics data center to reduce dropped calls for call center staff working remotely
- Regularly update Windows software and applications on laptops and servers
- Implemented bi-weekly status calls with Aunalytics Client Success Advisor
- Deployed 11 new HP laptops to replace older devices and ordered new laptops for Finance Department
- SWMBH Servers will be moved to faster disk by end of CY 2020 which will improve processing time and reduce backup time
- Investigating switching to a Help Desk application that integrates with Aunalytics ticketing system



Information Technology Services

Security Management

- Completed two comprehensive IT security audits from Aetna/CVS
- Converted Anti-spam software from Email Defender to Microsoft Advanced Threat Protection
- Created IT Incident Response Plan and completed annual Risk Assessment
- Implemented mobile device management on SWMBH smartphones
- 100% of SWMBH staff received training on Internet Security, Social Engineering and Common Threats. On phishing simulations SWMBH staff scored 9.8% compared to the industry average of 15.7%.
- Converted Anti-virus software to Sophos which has ransomware protection
- Isolated guest network from production network and enabled content filtering on the SWMBH firewalls
- Received excellent score on 2020 network penetration test with no high or critical vulnerabilities on endpoints

Information Technology Services

➢ Completed Data & Reports

- Non-Exempt Workers for Healthy Michigan Plan
- Recoupment of capitated payments for deceased clients
- Medicaid Utilization and Net Cost Report
- Inpatient Length of Stay and Hospital Follow-up Reports
- Missing BHTEDS reports and dashboards
- Encounter Data Quality Report
- Member Level Risk Data Reports
- Prevalence reports for the Region and by County
- Meridian cost settlement data
- Assessment extracts- LOCUS, SIS, CAFAS
- Risk stratification for Kalamazoo Health Connections program
- Complete data extracts for 820 payment and 834 enrollment to CMHs

Information Technology Services

➢Other Completed Projects and Work in Process

- Updated service bus to enable more efficient data exchange
- Converted Cobblestone License to Adobe sign for cost savings
- Converted provider tracking application from MS Access to Web based easy to use tool (Strategic Imperative)
- Working with Relias to install and test new Population Performance analytics tool
- Matched MDHHS logic on BHTEDS dashboard
- Added test environment for Tableau software
- Conversion from Unit Cost Reports to Encounter Quality Initiative (EQI)
- Adoption of Microsoft Teams for collaboration
- Support of MCG integration

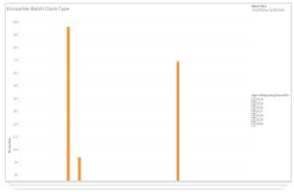
Information Technology Services

➢ITS Committees

- Data Exchange – John Holland, Chair RITC – Andy Aardema, Chair
  - Review Submission Status and Data Qualitv Dashboards


Encounter Submission to Resp...


File Exchange Status


MDHHS Encounter Batches - S...

  - Discuss Data Extracts
  - Discuss Current Initiatives (October 2020)
    - EQI and Milliman Rate Setting
    - BH-TEDS Double Entry Project
    - Direct Care Worker Wage Increase Reporting
  - Review SWMBH Tasks (Recently Completed)
    - Missing BHTEDS Permanent Exclusion List
    - Share CC360 Claim Extract Load ETL with Kalamazoo and Cass
    - MDHHS BH Teds FY 21 Validation Changes
    - BH Teds Wordgroup – Not Collected rates for federal Fields

Information Technology Services

- Future Initiatives
  - Multi-factor authentication
  - Data Loss prevention
  - Mobile Device Management on laptops
  - Conversion of SWMBH SharePoint to Microsoft cloud
  - Health Information Exchange

Information Technology Services

Industry Predictions

- The COVID-19 pandemic and mental health crisis will collide and demand attention. This will enable and force us to face our isolation but recognize our interconnected humanity, our compassion, and our empathy for others. Digital technologies, like telehealth, digital therapeutics and artificial intelligence/machine learning, are all candidates to catalyze a new world with a common cause. – Beckers

- More than one-third of virtual care visits will be for mental health. Mental health has become the shadow crisis of the pandemic and will be a major driver behind sustained virtual care engagement. The mental health crisis will stretch into 2021 as many suffering in silence reach a breaking point and consumers struggle to overcome barriers to affordable access. Virtual mental health visit demand will remain high, estimated to total 138 million visits in 2021. This will equal approximately 31% of all virtual care visits over the year. – Forrester

- Data is the new health care currency
  Artificial intelligence and real-world evidence are unlocking value in health data - Deloitte

Information Technology Services

Questions / Comments?

Community Mental Health Association of Michigan

2020 Lame Duck Tracker

Crisis Stabilization Units – HB 5832

In late June an amended version of HB 5832 was passed by the House Ways and Means Committee and then later in the evening it passed the full House on a 102-5 vote. The amendments are attached, as well as the new version of the bill.

HB 5832 creates crisis stabilization units, CSUs modernize the MH code regarding crisis services. Currently, there are too many grey areas around prescreening units, what they can do and not do and with the inpatient bed issue there is a need for change. These units are not required, they just provide the system another tool in the crisis continuum.

Before the bill passed the House CMHA was able to add the following amendments:

* Required as part of the certification standards that DHHS will develop any entity operating a CSU that would like to receive payment for the public mental health population must have a formal agreement in place with their local CMH, which will allow management of the risk of runaway costs.
* Removed a requirement that was added into the bill mandating face-to-face psychiatric supervision at a similar level as an inpatient setting (the language did not allow for telehealth services).

Universal Credentialing – HB 5178

On Thursday, September 24, the Senate Health Policy Committee approved HB 5178, which would require DHHS to establish, maintain, and revise, as necessary, a uniform CMH services credentialing program for State department or agency use. The State department's or agency's credentialing and recredentialing process would have to comply with national standards.

SB 813 – Reporting for Inpatient Units

On September 30, the full Senate approved SB 813, which would require the DHHS to investigate all deaths reported by a psychiatric hospital or psychiatric unit that were the result of suicide or where the cause of death was reported as unknown.

Senate Minority Leader Jim Ananich (D-Flint) testified that he's alarmed by reports of people dying shortly after leaving in-patient care at psychiatric facilities. Relatives usually feel relief when they check a

loved one into a psychiatric facility, he contended, knowing they are going to get the care, support and therapy they need.

The bill will "help us get our arms around the magnitude of this problem" and help the state to understand and identify patterns in the who, what, where, when and how many of these deaths are occurring, he said.

- **HB 5615 – Reporting for Inpatient Units**

- Psychiatric hospital death reporting. It moves responsibility for hospital licensing from LARA to MDHHS and expands what has to be reported to the state when it comes to psych hospital deaths.

Certificate of Need – SB 672 & 673

On Thursday, September 24, the House Health Policy committee approved the Certificate of Need package. The House committee did amend SB 672, which would eliminate the Certificate of Need (CON) process for all psychiatric inpatient beds in hopes that it would increase access and availability across the state. Below is the amendment:

* Eliminates the Certificate of Need requirement for psychiatric beds in counties with less than 40,000 residents. Additionally, the bill eliminates the certificate of need requirement for psychiatric beds for the entire state after 5-years.

SB 673 would remain unchanged and requires that a psychiatric hospital or psychiatric unit accept public patients and maintain 50% of beds available to public patients as a condition of licensure.

Mental Health Professionals – SB 826, would clarify PA/NPs role in the mental health code. The bill is described as an improvement to MH access, it has much more of an impact for hospitals than CMHs.

The three main changes would be:

1. Define PA/NP as mental health professions in the MH code. The current MH code currently defines "mental health professional" as a physician, psychologist, RN, MSW, licensed professional counselor, or a licensed marriage and family therapist.

2. Include PA/NP in the MH code as providers able to initiate safety restraints. This barrier only exists for patients receiving care in a psychiatric setting. PA/NP can protect their patients (and other providers) by issuing safety restraints in every other medical setting.

3. Include PA/NPs in the MH code as providers able to issue initial certification for a temporary emergency hold or transfer to a psychiatric facility. PAs and NPs can provide this critically important care in most states.

PRTF – HB 5298, would require the Department of Health and Human Services (DHHS) to establish psychiatric residential treatment facilities (PRTFs) for Medicaid patients under age 21, subject to appropriation of sufficient funding.

Mental Health First Aid – Senate Bill 41, would require mental health first aid training as a component of teacher's continuing education and professional development. The instruction would, in part, identify risk factors and warning signs for mental illness and SUD. The legislation saw a hearing in the Senate Education and Career Readiness Committee on Tuesday, October 6. Not vote has been held.

Senate Bill 898, would require insurers to have parity in coverage for telehealth services. A hearing was held in the Senate Health and Human Services committee but no votes have been taken.

HB 4700 – Preparole Mental Health Discharge Planning

House Bill 4700 would amend the Corrections Code to require a prerelease mental health discharge plan to be created for each prisoner who is receiving mental health services or mental health prescription medication before he or she is released on parole. DOC could seek consultative services from the Department of Health and Human Services (DHHS) in creating a plan for a prisoner.

A prerelease mental health discharge plan would have to include all of the following:

- A mental health assessment that includes the use of assessment tools specified in the bill (e.g., a generalized anxiety disorder seven-item scale and an opioid risk tool).
- Identification of risk factors related to transportation, housing, and family stress.
- An appointment scheduled after the prisoner's release with a mental health professional capable of providing postrelease mental health prescription medication and other mental health services.
- If the prisoner is receiving mental health prescription medication at the time of the discharge planning, steps that will provide the prisoner access to that medication between his or her release and the postrelease appointment with the mental health professional.
- An assessment of eligibility upon release for enrollment in Medicaid or Medicare. If eligible, information on enrollment must be provided.
- Goals and activities that address the needs and barriers identified under the above.
- A list of care team members that will support the prisoner as he or she transitions out of prison. This would include community health or social program providers.
- Input from the prisoner and a communication plan for the duration of parole.

Medicaid Reimbursement for Alcohol Use Disorder Treatment – HB 5408, the intent of the bill is to create a legislative fix requiring Medicaid to cover the cost of seeing a prescriber for individuals with an alcohol use disorder (reimbursing some MAT services in the same fashion as opioid use disorder).

Inpatient Bed Registry / MiCAL

HB 6188 – A state-operated registry of available inpatient psychiatric beds, crisis residential beds, or substance use disorder beds must report all data collected for that registry to the department or the

entity operating or maintaining the access line under contract with the department. (passed out of House Health Policy Committee on 11/10/20)

HB 6189 – The department must provide all of the information listed on the registry under this section to the contractor or entity that operates or maintains the Michigan crisis and access line. (passed out of House Health Policy Committee on 11/10/20)

REGIONAL ENTITY - PIHP COMPLEX CARE COORDINATION PILOT FOR MEDICAID UNENROLLED WITH SMI AND COMORBID PHYSICAL HEALTH CONDITIONS

From Michigan's 10 PIHPs
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Regional Entity & PIHP Pilot Proposal to MDHHS BHDDA & MSA for

PIHP Provision of Complex Care Management to Select Michigan Medicaid Unenrolled Beneficiaries

EXECUTIVE SUMMARY

The ten Regional Entities/Prepaid Inpatient Health Plans proudly present this Complex Care Management (CCM) Proposal to the Michigan Department of Health and Human Services (MDHHS) to the attention of Director Gordon and senior executives in BHDDA and MSA.

Michigan's unenrolled population with severe mental illness and chronic co-morbid medical conditions, while under PIHP Plan care for their mental illness, lack concerted care management support. These individuals have difficulty managing and accessing medical-surgical care leading to ineffective physical health care. This often results in reduced health status, reduced quality of life, increased mortality likelihood, avoidable healthcare service utilization, and avoidable healthcare costs.

A recent article from *American Journal of Managed Care (AJMC)* (2020), stated **"a complex care management program for high-need, high-cost Medicaid patients reduced total medical expenditures by 37% and inpatient utilization by 59%".** These results suggest that carefully designed and targeted complex care management can be effective among high-need, high-cost Medicaid patients. Community health workers and care coordinators can help engage and activate patients and their providers and natural supports, build trust, and better understand and manage the non-medical social determinants drivers of poor health and avoidable spending. Targeted interventions focused on modifiable risk factors are an effective and efficient approach for reducing unnecessary utilization. This same article from the AJMC (2020) showed that compared with patients randomized to usual care, **patients randomized to complex care management** had:

- **lower total medical expenditures of -$7732 per member per year** (95% CI, –$14,914 to –$550; *P* = .036);
- **fewer IP bed days of -3.46 per member per year** (95% CI, –4.03 to –2.89; *P* <.001);
- **fewer IP admissions of -0.32 per member per year**; (95% CI, –0.54 to –0.11; *P* = .014); and
- **fewer specialist visits of -1.35 per member per year** (CI, –1.98 to –0.73; *P* <.001).

in another study, the Minnesota Preferred Integrated Network program (PIN) and others who implemented care management programs also found that utilization of ER services was lower for PIN participants, especially those using telephonic navigation (2015).

Our design is supported by the referenced literature and Michigan's available data published by MDHHS and from RE/PIHPs. Our design is informed by National Committee for Quality Assurance's (NCQA) Managed Behavioral Health Organization Complex Care Management Standards, universally acknowledged as best practices for payers.

Our proposal is for new services to current and new clients requiring new skills, abilities and resources. The current PIHP-DHHS Agreement does not include these services in scope or in capitation payment amount. Thus, a separate PIHP-DHHS Agreement scoping the Project and developing payment, risk management and shared savings methods and amounts are required. REs/PIHPs cannot use current Medicaid, Medicaid savings or Internal Service Funds to capitalize or operate the program or for financial risk management purposes.

OUR PURPOSE

We propose that the Medicaid behavioral health benefits management via PIHPs is the primary and best source to fund and manage complex care management services to the Fee for Service (FFS) population given their otherwise absent related support. PIHPs have visibility and access to affect outcomes of members with specialty behavioral health services and physical health comorbidities. The FFS population inherently has more physical health comorbid conditions, services, and costs. PIHPs, their CMHSPs, and substance use disorder service treatment systems have been providing varying levels of care coordination/management for both physical and behavioral health care for decades. This is accomplished in two ways:

- PIHPs are responsible for the *entire Medicaid population* for specialty behavioral health services within their geographic regions, and
- Freedom of choice is waived through Michigan's Section 1115 Managed Care Waiver.

MDHHS has identified the high cost and inconsistently managed care for Michigan's Medicaid unenrolled population. Specifically, beneficiaries with specialty service needs and one or more chronic physical conditions have significant avoidable physical health services utilization and thus costs, lower levels of health status, and lower quality of life.

Michigan Medicaid offers benefits under a state managed FFS program or through Medicaid Health Plans (MHPs) for physical healthcare services for persons with specialty behavioral health services.[1] The behavioral health specialty services are managed through 10 RE/PIHPs *for all Medicaid beneficiaries*. As is the case in most Medicaid state programs, traditional MHP enrolled beneficiaries are primarily non-disabled children and adults under the age of 65 while the FFS program provides physical healthcare services to beneficiaries who are predominately disabled, higher cost, and largely exempt from mandatory MHP enrollment or inherently avoidant of managed care.

Michigan Medicaid spends a significant amount on both physical and behavioral healthcare for the unenrolled. Since Regional Entities, Prepaid Inpatient Health Plans and Community Mental Health Service Providers are already capitated for the provision of specialty behavioral health

[1] Specialty behavioral health services include services to persons with severe mental illness, intellectual/developmental disabilities, children with serious emotional disturbance and/or substance use disorders.

services for these Medicaid enrollees, the public behavioral health system is uniquely positioned to coordinate physical healthcare for them.

While PIHPs have contractually required Coordination of Care Agreements with MHPs with shared at-risk performance metrics including joint care coordination efforts, no such requirement or effort is required of PIHPs for persons in FFS status. Notably, PIHPs already have access to behavioral health (including substance use disorder) and certain physical health data via Care Connect 360 (CC360) to identify and stratify target subsets of unenrolled individuals for Complex Care Management. This combined with the decades of experience of the public behavioral health system in outreach, engagement, support, and whole health management for specialty populations makes our proposed approach ideal and promising.

CCM provided to high-risk, high-cost individuals will improve the management of behavioral and physical health disorders, reduce avoidable health services, reduce healthcare expenses, provide symptom management, and improve quality of life. Required components of CCM include assessment, care planning, healthcare information exchange, healthcare data analytics, personalized interventions, and objective evaluation.

According to Kastner et. al (2018), **"older adults with diabetes and either depression or cardiovascular disease, or with the coexistence of chronic obstructive pulmonary disease and heart failure, can benefit from care-coordination strategies with or without education to lower HbA, reduce depressive symptoms, improve health-related functional status, and increase the use of mental health services."** CCM works and the proposed design is adapted around identified best practices.

Four PIHPs have experience with CCM consistent with NCQA MBHO Standards (either through participation in the MI Health Link Financial Alignment Initiative Demonstration or through the NCQA accreditation process or both).

Each is willing to share its lessons learned, design and operational documents, and other knowledge.

OUR PLAN

Our proposal is for REs/PIHPs to contract on an individual voluntary basis with MDHHS to provide CCM for the Medicaid unenrolled fee for service specialty service population(s). These proposed contracts separate from PIHP contracts will include prospectively identified health services utilization targets, and health status outcome metrics and targets. CCM is different and unique from behavioral health Case Management and the coordination currently required and underway between PIHPs and MHPs as a contractual obligation. "Unlike case management, which tends to be disease-centric,… [Care Management] is organized around the precept that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care" (*Care Management: Implications for Medical Practice, Health Policy, and Health Services Research | Agency for Healthcare Research & Quality*, 2010).

This Program will require retrospective and ongoing data including, but not limited to, two-year retroactive Medicaid and Medicare behavioral health, physical health, and pharmacy data. While PIHPs will work with both behavioral and physical health providers to gain accurate health record information, it is imperative that encounter and service cost data is readily available to drive care and report outcomes for this proposed program.

Since the State and the REs/PIHPs are both governmental entities, MDHHS and the REs/PIHPs would share resultant savings from CCM for reinvestment into the public behavioral health system.

Advanced risk algorithms (such as those in the symmetry tool currently used by MDHHS) will identify eligible members with a severe mental illness or high risk of opioid abuse, and high medical co-morbidity risk. This information can be used to inform a risk triage stratification that identifies the highest and rising-risk members based on social demographics, behavioral health, medical comorbidity, and behavior attributes. Examples of high and rising-risk members include those who are seeing multiple providers gain access to multiple prescriptions, those who are not attending follow up appointments after hospitalizations or emergency room visits, members using multiple opioid or antipsychotic prescriptions, members with uncontrolled diabetes, and behavioral health members without metabolic testing.

REs/PIHPs will:

- Identify and stratify Medicaid beneficiaries in FFS status with at least one specialty services behavioral health disorder and at least one physical health co-morbidity;
- Detail the additional roles and functions of the REs/PIHPs in providing CCM;
- Quantify the resources required such that adequate additional prospective non-risk payments are made to REs/PIHPs for CCM services;
- Monitor the health status and utilization of physical health services for assigned individuals and quantify the favorable impacts; and
- Provide the physical health expense savings and physical health improvement performance bonus awards with proceeds earned by REs/PIHPs as local funds.

To accomplish CCM, REs/PIHPs CEOs will continue to design efforts and propose details and agreement language to MDHHS-appointed representatives.

PROPOSED DESIGN ELEMENTS

Eligible persons will be contacted by the PIHP via phone and in-person (when possible) to enroll from an array of professionals and para-professionals including but not limited to a Community Health Worker, Care Coordinator, and a team of allied health specialists. The allied health specialists may include but are not limited to nurses, pharmacists, occupational therapists, physical therapists, and medical specialists. Staff and consultants may be shared between PIHPs upon agreement between those PIHPs depending on full-time equivalent (FTE) needs. Innovative and supportive consumer assistive technology and applications will be encouraged

when appropriate. Referrals may also be made by community and partner providers, hospital systems, emergency departments, etc.

Established documentation will detail the Program description, benefits, objectives, and commitments. A consent to participate agreement will be utilized (with either written or verbal consent acceptable), and participants will be able to disenroll at any time. Promotional and training materials developed by PIHPs will introduce Participants, families, primary care teams, allied health practitioners, and community stakeholders to the details of the Program.

PIHPs will perform participant baseline health, functional and social determinant status assessments using validated instruments, such as Barriers to Health Screening Questionnaire, Short Form Health Survey (SF-12), World Health Organization Disability Assessment Schedule (WHODAS 2.0), Patient Health Questionnaire (PHQ-9), Patient Activation Measure (PAM-13), LOCUS, DLA, ASAM, and others. These instruments will provide a basis for developing case level and aggregate targets and assessing outcomes.

A shared care plan accessible to appropriate agencies on CC360 will be developed. Other Program development tasks include:

- Document health information exchange and healthcare data analytics pathways;
- educate, motivate and incentivize Participants and their natural supports;
- train providers in key concepts and skills in CCM;
- and objectively measure individual health status and Project success.

PIHPs will support participants and practitioners during transitions in care to ensure practitioners have an individual's current healthcare information, and that participants are engaged in discharge and continuity of care planning. PIHPs will not require participants to change behavioral health or primary care providers.

An area of focus will be to improve participant outcomes which will include addressing social determinants of health. The determinants will include but are not limited to food insecurity, housing instability, transportation, interpersonal violence, and toxic stress (*Social Determinants of Health | Healthy People 2020*, 2014).

Electronic communication channels will be established for Participants and Project Staff. Integrated Care Team (ICT) meetings will occur and Participants will be invited to attend along with their natural supports. Educational, motivational, and self-care applications such as myStrength, Relias, and Health A to Z will be made available to Participants. Assistive technology and resources will be selected and utilized based on each PIHP's resources and access.

WHAT PIHPs KNOW NOW ABOUT FFS

Goal: To establish an initial set of data that shows the total Unenrolled in the region and what percentage are receiving some sort of services and costs associated.

Medicaid Enrollment:
How many people are enrolled in Medicaid during a month in a region?

- To know how many persons are unenrolled and what percentage that is to the overall Medicaid Enrollment population, we must use a time period that allows for adjustment records (corrections, additions) and was close to current data. The data workgroup used March 2020 Medicaid Enrollment data. Finding ALL persons that are Medicaid beneficiaries is determined using the Medicaid Enrollment files (834 files produced by Optum from DHS Bridges system). This provides the total number in the region.

Unenrolled:
How many of those Medicaid Beneficiaries are NOT enrolled with a Medicaid Health Plan?

- Using that set of records, we find the persons unenrolled by selecting any Medicaid beneficiary that doesn't have a MHP specified. If a person is registered with a MHP, then it is identified in a column within the Medicaid Enrollment file per MDHHS guidelines.

Unenrolled by PIHP:
Where do those Unenrolled reside within the region and what PIHP could impact them?

- Using the county of residence column, we can associate the Unenrolled Beneficiaries to PIHPs.

Unenrolled Served by PIHP:
How many Unenrolled have received services within the region?

- We selected the first quarter before March (Oct. Nov. Dec.) for finding persons served for MH and/or SUD as those are the most complete for reporting encounters. (Using the 90-day reporting rule per MDHHS guidelines)

Percentage of Unenrolled Served by PIHP to Unenrolled in PIHP service area:
What is the penetration rate for Unenrolled?

- The straight calculation to show the current penetration rate with Unenrolled.

Total Units of Service:
What volume of service activity is involved with Unenrolled?

- Count of units of service on encounters to show how much activity is presently occurring with Unenrolled that are being served.

Total Cost on Encounters:
What is the estimated cost when providing services to Unenrolled?

- Sum of costs being reported on encounters to show how much expense is currently allocated to Unenrolled. This is only MH and SUD costs. No MHP cost data is available.

Figure 1

Medicaid Enrollment with No MHP Report					
Not enrolled with MHP during Q1 of FY20		**216,245**	Medicaid Enrollment during Q1 of FY20		**906,392**
Unique Consumers Served = encounter reported in first quarter of FY20					
	Not Enrolled	**Unique**	**Percent Served**	**Total Units**	**Total Cost**
PIHP - Mental Health	**with MHP**	**Consumers Served**	**by PIHP**	**of Service**	**on Encounters**
Macomb	45,309	3,473	7.7%	2,183,461	28,539,451
MSHN	79,424	8,095	10.2%	4,067,495	72,100,938
SWMBH	49,492	4,634	9.4%	935,045	25,956,449
CMHPSM	26,501	2,657	10.0%	1,444,390	28,111,933
Totals	**200,726**	**18,859**	**9.4%**	**8,630,391**	**154,708,772**
PIHP - Substance Use Disorder					
Macomb	45,309	248	0.5%	14,729	235,364
MSHN	79,424	491	0.6%	25,114	839,741
SWMBH	49,492	409	0.8%	19,848	458,930
CMHPSM	26,490	112	0.4%	4,411	102,138
Grand Totals	**200,715**	**20,119**	**10.0%**	**8,694,493**	**156,344,944**
		Average Cost per consumer served during 3 month period			**$7,771.01**

Discoveries:

- About 9% penetration rate across the 4 regions for MH and less than 1% for SUD; concern with why the SUD penetration rate is so low (even though SUD is typically lower than MH).
- There was no significant difference when changing from a single month enrollment dataset to 3 months when measuring the penetration rate.
- Milliman Drive tool can be used to determine the Unenrolled and Costs associated.
- Milliman uses a broader definition of Medicaid and can evaluate across ALL regions, where Medicaid Enrollment files are distributed by region only.
- Milliman Drive tool does not provide individual member level data.
- Medicaid Enrollment records will be required to match using a beneficiary ID with CareConnect 360 data to learn more about physical health characteristics.

OUR IDEAL PARTICIPANT

Inclusionary Criteria

Target beneficiaries will be identified and stratified through CC360 and PIHP internal data based upon findings from the literature, best practices, and PIHP-specific data. Considerations will include but not be limited to the number and type of comorbid health conditions, type and amount of avoidable health care utilization and costs, and social determinants of health.

We propose the use of the Joint Care Plan Risk Stratification (modified to removed MHP enrollment/services) which specifies that:

- The person must meet all the following-
    - 5 or more ED and/or Inpatient Hospitalizations within the last 3 months
    - 3 or more chronic conditions (physical and/or behavioral health)
- Once all the criteria above are met, then individuals are stratified by the highest risk according to the following-
    - Total number of all ED and/or Inpatient Hospitalizations with the last 3 months
    - Total number of all chronic conditions
    - Date of last PCP visit (the longer it has been since they have seen a PCP, the higher risk), and
- The inclusion of the following HEDIS measures for performance improvement opportunities and possible inclusion incentives, shared savings, etc-
    - Follow up to Hospitalization within 30 days
    - Primary Care Physician visit within the past 12 months
    - Reduction in Emergency Department Use within the past 12 months

Exclusionary Criteria

Persons enrolled in a MCO, PACE, MI Choice Waiver, MI Health Link, Beneficiary Monitoring Program (BMP), and persons with Medicaid spend-down, residents of hospice, or nursing facility will be excluded. This exclusionary criterion serves to prevent duplication of care management interventions. Medicare Advantage Plans will be included based on other models and literature that learned about the limitations that resulted in maximum exclusionary criteria. Those programs include Sutter Health: Sutter Care Coordination Program, SWMBH Kalamazoo Health Connections, and Care Management Plus, Oregon Health and Science University.

Targeted medical conditions for use in stratification and identification will be selected based on evidence-based practice, research, and internal data analysis. It may include but not be limited to cardiovascular disease, cancer, COPD, and type 2 diabetes (Chronic diseases and health promotion, 2020).

Participant Identification and Recruitment

Automatic enrollment with opt-out is proposed. Eligible individuals may also self-refer to the Project, or be referred by family, CMHs, FQHCs, and other behavioral health and physical health providers. Individuals who do not meet eligibility or decline the Project will be referred to other services as appropriate. Individuals who desired to be enrolled in a Medicaid Health Plan will be provided the information to autonomously enroll.

OUR TIMELINE

Assuming a focused effort and resourcing from both MDHHS and PIHPs it is conceivable that the program can "GO LIVE" with Program Participants in service within nine (9) months of finalization of a formal PIHP-DHHS Agreement. Design and development cannot be a "moonlighting job" for PIHPs or MDHHS. It may be true that some PIHPs can stand this Program up sooner than others and that a region by region roll out is advisable.

OUR VALUE EXCHANGE - FINANCING

This CCM for unenrolled Medicaid eligibles with behavioral health and chronic medical conditions proposal is grounded in the literature and best practices for which are most likely to result in savings for the Medicaid program from reduced unnecessary and avoidable physical health services, including but not limited to, reductions in emergency department usage, ambulatory sensitive hospital admissions, and readmissions. Further, program impacts at the case level and in the aggregate on health status, symptoms, and functionality will be assessed through the use of normed, standardized, and validated functional assessment tools.

Financial support for the Program is proposed in three manners:

- First, PIHPs will require start-up "seed" or "kicker" funding to establish the Program before Participants begin.
- Second, we propose a Per Enrollee Per Month (PEPM) funding model upon initiation of Enrollees.
- Third, we propose complementary performance-based funding and shared savings approaches once the program matures. Each is discussed in detail below.

Seed Funding

An undertaking such as this proposal requires material design and development activity, resources, and staffing not included in current PIHP duties or capitation rates. PIHPs seek to explore guidelines and preferences with MDHHS for Medicaid seed funding. Some suggestions are:

- up-front payments to PIHPs and/or
- a first fiscal year enhanced PEPM with cost settlement and/or
- an additional capitation amount actuarially certified.

Most PIHPs will not have a cash flow issue for start-up costs, but we will require written authorization from MDHHS to expend current capitation accordingly and be made whole for related Program expenses in full above the applicable fiscal year's Medicaid capitation amount. Additional options for consideration include:

- current or expanded SAMHSA Mental Health and/or Substance Abuse Block Grant;
- discretionary funding available to MDHHS MSA or other current or new state resources;
- Michigan Health Endowment Fund Grant; and/or
- other private Foundation Grant sources e.g., Kellogg Foundation, Kresge Foundation, etc.

Only MDHHS knows their latitude in this area and has direct access to CMS for technical assistance.

Ongoing Per Enrollee Per Month (PEPM)

PEPM is a common and widely accepted payment mechanism for health home type services such as this proposal. Current examples to consider include Michigan's Behavioral Health Home and Opioid Health Home Models. Once the Program is operating at scale, transitioning to PEPM is relatively straight forward. We are developing detailed staffing models with roles and titles, qualifications, and FTE estimates per 100 and per 1,000 enrollees, rounded out with other direct expense categories and estimates (Please see **Attachment A** for a sample model). Finalization can only occur after a conversation with MDHHS regarding the MDHHS preferences for model details.

Performance-Based Funding and Shared Savings

Performance-based funding can be initiated at the beginning of the Program. As enrollees in CCM will already be eligible for or under care from their PIHP, their MMBPIS and PBIP metric results are already captured in those data sets and can easily be reviewed against the CCM program involvement enrollee group. Note: The quality withhold and reconciliation for these metrics already occur and should not be duplicated or double-counted for this CCM program. Presumably, other CCM-only metrics can be mutually developed, perhaps following similar approaches for metric(s) and withholds used for BHH and OHH Programs. Our preference is to choose impact/results/outcomes metrics over process measures. As discussed in the "Our Ideal Participant" section, we recommend the use of baselines and targets for improvement of health status, symptom reduction, and improvements in functioning as measured by normed, standardized, and validated tools.

Shared Savings

A key goal of CCM is to reduce unnecessary, low value, redundant, and avoidable physical health service utilization and expenses. PIHPs have access to behavioral health (including SUD) and physical health treatment service utilization encounters, with behavioral health costs known or reliably estimable (see Figure 1). PIHPs also have tools and experience with healthcare data analytics platforms with sophisticated enrollee level encounters, assessment, and quality information along with sensitive algorithms to identify gaps in care and other unwanted anomalies. What PIHPs lack altogether are the physical health medical/surgical/pharmacy costs. We propose an early start with MDHHS in designing a shared savings program detailing the information, process, and report needs. It is likely that MDHHS solicits expertise and services from *Optum* (state data warehouse administrator) and/or *Altarum*. The pace of development of the shared savings component would be driven by MDHHS and available design and development resources.

Contracting

PIHPs require a separate Agreement with MDHHS for proposed CCM services which details eligibles, identification and enrollment process, CCM services, payment, and other terms and conditions.

OUR LITERATURE REVIEW SUMMARY

Model	**Summary Examples - Complex Care Management as part of dual eligible pilots for persons with BH and/or IDD needs**	**Published outcomes report/ reported or expected cost savings**	**Source/ citation**
UPMC Health Plan	The UPMC Health Plan patient-centered medical home (PCMH) model embeds practice-based care managers (PBCMs) in both UPMC system practices and other contracted network practices. Embedded care managers, who are employed by UPMC Health Plan, function as part of a physician's team at each practice; their primary role is to support physicians in managing their UPMC Health Plan members. PBCMs focus	**Outcomes:** From 2008 through 2010, sites participating in the UPMC pilot achieved lower medical and pharmacy costs; more efficient service delivery, such as lower hospital admissions and readmissions and less use of hospital emergency departments; and a 160 percent return on the plan's investment when compared with nonparticipating sites. **Matching Factors:** • Multiple morbidities/highest need	Rosenberg, C. N., Peele, P., Keyser, D., McAnallen, S., & Holder, D. (2012). Results from a patient-centered medical home pilot at UPMC Health Plan hold lessons for broader adoption of the model. *Health affairs (Project Hope)*, *31*(11), 2423–2431. https://doi.org/10.1377/hlthaff.2011.1002

	on patients who could benefit from greater intensity of care and interaction, including those with complex needs, those recently discharged from a hospital or diagnosed with a chronic condition, those who require self-management education or medication reconciliation, or those who have frequent admissions.	Integrated at clinic/provider level	Alliance of Community Health Plans. (2011). Health Plan Innovations In Patient-Centered Care. Retrieved from: https://www.achp.org/wp-content/uploads/ACHP-Care-Management-Handbook.pdf
PA SMI Innovations Project	Included two pilots in the Southeastern and Southwestern regions of the state designed to integrate physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness and co-occurring physical health conditions. The pilots paired a physical health managed care organization (MCO) with their respective county behavioral health MCO.	**Outcomes:** The pilot program, conducted in 2009 and 2010, demonstrated a number of improved health outcomes among enrollees, including reduced emergency room visits and fewer mental health hospitalizations and readmissions. "Results: Mental health hospitalizations (per 1000 members per month) decreased for the Connected Care group from 41.1 to 39.6, while increasing for the comparison group from 33.8 to 37.2 (P = .04). All-cause readmissions within 30 days decreased nearly 10% for Connected Care while increasing slightly for the comparison group (P <.01), with a similar pattern observed for 60- and 90-day all-cause readmissions. No differences were observed in physical health hospitalizations, drug and alcohol admissions, or ED use. Data from qualitative stakeholder interviews illuminated facilitators and barriers of implementing Connected Care." **Matching Factors:** • Enhanced Care Coordination/Care Management	J. Kim, T. Higgins, D. Esposito, A. Gerolamo, M. Flick. SMI Innovations Project in Pennsylvania: Final Evaluation Report. October 2012. Mathematica Policy Research. https://www.ajmc.com/journals/issue/2016/2016-vol22-n10/connected-care-improving-outcomes-for-adults-with-serious-mental-illness

UPMC Community Care	In Allegheny County, Pennsylvania, an innovative pilot program designed to better serve Medicaid beneficiaries with SMI is being re-engineered to address the needs of Medicare beneficiaries. UPMC Community Care, a Medicare Advantage plan jointly established by UPMC for You, a nonprofit managed care plan, and Community Care Behavioral Health, a managed behavioral health organization, will focus on Medicare beneficiaries (including beneficiaries dually eligible for Medicare and Medicaid) who have been diagnosed with a serious mental illness. The new program is based on a model of care tested in Allegheny County through the Center for Health Care Strategies' Rethinking Care Program, which sought to integrate physical and behavioral health services for Medicaid beneficiaries with SMI. (See previous entry; above) Though any Medicare beneficiary with a qualifying mental illness may enroll, UPMC Community Care was designed specifically with the needs of the dual eligible population in mind. Behavioral health issues are prevalent among Medicare-Medicaid	Expected cost saving around reduced ER visits and fewer mental health hospitalizations and readmissions. **Matching Factors:** • SMI focused Dual eligible focus	https://www.chcs.org/resource/extending-lessons-from-a-medicaid-pilot-to-improve-care-for-medicare-and-dual-eligible-beneficiaries/ J. Kim, T. Higgins, D. Esposito, A. Gerolamo, M. Flick. SMI Innovations Project in Pennsylvania: Final Evaluation Report. October 2012. Mathematica Policy Research. J. Kasper, M. O'Malley Watts, and B. Lyons. Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured. July 2010. Available at http://www.kff.org/medicaid/upload/8081.pdf MedPAC. A Data Book: Health Care Spending and the Medicare Program. June 2012. Available at: http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf

	enrollees, with approximately 44 percent having at least one mental and/or cognitive condition. Further, more than half of all Medicare inpatient psychiatric facility patients are dually eligible.		
New York FIDA and FIDA-IDD	FIDA is NY's Fully Integrated Duals Advantage. FIDA-IDD (Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities) covers medical primary care, plus long term services & supports, OPWDD (IDD HCBS) services, behavioral health services, and pharmacy benefits all in one plan. FIDA-IDD utilizes a care team model with an Interdisciplinary Team (IDT) made up individual, care manager from the FIDA-IDD plan, care coordinator and the DD service providers. Targeted to adults living in community in NYC, Nassau, Rockland, Suffolk or Westchester with IDD who are dually eligible.	**Matching Factors:** • I/DD focused, dual eligible model • Care team with assigned care manager **NOTE: NY ended FIDA in 2019 and is ending FIDA-IDD in December of 2020; likely transition to D-SNPs.**	https://www.macpac.gov/wp-content/uploads/2016/07/NY-FIDA-IDD-Capitated-Financial-Alignment-Demonstration.pdf https://opwdd.ny.gov/services-funded-fida-idd-managed-care-program-2019 https://cbcny.org/research/options-enhance-coordination-care-dually-eligible-individuals-new-york-state
Minnesota Preferred Integrated Network Program	Through the Preferred Integrated Network (PIN), Minnesota is pilot testing a partnership between Medica, a Medicare SNP serving dual eligible beneficiaries with disabilities, and Dakota County to integrate Medicare and Medicaid physical health services with behavioral health services. Program goals are to improve the physical and mental health	**Outcomes:** The clearest differences are in the greater use of mental health/substance abuse services by direct case management for both dual eligible and Medicaid-only enrollments. Telephonic case management had higher utilization of hospital outpatient clinics for Medicaid-only enrollees, though there was little difference for the dual-eligible group. It is interesting to note, too, that utilization of ER and inpatient services was lower for PIN	Human Services Research Institute & Desert Vista Consulting. (2015). Evaluation of the Minnesota Preferred Integrated Network Program. Retrieved from: http://www.desertvistaconsulting.com/sites/default/files/MN%20PIN_Fi

	of dual eligible individuals with SMI by offering: access to the full continuum of services; a single point of contact for health care system navigation; and shared program accountability through a public/private partnership. The program has successfully achieved integration of behavioral health services; however, it has had challenges maintaining full integration of Medicare benefits, since Medica is no longer operating its SNP. The partners are currently operating the PIN with Medicaid services provided through the Medica MCO and Medicare services provided through the fee-for-service (FFS) system, coordinated to the extent possible through the PIN. Thus, although short of full integration, the PIN is still seeking to coordinate the full range of benefits for its members with SMI.	participants receiving telephonic navigation. This finding may be related to differences in the functional levels served by the two navigation models, with the telephonic group being higher functioning as indicated by LOCUS scores. **Matching Factors:** • SMI focus Does not require SNP	nal%20Report%20Executive%20Summary.pdf

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County	Letters mailed July 2020	Signed Contract received
Barry	X	9/22/2020
Berrien	X	9/24/2020
Branch	X	7/13/2020
Calhoun	X	8/6/2020
Cass	X	12/2/2020
Kalamazoo	X	
St. Joesph	X	
Van Buren	X	8/11/2020

as of 12/2/20

PA2 Funded Outcomes Report Fiscal Year 2020

October 1, 2019 – September 30, 2020

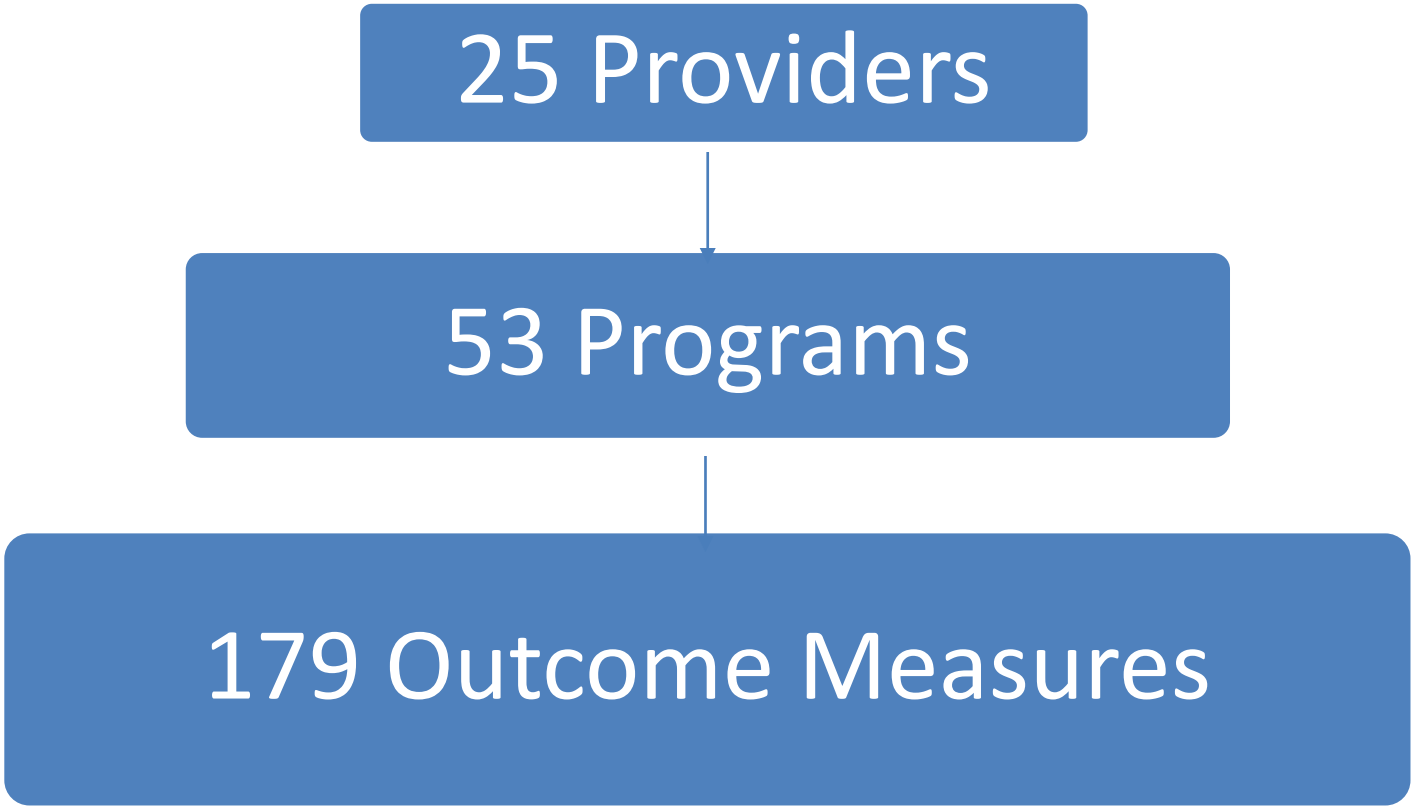
Southwest Michigan
BEHAVIORAL HEALTH

SWMBH Board, December 11, 2020

Brief History of PA2 Programs

- Each County determines use of local PA2 SUD dollars
- FY2015 was the first year SWMBH moved to outcomes
- Traditionally, measures were based on “counts” of services, not necessarily measuring change.
- Each provider must submit their own outcome measures – they define what they want to measure.
- SWMBH works with providers to make measures specific, measureable, attainable, and time limited.

Overview of PA2 Funded Programs: Fiscal Year 2020

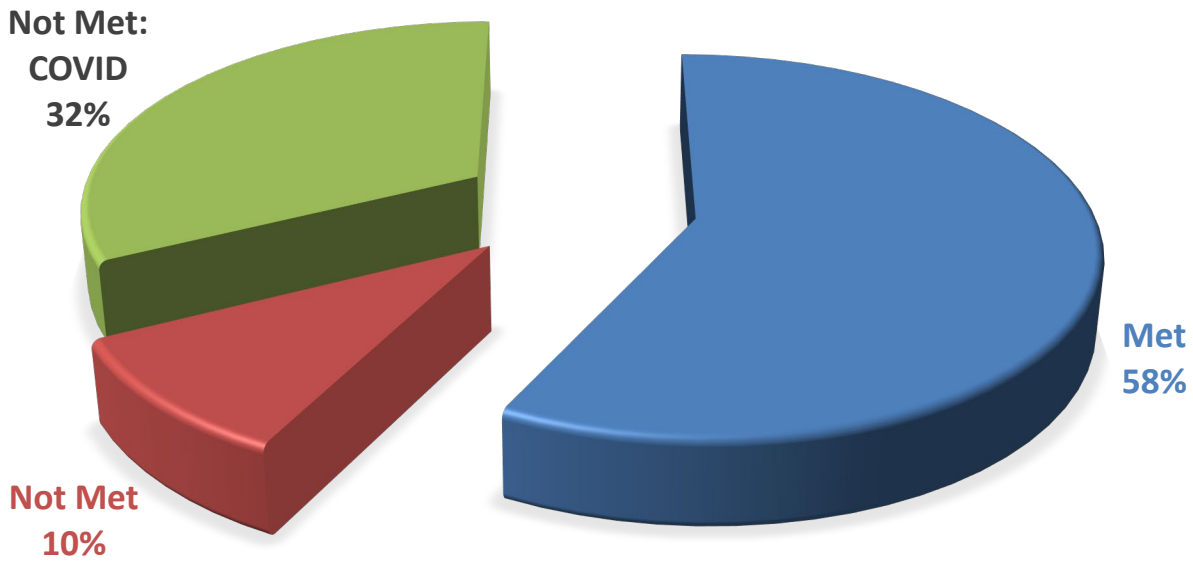


Measurement Definitions

Based on the Information Provided…

- **Met:** Clearly meets or exceeds outcome
- **Not Met**: Not meeting outcome
- **Measure not Met due to COVID 19:** Outcomes were significantly impacted by COVID 19 pandemic.

FY2020 Results – SWMBH Region



FY2020 Year Results – Counties

County	Total Outcome Measures	Met	Not Met	Not met due to Covid
Barry	4	1	0	3
Berrien	26	15	5	6
Branch	13	2	0	11
Calhoun	30	19	2	9
Kalamazoo	87	54	9	24
St Joe	12	7	1	4
Van Buren	7	5	1	1
	179	103	18	58

FY202 Year Observations

- 100% measures continue to be difficult to meet; SWMBH continues to work closely with providers to create measures that are specific, measurable, timely, and simple.
- COVID19 pandemic has impacted many providers ability to provide services (jail services, SBIRT, etc.) and obtain data resulting in low sample size.
- Providers have shown exceptional ability to transition to virtual programs when able to do so.
- Providers are more prepared to respond to the pandemic heading into current fiscal year.

Filonow Award of Excellence - 2020

Nick Filonow was the Quality Improvement and Information Systems Director of Newaygo County Mental Health for ten years, until he was taken from us in an auto accident in 2002. Nick believed in a high quality, publicly-provided Mental Health system for the State of Michigan. He demonstrated that dedicated individuals can make a difference in the lives of consumers and the agencies that serve them. The Michigan public mental health system is strong today because of the hard work and dedication of individuals, consumers, advocates and families. Nick would see opportunities, not obstacles. His dedication to providing community-based quality mental health services and his compassion for people was evident to all who came to know him on both a professional and personal level. The Nick Filonow Award of Excellence recognizes eligible individuals, committees or groups that have made a significant contribution or effort to improve the public mental health community-based system at a local or state-wide level through finance, technology or quality efforts.

SWMBH has nominated Jonathan Gardener for this award. Determination to be made in January 2021.

Southwest Michigan
BEHAVIORAL HEALTH

Per PA 228 of 2020:

- For calendar year 2020 Board meetings will be held remotely due to the COVID-19 pandemic.
- Members of the public may attend electronically by https://global.gotomeeting.com/join/515345453 or by dialing 1-571-317-3116 access code: 515 345 453.
- Members of the public may contact members of the Board to provide input or ask questions on any business that will come before the Board by contacting Michelle Jacobs at michelle.jacobs@swmbh.org prior to the meeting, or by commenting during the Board meeting Public Comment section as identified by the Board Chairman.
- Members of the public with disabilities who require special accommodations should contact Anne Wickham at anne.wickham@swmbh.org well before the meeting occurs.
- Members of the public are not required register or otherwise provide their name or other information as a condition of participation, other than mechanisms to permit participation in the public comment period.
- Members of the public are to be excluded from participation in a properly convened and held closed session of the Board.

Southwest Michigan Behavioral Health Board Meeting

January 8, 2021

9:30 am to 11:00 am

(d) means document provided

Draft: 11/24/20

1. **Welcome Guests/Public Comment**

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

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

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

4. **Consent Agenda**

    a. December 11, 2020 SWMBH Board Meeting Minutes (d)
    b. Operations Committee Quarterly Report (D. Hess) (d)

5. **Operations Committee**

    - Operations Committee Minutes November 18, 2020 (d)

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

    a. Autism Spectrum Disorder (R. Freitag) (d)
    b. Tools Update (M. Kean) (d)
        i. *Intellectual Developmental Disabilities (Supports Intensity Scale)
        ii. *Substance Use Disorders (American Society of Addiction Medicine)
        iii. *Serious Mental Illness (Level Of Care Utilization System)
        iv. *Serious Emotional Disturbances (Child and Adolescent Functional Assessments Scale)

7. **Board Actions to be Considered *(Requires motion)***

    a. Fiscal Year 2021 Revised Budget (T. Dawson) (to be displayed)
    b. Fiscal Year 2020 Performance Bonus Incentive Program (J. Gardner) (d)
    c. Fiscal Year 2021 Utilization Management Plan (A. Wickham) (d)

8. **Board Policy Review *(Requires motion)***
Is the Board in Compliance? Does the Policy Need Revision?

    a. BG-001 Committee Structure (d)
    b. BG-004 Board Ends and Accomplishments (d)
    c. BG-007 Code of Conduct (d)

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

    - BEL-001 Budgeting (S. Barnes) (d)

10. **Board Education**

    a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d)
    b. Fiscal Year 2021 Quality Assurance Performance and Improvement Plan (J. Gardner) (d)
    c. Fiscal Year 2020 Quality Assurance Performance and Improvement Evaluation Report (J. Gardner) (d)
    d. Fiscal Year 2020 Customer Services Report (S. Ameter) (d)
    e. Annual Board Compliance Education (M. Todd) (d)
    f. Fiscal Year 2020 Program Integrity Compliance Report (M. Todd) (d)

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

    a. Fiscal Year 2020 Medicaid Services Verification Report (M. Todd) (d)
    b. Intergovernmental Contract Status (B. Casemore) (d)
    c. February 12, 2021 Board Agenda (d)
    d. 2020 Board Member Attendance to CMHSPs
    e. Board Member Attendance Roster (d)
    f. February Board Policy Direct Inspection - none

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
February 12, 2021
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:												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Michael McShane (Cass)												
Erik Krogh (Kalamazoo)												
Vacant (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 11/13/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												
Robert Nelson (Barry)												
Janet Bermingham (St. Joe)												

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