Southwest Michigan Behavioral Health Board Meeting
Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001
February 10, 2023
9:30 am to 11:30 am
(d) means document provided
Draft: 2/1/23

1. **Welcome Guests/Public Comment**

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

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

   - Angie Dickerson – Van Buren Alternate
   - Mary Green – Operations Committee
   - Sherii Sherban – Summit Pointe

4. **Consent Agenda**

   - January 13, 2023 SWMBH Board Meeting Minutes (d) pg.3

5. **Operations Committee**

   - None

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

   - *Fiscal Year 2022 Behavioral Health Treatment Episode Data Set (J. Gardner) (d) pg.7

7. **Board Actions to be Considered**

   - May Board meeting and Board Retreat meeting (d) pg.10

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

   - BG-007 Code of Conduct (d) pg.11

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

   - None

10. Board Education

a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d) pg.13
b. Fiscal Year 2023 Utilization Management Plan (B. Guisinger) (d) pg.19
c. Fiscal Year 2022 Program Integrity Compliance Report (M. Todd) (d) pg.45
d. Fiscal Year 2022 Medicaid Services Verification Report (M. Todd) (d) pg.50
e. Regional Committees (B. Casemore) (d) pg.56

11. Communication and Counsel to the Board

a. Opioid Advisory Committee and Opioid Settlement Funds (B. Casemore) (d) pg.61
b. Substance Use Vulnerability Index (B. Casemore) (d) pg.66
c. Roslund Prestage Audit Planning Letter (d) pg.68
d. March 10, 2023 Draft Board Agenda (d) pg.70
e. Board Member Attendance Roster (d) pg.72
f. Intergovernmental Agreement (B. Casemore)
g. March Board Policy Direct Inspection – BEL-001 Budgeting (C. Naccarato)

12. Public Comment

13. Adjournment

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

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

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

Next Board Meeting

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

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting Minutes
January 13, 2023
Four Points Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
9:30 am-11:30 am
Draft: 1/17/23

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

Members Absent: None

Guests Present: Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Ric Compton, Riverwood Center; Cameron Bullock, St. Joseph County CMH; Sue Germann, Pines Behavioral Health; Richard Thiemkey, Barry County CMH; Jeanne Goodrich, Summit Pointe; Alena Lacey, Director of Clinical Quality, SWMBH; Jeanette Bayyapuneedi, Behavioral Health & Integrated Care Manager, SWMBH

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

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to approve the agenda as presented.
Second	Carol Naccarato
Motion Carried	

Financial Interest Disclosure (FID) Handling

Consent Agenda

Motion	Ruth Perino moved to approve the December 9, 2022 Board meeting minutes with one revision under the Financial Disclosure update, changing Ed Meny to Erik Krogh.
Second	Tom Schmeltzer
Motion Carried	

Operations Committee

Operations Committee Quarterly Report
Edward Meny noted the report in the packet for the Board's review, commented on the importance of the Operations Committee, its value to the SWMBH Board and requested a monthly report from the Operations Committee.

Ends Metrics

Fiscal Year 2022 Michigan Mission Based Performance Indicator System Results

Jonathan Gardner reported as documented. Discussion followed.

Motion Susan Barnes moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.

Second Erik Krogh

Motion Carried

Board Actions to be Considered

Financial Risk Management Plan

Garyl Guidry reported as documented. Discussion followed.

Motion Tom Schmelzer moved to approve the Financial Risk Management Plan with noted revisions as presented.

Second Susan Barnes

Motion Carried

Financial Management Plan

Garyl Guidry reported as documented. Discussion followed.

Motion Sherii Sherban moved to approve the Financial Management Plan as presented.

Second Erik Krogh

Motion Carried

Cost Allocation Plan

Garyl Guidry reported as documented. Discussion followed.

Motion Erik Krogh moved to approve the Cost Allocation Plan with noted revisions as presented.

Second Edward Meny

Motion Carried

2023 Quality Assurance and Performance Improvement Plan

Jonathan Gardner, QAPI Quality Director presented the 2023 Quality Assurance and Performance improvement Plan (QAPIP) to the SWMBH Board on January 13, 2023. During the presentation each of the (18) functional areas were covered as directed by the 2023 MDHHS QAPIP guidance document. Please refer to the presentation materials covered during the meeting for more details.

Motion Tom Schmelzer moved that the plan has been reviewed and approved as presented.

Second Erik Krogh

Motion Carried

Fiscal Year 2022 Board Audit Committee Appointments

Edward Meny discussed the upcoming Board Audit. Brad Casemore summarized the history and procedures for the Board Audit Committee. Sherii Sherban, Louie Csokasy and Tom Schmelzer volunteered to serve on the Board Audit Committee for the Fiscal Year 2022 Board Audit.

Draft May 12, 2023 Board Retreat Agenda

Brad Casemore reviewed the draft Board Retreat agenda and asked Board members to send him any topics for discussion and/or ideas to add to the agenda. The Board Retreat agenda will be reviewed again at the February 10, 2023 meeting.

Board Policy Review

BG-004 Board Ends and Accomplishments

Edward Meny reported as documented.

Motion Erik Krogh moved that the Board is in compliance with Policy BG-004 Board Ends and Accomplishments and the policy does not need revision.

Second Susan Barnes

Motion Carried

Executive Limitations Review

None

Board Education

Fiscal Year 2023 Year to Date Financial Statements

Garyl Guidry reported as documented. Discussion followed.

Fiscal Year 2022 Program Integrity Compliance Report

This item is moved to the February 10, 2023 Board Meeting.

Opioid Advisory Commission (OAC)

Brad Casemore shared that the OAC continues reviewing and editing their report which is due to the Governor on March 30, 2023.

Communication and Counsel to the Board

2022 SWMBH Board Attendance Letters

Brad Casemore noted that the 2022 SWMBH Board attendance letters were mailed out to the CMH Board Chairs and the CMH CEOs.

Community Mental Health Association of Michigan Did You Know

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

February 10, 2023 SWMBH Draft Board Agenda

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

Board Member Attendance Roster

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

House and Senate Appointments

Brad Casemore gave a brief update on new House and Senate Appointments.

Brad Casemore Contract Renewal

Edward Meny stated that the Board will review Brad Casemore's contract renewal agreement at the March 10, 203 Board meeting.

Public Comment

None

Adjournment

Motion	Sherii Sherban moved to adjourn at 11:25 pm
Second	Susan Barnes
Motion Carried	

2022 BEHAVIORAL HEALTH TREATMENT EPISODE (BHTEDS) COMPIANCE REPORT

PERFORMANCE METRIC DESCRIPTION	STATUS
SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY22. Metric Measurement Period: (1/1/2022 - 12/31/22) Metric Board Report Date: February 10, 2023 A. 97% of applicable **BH** 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 C. 97% of applicable **Crisis** 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. *BH TEDS - records the admissions and discharges for eligible consumers who are engaged in BH/MH/SUD programs and services. *BH TEDS are calculated by comparing the number of reportable encounters against the number of consumers, who have an active/updated BH TEDs record in the MDHHS system.	**Metric Achieved** MDHHS's current benchmark is a 95% compliance rate. **Status as of 11/30/22:** • MH: 99.65% • SUD: 97.53% • Crisis: 99.39% **2021 Results:** • MH: 94.63% • SUD: 97.03% • Crisis: N/A Regional Impact: BH TEDS compliance rates and other metrics are factored into the annual rate-setting calculations by Milliman/MDHHS.

Behavioral Health BH TEDS

FY23 MH Encounters w/BH-TEDS records

Encounters: 10/01/2022 - 11/30/2022* **BH-TEDS: 07/01/2020 - 01/06/2023**

Region Name	Submitter ID	Distinct Count of Individuals With Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation	Distinct Count of Individuals With Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assessment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion Rate
CMH Partnership of SE MI	00XT	7,614	551	92.76%
Detroit/Wayne	00XH	38,757	1,592	95.89%
Lakeshore Regional Entity	00ZI	11,957	435	96.36%
Macomb	00GX	5,097	116	97.72%
Mid-State Health Network	0107	23,761	1,313	94.47%
NorthCare Network	0101	4,437	73	98.35%
Northern MI Regional Entity	0108	8,038	230	97.14%
Oakland	0058	16,716	211	98.74%
Region 10	0109	13,549	387	97.14%
Southwest MI Behavioral Health	0102	11,895	42	99.65%
Statewide		141,821	4,950	96.51%

Key

95.00+ = Compliant

90.00-94.99

85.00-89.99

<85.00

*Encounters = All MH encounters **excluding**: A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, A0425, A0427, H0002, H2011, H2034, Q3014, S0209, S0215, S0280, S0281, S9484, T1023, T1040, T2001-T2005 ,90839, 90840, 99304-99310

Mental Health BH TEDS

FY23 SUD Encounters w/BH-TEDS records				
SUD Encounters from 10/01/2022-11/30/2022***			Does Not Have Open Admission at Time of Encounter as of 01/11/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-Health Home Encounters	Non-Health Home Encounters But NO BH-TEDS Record	Completion Rate
CMH Partnership of SE MI	00XT	1,287	15	98.83%
Detroit/Wayne	00XH	3,423	3	99.91%
Lakeshore Regional Entity	00ZI	2,525	86	96.59%
Macomb	00GX	NO FY22 Encounters Submitted Yet at 01/11/2023		
Mid-State Health Network	0107	4,359	1	99.98%
NorthCare Network	0101	784	2	99.74%
Northern MI Regional Entity	0108	1,034	19	98.16%
Oakland	0058	1,564	1	99.94%
Region 10	0109	2,442	13	99.47%
Salvation Army	002Y	NO FY22 Encounters Submitted Yet at 01/11/2023		
Southwest MI Behavioral Health	0102	2,465	61	97.53%
Statewide		19,883	201	98.99%
Key				
95.00+ = Compliant		***Encounters = All SUD encounters **excluding** H2034, S0280 & T1040		
90.00-94.99				
85.00-89.99				
<85.00				

Crisis Health BH TEDS

FY23 Crisis Encounters w/BH-TEDS records				
Encounters: 10/01/2022 - 11/30/2022**			BH-TEDS: 07/01/2020 - 01/06/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Crisis Encounters	Crisis Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion
CMH Partnership of SE MI	00XT	579	26	95.51%
Detroit/Wayne	00XH	2,377	42	98.23%
Lakeshore Regional Entity	00ZI	1,053	54	94.87%
Macomb	00GX	154	2	98.70%
Mid-State Health Network	0107	2,227	109	95.11%
NorthCare Network	0101	344	2	99.42%
Northern MI Regional Entity	0108	840	57	93.21%
Oakland	0058	585	10	98.29%
Region 10	0109	626	116	81.47%
Southwest MI Behavioral Health	0102	658	4	99.39%
Statewide		9,443	422	95.53%
Key				
95.00+ = Compliant		**Encounters include H2011, S9484, T1023, 90839, 90840		
90.00-94.99				
85.00-89.99				
<85.00				

Military (Service) BH TEDS Analysis Comparison by Year (FY 20-22)

		BranchServedIn		FamilyMilitaryService		MostRecentMilitaryServiceEra		VeteranStatus		VeteranSupport		**Grand Total**	
Year of Event Date	Category	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
FY 2020	Collected	8,766	97.27%	8,752	97.11%	8,749	97.08%	8,821	97.88%	8,727	96.84%	**43,815**	**97.24%**
	Not Collected	246	2.73%	260	2.89%	263	2.92%	191	2.12%	285	3.16%	**1,245**	**2.76%**
FY 2021	Collected	8,056	98.42%	8,060	98.47%	8,050	98.35%	8,086	98.79%	8,049	98.34%	**40,301**	**98.48%**
	Not Collected	129	1.58%	125	1.53%	135	1.65%	99	1.21%	136	1.66%	**624**	**1.52%**
FY 2022	Collected	11,101	99.21%	11,106	99.26%	11,100	99.20%	11,121	99.39%	11,091	99.12%	**55,519**	**99.24%**
	Not Collected	88	0.79%	83	0.74%	89	0.80%	68	0.61%	98	0.88%	**426**	**0.76%**

Suggested Motion:

The data presented is Relevant and Compelling. The Executive Officer is in Compliance. The Ends needs no revisions at this time.

Southwest Michigan Behavioral Health Board Retreat

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

May 12, 2023

Draft: 2/10/23

Agenda assuming 9:30 – 10:30 Board Meeting

10:45 am-11:30 am	Welcome, Introductions, Session Objectives and Participant Statements
11:30 am-12:30 pm	MDHHS Executive – Director Hertel or Chief Deputy Director for Health Farah Hanley
12:30 pm - 1:15 pm	Lunch
1:15 pm – 2:30 pm	
2:30 pm - 2:45 pm	Summary Discussion and Next Steps
3:00 pm	Adjourn

Invitees: Board Members and Board Alternates, CMH CEOs, Substance Use Disorder Oversight Policy Board Officers, Consumer Advisory Council Officers, select SWMBH Senior Leaders.

Facilitator and Content Subject Matter Expert Ideas: Scott Dzurka; Jessica McDuff Altarum Director of Behavioral Health; Jay Rosen CEO Health Management Associates; Lynda Zeller Michigan Health Endowment Fund Vice President Behavioral Health; Susan Radwan, Carver Policy Governance Consultant, Representative Julie Rogers (D-41) Chair House Health Policy, and Committee Member Military, Veterans, and Homeland Security; Insurance and Financial Services; and Local Government and Municipal Finance.

Potential Focus Areas: Carver Policy Governance generally; Ends and Ends Metrics; Delegation, Oversight and Monitoring.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Management/Governance	Policy Number: BG-007	Pages: 2
Subject: Code of Conduct	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH Executive Officer (EO)		Required Reviewer: SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
01.10.2014	1/14/22	1.09.15, 1/8/16, 1/13/17, 2/9/18,1/11/19, 1/10/20, 1/8/21

I. **PURPOSE:**

The Board commits itself to ethical, lawful, and businesslike conduct including proper use of authority and appropriate decorum when acting as Board Members.

II. **POLICY:**

It shall be the policy of SWMBH Board that SWMBH Board Members represent the interests of Southwest Michigan Behavioral Health. This accountability supersedes any potential conflicts of loyalty to other interests including advocacy or interest groups, membership on other Boards, relationships with others or personal interests of any Board Member.

III. **STANDARDS:**

1. Members will follow the SWMBH Conflict of Interest Policy

2. Board Members may not attempt to exercise individual authority over the organization except as explicitly set forth in Board policies.
    a. Members' interaction with the Executive Officer or with staff must recognize the lack of authority vested in individuals except when explicitly Board-authorized.
    b. Members' interaction with public, press or other entities must recognize the same limitation and the inability of any Board Member to speak for the Board unless provided in policy.
    c. Members' commenting on the agency and Executive Officer performance must be done collectively and as regards to explicit Board policies.

3. Members will respect the confidentiality appropriate to issues of a sensitive nature including, but not limited, to those related to business or strategy.

4. Confidentiality: Board Members shall comply with the Michigan Mental Health Code, Section, 330.1748, & 42 CFR Part 2 relative to substance abuse services, and any other applicable privacy laws (Materials can be found by contacting the SWMBH Compliance Department)

5. Members will be properly prepared for Board deliberation.

6. Member will support the legitimacy and authority of the final determination of the Board on any matter, without regard to the Member's personal position on the issue.

7. Delegation of Authority: SWMBH Board will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.

8. Excluded Individuals: Persons who have been excluded from participation in Federal Health Care Programs may not serve as Board Members. The Board Member becomes responsible for notifying the SWMBH Compliance Department if they believe they will become an excluded individual. The Board Member is responsible for providing information necessary to monitor possible exclusions. SWMBH shall periodically review Board Member names against the excluded list per regulatory and contractual obligations.

9. Members will read and seek to understand the SWMBH Compliance Plan and Code of Conduct.

    A. Members have a duty to report to the SWMBH Chief Compliance Officer any alleged or suspected violation of the Board Code of Conduct or related laws and regulations by themselves or another Board Member.
    B. Members may seek advice from the Board Chairman or the SWMBH Chief Compliance Officer concerning appropriate actions that may need to be taken in order to comply with the Code of Conduct or Compliance Plan.
    C. Reporting Suspected Fraud: SWMBH Board must report any suspected "fraud, abuse or waste" (consistent with the definitions as set forth in the Compliance Program Plan) of any SWMBH funding streams.
    D. Failure to comply with the Compliance Plan and Board Code of Conduct may result in the recommendation to a Participant CMH Board for the member's removal from the SWMBH Board.
    E. Members will participate in Board compliance trainings and educational programs as required.
    F. SWMBH Board will establish at SWMBH, and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations.
    G. SWMBH Board Members shall cooperate fully in any internal or external Medicaid or other SWMBH funding stream compliance investigation.

"Conflict of Interest" (Definition): means any actual or proposed direct or indirect financial relationship or ownership interest between the Board Member and any entity with which SWMBH has or proposes to have a contract, affiliation, arrangement or other transaction.

	E	F	H	J	K	L	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 12/31/2022		**P03FYTD22**	**3**									
3	*(For Internal Management Purposes Only)*												
4	***INCOME STATEMENT***		**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**Opioid Health Home Contract**	**CCBHC**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**
5													
6	**REVENUE**												
17	Contract Revenue		86,158,608	56,530,705	12,732,493	4,856,662	435,918	8,806,536	890,082	-	1,445,030	461,182	-
18	DHHS Incentive Payments		125,489	125,489	-	-	-	-	-	-	-	-	-
19	Grants and Earned Contracts		176,859	-	-	-	-	-	-	176,859	-	-	-
20	Interest Income - Working Capital		95,226	-	-	-	-	-	-	-	-	-	95,226
21	Interest Income - ISF Risk Reserve		2,000	-	-	-	-	-	-	-	-	-	2,000
22	Local Funds Contributions		322,338	-	-	-	-	-	-	-	-	-	322,338
23	Other Local Income		-	-	-	-	-	-	-	-	-	-	-
24													
25	**TOTAL REVENUE**		**86,880,519**	**56,656,194**	**12,732,493**	**4,856,662**	**435,918**	**8,806,536**	**890,082**	**176,859**	**1,445,030**	**461,182**	**419,563**
26													
27	**EXPENSE**												
28	**Healthcare Cost**												
29	Provider Claims Cost		6,040,682	1,080,947	2,043,190	-	290,772	-	1,009,459	124,087	1,239,802	252,425	-
30	CMHP Subcontracts, net of 1st & 3rd party		65,488,900	48,524,434	4,983,310	4,649,366	-	7,030,598	156,648	-	144,544	-	-
31	Insurance Provider Assessment Withhold (IPA)		936,491	650,796	285,695	-	-	-	-	-	-	-	-
32	Medicaid Hospital Rate Adjustments		-	-	-	-	-	-	-	-	-	-	-
33	MHL Cost in Excess of Medicare FFS Cost		-	323,723	-	-	-	-	(323,723)		-	-	-
34													
35	**Total Healthcare Cost**		**72,466,073**	**50,579,900**	**7,312,195**	**4,649,366**	**290,772**	**7,030,598**	**842,384**	**124,087**	**1,384,346**	**252,425**	**-**
36	**Medical Loss Ratio (HCC % of Revenue)**		**84.0%**	**89.3%**	**57.4%**	**95.7%**	**66.7%**	**79.8%**	**94.6%**		**95.8%**	**54.7%**	
38	**Administrative Cost**												
39	Purchased Professional Services		93,265	-	-	-	-	-	-	-	-	-	93,265
40	Administrative and Other Cost		1,887,231	-	-	-	-	-	-	52,772	15,861	-	1,816,540
41	Interest Expense		-	-	-	-	-	-	-	-	-	-	-
42	Depreciation		1,431	-	-	-	-	-	-	-	-	-	1,431
43	Functional Cost Reclassification		-	-	-	-	-	-	-	-	-	-	-
44	Allocated Indirect Pooled Cost		(0)	-	-	-	-	-	-	-	-	-	2,057
45	Delegated Managed Care Admin		4,879,838	4,177,834	462,889	222,328	-	-	16,788	-	-	-	-
46	Apportioned Central Mgd Care Admin		(0)	1,302,991	186,255	123,243	7,708	186,364	30,911	4,688	49,042	-	(1,891,203)
47													
48	**Total Administrative Cost**		**6,861,764**	**5,480,825**	**649,144**	**345,571**	**7,708**	**186,364**	**47,699**	**57,460**	**64,903**	**-**	**22,090**
49	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**9.8%**	**8.2%**	**6.9%**	**2.6%**	**2.6%**	**5.4%**		**4.5%**	**0.0%**	**2.4%**
50													
51	Local Funds Contribution		322,338	-	-	-	-	-	-	-	-	-	322,338
52	PBIP Transferred to CMHPs		-										-
53													
54	**TOTAL COST after apportionment**		**79,650,175**	**56,060,724**	**7,961,339**	**4,994,936**	**298,480**	**7,216,962**	**890,082**	**181,547**	**1,449,250**	**252,425**	**344,428**
55													
56	**NET SURPLUS before settlement**		**7,230,344**	**595,470**	**4,771,153**	**(138,275)**	**137,438**	**1,589,573**	**-**	**(4,688)**	**(4,219)**	**208,757**	**75,135**
57	**Net Surplus (Deficit) % of Revenue**		**8.3%**	**1.1%**	**37.5%**	**-2.8%**	**31.5%**	**18.0%**	**0.0%**	**-2.7%**	**-0.3%**	**45.3%**	**17.9%**
59	Prior Year Savings		17,316,484	16,894,122	422,362	-	-	-	-		-	-	-
60	Change in PA2 Fund Balance		(204,538)	-	-	-	-	-	-		-	(204,538)	-
61	ISF Risk Reserve Abatement (Funding)		(2,000)	-	-	-	-	-	-		-	-	(2,000)
62	ISF Risk Reserve Deficit (Funding)		-	-	-	-	-	-	-		-	-	-
63	Settlement Receivable / (Payable)		(1,959,892)	2,095,124	(2,466,279)	138,275	(137,438)	(1,589,573)	-	-	4,219	(4,219)	-
64	**NET SURPLUS (DEFICIT)**		**22,380,399**	**19,584,716**	**2,727,236**	**-**	**-**	**-**	**-**	**(4,688)**	**-**	**-**	**73,135**
65	*HMP & Autism is settled with Medicaid*												
66													
67	**SUMMARY OF NET SURPLUS (DEFICIT)**												
68	Prior Year Unspent Savings		12,987,363	12,670,592	316,772	-	-	-	-		-	-	-
69	Current Year Savings		4,618,742	2,208,277	2,410,465	-	-	-	-		-	-	-
70	Current Year Public Act 2 Fund Balance		-	-	-	-	-	-	-		-	-	-
71	Local and Other Funds Surplus/(Deficit)		4,774,295	4,705,848	-	-	-	-	-	(4,688)	-	-	73,135
73	**NET SURPLUS (DEFICIT)**		**22,380,399**	**19,584,716**	**2,727,236**	**-**	**-**	**-**	**-**	**(4,688)**	**-**	**-**	**73,135**
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*					Estimate P03				Estimate P03
2	For the Fiscal YTD Period Ended 12/31/2022			3									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
6	***Medicaid Specialty Services***			*HCC%*		76.3%	76.6%	80.2%	79.5%	86.4%	80.7%	86.0%	81.2%
7	Subcontract Revenue		56,530,705	4,339,990	52,190,715	2,579,206	11,119,708	2,924,080	10,330,563	3,625,601	13,349,831	2,888,664	5,373,063
8	Incentive Payment Revenue		125,489	93,726	31,764	529	9,001	-	22,233	-	-	-	-
9	**Contract Revenue**		**56,656,194**	**4,433,715**	**52,222,479**	**2,579,736**	**11,128,709**	**2,924,080**	**10,352,796**	**3,625,601**	**13,349,831**	**2,888,664**	**5,373,063**
10													
11	External Provider Cost		39,041,721	1,080,947	37,960,775	1,250,509	6,547,173	1,519,717	7,098,701	2,440,717	12,732,459	3,377,476	2,994,023
12	Internal Program Cost		11,040,021	-	11,040,021	1,004,338	2,214,891	675,184	2,678,335	1,279,131	763,043	317,694	2,107,407
13	SSI Reimb, 1st/3rd Party Cost Offset		(319,714)	-	(319,714)	-	(200,385)	(22,765)	(58,167)	-	(23,811)	(1,367)	(13,219)
14	Insurance Provider Assessment Withhold (IPA)		650,796	650,796	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		199,294	199,294	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**50,612,119**	**1,931,037**	**48,681,082**	**2,254,847**	**8,561,680**	**2,172,135**	**9,718,868**	**3,719,848**	**13,471,690**	**3,693,802**	**5,088,210**
17	**Medical Loss Ratio (HCC % of Revenue)**		**89.3%**		**93.2%**	**87.4%**	**76.9%**	**74.3%**	**93.9%**	**102.6%**	**100.9%**	**127.9%**	**94.7%**
18													
19	**Managed Care Administration**		**5,497,613**	**1,302,991**	**4,194,622**	**292,556**	**1,106,660**	**148,808**	**752,832**	**358,331**	**806,524**	**368,931**	**359,980**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.8%**	**2.3%**	**7.5%**	**11.5%**	**11.4%**	**6.4%**	**7.2%**	**8.8%**	**5.6%**	**9.1%**	**6.6%**
21													
22	**Contract Cost**		**56,109,732**	**3,234,028**	**52,875,703**	**2,547,403**	**9,668,340**	**2,320,944**	**10,471,700**	**4,078,179**	**14,278,214**	**4,062,734**	**5,448,190**
23	**Net before Settlement**		**546,463**	**1,199,687**	**(653,224)**	**32,333**	**1,460,369**	**603,136**	**(118,904)**	**(452,578)**	**(928,382)**	**(1,174,070)**	**(75,128)**
24													
25	Prior Year Savings		16,894,122	16,894,122	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		2,095,124	1,441,900	653,224	(32,333)	(1,460,369)	(603,136)	118,904	452,578	928,382	1,174,070	75,128
28	**Net after Settlement**		**19,535,708**	**19,535,708**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		180,777	180,777	180,777	9,963	34,077	10,634	35,067	10,596	47,312	14,825	18,303
32	Revenue PMPM		$ 104.47	$ 8.18	$ 96.29	$ 86.31	$ 108.86	$ 91.66	$ 98.41	$ 114.06	$ 94.06	$ 64.95	$ 97.85
33	Expense PMPM		$ 103.46	$ 5.96	$ 97.50	$ 85.23	$ 94.57	$ 72.75	$ 99.54	$ 128.29	$ 100.60	$ 91.35	$ 99.22
34	Margin PMPM		$ 1.01	$ 2.21	$ (1.20)	$ 1.08	$ 14.28	$ 18.91	$ (1.13)	$ (14.24)	$ (6.54)	$ (26.40)	$ (1.37)
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		180,777	180,777	180,777	9,963	34,077	10,634	35,067	10,596	47,312	14,825	18,303
41	Budget		174,379	174,379	174,379	9,423	33,008	10,297	33,586	10,237	45,533	14,354	17,941
42	Variance - Favorable / (Unfavorable)		6,398	6,398	6,398	540	1,069	337	1,481	359	1,779	471	362
43	% Variance - Fav / (Unfav)		3.7%	3.7%	3.7%	5.7%	3.2%	3.3%	4.4%	3.5%	3.9%	3.3%	2.0%
44													
45	**Contract Revenue before settlement**												
46	Actual		56,656,194	4,433,715	52,222,479	2,579,736	11,128,709	2,924,080	10,352,796	3,625,601	13,349,831	2,888,664	5,373,063
47	Budget		65,589,527	6,376,467	59,213,060	2,529,611	11,086,172	3,172,910	10,373,203	3,230,820	19,149,318	4,279,958	5,391,067
48	Variance - Favorable / (Unfavorable)		(8,933,333)	(1,942,752)	(6,990,581)	50,124	42,537	(248,830)	(20,407)	394,781	(5,799,487)	(1,391,295)	(18,004)
49	% Variance - Fav / (Unfav)		-13.6%	-30.5%	-11.8%	2.0%	0.4%	-7.8%	-0.2%	12.2%	-30.3%	-32.5%	-0.3%
50													
51	**Healthcare Cost**												
52	Actual		50,612,119	1,931,037	48,681,082	2,254,847	8,561,680	2,172,135	9,718,868	3,719,848	13,471,690	3,693,802	5,088,210
53	Budget		52,989,206	2,644,694	50,344,512	2,234,177	9,718,868	3,120,705	10,219,784	3,083,718	13,264,465	3,614,584	5,088,210
54	Variance - Favorable / (Unfavorable)		2,377,087	713,657	1,663,430	(20,669)	1,157,188	948,570	500,916	(636,130)	(207,225)	(79,219)	-
55	% Variance - Fav / (Unfav)		4.5%	27.0%	3.3%	-0.9%	11.9%	30.4%	4.9%	-20.6%	-1.6%	-2.2%	0.0%
56													
57	**Managed Care Administration**												
58	Actual		5,497,613	1,302,991	4,194,622	292,556	1,106,660	148,808	752,832	358,331	806,524	368,931	359,980
59	Budget		5,668,505	2,143,194	3,525,311	282,010	752,832	115,259	783,265	418,818	670,171	142,977	359,980
60	Variance - Favorable / (Unfavorable)		170,892	840,202	(669,311)	(10,546)	(353,828)	(33,550)	30,433	60,487	(136,352)	(225,955)	-
61	% Variance - Fav / (Unfav)		3.0%	39.2%	-19.0%	-3.7%	-47.0%	-29.1%	3.9%	14.4%	-20.3%	-158.0%	0.0%
62													
63	**Total Contract Cost**												
64	Actual		56,109,732	3,234,028	52,875,703	2,547,403	9,668,340	2,320,944	10,471,700	4,078,179	14,278,214	4,062,734	5,448,190
65	Budget		58,657,710	4,787,887	53,869,823	2,516,187	10,471,700	3,235,964	11,003,049	3,502,536	13,934,636	3,757,560	5,448,190
66	Variance - Favorable / (Unfavorable)		2,547,979	1,553,859	994,120	(31,216)	803,360	915,020	531,349	(575,643)	(343,577)	(305,173)	-
67	% Variance - Fav / (Unfav)		4.3%	32.5%	1.8%	-1.2%	7.7%	28.3%	4.8%	-16.4%	-2.5%	-8.1%	0.0%
68													
69	**Net before Settlement**												
70	Actual		546,463	1,199,687	(653,224)	32,333	1,460,369	603,136	(118,904)	(452,578)	(928,382)	(1,174,070)	(75,128)
71	Budget		6,931,817	1,588,580	5,343,237	13,424	614,472	(63,053)	(629,846)	(271,716)	5,214,682	522,398	(57,123)
72	Variance - Favorable / (Unfavorable)		(6,385,354)	(388,893)	(5,996,461)	18,908	845,897	666,190	510,942	(180,862)	(6,143,064)	(1,696,468)	(18,004)
73													
74													

	F	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***		*Mos in Period*					Estimate P03				Estimate P03
2	For the Fiscal YTD Period Ended 12/31/2022		3									
3	*(For Internal Management Purposes Only)*		*ok*									
4	***INCOME STATEMENT***	**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5												
75	***Healthy Michigan Plan***		*HCC%*		12.9%	9.2%	14.0%	7.7%	7.0%	9.0%	13.0%	9.0%
76	**Contract Revenue**	**12,732,493**	**3,243,393**	**9,489,100**	**545,052**	**2,125,894**	**522,702**	**1,808,818**	**655,976**	**2,363,064**	**533,527**	**934,066**
77												
78	External Provider Cost	4,597,202	2,043,190	2,554,012	154,989	265,043	114,966	438,192	85,201	876,110	322,010	297,500
79	Internal Program Cost	2,429,298	-	2,429,298	225,527	788,392	268,856	514,035	214,502	142,011	7,306	268,669
80	SSI Reimb, 1st/3rd Party Cost Offset	-	-	-	-	-	-	-	-	-	-	-
81	Insurance Provider Assessment Withhold (IPA)	285,695	285,695	-	-	-	-	-	-	-	-	-
82	**Total Healthcare Cost**	**7,312,195**	**2,328,885**	**4,983,310**	**380,516**	**1,053,435**	**383,822**	**952,226**	**299,704**	**1,018,121**	**329,316**	**566,169**
83	**Medical Loss Ratio (HCC % of Revenue)**	**57.4%**		**52.5%**	**69.8%**	**49.6%**	**73.4%**	**52.6%**	**45.7%**	**43.1%**	**61.7%**	**60.6%**
84												
85	**Managed Care Administration**	**649,144**	**186,255**	**462,889**	**49,370**	**94,987**	**59,255**	**73,321**	**34,556**	**60,845**	**50,499**	**40,055**
86	**Admin Cost Ratio (MCA % of Total Cost)**	**8.2%**	**2.3%**	**5.8%**	**11.5%**	**8.3%**	**13.4%**	**7.1%**	**10.3%**	**5.6%**	**13.3%**	**6.6%**
87												
88	**Contract Cost**	**7,961,339**	**2,515,141**	**5,446,199**	**429,887**	**1,148,422**	**443,077**	**1,025,548**	**334,260**	**1,078,966**	**379,815**	**606,225**
89	**Net before Settlement**	**4,771,153**	**728,252**	**4,042,901**	**115,165**	**977,472**	**79,626**	**783,270**	**321,716**	**1,284,098**	**153,712**	**327,841**
90												
91	Prior Year Savings	422,362	422,362	-	-	-	-	-	-	-	-	-
92	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
93	Contract Settlement / Redistribution	(2,466,279)	1,576,622	(4,042,901)	(115,165)	(977,472)	(79,626)	(783,270)	(321,716)	(1,284,098)	(153,712)	(327,841)
94	**Net after Settlement**	**2,727,236**	**2,727,236**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
95												
96	**Eligibles and PMPM**											
97	Average Eligibles	79,360	79,360	79,360	4,045	15,487	3,791	14,502	4,824	22,991	6,122	7,597
98	Revenue PMPM	$ 53.48	$ 13.62	$ 39.86	$ 44.92	$ 45.76	$ 45.96	$ 41.58	$ 45.32	$ 34.26	$ 29.05	$ 40.98
99	Expense PMPM	33.44	10.56	22.88	35.43	24.72	38.96	23.57	23.10	15.64	20.68	26.60
100	Margin PMPM	$ 20.04	$ 3.06	$ 16.98	$ 9.49	$ 21.04	$ 7.00	$ 18.00	$ 22.23	$ 18.62	$ 8.37	$ 14.38
101												
102	***Healthy Michigan Plan***											
103	**Budget v Actual**											
104												
105	**Eligible Lives (Average Eligibles)**											
106	Actual	79,360	79,360	79,360	4,045	15,487	3,791	14,502	4,824	22,991	6,122	7,597
107	Budget	74,889	74,889	74,889	3,793	14,729	3,546	13,688	4,485	21,571	5,873	7,204
108	Variance - Favorable / (Unfavorable)	4,471	4,471	4,471	252	758	245	815	339	1,420	249	393
109	% Variance - Fav / (Unfav)	6.0%	6.0%	6.0%	6.6%	5.1%	6.9%	6.0%	7.6%	6.6%	4.2%	5.5%
110												
111	**Contract Revenue before settlement**											
112	Actual	12,732,493	3,243,393	9,489,100	545,052	2,125,894	522,702	1,808,818	655,976	2,363,064	533,527	934,066
113	Budget	12,295,385	2,358,221	9,937,164	499,631	1,930,316	466,955	1,836,499	585,950	2,904,538	775,015	938,260
114	Variance - Favorable / (Unfavorable)	437,107	885,172	(448,065)	45,421	195,578	55,747	(27,681)	70,026	(541,474)	(241,488)	(4,194)
115	% Variance - Fav / (Unfav)	3.6%	37.5%	-4.5%	9.1%	10.1%	11.9%	-1.5%	12.0%	-18.6%	-31.2%	-0.4%
116												
117	**Healthcare Cost**											
118	Actual	7,312,195	2,328,885	4,983,310	380,516	1,053,435	383,822	952,226	299,704	1,018,121	329,316	566,169
119	Budget	8,484,327	2,082,786	6,401,541	337,049	952,226	640,415	1,512,141	249,523	1,390,998	753,019	566,169
120	Variance - Favorable / (Unfavorable)	1,172,132	(246,099)	1,418,231	(43,468)	(101,209)	256,594	559,915	(50,180)	372,877	423,703	-
121	% Variance - Fav / (Unfav)	13.8%	-11.8%	22.2%	-12.9%	-10.6%	40.1%	37.0%	-20.1%	26.8%	56.3%	0.0%
122												
123	**Managed Care Administration**											
124	Actual	649,144	186,255	462,889	49,370	94,987	59,255	73,321	34,556	60,845	50,499	40,055
125	Budget	740,247	325,618	414,629	42,544	73,321	34,392	121,789	33,889	49,316	19,322	40,055
126	Variance - Favorable / (Unfavorable)	91,103	139,362	(48,260)	(6,826)	(21,666)	(24,863)	48,468	(667)	(11,530)	(31,177)	-
127	% Variance - Fav / (Unfav)	12.3%	42.8%	-11.6%	-16.0%	-29.5%	-72.3%	39.8%	-2.0%	-23.4%	-161.4%	0.0%
128												
129	**Total Contract Cost**											
130	Actual	7,961,339	2,515,141	5,446,199	429,887	1,148,422	443,077	1,025,548	334,260	1,078,966	379,815	606,225
131	Budget	9,224,574	2,408,404	6,816,170	379,593	1,025,548	674,808	1,633,931	283,413	1,440,314	772,341	606,225
132	Variance - Favorable / (Unfavorable)	1,263,235	(106,737)	1,369,972	(50,294)	(122,874)	231,731	608,383	(50,847)	361,347	392,526	-
133	% Variance - Fav / (Unfav)	13.7%	-4.4%	20.1%	-13.2%	-12.0%	34.3%	37.2%	-17.9%	25.1%	50.8%	0.0%
134												
135	**Net before Settlement**											
136	Actual	4,771,153	728,252	4,042,901	115,165	977,472	79,626	783,270	321,716	1,284,098	153,712	327,841
137	Budget	3,070,811	(50,183)	3,120,994	120,039	904,768	(207,852)	202,569	302,537	1,464,224	2,674	332,035
138	Variance - Favorable / (Unfavorable)	1,700,342	778,435	921,907	(4,873)	72,704	287,478	580,702	19,179	(180,126)	151,038	(4,194)
139												
140												

	F	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		*Mos in Period*					Estimate P03				Estimate P03
2	For the Fiscal YTD Period Ended 12/31/2022		3									
3	*(For Internal Management Purposes Only)*		*ok*									
4	**INCOME STATEMENT**	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5												
141	**Autism Specialty Services**		*HCC%*		3.7%	12.9%	0.2%	9.3%	0.0%	6.9%	0.1%	6.2%
142	**Contract Revenue**	**4,856,662**	**267,846**	**4,588,816**	**255,362**	**892,443**	**259,655**	**881,089**	**-**	**1,405,011**	**390,511**	**504,746**
143												
144	External Provider Cost	4,513,991	-	4,513,991	-	1,466,082	-	1,139,298	-	1,528,568	5,043	375,000
145	Internal Program Cost	135,375	-	135,375	108,344	2,945	6,675	325	-	-	592	16,494
146	SSI Reimb, 1st/3rd Party Cost Offset	-	-	-	-	-	-	-	-	-	-	-
147	Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-
148	**Total Healthcare Cost**	**4,649,366**	**-**	**4,649,366**	**108,344**	**1,469,027**	**6,675**	**1,139,623**	**-**	**1,528,568**	**5,635**	**391,494**
149	**Medical Loss Ratio (HCC % of Revenue)**	**95.7%**	**0.0%**	**101.3%**	**42.4%**	**164.6%**	**2.6%**	**129.3%**	**0.0%**	**108.8%**	**1.4%**	**77.6%**
150												
151	**Managed Care Administration**	**345,571**	**123,243**	**222,328**	**14,057**	**-**	**1,471**	**87,751**	**-**	**91,351**	**-**	**27,697**
152	**Admin Cost Ratio (MCA % of Total Cost)**	**6.9%**	**2.5%**	**4.5%**	**11.5%**	**0.0%**	**18.1%**	**7.1%**	**0.0%**	**5.6%**	**0.0%**	**6.6%**
153												
154	**Contract Cost**	**4,994,936**	**123,243**	**4,871,693**	**122,402**	**1,469,027**	**8,146**	**1,227,374**	**-**	**1,619,919**	**5,635**	**419,191**
155	**Net before Settlement**	**(138,275)**	**144,602**	**(282,877)**	**132,960**	**(576,584)**	**251,509**	**(346,284)**	**-**	**(214,909)**	**384,876**	**85,555**
156	Contract Settlement / Redistribution	138,275	(144,602)	282,877	(132,960)	576,584	(251,509)	346,284	-	214,909	(384,876)	(85,555)
157	**Net after Settlement**	**0**	**0**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
158												
159												
160	**Certified Community Behavioral Health Clin**		*HCC%*		0.0%	0.0%	0.0%	0.0%	0.0%	23.8%	30.6%	0.0%
161	**Contract Revenue**	**8,806,536**	**126,583**	**8,679,952**	**-**	**-**	**-**	**-**	**-**	**6,862,249**	**1,817,703**	**-**
162												
163	External Provider Cost	3,094,204	-	3,094,204	-	-	-	-	-	1,292,835	1,801,369	-
164	Internal Program Cost	3,936,394	-	3,936,394	-	-	-	-	-	3,936,394	-	-
165	SSI Reimb, 1st/3rd Party Cost Offset	-	-	-	-	-	-	-	-	-	-	-
166	**Total Healthcare Cost**	**7,030,598**	**-**	**7,030,598**	**-**	**-**	**-**	**-**	**-**	**5,229,230**	**1,801,369**	**-**
167	**Medical Loss Ratio (HCC % of Revenue)**	**79.8%**	**0.0%**	**81.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**76.2%**	**99.1%**	**0.0%**
168												
169	**Managed Care Administration**	**186,364**	**186,364**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
170	**Admin Cost Ratio (MCA % of Total Cost)**	**2.6%**	**2.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
171												
172	**Contract Cost**	**7,216,962**	**186,364**	**7,030,598**	**-**	**-**	**-**	**-**	**-**	**5,229,230**	**1,801,369**	**-**
173	**Net before Settlement**	**1,589,573**	**(59,781)**	**1,649,354**	**-**	**-**	**-**	**-**	**-**	**1,633,020**	**16,335**	**-**
174	PPS-1 Supplemental Payment Difference	(2,869,977)	-	(2,869,977)	-	-	-	-	-	(2,886,312)	16,335	-
175	Contract Settlement / Redistribution	-	(1,220,623)	1,220,623	-	-	-	-	-	1,253,292	(32,669)	-
176	**Net after Settlement**	**(1,280,404)**	**(1,280,404)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
177												
178												
179	**SUD Block Grant Treatment**		*HCC%*		0.6%	0.3%	0.2%	0.3%	0.5%	0.0%	0.1%	0.3%
180	**Contract Revenue**	**1,445,030**	**1,309,883**	**135,147**	**9,439**	**48,824**	**7,067**	**48,824**	**5,060**	**-**	**-**	**15,934**
181												
182	External Provider Cost	1,239,802	1,239,802	-	-	-	-	-	-	-	-	-
183	Internal Program Cost	144,544	-	144,544	16,572	38,815	6,574	38,371	23,125	-	4,763	16,323
184	Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-
185	**Total Healthcare Cost**	**1,384,346**	**1,239,802**	**144,544**	**16,572**	**38,815**	**6,574**	**38,371**	**23,125**	**-**	**4,763**	**16,323**
186	**Medical Loss Ratio (HCC % of Revenue)**	**95.8%**	**94.6%**	**107.0%**	**175.6%**	**79.5%**	**93.0%**	**78.6%**	**457.0%**	**0.0%**	**0.0%**	**102.4%**
187												
188	**Managed Care Administration**	**49,042**	**49,042**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
189	**Admin Cost Ratio (MCA % of Total Cost)**	**3.4%**	**3.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
190												
191	**Contract Cost**	**1,433,389**	**1,288,845**	**144,544**	**16,572**	**38,815**	**6,574**	**38,371**	**23,125**	**-**	**4,763**	**16,323**
192	**Net before Settlement**	**11,641**	**21,038**	**(9,397)**	**(7,133)**	**10,009**	**493**	**10,453**	**(18,065)**	**-**	**(4,763)**	**(389)**
193	Contract Settlement	4,219	(5,177)	9,397	7,133	(10,009)	(493)	(10,453)	18,065	-	4,763	389
194	**Net after Settlement**	**15,861**	**15,861**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
195												
196												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*					**Estimate P03**				**Estimate P03**
2	For the Fiscal YTD Period Ended 12/31/2022			3									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
197	***SWMBH CMHP Subcontracts***												
198	Subcontract Revenue		84,371,425	9,287,694	75,083,731	3,389,059	14,186,869	3,713,504	13,069,294	4,286,637	23,980,155	5,630,405	6,827,809
199	Incentive Payment Revenue		125,489	93,726	31,764	529	9,001	-	22,233	-	-	-	-
200	**Contract Revenue**		**84,496,915**	**9,381,420**	**75,115,495**	**3,389,588**	**14,195,870**	**3,713,504**	**13,091,527**	**4,286,637**	**23,980,155**	**5,630,405**	**6,827,809**
201													
202	External Provider Cost		52,486,921	4,363,939	48,122,981	1,405,499	8,278,299	1,634,683	8,676,190	2,525,918	16,429,972	5,505,897	3,666,523
203	Internal Program Cost		17,685,633	-	17,685,633	1,354,781	3,045,044	957,287	3,231,066	1,516,759	4,841,448	330,355	2,408,893
204	SSI Reimb, 1st/3rd Party Cost Offset		(319,714)	-	(319,714)	-	(200,385)	(22,765)	(58,167)	-	(23,811)	(1,367)	(13,219)
205	Insurance Provider Assessment Withhold (IPA)		936,491	936,491	-	-	-	-	-	-	-	-	-
206	PPS-1 Supplemental Payment Difference		(2,869,977)	-	(2,869,977)	-	-	-	-	-	2,886,312	(16,335)	-
207	MHL Cost in Excess of Medicare FFS Cost		199,294	199,294	-	-	-	-	-	-	-	-	-
208	**Total Healthcare Cost**		**68,118,647**	**5,499,724**	**62,618,923**	**2,760,280**	**11,122,958**	**2,569,205**	**11,849,088**	**4,042,677**	**24,133,921**	**5,818,551**	**6,062,197**
209	**Medical Loss Ratio (HCC % of Revenue)**		**80.6%**	**58.6%**	**83.4%**	**81.4%**	**78.4%**	**69.2%**	**90.5%**	**94.3%**	**100.6%**	**103.3%**	**88.8%**
210													
211	**Managed Care Administration**		**6,727,734**	**1,847,896**	**4,879,838**	**355,984**	**1,201,647**	**209,534**	**913,904**	**392,887**	**958,720**	**419,430**	**427,733**
212	**Admin Cost Ratio (MCA % of Total Cost)**		**9.0%**	**2.5%**	**6.5%**	**11.4%**	**9.7%**	**7.5%**	**7.2%**	**8.9%**	**3.8%**	**6.7%**	**6.6%**
213													
214	**Contract Cost**		**74,846,381**	**7,347,621**	**67,498,760**	**3,116,263**	**12,324,604**	**2,778,740**	**12,762,992**	**4,435,564**	**25,092,641**	**6,237,981**	**6,489,930**
215	**Net before Settlement**		**9,650,533**	**2,033,799**	**7,616,734**	**273,325**	**1,871,266**	**934,764**	**328,535**	**(148,927)**	**(1,112,485)**	**(607,576)**	**337,879**
216													
217	Prior Year Savings		17,316,484	17,316,484	-	-	-	-	-	-	-	-	-
218	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
219	Contract Settlement		(228,661)	2,868,742	(3,097,403)	(273,325)	(1,871,266)	(934,764)	(328,535)	148,927	2,745,505	623,911	(337,879)
220	**Net after Settlement**		**26,738,356**	**22,219,025**	**4,519,331**	**-**	**-**	**-**	**-**	**-**	**1,633,020**	**16,335**	**(0)**
221													
222													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*					Estimate P03				Estimate P03
2	For the Fiscal YTD Period Ended 12/31/2022			3									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
223	***State General Fund Services***			*HCC%*	2.5%	6.6%	1.0%	5.3%	3.2%	6.2%	1.4%	0.8%	3.3%
224	**Contract Revenue**				**3,306,841**	**233,831**	**556,363**	**220,152**	**552,097**	**216,771**	**975,129**	**260,640**	**291,858**
225													
226	External Provider Cost				325,230	33,743	51,689	14,441	87,638	112,719	-	-	25,000
227	Internal Program Cost				987,009	160,886	57,043	131,383	300,124	154,680	-	-	182,893
228	SSI Reimb, 1st/3rd Party Cost Offset				-	-	-	-	-	-	-	-	-
229	**Total Healthcare Cost**				**1,312,238**	**194,629**	**108,732**	**145,824**	**387,762**	**267,398**	**-**	**-**	**207,893**
230	**Medical Loss Ratio (HCC % of Revenue)**				**39.7%**	**83.2%**	**19.5%**	**66.2%**	**70.2%**	**123.4%**	**0.0%**	**0.0%**	**71.2%**
231													
232	**Managed Care Administration**				**126,450**	**28,468**	**5,874**	**28,956**	**29,858**	**16,960**	**-**	**-**	**16,333**
233	**Admin Cost Ratio (MCA % of Total Cost)**				**8.8%**	**12.8%**	**5.1%**	**16.6%**	**7.1%**	**6.0%**	**0.0%**	**0.0%**	**7.3%**
234													
235	**Contract Cost**				**1,438,688**	**223,097**	**114,606**	**174,781**	**417,620**	**284,358**	**-**	**-**	**224,226**
236	**Net before Settlement**				**1,868,153**	**10,734**	**441,757**	**45,371**	**134,477**	**(67,587)**	**975,129**	**260,640**	**67,632**
237													
238	Other Redistributions of State GF				(122,037)	-	(294,240)	-	-	28,436	133,932	9,834	-
239	Contract Settlement				(62,884)	(9,846)	-	-	-	-	-	-	(53,039)
240	**Net after Settlement**				**1,683,231**	**888**	**147,517**	**45,371**	**134,477**	**(39,151)**	**1,109,061**	**270,474**	**14,593**
241													

Southwest Michigan Behavioral Health

Utilization Management Program for Members Enrolled in Medicaid, Healthy Michigan Plan, SUD Community Grant, Flint 1115 Waiver, Autism Benefit, SED, Child, or Habilitation Supports Waivers

FY 2023 (October 1, 2022 – September 30, 2023)

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Introduction

Southwest Michigan Behavioral Health is the Regional Entity designated to function as the Prepaid Inpatient Health Plan performing the benefits management function for members receiving services under the Medicaid Managed Specialty Supports and Services Demonstration 1115 Waiver, 1915 (c) (i) Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs for behavioral health specialty and substance use disorder services for the eight county region of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St Joseph and Van Buren counties. The specialty mental health services are provided by eight Community Mental Health Services Programs (CMHSP's: Barry County Community Mental Health and Substance Abuse Services, Community Mental Health and Substance Abuse Services of St. Joseph County, Kalamazoo Community Mental Health and Substance Abuse Services, Pines Behavioral Health, Riverwood Center, Summit Pointe, Van Buren Community Mental Health, Woodlands Behavioral Health Network) and their provider networks. The substance use disorder services are managed and/or provided by a combination of various CMHSP's and the SWMBH provider network.

These various funding source/programs managed by SWMBH possess different definitions, criteria, and benefits. The Medicaid Managed Specialty Supports and Services program is available to both children and adults and is funded under Medicaid which is a Federal and state entitlement program that provides physical and behavioral health benefits to low-income individuals who have no insurance. Criteria for Medicaid varies based among other indicators including on disability type, physical health status, age, and income. Healthy Michigan Plan provides comprehensive health care coverage for a category of eligibility for individuals who are 19-64 years of age; have income at or below 133% of the federal poverty level; do not qualify for or are not enrolled in Medicare; do not qualify for or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State of Michigan. The Flint 1115 Waiver a program available under Medicaid. Eligibility for coverage includes children up to the age of 21 who are or were being served by Flint's water system between April 2014 and a future date when the water system is deemed safe. Pregnant women and their children also will be made eligible. Substance Use Disorder Community Block Grant is a Federal program that provides substance use disorder benefits to low-income individuals who have no insurance.

Purpose

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR. The PIHP must ensure services identified in 42 CFR §438.210(a)(1) must be furnished in an amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Values

SWMBH intends to operate a high-quality utilization management system for public behavioral health and substance abuse services which is responsive to community, family, and individual needs. The entry process must be clear, readily available, and well known to all constituents. To be effective, information, assessment, referral, and linkage capacity must be readily and seamlessly available. Level of care and care management decisions must be based on medical necessity and on evidenced based, wellness, recovery, and best practice. SWMBH is committed to ensuring use of evidence-based services with member matching that drive outcomes/results/value for taxpayer dollar and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, SWMBH is committed to the identification, development and use of innovative and less costly supportive services (e.g., Assistive Technology, Certified Peer Supports and Recovery Coaches, etc.) while meeting the service needs of members in the region. SWMBH recognizes that access to physical and behavioral health services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing access to integrated service depends upon appropriate utilization throughout all aspects of the screening, assessment, level of care and care management decision making processes and care coordination and through oversight, fidelity and outcomes monitoring.

Authority and Structure

Program Oversight

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director. Additionally, the Regional Utilization Management Committee shall serve in a critical role involving deliberation, consultation, and proof of performance realms. The SWMBH Medical Director is accountable for management of the PIHP's Utilization Management Program. Jointly with the board-certified Medical Director, the Director of Utilization Management and Director of Clinical Quality provide clinical and operational oversight and direction to the UM program and staff, while ensuring SWMBH has qualified staff accountable to the organization for decisions impacting customers.

Committee

SWMBH has established the Regional Utilization Management Committee (RUM) to review and provide input on monitoring and ensuring the uniformity and consistent application of standardized screening and assessment tools and level of care, service determination and eligibility criteria at a local care management level. Using level of care and utilization data to track service provision to customers and to the implementation of level of care and care management practices. Further, the committee is responsible for identifying service gaps and training needs for regional utilization management activities.

Staffing

RUM is a PIHP Committee consisting of cross-collaborative leadership representation from SWMBH including the Director of Utilization Management and the Director of Clinical Quality and representation from each of the eight Community Mental Health Service Programs. At a minimum, collaboration occurs with the Quality Management Committee (QMC) on an annual basis. Ongoing consultation and ad hoc representation from the SWMBH Medical Director, Customer Services, QMC, Finance, IT, Provider Network, and Outcomes is available to the committee. RUM clinical representatives are experienced clinical professionals with specialty representation for Child and Adolescent Serious Emotional Disturbance, Adults and Children with Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Adults and Children with Substance Use Disorders. The committee members are designated by the CEOs and empowered to make policy decisions for their CMHSP's as required by the scope of the committee in Utilization Management. These members ensure that pertinent information from the committee is shared with their respective CMHSPs. The RUM committee meets at a minimum of 6 times per year.

Roles of the Committee

The RUM is charged with the following:

1. Ensure adherence to consistent and application of assessment tools, level of care guidelines and medical necessity criteria at the Local Care Management Level and development of recommendations for UM level of care guidelines.
2. Review and provide input on the UM Program on an annual basis assuring adherence to and synchronization with Operating Agreement sections and RUM Charter, with final approval by the Director of Utilization Management, the Director of Clinical Quality, and the Medical Director.
3. Provide input regarding the outlier management program including level of care and service utilization guidelines that may be provided without authorization, level of care and typical service utilization guidelines reviewed at the local care management level and outlier levels of care and typical service utilization data reviewed by the PIHP. This information is reviewed by the Operating Committee.
4. Ensure that services rendered are delivered by qualified staff or contracted practitioner providers. Ensure that timely and focused utilization review (UR) is provided for delegated Utilization Management functions.
5. Develop, review and act upon service utilization and outcomes data and/or reports for purposes of demonstrating consistent Uniform Benefit (including reports of under and over utilization).
6. Review service use and population health data that may affect policy and procedure including, but not limited to Appeal/Fair Hearing determinations, Recipient Right decisions, clinical best practices and service utilization and cost data.
7. Assures adherence to related data and report specification's through cross collaboration with other applicable regional committees including the Regional Quality Management, Regional Clinical Practices and Regional Customer Services Committees.

Standards and Philosophy

SWMBH is responsible for monitoring the provision of services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH ensures adherence to statutory, regulatory, and contractual obligations. Furthermore, the utilization management program is designed to be consistent with and supportive of assuring achievement of SWMBH's Board focus and guiding principles.

The UM program document and subsequent policies provide a description of processes, procedures, and criteria necessary to ensure cost-effectiveness, achieving the best customer outcome for the resources spent. As a Regional Entity, SWMBH's duty is to assure region-wide uniformity of:

1. Benefit
2. Adequate timely access
3. Application of functional assessment tools, evidenced based practices and medical necessity criteria
4. UM decision-making including application of eligibility criteria and level of care guidelines

Management information system(s) adequate to support the UM Program is central, as SWMBH, the participant CMHSP's and the SWMBH provider network rely on SWMBH IT IS, QAPI and PNM for reports. The functionalities and maintenance of such systems include, but are not limited to:

1. Utilization of electronic health information systems and incorporation/integration of behavioral health and physical health data
2. Real-time access to aggregate and case level information, which is complete, accurate, timely
3. Reporting services which are automated and routine, inclusive of rule-based alerts
4. Reporting formats which are readily available, graphically presented, easy to understand and present actionable information aligned to SWMBH Ends and Goals
5. Utilization of a managed care information system that meets meaningful use standards
6. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provide input into severity of illness and a means to provide the data to SWMBH to manage over/under utilization and employ risk stratification models both in effort to manage and impact population health.

Access to SWMBH Behavioral Health Services

A beneficiary may access the system through any of the following avenues:

1. Requesting services directly from SWMBH during business and after-hours toll-free access/crisis line.
2. Telephonic screening or face-to-face assessment by the local CMHSP
3. Crisis behavioral health services through the local CMHSP, inpatient hospitals, mobile crisis teams, and urgent care centers
4. Requesting services from a local substance use disorder provider or CMHSP who, depending on the level of medically necessary care, subsequently collaborates with SWMBH UM for screening and authorization.

Access Standards

1. The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
2. The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services.
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
5. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)
6. Achieve a call abandonment rate of 5% or less.
7. Average call answer time 30 seconds or less.

Level of Intensity of Service Determination

Level of Intensity	Definition	Expected Decision/Response Time
Emergent - Psychiatric	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request
Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services are denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 days; Prior authorization required
Retrospective	Accessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided	Within 30 calendar days of request
Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition	Within 1 hour of request

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a

Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

1. SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.
2. Access and Eligibility: To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see Policy Access Management). SWMBH ensures that the Access Standards are met, including MMBPIS.
3. Clinical Protocols: To ensure Uniform Benefit for Customers, consistent functional assessment tools, medical necessity, level of care and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
4. Service Authorization: Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness.
5. Utilization Management: Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH Utilization Management plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization Management Plan endorses two core functions.

1. Outlier Management of identified high cost, high risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions.

The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, EQRO, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process

requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including Over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Review Activities

Utilization Management

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and some CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone. Based upon the UM Program review, annual audits and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers or SWMBH departments.

Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs and workforce training. Each CMHSP is required to have their own utilization management/review process. The Medical Director and a Physician board-certified in addiction medicine, meet weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director who holds an unrestricted license is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. For the purposes of utilization control, SWMBH ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer;
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided);
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience;
5. Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential; and
6. Provided with consideration for and attention to integration of physical and behavioral health needs.

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the member.
2. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, and/or long-term services and supports needs.
3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate.
4. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
5. Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
7. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
8. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

The PIHP specifies what constitutes "medically necessary services" in a manner that is no more restrictive that what is used in the MDHHS Medicaid program, and includes quantitative and non-quantitative treatment limits, as indicated in MDHHS statutes and regulations, the MDHHS Plan, and other MDHHS policy and procedures. The medically necessary services should address to what extent the PIHP is responsible for covering services that address the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability; the ability for a member to achieve age-appropriate growth and development; the ability for a member to attain, maintain, or regain functional capacity; and the opportunity for a member to have access to the

benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Use of Incentives

The use of incentives related to service determination approvals, denials or promotion of underutilization is prohibited. Service determinations are based only on medical necessity criteria and benefits coverage information. This information is provided to members, staff and providers via policy and other informational documentation such as the member handbook and the SWMBH website.

Intensity of Service and Severity of Illness (Levels of Care)

The expectation for service provision is that intensity of service will be aligned with severity of illness. For each population served (adults with mental illness, youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders), SWMBH utilizes a standardized functional assessment to identify level of need at initiation of services and at established intervals throughout service provision. SWMBH and its participant CMHs have established regional Levels of Care that correspond to needs identified through the functional assessment process, which are based on severity of illness and intensity of need. Levels of Care and Core Service Menus are in place for adults with mental illness, youth with emotional disturbances, adults with intellectual and developmental disabilities, and persons with substance use disorders. The levels and service menus that were developed in 2016 are being used for those population areas until the updates are complete.

Each Level of Care contains a Core Service Menu with suggested service types as well as expected annual amounts of services, corresponding to needs commonly presenting at each level. Services that fall within the Core Service Menu for a given Level of Care are services for which medical necessity has been established via the functional assessment, and do not require additional UM review. Services requested that fall outside of the Core Service Menu for an individual's Level of Care may be authorized if medical necessity is established through a utilization review. These requests are referred to as Exceptions.

Most services designated as Exceptions are authorized through Local Care Management via a delegation to the CMHSPs. CMHSPs are delegated Healthy Michigan Plan and Medicaid authorization/UM functions for behavioral health community-based supports and services. For those CMHSPs which are delegated authorization/UM functions for substance use services, CMHSPs authorize and provide medically necessary services according to the SWMBH Levels of Care for SUD. For authorization of any Exception, a utilization management professional will review the request to determine if medical necessity has been established for the service, including the amount, scope, and duration of the service being requested. Exception approvals always clearly document medical necessity, and how the intensity of the service is indicated by the individual's level of need.

Levels of Care for Mental Health Specialty Services

Levels of Care for each of the SWMBH population areas are described below. Core Service Menus with recommended authorization thresholds for all levels of care (except for children with intellectual and developmental disabilities) have been developed and are attached to SWMBH Regional Policy 4.10 Levels of Care.

PIHP Service Eligibility

Not all Medicaid-eligible persons with mental illness or emotional disturbances are eligible for PIHP services. For adults with mental illness and youth with emotional disturbance, thresholds for meeting eligibility for PIHP services are denoted below Level of Care descriptions that follow. Behavioral health services for persons with mild to moderate mental illness or emotional disturbances are provided

through Medicaid health plans. All Medicaid behavioral health services for persons with substance use disorders and intellectual and developmental disabilities are provided through the PIHP.

Crisis Services

Crisis services are considered a benefit for any SWMBH customer or anyone who is physically in a county of the SWMBH region who needs urgent intervention. Crisis services are not considered a Level of Care and do not require prior authorization. Appropriately trained and qualified CMHSP behavioral health practitioners with sufficient clinical experience who meet the qualifications for a preadmission unit pursuant to Michigan Mental Health Code 330.1409 Sec 409 provide prescreening services and authorization of 1-3 days of psychiatric inpatient or crisis residential, and any appropriate diversion and/or second opinion services.

Levels of Care for Adults (18 years and older) with Serious Mental Illness or Co-occurring MI and Substance Use Disorders

Level of Care Utilization System (LOCUS) The LOCUS is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level VI- Intensive High Need/Acute (Medically Managed Residential)

Customers receiving services at this level of care are adults with a LOCUS score typically of 28 or higher including a score of 4 on dimension I and who present as a persistent danger to self or others. Treatment is typically provided in an inpatient setting and is aimed at ensuring safety and minimizing danger to self and others and alleviating the acute psychiatric crisis

Level V – Intense Need/Acute (Medically Monitored Residential)

Customers receiving services at this level of care are adults with a LOCUS score typically of 23-27 including a score of 4 on dimension II or III and who present as danger to self or others. Treatment is typically provided in a community based free standing residential setting such as Crisis Residential and is aimed at providing reasonable protection of personal safety and property and minimizing danger to self and others.

Level IV – High Need (Medically Monitored Non- Residential Services)

Customers receiving services at this level of care are adults with a LOCUS score typically of 20-22 including a score of 4 on dimension IV or V and who present with a significant impairment of functioning in most areas, moderate to significant risk of harm to self or others, with significant supported needed to function independently in the community. May be engaging in high-risk behaviors and be involved in the criminal justice system. Treatment typically is provided in the community and include services such as Assertive Community Treatment and Partial Hospitalization

Level III – Moderate Need (High Intensity Community Based Services)

Customers receiving services at this level of care are adults with a LOCUS score typically of 17-19 including a sum score of 5 or less on dimension IV A & B and who present with intensive support and treatment needs however demonstrate low to moderate risk of harm to self or others, require minimal support to reside independently in the community. Occasional risk activities. Needs regular assistance with linking/coordinating and developing skills and self-advocacy. Treatment is typically provided in the community and include such services as targeted case management and supports coordination

Level II – Low Need (Low Intensity Community Based Need)

Customers receiving services at this level of care are adults with a LOCUS score typically of 14-16 who present with ongoing treatment needs however have a low impairment of functioning in most areas, low to minimal risk of harm to self or others, able to reside independently in the community. Minimal assistance with linking/coordinating actively utilizing self-

improvement and treatment skills acquired. Treatment is provided in the community and is typically clinic based.

Level I – Minimal Need (Recovery Maintenance and health Management)

Customers receiving services at this level of care are adults with a LOCUS score typically of 10-13 with minimal impairment of functioning, minimal to no risk of harm to self or others, reside independently in the community. Minimal encouragement with linking/coordinating actively utilizing self-improvement and treatment skills acquired. May use PSR assistance with maintaining recovery. Treatment is provided in the community and is typically clinic based.

Level 0 -- Basic Services

Basic services are those services that should be available to all members of a community. They are services designed to prevent illness or to limit morbidity. They often have a special focus on children and are provided primarily in community settings but also in primary care settings. There is clinical capability for emergency care, evaluations, brief interventions, and outreach to various portions of the population. This would include outreach to special populations, victim debriefing, high-risk screening, educational programs, mutual support networks, and day care programs. There are a variety of services available to provide support, address crisis situations and offer prevention services.

Thresholds for PIHP Service Eligibility for Adults with Mental Illness (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- LOCUS Recommended Disposition Level of 3, 4, 5, or 6, or
- LOCUS Recommended Disposition Level of 2 with need for specialty behavioral supports and services as evidenced by meeting Michigan Mental Health code definition for SMI

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- LOCUS Recommended Disposition Level 0 or 1, or
- LOCUS Recommended Disposition Level of 2 but does not meet Michigan Mental Health code definition for SMI.

Levels of Care for Children (ages 4 – 18) with Serious Emotional Disturbance (SED) or Co-occurring SED and Substance use Disorders

The Child and Adolescent Functional Assessment Scale (CAFAS) is utilized for ages 7-18, and the Pre-school and Early Childhood Functional Assessment Scale (CAFAS) is utilized for ages 4-6, to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level IV -- Intense Need

Customers in this level of care are children with a CAFAS or PECFAS score of 160 or higher who require total assistance and present with inability to function in most areas, persistent danger to self and others, at significant risk of institutionalization or placement out of the home, involved in numerous provider systems (criminal justice, mental health, department of human services, school). High risk difficulties in school/day care setting or substance use dominates life or is out of control.

Level III – High Need

Customers in this level of care are children with a CAFAS or PECFAS score of 120-150 with inability to function in most areas, persistent danger to self and others, at moderate to significant risk of institutionalization or placement out of the home, likely involved in numerous provider systems (criminal justice, mental health, department of human services, school). Significant difficulties in school/day care setting. Treatment needs likely beyond home based services.

Level II – Moderate Need

Customers in this level of care are children with a CAFAS or PECFAS score of 80-110 with moderate to significant inability to function in many areas, instability in living environment, multiple service needs, family requires regular support, crisis intervention services needed. Likely at risk for out of home placement, displays disruptive behavior.

Level I – Low Need

Customers in this level of care are children with a CAFAS or PECFAS score of 50-70 with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention not needed or infrequently need.

Level 0 – Minimal Need

Customers in this level of care are children with a CAFAS or PECFAS score of 40 and below with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention services not needed or needed infrequently. Children ages Infant-7 are typically placed in the Level I category for utilization management purposes with needed services authorized based upon medical necessity.

Thresholds for PIHP Service Eligibility for Youth with Emotional Disturbance, ages 7-17 (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- CAFAS total score of 50 or greater (using the eight subscale scores), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- CAFAS total score of less than 50 (using the eight subscale scores), and
- No more than one 20 on any of the first eight subscales of the CAFAS, and
- No 30 on any subscale of the CAFAS, except for substance abuse only.

Levels of Care for Adults (Ages 18 and older) Intellectual and Developmental Disabilities

The Supports Intensity Scale (SIS) is utilized to identify level of support needs for adults with intellectual and developmental disabilities. The SIS ABE score (the composite score of SIS Part A: Home Living Activities; Part B: Community Living Activities; and Part E: Health and Safety Activities), and the Medical and Behavioral Needs scales, are used to determine recommended level of care.

Level VI- Acute (Any functional support needs, extraordinary medical and/or behavioral support needs). ABE - Any Score. Medical 10+ OR Behavior 10+

Customers receiving services at this level of care are adults (18 years or older) and demonstrate extraordinary behavioral and/or medical needs typically provided in an acute care setting or a nursing home. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring monitoring and/or oversight multiple times during the day. Nursing services typically required to develop and train on health care protocols, if applicable.

Level V – Intense Need (Any functional support needs, high medical and/or behavioral support needs). ABE - Any Score. Medical 7-9 OR Behavior 7-9

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate significant medical needs and/or extensive behavioral needs and require total

assistance on a daily basis with 1:1 or higher level of staffing. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring daily (or more) monitoring and/or oversight and hands-on assistance. Nursing services may be required to develop and train on health care protocols, if applicable.

Level IV – High Need (Any functional support needs, moderate medical and/or behavioral support needs). ABE - Any Score. Medical 4-6 OR Behavior 4-6

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate substantial behavioral needs and/moderate physical healthcare needs due to medical conditions. Safety risks exist to self or others, potentially with need for environmental accommodations. May have harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have medical/health needs requiring weekly (or more) monitoring and/or oversight and assistance.

Level III – Moderate Need (High functional support needs, low medical and behavioral support needs). ABE Score 28+, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require frequent prompts/reminders, coaching, and/or training to engage or complete activities (less than daily/more than weekly) or physical support, or some hands-on physical support/guidance. Moderate behavioral issues may be present with or without the need for a Behavior Plan. May experience physical health issues that require increased supports.

Safety risks may be present that need to be addressed or monitored; includes safety to self and safety in the community.

Level II – Low Need (Moderate functional support needs, low medical and behavioral support needs. ABE Score 23-27, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require occasional verbal prompts/reminders, coaching, and/or training to engage or complete activities (weekly or less) and monitoring of support needs with changes as situation dictates. May require a behavior support plan to ensure consistency and proactive approaches.

Level I – Minimal Need (Low functional support needs, low medical and behavioral support needs). ABE Score 0-22, and Medical Score 0-3, and Behavior Score 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion. May require a behavior support plan to ensure consistency and proactive approaches.

Levels of Care for Children Developmental Disabilities (infants through age 17) (Functional Assessment Tool TBD)

Level V – Intense Need

Customers receiving services at this level of care are children and typically require total assistance on a daily basis including enriched staffing (24 hours per day, 2:1, or 1:1 staffing during awake hours).

Level IV – High Need

Customers receiving services at this level of care are children who typically require daily reminders to engage or complete activities and personal support which may include enhanced staffing (24 hours per day, 1:2 or 1:1 staffing while awake) has an active Behavior Management Plan and or specialty professional staff (OT, PT, etc.).

Level III – Moderate Need

Customers receiving services at this level of care are children who typically require frequent prompts/reminders to engage or complete activities (less than daily/more than weekly) or physical support. Moderate behavioral issues may be present with or without the need for a Behavior Plan.

Level II – Low Need

Customers receiving services at this level of care are children who typically require occasional prompts/reminders to engage or complete activities (weekly or less) to insure maintenance of skills or physical support. Mild/moderate behavioral issues without the need for a Behavior Management Plan.

Level I – Minimal Need

Customers receiving services at this level of care are children who typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion.

Levels of Care for Substance Use Treatment Services for Adults and Adolescents

The American Society of Addiction Medicine - Patient Placement Criteria (ASAM) are utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level 0.5 – Early Intervention

Services include assessment and education for those who are at risk, but do not currently meet the diagnostic criteria for a substance-related disorder. Customers who are determined to have this level of need are typically referred to available community resources including support groups and prevention activities. Customer is screened for co-occurring mental health issues and referred to appropriate levels of care to meet identified needs. Per definition, early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

Level 1.0 – Outpatient Services

Community-based substance use outpatient treatment of less than 9 hours per week for adults and less than 6 hours per week for youth. Treatment is directed at recovery, motivational enhancement therapy and strategies to reduce or eliminate substance use and improve ability to cope with situations without substance use.

Level OTP – Opioid Treatment Program

Opioid medication and counseling available daily or several times per week to maintain multidimensional stability for those with opioid dependence. Opioid maintenance therapy is an appropriate and effective treatment for opiate addiction for some customers, particularly customers who have completed other treatment modalities without success and are motivated to actively engage in the treatment necessary in OMT.

Level 2.1 – Intensive Outpatient

Community-based substance use outpatient treatment of greater than 9 hours per week for adults and greater than 6 hours per week for youth. Treatment is directed to treat multidimensional instability. This level of care may be authorized as a step-down from a higher level of care or in situations in which a higher level of care would otherwise be warranted but is not an appropriate option (either due to inability to participate in a residential treatment program or motivational issues).

Level 2.5 – Partial Hospitalization

Partial Hospitalization treatment is a structured treatment similar to the treatment available in a residential setting, however, is directed toward customers who require greater than 20 hours per week of treatment for multidimensional stability, but not requiring 24-hour care.

Level 3.1 – Clinically-Managed Low-Intensity Residential

Clinically managed low-intensity residential treatment includes a 24-hour setting with available trained staff and at minimum 5 hours of clinical treatment services per week.

Level 3.3 – Clinically-Managed Medium-Intensity Residential

Clinically managed medium-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger.

Level 3.5 – Clinically Managed High Intensity Residential

Clinically managed high-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger and prepare for outpatient step-down. Member must be able to tolerate and use full active milieu available.

Level 3.7 – Medically-Monitored Intensive Inpatient

Medically-Monitored Intensive Inpatient – Nursing care with physician availability 24-hours per day for significant problems that arise in Dimensions 1, 2, or 3. Counselor is available 16 hours per day.

Level 4 – Medically-Managed Intensive Inpatient

Medically-Managed Intensive Inpatient – Nursing care and daily physician care 24-hours per day for severe, unstable problems that arise in Dimensions 1, 2, or 3. Counselor is available to engage the member in treatment.

Level 1-WM – Ambulatory Withdrawal Management without Extended On-Site Monitoring

The patient is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 2-WM – Ambulatory Withdrawal Management with Extended On-Site Monitoring

The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 3.2-WM – Clinically Managed Residential Withdrawal Management

The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management

The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.

Level 4-WM – Medically Managed Intensive Inpatient Withdrawal Management

The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.

Review Process

A Prospective Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service delivery. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

UM staff obtain review information from any reasonably reliable source. The purpose of review is to obtain the most current, accurate, and complete clinical presentation of the customer's needs and whether the services requested are appropriate, sufficient, and cost-effective to achieve positive clinical outcomes. Only information necessary to make the authorization admission, services, length of stay, frequency and duration is requested.

SWMBH or the delegated CMHSP may place appropriate limits on a service for the following reasons:

1) On the basis criteria applied under the MDHHS plan, such as for medical necessity and lack thereof; and
2) The purposes of utilization control provided that
    a. The services can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i); or
    b. The services supporting individuals with ongoing or chronic conditions or who require long-term service and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.

Outlier Management

An integral part of SWMBH's Performance Improvement Based Utilization Management Program is continued development and implementation of its outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focus by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan customers covered by the PIHP. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP(s).

1) Outlier Definition

"Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:

> A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

2) Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3) Outlier Management Procedures

a. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.
b. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.
c. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion. Corrective action plans might include:
    i. Brief description of the finding(s) and supporting information.
    ii. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps.
    iii. A description of the monitoring to be performed to ensure that the steps are taken.
    iv. A description of the monitoring to be performed that will reflect the resolution of the situation.
    v. Following initial review and efforts for resolution at a desk audit level, the disposition can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff.
    vi. Following consultation, recommendations are reviewed by the Director of Utilization Management, the Director of Clinical Quality and/or the Medical Director for disposition determination. The appropriate directors will review the recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.
d. The Director of Utilization Management, Director of Clinical Quality, and/or Medical Director will take into consideration the outlier severity in determining recommended remedies. The following options available at this level include:
    i. Acceptance of PIHP recommendations.
    ii. Direction for additional PIHP staff and provider action(s),
    iii. Clinical Peer Review -The Peer Review consists of review, consultation, and recommendations for resolution.
    iv. Render final disposition.
    v. Provide recommendations for action for remediation to the SWMBH CEO
e. If the utilization trends or patterns are determined to be systemic or regional in nature, collaborative corrective action is jointly discussed at the regional committee level with defined timelines for completion. Corrective action includes:
    i. Brief description of the finding(s) and supporting information.
    ii. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps at the PIHP and CMHSP/Provider level.
    iii. A description of the monitoring to be performed to ensure that the steps are taken.
    iv. A description of the monitoring to be performed that will reflect the resolution of the situation.

v. Following initial review and efforts for resolution, the review findings can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff.

f. The spectrum of remedies available to the PIHP in relation to its provider panels stems from the authority of the PIHP Board. Subject to PIHP CEO's approval, possible remedies can include but are not limited to:
   i. Non-payment for case.
   ii. Plan member switch to new provider.
   iii. Provider loss of "Delegated Benefit Management" status.
   iv. Loss of credential for specified service(s).
   v. Pro-rata payback on class of cases.
   vi. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
   vii. Removal from provider panel.

Data Management

Data management and standardized functional assessment tools and subsequent reporting tools are an integral piece to utilization management and application of uniform benefit. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, patient safety, call rates, Access standards and customer quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/Central Care Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of customer level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for customers can be assigned. This work allows for people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It is a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

Communication

UM Program Plan

The UM Program Plan is developed as part of the Quality Assurance Improvement Plan and formally approved and distributed as part of it. The UM plan is reviewed by and input sought from various committees including RUM, Quality Improvement, and the Customer Advisory Council. The UM plan is distributed to providers according to the SWMBH distribution policy. Providers, customers, and general stakeholders can access the UM plan through the SWMBH website. The SWMBH Board receives UM education annually.

Availability of Utilization Management Staff

SWMBH UM staff are available by telephone (toll free) from 8:00 a.m. to 5:00 p.m. Monday through Friday of each normal business day. Utilization Review staff respond to email and telephonic communications within one business day during provider's normal business hours. UM staff identify

themselves by name, title, and organization during correspondence. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, SWMBH provides the opportunity for the requesting customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

After-hours emergency services are available to customers and providers through a phone service which provides emergency referral and information outside of normal business hours by licensed professional staff. Additionally, UM staff are available to providers after hours, weekends and holidays to make determinations for a limited set of acute services. Customers and providers can leave a message for UM staff through this service and can fax information to SWMBH after hours. Each CMHSP with UM Medicaid/HMP delegated functions manages the UM process based on local policy and procedure that adheres to regional contractual and statutory requirements.

Peer Clinical Review

Utilization Management staff are available to discuss authorization decisions with the requesting customer, provider and attending physician (if applicable). The Utilization Management staff assist with physician-to-physician communication with the Medical Director and assist in obtaining relevant clinical information and documentation for review. When a decision is made to deny an authorization request, UM staff provides within one business day, upon request, the opportunity to discuss the determination with the UM Peer Reviewer who made the determination, or another Peer Clinical Reviewer if the original reviewer cannot be available within one business day. If this Peer communication does not result in an authorization, the provider is given information regarding how to appeal the determination and any applicable timelines. UM will provide specific clinical rationale on which the decision to deny the authorization was made.

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year goals have been achieved and identify trends and areas for improvement. While the Regional Quality Management Committee manages the evaluation, the RUM is involved with this review and responsible for implementing any improvement activities at the CMHSP and throughout their provider network. The purpose of the annual evaluation is to identify any best practices that could be incorporated into the UM plan as well as continue to improve on the care provided to SWMBH customers. Additionally, Inter-rater reliability of application of medical necessity will be evaluated annually. Oversight and monitoring of medical necessity determinations and utilization management decisions will be conducted annually to validate consistent application and understanding of uniform benefit, clinical protocols, and medical necessity criteria.

Definitions

Authorization: An authorization is an approval of service(s) by an insurance company.
Core Service Menu: The services which are available with defined Recommended Thresholds for an identified population at a given Level of Care.

Exception: Service(s) that fall above the Recommended Threshold or outside of the Core Service Menu for a given Level of Care.

Level of Care: Refers to the intensity of services (setting, frequency, and mode) an individual will receive during a specific stage of treatment.

Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. (Medicaid Provider Manual)

Medical Necessity Criteria: Guidelines that direct the most appropriate service or level of care which can reasonably be expected to improve symptoms associated with the customer's diagnosis and is consistent with generally accepted standards of practice.

Outlier: A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

Person-Centered Planning: Person-centered planning means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. MCL 330.1700(g)

Serious Emotional Disturbance: As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

1) A substance use disorder
2) A developmental disorder
3) A "V" code in the diagnostic and statistical manual of mental disorders

Serious Mental Illness: As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances,

but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Uniform Benefit/Uniformity of Benefit: Consistent application of and criteria for benefit eligibility, level of care determination and service provision regardless of various demographics including geographic location, based upon the clinical and functional presentation of the person served, over time.

Utilization Management: A set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the application of written policies and procedures, Utilization Management is designed to ensure that only eligible beneficiaries receive specialty plan benefits; that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires; and that beneficiaries are linked to other Medicaid Health Plan or other services when necessary. Utilization Management functions include: Access and eligibility determination, level of care assessment and service selection, Authorization processes, utilization review, and care management activities.

Utilization Review: The process of monitoring, evaluating medical necessity, use, delivery, cost effectiveness, appropriateness, and the efficient use of health care services provided by health care professionals on a prospective, concurrent, or retrospective basis. Utilization review activities include monitoring of individual consumer records, specific provider practices and system trends. to determine appropriate application of Guidelines and Criteria in the following areas: level of care determination, Application of Service Selection Criteria, Application of Best Practice Guidelines, Consumer outcomes, Over-Utilization/under Utilization, and Review of clinical or resource utilization Outliers.

Roles

CMH Role: Adhere to prescribed Assessment Tools use, frequency and reporting to SWMBH. Adhere to Level of Care Guidelines. Report and Perform Local Care Management per UM Plan, Delegation Agreement and Policy. Report Authorizations, Assessment and Encounter data to SWMBH as prescribed.

SWMBH Role: Perform Central Care Management per UM Plan and Policy. Oversee and monitor delegated Local Care Management per UM Plan and Policy. Provide regular UM analytic management reports for SWMBH and CMHs. Regularly identify trends and material variations.
Shared Role (Director of Clinical Quality, Local Care Manager designees and RUM Committee): Regularly review UM analytic management reports. Identify trends and variations, including gaps in completeness, timeliness, and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications, as necessary. Adjust business process and/or decision trees, as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

References/Additional Guiding Document

- SWMBH UM Policy Manual Section 4 and Attachments
- SWMBH Level of Care Guidelines

Plan Review and Approval

B.K. Ramesh (Nov 18, 2022 07:08 PST)	Nov 18, 2022
Medical Director Signature	Date of Review
Beth Guisinger (Nov 18, 2022 10:15 EST)	Nov 18, 2022
Director of Utilization Management	Date of Review
Alena Lacey	Dec 28, 2022
Director of Clinical Quality	Date of Review

SWMBH FY23 Medicaid HMP Autism SUD BG UM Plan Final

Final Audit Report 2022-12-28

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SWMBH FY 2022 Program Integrity - Compliance Board Report
10/01/2021 – 09/30/2022

Date Prepared: November 29, 2022
Chief Compliance Officer: Mila C. Todd

1. Compliance Allegations/Reports:

Issue Reported	#	Investigation Opened		Investigation Completed		Complaint Substantiated		Outcome
		Yes	No	Yes	No	Yes	No	
Subcontracted provider not signing family training service documentation	NA		X					Contacted MI-OIG, gave SWMBH permission to NOT consider the unsigned documents invalid. No recoupments required, as the service documentation met all other Medicaid requirements. CMH educated the provider and documentation has met all requirements since.
Customer complaint: Felt pressured by CMH staff to exaggerate symptoms when calling SWMBH UM in order to qualify for a higher level of SUD care (residential vs out-patient)	2022-01	X		X			X	No FWA substantiated. Need for additional education to providers and peers/recovery coaches. UM/SUD staff provided education.
Methadone provider billing methadone dosing as telehealth	2022-02	X		X		X		No overpayment but claims using the telehealth place of service code were all corrected. On-going monitoring per quarterly audits.
Former CMH employee expressed a variety of concerns with her limited time at the CMH.	NA		X					No FWA or other compliance implications.
CFO at a CMH voided checks in SWMBH Streamline (SWMBH was adjudicating the CMH provider claims), checks had already been cut and sent to providers. New checks were then sent to the providers.	2022-03	X		X		X		Overpayments collected. CFO Streamline privileges were limited to avoid any additional issues.
SUD Provider manually changing start dates on Treatment Plans for the purpose of matching the Txt Plan dates to the	2022-04	X		X		X		Education provided on the authorization process and Treatment Plan requirements. On-going monitoring via

authorization request dates.								quarterly audits.
CMH employee reported that there was a break-in at the office, laptops and checks were stolen	NA		X					Reported to the CMH Compliance Officer and confirmed no PHI was able to be accessed.
Concern that SUD provider is assisting customers in inappropriately changing their address for the purpose of getting services through a different PIHP	NA		X					No FWA. Educated provider.
SUD Block Grant provider not following ATP policies/procedures	2022-05	X		X		X		Recoupments issued, CAP provided. On-going monitoring per quarterly audits.
SUD Provider requesting authorizations outside of Treatment Plan dates. Treatment Plan Addendums not being labeled as such and not signed appropriately by clinician & customer.	2022-06	X		X		X		CAP issued for Treatment Plan requirements. Education provided. CAP approved. On-going monitoring via quarterly audits.
Uncovered during a Medicaid audit that a CMH did not have active Treatment Plans for Meds Only customers-though the internal service had been authorized. Upon requesting additional information, it was found that this may be a more wide-spread issue	2022-07	X		X		X		Substantiated. CAP issued (to be monitored via additional Site Review CAPs) and recoupments processed. On-going monitoring per quarterly audits.
CMH reported that a subcontracted provider was rounding start/stop times when submitting claims.	2022-08	X		X			X	Not substantiated; however, it was discovered that the provider was not using the required U-modifiers for number of customers served. Claims reverted, CAP issued. On-going monitoring via quarterly audits.
ROIs in Streamline automatically merging with different customer records when uploading	2022-09	X		X		X		Issue corrected and resolved.
Spec Res provider asking about accepting gifts from customer family members	NA		X					Staff spoke with the caller and determined none of the gifts

								exceeded $25 allowable amount per SWMBH policy.
Customer alleges that SUD Provider is upcoding for telehealth therapy and medication reviews. Additional concerns noted that may be more clinical quality than compliance	2022-10	X		X			X	Unsubstantiated. Clinical concerns addressed by SUD Team. Resolved.
SUD provider submitting duplicate drug screening claims (which were paid)	2022-11	X		X		X		Recoupments issued. SmartCare global rules updated to limit code to one unit/day per contract.
SUD Residential provider billing day of discharge	2022-12	X		X		X		Recoupments issued, CAP provided. On-going monitoring per monthly data-mining.
CLS/Respite subcontracting provider not meeting service documentation requirements	NA		X					Per quarterly Medicaid audit. Recoupments issued, live education provided, CAP provided. On-going monitoring per quarterly audits.
CMH board member expressed concerns with the CMH organizational culture	NA		X					Concern sent to Brad Casemore for follow-up.
SUD Block Grant provider not following ATP policies/procedures – repeat issue from provider (investigated FY21)	2022-13	X		X		X		Substantiated. Recoupments issued. Updated CAP required and provided. On-going monitoring per quarterly audits.
Inappropriate use of Q3014 telehealth site code per MDHHS memo/email.	2022-14	X		X		X		Only one CMH using this code-determined use was inappropriate. Encounters reverted.
SUD provider self-reported duplicate claims submitted and paid.	2022-15	X		X		X		Recoupments issued, CAP provided. Pre-payment monitoring. Discovered inappropriate “job” running in Streamline (in addition to the provide inappropriately submitting duplicate claims). Streamline issue resolved. Pre-payment review continues until 1/13/2023.
Former subcontracted	2022-16	X		X			X	Unable to substantiated

provider staff reporting falsification of service documentation.								claim after extensive documentation review. Further education to provider. CAP provide, recoupment issued. On-going monitoring per quarterly audits.
OIG Referred: Subcontracted provider owner accused of inappropriate usage of Medicaid dollars	2022-17	X		X			X	Unsubstantiated. Reported back to OIG, as required.
CMH staff falsified travel vouchers. Referred to OIG.	2022-18	X		X		X		Claim substantiated. Staff resigned prior to CMH termination. Pending OIG final response following additional audit per OIG request.
Subcontracted autism provider using multiple provider-qualification modifiers.	2022-19	X		X		X		Substantiated, no overpayment. Claims corrected.
Customer complaint that SUD Residential provider was billing for full stays when customers left program early, mice in facility, carbon dioxide issues within facility, general cleanliness concerns.	2022-20	X		X			X	Unsubstantiated. Some service documentation deficiencies noted, CAP required from provider.
SUD provider using inappropriate/disallowed place of service codes	2022-21	X		X		X		Substantiated. Claims corrected. No overpayment. On-going monitoring per quarterly audits.
CMH therapist inappropriately reporting telehealth service encounters.	2022-22	X		X		X		Referred to OIG. Overpayment under the $5,000 limit for OIG to investigate. Therapist terminated. Investigation closed.
SUD customer authorized for SUD residential stay (claimed and paid). Discovered his actual address is in Indiana and he has been a resident of IN for the entire calendar year-still has Michigan Medicaid	NA		X					Reported to MDHHS per contractual obligations. Residential stay paid per MDHHS guidance. No further action.
Multiple CLS providers not using the correct modifiers/code for	NA		X					Informed all CMHs of the issue. CMHs are to work with providers to

overnight health and safety.								educate and correct claims. Will be monitored via quarterly Medicaid audits.
Multiple concerns reported from two CMHs regarding a new autism provider. Concerns range from compliance FWA to clinical and recipient rights.								Pending SWMBH investigation following receipt of CMH investigation findings.
Total	**33**	**22**	**11**	**22**	**0**	**15**	**7**	

2. Privacy/Security Allegations/Reports

A total of forty-six (46) incidents were reported to the SWMBH Breach Team during Fiscal Year 2022. The Breach Team reviewed each incident and evaluated whether an exception applies under the law, and the probability of compromise to the Protected Health Information used or disclosed. Of the forty-six (46) incidents reviewed, NONE were determined to be reportable.

3. Planned Audits

Audit	# Services/Claims Reviewed	Result/Progress	Recoupments
Medicaid Verification			
Quarter 1	453	Complete	29 recoupments ($3,109.80)
Quarter 2	465	Complete	27 recoupments ($3,572.66)
Quarter 3	465	Complete	23 recoupments ($6,403.78)
Quarter 4	465	In Process	
MI Health Link			
Quarter 1	227	Completed	None
Quarter 2	240	Completed	None
Quarter 3	212	In Process	
Quarter 4	240	In Process	
SUD Block Grant Claims			
Quarter 1	30	Complete	2 recoupments ($77.60)
Quarter 2	30	Complete	2 recoupments ($189.00)
Quarter 3	30	Complete	None
Quarter 4	30	In Process	
SUD Coordination of Benefits			
Quarter 1	30	Completed	1 recoupment ($68.64)
Quarter 2	30	Completed	None
Quarter 3	30	Completed	2 recoupments ($81.66)
Quarter 4	30	In Process	

Medicaid Claims/Service Encounter Verification Report
Southwest Michigan Behavioral Health

Prepaid Inpatient Health Plan/Regional Entity

For the time period 10/01/2021 – 09/30/2022
Submitted December 22, 2022

Pursuant to MDHHS-SWMBH FY22 Contract
Schedule A Section 1.C.4 Medicaid Services Verification

Submitted by:
Mila C. Todd, Esq., CHC, CHPC, Chief Compliance Officer

Introduction:

Southwest Michigan Behavioral Health (SWMBH) is the Regional Entity and Medicaid Prepaid Inpatient Health Plan (PIHP) for eight counties and Community Mental Health Service Programs (CMHSP) in southwest Michigan. These eight CMHSPs are: Barry County Community Mental Health Authority, Riverwood Center (Berrien Mental Health Authority), Pines Behavioral Health Services (Branch County Community Mental Health Authority), Summit Pointe (Calhoun County Community Mental Health Authority), Woodlands Behavioral Healthcare Network (Cass County Community Mental Health Authority), Integrated Services of Kalamazoo (Kalamazoo County Community Mental Health Authority), Community Mental Health and Substance Abuse Services of St. Joseph County (St. Joseph County Community Mental Health Authority), and Van Buren Community Mental Health Authority. The FY2022 MDHHS-SWMBH contract Schedule A. Section 1.R.1. Program Integrity contains provisions for internal monitoring and auditing. To that end, SWMBH has conducted verification of Medicaid claims as detailed by the methodology outlined below, in conformity with contract Schedule A Section 1.C.4 Medicaid Services Verification Process.

In performing the verification of sampled Medicaid claims, SWMBH conducted quarterly audits of service encounters for each CMHSP and reviewed claims from contracted substance use disorder providers and service providers subcontracted with Participant CMHSPs. The following is SWMBH's Medicaid Verification report with audit activities and results.

Data Collection Methodology:

The universe of claims for the Medicaid Verification testing process consisted of a quarterly review of Medicaid claims approved for payment by SWMBH between the dates of October 1, 2021 and September 30, 2022. The Random Number function of the OIG's statistical software package, RAT-STATS, was used to select the random samples of claims for review from the total universes.

The Medicaid Verification testing sample size was a total of one thousand eight hundred forty-eight (1,848) claims/encounters, representing eighteen thousand eight hundred forty (18,840) units and $1,237,688.76. These claims/encounters were reviewed based on Fiscal Year Quarters, divided as follows:

- Thirty (30) unique dates of service from each of the eight participant CMHSPs, stratified to include fifteen (15) encounters (CMHSP-provided services) and fifteen (15) subcontracted provider claims, per quarter.
    - Nine hundred sixty (960) unique dates of service reviewed in total for FY22;
    - Represented nine thousand eighty-five (9,085) units and $210,788.19.
- Thirty (30) claims/encounters from the total universe of Substance Use Disorder providers, stratified to remove claims from providers already reviewed in the CMHPs or Region-Wide samples, per quarter.
    - One hundred twenty (120) claims/encounters reviewed in total for FY22;
    - Represented two hundred twenty-four (224) units and $13,166.16.

- Fifteen (15) claims/encounters for each of the top three hospital providers (by dollar volume) subcontracted with CMHSPs, per quarter.*
    - One hundred forty-eight (148) claims reviewed in total for FY22;
    - Represented nine hundred sixty-nine (969) units and $898,061.35.
    - *For quarter one, due to low claim volume, one hospital had only three (3) claims reviewed.
- Thirty (30) claims for each of the top three service providers (by dollar volume), stratified to remove the top three service providers from FY21, subcontracted with a Participant CMHSP, per quarter.
    - Three hundred sixty (360) claims reviewed in total for FY22;
    - Represented six thousand eight hundred and two (6,802) units and $26,634.62.
- Sixty (60) claims/encounters from a region-wide universe, stratified to remove claims for services provided by any of the top three hospitals, any of the top three subcontracted service providers, and any providers already pulled into the CMHSP samples, per quarter.
    - Two-hundred forty (240) claims/encounters reviewed in total for FY22;
    - Represented one thousand seven hundred sixty (1,760) units and $53,038.44.

Analysis Summary:

SWMBH's findings of the internal and external clinical records of participant CMHSPs and Substance Use Disorder providers show an overall compliance rate of 94.64% encompassing all review questions.

Identified Deficiencies. Out of a total sample of one thousand eight hundred forty-eight (1,848) claims/encounters reviewed, one thousand seven hundred forty-nine (1,749) were verified to be a valid service reimbursable by Medicaid. The following is a summary of the deficiencies noted among the seven questions addressed in the review tool for the ninety-nine (99) invalid claims:

- Was the person eligible for Medicaid coverage on the date of service reviewed? **0 deficiencies**
- Is the provided service eligible for payment under Medicaid? **0 deficiencies**
- Is there a current treatment plan on file which covers the date of service? **10 deficiencies** (This includes Treatment Plans deemed invalid due to no clinician signature at the time of the service.)
- Does the treatment plan contain a goal/objective/intervention for the service billed? **0 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer? **33 deficiencies** (This includes documentation that was completed/signed after the submission of the claim, which is a violation of SWMBH policy)

- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **5 deficiencies** (This includes claims for which there was an incorrect provider-qualifications modifier and/or there was no documentation provided to support the use of a particular provider-qualifications modifier).
- Was the appropriate amount paid (contract rate or less)? **3 deficiencies** (These are deemed to be paid inappropriately due to the customer having commercial insurance or Medicare that was not billed prior to billing Medicaid.)
- Other deficiencies noted:
    - Service documentation insufficient to support the claim/documentation does not address the Treatment Plan goals/objectives/interventions.
    - Claim was for CLS overnight health and safety but did not use the appropriate modifier/code.
    - No start/stop times documented for per unit services.
    - Duplicative service documentation
    - Service documentation not signed by the rendering provider
    - Duplicate claims
    - Billed in error/customer LOA for part of service claimed.

Verification Process:

Medicaid Verification was facilitated through a remote desk audit for each sampled claim/encounter, consisting of a review of relevant documents maintained within the electronic medical record used by all participant CMHSPs as well as service documentation sent electronically (if not maintained in the customer electronic medical record). The remote desk audits were scheduled between January 2022 and December 2022. A standardized verification tool was developed and used by all reviewers for both claims and encounters. The questions on the review tool included the following:

1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?
5. Is there documentation on file to support that the service was provided to the consumer?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

The Medicaid Verification reviews were conducted by SWMBH's Chief Compliance Officer (or designee, and under the direction of SWMBH's Chief Compliance Officer).

Medicaid Eligibility Assurance:

In addition to the Medicaid verification methodology used above, SWMBH has developed an automated verification process and management exception reports for use in verifying on a daily basis that all encounters reported to Medicaid capitated plans are

checked against the monthly Medicaid Enrollment eligibility files received from MDHHS. SWMBH has a centralized data warehouse where all information is stored. These reports are available to each CMHSP for use. The reports verify each transaction against the eligibility file and return to the user a report which identifies those individuals that have services charged to Medicaid that either do not exist in the eligibility file or do not show current eligibility. These reports are then verified by the agency utilizing the report using the CHAMPS eligibility lookup to determine true eligibility or non-eligibility on the given date of service and corrected accordingly.

Description of Follow-up Activities and Improvements:

Over the course of Fiscal Year 2022, SWMBH reviewed the service documentation and claims processing procedures of each participant CMHSP to ensure that both the applicable delegated and non-delegated functions follow Medicaid regulations and SWMBH policies.

With regard to the deficiencies noted pertaining to a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the service billed, the majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with a clinician signature prior to the provision of service and within 15 business days of the effective date of the plan. SWMBH will continue to work with our CMHSPs and sub-contracted providers to address the timeliness of treatment planning and the signatures of the clinician validating the treatment plan. Additionally, SWMBH will continue to educate providers on the importance of specific and individualized goals/objectives/interventions for services contained within the treatment plan.

Regarding deficiencies noted for documentation on file to support that the service was provided, some providers continued to struggle with the MDHHS requirement of a provider signature and signature date on documentation and the inclusion of actual begin and end times of face-to-face per unit services. Additionally, the newly required modifier/code for Community Living Services Overnight Health and Safety was identified as an area of improvement and education. SWMBH has been working and will continue to work with CMHSPs and subcontracted providers to ensure adherence to all MDHHS clinical records policies and requirements.

In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative and administrative review process, designed to provide ongoing feedback to both participant CMHSPs and external service providers.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in Medicaid fraud and abuse prevention. In Fiscal Year 2023, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan timeliness, the appropriate use of place of service codes, proper recording of face-to-face service start and stop times, and service

documentation standards. Additionally, SWMBH will be closely monitoring the reporting of in-home Community Living Support claims for the proper use of modifiers.

Corrective Action and Follow-Up Process

Performance standards have been set based on the percentage of deficiencies identified which dictates the frequency of follow-up:

- Verification reviews with a score of greater than or equal to 90% – No corrective action plan is needed, and reviews will be performed annually. No follow-up is necessary.
- Verification reviews less than or equal to 89.9% – SWMBH will require the applicable agency to create a written corrective action plan within 30 days, which must be approved by the SWMBH Compliance Committee.

Given this year's findings, ongoing education and training will be provided with an emphasis on documentation standards, proper reporting of face-to-face service start and stop times, treatment planning timeliness, and new required modifiers (U-modifiers and provider-qualification modifiers specifically). As a result of the anticipated staff training, efforts to continuously improve in this area will be ongoing. The Medicaid Verification findings are reported to the SWMBH Board of Directors and the Member Advisory Committee. The SWMBH Executive Officer, the Chief Compliance Officer, the SWMBH Corporate Compliance Oversight Committee and the SWMBH Leadership Team will also review the findings and identify any additional strategies needed to improve the findings. Given the overall compliance rate of 94.64% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP is not required and will not be submitted; however, SWMBH will continue the efforts described above in order to improve service claim processes congruous with Medicaid requirements.

The ninety-nine (99) claims/encounters identified as invalid represent a total of one thousand eight hundred twelve (1,812) units and resulted in payment adjustments totaling $17,314.04. Payment adjustments were communicated to the applicable agency via a recoupment ticket contained in the final audit report. Applicable agencies were advised of their appeal rights, and that once the appeal period had passed (30 days) the invalid claims will be reverted, and the funds recouped. When the claims are reverted and denied, the encounter that was previously submitted to MDHHS is voided.

SWMBH BOARD COMMITTEES AND OVERSIGHT BOARDS

Pursuant to the SWMBH Bylaws, the SWMBH Board shall create the following Committees or Oversight Boards:

- Operations Committee;

Operations Committee

"An Operations Committee will be formed consisting of the CEOs of the CMHSPs or their designees. The Operations Committee will have the responsibilities and authorities assigned by the Board and outlined in the Operating Agreement." (*SWMBH Bylaws 5.1.1)*

The SWMBH Operations Committee is comprised of the Participant CEOs/Executive Directors, or their designees, and the SWMBH EO. The SWMBH EO participates in an ex-officio capacity without vote. The Operations Committee, in collaboration with the EO and SWMBH Board, participates in the development of the vision, mission and long-term plans of SWMBH. The Operations Committee, in a manner consistent with SWMBH Board directives, contributes to the hiring and evaluation process of the EO. The EO, in concert with the Operations Committee, develops and recommends priorities for the SWMBH Board's consideration and makes recommendations to the SWMBH Board with respect to policy and fiscal matters. The EO collaborates with the Operations Committee in the development of the contracts between the Participants and SWMBH. Each CMHSP CEO is charged with assuring that its CMHSP complies with applicable federal and state standards and regulations. The Operations Committee is advisory to both the EO and SWMBH Board. Any items requiring approval from the Operations Committee requires a super majority (75% of present members) vote.

The Operations Committee shall function with a large degree of independence in the discharge of its responsibilities. The Operations Committee shall assess the information provided by the SWMBH management, in accordance with its business judgment; and will work in collaborative partnership with the SWMBH Executive Officer (EO) in carrying-out its responsibilities, and in the provision of advice and recommendations to the Board.

Operations Committee Responsibilities and Authorities

The Operations Committee and the individual CMHSP CEOs/Executive Directors will work actively and constructively to:

A. Assure Participant CMHSP and community awareness of and alignment to SWMBH approved contracts, Participant subcontracts and related Plans, Policy and Procedures.
B. Assure its CMHSP personnel are constructively involved in SWMBH Committees and related activities.
C. Contribute to SWMBH and Participant CMHSP environmental awareness and SWMBH regional planning activities, including but not limited to strategic planning, Mission development, operational and capital budgeting, growth, infrastructure, products and markets.
D. Seek to resolve boundary issues, differences and disputes.

E. On an ongoing basis consider possible administrative efficiencies where appropriate (Bylaws 11.2).

As listed throughout the Operating Agreement the Operations Committee does the following:

A. Advises both the EO and SWMBH Board.
B. Participates in the development of the vision, mission, and long-term plans of SWMBH and ensures alignment with common CMHSP goals.
C. Reviews the annual operating and capital budget, Financial Management Plan, Cost Allocation Plan and Financial Risk Management Plan prior to presentation and approval by the SWMBH Board.
D. Reviews the Quality Assurance and Program Improvement Program (QAPIP) prior to presentation and approval by the SWMBH Board.
E. Reviews the Utilization Management Program (UM Plan) prior to implementation and/or presentation to the SWMBH Board.
F. Advises the EO in advance of, and throughout, engaging in any meaningful discussion with other entities that may impact the operations or decision of participants' CMHSP or SWMBH.
G. Attempts to resolve disputes between the Participants or one or more Participants and SWMBH at step 2 in the formal Dispute Resolution process.
H. Assists the SWMBH Board in hiring and retention decisions regarding the SWMBH EO in a manner consistent with Board policy, and as requested.
I. Responds to the EO's consultation before the EO renders a formal policy interpretation that may materially or negatively affect the Participants - where feasible.
J. Reviews all grant applications submitted on behalf of SWMBH prior to being submitted.
K. Responds to the EO's consultation before the EO determines what functions remain with SWMBH and which can be delegated to the Participants consistent with the Balanced Budget Act. Medicaid Managed Care Regulations.
L. Advises the EO regarding any additional SWMBH contractual arrangements that involve the Participants.
M. Provides a recommendation to the SWMBH Governing Board regarding any additional SWMBH contractual arrangements that involve the Participants and/or other vendors and requires approval by the SWMBH Governing Board.
N. Where appropriate, reviews and comments on agendas, materials, and minutes of the Substance Use Disorder Oversight Policy Board (SUDOPB).

OPERATIONAL COMMITTEES AND POLICY BOARD COMMITTEES

SWMBH POLICY BOARDS AND COMMITTEES

Substance Use Disorder Oversight Policy Board is established to assist SWMBH develop and sustain a comprehensive array of prevention programs, treatment and other services and a provider network capable of meeting the needs of persons with substance use disorders. SWMBH has executed an Intergovernmental Contract with 8 county commissions. This contract and related statutes and regulations shall guide the responsibilities of the SUD Oversight Policy Board. The Substance Use Disorder Oversight Policy Board will be constituted as required under MCL 330.1100a et seq. (PA 500 of

2012; Mental Health Code) and shall advise the SWMBH on issues concerning services to persons with substance use disorders. The functions and responsibilities assigned to the Board under law will include:

A. Approval of that portion of SWMBH budget that includes local funds (PA2) for treatment or prevention of substance use disorders;
B. Advice and recommendations regarding SWMBH budget for substance use disorder treatment or prevention using other nonlocal funding sources;
C. Advice and recommendations regarding contracts with substance use disorder treatment or prevention providers;
D. Other functions and responsibilities requested by SWMBH and accepted by amending Intergovernmental Contract.

Customer Advisory Committee (CAC) is established to advise SWMBH. The CAC is comprised of active or former customers, and may also include family members. Membership will include at least two but not more than three representatives from each county, nominated by Participants and other sources, recommended by the SWMBH EO, and appointed by the SWMBH Board, unless otherwise required by contract or regulation. Representatives will reflect the SWMBH population served and include those living with developmental disabilities, mental illness, serious emotional disturbance, and substance use disorders.

SWMBH Corporate Compliance Committee is established to develop the Compliance Plan for SWMBH Board approval and assist in implementing Program Integrity/Compliance Program of SWMBH. Committee members will include the SWMBH key functional areas such as Compliance, Utilization Management, Quality Management, Information Technologies, Finance, etc. as appointed by the EO. The Corporate Compliance Officer has a dual reporting relationship with the EO and the SWMBH Board. The Operations Committee will appoint a member to the SWMBH Compliance Committee.

SWMBH Standing Committees

Standing Operating Committees of SWMBH are:

- Finance Committee
- Quality Management Committee
- Utilization Management Committee
- Clinical Practices Committee
- Provider Network Management Committee
- Regional Information Technology Committee
- Customer Services Committee
- Regional Compliance Coordinating Committee

The CMHSP CEOs will ensure representatives from participant CMHSPs on all SWMBH Standing Committees. Each Participant CMHSP shall identify their representative to each committee. The EO with CMHSP support and involvement will actively pursue customer representation on standing committees. Committee work plans and goals shall be reviewed by the Operations Committee

annually and in the event of changes to ensure alignment with SWMBH and common CMHSP goals. At its discretion, the Operations Committee may request an in-depth committee report or update.

Finance Committee is established to advise the EO and is comprised of the SWMBH Fiscal Officer and participant CMHSP Fiscal Officer or Finance Director, as appointed by the Participant CEOs/Executive Directors. The Finance Committee will be charged with advising the EO and SWMBH CFO in the development of the annual operating and capital budget; Financial Management Plan, Cost Allocation Plan, and Financial Risk Management Plan, for review by the SWMBH Operating Committee prior to presentation and approval by the SWMBH Board.

Quality Management Committee is established to advise the EO and is comprised of both SWMBH QAPI leader and Participant CMHSP QM staff. The Quality Management Committee will be charged with advising the EO and SWMBH QAPI Director in the development of the Quality Assurance and Program Improvement Program (QAPIP), for review by the SWMBH Operating Committee prior to presentation and approval by the SWMBH Board.

Utilization Management Committee is established to advise the EO and is comprised of both SWMBH Clinical leader and Participant CMHSP UM staff. The UM Committee will be charged with advising the EO and the SWMBH staff in the development of the Utilization Management Program (UM Plan) for review by the SWMBH Operations Committee prior to implementation, and/or presentation to the SWMBH Board.

Clinical Practices Committee is established to advise the EO and is comprised of both SWMBH Clinical leader and Participant CMHSP clinical staff. The CP Committee will be charged with advising the EO and the SWMBH staff in the development of the Clinical Practices Program for review by the SWMBH Operations Committee prior to implementation, and/or presentation to the SWMBH Board.

Provider Network Management Committee is established to advise the EO and is comprised of both SWMBH Provider Network Manager Leader and Participant CMHSP PNM staff, as appointed by the Participant CEOs/Executive Directors.

Regional Information Technology Committee is established to advise the EO and is comprised of both SWMBH CIO and Participant CMHSP IS/IT staff, as appointed by the Participant CEOs/Executive Directors.

Customer Services Committee is established to advise the EO and is comprised of both SWMBH staff and Participant CMHSP CS leader, as appointed by the Participant CEOs/Executive Directors.

Regional Compliance Coordinating Committee consists of both SWMBH Chief Compliance Officer and CMHSP Compliance Officers as appointed by the Participant CEOs/Executive Directors. It is established to insure sharing of Compliance knowledge and best practice among the participants.

Each Committee shall have a Charter, subject to review by the Operations Committee. Periodic Operations Committee reviews of Committee Charters at the direction of the Operations Committee and SWMBH EO.

Responsibilities of SWMBH and Participants Regarding the Participants and Committees

SWMBH EO and the Participant CMHSP CEOs/Executive Directors shall mutually assure communication and collaboration including but not limited to:

A. Provide all parties, in a timely manner, copies of correspondence of a substantive nature to allow full consideration and deliberation prior to being called on to take action on such items. This includes but is not limited to: 1) policy, 2) contracts, 3) funding, 4) State and federal mandates, 5) items requiring a parties action and 6) legislative initiatives;
B. Provide all parties with copies of minutes from meetings attended by staff as representatives of SWMBH, and provide timely reports to the Operations Committee, as requested;
C. It is the intent of the parties to operate an efficient and well managed organization, keeping cost reasonable, thus allowing a maximum flow of funding for services. To this end all parties will share in representing the SWMBH at State level meetings and on committees at the regional, State, federal, and any association levels. Only those authorized to do so by the EO may speak on behalf of SWMBH, and those representing SWMBH are to provide a written summary or minutes of the proceedings. Determination of SWMBH representation, if other than SWMBH staff appointed by the EO, at standing statewide PIHP committees or meetings will be discussed by the Operations Committee;
D. Provide timely and accurate financial reports, with detail at the level necessary to allow the Participant CEOs/Executive Directors to have a full understanding of fiscal operations and status of SWMBH matters;
E. Provide data to all parties Boards in a complete and timely manner, and provide additional reasonable detail as requested by the Participants;
F. Contribute to SWMBH and Participant CMHSPs environmental awareness and SWMBH regional planning activities, including but not limited to strategic planning, Mission development, operational and capital budgeting, growth, infrastructure, products and markets;
G. Advise the Operations Committee in advance of engaging in any meaningful discussion with other entities that may impact the operations or decision of CMHSPs; and
H. Establish and sustain a regular schedule for standing committee meetings and arrange for appropriate space and clerical support.

Act No. 84
Public Acts of 2022
Approved by the Governor
May 19, 2022
Filed with the Secretary of State
May 19, 2022
EFFECTIVE DATE: May 19, 2022

STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Senator Huizenga

ENROLLED SENATE BILL No. 994

AN ACT to amend 1986 PA 268, entitled "An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates," (MCL 4.1101 to 4.1901) by amending the title, as amended by 2018 PA 638, and by adding chapter 8A.

The People of the State of Michigan enact:

TITLE

An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to create the opioid advisory commission and prescribe its powers and duties; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates.

CHAPTER 8A

OPIOID ADVISORY COMMISSION

Sec. 850. As used in this chapter:

(a) "Michigan opioid healing and recovery fund" means the Michigan opioid healing and recovery fund created in section 3 of the Michigan trust fund act, 2000 PA 489, MCL 12.253.

(b) "Opioid advisory commission" means the opioid advisory commission created in section 851.

Sec. 851. (1) The opioid advisory commission is created in the council.

(2) The opioid advisory commission must consist of the following members:

(a) Twelve voting members that have experience in substance abuse prevention, health care, mental health, law enforcement, local government, first responder work, or similar fields appointed as follows:

(*i*) Four members appointed by the senate majority leader.

(*ii*) Four members appointed by the speaker of the house of representatives.

(*iii*) One member appointed by the senate minority leader.

(*iv*) One member appointed by the minority leader of the house of representatives.

(*v*) One member appointed by the senate majority leader and the speaker of the house of representatives and selected from a list of 3 individuals provided by the governor.

(*vi*) One member appointed by the senate majority leader and the speaker of the house of representatives and selected from a list of 3 individuals provided by the attorney general.

(b) The director of the department of health and human services, or his or her designee, who shall serve as an ex officio member without vote.

(c) The council administrator, or his or her designee, who shall serve as an ex officio member without vote.

(3) In appointing members or providing a list from which members will be selected under subsection (2)(a), the governor, the senate majority leader, the speaker of the house of representatives, the senate minority leader, the minority leader of the house of representatives, and the attorney general shall ensure that the members of the opioid advisory commission, to the extent possible, reflect the geographic diversity of this state.

(4) All initial opioid advisory commission members must be appointed within 60 days after the effective date of the amendatory act that added this section.

(5) Of the first voting members appointed, 4 shall be appointed to 1-year terms, 4 shall be appointed to 2-year terms, and 4 shall be appointed to 3-year terms, as determined by the senate majority leader and the speaker of the house of representatives. After the first appointments, the term of a voting member of the opioid advisory commission is 3 years or until a successor is appointed under subsection (2), whichever is later.

(6) If a vacancy occurs on the opioid advisory commission, an individual must be appointed in the same manner as the original appointment to fill the vacancy for the balance of the term.

(7) The senate majority leader and the speaker of the house of representatives may concur to remove a member of the opioid advisory commission for incompetence, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(8) The council administrator, or his or her designee, shall call the first meeting of the opioid advisory commission. At the first meeting, the opioid advisory commission shall elect a member as a chairperson and, except as otherwise provided in this subsection, may elect other officers that it considers necessary or appropriate. The council administrator, or his or her designee, shall serve as secretary. The opioid advisory commission shall meet at least quarterly. The opioid advisory commission may meet more frequently at the call of the chairperson or at the request of at least 7 members.

(9) Seven voting members of the opioid advisory commission constitute a quorum for transacting business. A majority vote of the voting members appointed and serving is required for any action of the opioid advisory commission.

(10) The opioid advisory commission shall conduct its business in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(11) A writing that is prepared, owned, used, possessed, or retained by the opioid advisory commission in performing an official function is subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(12) A member of the opioid advisory commission is not entitled to compensation for service on the opioid advisory commission, but the opioid advisory commission may reimburse a member for actual and necessary expenses incurred in serving.

(13) The opioid advisory commission shall do all of the following:

(a) Adopt policies and procedures for the administration of the opioid advisory commission as allowed by law.

(b) Review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families affected by substance use disorders and co-occurring mental health conditions, and establish priorities to address substance use disorders and co-occurring mental health conditions, for the purpose of recommending funding initiatives to the legislature.

(c) By March 30 of each year, provide a written report to the governor, the attorney general, the senate majority

leader, the speaker of the house of representatives, and the chairs of the senate and house of representatives appropriations committees that includes all of the following:

(*i*) A statewide evidence-based needs assessment that includes at least all of the following:

(A) A summary of current local, state, and federal funding used to address substance use disorders and co-occurring mental health conditions.

(B) A discussion about how to prevent overdoses, address disparities in access to health care, and prevent youth substance use.

(C) An analysis, based on quantitative and qualitative data, of the effects on this state of substance use disorders and co-occurring mental health conditions.

(D) A description of the most common risk factors associated with substance use disorders and co-occurring mental health conditions.

(*ii*) Goals and recommendations, including the rationale behind the goals and recommendations, sustainability plans, and performance indicators relating to all of the following:

(A) Substance use disorder and co-occurring mental health conditions prevention, treatment, recovery, and harm reduction efforts.

(B) Reducing disparities in access to prevention, treatment, recovery, and harm reduction programs, services, supports, and resources.

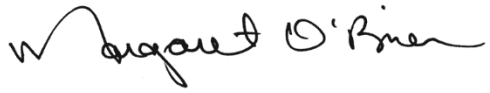
(*iii*) An evidence-based assessment of the prior use of money appropriated from the Michigan opioid healing and recovery fund, including the extent to which such expenditures abated the opioid crisis in this state.

(*iv*) Recommended funding for tasks, activities, projects, and initiatives that would support the objectives of the commission.

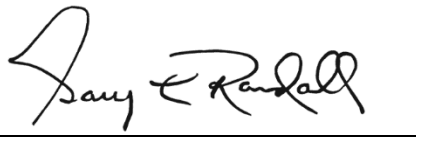
(*v*) If applicable, recommended additional legislation needed to accomplish the objectives of the commission.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 993 of the 101st Legislature is enacted into law.

This act is ordered to take immediate effect.



Secretary of the Senate



Clerk of the House of Representatives

Approved_____

_____

Governor

NATIONAL OPIOID SETTLEMENTS
MICHIGAN UPDATES AS OF 12.22.2022

- **Distributors (McKesson, AmerisourceBergen, Cardinal Health)**
  - A national settlement with the Distributors was reached. Michigan signed on to the settlement. The total payments to the State of Michigan and Local Michigan Governments is $631,211,905.76 over 18 years. The State of Michigan share is approximately $315,605,905.88 over 18 years.

  - The first payment of the Distributors was received by the State earlier this month (the Local share was not paid due to a dispute by Ottawa County). The amount received by the State was $13,457,661.76.

  - The payment process for the second payment began on December 15; the deadline to dispute the calculations is January 5. Ottawa County has objected to this payment as well. The State's portion is $14,169,384.86.

- **Janssen**
  - A national settlement with Janssen was reached. Michigan signed on to the settlement. The total payments to the State of Michigan and Local Governments is $145,083,217.53 over 9 years. The State of Michigan share is approximately $72,541,608.50 over 9 years.

  - The payment process for the first payment began on December 15; the deadline to dispute the calculations is January 5. The State's portion is $54,638,181.13. The payment is larger because of an acceleration clause in the Janssen settlement for State's that achieve Incentive A. This is the payments 1 through 5 of Janssen.

- **McKinsey and Co.**
  - A national settlement with McKinsey was reached in 2021. Michigan's share of the settlement is $19,557,215.93 over 5 years. So far, we have received approximately $17 million of the settlement with 3 payments remaining (2023, 2024, 2025).

- **CVS**
  - A national settlement was announced. The deadline to sign on to the settlement is December 30.

- **Walgreens**
  - A national settlement was announced. Our case, filed in the Third Circuit Court in Wayne County, is scheduled for trial in February 2023.

- **Walmart**
  - A national settlement was announced. Michigan signed on to the settlement.

- **Purdue**
  - Purdue's bankruptcy plan is still on appeal.

- **Mallinckrodt**
  - Mallinckrodt payments may begin in 2023. The State amount is unknown at this time.

- **Teva**
  - A national settlement was announced. Michigan signed on to the settlement.

- **Allergan**
  - A national settlement was announced. Michigan signed on to the settlement.

- **Endo**
  - Endo has filed for Chapter 11 bankruptcy. A bankruptcy plan has not been reached.

Michigan Substance Use Vulnerability Index

MDHHS developed the **Michigan Substance Use Vulnerability Index** (MI-SUVI) to consider the factors that influence a community's vulnerability related to substance use. It provides a standardized, single composite measure of vulnerability and was created to be used as a tool in allocation of resources and program planning.

Health equity was prioritized by giving it equal weighting to burden and resource components. 26 potential indicators were considered for inclusion, and based on stakeholder feedback, review of literature, and subject matter expertise, eight are included. The MI-SUVI score is made of three equally weighted components which use the average of the relevant indicators.

Substance Use Burden: negative outcomes associated with SUD that place a burden on individuals and community resources such as the healthcare and justice systems.

(1) OD Death Rate, (2) Nonfatal OD ED Visit Rate, (3) Opioid Prescribing Rate, and (4) Drug Related Arrest Rate.

Substance Use Resources: resources available to the community that can be used to address the negative outcomes associated with SUD.

(5) % of population within 30-minute drive of SUD Tx, (6) % of population within 15-minute drive of Syringe, and (7) Buprenorphine Prescription Rate.

Social Vulnerability: a measure of community level characteristics known to be important drivers of health (i.e., social determinants of health)

(8) uses the CDC social vulnerability index themes and indicators of socioeconomic status, household characteristics, racial & ethnic minority status, and housing type & transportation with the ***addition of a fifth theme,*** "Healthcare Connectedness": % without computer with broadband internet access, % of population within a 30-minute drive to acute care hospital, and % within a 15-minute drive to a pharmacy

The MI-SUVI may be used to track "improvement" over time for a given county. Rates are provided for all eight components so a decrease Drug Related Arrest Rate or Overdose Death Rate statistics would be an "improvement" for that county. MI-SUVI scores are currently available only for 2020 in the component areas of overdose rates, prescriptions, arrests, and social vulnerability; 2021 data is being used for drive times to SUD and syringe service.

Counties which rank with low rates of vulnerability may be sources for determining practices and methodology for program planning. As a tool in determining allocation of resources, the indicator statistics may be useful as well.

Resources:

Michigan Substance Use Vulnerability Index Documentation, June 2022, retrieved January 26, 2023, from: 4651dMichigan-SUVI-Documentation.pdf.

MI County Substance Use Vulnerability Index Results Web Version V2, retrieved January 26, 2023, Data (michigan.gov)

2021 Unconfirmed ranks received from Program Coordinator for Michigan's Opioid Advisory Commission via email January 13, 2023.

Michigan Substance Use Vulnerability Index

In the below table SWMBHs counties are ranked with all Michigan counties, **1 is the most vulnerable** and 83 the least vulnerable.

County	MI-SUVI Burden Score, 2020 *County Rank*	MI-SUVI Resource Score, 2020 *County Rank*	MI-SUVI Social Vulnerability Score, 2020 *County Rank*	MI-SUVI Score, 2020 *County Rank*	2021 (most current) Unconfirmed Ranks
Branch	37	72	10	10	10
Van Buren	19	65	16	11	11
Calhoun	3	16	23	14	14
Berrien	38	67	18	17	16
St. Joseph	42	73	22	19	19
Kalamazoo	48	36	43	50	
Cass	77	74	61	63	
Barry	66	69	81	73	

Communication with Those Charged with Governance during Planning

January 20, 2023

To the Members of the Board
Southwest Michigan Behavioral Health
Portage, Michigan

We are engaged to audit the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Southwest Michigan Behavioral Health (the PIHP) for the year ended September 30, 2022. Professional standards require that we provide you with the following information related to our audit.

We would also like to extend the opportunity for you to share with our firm any concerns you may have regarding the PIHP, whether they be in relation to controls over financial reporting, controls over assets, or issues regarding personnel, as well as an opportunity for you to ask any questions you may have regarding the audit.

Our Responsibilities under U.S. Generally Accepted Auditing Standards, *Government Auditing Standards*, and the Uniform Guidance

As stated in our engagement letter, our responsibility, as described by professional standards, is to express opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we will consider the PIHP's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinions on the financial statements and not to provide assurance on the internal control over financial reporting. We will also consider internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with the Uniform Guidance.

As part of obtaining reasonable assurance about whether the PIHP's financial statements are free of material misstatement, we will perform tests of its compliance with certain provisions of laws, regulations, contracts, and grants. However, providing an opinion on compliance with those provisions is not an objective of our audit. Also in accordance with the Uniform Guidance, we will examine, on a test basis, evidence about the PIHP's compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Compliance Supplement applicable to each of its major federal programs for the purpose of expressing an opinion on the PIHP's compliance with those requirements. While our audit will provide a reasonable basis for our opinion, it will not provide a legal determination on the PIHP's compliance with those requirements.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. We are responsible for communicating significant matters related to the audit that are, in our professional judgement, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters.

Planned Scope, Timing of the Audit, and Other

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial

ROSLUND, PRESTAGE & COMPANY, P.C.
525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN

reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity.

We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We have identified the following significant risks of material misstatement as part of our auditing planning:

- Management override of controls
- Improper revenue recognition due to fraud

To address these risks, we incorporate unpredictability into our audit procedures, emphasize the use of professional skepticism, and assign staff to the engagement with industry expertise.

Derek Miller is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

This information is intended solely for the use of those charged with governance and management of the PIHP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

Southwest Michigan Behavioral Health Board Meeting
Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001
March 10, 2023
9:30 am to 11:30 am
(d) means document provided
Draft: 1/27/23

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda**

   - February 10, 2023 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   - January 25, 2023 Meeting Minutes (D. Hess) (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. *2022 Customer Service Survey Results (J. Gardner) (d)

7. **Board Actions to be Considered**

   a. Bradley Casemore Employment Agreement First Consideration
   b. May 12, 2023 Board Retreat Agenda (d)

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

   - BG-001 Committee Structure (d)

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

   - BEL-001 Budgeting (C. Naccarato) (d)

10. **Board Education**

    a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d)
    b. Fiscal Year 2022 Quality Assurance and Performance Improvement Program Evaluation (J. Gardner) (d)
    c. Delegation, Oversight and Monitoring – Results and Follow Ups (B. Casemore, M. Todd) (d)

11. Communication and Counsel to the Board

a. Opioid Advisory Commission (B. Casemore)
b. MI Health Link Extrication (E. DeLeon) (d)
c. April 14, 2023 Draft Board Agenda (d)
d. Board Member Attendance Roster (d)
e. April 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 Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
April 14, 2023
9:30 am - 11:30 am

2023 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Sherii Sherban (Calhoun)												
Louie Csokasy (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarato (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Jeanne Jourdan (Cass)												
Karen Longanecker (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 1/13/23

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