Board Meeting

Please join the meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/515345453
You can also dial in using your phone:
1-571-317-3116 - Access Code: 515-345-453
February 12, 2021
9:30 am to 11:00 am
(d) means document provided
Draft: 2/4/21

1. **Welcome Guests/Public Comment**

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

3. **Financial Interest Disclosure Handling (M. Todd)**
   - Terry Proctor, Cass County (Woodlands BHN)

4. **Consent Agenda**
   - January 8, 2021 SWMBH Board Meeting Minutes (d) pg.3

5. **Operations Committee**
   - Operations Committee Minutes December 16, 2020 (d) pg.8

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

   - None

7. **Board Actions to be Considered**
   a. Executive Officer Employment Agreement Extension
   b. Fiscal Year 2021 Revised Budget (T. Dawson) (d) pg.11
   c. Strategic Planning
      - Debrief January 8 meeting (d) pg.12
      - CEO reflections, responses, recommendations (d) pg.13
      - Next steps

8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - None Scheduled

9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   - BEL-001 Budgeting (S. Barnes) (d) pg.14

10. **Board Education**
    a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d) pg. 18
    b. Fiscal Year 2020 Customer Services Report (S. Ameter) (d) pg. 26
    c. Fiscal Year 2020 Program Integrity Compliance Report (M. Todd) (d) pg. 43
    d. Fiscal Year 2020 Medicaid Verification Results (M. Todd) (d) pg.47

11. **Communication and Counsel to the Board**
    a. Keynote Update from MDHHS (d) pg.53
    b. 2021 HMA Emerging Policy Environment Impacts on Publicly Funded Healthcare (d) pg.73
    c. Unified Vision (d) pg.85
    d. March 12, 2021 Board Agenda (d) pg.102
    e. Board Member Attendance Roster (d) pg.104
    f. March Board Policy Direct Inspection - none

12. **Public Comment**

13. **Adjournment**

SWMBH shall comply with 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 Meeting:
March 12, 2021
9:30am – 11:00am

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
January 8, 2021
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 1/8/21

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

Guests Present via phone: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Kris Kirsch, St. Joseph CMH; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Board Alternate; Pat Guenther, ISK Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe; Jeff Patton, ISK; Brad Sysol, Summit Pointe

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

Public Comment
None

Agenda Review and Adoption

Motion	Ruth Perino moved to accept the agenda with revisions of moving the Fiscal Year 2021 Quality Assurance Performance and Improvement Plan under Board actions and moving the Fiscal Year 2021 Utilization Management Plan under Board education.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes
Motion Carried		

Financial Interest Disclosure Handling
None

Consent Agenda

Motion	Erik Krogh moved to approve the December 11, 2020 Board meeting minutes as presented.	
Second	Mary Middleton	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes
Motion Carried		

Operations Committee

Operations Committee Minutes November 18, 2020

Debbie Hess noted the minutes as documented and stated that she did not have any additional comments. Minutes accepted.

Operations Committee Quarterly Report

Debbie Hess noted the report as documented.

Ends Metrics

None

Board Actions to be Considered

Fiscal Year 2021 Quality Assurance Performance and Improvement Plan

Jonathan Gardner reported as documented. Discussion followed.

Motion	Erik Krogh moved to approve the Fiscal Year 2021 Quality Assurance Performance and Improvement Plan as presented.	
Second	Tom Schmelzer	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Board Policy Review

BG-001 Committee Structure

Edward Meny reported as documented.

Motion	Tom Schmelzer moved the Board is in compliance and the Policy BG-001 Committee Structure does not need revision.	
Second	Ruth Perino	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

BG-004 Board Ends and Accomplishments

Edward Meny reported as documented.

Motion	Erik Krogh moved the Board is in compliance with Policy BG-004 Board Ends and Accomplishments.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

Motion	Tom Schmelzer moved that the Policy BG-004 Board Ends and Accomplishments does not need revision.	
Second	Ruth Perino	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

BG-007 Code of Conduct

Edward Meny reported as documented.

Motion	Patrick Garrett moved the Board is in compliance and the Policy BG-007 Code of Conduct does not need revision.	
Second	Susan Barnes	
Roll call vote	Ruth Perino	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Patrick Garrett	yes
	Mary Middleton	yes
	Erik Krogh	yes
	Carol Naccarato	yes
	Susan Barnes	yes

Motion Carried

Executive Limitations Review

None

Board Education

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Fiscal Year 2021 Utilization Management Plan

Anne Wickham reported as documented. Discussion followed.

Communication and Counsel to the Board

Fiscal Year 2020 Medicaid Services Verification Report

Mila Todd reported as documented.

Intergovernmental Contract Status

Brad Casemore reviewed the history of the contract and noted that SWMBH has received signed contracts from all eight county administrators.

February 12, 2021 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.

2020 SWMBH Retirement Plan Fiduciary Review

Brad Casemore reported as documented reviewing highlights and minutes from recent meeting with Rose Street Advisors on SWMBH retirement plans.

2020-2021 Outlook Biden's Policy Agenda and SDOH Investing

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

MDHHS COVID-19 Interactive Dashboard
Brad Casemore noted the document in the packet for the Board's review.

Substance Abuse Block Grant Memo
Brad Casemore noted the document in the packet for the Board's review.

Public Comment
None

Adjournment

Motion Susan Barnes moved to adjourn at 10:55am
Second Ruth Perino
Unanimous Voice Vote
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: December 16, 2020 9:00am-12:00pm

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

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, SWMBH; Paul Ongwela, Business Data Analyst II, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Gale Hackworth, Clinical Consultant, SWMBH; Brad Sysol, Summit Pointe; Paul Reed; Pat Davis and Sheila Hibbs, Integrated Services of Kalamazoo

Call to Order – Brad Casemore began the meeting at 9:00 am.

CMH Updates – CMHSP CEOS's shared current updates and sought input from colleagues focused on response plans to the pandemic, challenges, and regulations. Also highlighted new grants and projects unrelated to the pandemic.

Review and approve agenda – Agenda approved.

Review and approve minutes from 11/18/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported as documented noting that the region is starting out the fiscal year in a better position than last year.

Fiscal Year 2020 Encounters and Close Out – Tracy Dawson reported as documented noting that the encounter reports are available on Tableau. Encounter close out deadline submission was 12/15/20, but please continue to submit all encounters. Natalie Spivak asked CMHSPs to work on clean up errors ASAP.

Fiscal Year 2021 Rate Setting Files Analysis – Tracy Dawson reported as documented. Pat Davis, Natalie Spivak and Andy Aardema continue to work on accuracies on Milliman data. Natalie Spivak and Pat Davis reported on prevalence report and summary of findings. SWMBH to follow up with Milliman.

Cost Allocation, Encounter Quality Improvement (EQI) and Rate Setting Development Workgroup – Tracy Dawson reported that cost allocation trainings have started and highlighted timeframes. Changes being implemented in cost centers for staff reporting and general ledger set up. Medical Loss Ratio interpretation was also discussed at the training. Discussion followed.

Tableau Management Reports Primer – Paul Ongwela gave a 30-minute demonstration of Tableau where he covered various reports, features, dashboards, custom views and data sources.

January Board Planning Session-Survey Questions – Brad Casemore stated that a link to a survey regarding Board planning was sent out and ask each CMH CEO to complete the 4-question survey by 12/18/20.

Requirements for Reporting Assertive Community Treatment (ACT) – Mila Todd reported as documented.

Substance Use Disorder Block Grant – Joel Smith reported that Block Grant funding was reduced by 30% and SWMBH staff have been working to revise funding and services in adjustment to the funding decrease.

Community Living Supports Report – Tracy Dawson reported as documented.

Habilitation Supports Waiver Releases need for payment – Tracy Dawson reported as documented.

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd stated that a letter from Licensing and Regulatory Affairs was received regarding governmental entities and SUD licenses. PIHPs are working with MDHHS on contract revisions regarding the letter.

Fiscal Year 2020 Data Certifications – Mila Todd stated that new data certifications will be sent out in mid-January.

Data Use Agreements – Mila Todd stated that Care Connect 360 and MDHHS data use agreements are signed. When SWMBH receives those signed agreements then each county will receive their agreement to sign.

Provider Stability Plans 2021 – Mila Todd reported as documented.

Behavioral Health Treatment Episode Data Set Status – Natalie Spivak reported as documented.

Assessment Tools Status – Natalie Spivak reported as documented.

Fiscal Year 2021 Quality Assurance and Performance Improvement Plan – Jonathan Gardner

Health Services Advisory Group 2019-2020 External Quality Review Audit Results – Jonathan Gardner

Fiscal Year 2021 Utilization Management Plan – Anne Wickham reported as documented.

MCG Installation – Anne Wickham stated that MCG implementation and medical necessity guidelines are currently in process. SWMBH met with MCG on 12/7/20. MCG has meetings set with Streamline users on 1/6/21 and PCE users on 1/14/21.

Opioid Health Homes (OHH) – Joel Smith stated that currently there are 225 enrollees with claims being processed. Brad Casemore encouraged other counties to consider implementing OHH.

Substance Use Disorder Standardized Assessment Update – Joel Smith reported as documented.

Children's Waiver Program (CWP) Available Slots – Brad Casemore reported as documented noting that there are open slots for CWP.

MI Health Link 2021 and Beyond – Brad Casemore stated that contracts with Aetna and Meridian have been executed.

Managed Care Organization Opportunities – Brad Casemore stated that SWMBH has not been approached by any Medicaid Health Plan and asked if any of the CMHSPs were approached.
Calendar Year 2021 Intergovernmental Contract Update – Brad Casemore shared that of the eight counties in the region SWMBH is waiting for one signed contract from Kalamazoo County.

January 8, 2021 SWMBH Board Agenda – Brad Casemore noted the agenda in the packet for the committee's review.

Recipient Rights Roles – Brad Casemore reported as documented.

Michigan "Clean Slate" Bills – Brad Casemore reported as documented.

Adjourned – Meeting adjourned at 11:50am

	E	F	G	H	J	K	O
1	***Southwest Michigan Behavioral Health***						
2	For the Fiscal YTD Period Ended 9/30/2021				**Revised FY21 Budget**		
3	*(For Internal Management Purposes Only)*				**DRAFT**		
4	***INCOME STATEMENT***			**For Board Consideration**	**FY21 Budget Current Status**	**Variance**	**FY20 Budget**
5							
7	**REVENUE**						
8	**Contract Revenue**						
9	Medicaid Capitation			219,637,271	213,594,312	6,042,959	209,466,803
10	Healthy Michigan Plan Capitation			41,693,914	39,412,095	2,281,819	32,039,762
11	Autism Services Capitation			22,388,826	17,250,441	5,138,386	12,559,000
12	Dual Eligibles Demonstration Project			3,480,161	3,480,161	-	3,414,767
13	SA Block Grant Funding			7,801,586	7,801,586	-	8,171,316
14	SA PA2 Funding			1,797,973	1,797,973	-	1,884,850
15							
16	Contract Revenue			296,799,730	283,336,567	13,463,163	267,536,498
17	DHHS Incentive Payments			629,741	629,741	-	650,920
18	Grants and Earned Contracts			1,521,294	1,521,294	-	461,128
19	Interest Income - Working Capital			101,227	101,227	-	198,574
20	Interest Income - ISF Risk Reserve			5,123	5,123	-	48,015
21	Local Funds Contributions			1,726,192	1,726,192	-	2,163,020
22	Other Local Income			-	-	-	243,099
23				-	-	-	
24	**TOTAL REVENUE**			**300,783,307**	**287,320,144**	**13,463,163**	**271,301,256**
25							
26	**EXPENSE**						
27	**Healthcare Cost**						
28	Provider Claims Cost			22,233,468	22,233,468	-	22,415,051
29	CMHP Subcontracts, net of 1st & 3rd party			230,237,545	230,237,545	-	216,125,411
30	Insurance Provider Assessment Withhold (IPA)			2,894,655	2,894,655	-	2,590,858
31	Medicaid Hospital Rate Adjustments			3,614,277	3,614,277	-	139,821
33	Provider Stability and DCW Payments			-	-	-	
34	**Total Healthcare Cost**			**258,979,946**	**258,979,946**	**-**	**241,271,141**
35	**Medical Loss Ratio (HCC % of Revenue)**			**87.1%**	**91.2%**	**0.0%**	**90.0%**
36							
37	**Administrative Cost**						
38	Purchased Professional Services			697,240	697,240	-	623,000
39	Administrative and Other Cost			9,649,819	9,313,774	-	8,293,670
41	Depreciation			89,172	89,172	-	109,640
42	Functional Cost Reclassification			-	-	-	-
43	Allocated Indirect Pooled Cost			-	-	-	-
44	Delegated Managed Care Admin			15,620,489	16,870,489	(1,250,000)	14,585,702
45	Apportioned Central Mgd Care Admin			0	0	-	0
46							
47	**Total Administrative Cost**			**26,056,720**	**26,970,674**	**(1,250,000)**	**23,612,012**
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.4%**	**100.0%**	**9.0%**
49						-	
50	Local Funds Contribution			1,726,192	1,726,192	-	2,163,020
51							
52	**TOTAL COST after apportionment**			**286,762,858**	**287,676,813**	**(1,250,000)**	**267,046,173**
53							
54	**NET SURPLUS before settlement**			**14,020,449**	**(356,669)**	**14,713,163**	**4,255,082**
55	**Net Surplus (Deficit) % of Revenue**			**4.7%**	**-0.1%**	**109.3%**	**1.6%**
56							
57	Prior Year Savings			-	-	-	
58	Change in PA2 Fund Balance			(245,383)	(255,959)	-	(30,389)
59	ISF Risk Reserve Abatement (Funding)			(5,123)	(5,123)	-	(48,015)
60	ISF Risk Reserve Deficit (Funding)			-	655,678	-	-
61	Settlement Receivable / (Payable)			-	(0)	-	(17,147)
62	**NET SURPLUS (DEFICIT)**			**13,769,943**	**37,927**	**14,713,163**	**4,159,531**
63	*HMP & Autism is settled with Medicaid*						

SWMBH Strategic Planning Meeting Notes Synopsis
1-8-21 Discussion

Update from MDHHS

- Al Jansen—Rep. Whiteford, this week, initiated conversations with house and senate, department, providers, and providers associations without CMH or PIHP. Topic continued discussion about BH transformation. BHDDA continues to pay close attention to activity.
- Lame duck session – some things passed – pursuing psychiatric r t facility for youth in Medicaid program.
- Modification for crisis stabilization units.
- Crisis lines
- BH lawsuit – KB lawsuit – high level department involvement. Need to pay attention to and influence.
- FY 22 budget process has begun.

Review of survey questions/General Comments

- Survey came at time of uncertainty – elections, Covid-19, State and Federal Budgets, etc. Difficult to project
- Survey was vague and open to individual interpretation
- Disunity of opinion both within Board and within the Board/CMH responses.
- Are we more vulnerable in our conviction and dedication to weaken what we are currently doing
- Size of CMH determines time and manpower capacity to absorb tasks
- PIHP has been critical support system for CMHs success
- Draw on each other for strength and decisions
- Will reduced reimbursements from the State cause cuts to areas, if so, what areas. BH has always been an area identified for cuts
- Should not jeopardize the core mission
- Just because you can do something doesn't mean you should do something
- Change is inevitable. CCBHC may be the threat to the PIHP survival
- PIHPs created to assure services are run as designed
- Encouraged to discover reasons for the differences of opinions
- Integration and innovation have been part of the CMH system
- Understanding the view and function of PIHP
- Communications are restricted through virtual meeting platforms
- Need clarification as to what is the new direction
- What is cost benefit of change
- Does taking on additional geographic boundaries risk our performance standing with the State
- Taxing staff, resources, etc. may not be best move
- Purpose of PIHP is to support CMHs
- Economy of scale/part of a large system is valuable
- Additional conversations regarding what each county is doing and how to support each other
- Need to continue to focus on serving the people

mab

CEO Casemore Reflections, Responses & Recommendations from January 8, 2021 Board Planning Session

Brad Casemore, CEO

- First and foremost, thanks you for your preparation and participation.
- The questions were designed to establish baseline individual and group views. We recognize that many environmental factors including but not limited to emerging federal and state Policy in healthcare, behavioral health and Medicaid will influence ongoing discussions.
- There is little or no support for outside region opportunities planning.
- Uncertainty about future developments and our response thereto is to be expected and managed.
- Our purpose is not to create an either-or or an inappropriately rapid set of forced choices. Board viewpoint assists management in best knowing what not to do and not to prepare for. This in turn enables focus and resource conservation.
- Certified Community Behavioral Health Clinic expansion at CMHs is welcomed and supported by SWMBH.
- Agreed, core mission is to serve as PIHP and support CMHSP excellence as Providers with delegated managed care roles and functions with unwavering focus on persons served and their needs.
- SWMBH and CMHs will continue efforts at Healthcare Information Exchange, Healthcare Data Analytics, Clinical Informatics and Outcomes Measurement.
- February through May will bring clearer pictures on federal and state health Policy and budgets. Management recommends a follow up Board planning session in May.

Southwest Michigan Behavioral Health
Executive Limitations
Monitoring to Assure Executive Performance

February 12, 2021

Policy Number: BEL-001
Policy Name: Budgeting
Board Date: February 12, 2021
Assigned Reviewer: Susan Barnes

Policy:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from a multi-year plan.

CEO Response: This report addresses fiscal year 2020 (October 1, 2019 to September 30, 2020) and budget process for fiscal year 2021 (October 1, 2020 to September 30, 2021). Budgeting and financial reporting have been driven by adopted Board Ends Metrics, Board-reviewed Assumptions and fiscal parameters as well as Board directives from Board Planning Sessions.

Accordingly, the CEO may not allow budgeting which:

1. *Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.*

CEO Response: Fiscal year 2020 and fiscal year 2021 budgeting and financial reporting each included as much information from the state as they would provide to enable credible projection and tracking of revenues. Expense projections include appropriate categories with specificity on the multiple SWMBH contracts and business lines and across eight Participant CMHs. Capital and operational items were budgeted and reported as were cash flows.

SWMBH provided technical assistance and expectations guidance to CMHSP's throughout the FY2021 budget development process, and Medicaid and Healthy Michigan eligibles trending and projections (which drive projected Medicaid and Healthy Michigan revenues) were made for fiscal year 2020 and fiscal year 2021.

Fiscal year 2020 Medicaid revenue actual receipts to budget projections were up $21,391,168 (an increase of (8.3%) noting $7+ million was related to

Direct Care Wage funding. Up $20,916,320 (8.9%) from fiscal year 2019. The increase continues to evolve due to changes in the rate setting process and changes due to the COVID environment.

Healthy Michigan Plan fiscal year 2020 revenue receipts were up $9,566,588 (33%) from budget, and up $ 5,371,150 (15%) from fiscal year 2019.

Capital and operational items are detailed consistent with GAAP. Cash flows are projected and monitored. Budget documents, financial reports and accompanying materials disclose related planning assumptions which were reviewed with the Board in June 2019 for fiscal year 2020, and in June 2020 for fiscal year 2021.

Monthly fiscal year 2020 year to date financial reports have been provided to the Board monthly. All files are maintained at SWMBH Finance Department. Participant CMH CFOs and CEOs routinely review financial projections and results, as well as budget development materials.

Significant efforts by all have occurred to assure common cost allocation per federal regulations the SWMBH Board-approved Financial Risk Management and Cost Allocation Plans and MDHHS guidance.

2. *Plans the expenditures in any fiscal year of more funds than are conservatively projected to be received in that period.*

CEO Response: SWMBH Board approved budget for fiscal year 2020 did plan for the expenditures to be more than funds projected to be received. For fiscal year 2021 the approved budget did not plan for expenditures more than projected revenue.

3. *Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, board development, board and committee meetings, and board legal fees.*

CEO Response: The fiscal year 2020 and 2021 budget included line items and sufficient amounts for Board prerogatives including costs of financial and compliance audit, board development, board and committee meetings and board legal fees.

4. *Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve future ends.*

CEO Response: The fiscal year 2020 actual performance and the fiscal year 2021 budget and performance year to date are expected to be improved results in part due to the regions deep dive into all areas of cost and circumstances of reduced cost due to the FY2020 environment. SWMBH did

not ignore the building of organizational capability sufficient to achieve Ends in future years and currently expects to be able to place funds into Medicaid Savings Risk Corridor for a consecutive fiscal year. SWMBH has been active in several expense reductions, revenue maximization and funding advocacy efforts with some successes.

5. *Cannot be shared with the board on a monthly basis.*

CEO Response: The fiscal year 2020 and 2021 financial reports have been shared with the Board congruous with the Board's governing documents, and in format(s) approved or accepted by the Board. Throughout fiscal year 2020 and into 2021 monthly financial reports, critical assumptions, and threats to fiscal health were regularly shared with the Board.

The CEO provided this report and supporting materials to assigned Reviewer. CEO and CFO offered to meet with assigned Reviewer.

Supporting Documents

- Fiscal Year 2021 Budget Assumptions and Parameters
- Fiscal Year 2020 Board approved Budget
- Fiscal Year 2021 Board approved Budget

END

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-001	Pages: 1
Subject: Budgeting	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.2014	**Last Review Date**: 1/10/20	**Past Review Dates**: 8.8.14, 11/13/15, 1/13/17, 1/12/18,1/11/19

I. **PURPOSE:**

II. **POLICY:**
Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

III. **STANDARDS:**
Accordingly the Executive Officer may not allow budgeting which;

1. Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.

2. Plans the expenditures in any fiscal year of more funds than are conservatively projected to be available for that period.

3. Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, Board development, Board and Committee meetings, and Board legal fees.

4. Endangers the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends.

5. Cannot be shared with the Board on a monthly basis.

	E	F	G	H	J	K	L	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***				***Mos in Period***									
2	For the Fiscal YTD Period Ended 12/31/2020			**P03FYTD21**	**3**									
3	*(For Internal Management Purposes Only)*													
4	***INCOME STATEMENT***			**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**	**Indirect Pooled Cost**	
5														
6														
7	**REVENUE**													
16	Contract Revenue			78,205,040	58,964,149	10,650,484	5,748,880	866,291	-	1,356,696	519,767	98,774	-	
17	DHHS Incentive Payments			167,269	167,269	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			36,086	-	-	-	-	36,086	-	-	-	-	
19	Interest Income - Working Capital			2,354	-	-	-	-	-	-	-	2,354	-	
20	Interest Income - ISF Risk Reserve			284	-	-	-	-	-	-	-	284	-	
21	Local Funds Contributions			431,548	-	-	-	-	-	-	-	431,548	-	
22	Other Local Income			-	-	-	-	-	-	-	-	-	-	
23														
24	**TOTAL REVENUE**			**78,842,579**	**59,131,417**	**10,650,484**	**5,748,880**	**866,291**	**36,086**	**1,356,696**	**519,767**	**532,960**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			5,158,679	922,687	1,952,256	-	854,817	3,035	1,175,964	249,919	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			57,588,726	48,186,621	5,316,066	3,585,544	378,559	-	121,937	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			813,433	813,433	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			-	-	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	432,377	-	-	(432,377)		-	-	-		
33														
34	**Total Healthcare Cost**			**63,560,838**	**50,355,118**	**7,268,322**	**3,585,544**	**800,998**	**3,035**	**1,297,901**	**249,919**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**81.1%**	**85.2%**	**68.2%**	**62.4%**	**92.5%**		**95.7%**	**48.1%**			
37	**Administrative Cost**													
38	Purchased Professional Services			93,780	-	-	-	-	-	-	-	93,780	-	
39	Administrative and Other Cost			1,805,734	-	-	-	-	33,051	19,821	-	1,751,175	1,687	
40	Interest Expense			-	-	-	-	-	-	-	-	-	-	
41	Depreciation			22,188	-	-	-	-	-	-	-	22,188	-	
42	Functional Cost Reclassification			-	-	-	-	-	-	-	-	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	-	1,687	(1,687)	
44	Delegated Managed Care Admin			4,355,684	3,647,327	403,501	276,042	28,814	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			(0)	1,452,469	214,970	106,047	36,479	1,067	38,973	-	(1,850,005)	-	
46														
47	**Total Administrative Cost**			**6,277,385**	**5,099,796**	**618,470**	**382,089**	**65,293**	**34,118**	**58,795**	**-**	**18,824**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.2%**	**7.8%**	**9.6%**	**7.5%**		**4.3%**	**0.0%**	**2.6%**		
49														
50	Local Funds Contribution			431,548	-	-	-	-	-	-	-	431,548	-	
51	PBIP Transferred to CMHPs			-								-		
52														
53	**TOTAL COST after apportionment**			**70,269,771**	**55,454,915**	**7,886,793**	**3,967,632**	**866,291**	**37,153**	**1,356,696**	**249,919**	**450,372**	**-**	
54														
55	**NET SURPLUS before settlement**			**8,572,809**	**3,676,502**	**2,763,691**	**1,781,248**	**-**	**(1,067)**	**-**	**269,847**	**82,587**	**-**	
56	**Net Surplus (Deficit) % of Revenue**			**10.9%**	**6.2%**	**25.9%**	**31.0%**	**0.0%**	**-3.0%**	**0.0%**	**51.9%**	**15.5%**		
58	Prior Year Savings			-	-	-	-	-		-	-	-		
59	Change in PA2 Fund Balance			(269,847)	-	-	-	-		-	(269,847)	-		
60	ISF Risk Reserve Abatement (Funding)			(284)	-	-	-	-		-	-	(284)		
61	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-		-	-	-		
62	Settlement Receivable / (Payable)			-	2,414,842	(633,595)	(1,781,248)	-	-	-	-	-		
63	**NET SURPLUS (DEFICIT)**			**8,302,677**	**6,091,344**	**2,130,097**	**-**	**-**	**(1,067)**	**-**	**-**	**82,303**	**-**	
64	*HMP & Autism is settled with Medicaid*													
65														
66	**SUMMARY OF NET SURPLUS (DEFICIT)**													
67	Prior Year Unspent Savings			-	-	-	-	-		-	-	-		
68	Current Year Savings			8,221,441	6,091,344	2,130,097	-	-		-	-	-		
69	Current Year Public Act 2 Fund Balance			-	-	-	-	-		-	-	-		
70	Local and Other Funds Surplus/(Deficit)			81,236	-	-	-	-	(1,067)	-	-	82,303	-	
72	**NET SURPLUS (DEFICIT)**			**8,302,677**	**6,091,344**	**2,130,097**	**-**	**-**	**(1,067)**	**-**	**-**	**82,303**	**-**	
73														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 12/31/2020			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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P03 projected by SWMBH**			
6	***Medicaid Specialty Services***			*HCC%*	80.5%	77.0%	79.0%	78.3%	80.0%	80.5%	81.6%	82.6%	82.4%
7	Subcontract Revenue		58,964,149	3,538,144	55,426,005	2,403,569	11,023,210	3,081,183	10,018,771	2,838,044	17,070,785	3,674,573	5,315,869
8	Incentive Payment Revenue		167,269	104,632	62,636	4,765	7,942	15,885	28,063	1,215	-	4,765	-
9	**Contract Revenue**		**59,131,417**	**3,642,776**	**55,488,641**	**2,408,334**	**11,031,153**	**3,097,068**	**10,046,834**	**2,839,259**	**17,070,785**	**3,679,338**	**5,315,869**
10													
11	External Provider Cost		36,575,354	922,687	35,652,666	1,227,030	7,264,374	1,541,172	6,855,111	1,537,536	11,658,428	2,737,333	2,831,684
12	Internal Program Cost		13,098,344	-	13,098,344	746,932	2,513,800	762,636	2,912,889	839,536	2,155,475	1,248,930	1,918,146
13	SSI Reimb, 1st/3rd Party Cost Offset		(185,831)	-	(185,831)	(722)	(41,074)	(12,623)	(21,112)	(10,754)	(71,173)	(12,859)	(15,513)
14	Insurance Provider Assessment Withhold (IPA)		813,433	813,433	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		25,004	25,004	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**50,326,305**	**1,761,125**	**48,565,180**	**1,973,239**	**9,737,100**	**2,291,184**	**9,746,887**	**2,366,318**	**13,742,729**	**3,973,404**	**4,734,317**
17	**Medical Loss Ratio (HCC % of Revenue)**		**85.1%**	**48.3%**	**87.5%**	**81.9%**	**88.3%**	**74.0%**	**97.0%**	**83.3%**	**80.5%**	**108.0%**	**89.1%**
18													
19	**Managed Care Administration**		**5,128,610**	**1,452,469**	**3,676,141**	**214,853**	**751,940**	**194,195**	**650,924**	**215,284**	**1,139,459**	**219,113**	**290,373**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.2%**	**2.6%**	**6.6%**	**9.8%**	**7.2%**	**7.8%**	**6.3%**	**8.3%**	**7.7%**	**5.2%**	**5.8%**
21													
22	**Contract Cost**		**55,454,915**	**3,213,594**	**52,241,321**	**2,188,092**	**10,489,040**	**2,485,379**	**10,397,811**	**2,581,603**	**14,882,189**	**4,192,517**	**5,024,690**
23	**Net before Settlement**		**3,676,502**	**429,182**	**3,247,320**	**220,243**	**542,112**	**611,688**	**(350,977)**	**257,657**	**2,188,597**	**(513,178)**	**291,179**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		2,414,842	5,662,162	(3,247,320)	(220,243)	(542,112)	(611,688)	350,977	(257,657)	(2,188,597)	513,178	(291,179)
28	**Net after Settlement**		**6,091,344**	**6,091,344**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		161,806	161,806	161,806	8,583	31,139	9,264	30,656	9,621	42,372	13,350	16,821
32	Revenue PMPM		$ 121.82	$ 7.50	$ 114.31	$ 93.53	$ 118.09	$ 111.44	$ 109.24	$ 98.37	$ 134.29	$ 91.87	$ 105.34
33	Expense PMPM		$ 114.24	$ 6.62	$ 107.62	$ 84.98	$ 112.28	$ 89.43	$ 113.06	$ 89.44	$ 117.08	$ 104.68	$ 99.57
34	Margin PMPM		$ 7.57	$ 0.88	$ 6.69	$ 8.55	$ 5.80	$ 22.01	$ (3.82)	$ 8.93	$ 17.22	$ (12.81)	$ 5.77
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		161,806	161,806	161,806	8,583	31,139	9,264	30,656	9,621	42,372	13,350	16,821
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		13,399	13,399	13,399	1,062	2,167	827	2,743	1,071	3,249	1,128	1,152
43	% Variance - Fav / (Unfav)		9.0%	9.0%	9.0%	14.1%	7.5%	9.8%	9.8%	12.5%	8.3%	9.2%	7.4%
44													
45	**Contract Revenue before settlement**												
46	Actual		59,131,417	3,642,776	55,488,641	2,408,334	11,031,153	3,097,068	10,046,834	2,839,259	17,070,785	3,679,338	5,315,869
47	Budget		51,017,212	4,310,510	46,706,703	1,849,094	9,299,035	2,497,307	8,570,776	2,438,090	14,441,302	3,135,243	4,475,856
48	Variance - Favorable / (Unfavorable)		8,114,205	(667,733)	8,781,938	559,240	1,732,118	599,760	1,476,058	401,169	2,629,483	544,096	840,014
49	% Variance - Fav / (Unfav)		15.9%	-15.5%	18.8%	30.2%	18.6%	24.0%	17.2%	16.5%	18.2%	17.4%	18.8%
50													
51	**Healthcare Cost**												
52	Actual		50,326,305	1,761,125	48,565,180	1,973,239	9,737,100	2,291,184	9,746,887	2,366,318	13,742,729	3,973,404	4,734,317
53	Budget		47,662,309	2,582,511	45,079,798	1,944,044	9,113,266	2,389,803	8,036,189	2,314,194	13,663,877	3,242,940	4,375,485
54	Variance - Favorable / (Unfavorable)		(2,663,996)	821,386	(3,485,382)	(29,195)	(623,835)	98,619	(1,710,698)	(52,125)	(78,852)	(730,464)	(358,831)
55	% Variance - Fav / (Unfav)		-5.6%	31.8%	-7.7%	-1.5%	-6.8%	4.1%	-21.3%	-2.3%	-0.6%	-22.5%	-8.2%
56													
57	**Managed Care Administration**												
58	Actual		5,128,610	1,452,469	3,676,141	214,853	751,940	194,195	650,924	215,284	1,139,459	219,113	290,373
59	Budget		5,146,441	1,741,982	3,404,459	144,763	679,322	199,578	579,984	177,322	1,148,632	202,481	272,377
60	Variance - Favorable / (Unfavorable)		17,831	289,513	(271,683)	(70,089)	(72,618)	5,383	(70,940)	(37,963)	9,173	(16,632)	(17,996)
61	% Variance - Fav / (Unfav)		0.3%	16.6%	-8.0%	-48.4%	-10.7%	2.7%	-12.2%	-21.4%	0.8%	-8.2%	-6.6%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 12/31/2020			**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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P03 projected by SWMBH**			
62													
63	**Total Contract Cost**												
64	Actual		55,454,915	3,213,594	52,241,321	2,188,092	10,489,040	2,485,379	10,397,811	2,581,603	14,882,189	4,192,517	5,024,690
65	Budget		52,808,750	4,324,493	48,484,257	2,088,807	9,792,587	2,589,381	8,616,173	2,491,515	14,812,509	3,445,421	4,647,863
66	Variance - Favorable / (Unfavorable)		(2,646,165)	1,110,899	(3,757,064)	(99,285)	(696,453)	104,001	(1,781,638)	(90,087)	(69,680)	(747,096)	(376,827)
67	% Variance - Fav / (Unfav)		-5.0%	25.7%	-7.7%	-4.8%	-7.1%	4.0%	-20.7%	-3.6%	-0.5%	-21.7%	-8.1%
68													
69	**Net before Settlement**												
70	Actual		3,676,502	429,182	3,247,320	220,243	542,112	611,688	(350,977)	257,657	2,188,597	(513,178)	291,179
71	Budget		(1,791,537)	(13,983)	(1,777,554)	(239,713)	(493,553)	(92,074)	(45,397)	(53,425)	(371,207)	(310,178)	(172,007)
72	Variance - Favorable / (Unfavorable)		5,468,040	443,166	5,024,874	459,956	1,035,665	703,762	(305,580)	311,082	2,559,803	(203,000)	463,187
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 12/31/2020			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	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5										P03 projected by SWMBH			
75	***Healthy Michigan Plan***			*HCC%*	8.8%	13.7%	8.0%	9.7%	10.9%	7.3%	7.6%	9.0%	7.7%
76	**Contract Revenue**		**10,650,484**	**2,052,519**	**8,597,965**	**430,203**	**1,733,470**	**414,775**	**1,579,807**	**473,826**	**2,468,019**	**670,193**	**827,672**
77													
78	External Provider Cost		4,757,113	1,952,256	2,804,857	161,972	547,130	130,446	552,536	42,271	997,047	163,587	209,867
79	Internal Program Cost		2,511,209	-	2,511,209	190,146	440,329	151,919	776,040	173,601	274,814	270,661	233,699
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**7,268,322**	**1,952,256**	**5,316,066**	**352,118**	**987,459**	**282,365**	**1,328,576**	**215,872**	**1,271,861**	**434,248**	**443,566**
82	**Medical Loss Ratio (HCC % of Revenue)**		**68.2%**	**95.1%**	**61.8%**	**81.8%**	**57.0%**	**68.1%**	**84.1%**	**45.6%**	**51.5%**	**64.8%**	**53.6%**
83													
84	**Managed Care Administration**		**618,470**	**214,970**	**403,501**	**38,340**	**76,256**	**23,933**	**88,726**	**19,640**	**105,455**	**23,947**	**27,206**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**7.8%**	**2.7%**	**5.1%**	**9.8%**	**7.2%**	**7.8%**	**6.3%**	**8.3%**	**7.7%**	**5.2%**	**5.8%**
86													
87	**Contract Cost**		**7,886,793**	**2,167,226**	**5,719,567**	**390,458**	**1,063,715**	**306,298**	**1,417,302**	**235,512**	**1,377,315**	**458,194**	**470,772**
88	**Net before Settlement**		**2,763,691**	**(114,707)**	**2,878,399**	**39,745**	**669,755**	**108,477**	**162,505**	**238,314**	**1,090,704**	**211,998**	**356,900**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(633,595)	2,244,804	(2,878,399)	(39,745)	(669,755)	(108,477)	(162,505)	(238,314)	(1,090,704)	(211,998)	(356,900)
93	**Net after Settlement**		**2,130,097**	**2,130,097**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		64,147	64,147	64,147	3,216	12,946	3,086	11,617	3,885	18,170	4,999	6,227
97	Revenue PMPM		$ 55.34	$ 10.67	$ 44.68	$ 44.59	$ 44.63	$ 44.80	$ 45.33	$ 40.65	$ 45.28	$ 44.69	$ 44.31
98	Expense PMPM		40.98	11.26	29.72	40.47	27.39	33.08	40.67	20.21	25.27	30.55	25.20
99	Margin PMPM		$ 14.36	$ (0.60)	$ 14.96	$ 4.12	$ 17.24	$ 11.72	$ 4.66	$ 20.45	$ 20.01	$ 14.14	$ 19.10
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		64,147	64,147	64,147	3,216	12,946	3,086	11,617	3,885	18,170	4,999	6,227
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		12,577	12,577	12,577	704	2,536	655	2,449	910	3,118	1,082	1,124
108	% Variance - Fav / (Unfav)		24.4%	24.4%	24.4%	28.0%	24.4%	26.9%	26.7%	30.6%	20.7%	27.6%	22.0%
109													
110	**Contract Revenue before settlement**												
111	Actual		10,650,484	2,052,519	8,597,965	430,203	1,733,470	414,775	1,579,807	473,826	2,468,019	670,193	827,672
112	Budget		7,256,754	1,254,050	6,002,704	289,814	1,211,139	281,307	1,074,141	342,077	1,762,403	454,215	587,608
113	Variance - Favorable / (Unfavorable)		3,393,730	798,469	2,595,261	140,390	522,331	133,468	505,666	131,749	705,616	215,978	240,064
114	% Variance - Fav / (Unfav)		46.8%	63.7%	43.2%	48.4%	43.1%	47.4%	47.1%	38.5%	40.0%	47.5%	40.9%
115													
116	**Healthcare Cost**												
117	Actual		7,268,322	1,952,256	5,316,066	352,118	987,459	282,365	1,328,576	215,872	1,271,861	434,248	443,566
118	Budget		6,281,931	1,453,257	4,828,674	345,188	722,113	316,457	1,190,950	245,609	1,282,070	291,328	434,959
119	Variance - Favorable / (Unfavorable)		(986,391)	(499,000)	(487,392)	(6,930)	(265,346)	34,092	(137,626)	29,737	10,209	(142,920)	(8,608)
120	% Variance - Fav / (Unfav)		-15.7%	-34.3%	-10.1%	-2.0%	-36.7%	10.8%	-11.6%	12.1%	0.8%	-49.1%	-2.0%
121													
122	**Managed Care Administration**												
123	Actual		618,470	214,970	403,501	38,340	76,256	23,933	88,726	19,640	105,455	23,947	27,206
124	Budget		601,414	237,640	363,774	25,704	53,828	26,428	85,953	18,819	107,775	18,190	27,077
125	Variance - Favorable / (Unfavorable)		(17,056)	22,671	(39,727)	(12,635)	(22,428)	2,495	(2,773)	(820)	2,321	(5,757)	(129)
126	% Variance - Fav / (Unfav)		-2.8%	9.5%	-10.9%	-49.2%	-41.7%	9.4%	-3.2%	-4.4%	2.2%	-31.6%	-0.5%
127													
128	**Total Contract Cost**												
129	Actual		7,886,793	2,167,226	5,719,567	390,458	1,063,715	306,298	1,417,302	235,512	1,377,315	458,194	470,772
130	Budget		6,883,345	1,690,897	5,192,448	370,893	775,941	342,885	1,276,903	264,428	1,389,845	309,518	462,035
131	Variance - Favorable / (Unfavorable)		(1,003,447)	(476,329)	(527,118)	(19,565)	(287,774)	36,588	(140,399)	28,916	12,530	(148,676)	(8,737)

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 12/31/2020			**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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P03 projected by SWMBH**			
132	% Variance - Fav / (Unfav)		-14.6%	-28.2%	-10.2%	-5.3%	-37.1%	10.7%	-11.0%	10.9%	0.9%	-48.0%	-1.9%
133													
134	**Net before Settlement**												
135	Actual		2,763,691	(114,707)	2,878,399	39,745	669,755	108,477	162,505	238,314	1,090,704	211,998	356,900
136	Budget		373,409	(436,847)	810,256	(81,079)	435,197	(61,579)	(202,762)	77,649	372,558	144,697	125,573
137	Variance - Favorable / (Unfavorable)		2,390,283	322,140	2,068,143	120,824	234,557	170,056	365,267	160,665	718,146	67,301	231,327
138													
139													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 12/31/2020			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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										P03 projected by SWMBH			
140	**Autism Specialty Services**			*HCC%*	5.9%	5.3%	9.1%	3.4%	3.8%	4.9%	6.6%	4.8%	4.8%
141	**Contract Revenue**		**5,748,880**	**76,658**	**5,672,222**	**298,395**	**1,078,646**	**327,502**	**1,053,997**	**215,201**	**1,650,509**	**466,237**	**581,734**
142													
143	External Provider Cost		3,439,090	-	3,439,090	-	1,123,569	99,020	463,462	143,610	1,114,505	223,671	271,254
144	Internal Program Cost		146,454	-	146,454	136,532	1,555	-	-	647	-	5,132	2,588
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**3,585,544**	**-**	**3,585,544**	**136,532**	**1,125,124**	**99,020**	**463,462**	**144,256**	**1,114,505**	**228,803**	**273,841**
147	**Medical Loss Ratio (HCC % of Revenue)**		**62.4%**	**0.0%**	**63.2%**	**45.8%**	**104.3%**	**30.2%**	**44.0%**	**67.0%**	**67.5%**	**49.1%**	**47.1%**
148													
149	**Managed Care Administration**		**382,089**	**106,047**	**276,042**	**14,866**	**86,887**	**8,393**	**30,951**	**13,124**	**92,408**	**12,617**	**16,796**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.6%**	**2.7%**	**7.0%**	**9.8%**	**7.2%**	**7.8%**	**6.3%**	**8.3%**	**7.7%**	**5.2%**	**5.8%**
151													
152	**Contract Cost**		**3,967,632**	**106,047**	**3,861,585**	**151,398**	**1,212,010**	**107,413**	**494,413**	**157,380**	**1,206,913**	**241,420**	**290,637**
153	**Net before Settlement**		**1,781,248**	**(29,389)**	**1,810,636**	**146,996**	**(133,364)**	**220,089**	**559,584**	**57,821**	**443,597**	**224,817**	**291,097**
154	Contract Settlement / Redistribution		(1,781,248)	29,389	(1,810,636)	(146,996)	133,364	(220,089)	(559,584)	(57,821)	(443,597)	(224,817)	(291,097)
155	**Net after Settlement**		**-**	**(0)**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	**SUD Block Grant Treatment**			*HCC%*	0.2%	0.7%	0.5%	0.5%	0.0%	0.9%	0.0%	0.3%	-0.2%
159	**Contract Revenue**		**1,356,696**	**1,198,459**	**158,236**	**9,439**	**48,824**	**4,711**	**-**	**36,909**	**27,989**	**19,742**	**10,623**
160													
161	External Provider Cost		1,175,964	1,175,964	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		121,937	-	121,937	18,900	55,746	15,899	-	25,049	522	15,223	(9,401)
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**1,297,901**	**1,175,964**	**121,937**	**18,900**	**55,746**	**15,899**	**-**	**25,049**	**522**	**15,223**	**(9,401)**
165	**Medical Loss Ratio (HCC % of Revenue)**		**95.7%**	**98.1%**	**77.1%**	**200.2%**	**114.2%**	**337.5%**	**0.0%**	**67.9%**	**1.9%**	**77.1%**	**-88.5%**
166													
167	**Managed Care Administration**		**38,973**	**38,973**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**2.9%**	**2.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**1,336,874**	**1,214,938**	**121,937**	**18,900**	**55,746**	**15,899**	**-**	**25,049**	**522**	**15,223**	**(9,401)**
171	**Net before Settlement**		**19,821**	**(16,478)**	**36,300**	**(9,461)**	**(6,922)**	**(11,188)**	**-**	**11,860**	**27,468**	**4,519**	**20,024**
172	Contract Settlement		-	36,300	(36,300)	9,461	6,922	11,188	-	(11,860)	(27,468)	(4,519)	(20,024)
173	**Net after Settlement**		**19,821**	**19,821**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 12/31/2020			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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P03 projected by SWMBH**			
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		76,720,208	6,865,780	69,854,428	3,141,606	13,884,150	3,828,171	12,652,576	3,563,980	21,217,303	4,830,745	6,735,898
178	Incentive Payment Revenue		167,269	104,632	62,636	4,765	7,942	15,885	28,063	1,215	-	4,765	-
179	**Contract Revenue**		**76,887,476**	**6,970,412**	**69,917,064**	**3,146,371**	**13,892,093**	**3,844,056**	**12,680,639**	**3,565,195**	**21,217,303**	**4,835,510**	**6,735,898**
180													
181	External Provider Cost		45,947,521	4,050,908	41,896,613	1,389,002	8,935,072	1,770,638	7,871,109	1,723,417	13,769,979	3,124,591	3,312,805
182	Internal Program Cost		15,877,944	-	15,877,944	1,092,510	3,011,431	930,454	3,688,929	1,038,833	2,430,810	1,539,946	2,145,031
183	SSI Reimb, 1st/3rd Party Cost Offset		(185,831)	-	(185,831)	(722)	(41,074)	(12,623)	(21,112)	(10,754)	(71,173)	(12,859)	(15,513)
184	Insurance Provider Assessment Withhold (IPA)		813,433	813,433	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		25,004	25,004	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**62,478,071**	**4,889,345**	**57,588,726**	**2,480,790**	**11,905,429**	**2,688,469**	**11,538,925**	**2,751,495**	**16,129,617**	**4,651,678**	**5,442,323**
187	**Medical Loss Ratio (HCC % of Revenue)**		**81.3%**	**70.1%**	**82.4%**	**78.8%**	**85.7%**	**69.9%**	**91.0%**	**77.2%**	**76.0%**	**96.2%**	**80.8%**
188													
189	**Managed Care Administration**		**6,168,143**	**1,812,459**	**4,355,683**	**268,058**	**915,083**	**226,521**	**770,601**	**248,048**	**1,337,322**	**255,676**	**334,375**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.0%**	**2.6%**	**6.3%**	**9.8%**	**7.1%**	**7.8%**	**6.3%**	**8.3%**	**7.7%**	**5.2%**	**5.8%**
191													
192	**Contract Cost**		**68,646,214**	**6,701,805**	**61,944,409**	**2,748,848**	**12,820,512**	**2,914,989**	**12,309,527**	**2,999,544**	**17,466,938**	**4,907,354**	**5,776,698**
193	**Net before Settlement**		**8,241,263**	**268,608**	**7,972,655**	**397,523**	**1,071,581**	**929,066**	**371,112**	**565,652**	**3,750,365**	**(71,844)**	**959,200**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		-	7,972,655	(7,972,655)	(397,523)	(1,071,581)	(929,066)	(371,112)	(565,652)	(3,750,365)	71,844	(959,200)
198	**Net after Settlement**		**8,241,263**	**8,241,263**	**(0)**	**(0)**	**-**	**-**	**(0)**	**-**	**0**	**0**	**(0)**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 12/31/2020			**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**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5										**P03 projected by SWMBH**			
201	***State General Fund Services***			*HCC%*	4.6%	3.2%	3.4%	8.1%	5.3%	6.4%	4.2%	3.2%	5.3%
202	**Contract Revenue**				**2,917,049**	**198,312**	**504,819**	**187,884**	**492,384**	**152,946**	**938,145**	**185,975**	**256,584**
203													
204	External Provider Cost				1,221,308	43,559	122,362	44,063	185,704	122,147	490,720	105,907	106,846
205	Internal Program Cost				1,560,774	39,437	297,074	192,642	462,898	66,847	253,742	50,028	198,107
206	SSI Reimb, 1st/3rd Party Cost Offset				(35,027)	-	-	-	-	-	(35,027)	-	-
207	**Total Healthcare Cost**				**2,747,056**	**82,996**	**419,436**	**236,704**	**648,602**	**188,994**	**709,435**	**155,936**	**304,953**
208	**Medical Loss Ratio (HCC % of Revenue)**				**94.2%**	**41.9%**	**83.1%**	**126.0%**	**131.7%**	**123.6%**	**75.6%**	**83.8%**	**118.9%**
209													
210	**Managed Care Administration**				**231,460**	**10,163**	**36,218**	**22,504**	**47,947**	**18,782**	**65,609**	**9,613**	**20,624**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.9%**	**7.9%**	**8.7%**	**6.9%**	**9.0%**	**8.5%**	**5.8%**	**6.3%**
212													
213	**Contract Cost**				**2,978,516**	**93,159**	**455,654**	**259,208**	**696,548**	**207,776**	**775,044**	**165,549**	**325,578**
214	**Net before Settlement**				**(61,466)**	**105,153**	**49,165**	**(71,324)**	**(204,164)**	**(54,830)**	**163,101**	**20,426**	**(68,994)**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(323,090)	(103,190)	(44,946)	-	-	-	(159,677)	(15,278)	-
218	**Net after Settlement**				**(384,557)**	**1,963**	**4,219**	**(71,324)**	**(204,164)**	**(54,830)**	**3,424**	**5,148**	**(68,994)**
219													

Southwest Michigan
BEHAVIORAL HEALTH

FY 20 Customer Service Annual Report

February 12, 2021

SWMBH Customer Services Office Responsibilities

- Welcome and orient individuals to services and benefits available and to the provider network.
- Develop and provide information to members about how to access mental health, primary health, and other community services.
- Provide information to members about how to access the various Rights processes.
- Help individuals with problems and questions regarding benefits.
- Assist people with and oversee local complaint and grievance processes.
- Track and report patterns of problem areas for the organization.

SWMBH Customer Services Office Responsibilities

- Maintain Policies and Procedures that meet and exceed all expectations set.
- Manage Regional Customer Services Committee Charter and membership to represent all of SWMBH member counties.
- Manage and Distribute the SWMBH Medicaid and MI Health Link Customer Handbooks.
- Update regional documents to communicate with customers regarding SWMBH-level service decisions.
- Maintain marketing and member related communications and brochures

SWMBH Customer Services Activities

Updated and/or distributed SWMBH network customer/stakeholder educational materials.

- 3 Members Newsletters
  - Provided electronic version via Facebook and website
- 2 Handbooks
  - Both Medicaid and MHL handbooks were updated
- Informational materials- SWMBH general, Substance Use Disorder, Recovery Oriented Systems of Care, MI Health Link, VA Navigator, Complex Case Management, and Autism Services Brochures
- SWMBH and Recovery Oriented Systems of Care Marketing Materials
- MI Health Link Welcome Packet and orientation materials

SWMBH Customer Services Activities

- NCQA reaccreditation preparation
  - Lead to the implementation of a new process
    - Member notification of denial of claims
- MHL reporting requirements-ICO audits
  - Lead to the implementation of a new process
    - Member notification of denial of claims
- Created and implemented a new regional G&A reporting tool
  - Many different categories within each system being reported
  - Agreed to main categories to be reported out as region, created crosswalk to capture/define the various categories

SWMBH Customer Services Activities

- Customer Advisory Committee (CAC) convened 10 times in FY 20
- Currently meeting via phone or GoTo Meeting since May 2020
- Increased stipend rate for participation effective FY21
  - Two rates now- $40 for in-person meeting, $25 for virtual participation
  - Currently paying our members the in-person rate until restrictions have been lifted
- Added 2 new members in November 2019
- Still need representation from Barry, Berrien and Branch Counties
- Seated county representatives on operating committees

SWMBH Customer Services Activities

- October 2019- September 2020 Customer/Member Services fielded 2482 phone calls on the designated lines
  - MA Customer Service line received 1419 calls
  - MHL Member Service line received 1063 calls

- Completed follow up calls
  - Members discharged from Substance Use Disorder residential settings = 797
  - Calls to members who were discharged from Inpatient Psychiatric setting was transferred to Integrated Health for FY 20. This task has since been returned to Customer Service as of Nov. 2020

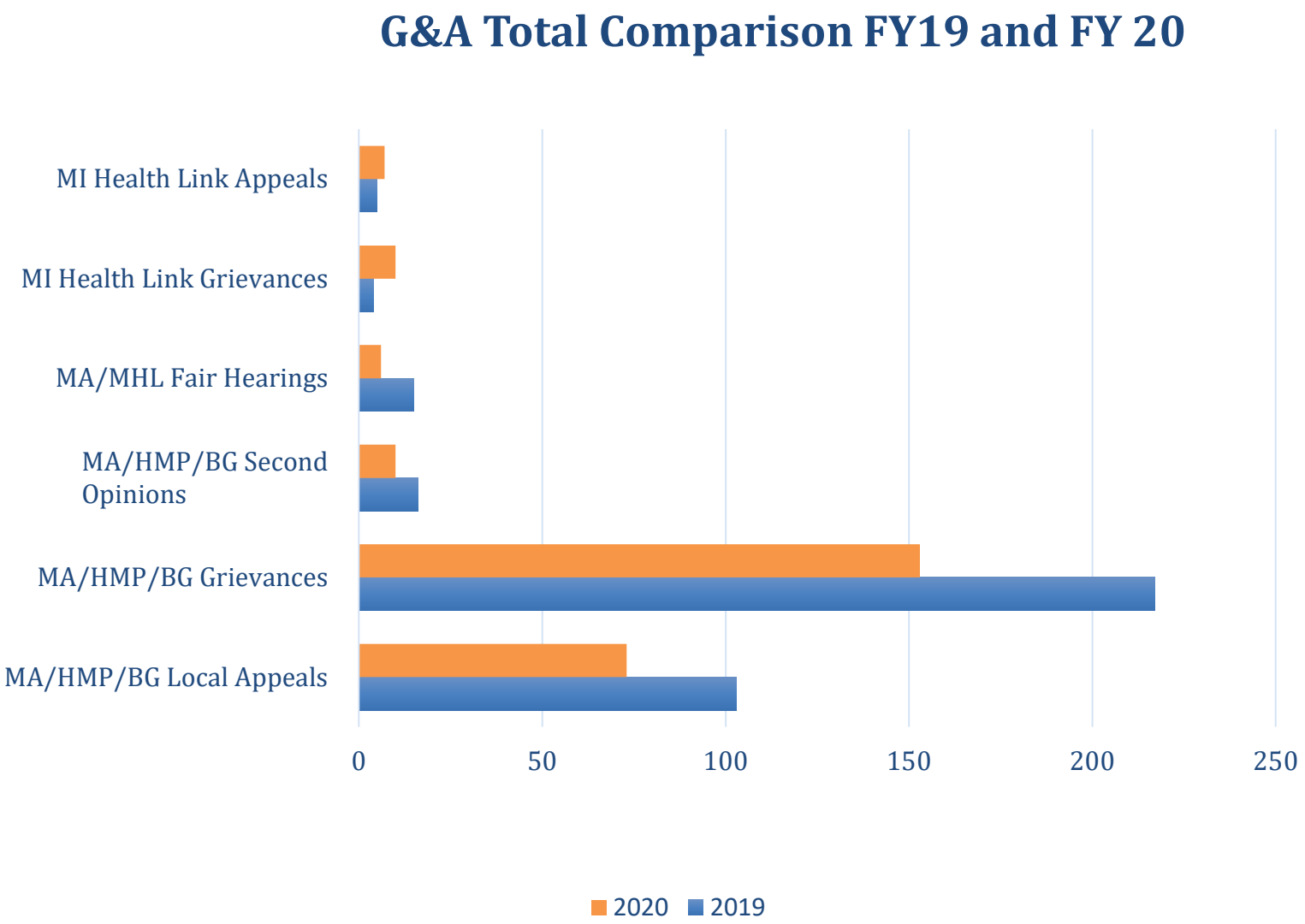
While call volume has decreased this year, the intensity and complexity of the calls has increased due to heightened challenges due to COVID 19 restriction

SWMBH Customer Services Activities

SWMBH and 8 affiliate CMH providers managed and/or provided oversite of 249 Medicaid and MI Health Link Grievances, Appeals and 2nd Opinions

- MA/HMP/BG Local Appeals reported: 73
- MA/HMP/BG Grievances reported: 143
- MA/HMP/BG Second Opinions reported: 10
- MA/MHL Fair Hearings reported: 6
- MI Health Link Grievances reported: 10
- MI Health Link Appeals reported: 7

SWMBH Customer Services Activities

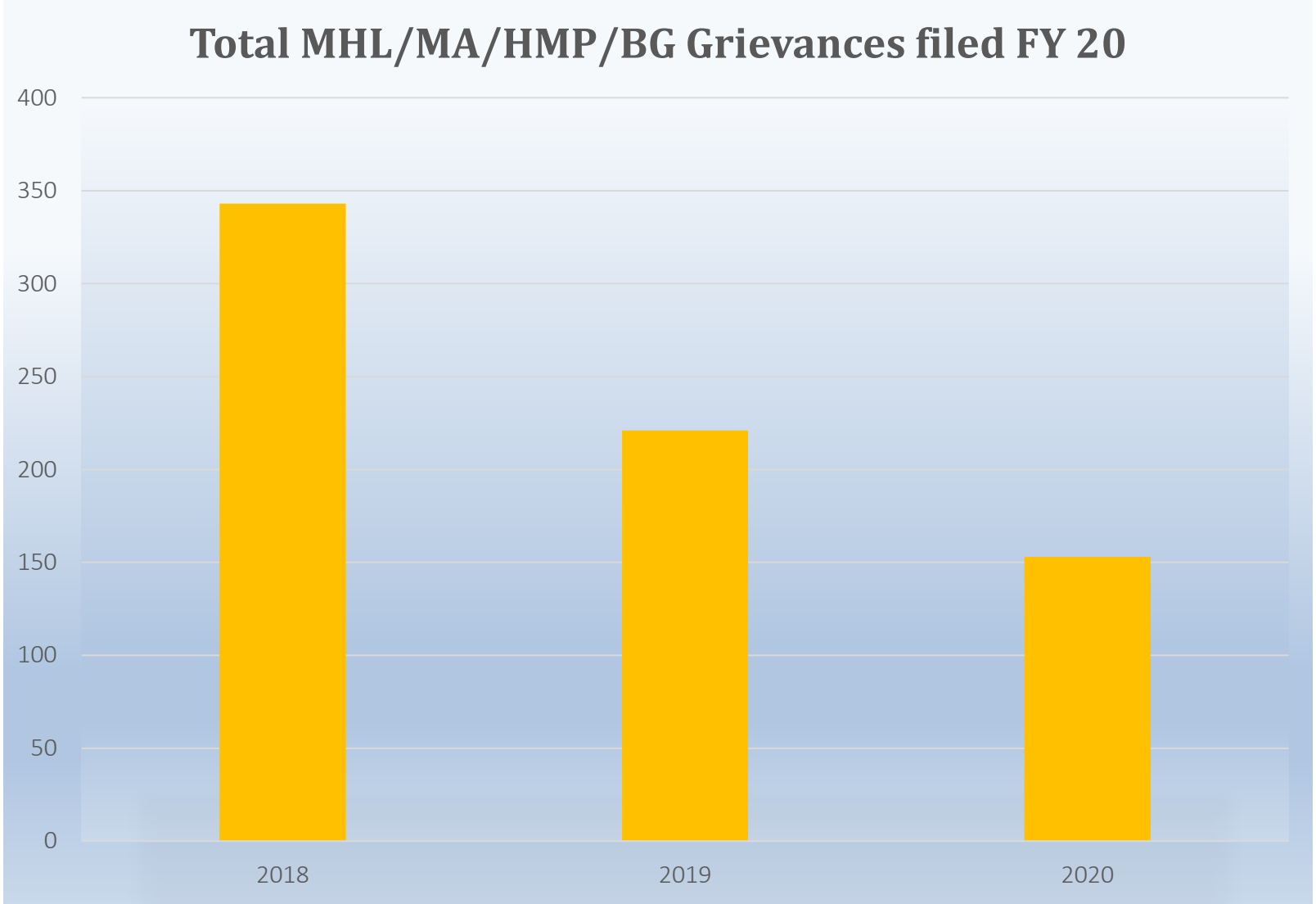


SWMBH Customer Services Activities

SWMBH REGIONAL GRIEVANCE TOTALS (*MHL/MA/HMP/BG*)
FY 2019 - 2020

Category	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Access to Services	6	2	3	5	16
Attitude and Service	26	19	20	19	84
Quality of Care	16	14	6	14	50
Quality of Office Site	2	1	0	0	3
Grand Total	**50**	**36**	**29**	**38**	**153**

SWMBH Customer Services Activities

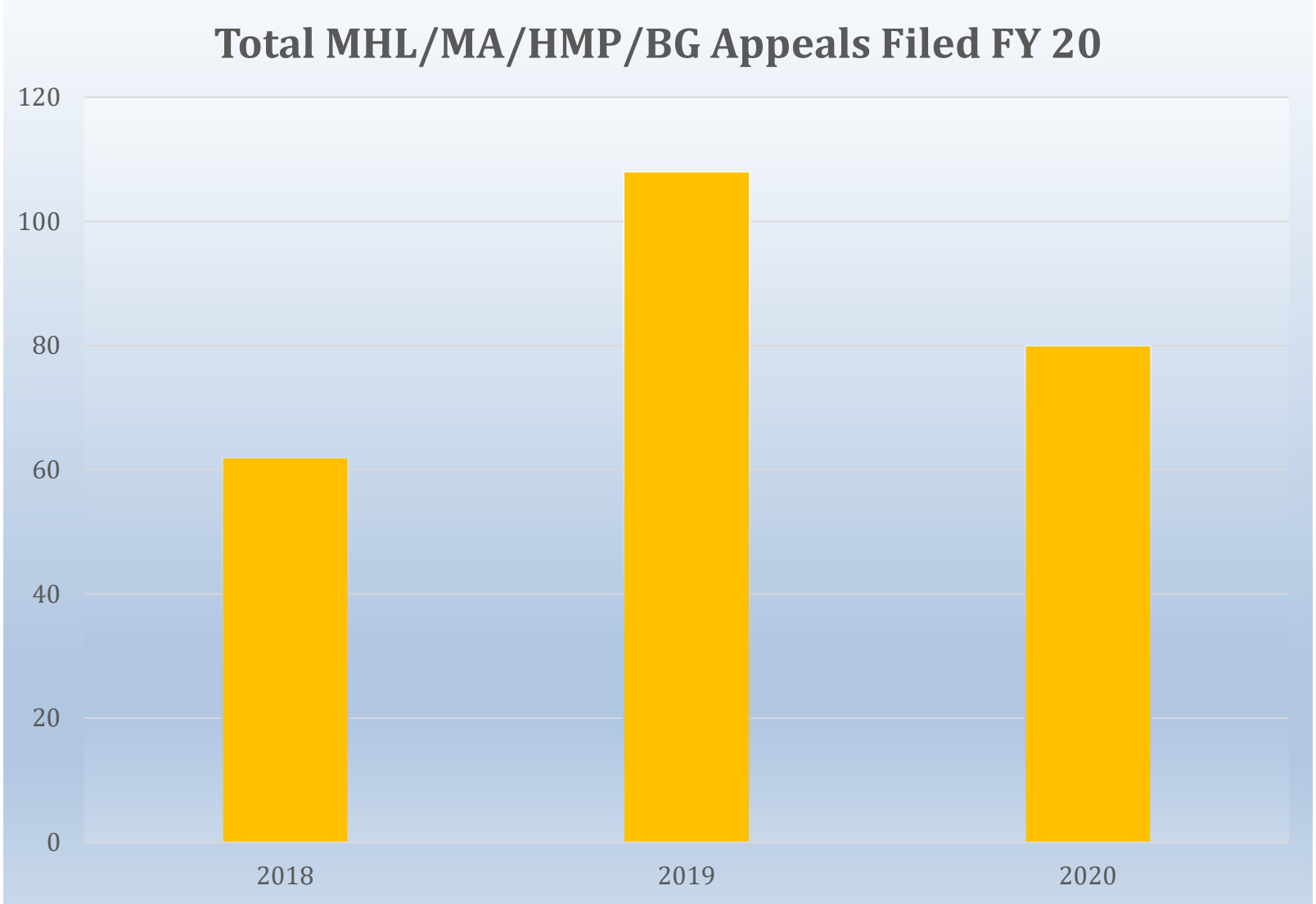


SWMBH Customer Services Activities

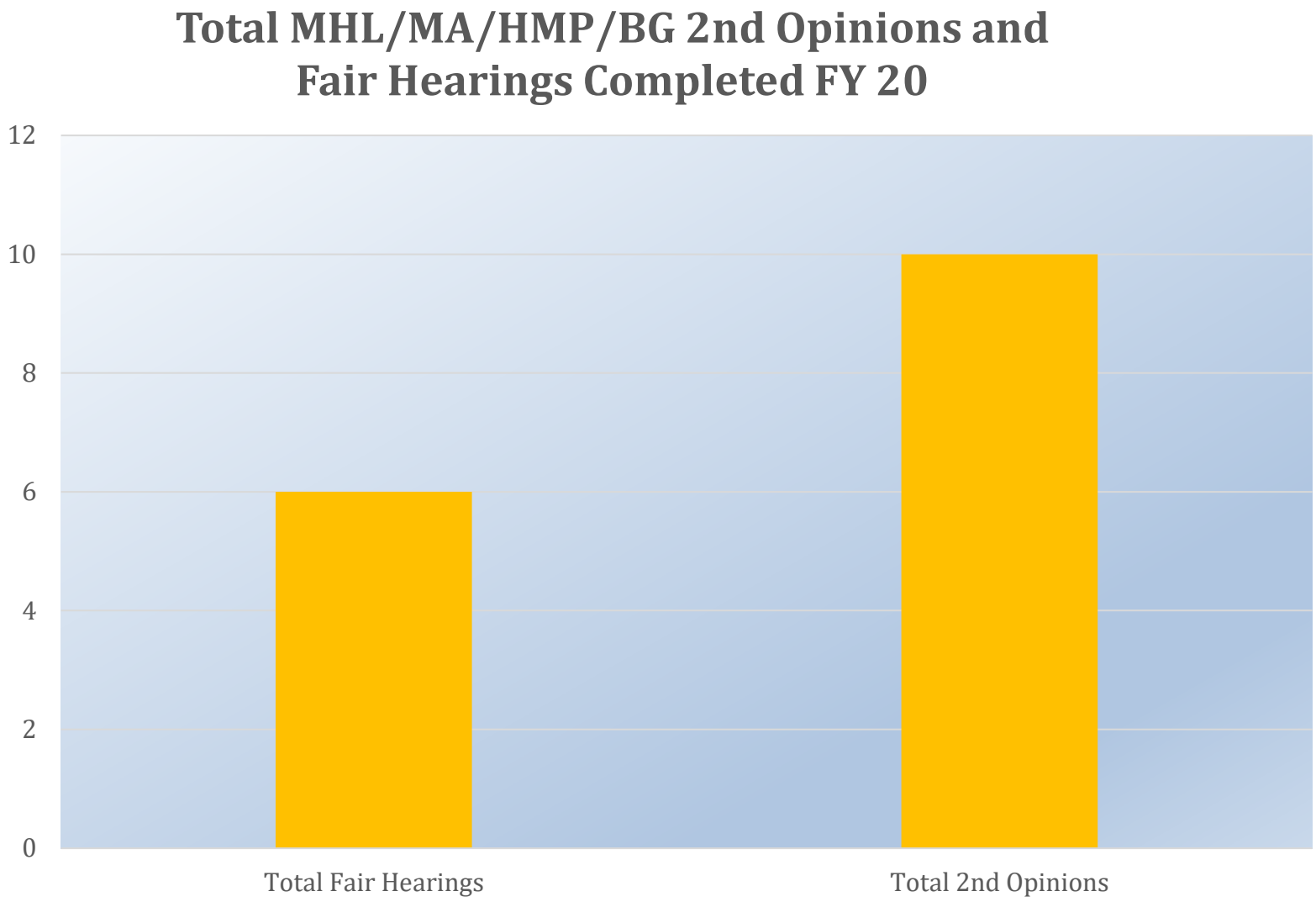
SWMBH REGIONAL APPEAL TOTALS (*MHL, MA, HMP, BG*)
FY 2019-2020

Category	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Affirmed	9	13	9	7	38
Reversed	10	10	3	6	29
Split Resolution	1	1		1	3
Withdrawn/Dismissed	1	4	2	3	10
Grand Total	**21**	**28**	**14**	**17**	**80**

SWMBH Customer Services Activities



SWMBH Customer Services Activities



Community and Advocacy Events

- SWMBH participated in very few community events region-wide due to COVID restrictions. However, we were able to participate in a few during the fall 2019:
  - Michigan CIT Conference,
  - VA Stand Downs (St. Joseph, Van Buren, and Calhoun Counties),
  - Trunk or Treat (pumpkins donation).
  - Portage Christmas Tree display
- SMMBH continues to provide training, education and informational materials virtually when possible

Looking to FY 21

- Complete the NCQA Re-Accreditation successfully for Utilization Management and Rights and Responsibilities.
- Advance Directives – Create and update educational and training materials related to Advance Directives.
- Mediation Process: Ensure region is following mediation practices according to the Michigan Mental Health Code.
- Independent Facilitation: Collaborate and participate with TBD Solutions and Building Better Lives Project to increase awareness and availability of Independent Facilitators within the region by:
- Increase communication options to ensure access to customer service offices and functions throughout the region.

Southwest Michigan
BEHAVIORAL HEALTH

Questions

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

Date Prepared: December 18, 2020
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	
SUD detox and SUD residential per diem codes billed overlapping by three (3) different providers	2020-01	x		x		x		Recoupments totaling $9,645.34
Provider submitted an Authorization request for DOS while customer reported being incarcerated.	2020-02	X		X		X		Compliance reviewed for inappropriate use of Medicaid funds – no funds expended. Authorization request was denied.
Duplicate billing; Global billing rules not functioning appropriately	2020-03	X		X		X		Recoupments totaling $3,016.18; Global billing rules corrected
CMH referral to SWMBH – CLS worker providing services to multiple customers at the same time then billing for each separately (increases hours worked)	2020-04	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. $931.42 reverted to CMH General Funds.
CMH referral to SWMBH – Self-D worker submitted timesheet and progress note for a DOS that customer was inpatient.	2020-05	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. Self-D arrangement terminated. $311.55 in improper payments.
CMH referral to SWMBH - Customer's commercial insurance terminated retroactively, making Medicaid responsible for multiple inpatient psych	2020-06	X		X			X	CMH referred to SWMBH; SWMBH referred to MI OIG. OIG found no improper

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

Train & Educate		Audit & Monitor			Report & Evaluate			
stays. Questions re: conflicts of interest.								action.
CMH referral to SWMBH – Self-D worker submitted timesheets with inaccurate times.	2020-07	X		X		X		CMH referred to SWMBH; SWMBH referred to MI OIG. Recoupment totaling $1,006.36. Self-D worker terminated.
OIG referral to SWMBH – anonymous complaint that an Autism provider was not appropriately qualified to perform service being delivered.	2020-08	X		X			X	Report sent to MI OIG. Initial allegations not substantiated. Documentation discrepancies identified and a recoupment totaling $2,305.00 is indicated.
Duplicate billing identified as part of MHL audit.	2020-09	X		X		X		Recoupment totaling $1,527.96. Duplicate billing unintentional.
CMH referral to SWMBH – Provider “recreated” documentation when it was requested by a CMH.	2020-10	X		X		X		CMH implemented a Corrective Action Plan for the provider.
CMH referral to SWMBH – subcontracted provider staff billing for services that did not occur. Customer was on a spenddown.	2020-11	X		X		X		CMH made referral to MI OIG and the implicated funds were GF due to spenddown not being met.
SUD provider notified SWMBH that it identified one of its staff submitting inappropriate documentation times (billing for longer services than were provided).	2020-12	X		X		X		SWMBH referred to MI OIG. Recoupment totaling $1,960.
CMH referral to SWMBH – staff completed an Assessment and Treatment Plan without making contact with the customer. Assessment and Treatment Plan were	2020-13	X		X		X		No recoupment indicated. Inappropriate documentation practices did not result in damage to

NOT billed to Medicaid, but subsequent services were.								Medicaid. MDHHS instruction that services to continue during COVID.
OIG referral to SWMBH – report that provider staff was billing for services not rendered.	2020-14	X		X			X	Allegations were not substantiated. Recoupment totaling $228.53 based on documentation deficiencies.
CMH referral to SWMBH – provider identified fraudulent billing but did not correct the claims.	2020-15	X		X			X	Referred to MI OIG. Provider corrected the billing during the course of CMH's compliance review, but without knowledge of the compliance review.
Total	**15**	**15**		**15**		**11**	**4**	

2. Privacy/Security Allegations/Reports

A total of thirty-one (31) incidents were reported to the SWMBH Breach Team in FY2020. 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 thirty-one (31) incidents reviewed, NONE were determined to be reportable.

3. Planned Audits

Audit	# Services/Claims Reviewed	Result/Progress	Recoupments
Medicaid Verification	1,800	Completed	54 payment adjustments ($24,654.49)
MI Health Link			
Quarter 1	240	Completed	2 recoupments ($51.10)
Quarter 2	239	Completed	None
Quarter 3	284	In-process	
Quarter 4	277	In-process	
SUD Block Grant Claims	219	Completed	1 recoupment ($54.00) 54 reallocations to Medicaid/HMP ($3,954.02)

SWMBH FY 2020 Program Integrity - Compliance Board Report
10/01/2019 – 09/30/2020

SUD Coordination of Benefits			
Quarter 1	30	Completed	None
Quarter 2	30	Completed	None
Quarter 3	30	Completed	None
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 10/01/2019 – 09/30/2020
Submitted December 14, 2020

Pursuant to MDHHS-SWMBH FY20 Contract
Section 6.4 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 County Community 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 County Community Mental Health Authority. The Quality Assessment and Performance Improvement Programs for PIHP Standards (Contract Attachment P 7.9.1) contains a requirement that PIHPs verify whether services reimbursed by Medicaid were actually furnished to enrollees by CMHSPs, contracted providers and subcontractors. To that end, SWMBH has conducted verification of Medicaid claims as detailed by the methodology outlined below, in conformity with the Medicaid Services Verification Technical Advisory (Contract Attachment P 6.4.1).

In conducting the verification of sampled Medicaid claims, SWMBH conducted the internal audit of CMHSP service encounters for each CMHSP, all respective county substance use disorder providers, and SWMBH reviewed claims from 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, 2019 and September 30, 2020. 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 (1,800) claims/encounters. 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.
    - Nine hundred sixty (960) unique dates of service reviewed in total for FY20;
    - Represented eight thousand fourteen (8,014) units and $298,450.35.
- Thirty (30) claims/encounters for 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 FY20;
    - Represented one hundred forty-seven (147) units and $4,013.33.

- Fifteen (15) claims/encounters for each of the top three hospital providers (by dollar volume) subcontracted with a Participant CMHSP, per quarter.
    - One hundred eighty (180) claims reviewed in total for FY20;
    - Represented seven hundred twenty-two (722) units and $683,836.67.
- Thirty (30) claims for each of the top three service providers (by dollar volume), stratified to remove the top three service providers from FY19, subcontracted with a Participant CMHSP, per quarter.*
    - Three-hundred sixty (300) claims reviewed in total for FY20;
    - Represented three thousand six hundred ninety-seven (3,697) units and $126,542.14.
    - * For quarter two, due to COVID-19 each top provider had a sample of 10 claims.
- Sixty (60) claims/encounters from a region-wide universe that was stratified to remove claims for services provided by any of the top three hospitals already reviewed, or by any of the top three external subcontracted providers already reviewed, per quarter.
    - Two-hundred forty (240) claims/encounters reviewed in total for FY20;
    - Represented one thousand five hundred fifty (1,550) units and $58,837.62.

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 97.11% encompassing all review questions.

Identified Deficiencies. Out of a total sample of one thousand eight hundred (1,800) claims/encounters reviewed, one thousand seven hundred forty-eight (1,748) 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 fifty-two (52) invalid claims:

- Was the person eligible for Medicaid coverage on the date of service reviewed? **1 deficiency**
- 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? **34 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed? **13 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer? **82 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **4 deficiencies**
- Was the appropriate amount paid (contract rate or less)? **30 deficiencies**

Verification Process:

Medicaid Verification was facilitated through site visits and/or through a remote desk review of each applicable provider, of relevant documents maintained within the electronic medical record used by all participant CMHSPs. The site visits and/or remote desk reviews were scheduled between January 2020 and December 2020. 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 2020, 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.

In 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.

With regard to the deficiencies noted regarding documentation on file to support that the service was provided, many providers struggled 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. SWMBH has been working and will continue to work with CMHSPs and sub-contracted providers to ensure adherence to all MDHHS clinical records policies and requirements.

With regard to the deficiencies noted for the appropriate amount paid (contracted rate or less), SWMBH identified claims/encounters which were paid appropriately (contracted rate or less) but which did not use the required/appropriate place of service code. All disallowed/inappropriate place of service codes were corrected by the provider following the claim review.

In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative documentation review process, designed to provide ongoing feedback to both participant CMHSPs and external service providers in order to continue improving documentation and claims submission efforts.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in the area of Medicaid fraud and abuse prevention. In Fiscal Year 2021, 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, and service documentation standards. Additionally, SWMBH will be closely monitoring the reporting of in-home Community Living Support claims following the transition of the per diem code to the per unit code.

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, treatment planning timeliness, and place of service codes. 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 97.11% 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 fifty-two (52) claims/encounters identified as invalid represent a total of five hundred fifty (550) units and resulted in payment adjustments totaling $24,654.49. 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.

COMMUNITY MENTAL HEALTH ASSOCIATION

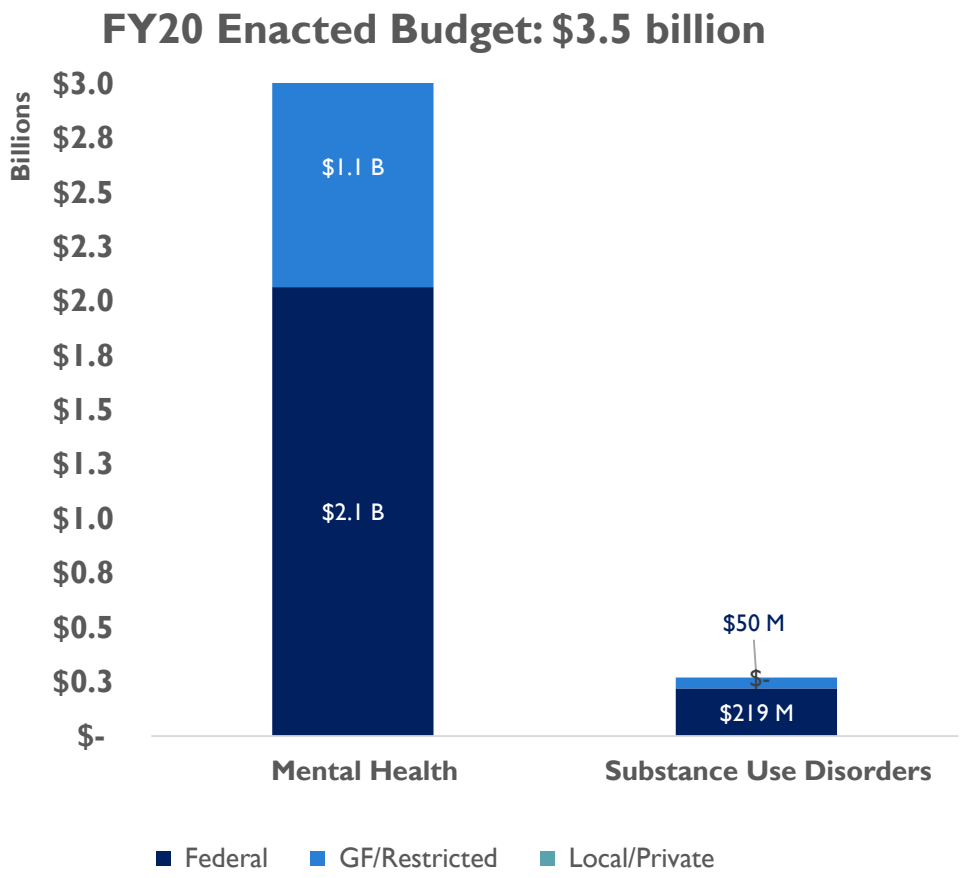
Improving Outcomes Conference

January 19, 2021

Allen Jansen, Senior Deputy Director
Behavioral Health And Developmental Disabilities Administration
Michigan Department Of Health And Human Services

MICHIGAN'S PUBLIC BEHAVIORAL HEALTH SYSTEM – COMMUNITY-BASED SERVICES

- **46 Community Mental Health Services Programs (CMHSPs)**
- **10 Medicaid Prepaid Inpatient Health Plans (PIHPs)**
- **Populations Served**
  1. People in crisis
  2. Persons with:
     a. Adults: Serious Mental Illness (SMI)
     b. Children: Serious Emotional Disturbance (SED)
     c. Intellectual/Developmental Disabilities (I/DD)
     d. Substance Use Disorders (SUD)
- **Total Served (2019): 308,738***
  - $3.2 billion for Mental Health (92%)
  - $269 million for Substance Use Disorders (8%)
  - Nearly 90% served through Medicaid; roughly 10% GF



FY20 STRATEGIC PRIORITIES AND PROGRESS

- Expand integration at the service delivery level
- Increase access to safety-net psychiatric care
- Bolster the continuum of crisis services
- Implement Michigan's 1115 Behavioral Health Demonstration
- Continue to mitigate the substance use crisis
- Optimize PIHP/CMHSP financial and operational structures
- Strengthen services to persons exiting incarceration
- Promote self-direction and community inclusion for persons with intellectual/developmental disabilities

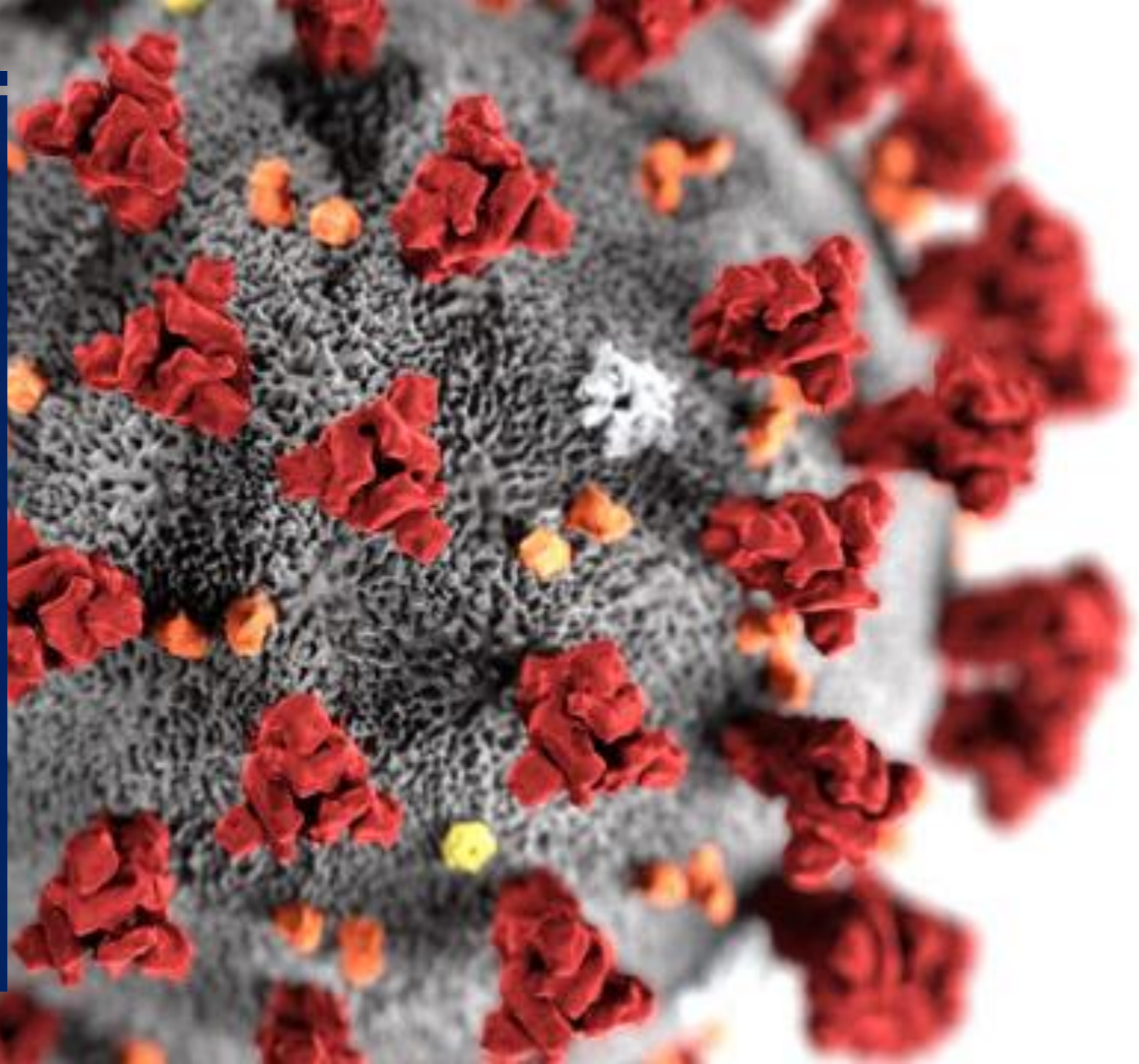
LOOKING FORWARD:

FY21 STRATEGIC PRIORITIES

- Certified Community Behavioral Health Clinic (CCBHC) Demonstration
- Medicaid Health Home Expansions
- Michigan Psychiatric Care Improvement Project (MPCIP)
  - MiCAL
  - Psychiatric Bed Registry
  - Medical Clearance
- 1115 Behavioral Health Demonstration
  - SUD Implementation Plan
  - SUD Health IT Plan
- Strengthen BHDDA's Policy and Operational Oversight
- Optimize PIHP/CMHSP Financial and Operational Structures
- KB Lawsuit
- Diversity, Equity, and Inclusion

BUT 2020 HAD OTHER PLANS

BHDDA'S RECALIBRATION OF RESOURCES TO ATTEND TO THE PUBLIC HEALTH EMERGENCY



COVID-19: SELECT RESPONSE INITIATIVES

- **Medicaid Emergency Authorities**
  - COVID-19 State 1135 Waiver
  - COVID-19 State 1115 Waiver Demonstration
  - COVID-19 Appendix K for 1915(c) HCBS Waivers

- **Awarded and Implemented Federal Grants**
  - SAMHSA COVID-19 Emergency Services for SMI/SUD ($2 million)
  - SAMHSA/FEMA Crisis Counseling Program

- **Crisis Text Line**

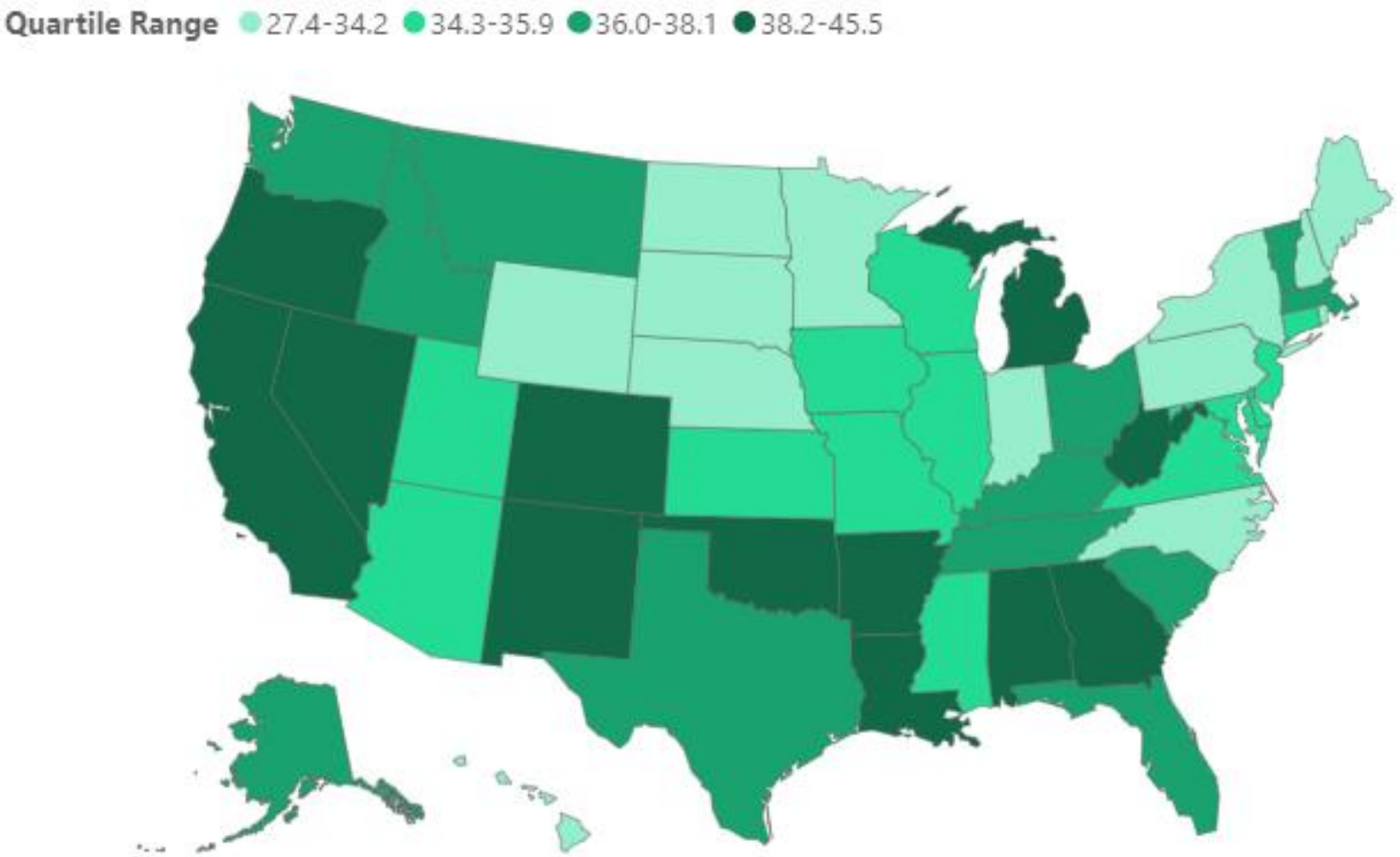
- **$5 million GF to the CMHSPs**

COVID-19: THE IMPACT

- **Behavioral Health**
  - Suicide rates increase by 1.3% for every increase in unemployment of 1%
  - Anxiety/Depression increased by 30.9 %
  - Trauma Disorders increased by 26.3%
  - Use of Substances increased by 13.3 %
- **Utilization of Suicide/Crisis Lines**
  - 1000% increase in use of Disaster/Distress Lines
- **Operational Hindrances**
  - Behavioral Health Providers who have decreased some of their operations 92.6%
  - Behavioral Health Providers who can survive financially more than 3 months is 37.9%
  - Patients have been turned away, cancelled or rescheduled is 31%

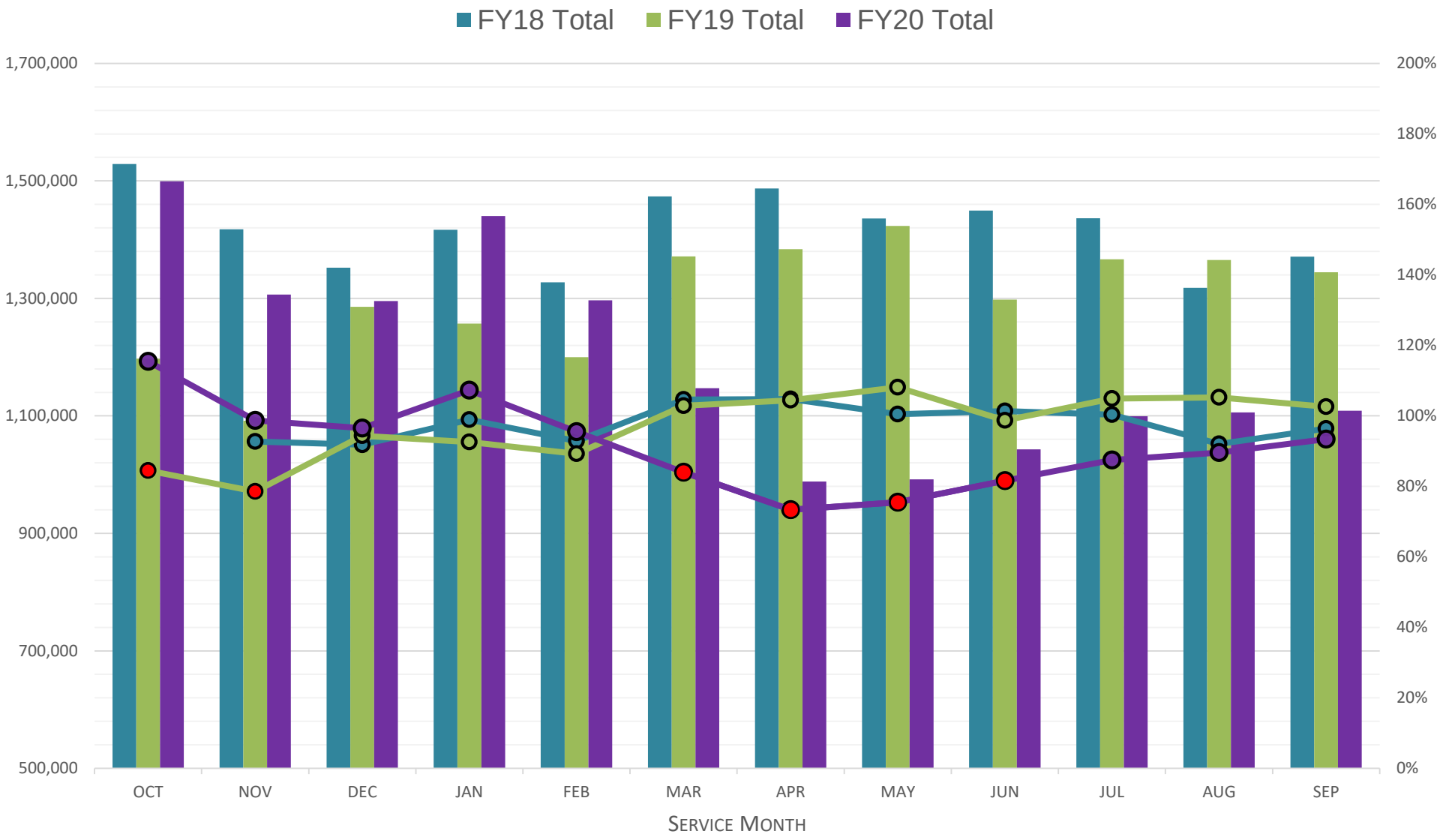
Source: all stats are from 08/2020 and compiled by SAMHSA

SYMPTOMS OF ANXIETY DISORDER

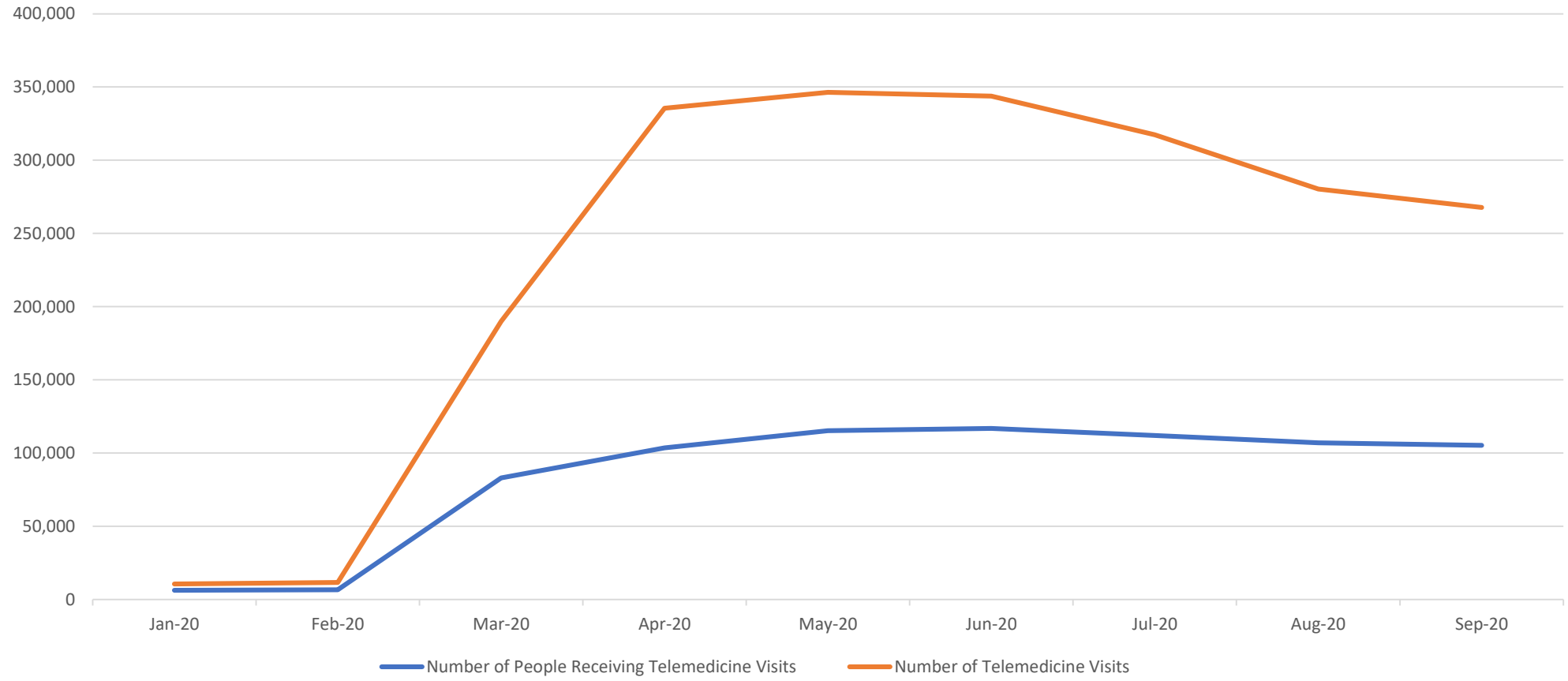


https://www.cdc.gov/

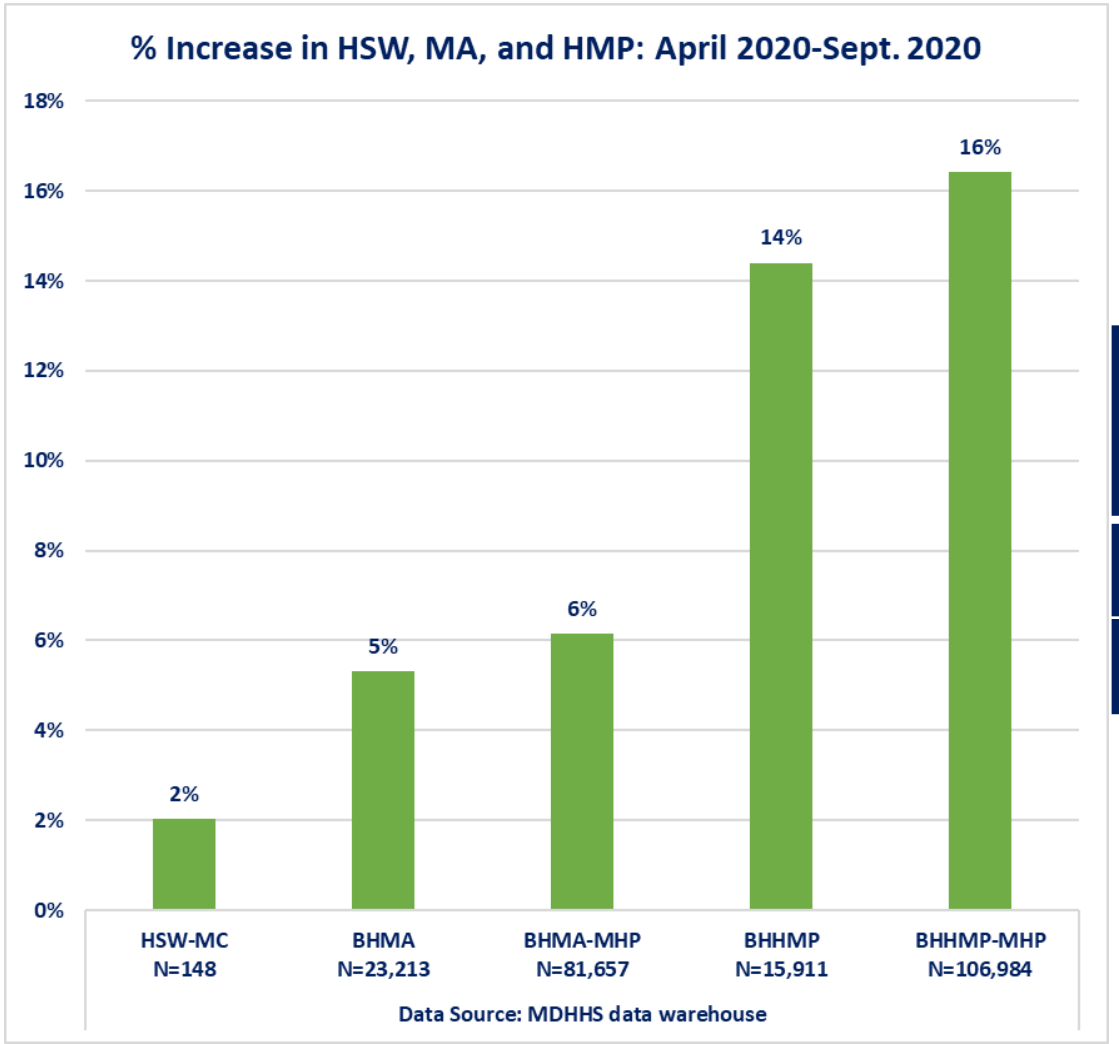
Number of Services Provided by PIHPs and CMHSPs



TELEMEDICINE VISITS FOR SPECIALTY BEHAVIORAL HEALTH
PIHPs and CMHSPs
JANUARY 2020 - SEPTEMBER 2020



THE BELOW GRAPH AND CHART SHOW THE CHANGE IN NUMBER OF ENROLLED INDIVIDUALS FROM APRIL TO SEPTEMBER 2020. (ENROLLMENT NUMBERS HAVE CONTINUED TO CLIMB FROM OCTOBER 2020 TO TODAY.)



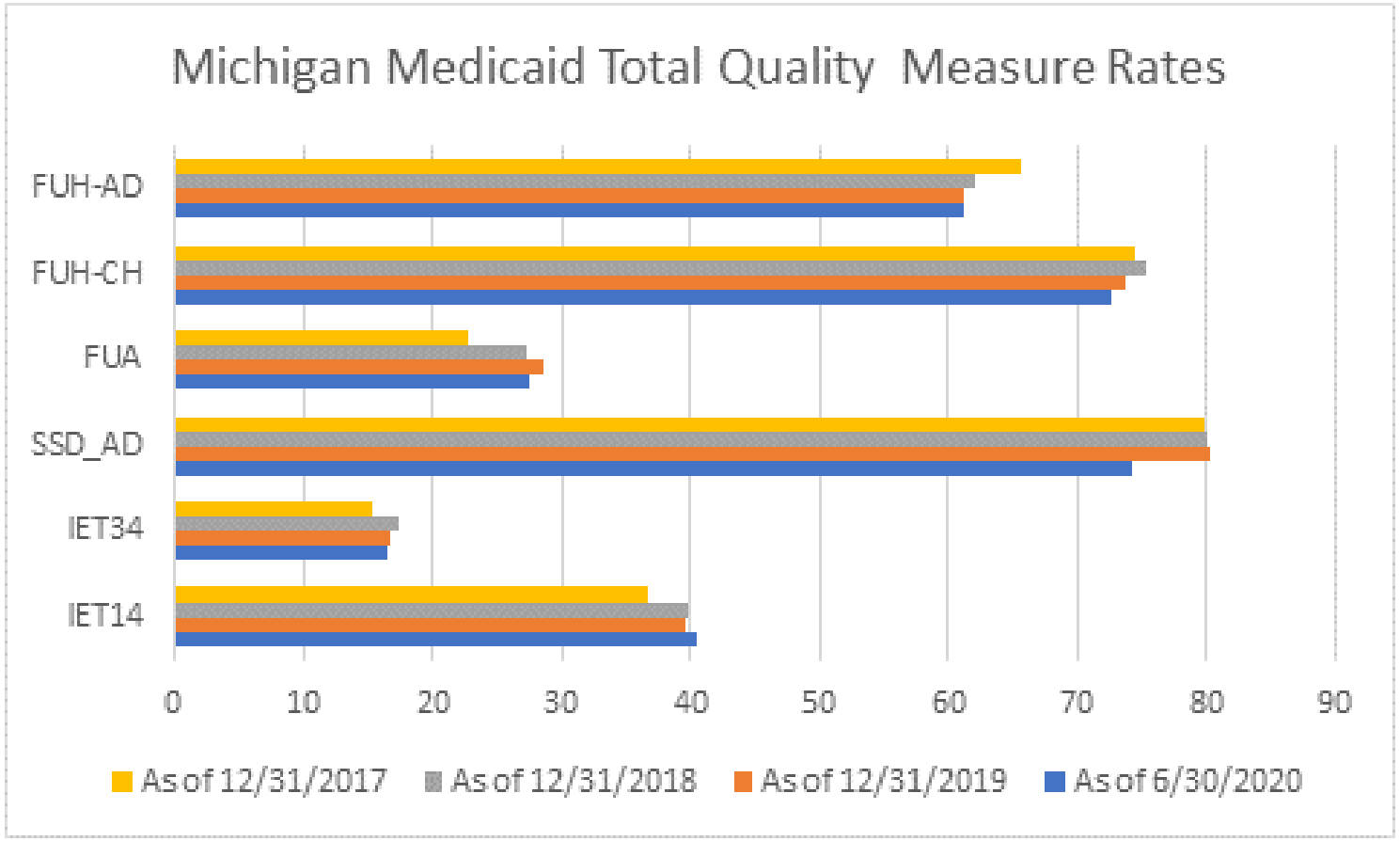
	Hab Waiver	Traditional Medicaid		Healthy Michigan Plan	
# Individuals Enrolled	HSW-MC	BHMA	BHMA-MHP	BHHMP	BHHMP-MHP
As of April 2020	7,124	412,847	1,244,480	94,574	544,266
As of Sept. 2020	7,272	436,060	1,326,137	110,485	651,250

PERFORMANCE INDICATOR SYSTEM REVISION

- BHDDA is in the process of revising its current performance measure system set of sixteen indicators.
- Both CMS and the external quality review organization noted that PIHP had achieved such a high level of performance on these measures that the indicators were no longer useful to facilitate quality improvement.
- To address this, the Performance Indicator Workgroup redesigned the following three indicators:
  - The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.
  - The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.
  - Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
- BHDDA has received data on these new indicators for the third and fourth quarter 2020.

FULL MEASURE NAMES

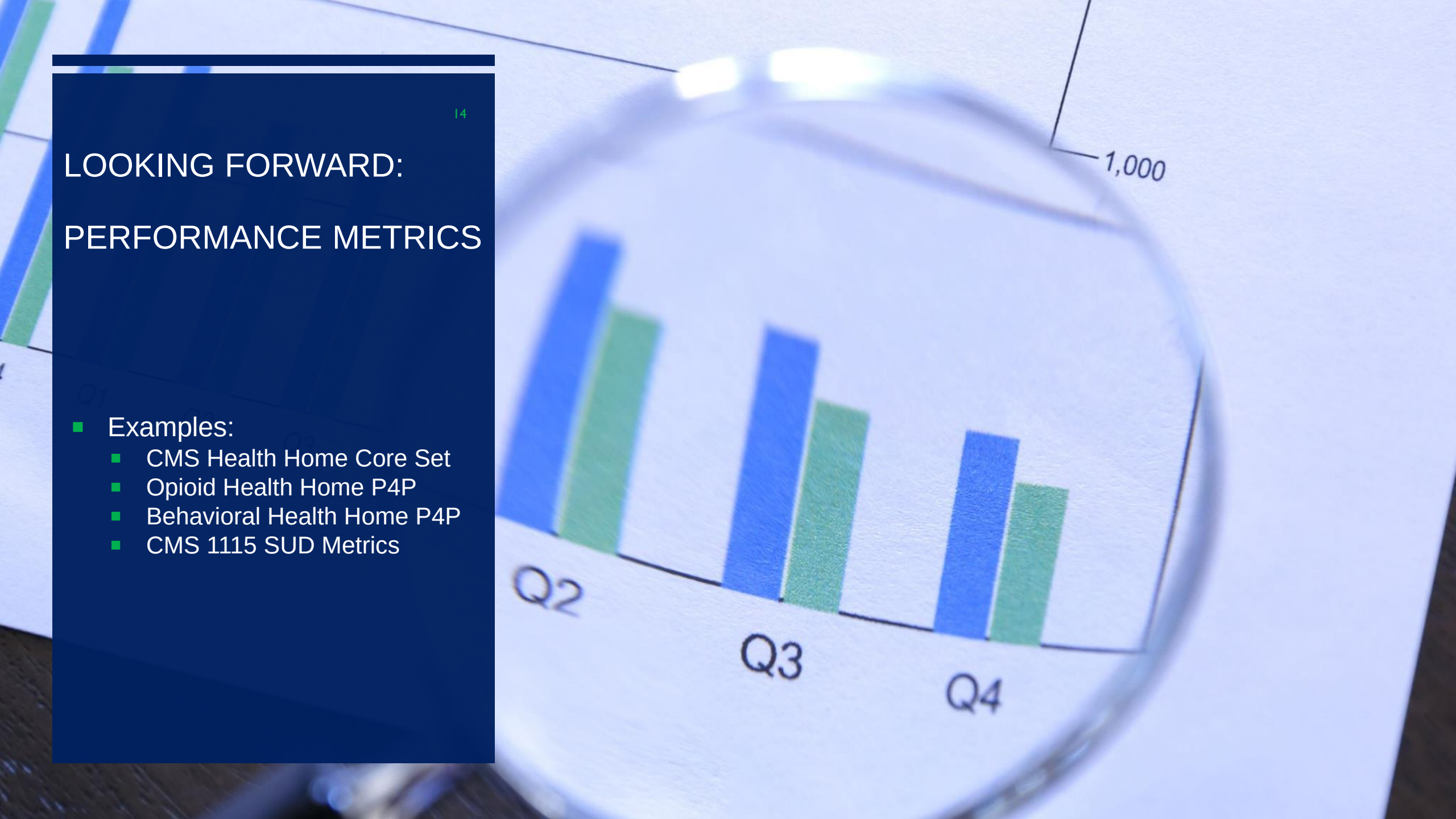
- FUH: Follow-up After Hospitalization for Mental Illness within 30 Days (Child and Adult)
- FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- SSD-AD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder : Who Are Using Antipsychotic Medications
- IET-14 and IET-34: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment



LOOKING FORWARD:

PERFORMANCE METRICS

- Examples:
  - CMS Health Home Core Set
  - Opioid Health Home P4P
  - Behavioral Health Home P4P
  - CMS 1115 SUD Metrics



PERFORMANCE METRICS – HEALTH HOME CORE SET

2020 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Hea Core Set)

NQF #	Measure Steward	Measure Name	Data Collecti
Core Set Measures			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative o
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, h
0418/0418e	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative o
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)*	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)*	Administrative
NA	NCQA	Adult Body Mass Index Assessment (ABA-HH)	Administrative o
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
NA	CMS	Admission to an Institution from the Community (AIF-HH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
NA	CMS	Inpatient Utilization (IU-HH)	Administrative

* This measure was added to the 2020 Health Home Core Set. More information on new substance use disorder (SUD) quality measures Health Home Core Set is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112719.pdf.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

PERFORMANCE METRICS – OPIOID HEALTH HOME P4P

P4P Measure	Measure Steward	Allocation % of P4P Budget
Initiation and engagement of alcohol and other drug dependence treatment NCQA (0004)	NCQA	50%
Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	NCQA	30%
Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	NCQA	20%

PERFORMANCE METRICS – BEHAVIORAL HEALTH HOME P4P

P4P Measure	Measure Steward	Allocation % of P4P Budget
Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	NCQA	50%
Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
Access to Preventive/Ambulatory Health Services (AAP)	NCQA	30%

#	Metric name
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)
4	Medicaid Beneficiaries with SUD Diagnosis (annually)
5	Medicaid Beneficiaries Treated in an IMD for SUD
6	Any SUD Treatment
7	Early Intervention
8	Outpatient Services
9	Intensive Outpatient and Partial Hospitalization Services
10	Residential and Inpatient Services
11	Withdrawal Management
12	Medication Assisted Treatment
36	Average Length of Stay in IMDs
13	SUD Provider Availability
14	SUD Provider Availability - MAT
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)[NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[PQA, NQF #2940; Medicaid Adult Core Set]
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]

PERFORMANCE METRICS – 1115 SUD METRICS

#	Metric name
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge[Joint Commission; NQF #1664]
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]b
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]c
Q1	PDMP Checking by Providers
Q2	Consent Management
Q3	Care Management
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
25	Readmissions Among Beneficiaries with SUD
26	Overdose Deaths (count)
27	Overdose Deaths (rate)
28	SUD Spending
29	SUD Spending Within IMDs
30	Per Capita SUD Spending
31	Per Capita SUD Spending Within IMDs
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure]
33	Grievances Related to SUD Treatment Services
34	Appeals Related to SUD Treatment Services
35	Critical Incidents Related to SUD Treatment Services
S.1	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]b
S.2	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]c

PERFORMANCE METRICS – 1115 SUD METRICS (CONT.)

QUESTIONS AND CONTACT INFORMATION

STAY WELL
Michigan.gov/StayWell

Al Jansen: JansenA2@michigan.gov

MDHHS
Michigan Department of Health & Human Services

Emerging Policy Environment and Implications for Publicly-Funded Health Care

January 2021

2021 Health Care Agenda Will Be Shaped by Narrow Democrat-Controlled Government and Exogenous Factors

2020 Election Results

Presidency	Senate	House	Governors	State Houses
				
306 – 232 Joseph Biden Elected	48 – 2 – 50 Democrat control (w/ VP tiebreaker)	222 – 2 – 211 Democrat Control	Republicans will control 28 governorships; Democrats 22	Republicans control 29 legislatures; Democrats 19 (1 split and 1 non-partisan)

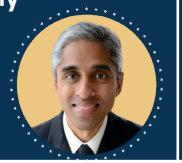
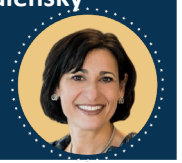
Exogenous Factors Will Shape Health Care Agenda

- COVID-19 pandemic at highest peak levels
- Economy has yet to rebound, and may be further falling
- State and local government fiscal crisis deepening
- Congressional fallout following Capitol Hill riot – timing of legislative priorities is unclear
- Supreme Court ACA actions still pending

Political Implications of Democrat Federal Government

- Elements of Biden's platform (including American Rescue Plan) and other budget related actions can pass Senate on simple majority through budget reconciliation process
  - Other elements may be stripped or could pass if bipartisan support
- Senate may become the starting point for future legislation and negotiation
- Democrat-controlled Senate should allow for Biden appointees to be confirmed quickly

Significant Pending Nominations and Appointments To Date: Health Care Team

	HHS Secretary Xavier Becerra 	General Surgeon Dr. Vivek Murthy 	Chief Medical Advisor Dr. Anthony Fauci 	COVID-19 Equity Task Force Chair Dr. Marcella Nunez-Smith 	COVID-19 Czar Jeffrey Zients 	CDC Director Dr. Rochelle Walensky 
Duties	Administer and oversee the Department of Health and Human Services' 11 agencies; Advise president on issues relating to health, welfare, and income security programs	Provide Americans with the best scientific information available on how to improve their health and reduce the risk of illness and injury; Oversee the U.S. Public Health Service (USPHS) Commissioned Corps	Advise president on public health policy	Ensure response, care, and treatment for COVID-19 is distributed equitably	Coordinate Biden administration COVID-19 response; Oversee testing, mobilization of economic aid and vaccine rollout, among other top priorities	Execute CDC's mission to protect public health and safety through the control and prevention of disease, injury, and disability in the US and internationally; Lead management of vaccine distribution across U.S., including COVID-19
Current Role	Attorney General of CA (2017-Present)	Health adviser on Biden campaign; Co-chair of President-Elect Covid-19 advisory board	Director of NIAID (1984-Present); White House COVID-19 Task Force member (Jan 2020-Present)	Associate professor of medicine and epidemiology at the Yale School of Medicine; Associate Dean for Health Equity Research	Co-chair of Biden transition team	Associate professor of medicine and epidemiology at the Yale School of Medicine; Associate Dean for Health Equity Research
Relevant Experience	Member of the House of Representatives (1993 – 2017); Served on Health Subcommittee and Social Security Subcommittee in Committee on Ways & Means as congressman	Surgeon General (2014-2017); Key leader in addressing Ebola and Zika outbreaks and Opioid crisis	Infectious disease expert, including COVID-19 and HIV/AIDS; HIV/AIDS Researcher	Founding director of the Equity Research and Innovation Center	Addressed mismanaged rollout of Healthcare.gov; Director of National Economic Council (2014-2017); Acting Director of Office of Management and Budget (2010 & 2013)	Infectious disease expert, primarily HIV/AIDS; Advisor to WHO and UNAIDS
Requires Senate Confirmation	Yes	Yes	No	No	No	No

Source: Pictures of nominees from Biden-Harris transition website

Biden Actions/Policies on COVID Response- American Rescue Plan

Biden's "American Rescue Plan": $1.9 trillion economic recovery and coronavirus plan **(L)**

1. National vaccination program: $20 billion **(L)**
2. Expanded testing: $50 billion cover the purchase of rapid tests, expand lab capacity and assist schools with testing protocols **(L)**
3. School funding: $130 billion to help schools reopen; can include modifying spaces for social distancing or improving, improving ventilation, or providing PPE **(L)**
4. Significant funding for new health care workers (100,000 community health workers) and community clinics and tribal clinics **(L)**
5. Financial support for congregate settings to deal with outbreaks **(L)**
6. Extension of 15% increase in monthly SNAP benefits and other direct relief to families **(E/L)**
7. Increase subsides for insurance to increase coverage and reduce out of pocket costs **(L)**
8. Reinstate paid leave supports and cost protections for COVID-19 infected people **(L)**

Policies to Watch:

- Future distributions and guidance of the Provider Relief Fund
- Extensions/additions of Medicaid waivers and Medicare payment flexibilities
- Federal standards that may override state vaccine distribution and response, testing, and staffing requirements
- Funding distribution and usage rules for states and local stimulus

Potential Disruptors/Influencers:

- Vaccine and vaccinator availability as well as the distribution infrastructure are already stretched, need to fill the gap. Data systems and vaccination tracking are disorganized and underfunded.
- Vaccine uptake still problematic—slowing progress towards herd immunity even if supply/distribution path is smoothed

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies to Restore the ACA

Biden Campaign Proposals:

1. Provide new choices of ACA coverage through a public option plan **(L)**
2. Expand tax credit eligibility and limit the cost of coverage to make ACA coverage more affordable **(L)**

Policies to Watch:

- Expansion of Marketplace enrollment, extension of open enrollment, restoration of Navigator program and renewed education and marketing, updated guidance on Section 1332 waivers
- Reversal of "market stabilization" regulations and Section 1557 (discrimination in health programs) changes that limited scope of protections
- Rescinding prior executive orders such as interstate insurance sales, short-term limited-duration health plans, and religious exceptions to coverage for LGBTQ and women's reproductive health
- Expansion of Essential Health Benefits to cover pandemic-related services, require standardized plans, limit surprise medical billing

Potential Disrupters/Influences:

- Supreme Court Outcome in April-June 2021; Senate's interest in legislative fixes after Supreme Court decision
- Roll back of Trump Administration's 2019 guidance on 1332 waivers; implementation of new paradigm for 1332 waivers
- Shift in Senate balance could open new doors for ACA policy, but unlikely dramatic changes on legislative front

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Potential Biden Administration Actions/Policies for Medicaid

Biden Campaign Proposals:

1. Provide premium-free coverage through a public option for eligible individuals in states that have not expanded Medicaid coverage; provide states that have expanded Medicaid the choice to move expansion populations to the public option **(L)**
2. Ensure that people making less than 138% of federal poverty level (FPL) are automatically enrolled for coverage through public schools or by eligibility for other federal programs. **(L)**
3. Expand access to home and community bases services (HCBS) by eliminating the current waitlist and providing states with option to convert current HCBS waivers into a new state plan option with an enhanced federal match **(L)**

Policies to Watch:

- Suspension of all actions to promote or approve work requirements and implement block grants, including recent waiver approvals
- Review recent and pending regulations and promulgate changes
- Continuation of flexibilities provided to states in response to COVID
- Incentives and dollars for non-expansions states to expand coverage
- Promotion of health disparities initiatives and greater state accountability to address them
- Reform of long-term services and supports to ensure safer living environments

Potential Disrupters/Influences:

- Supreme Court Outcome in April-June 2021
- State fiscal crisis may inhibit or drive uptake of different options, including COVID flexibilities
- Response of Republican-led states receiving Trump era waivers (GA, TN, FL, etc.)

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Potential Biden Administration Actions/Policies for Medicare

Biden Campaign Proposals:

1. Expand Medicare to individuals 60-65 **(L)**
   - The Biden Campaign proposed to lower Medicare eligibility to those age 60 and to permit individuals age 60-65 to "buy-into" the program on a voluntary basis. The Campaign stated that any new Medicare costs associated with the policy would be paid from sources outside of the Medicare trust fund
2. Reduce prices of pharmaceuticals (see slide 9) **(L, though additional regulatory proposals may be considered)**

Policies to Watch:

- Potential changes to Medicare Advantage payment rates
- Extensions of COVID-19 waivers and flexibilities including telehealth
- Promotion of value-based payments and Center for Medicare and Medicaid Innovation (CMMI) agenda

Potential Disruptors/Influencers:

- Medicare Trust Fund is projected to go insolvent in 2024 which may accelerate Congressional and Administration actions to reduce Medicare costs

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Potential Biden Administration Actions/Policies on Commercial Market

Biden Campaign Proposals

1) Promote public option to put greater pressure on provider reimbursements and private insurance premiums **(L)**
2) Address market concentration across the health care system by implementing more aggressive anti-trust enforcement of health care mergers **(E)**
3) Create limitations on practices that drive medical debt **(can be done through E but strongest protections require L)**
4) Reduce prices of pharmaceuticals (see following slide)
5) Increase wages and benefits for low-wage direct care workers (e.g., home health workers) **(L)**
6) Double federal investment in community health centers **(L)**

Policies to Watch:

- Reinstatement of limitations on short-term health insurance; rollback of Trump administration 12 months limit to Obama-era 90 days
- Acceleration of testing and deployment of innovations that target higher quality across the health care system
- Implementation of the recent "surprise billing" prohibition passed in December

Potential Disruptors/Influencers:

- State-level commercial market reforms

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Potential Biden Administration Prescription Drug Pricing Priorities

Biden Campaign Proposals

1. Lower Medicare prescription drug costs by: 1) repealing the statutory prohibition on Medicare negotiating drug prices with manufacturers **(E)**; 2) establishing an independent review board to assess the value of "specialized biotech drugs that will have little to no competition **(E)**; and 3) limiting the increase of brand, biotech and "abusively priced" generic drugs **(L)**
2. Leverage International Reference Pricing by creating a Review Board that will use International Reference Pricing to help set drug prices for newly launched specialty (Part B) drugs **(L)**
3. Allow drug reimportation **(L)**
4. Limit drug price increases to inflation, including Medicaid and Public Option (if implemented) and all brands, biologics, and some generics **(L)**
5. Eliminate the tax break for advertising drugs **(L)**

Policies to Watch:

- Biden Administration actions to repeal or modify pending Trump Administration regulations and Executive Orders to control drug prices
- Action on the Grassley-Wyden introduced legislation (S. 4199)
- Actions to further regulate pharmacy benefit managers in the post Rutledge v. PCMA decision that favors independent pharmacies
- Joint legislative and FDA policy making on removing/amending patent barriers and drug exclusivity periods to bring lower cost generics to market faster
- State waiver authority to allow states to maneuver around Section 1927 of the SSA (closed formulary provisions in TN Waiver) and pool drug purchasing

Potential Disruptors/Influencers:

- COVID-19 vaccine successes could mean manufacturers enjoy a hiatus in criticism over drug pricing, which could ameliorate Executive administrative actions
- Drug shortages for COVID-19 treatments could raise drug prices/rationing
- Supply chain issues with getting approved COVID-19 vaccines to communities quickly will continue to be a focus in the first term

Note: E= Likely can be done through executive action/L= May require legislation. Some policies/elements of policies noted as requiring legislation may be able to be implemented through executive action, particularly if federal or state waiver authority is used

Potential Biden Administration Actions/Policies to Address Behavioral Health

Biden Campaign Proposals

1. Appropriate $4 billion to SAMHSA and HRSA to expand access to mental health and substance use disorder services (L) (this funding is included in Biden's recent American Rescue Plan)
2. Provide flexible grants to states and localities for prevention, treatment, and recovery efforts **(L)**
3. Ensure that Medication Assisted Treatment (MAT) is universally available **(L** if new funding is needed**)**
4. Support development and expand coverage for alternative pain medications and treatments **(E)**
5. Enforce mental health parity laws **(E)**

Policies to Watch:

- Federal opioid settlements
- Promotion of new Medicare/Medicaid models to better integrate behavior health services
- Expansion of telehealth services

Potential Disruptors/Influencers:

- COVID-19 pandemic overshadowing opioid epidemic as priority public health crisis
- State-level settlements will differ state by state in their use and oversight models

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Trump Administration Actions Likely to be Reviewed by Biden Administration

- ACA related:
  - Length of open enrollment period (returning to 90 days)
  - "Market stabilization" rule changes that increased access to short term plans, supported grandfathered plans
  - 2019 guidance on Section 1332 waivers
  - Women's health related policies, including payment for abortion, Section 1557 (discrimination in health programs), "provider conscience" protections, exemptions to the contraceptive mandate
- Medicare/Prescription Drugs
  - Review of recent drug pricing proposals issued through rulemaking (e.g., Most Favored Nation, Rebate Rule)
  - Medicare Advantage payment rates
  - Review of/modifications to recent CMMI demonstration models (e.g., Geographic Direct Contracting)
- Medicaid
  - Approval of TN waiver: 10-year demonstration providing fixed Medicaid funding on a per-capita cap basis. Provides enhanced state discretion on services offered; and includes implementation of prescription drug formulary. The Operational Plan requires approval by TN state legislature
  - SCOTUS agrees to hear Trump admin appeal on Medicaid work requirement pilot programs in Arkansas (*Azar v. Gresham*) and New Hampshire (*Azar v. Philbrick*)
  - Managed care regulations
  - CMS guidance to help state Medicaid and CHIP programs transition back to normal operations when COVID-19 PHE ends (Addresses pending eligibility and enrollment actions developed during the COVID-19 PHE and other planning considerations, including steps needed to be taken should states make any of the temporary flexibilities permanent

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QUESTIONS? CONTACT US

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A Unified Vision for Transforming Mental Health and Substance Use Care

To improve the lives of people with mental health and substance use disorders through a transformed system of care.

As leading organizations in the United States dedicated to improving outcomes for people with mental health and substance use disorders, we aspire to create the vital conditions that promote well-being and a system of care where all people have readily available access to evidence-informed services across a full continuum.

To improve outcomes and work toward the ideal state where all people thrive, we must fundamentally shift perceptions around mental health, substance use, and well-being; embrace the concept of population health, which includes prevention, promotion, and recovery; address vital conditions such as housing, transportation, and employment; transform the systems that impact whole-person health; integrate care; and dedicate adequate resources to ensure people receive the services and support they need, when and where they need them.

We must institute policies, programs, and standards that value the critical importance of mental health. We must intentionally address racism and discrimination that have created inequities in care and unacceptable disparities in outcomes. We must invest in comprehensive system solutions that integrate and work to make health and well-being realities for all.

Though we represent a wide range of constituencies, the primary goal for each of our organizations is to improve lives. Serving as the stewards to advance the conditions that allow everyone to live a meaningful, healthy, and productive life, it is the responsibility of our organizations to establish common goals, and incumbent upon us to work together to bring about the changes necessary to reach those goals.

Possible Pathways for Success

Solutions to achieve the vision will require policy change at a federal, state, and local level. This document is meant to give guidance to policymakers on the intended goals, as well as possible pathways for success. Each named organization supports this vision and the critical elements, though they may differ on specific pathways to advance shared goals.

Critical Elements

Early identification and Prevention. Achieve optimal outcomes through prevention, early identification and intervention, with a targeted focus on children, youth, and families.

Emergency and Crisis Response. Improve crisis response and suicide/overdose prevention.

Equity. Address social/political constructs and historical systemic injustices, such as racism and discriminatory structures and policies, that disproportionately impact the mental health of people of color. Eliminate inequitable conditions for people with mental health and substance use conditions.

Integration. Improve access to services and quality of care by integrating physical health, mental health, and substance use services.

Parity. Ensure fair and equivalent coverage for mental health and substance use disorders.

Standards. Hold systems accountable to evidence-based standards of care that improve outcomes and quality of life.

Workforce. Increase the number and diversity of mental health and substance use disorder providers.

Early Identification and Prevention

Achieve optimal outcomes through prevention, early identification and intervention, with a targeted focus on children, youth, and families.

Reducing the severity of mental health and substance use disorders through community prevention, early identification, and intervention is a critical component in changing the trajectory of mental illness and substance use. Because 50% of mental illness begins by age 14 and 75% by the time the brain finishes developing in the mid-20s, early identification and intervention efforts must be focused on children, families, and schools, with special emphasis on the community-based risk factors that negatively impact parents and children. In addition, addressing the underlying vital conditions of a community – social and community factors like affordable housing, reliable transportation, and employment go a long way in setting a positive path for mental health and well-being.

Goals	Possible Pathways for Success*
Research	
• **National health data collection includes robust data on mental health and substance use disorders (MH/SUD)**	• Improve surveillance systems to require mental health symptom and behavior/case reporting
• **Research on chronic health conditions includes research on co-morbid MH/SUD and their pediatric antecedents, including trauma/ adverse childhood experiences (ACEs), social determinants, and health disparities**	• Integrate mental health research throughout National Institutes of Health (NIH) institutes/ centers to improve the safety and efficacy of treatments and address comorbid conditions, pediatric mental illness, and trauma
• **Safe, effective treatments are developed for the earliest stages of MH/SUD**	• Create consistent processes/standards for ensuring people receive precise diagnoses and personalized interventions
• **Evidence-based assessment to improve differential diagnosis, treatment planning and progress monitoring**	• Expand research in range of health service settings and develop/expand appropriate clinical trial networks to stand up and test interventions more quickly and in more diverse populations
Vital Conditions for Prevention and Population Health	
• **All people experience the vital conditions that promote mental wellness and reduce health inequities and minimize adverse mental health outcomes**	• Require all delivery sites to make assessing social needs a part of any screening process
• **People with or at risk of MH and/or SUDs, receive needed supports and services to address social determinants of health, including:**	• Require federal agencies to work with mental health stakeholders to revise instrumental activities of daily living (IADLs) to incorporate psychiatric impairments
– **Affordable, stable, and appropriate housing**	• Align federal policies and structures to support effective supported employment and education services
– **Competitive employment or other income supports**	• Require federal agencies to work together to develop effective housing and employment supports
– **Completion of educational goals**	
– **Essential transportation**	
– **Food security**	

Goals

Reducing Severity Through Early Detection

- **Signs of MH/SU challenges are recognized early throughout one's life, and initially approached through a wellness and recovery-focused lens whenever possible**
- **Children and adults receive help to develop, promote, and maintain wellness and resiliency**
- **The role of social determinants of health and other drivers of health disparities are explicitly identified and proactively addressed, including racism, poverty, and inequitable access to healthcare**
- **All settings where children and youth receive services — childcare, school, health, social services — are trauma-informed**

Possible Pathways for Success*

- Provide routine MH/SUD screenings through health systems, primary care providers, and schools
- Implement early identification campaigns similar to the Centers for Disease Control's (CDC) "Know the Signs. Act Early" for developmental delays
- Expand nationwide nurse home visiting programs (e.g. Nurse Family Partnership, Family Connects)
- Require social-emotional learning curricula and a Multi-Tiered System of Supports to promote educational achievement through healthy development and recognize signs and symptoms of MH/SUD in peers (e.g. Teen/Youth Mental Health First Aid)

Early Intervention

- **Every person at risk of or with early signs of MH/SUD receives evidence-informed care at the earliest possible point of intervention**
- **Initial diagnoses are detected in health care settings, rather than justice or child welfare settings, but when youth are in justice or child welfare settings that have bypassed health care settings, they are also screened and assessed routinely and detected for MH/SUD**

- Incentivize intensive evidence-based interventions for youth (e.g. universal access to Coordinated Specialty Care for psychosis, Multisystemic Therapy for justice-involved youth and families) by public and private payers
- Provide long-term mental health services to children and adults exposed to community violence
- Conduct MH/SUD screening in the population in accordance with the recommendations of the US Preventive Services Task Force (USPSTF)
- Include MH/SUD screening, supports, and services into all pandemic/natural disaster response efforts
- Support to schools for implementing a continuum of MH/SUD supports, including primary prevention to access to MH/SUD services in the schools and liaisons with outside specialized services as in the Positive Behavioral Interventions and Supports and Interconnected Systems Frameworks models
- Include full federal funding of the Individuals with Disabilities Education Act (IDEA) mandate to ensure that all children with serious mental health conditions are enrolled in and offered the special education services they need to succeed academically

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Emergency and Crisis Response

Improve crisis response and suicide/overdose prevention.

Crises—from relapses to severe symptoms of paranoia or delusions to suicidal thinking to overdose—contribute to tragic outcomes. Crisis response and suicide/overdose prevention are indispensable elements in helping people stabilize and get on a path of recovery. There is an explicit focus on removing people from prisons who don't belong and focusing on primary health (rather than public safety) to respond to crisis.

Goals	Possible Pathways for Success*
Crisis Services	
• **Crises are stabilized with effective and humane MH/SUD crisis response services integrated within health systems so co-morbid conditions are addressed and linked to ongoing community-based care to prevent future crises**	• Incentivize crisis response lines and trauma-informed 24/7 mobile crisis teams nationwide, including Crisis Now and the Certified Community Behavioral Health Clinic (CCBHC) model as defined in statute
• **Crisis planning and services facilitate patient choice and continuity of care**	• Integrate crisis response within 911
• **People receive services and supports that facilitate stable housing, benefits and continuity of care post-crisis**	• Implement fully the 988 number and response that is driven by healthcare, not public safety
	• Incentivize inpatient, crisis stabilization programs, sub-acute care and respite care
	• Establish Medicaid state plan option to cover short-term acute care in specialized inpatient and residential settings including IMDs, while also improving transitions and access to outpatient treatment
Adverse Outcome Prevention	
• **Suicide and overdose rates trend rapidly downward for all groups of people**	• Implement federal incentives and systemic requirements for all hospital systems to achieve zero suicides, overdose; accrediting bodies e.g. URAC, JACHO will also require health systems to work on these issues
• **Reduced rates of morbidity and mortality for people with co-occurring MH/SUD and chronic medical conditions**	• Provide incentives for increasing delivery of suicide-specific and overdose-specific therapies
	• Explicitly address the co-morbid burden of diseases worsened by MH/SUD
	• Provide universal access to proven, trauma-informed treatments to reduce justice system involvement, including Multisystemic Therapy

Goals

Criminal Justice System Diversion

- **People with MH/SUD-related crises are met with a health response (paramedics, social workers, peers), not a police response**
- **End the incarceration of nonviolent offenders who have mental illnesses**
- **Individuals whose main interaction with the criminal justice system is due to MH/SUD are diverted to treatment instead of incarcerated**

Possible Pathways for Success*

- Create new pathways beyond law enforcement that respond to MH/SUD crisis and build a health response centered on social work/community paramedics/peers nationwide (e.g. Crisis Assistance Helping Out On The Streets [CAHOOTS], RIGHT Care) and ensure understanding of culture, race and trauma in emergency responses
- Remove individuals with MH/SUD conditions from local, state and federal justice systems
- Require law enforcement receiving federal funding to train officers in recognizing signs and symptoms of MH/SUD as well as de-escalation using models with all having specialized training (e.g. Crisis Intervention Team [CIT], Law Enforcement Assisted Diversion [LEAD], Mental Health First Aid [MHFA])
- Require local justice systems, including law enforcement, to develop comprehensive diversion plans with health systems and MH/SUD providers in their community
- Implement broad-based diversion efforts across the continuum of sequential intercepts for people with MH/SUD to prevent arrest and incarceration so rates for people with MH/SUD are equal to other groups
- Increase funding necessary to provide a robust community response to prevent nonviolent individuals with serious mental illness from becoming incarcerated

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Equity

Address social/political constructs and historical systemic injustices, such as racism and discriminatory structures and policies, that disproportionately impact the mental health of people of color. Eliminate inequitable conditions for people with mental health and substance use conditions.

People with mental health and substance use conditions also experience poor rates of access to care and typically poor health and life outcomes. For people of color and other marginalized communities, access to care and outcomes are generally worse. Lack of representation of people of color in the workforce and access to culturally and linguistically competent care further contribute to disparities. Eliminating disparities, particularly through addressing social determinants of health and modifying law enforcement and justice-driven responses to MH/SUD needs, is a cornerstone of a transformed system.

Goals

Decrease Inequity

- **Mental health and substance use disorder services are included as an essential component of all anti-racism efforts**
- **Mental health system policies and investments eliminate disproportionate adverse impacts on people of color and other underserved populations like lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) persons**
- **Reduce disparities in the prevalence of MH/SUD conditions and adverse health outcomes**
- **Veterans, including veterans of color, have equitable access to and outcomes of care**
- **Patient experience and cultural competence measures are implemented and reported by race, ethnicity, and language**
- **People with mental health and substance use conditions experience culturally competent care**

Possible Pathways for Success*

- Include race, ethnicity, and language data collection in all MH/SUD programs with respect to people served, providers and outcomes, data on serious mental illness (SMI) collected in health programs such as jail, emergency medical services (EMS), emergency room (ER) and hospital use
- Develop screening, caregiver, and treatment programs that are responsive and have humility about culture and race
- Include training to reduce health disparities, including anti-racist and anti-discrimination curricula
- Address adverse childhood experiences (ACEs) and other social determinants in childhood, with an explicit focus on racism and discrimination to reduce disparities in the prevalence of MH/SUDs and adverse health outcomes
- Ensure health equity by enforcing all standards across race, ethnicity, income, gender identity, sexual orientation, and other factors known to correlate with health disparities
- Provide access to community-based mental health clinicians who are appropriately trained to work with service members and veterans, with Department of Defense (DoD) and the Department of Veterans Affairs (VA), respectively, as the coordinators of care
- Acknowledge and address the history of racism in the establishment and delivery of mental health systems through policies and investments that eliminate the disproportionate impact on people of color
- Ensure that veteran status is tracked across all health settings (not just the VA, as most veterans receive care outside the VA) and that veterans and their families achieve equitable access to and outcomes of care

Goals

Care in Custody and Reentry

- **People with MH/SUD conditions are not disproportionately involved in the justice system**
- **People who are justice-involved receive screening and treatment for MH/SUD**

Possible Pathways for Success*

- Provide federal incentives for criminal justice employee education and training to recognize MH and SUD signs and direct facilities to exercise periodic screenings of all inmates for mental health and substance use disorders from custody to reentry
- Apply federal standards for constitutional health care to treatment of MH/SUD for incarcerated persons

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Integration

Improve access to services and quality of care by integrating physical health, mental health, and substance use services.

Integrating mental health and substance use care with other health services is fundamental to shifting from siloed, marginalized services to holistic care for the whole person. Care integration not only facilitates better and earlier care, it reduces stigma and decreases barriers to accessing care early, effectively, and efficiently. In addition, integrating care with research across health systems and universities enables continuous improvement of outcomes.

Goals

Enhance the Integration of Care

- **People of all ages receive MH/SUD screening and services that are well-integrated into primary care and primary care screening and services that are well-integrated into specialty MH/SUD care**
- **Mental health and addiction services are readily available in primary care**
- **People receive effective treatment for co-occurring MH/SUD conditions**
- **People with co-occurring MH/SUD and chronic health conditions, including chronic pain, receive effective, multi-disciplinary team-based treatment**

Possible Pathways for Success*

Structure

- Align regulations and facilitate seamless data and information exchange and integration between MH/SUD providers, the medical system, and research institutions
- Ensure universal access in pediatric settings to child psychiatry access programs (CPAP)

Financing

- Forbid same-day billing restrictions in Medicaid programs
- Universal access to and increased payment for Collaborative Care Model billing codes, including technical support to practices
- Fund and scale financial mechanisms like those in the CCBHC model for specialty mental health centers
- Pursue non-fee-for-service payment models that support integrated care
- Ensure coverage of Evidence Based Assessment to facilitate differential diagnosis, treatment planning and progress monitoring
- Fund agencies such as the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to support research integrated among MH/SUD providers and universities nationwide
- Expand the use of Home and Community Based Services (HCBS) waivers and other financing mechanisms to support community-based services that promote independent living for all people with serious mental health conditions

Possible Pathways for Success*

Training

- Increase funding for Project ECHO (Extension for Community Healthcare Outcomes), child psychiatry access programs, and other programs to train physicians on mental health and substance use
- Integrate screening and measurement-based care training for primary care professionals into the Heath Resources and Services Administration (HRSA) primary care training grants

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Parity

Ensure fair and equivalent coverage for mental health and substance use disorders.

Coverage and funding drives health system behavior, so it is crucial to break down the treatment limitations, barriers and inequities that continue to marginalize mental health and substance use services. Striking down these systemic impediments is essential to realizing the intent of the Mental Health Parity and Addiction Equity Act (MHPAEA) and state mental health parity laws.

Goals

Parity Coverage and Payment

- **Every health plan provides parity mental health and substance use coverage on par with medical/surgical and enforces those standards**
- **MH/SUD providers, including the peer workforce, are paid on par with comparable health care providers**

Possible Pathways for Success*

- Enact federal telehealth parity law that prohibits any discrimination against telehealth and mandates equal reimbursement; include access to audio-only care as an option given inequitable access to broadband
- Require all health plan medical necessity determinations to be fully consistent with generally accepted standards of care for MH/SUD
- Apply MHPAEA to all current and future public and private payers (including Medicare, Medicaid Fee-for-Service, TRICARE and Indian Health Services)
- Increase funding for parity enforcement of Employee Retirement Income Security Act (ERISA) plans by the US Department of Labor
- Ensure that state and federal regulators and lawmakers are requiring compliance with MHPAEA and requiring transparency by health plans about benefit design and application
- Eliminate all restrictions on SUD care, including limitations on providers prescribing medication-assisted treatment (MAT) and telehealth restrictions limiting access for people with SUD
- Monitor and enforce standards to eliminate non-quantitative treatment limitations (NQTLs)
- Eliminate caps that government payers place on mental health (e.g. eliminate Medicare 190-day lifetime psychiatric inpatient limit and Medicaid coverage limitations for certain facility-based care)

Goals

Coverage Expansion

- **All people with mental health and substance use conditions are covered for care**
- **All quantitative and non-quantitative limitations to care are eliminated**

Possible Pathways for Success*

- Address policies that may limit coverage like the Medicaid inmate exclusion prohibiting Medicaid coverage in jails and prisons
- Create special Medicaid eligibility coverage for young people with early psychosis and youth involved in the juvenile justice system
- Preserve Medicaid expansion and patient protections in the Affordable Care Act

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Standards

Hold systems accountable to evidence-based standards of care that improve outcomes and quality of life.

To improve health outcomes and quality of life for people with mental health and substance use conditions, it is necessary to establish and hold systems accountable to implementing standards of quality care and to adopting payment models that support the cost of providing effective, integrated care.

Goals

Standards of Care

- **People in all settings receive quality care based on well-established standards of care**
- **Measurement-based care for MH/SUD conditions is universally adopted, including universal screening and detection and repeated measures with reliable tools for all people in care**
- **People routinely access a continuum of innovative, evidence-based interventions and technologies**
- **Access to newer and effective medications should not be limited or denied solely because of cost without regard to efficacy**
- **Individuals with opioid use disorders (OUD) routinely access Food and Drug Administration (FDA) approved medication for OUD and other substance use disorders as a first line treatment in all medical and MH/SUD settings**
- **People can compare health plans and mental health facilities and programs through public reports on meaningful MH/SUD quality measures**
- **Trauma-informed early intervention, symptom remission, and recovery are all central tenets of MH/SUD services and require reporting on these factors**
- **Custodial care services for all age groups are offered only as a last resort and in least restrictive environments possible**
- **Outcomes consistently improve over time through implementation of evidence-based models**

Possible Pathways for Success*

Structure

- Develop and frequently update evidence-based standards of care developed by clinical specialty organizations that do not service managed care organizations (MCOs) as primary clients for MH/SUD
- Extend measurement-based care requirements to primary care (see URAC requirements, extend current Joint Commission requirements)
- Implement quality measures to reduce disparities, improve outcomes, and improve MH/SUD experience of care and transitions in care
- Remove barriers to filling gaps in continuum of care, such as sub-acute care and alternatives to hospitalization
- Fund and scale the CCBHC model nationwide, which incorporates core federal standards reflective of the vision outlined here

Financing

- Ensure that Collaborative Care reimbursement rates are adequate to support universal access to measurement-based care
- Require Medicaid, Medicare, TRICARE and the Indian Health Service (IHS) to reimburse for FDA-cleared and regulated prescription digital therapeutics
- Incentivize evidence-based interventions for severe MH/SUD and co-occurring disorder treatment
- Promote measurement-based care and value-based financing
- Eliminate the use of "fail first" policies for medication therapies

Training

- Incentivize training in trauma-informed, recovery-focused, evidence-based interventions and technologies

Goals

Caregiver Supports

- **All caregivers receive information, support and system navigation to help successfully care for someone with MH/SUD**
- **Barriers to the involvement of culturally-defined family and caregivers in the care of children and family members are eliminated**

Possible Pathways for Success*

- Develop a robust nationwide caregiver support and navigation system similar to those available for seniors and people with developmental disabilities
- Create financial mechanisms to pay for caregivers for taking care of their family in home-based settings

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Workforce

Increase the number and diversity of mental health and substance use disorder providers.

To meet growing demand, the mental health delivery system of the future must expand the professional workforce as well as leverage community skills and resources. New service delivery models can ensure that those with greatest need have access to skilled clinicians while creating support in the community for those with less intensive needs.

Goals

Workforce Capacity

- **The MH/SUD workforce is diverse and has the capacity to quickly, effectively, and sensitively meet the needs of our communities**
- **Access to peer supports and community-based care, including free support groups**
- **Inclusion of licensed mental health and addiction clinicians in insurance networks equal to other licensed health professionals in medical/surgical networks**
- **Mental health and substance use professionals collaborate broadly on interprofessional teams**
- **People with mental health and/or substance use disorder are universally provided telehealth, including audio-only, options for care**

Possible Pathways for Success*

Structure

- Remove telehealth barriers to practicing across state lines (licensing) where necessary for continuity of care – i.e., existing patients are receiving care across state lines due to COVID-19 or are changing locations (returning from/to college, moving to a new state)
- Enact federal telehealth parity law that guarantees access by removing geographic restrictions and allowing patients to be seen in their home for mental health treatment and mandates equal reimbursement to in-person care; include access to audio-only care as an option when broadband, age, or ability considerations dictate

Financing

- Require all payers to reimburse for certified peer support specialists and community health workers (to address health disparities in access)
- Institute incentives to recruit a diverse mental health and substance use disorder workforce
- Establish cost-related payment rates that enable clinics to recruit, hire, and train staff according to the diversity, equity, and inclusion needs of clients served
- Repair core rate deficiencies, which are parity violations, and which drive licensed behavioral health clinicians out of insurance-based care

Possible Pathways for Success*

Training

- Establish uniform standards for certified peer support specialists and community health workers
- Improve training for all mental health and substance use disorder workforce in culture competence and trauma-informed care
- Expand existing loan-repayment/forgiveness programs and increase investments in mental health workforce development programs, such as Graduate Medical Education (GME), Graduate Psychology Education (GPE), Behavioral Health Workforce Education and Training (BHWET), and the Minority Fellowship Program
- Provide incentives, such as loan repayment, for graduating residents to take Medicaid and Medicare patients
- Eliminate the barrier for child and adolescent psychiatrists to receive HRSA loan repayment
- Expand fellowship programs and college programs to encourage more diversity in all mental health professions

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Now, more than ever, there is a need for collective action to advance mental health and substance use disorder care in the United States.

Leaders from the undersigned organizations have worked closely on the development of this shared vision to achieve a common goal — improving lives. This landmark effort culminated on World Mental Health Day 2020 and demonstrates a strong commitment from leaders in the sector to work together to chart a new course for mental health in our country.

Designed by Collectively Creative

Southwest Michigan Behavioral Health Board Meeting

Please join the meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/515345453
You can also dial in using your phone:
1-571-317-3116 - Access Code: 515-345-453
March 12, 2021
9:30 am to 11:00 am
(d) means document provided
Draft: 2/4/21

1. **Welcome Guests/Public Comment**

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

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

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

4. **Consent Agenda**

   - February 12, 2021 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   - Operations Committee Minutes January 27, 2021 (d)

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

   a. *Fiscal Year 2020 Customer Satisfaction Survey Results (d) (J. Gardner)
   b. *SWMBH 2020 Health Services Advisory Group (HSAG) External Quality Review Compliance Monitoring Report (d) (J. Gardner)
   c. *Fiscal Year 2020 Performance Bonus Incentive Program Results (d) (J. Gardner)
   d. Autism Spectrum Disorder (R. Freitag) (d)

7. **Board Actions to be Considered**

   - Operating Agreement Review (B. Casemore) (d)

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

   - None Scheduled

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

   - None Scheduled

10. Board Education

a. Fiscal Year 2021 Year to Date Financial Statements (T. Dawson) (d)
b. Integrated Care (M. Kean) (d)
c. 2020 Quality Assurance – Performance Improvement Program Evaluation (J. Gardner) (d)
d. Fiscal Year 2020 Quality Assurance Performance and Improvement Evaluation Report (J. Gardner) (d)
e. Performance Bonus Incentive Pool Fiscal Year 2020 Earnings (T. Dawson and J. Gardner) (d)
f. Fiscal Year 2020 HIPAA Privacy/Security Report (M. Todd) (d)

11. Communication and Counsel to the Board

a. April 9, 2021 Board Agenda (d)
b. Board Member Attendance Roster (d)
c. April Board Elections
d. 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
April 9, 2021
9:30 am - 11:00 am

2021 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Vacant (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarto (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Randy Hyrns (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Mary Middleton (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 1/8/21

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