Southwest Michigan Behavioral Health Board Meeting
Air Zoo Aerospace & Science Museum
6151 Portage Rd, Portage, MI 49002
February 14, 2025
9:30 am to 11:30 am
(d) means document provided
Draft: 2/7/25

1. **Welcome Guests/Public Comment**

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

3. **Financial Interest Disclosure Handling (5 minutes)**

   - Michael Seals (Kalamazoo County)

4. **Consent Agenda (2 minutes)**

   a. January 3, 2025 SWMBH Special Board Meeting Minutes (d) pg.3
   b. January 10, 2025 SWMBH Board Meeting Minutes (d) pg.6
   c. January 22, 2025 Operations Committee Meeting Minutes (d) pg.11
   d. January 3, 2025 Board Finance Committee (d) pg.15

5. **Financial Statements and Cash Flow Analysis (15 minutes)**

   a. Fiscal Year 2025 Year to Date Financials and Cash Flow Analysis (G. Guidry) (d) pg.16
   b. Operations Committee update(s) (J. Goodrich) (d)

6. **Required Approvals (15 minutes)**

   - 2025 Quality Assurance and Performance Improvement Plan (A. Lacey) (d) pg.24

7. **Ends Metrics Updates *(*Requires motion)* (0 minutes)**
   Proposed Motion: Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Do the Ends need Revision?

   - None scheduled

8. **Board Actions to be Considered (15 minutes)**

   - Eleos Group Purchase Agreement (M. Todd) (d) pg.68

9. **Board Policy Review (5 minutes)**
Proposed Motion: Is the Board in Compliance? Does the Policy Need Revision?

   a. BG-004 Board Ends and Accomplishments (d) pg.69
   b. BG-007 Code of Conduct (d) pg.70

10. **Executive Limitations Review (0 minutes)**
Proposed Motion: Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?

   - None scheduled

11. **Board Education (15 minutes)**

   a. Strategic Plan (B. Casemore)
   b. Board Education Planning 2025 (B. Casemore) (d) pg.72

12. **Communication and Counsel to the Board (5 minutes)**

   a. Operations Committee Delegation Assessment Plan (M. Todd) (d) pg.73
   b. Board Ends, Interpretations and Metrics (B. Casemore)
   c. Quality Assurance and Performance Improvement Program Fiscal Year 2024 Evaluation (A. Lacey) (d) pg.74
   d. March Board Policy Direct Inspection – None scheduled
   e. New Board Member Orientation – 2/14/25 from 12pm-1pm. Member confirmed attendees are: Sherii Sherban, Tina Leary, Lorraine Lindsey, Allen Edlefson, Michael Seals, Joyce Locke and Gail Patterson-Gladney (other Board members welcome to attend)

13. **Public Comment**

14. **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
March 14, 2025
9:30 am - 11:30 am

Southwest Michigan
BEHAVIORAL HEALTH

Special Board Meeting Minutes
January 3, 2025
Air Zoo Aerospace & Science Museum, 6151 Portage Rd, Portage, MI 49002
9:00 am-11:00 am
Draft: 1/7/25

Members Present: Sherii Sherban**,** Tom Schmelzer, Louie Csokasy, Erik Krogh, Carol Naccarato, Lorraine Lindsey, Tina Leary, Allen Edlefson (alt)

Members Absent: Edward Meny

Guests Present: Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer and Director of Provider Network, SWMBH; Cameron Bullock, Pivotal; Jeannie Goodrich, Summit Pointe; John Ruddell, Woodlands; Sue Germann, Pines BH; Ric Compton, Riverwood; Michael Seals; Neil Marchand, Miller Johnson Attorneys; Jordan Valentine, Varnum LLP; Sarah Wixson, Varnum LLP

Welcome Guests
Sherii Sherban called the meeting to order at 9:06 am.

Public Comment
None

Agenda Review and Adoption

Motion	Tom Schmelzer moved to approve the agenda with the revision of removing the action on Michael Seals Financial Interest Disclosure Statement as paperwork has not yet been received.
Second	Lorraine Lindsey
Motion Carried	

Financial Interest Disclosure (FID) Handling
Mila Todd reviewed the financial disclosure information for Allen Edlefson, who is a member of the Riverwood Board, noting the inherent conflict of interest.

Motion Louie Csokasy moved that a conflict exists and that:

1) The Board is not able to obtain a more advantageous arrangement with someone other than Allen Edlefson

2) The Financial Interest disclosed by Allen Edlefson is not so substantial as to be likely to affect the integrity of the services that SWMBH may expect to receive; and

3) A Conflict of Interest Waiver should be granted.

Second Carol Naccarato

Motion Carried

Required Approvals

Executive Officer request for 30-day personal leave

Motion Lorraine Lindsey moved that the Board approve Brad Casemore personal leave from 1/6/25 to 2/3/25 as requested**.**

Second Allen Edlefson

Motion Carried

Recommendation and appointment of Interim Executive Officer

Anne Wickham informed the Board of the recommendation of Brad Casemore to appoint Mila Todd as the Interim Executive Officer in his absence per Board policy EO-003.

Motion Louie Csokasy moved that the Board appoint Mila Todd as the Interim Executive Officer until Brad Casemore returns.

Second Allen Edlefson

Motion Carried

Dispute Resolution Step 3

Sherii Sherban asked a CEO member of the public present to give impromptu summary of what had occurred at the Operation Committee Step 2 decision regarding delegation of UM for continuing stay reviews. Ric Compton gave the Operations Committee summary and that decision was based on 1. They believe the MH Code grants them sole authority over inpatient. 2. ISK has always done it 3. Majority of other CMHs across state are doing it.

Sarah Wixson advised Board that for its protection of attorney/client privilege the Board go into closed session to discuss the need for Sherii Sherban and Carol Naccarato to recuse themselves from discussion, deliberation or voting in regards to this matter. Sherri and Carol agreed to recuse themselves from voting but not from discussion. The Board had additional discussion regarding going into closed session to discuss attorney-client privileged material related to conflict of interest versus the Board voting, in an open session, to enforce the existing Conflict of Interest Waivers that include a restriction requiring that a Board member recuse themselves and not be present for discussions, deliberations, or voting on matters related to a dispute between the member's CMH and SWMBH.

Motion Tom Schmelzer moved to enforce the existing conflict of interest waivers.

Second Erik Krogh

Roll Call Vote

Tina Leary	Yes
Allen Edlefson	Yes
Louie Csokasy	Yes
Sherii Sherban	No
Lorraine Lindsey	No
Tom Schmelzer	Yes

Erik Krogh	Yes
Carol Naccarato	No
Motion Fails	

Motion	Allen Edlefson moved that the SWMBH Board refer the matter of the Pivotal and Summit Pointe dispute resolutions presented at the December 13, 2024 meeting of the SWMBH Board to the Operations Committee to develop a plan for allowing regional CMHs to become responsible for continuing stay reviews for psychiatric inpatient care for submission to the SWMBH Board at their February 14, 2025 meeting.
Second	Erik Krogh
Roll Call Vote	
Allen Edlefson	Yes
Tina Leary	Yes
Louie Csokasy	Yes
Sherii Sherban	Recused
Lorraine Lindsey	Yes
Tom Schmelzer	Yes
Erik Krogh	Yes
Carol Naccarato	Recused
Motion Carried	

Public Comment

None

Adjournment

Motion	Tom Schmelzer moved to adjourn at 10:35 a.m.
Second	Lorraine Lindsey
Motion Carried	

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting Minutes
January 10, 2025
Air Zoo Aerospace & Science Museum, 6151 Portage Rd, Portage, MI 49002
9:30 am-11:30 am
Draft: 1/13/24

Members Present: Sherii Sherban**,** Tom Schmelzer, Louie Csokasy, Edward Meny, Erik Krogh, Cathi Abbs, Lorraine Lindsey, Tina Leary

Members Absent: Carol Naccarato

Guests Present: Mila Todd, Interim CEO, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Ella Philander, Executive Projects Manager, SWMBH; Cameron Bullock, Pivotal; Jeannie Goodrich, Summit Pointe; John Ruddell, Woodlands; Sue Germann, Pines BH; Debbie Hess, Van Buren County CMH; Richard Thiemkey, Barry County CMH; Ric Compton, Riverwood; Jeff Patton, ISK; Michael Seals; Allen Edlefson; Joyce Locke; Richard Carpenter; Marsha Bassett

Welcome Guests
Sherii Sherban called the meeting to order at 9:30 am.

Public Comment
Louie Csokasy introduced his replacement, Joyce Locke, on the SWMBH Board. Joyce Locke shared her experience and interest about serving on the Board.

Agenda Review and Adoption

Motion	Tom Schmelzer moved to approve the agenda as presented.
Second	Lorraine Lindsey
Motion Carried	

Financial Interest Disclosure (FID) Handling
Mila Todd distributed annual Financial Interest Disclosures to Board Members for their completion.
Mila Todd reviewed the financial disclosure information for Gail Patterson-Gladney, who is a member of the VanBuren CMH Board, noting the inherent conflict of interest.

Motion Tom Schmelzer moved that a conflict exists and that:

1) The Board is not able to obtain a more advantageous arrangement with someone other than Gail Patterson-Gladney

2) The Financial Interest disclosed by Gail Patterson-Gladney is not so substantial as to be likely to affect the integrity of the services that SWMBH may expect to receive; and

3) A Conflict of Interest Waiver should be granted.

Second Lorrainne Lindsey

Motion Carried

December 13, 2024 Second Closed Session Meeting Minutes – Dispute Resolution

Motion Tom Schmelzer moved to move the December 13, 2024 Second Closed Session Meeting minutes under the consent agenda for approval.

Second Lorrainne Lindsey

Motion Carried

Consent Agenda

Motion Lorraine Lindsey moved to approve the December 13, 2024 Board minutes, December 13, 2024 First Closed Session Board minutes, December 13, 2024 Second Closed Session Board minutes, December 4, 2024 Operations Committee Meeting minutes, Board Finance Committee Meeting minutes and Board Regulatory Compliance Committee Meeting minutes as presented.

Second Cathi Abbs

Motion Carried

Required Approvals

None scheduled

Ends Metrics Updates

None scheduled

Operations Committee Update-Status update on OC recommendations re: regional financial position

Jeannie Goodrich shared the Operations Committee thoughts on the Fiscal Year 2025 budget and an 8-million-dollar deficit. The Operations Committee engaged the services of Richard Carpenter of Rehman Robson to perform an analysis of the region's revenue and expenses. Richard Carpenter stated that there are two phases in his analysis with the first phase being the revenue phase. Richard Carpenter distributed a projected revenue report and reported as documented noting the following:

- Region 4 gets paid less per member than all other regions in the State of Michigan
- Discrepancies in SWMBH's Health Michigan
- Trend shows we will continue to lose eligibles throughout the course of the Fiscal Year 2025
- Data validation to compare to payments received

Discussion followed. Richard Carpenter said that a Phase 2 expense report would be presented soon to the SWMBH Board.

Jeannie Goodrich thanked Richard Carpenter for his work and presentation and shared the following CMH CEOs Recommendations:

-Operations would request these documents to continue to monitor SWMBH's Financial Condition

*Statement of Net Position

*Statement of Net Activities

*Statement of Net Activities to Budget

-The SWMBH Board Approved Balanced Budget for FY25

*approved with $8.8M deficit recognized

The SWMBH Budget should be updated:

*with projections – FY25 will recognize $18.9M deficit may change as there are 3 CMH's that have provided estimates at this time but is expected to be fully accurate for December.

-Operations recommends

*Review Budget with Rehmann Revenue projections ($18.9 deficit)

*CMHs will provide estimate of FY25 expenses based on first quarter results

*Collectively review at Operations the FY25 Budget

*Action Plan for expense reduction that includes SWMBH and CMH

*Not 90/10 reduction to balance budget

-Rehman Expense/Encounter Analysis (Phase 2) is due for Review end of January

*Reviewed by Operations

*Plan to be developed to review across the Region within SWMBH structure for reductions

*ensure through review of State files to CMH reporting that all encounters are reported with Accuracy – not through SWMBH data warehouse (verifying data) CMH to SWMBH, SWMBH to State, and State back to SWMBH

-CMH CEOs recommend to the SWMBH Board to appoint CMH CFO (specifically Amy Rottman, ISK) to the SWMBH Board Finance Committee to provide CMH perspective to support that Finance Committee.

-CMH CEOs recommend SWMBH immediately contract with Rehman to provide:

*Financial Oversight

*Assurance of SCA Compliance – FY25 (or FY26) requirement for audit for PHIP

*Assurance of SCA/Financial alignment of CMH to SWMBH reporting

(align with CMH reporting structure)

-CEOs recommend PCE Implementation

*Better linkage between CMH

*All other PIHPs are on this data platform

*Ease of reporting/current state requirements

For the last two recommendations. CMH CEOs understand this is an additional expense.

The structure of Financial oversight and Data reporting needs to be changed.

In a time of Financial Crisis, doing the same doesn't change the outcome. We need to better understand and take quicker action on these issues.

Board Actions to be Considered

Calendar Year 2025 Board Meeting Calendar

Sherii Sherban reported as documented.

Motion Tom Schmelzer moved to approve the Calendar Year 2025 Board Meeting Calendar as presented.

Second Edward Meny

Motion Carried

Calendar Year 2025 Board Policy Calendar

Sherii Sherban reported as documented.

Motion Tom Schmelzer moved to approve the 2025 Board Policy Calendar as presented.

Second Edward Meny

Motion Carried

Holiday Luncheon

Sherii Sherban reported as documented.

Motion Cathi Abbs moved that the Board would not have a luncheon.

Second Lorrainne Lindsey

Motion Carried

Board Policy Review

BG-005 Chairperson's Role

Sherii Sherban reported as documented. Discussion of Chair's authority to appoint Board Members to committees without a Board vote. Board members noted that 6.6 of the policy covers this issue.

Motion Lorraine Lindsey moved that the Board is in compliance with BG-005 Chairperson's Role and that the policy does not need revisions.

Second Edward Meny

Motion Carried

EO-002 Monitoring Executive Officer Performance

Edward Meny reported as documented. Sherii Sherban commented that there could be future revisions to this policy based on new Board Ends being established. Discussion followed.

Motion Edward Meny moved that the Board is in compliance with EO-002 Monitoring Executive Officer Performance and the policy does not need revisions.

Second Lorraine Lindsey

Motion Carried

Executive Limitations Review

BEL-003 Asset Protection

Erik Krogh reported as documented. Discussion followed.

Motion Erik Krogh moved that the Executive Officer is in compliance with BEL-003 Asset Protection and that the policy does not need revisions.

Second Tom Schmelzer

Motion Carried

Board Education

Fiscal Year 2025 Year to Date Financial Statements

Garyl Guidry reported as documented. Garyl Guidry shared a current cash flow analysis. Louie Csokasy asked that the financials be moved to the beginning of the agenda. Board Members agreed. Discussion on financials followed.

Communication and Counsel to the Board

Fiscal Year 2024 Contract Vendor Summary
Report is included in the packet for the Board's information.

Fiscal Year 2024 Customer Services Report
Report is included in the packet for the Board's information.
February Board Policy Direct Inspection
None scheduled.

Public Comment

Mila Todd updated Board at recent PIHP/MDHHS meeting that CMS approved the HAB Waiver so Conflict Free Access and Planning (CFAP) is restarting implementation at a date to be determined by MDHHS. Cathi Abbs asked if the Board was doing something for Brad Casemore. Discussion followed and Anne Wickham will follow up on the Board's behalf. Louie Csokasy stated that SWMBH will be out of money by August. Jeff Patton stated that it's important that the region take things step by step and exercise patience.

Adjournment

Motion	Louie Csokasy moved to adjourn at 11:35am
Second	Edward Meny
Motion Carried	

Date:	1/22/25
Time:	9:00 am-11:00 am
Facilitator:	Debbie
Minute Taker:	Cameron
Meeting Location:	SWMBH, 5250 Lovers Lane, Suite 200, Portage, MI 49002 Click here to join the meeting

Present: ☒ Rich Thiemkey (Barry) ☒ John Ruddell (Woodlands) ☐ Brad Casemore (SWMBH)
☒ Ric Compton (Riverwood) ☒ Jeff Patton (ISK) ☒ Mila Todd (SWMBH)
☒ Sue Germann (Pines BHS) ☒ Cameron Bullock (Pivotal) ☒ Garyl Guidry (SWMBH)
☐ Jeannie Goodrich (Summit) ☒ Debbie Hess (Van Buren)
☐ Guest(s):

Version: 1/15/25

Agenda Topics:	Discussion Points:	Minutes:
1. Agenda Review & Adoption (d)		
2. Prior Minutes (d)		• Accepted after last meeting and sent to board already
3. FY 2025 YTD financials (Garyl) (d)		• No new financials. P3 financials are due to SWMBH by 1/23/25 • Ten PIHPS are examining FY 25 revenue. Actual revenues have been reviewed from October through December, and rough revenue assumptions are even lower than Rehmann's. • Significant loss of eligibles in December. • Garyl hopes to have updated financials as requested by Ops Comm within the next few periods.
4. Department Meeting PPT Review		• Jeff asks that CMH CEOs review the ABA dx codes to match what Milliman uses for their cost apportionment. Diagnosis codes F840, F843, F845, F848, and F849. • Mila presented PPT that is to be shown during the department meeting on 1/23/25- Mila will send it out to CEOs

		once the meeting with Mila, Garyl, Jeff, Amy, and John later this afternoon. • SUE project- Garyl to update with EQI P2 and send it to CEOs. • SWMBH has five positions open but frozen and will not be filled • Group purchasing has been implemented to help with non-service expenses. • Ric inquired about the status of the BH-TEDs being required for an encounter to be sent- It is requested that Mila reach out to other PIHPs to see if they require BH-Teds for encounters to be submitted. o Mila stated that there were some issues with timely resubmissions of BH-TED data o Garyl stated there would be a benefit to have an encounter analysis to determine how many encounters are not being sent. Mila sent an ask out to Natalie and John to find out the information. • Ric will send a report that Caleb has been working on for Encounter data reports. • Request that Ops Comms that encounter submissions/BH-TEDs errors be presented monthly for CEO review. o Rough Estimate for FY 24 o Roughly 2 million encounters accepted by MDHHS o 3,750 not accepted due to BH-TEDs -.14% ▪ How many were rejected for other reasons unrelated to BH-TEDs and not sent to the state? o Questions outstanding: ▪ How many encounters from the CMH to SWMBH were not sent due to BH-TEDs or other SWMBH/contract reasoning?

		• This is a CMH review, not SWMBH. • Current deficit projections show $23.5 Million. ISF is not sufficient to cover FY 25 expenses.
4. QAPI Eval and Plan (Mila)		• No questions/comments/concerns listed. • Reviewed by Ops Comm

5. PCE Update (Mila)		• TBD sent the RFI last week. Revisions have been made and will go out to PCE tomorrow, 1/23/25.
		• Once PCE receives the RFI and responds, pricing will be presented to SMWBH.
		• Mila pondered what would happen with moving forward without any money to do it…
		  ○ Cameron stated that there are numerous benefits to having the same system and that without the system implementation, we will continue to have administrative duplication, etc.
		  ○ Ric states that if we continue to wait, the problem continues to get pushed down the road, and we cannot fix issues with the current system.

6. PBIP (Mila)		• A draft report from the department regarding PBIP performance was obtained by SWMBH on 1/21/2025. Being reviewed by the SWMBH internal team.
7. Plan for allowing CMHs to become responsible for continuing stay reviews for psychiatric inpatient care.		• Mila presented the Proposed Plan for Continued Stay Reviews for CEO approval. This was worked on in conjunction with Summit Point and Pivotal to be able to present to the SWMBH board. • Debbie and Ric would like to see timeframes listed in the workflow, establishing a standard for both CMHs and SWMBHs. • Mila hesitates to hold a strict time frame as it may hold CMH or SWMBH to unreasonable standards that either CMH

		or SWMBH may not want or be ready for. • Rich states that this is where the Ops Comm Survey shows mutual distrust between SMWBH and CEOs, which hasn't been dived into and wants concrete information to be able to move forward. • Mila will send to CEOs revisions made in the Ops Comm Meeting and feedback or changes to Mila by 1/30/25, if needed, can get final approval at the 1/30/25 meeting. • Rich would like to thank SWMBH, Summit Point, and Pivotal for working collaboratively to reach a mutual understanding of this process.
8. Next Meeting January 30-Rehman Analysis **Agenda:**		
9. Feb 12th, 2025		• Financial Plans for Ops Comm Approval (Garyl) • MDHHS Follow Up (Mila) • PBIP disbursement draft if available (Mila) • Financials (Garyl)

Southwest Michigan
BEHAVIORAL HEALTH

Board Finance Committee Meeting Minutes
January 3, 2025
Air Zoo, 6150 Portage Rd., Portage, Michigan 49002
10:45-11:50 am
Draft: 1/8/25

Members Present: Tom Schmelzer, Louie Csokasy, Carol Naccarato, Sherii Sherben

Guest: Michael Seals

Members Absent: None

SWMBH Staff Present: Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Interim EO, SWMBH; Anne Wickham

Review Agenda

Motion	Louie Csokasy moved to approve the agenda as presented.
Second	Carol Naccarato
Motion Carried	

Central Topics

Review prior meeting minutes

Motion	Carol Naccarato moved to approve the minutes as presented.
Second	Louie Csokasy
Motion Carried	

Review SWMBH YTD financial statements
Garyl reviewed YTD financial statements noting revenue, expenses, and projections for 2025. Garyl noted estimates from CMHs and expectations following 1st Quarter. Discussion followed.

SWMBH Check Registers
Garyl reviewed the checks registers as documented. Discussion followed.

SWMBH Cash Flow Analysis
Garyl reviewed current forecast of Cash Flow Analysis. Discussion followed.

Financial Risk Management, Financial Management and Cost Allocation Plans
Garyl presented these plans and indicated he is taking input from multiple sectors including this committee and they will go to Board for approval in February.

Adjournment

Meeting adjourned at 11:50 am

	E	F	I	J	K
1	***Southwest Michigan Behavioral Health***				
2	For the Fiscal YTD Period Ended 9/30/2025			**FY25 PIHP**	
3	*(For Internal Management Purposes Only)*				
4			**FY25 Budget**	**FY25 Actual as P03**	**FY 25 Projection**
6	**REVENUE**				
16	Contract Revenue		318,934,780	77,667,936	310,671,744
17	CMHSP Incentive Payments		419,357	109,604	438,418
18	PIHP Incentive Payments		2,483,291	620,823	2,483,291
19	Interest Income - Working Capital		1,222,315	240,943	963,773
20	Interest Income - ISF Risk Reserve		-	129,188	516,753
21	Local Funds Contributions		852,520	213,130	852,520
22	Other Local Income				-
23					
24	**TOTAL REVENUE**		**323,912,264**	**78,981,625**	**315,926,498**
25					
26	**EXPENSE**				
27	**Healthcare Cost**				
28	Provider Claims Cost		23,023,897	5,199,916	20,799,663
29	CMHP Subcontracts, net of 1st & 3rd party		263,904,801	65,065,130	260,260,519
30	Insurance Provider Assessment Withhold (IPA		3,746,326	731,867	2,927,467
31	Medicaid Hospital Rate Adjustments		12,089,192	3,022,298	12,089,192
33			-	-	-
34	**Total Healthcare Cost**		**302,764,215**	**74,019,210**	**296,076,841**
35	**Medical Loss Ratio (HCC % of Revenue)**		**94.9%**	**95.3%**	**95.3%**
36					
37	**Administrative Cost**				
39	Administrative and Other Cost		12,805,756	2,218,177	8,872,706
44	Delegated Managed Care Admin		24,714,174	6,253,640	25,014,560
45	Apportioned Central Mgd Care Admin		(2,665,293)	(421,493)	(1,685,971)
46					
47	**Total Administrative Cost**		**34,854,637**	**8,050,324**	**32,201,296**
48	**Admin Cost Ratio (MCA % of Total Cost)**		**10.3%**	**9.8%**	**9.8%**
49					
50	Local Funds Cost		852,520	213,130	852,520
52					
53	**TOTAL COST after apportionment**		**338,471,372**	**82,282,664**	**329,130,656**
54					
55	**NET SURPLUS before settlement**		**(14,559,107)**	**(3,301,040)**	**(13,204,158)**
56	**Net Surplus (Deficit) % of Revenue**		**-4.5%**	**-4.2%**	**-4.2%**
57					
58	Prior Year Savings Utilization				
61	ISF Risk Reserve Utilization		1,929,280	1,382,670	1,382,670
62	CCBHC Supplemental Receivable (Payable)		3,813,725	-	-
63	MDHHS Shared Risk Utilization		-	-	-
66	**NET SURPLUS (DEFICIT)**		**(8,816,103)**	**(1,918,370)**	**(11,821,489)**
67	*HMP & Autism is settled with Medicaid*				

	A	B	C	D	E
1	***Southwest Michigan Behavioral Health***				
2	For the Fiscal YTD Period Ended 9/30/2025			**FY25 CCBHC**	
3	*(For Internal Management Purposes Only)*				
4			**FY25 Budget**	**FY25 Actual as P03**	**FY 25 Projection**
5					
6	**REVENUE**				
16	Contract Revenue		94,989,631	24,069,428	96,277,713
17	CMHSP Incentive Payments		3,422,650	855,662	3,422,650
18					
19	**TOTAL REVENUE**		**98,412,281**	**24,925,091**	**99,700,363**
20					
21	**EXPENSE**				
22	**Healthcare Cost**				
23	CCBHC Subcontracts		82,461,854	18,942,780	75,771,119
24					
25	**Total Healthcare Cost**		**82,461,854**	**18,942,780**	**75,771,119**
26	**Medical Loss Ratio (HCC % of Revenue)**		**83.8%**	**76.0%**	**76.0%**
27					
28					
29	**Administrative Cost**				
30	Apportioned Central Mgd Care Admin		2,665,293	421,493	1,685,971
31					
32	**Total Administrative Cost**		**2,665,293**	**421,493**	**1,685,971**
33	**Admin Cost Ratio (MCA % of Total Cost)**		**3.1%**	**2.2%**	**2.2%**
34					
35	**TOTAL COST**		**85,127,147**	**19,364,273**	**77,457,090**
36					
37	**NET SURPLUS before non MCA cost**		**13,285,134**	**5,560,818**	**22,243,273**
38	**Net Surplus (Deficit) % of Revenue**		**13.5%**	**22.3%**	**22.3%**
39					
40	CCBHC Non Medicaid Cost		(10,261,247)	(3,477,469)	(13,909,877)
41					
42	**CCBHC Net Surplus/(Deficit)**		**3,023,886**	**2,083,349**	**8,333,395**
43					

Southwest Michigan Behavioral Health

MEDICAID Summary Income Statement

For the Fiscal YTD Period Ended 12/31/2024

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
Medicaid Specialty Services											
Contract Revenue	$ 64,466,783	$ 2,911,723	$ 61,555,060	$ 2,538,825	$ 11,838,522	$ 3,129,924	$ 11,262,354	$ 4,178,226	$ 17,959,148	$ 4,002,762	$ 6,645,298
Budget v Actual	$ (2,033,293)	$ (4,027,940)	$ 1,994,647	$ (58,831)	$ 523,251	$ (111,000)	$ 750,195	$ 223,738	$ (329,322)	$ (30,590)	$ 1,027,207
% Variance - Fav / (Unfav)	-3.1%	-58.0%	3.3%	-2.3%	4.6%	-3.4%	7.1%	5.7%	-1.8%	-0.8%	18.3%
Healthcare Cost	$ 61,531,154	$ 1,658,441	$ 59,872,713	$ 1,717,870	$ 11,194,583	$ 1,905,330	$ 10,377,250	$ 5,002,471	$ 19,101,284	$ 4,376,562	$ 6,197,363
Budget v Actual	$ 2,415,647	$ 1,889,470	$ 526,177	$ 249,030	$ (86,889)	$ 1,008,313	$ (34,878)	$ (543,663)	$ 556,964	$ 171,393	$ (794,093)
% Variance - Fav / (Unfav)	3.8%	53.3%	0.9%	12.7%	-0.8%	34.6%	-0.3%	-12.2%	2.8%	3.8%	-14.7%
MLR	95.4%	57.0%	97.3%	67.7%	94.6%	60.9%	92.1%	119.7%	106.4%	109.3%	93.3%
Managed Care Administration	$ 6,924,830	$ 1,354,743	$ 5,570,086	$ 259,783	$ 1,154,125	$ 145,606	$ 1,159,282	$ 428,864	$ 1,362,675	$ 449,601	$ 610,150
Budget v Actual	$ 622,990	$ 630,346	$ (7,356)	$ (89,967)	$ (46,475)	$ 54,935	$ (63,945)	$ (93,334)	$ 361,090	$ (54,126)	$ (75,533)
% Variance - Fav / (Unfav)	8.3%	31.8%	-0.1%	-53.0%	-4.2%	27.4%	-5.8%	-27.8%	20.9%	-13.7%	-14.1%
ACR	10.1%	2.0%	8.1%	13.1%	9.3%	7.1%	10.0%	7.9%	6.7%	9.3%	9.0%
Total Contract Cost	$ 68,455,983	$ 3,013,184	$ 65,442,799	$ 1,977,653	$ 12,348,708	$ 2,050,936	$ 11,536,532	$ 5,431,335	$ 20,463,959	$ 4,826,163	$ 6,807,514
Budget v Actual	$ 3,038,637	$ 2,519,816	$ 518,821	$ 159,063	$ (133,365)	$ 1,063,248	$ (98,823)	$ (636,997)	$ 918,054	$ 117,267	$ (869,627)
Variance - Favorable / (Unfavorable)	4.3%	45.5%	0.8%	7.4%	-1.1%	34.1%	-0.9%	-13.3%	4.3%	2.4%	-14.6%
Net before Settlement	$ (3,989,201)	$ (101,462)	$ (3,887,739)	$ 561,172	$ (510,186)	$ 1,078,989	$ (274,178)	$ (1,253,109)	$ (2,504,810)	$ (823,401)	$ (162,216)
Budget v Actual	$ 1,005,344	$ (1,508,123)	$ 2,513,468	$ 100,232	$ 389,886	$ 952,248	$ 651,371	$ (413,259)	$ 588,732	$ 86,677	$ 157,580
Variance - Favorable / (Unfavorable)	20.1%	-107.2%	39.3%	21.7%	43.3%	751.3%	70.4%	-49.2%	19.0%	9.5%	49.3%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 1/28/2025

within +/- 2%
>2% favorable
between -2&-4%
>4% unfavorable

Southwest Michigan Behavioral Health

HEALTHY MICHIGAN Summary Income Statement

For the Fiscal YTD Period Ended 12/31/2024

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
	-	-	-	-	-	-	-	-	-	-	-
Healthy Michigan Plan (HMP)											
Contract Revenue	$ 7,088,736	$ 1,884,417	$ 5,204,319	$ 226,784	$ 1,064,193	$ 159,262	$ 1,219,845	$ 434,372	$ 1,214,247	$ 420,022	$ 465,594
Budget v Actual	$ (3,817,856)	$ (1,293,066)	$ (2,524,790)	$ (148,906)	$ (491,449)	$ (182,035)	$ (168,997)	$ (129,242)	$ (1,026,505)	$ (146,314)	$ (231,344)
% Variance - Fav / (Unfav)	-35.0%	-40.7%	-32.7%	-39.6%	-31.6%	-53.3%	-12.2%	-22.9%	-45.8%	-25.8%	-33.2%
Healthcare Cost	$ 7,308,166	$ 2,209,970	$ 5,098,196	$ 228,936	$ 1,021,605	$ 183,257	$ 1,340,302	$ 462,896	$ 1,024,531	$ 424,069	$ 412,600
Budget v Actual	$ 1,802,839	$ 1,467,748	$ 335,092	$ (32,141)	$ (198,378)	$ (3,249)	$ 71,290	$ (20,603)	$ 284,796	$ (283)	$ 233,660
% Variance - Fav / (Unfav)	19.8%	39.9%	6.2%	-16.3%	-24.1%	-1.8%	5.1%	-4.7%	21.8%	-0.1%	36.2%
MLR	103.1%	117.3%	98.0%	100.9%	96.0%	115.1%	109.9%	106.6%	84.4%	101.0%	88.6%
Managed Care Administration	$ 841,806	$ 158,252	$ 683,554	$ 63,337	$ 159,074	$ 26,458	$ 184,840	$ 44,684	$ 73,090	$ 50,840	$ 81,230
Budget v Actual	$ 18,621	$ 86,362	$ (67,740)	$ (46,755)	$ (32,490)	$ 720	$ (170)	$ (8,841)	$ 40,605	$ 1,538	$ (22,348)
% Variance - Fav / (Unfav)	2.2%	35.3%	-11.0%	-282.0%	-25.7%	2.6%	-0.1%	-24.7%	35.7%	2.9%	-38.0%
ACR	10.3%	1.9%	8.4%	21.7%	13.5%	12.6%	12.1%	8.8%	6.7%	10.7%	16.4%
Total Contract Cost	$ 8,149,971	$ 2,368,221	$ 5,781,750	$ 292,273	$ 1,180,679	$ 209,716	$ 1,525,142	$ 507,581	$ 1,097,621	$ 474,909	$ 493,830
Budget v Actual	$ 9,971,432	$ 3,922,331	$ 6,049,101	$ 213,377	$ 949,811	$ 207,187	$ 1,596,262	$ 478,136	$ 1,423,022	$ 476,164	$ 705,142
% Variance - Fav / (Unfav)	18.3%	39.6%	4.4%	-37.0%	-24.3%	-1.2%	4.5%	-6.2%	22.9%	0.3%	30.0%
Net before Settlement	$ (1,061,235)	$ (483,804)	$ (577,431)	$ (65,489)	$ (116,486)	$ (50,454)	$ (305,297)	$ (73,208)	$ 116,626	$ (54,887)	$ (28,236)
Budget v Actual	$ (1,996,396)	$ 261,043	$ (2,257,439)	$ (227,802)	$ (722,317)	$ (184,564)	$ (97,876)	$ (158,687)	$ (701,103)	$ (145,059)	$ (20,032)
% Variance - Fav / (Unfav)	-213.5%	35.0%	-134.4%	-140.3%	-119.2%	-137.6%	-47.2%	-185.6%	-85.7%	-160.9%	-244.2%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 1/28/2025

within +/- 2%
>2% favorable
between -2&-4%
>4% unfavorable

	E	F	H	J	K	M	N	P	Q	R	S
1	***Southwest Michigan Behavioral Health***			*Mos in Period*							
2	For the Fiscal YTD Period Ended 12/31/2024		**P03FYTD24**	**3**							
3	*(For Internal Management Purposes Only)*										
4	***INCOME STATEMENT***		**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Opioid Health Home Contract**	**CCBHC**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**
5											
6	**REVENUE**										
18	Contract Revenue		98,715,066	64,357,178	7,088,736	394,003	24,069,428	126,860	1,768,662	910,198	-
19	DHHS Incentive Payments		109,604	109,604	-	-	-	-	-	-	-
21	Interest Income - Working Capital		240,943	-	-	-	-	-	-	-	240,943
22	Interest Income - ISF Risk Reserve		129,188	-	-	-	-	-	-	-	129,188
23	Local Funds Contributions		213,130	-	-	-	-	-	-	-	213,130
24	Other Local Income		-	-	-	-	-	-	-	-	-
25											
26	**TOTAL REVENUE**		**99,407,932**	**64,466,783**	**7,088,736**	**394,003**	**24,069,428**	**126,860**	**1,768,662**	**910,198**	**583,261**
27											
28	**EXPENSE**										
29	**Healthcare Cost**										
30	Provider Claims Cost		5,200,103	1,122,569	2,013,975	184,751	-	6,874	1,592,616	279,131	-
31	CMHP Subcontracts, net of 1st & 3rd party		84,007,909	59,872,713	5,098,196	-	18,942,780	-	94,220	-	-
32	Insurance Provider Assessment Withhold (IPA)		731,867	535,872	195,995	-	-	-	-	-	-
33	Medicaid Hospital Rate Adjustments		-	-	-	-	-	-	-	-	-
34	MHL Cost in Excess of Medicare FFS Cost		-	192	-	-	-		-	-	-
35											
36	**Total Healthcare Cost**		**89,939,880**	**61,531,346**	**7,308,166**	**184,751**	**18,942,780**	**6,874**	**1,686,837**	**279,131**	**-**
37	**Medical Loss Ratio (HCC % of Revenue)**		**91.0%**	**95.4%**	**103.1%**	**46.9%**	**78.7%**		**95.4%**	**30.7%**	
38											
40	Purchased Professional Services		126,998	-	-	-	-	-	-	-	126,998
41	Administrative and Other Cost		2,091,179	-	-	-	-	119,987	40,928	-	1,928,542
43	Depreciation		-	-	-	-	-	-	-	-	-
44	Functional Cost Reclassification		-	-	-	-	-	-	-	-	-
45	Allocated Indirect Pooled Cost		(0)	-	-	-	-	-	-	-	1,722
46	Delegated Managed Care Admin		6,253,640	5,570,086	683,554	-	-	-	-	-	-
47	Apportioned Central Mgd Care Admin		(0)	1,354,743	158,252	4,111	421,493	2,823	40,897	-	(1,982,323)
48											
49	**Total Administrative Cost**		**8,471,817**	**6,924,830**	**841,806**	**4,111**	**421,493**	**122,809**	**81,825.19**	**-**	**74,939**
50	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**10.1%**	**10.3%**	**2.2%**	**2.2%**		**4.6%**	**0.0%**	**2.0%**
51											
52	Local Funds Contribution		213,130	-	-	-	-	-	-	-	213,130
54											
55	**TOTAL COST after apportionment**		**98,624,826**	**68,456,175**	**8,149,971**	**188,862**	**19,364,273**	**129,683**	**1,768,662**	**279,131**	**288,069**
56											
57	**NET SURPLUS before settlement**		**783,106**	**(3,989,392)**	**(1,061,235)**	**205,141**	**4,705,156**	**(2,823)**	**-**	**631,067**	**295,192**
58	**Net Surplus (Deficit) % of Revenue**		**0.8%**	**-6.2%**	**-15.0%**	**52.1%**	**19.5%**	**-2.2%**	**0.0%**	**69.3%**	**50.6%**
60	Prior Year Savings		-	-	-	-	-		-	-	-
61	Change in PA2 Fund Balance		(631,067)	-	-	-	-		-	(631,067)	-
62											
63	ISF Risk Reserve Abatement (Funding)		(129,188)	-	-	-	-		-	-	(129,188)
64	ISF Risk Reserve Deficit (Funding)		1,382,670	1,382,670	-	-	-		-	-	-
65	CCBHC Supplemental Reciveable (Payable)		(1,050,348)				(1,050,348)				
66	Settlement Receivable / (Payable)		0	(856,094)	1,061,235	(205,141)	-	-	-	-	-
67	**NET SURPLUS (DEFICIT)**		**355,173**	**(3,462,817)**	**-**	**-**	**3,654,808**	**(2,823)**	**-**	**-**	**166,004**
68	*HMP & Autism is settled with Medicaid*										
69											
70	**SUMMARY OF NET SURPLUS (DEFICIT)**										
71	Prior Year Unspent Savings		-	-	-	-	-		-	-	-
72	Current Year Savings		-	-	-	-	-		-	-	-
73	Current Year Public Act 2 Fund Balance		-	-	-	-	-		-	-	-
74	Local and Other Funds Surplus/(Deficit)		355,173	(3,462,817)	-	-	3,654,808	(2,823)	-	-	166,004
75											
76	**NET SURPLUS (DEFICIT)**		**355,173**	**(3,462,817)**	**-**	**-**	**3,654,808**	**(2,823)**	**-**	**-**	**166,004**

	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 12/31/2024			3									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			HCC%		44.5%	69.3%	55.1%	63.0%	87.1%	85.1%	63.2%	69.1%
7	Subcontract Revenue		64,357,178	2,802,118	61,555,060	2,538,825	11,838,522	3,129,924	11,262,354	4,178,226	17,959,148	4,002,762	6,645,298
8	Incentive Payment Revenue		109,604	109,604	-	-	-	-	-	-	-	-	-
9	**Contract Revenue**		**64,466,783**	**2,911,723**	**61,555,060**	**2,538,825**	**11,838,522**	**3,129,924**	**11,262,354**	**4,178,226**	**17,959,148**	**4,002,762**	**6,645,298**
10													
11	External Provider Cost		56,732,247	1,122,569	55,609,679	1,424,266	10,948,100	1,799,148	9,624,447	3,643,935	18,546,930	4,189,188	5,433,664
12	Internal Program Cost		4,423,903	-	4,423,903	293,604	373,052	107,937	752,804	1,358,536	555,272	187,374	795,324
13	SSI Reimb, 1st/3rd Party Cost Offset		(160,868)	-	(160,868)	-	(126,569)	(1,756)	-	-	(918)	-	(31,625)
14	Insurance Provider Assessment Withhold (IPA)		535,872	535,872	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**61,531,154**	**1,658,441**	**59,872,713**	**1,717,870**	**11,194,583**	**1,905,330**	**10,377,250**	**5,002,471**	**19,101,284**	**4,376,562**	**6,197,363**
17	**Medical Loss Ratio (HCC % of Revenue)**		**95.4%**	**57.0%**	**97.3%**	**67.7%**	**94.6%**	**60.9%**	**92.1%**	**119.7%**	**106.4%**	**109.3%**	**93.3%**
18													
19	**Managed Care Administration**		**6,924,830**	**1,354,743**	**5,570,086**	**259,783**	**1,154,125**	**145,606**	**1,159,282**	**428,864**	**1,362,675**	**449,601**	**610,150**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**10.1%**	**2.0%**	**8.1%**	**13.1%**	**9.3%**	**7.1%**	**10.0%**	**7.9%**	**6.7%**	**9.3%**	**9.0%**
21													
22	**Contract Cost**		**68,455,983**	**3,013,184**	**65,442,799**	**1,977,653**	**12,348,708**	**2,050,936**	**11,536,532**	**5,431,335**	**20,463,959**	**4,826,163**	**6,807,514**
23	**Net before Settlement**		**(3,989,201)**	**(101,462)**	**(3,887,739)**	**561,172**	**(510,186)**	**1,078,989**	**(274,178)**	**(1,253,109)**	**(2,504,810)**	**(823,401)**	**(162,216)**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		1,382,670	1,382,670	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(856,094)	(4,743,833)	3,887,739	(561,172)	510,186	(1,078,989)	274,178	1,253,109	2,504,810	823,401	162,216
28	**Net after Settlement**		**(3,462,625)**	**(3,462,625)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		148,853	148,853	148,853	7,736	28,177	8,840	29,091	8,614	39,957	11,679	14,759
32	Revenue PMPM		$ 144.36	$ 6.52	$ 137.84	$ 109.39	$ 140.05	$ 118.02	$ 129.05	$ 161.68	$ 149.82	$ 114.24	$ 150.08
33	Expense PMPM		$ 153.30	$ 6.75	$ 146.55	$ 85.21	$ 146.08	$ 77.34	$ 132.19	$ 210.17	$ 170.72	$ 137.74	$ 153.75
34	Margin PMPM		$ (8.93)	$ (0.23)	$ (8.71)	$ 24.18	$ (6.04)	$ 40.69	$ (3.14)	$ (48.49)	$ (20.90)	$ (23.50)	$ (3.66)
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		148,853	148,853	148,853	7,736	28,177	8,840	29,091	8,614	39,957	11,679	14,759
41	Budget		163,202	163,202	163,202	8,863	30,720	9,623	31,859	9,485	43,130	13,220	16,302
42	Variance - Favorable / (Unfavorable)		(14,349)	(14,349)	(14,349)	(1,127)	(2,543)	(783)	(2,768)	(871)	(3,173)	(1,541)	(1,543)
43	% Variance - Fav / (Unfav)		-8.8%	-8.8%	-8.8%	-12.7%	-8.3%	-8.1%	-8.7%	-9.2%	-7.4%	-11.7%	-9.5%
44													
45	**Contract Revenue before settlement**												
46	Actual		64,466,783	2,911,723	61,555,060	2,538,825	11,838,522	3,129,924	11,262,354	4,178,226	17,959,148	4,002,762	6,645,298
47	Budget		66,500,076	6,939,662	59,560,414	2,597,657	11,315,271	3,240,924	10,512,159	3,954,488	18,288,471	4,033,352	5,618,091
48	Variance - Favorable / (Unfavorable)		(2,033,293)	(4,027,940)	1,994,647	(58,831)	523,251	(111,000)	750,195	223,738	(329,322)	(30,590)	1,027,207
49	% Variance - Fav / (Unfav)		-3.1%	-58.0%	3.3%	-2.3%	4.6%	-3.4%	7.1%	5.7%	-1.8%	-0.8%	18.3%
50													
51	**Healthcare Cost**												
52	Actual		61,531,154	1,658,441	59,872,713	1,717,870	11,194,583	1,905,330	10,377,250	5,002,471	19,101,284	4,376,562	6,197,363
53	Budget		63,946,801	3,547,911	60,398,890	1,966,900	11,107,694	2,913,643	10,342,372	4,458,808	19,658,248	4,547,956	5,403,270
54	Variance - Favorable / (Unfavorable)		2,415,647	1,889,470	526,177	249,030	(86,889)	1,008,313	(34,878)	(543,663)	556,964	171,393	(794,093)
55	% Variance - Fav / (Unfav)		3.8%	53.3%	0.9%	12.7%	-0.8%	34.6%	-0.3%	-12.2%	2.8%	3.8%	-14.7%
56													
57	**Managed Care Administration**												
58	Actual		6,924,830	1,354,743	5,570,086	259,783	1,154,125	145,606	1,159,282	428,864	1,362,675	449,601	610,150
59	Budget		7,547,820	1,985,090	5,562,730	169,817	1,107,650	200,541	1,095,337	335,530	1,723,764	395,474	534,617
60	Variance - Favorable / (Unfavorable)		622,990	630,346	(7,356)	(89,967)	(46,475)	54,935	(63,945)	(93,334)	361,090	(54,126)	(75,533)
61	% Variance - Fav / (Unfav)		8.3%	31.8%	-0.1%	-53.0%	-4.2%	27.4%	-5.8%	-27.8%	20.9%	-13.7%	-14.1%
62													
63													
64	**Total Contract Cost**												
65	Actual		68,455,983	3,013,184	65,442,799	1,977,653	12,348,708	2,050,936	11,536,532	5,431,335	20,463,959	4,826,163	6,807,514
66	Budget		71,494,621	5,533,001	65,961,620	2,136,716	12,215,344	3,114,184	11,437,709	4,794,339	21,382,013	4,943,430	5,937,887
67	Variance - Favorable / (Unfavorable)		3,038,637	2,519,816	518,821	159,063	(133,365)	1,063,248	(98,823)	(636,997)	918,054	117,267	(869,627)
68	% Variance - Fav / (Unfav)		4.3%	45.5%	0.8%	7.4%	-1.1%	34.1%	-0.9%	-13.3%	4.3%	2.4%	-14.6%
69													
70	**Net before Settlement**												
71	Actual		(3,989,201)	(101,462)	(3,887,739)	561,172	(510,186)	1,078,989	(274,178)	(1,253,109)	(2,504,810)	(823,401)	(162,216)
72	Budget		(4,994,545)	1,406,662	(6,401,207)	460,940	(900,072)	126,741	(925,550)	(839,850)	(3,093,542)	(910,078)	(319,796)
73	Variance - Favorable / (Unfavorable)		1,005,344	(1,508,123)	2,513,468	100,232	389,886	952,248	651,371	(413,259)	588,732	86,677	157,580
74			20.1%	-107.2%	39.3%	21.7%	43.3%	751.3%	70.4%	-49.2%	19.0%	9.5%	49.3%
75													

	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 12/31/2024			3									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5													
76	**Healthy Michigan Plan**			*HCC%*		5.9%	6.3%	5.3%	8.1%	8.1%	10.4%	6.1%	4.6%
77	**Contract Revenue**		**7,088,736**	**1,884,417**	**5,204,319**	**226,784**	**1,064,193**	**159,262**	**1,219,845**	**434,372**	**1,214,247**	**420,022**	**465,594**
78													
79	External Provider Cost		6,524,431	2,013,975	4,510,456	224,777	976,817	172,272	1,281,309	57,642	1,019,529	405,029	373,080
80	Internal Program Cost		587,792	-	587,792	4,159	44,788	10,985	58,992	405,254	5,053	19,040	39,520
81	SSI Reimb, 1st/3rd Party Cost Offset		(51)	-	(51)	-	-	-	-	-	(51)	-	-
82	Insurance Provider Assessment Withhold (IPA)		195,995	195,995	-	-	-	-	-	-	-	-	-
83	**Total Healthcare Cost**		**7,308,166**	**2,209,970**	**5,098,196**	**228,936**	**1,021,605**	**183,257**	**1,340,302**	**462,896**	**1,024,531**	**424,069**	**412,600**
84	**Medical Loss Ratio (HCC % of Revenue)**		**103.1%**	**117.3%**	**98.0%**	**100.9%**	**96.0%**	**115.1%**	**109.9%**	**106.6%**	**84.4%**	**101.0%**	**88.6%**
85													
86	**Managed Care Administration**		**841,806**	**158,252**	**683,554**	**63,337**	**159,074**	**26,458**	**184,840**	**44,684**	**73,090**	**50,840**	**81,230**
87	**Admin Cost Ratio (MCA % of Total Cost)**		**10.3%**	**1.9%**	**8.4%**	**21.7%**	**13.5%**	**12.6%**	**12.1%**	**8.8%**	**6.7%**	**10.7%**	**16.4%**
88													
89	**Contract Cost**		**8,149,971**	**2,368,221**	**5,781,750**	**292,273**	**1,180,679**	**209,716**	**1,525,142**	**507,581**	**1,097,621**	**474,909**	**493,830**
90	**Net before Settlement**		**(1,061,235)**	**(483,804)**	**(577,431)**	**(65,489)**	**(116,486)**	**(50,454)**	**(305,297)**	**(73,208)**	**116,626**	**(54,887)**	**(28,236)**
91													
92	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
93	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
94	Contract Settlement / Redistribution		1,061,235	483,804	577,431	65,489	116,486	50,454	305,297	73,208	(116,626)	54,887	28,236
95	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
96													
97	**Eligibles and PMPM**												
98	Average Eligibles		54,443	54,443	54,443	2,618	11,339	2,670	10,354	3,151	15,494	4,054	4,764
99	Revenue PMPM		$ 43.40	$ 11.54	$ 31.86	$ 28.87	$ 31.28	$ 19.88	$ 39.27	$ 45.96	$ 26.12	$ 34.54	$ 32.58
100	Expense PMPM		49.90	14.50	35.40	37.21	34.71	26.18	49.10	53.70	23.61	39.05	34.56
101	Margin PMPM		$ (6.50)	$ (2.96)	$ (3.54)	$ (8.34)	$ (3.42)	$ (6.30)	$ (9.83)	$ (7.75)	$ 2.51	$ (4.51)	$ (1.98)
102													
103	**Healthy Michigan Plan**												
104	**Budget v Actual**												
105													
106	**Eligible Lives (Average Eligibles)**												
107	Actual		54,443	54,443	54,443	2,618	11,339	2,670	10,354	3,151	15,494	4,054	4,764
108	Budget		66,175	66,175	66,175	3,411	13,229	3,209	12,205	3,854	18,971	5,038	6,258
109	Variance - Favorable / (Unfavorable)		(11,732)	(11,732)	(11,732)	(793)	(1,890)	(539)	(1,852)	(703)	(3,477)	(984)	(1,494)
110	% Variance - Fav / (Unfav)		-17.7%	-17.7%	-17.7%	-23.2%	-14.3%	-16.8%	-15.2%	-18.2%	-18.3%	-19.5%	-23.9%
111													
112	**Contract Revenue before settlement**												
113	Actual		7,088,736	1,884,417	5,204,319	226,784	1,064,193	159,262	1,219,845	434,372	1,214,247	420,022	465,594
114	Budget		10,906,592	3,177,484	7,729,109	375,690	1,555,642	341,296	1,388,842	563,614	2,240,751	566,335	696,938
115	Variance - Favorable / (Unfavorable)		(3,817,856)	(1,293,066)	(2,524,790)	(148,906)	(491,449)	(182,035)	(168,997)	(129,242)	(1,026,505)	(146,314)	(231,344)
116	% Variance - Fav / (Unfav)		-35.0%	-40.7%	-32.7%	-39.6%	-31.6%	-53.3%	-12.2%	-22.9%	-45.8%	-25.8%	-33.2%
117													
118	**Healthcare Cost**												
119	Actual		7,308,166	2,209,970	5,098,196	228,936	1,021,605	183,257	1,340,302	462,896	1,024,531	424,069	412,600
120	Budget		9,111,005	3,677,717	5,433,288	196,795	823,227	180,008	1,411,592	442,293	1,309,327	423,786	646,261
121	Variance - Favorable / (Unfavorable)		1,802,839	1,467,748	335,092	(32,141)	(198,378)	(3,249)	71,290	(20,603)	284,796	(283)	233,660
122	% Variance - Fav / (Unfav)		19.8%	39.9%	6.2%	-16.3%	-24.1%	-1.8%	5.1%	-4.7%	21.8%	-0.1%	36.2%
123													
124	**Managed Care Administration**												
125	Actual		841,806	158,252	683,554	63,337	159,074	26,458	184,840	44,684	73,090	50,840	81,230
126	Budget		860,427	244,614	615,813	16,583	126,584	27,178	184,671	35,843	113,695	52,378	58,882
127	Variance - Favorable / (Unfavorable)		18,621	86,362	(67,740)	(46,755)	(32,490)	720	(170)	(8,841)	40,605	1,538	(22,348)
128	% Variance - Fav / (Unfav)		2.2%	35.3%	-11.0%	-282.0%	-25.7%	2.6%	-0.1%	-24.7%	35.7%	2.9%	-38.0%
129													
130	**Total Contract Cost**												
131	Actual		8,149,971	2,368,221	5,781,750	292,273	1,180,679	209,716	1,525,142	507,581	1,097,621	474,909	493,830
132	Budget		9,971,432	3,922,331	6,049,101	213,377	949,811	207,187	1,596,262	478,136	1,423,022	476,164	705,142
133	Variance - Favorable / (Unfavorable)		1,821,461	1,554,109	267,351	(78,896)	(230,868)	(2,529)	71,121	(29,445)	325,402	1,255	211,312
134	% Variance - Fav / (Unfav)		18.3%	39.6%	4.4%	-37.0%	-24.3%	-1.2%	4.5%	-6.2%	22.9%	0.3%	30.0%
135													
136	**Net before Settlement**												
137	Actual		(1,061,235)	(483,804)	(577,431)	(65,489)	(116,486)	(50,454)	(305,297)	(73,208)	116,626	(54,887)	(28,236)
138	Budget		935,160	(744,847)	1,680,007	162,312	605,831	134,109	(207,420)	85,479	817,729	90,172	(8,204)
139	Variance - Favorable / (Unfavorable)		(1,996,396)	261,043	(2,257,439)	(227,802)	(722,317)	(184,564)	(97,876)	(158,687)	(701,103)	(145,059)	(20,032)
140			-213.5%	35.0%	-134.4%	-140.3%	-119.2%	-137.6%	-47.2%	-185.6%	-85.7%	-160.9%	-244.2%
141													
142	**Certified Community Behavioral Health Clin**			*HCC%*		0.0%	0.0%	0.0%	0.0%	0.0%	27.5%	0.0%	0.0%
143	**Contract Revenue**		**24,069,428**	**1,056,184**	**23,013,244**	**1,434,673**	**4,481,501**	**1,707,573**	**4,459,758**	**-**	**8,964,327**	**1,965,411**	**-**
144													

	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 12/31/2024			3									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
145	External Provider Cost		6,389,005	-	6,389,005	-	-	-	-	-	6,389,005	-	-
146	Internal Program Cost		12,572,275	-	12,572,275	1,496,070	3,060,957	1,140,240	3,491,958	-	1,759,829	1,623,222	-
147	CCBHC General Fund Pass-through		-	-	-	-	-	-	-	-	-	-	-
148	SSI Reimb, 1st/3rd Party Cost Offset		(18,501)	-	(18,501)	-	-	-	-	-	-	(18,501)	-
150	**Total Healthcare Cost**		**18,942,780**	**-**	**18,942,780**	**1,496,070**	**3,060,957**	**1,140,240**	**3,491,958**	**-**	**8,148,834**	**1,604,721**	**-**
151	**Medical Loss Ratio (HCC % of Revenue)**		**78.7%**	**0.0%**	**82.3%**	**104.3%**	**68.3%**	**66.8%**	**78.3%**	**0.0%**	**90.9%**	**81.6%**	**0.0%**
152													
153	**Managed Care Administration**		**421,493**	**421,493**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
154	**Admin Cost Ratio (MCA % of Total Cost)**		**2.2%**	**2.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
155													
156	**Contract Cost**		**19,364,273**	**421,493**	**18,942,780**	**1,496,070**	**3,060,957**	**1,140,240**	**3,491,958**	**-**	**8,148,834**	**1,604,721**	**-**
157	**Net before Settlement**		**4,705,156**	**634,692**	**4,070,464**	**(61,396)**	**1,420,544**	**567,333**	**967,799**	**-**	**815,493**	**360,690**	**-**
158	PPS-1 Supplemental Payment Difference		(1,050,348)	-	(1,050,348)	(33,847)	(183,228)	(105,223)	(1,498,254)	-	229,053	541,151	-
159	Contract Settlement / Redistribution		3,654,808	634,692	3,020,116	(95,243)	1,237,317	462,111	(530,455)	-	1,044,546	901,841	-
160	**Net after Settlement**		**3,654,808**	**634,692**	**3,020,116**	**(95,243)**	**1,237,317**	**462,111**	**(530,455)**	**-**	**1,044,546**	**901,841**	**-**
161													
162													
181	***SWMBH CMHP Subcontracts***												
182	Subcontract Revenue		95,515,343	5,742,720	89,772,623	4,200,282	17,384,217	4,996,759	16,941,957	4,612,599	28,137,722	6,388,195	7,110,892
183	Incentive Payment Revenue		109,604	109,604	-	-	-	-	-	-	-	-	-
184	**Contract Revenue**		**95,624,947**	**5,852,324**	**89,772,623**	**4,200,282**	**17,384,217**	**4,996,759**	**16,941,957**	**4,612,599**	**28,137,722**	**6,388,195**	**7,110,892**
185													
186	External Provider Cost		69,645,683	3,136,544	66,509,139	1,649,043	11,924,917	1,971,420	10,905,756	3,701,578	25,955,464	4,594,217	5,806,744
187	Internal Program Cost		17,583,970	-	17,583,970	1,793,833	3,478,797	1,259,163	4,303,754	1,763,789	2,320,154	1,829,636	834,844
188	CCBHC General Fund Pass-through		-										
189	SSI Reimb, 1st/3rd Party Cost Offset		(179,421)	-	(179,369)	-	(126,569)	(1,756)	-	-	(918)	(18,501)	(31,625)
190	Insurance Provider Assessment Withhold (IPA)		731,867	731,867	-	-	-	-	-	-	-	-	-
192	**Total Healthcare Cost**		**87,782,100**	**3,868,411**	**83,913,740**	**3,442,876**	**15,277,145**	**3,228,827**	**15,209,510**	**5,465,367**	**28,274,700**	**6,405,352**	**6,609,963**
193	**Medical Loss Ratio (HCC % of Revenue)**		**91.8%**	**66.1%**	**93.5%**	**82.0%**	**87.9%**	**64.6%**	**89.8%**	**118.5%**	**100.5%**	**100.3%**	**93.0%**
194													
195	**Managed Care Administration**		**8,188,128**	**1,934,488**	**6,253,640**	**323,121**	**1,313,199**	**172,064**	**1,344,122**	**473,549**	**1,435,764**	**500,440**	**691,380**
196	**Admin Cost Ratio (MCA % of Total Cost)**		**8.5%**	**2.0%**	**6.5%**	**8.6%**	**7.9%**	**5.1%**	**8.1%**	**8.0%**	**4.8%**	**7.2%**	**9.5%**
197													
198	**Contract Cost**		**95,970,228**	**5,802,898**	**90,167,380**	**3,765,997**	**16,590,344**	**3,400,891**	**16,553,632**	**5,938,916**	**29,710,465**	**6,905,793**	**7,301,344**
199	**Net before Settlement**		**(345,280)**	**49,426**	**(394,758)**	**434,286**	**793,873**	**1,595,868**	**388,324**	**(1,326,317)**	**(1,572,742)**	**(517,598)**	**(190,451)**
200													
201	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
202	Internal Service Fund Risk Reserve		1,382,670	1,382,670	-	-	-	-	-	-	-	-	-
203	Contract Settlement		3,859,949	(4,260,029)	3,414,823	(529,529)	443,444	(1,133,757)	(918,779)	1,326,317	2,617,237	1,419,439	190,451
204	**Net after Settlement**		**4,897,339**	**(2,827,933)**	**3,020,065**	**(95,243)**	**1,237,317**	**462,111**	**(530,455)**	**-**	**1,044,495**	**901,841**	**(0)**
205													

Quality Assurance and Performance Improvement Program (QAPIP) Fiscal Year 2025 Plan

All SWMBH Medicaid Business Lines

October 1, 2024 - September 30, 2025

Reviewed and Approved by:
SWMBH Board of Directors on 02/14/2025

Provided for Review:
SWMBH Operations Committee on 01/08/2025
SWMBH Quality Management Committee on 01/14/2025

Submitted to MDHHS for Review by 02/28/2025

X

Sherii Sherban
SWMBH Board of Directors Chair

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Descriptions and Work Plan

Attachments

I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assurance and Performance Improvement Program (QAPIP) that meets the required federal regulations: the Medicaid Managed Care rules, 42 CFR § 438, and requirements outlined in the PIHP/MDHHS contract.

Southwest Michigan Behavioral Health (SWMBH) uses the QAPIP Plan and Evaluation to assure all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the eight Community Mental Health Service Partners (CMHSPs) in the region, are met. The QAPIP Plan describes the organizational structure for the SWMBH's administration and evaluation of the QAPIP, the elements, components, and activities of the QAPIP, the role of recipients of service in the QAPIP, the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels.

For SWMBH purposes, "beneficiary" includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving, or may potentially receive, covered services and supports. The following terms may be used interchangeably within this definition: member, customer, recipient, enrollee, individual, and person served.

II. Purpose

The QAPIP Plan delineates the features of the SWMBH Quality Management program. The QAPIP promotes high quality health care services and outcomes for beneficiaries through systematic monitoring of key performance elements, integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical and non-clinical service delivery within the network as well as the benefit management processes within SWMBH. Populations served by SWMBH and the CMHSPs within the region include eligible individuals and their families who experience mental illnesses, developmental disabilities, and substance use disorders.

Additional purposes of the QAPIP are to:

- Monitor, evaluate, and drive process improvement throughout the system and the region.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, integration of care, beneficiary satisfaction, and data integrity, while promoting the timely identification and resolution of quality-of-care issues.
- Promote and support best practices that guide optimal benefits in service areas of accessibility, acceptability, value, impact, and risk-management for all beneficiaries.
- Monitor and report the results of ongoing performance monitoring to ensure performance standards and other requirements are met.
- Meet the needs of internal and external stakeholders and provide performance improvement leadership to other departments and throughout the region. Stakeholders are defined as a person, group, or organization that has an interest in the organization, including beneficiaries, family members, guardians, staff, community members, advocates, etc.

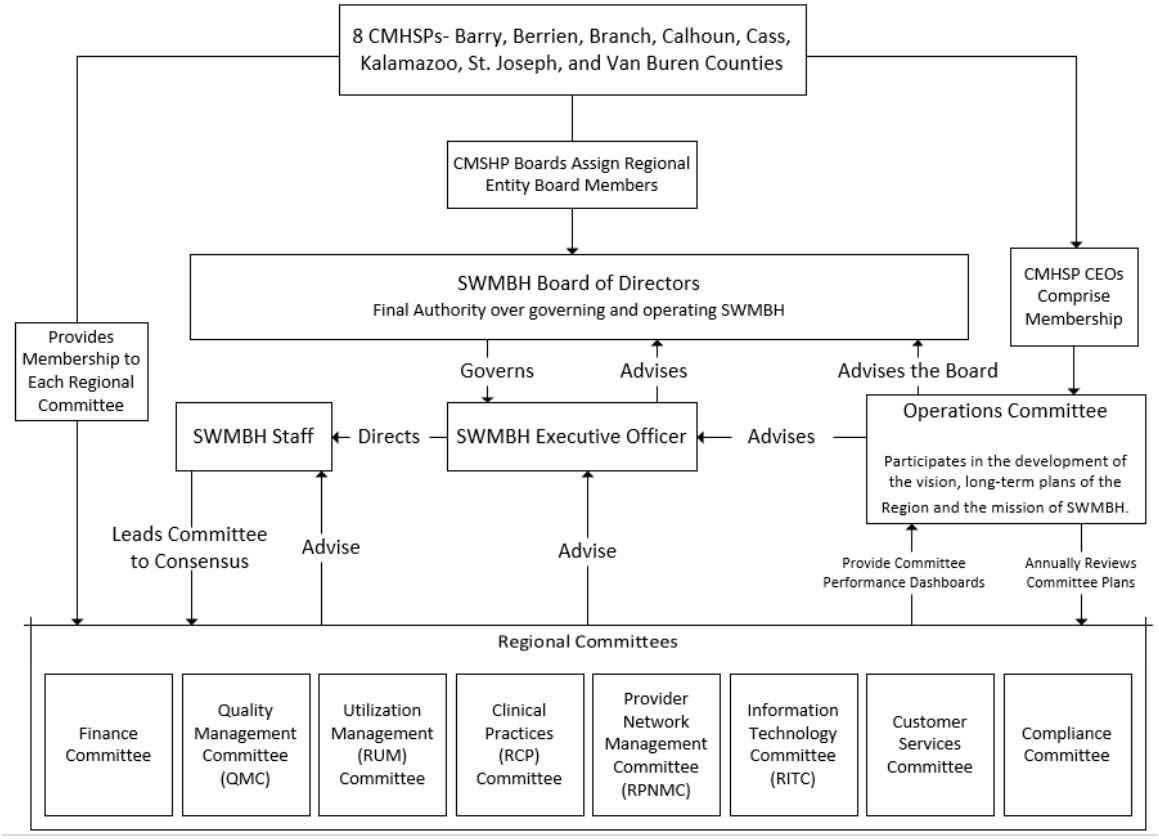
III. QAPIP Authority

The QAPIP is accountable to the SWMBH Board of Directors which acts as the governing body and is a PIHP Regional Entity (see Attachment B – SWMBH Board Roster). Responsibilities of the Board for monitoring, evaluating, and making improvements to care include:

- Oversight of the QAPIP- the Board must approve the overall QAPIP and Plan annually.
- QAPIP Progress Reports- the Board receives written reports related to performance improvement projects undertaken, the actions taken, and the results of those actions.

- Annual QAPIP Review- the Board formally reviews a written report on the operation of the QAPIP no less than annually.
- Submission of the QAPIP Plan and Evaluation to MDHHS by the contractually defined due date each year. The report includes a list of the Board Members.

In addition to the review by the SWMBH Board and SWMBH EO, the QAPIP Plan and Evaluation are taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement initiatives throughout the Region. The SWMBH Operations Committee consists of the CEO, or their designee, for each of the eight CMHSPs in the region and advises the SWMBH Board.



IV. Guiding Principles

The Board Ends serve as the guiding principles for the development of annual Board Ends Metrics, SWMBH Agency Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. In October 2024, the SWMBH Board adopted a revised set of Board Ends, which directs SWMBH towards the benefits to be produced, for whom, and at what cost reflecting the organization's vision and reason for being. Developing revised Board Ends included multiple contacts with each of the eight CMHSP Boards to ensure their values are expressed through the Board Ends.

Board Global End: As a benefits manager of state and federal funds, SWMBH exists to assure that member agencies and providers create sustainable programs and provide specialty services so that persons in the SWMBH region have access to appropriate resources and experience improvements in their health status and quality of life, optimizing self-sufficiency, recovery, and family preservation. Quality services are provided while minimizing costs through efficient stewardship of human, financial, and technology resources available and use of shared knowledge.

- Member CMHSP boards, EOs, and staff value the partnership with SWMBH, and experience the relationship as collaborative, transparent, responsive, and reciprocal.
- Member CMHSPs are aware of environmental disruptors and trends and benefit from SWMBH's regional and statewide regulatory and public relations advocacy impacting the Mental Health Community.
- Member CMHSPs have the resources needed to address their communities' individualized needs, successfully access appropriate resources and successfully meet contractual obligations *(including managed care functions)*.
- Member CMHSPs and other providers assure and monitor ready access to appropriate programs and services for their consumers and contribute accurate data so SWMBH can create aggregated, comprehensive, and comparative regional results which supports access to maximum funding available.
- The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.

V. Quality Organizational Structure

The general oversight of the development and implementation of the QAPIP is given to SWMBH's Quality Management and Clinical Outcomes Department. The Director of Quality Management and Clinical Outcomes is the designated senior official responsible for overseeing the department and QAPIP implementation. The Quality Management and Clinical Outcomes Department is additionally staffed with a Quality and Performance Improvement Manager, Clinical Quality Specialists, Clinical Data Analysts, a Clinical Projects Specialist, and SWMBH's Integrated Care Team. Together, the department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the program (including Performance Improvement Projects), and chairs and facilitates the Quality Management Committee (QMC) and Regional Clinical Practices (RCP) Committee. Additionally, the Director of Quality Management and Clinical Outcomes collaborates on many of the QAPIP goals and objectives with the SWMBH Senior Leadership team and with SWMBH Regional Committees including QMC, RCP, Regional Information Technology (RIT) Committee, Regional Utilization Management (RUM) Committee, Regional Provider Network Management Committee (RPNMC), and the Regional Compliance Committee.

SWMBH also has access to the Medical Director to support and advise the department in meeting the QAPIP deliverables. The Medical Director provides supervision and oversight of all SWMBH clinical functions to include Utilization Management, Customer Services, Integrated Care, Provider Network, Substance Use Prevention and Treatment, and other clinical initiatives. The Medical Director also provides clinical expertise and programmatic consultation to the Quality Management and Clinical Outcomes Director to ensure complete, accurate, and timely submission of clinical quality program data.

VI. Communication

To effectively adopt and communicate process and outcome improvements, SWMBH utilizes a structured approach that ensures continuous evaluation, transparency, and collaboration across all levels of the organization and region. By using this structured approach, SWMBH ensures that improvements are adopted effectively, and the results are communicated transparently to everyone involved, fostering a culture of continuous improvement. Key mechanisms include:

- **Data Monitoring and Analysis:** SWMBH places a strong emphasis on the use of data to guide treatment and decision-making. By leveraging both quantitative and qualitative data, SWMBH continuously monitors the information, identifies trends, and tailors interventions to meet individual, organizational, and regional needs. This data-driven approach allows SWMBH to improve the effectiveness of services,

ensure that improvement efforts are targeted, and provide measurable outcomes that inform decisions. SWMBH is committed to integrating research, beneficiary feedback, and clinical insights to ensure that every aspect of care is grounded in the best available information.

- **Stakeholder Involvement:** Input from beneficiaries, families, and other internal and external stakeholders is integral to the process. SWMBH engages those groups through surveys, committee meetings, and other collaborative discussions to ensure that improvements align with regional needs and goals.
- **Transparent Communication Channels:** SWMBH provides ongoing education and training for the region to ensure there is understanding of any new or updated processes and the rationale behind changes. SWMBH also uses various communication tools (member and provider newsletters, meetings, and SWMBH's website) to share progress and outcomes with all stakeholders. This ensures that everyone is aware of the improvements, their rationale, and the impact on service delivery and care.
- **Regular Feedback Loops:** After implementing improvements, SWMBH establishes continuous feedback loops to monitor progress. This includes regular check-ins, meetings, and ongoing monitoring to track outcomes, ensure understanding, and gather input from those directly involved in the process.
- **Performance Metrics:** Clear and measurable performance indicators are used to measure and assess the effectiveness, efficiency, and outcomes of specific processes, initiatives, or interventions. These metrics are communicated regularly to all stakeholders to demonstrate progress and inform future strategies.

The Quality Management and Clinical Outcomes Department interacts with all other departments within SWMBH as well as with the CMHSPs, which is a critical component to the success of the QAPIP. At least annually, the Quality Management and Clinical Outcomes Department shares the QAPIP Plan and Evaluation, beneficiary satisfaction survey results, and other relevant information in newsletter articles and on the SWMBH website for stakeholders to review.

VII. Participation of Providers and Individuals in the QAPIP Processes

Providers and beneficiaries serve as members of SWMBH's Regional committees, sub-groups, and workgroups as appropriate. Committee and group members are expected to attend all meetings virtually, by phone, or in person. If members cannot attend a meeting, they are expected to send an alternative in their place. Members hold the responsibility of communicating all relevant information discussed during the meetings (and included in meeting materials and minutes) back to the appropriate individuals and/or departments within their organizations. Members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting recordings, meeting minutes, and/or other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meeting.

SWMBH additionally hosts a Customer Advisory Committee (CAC) which is made up of beneficiaries actively receiving services, with representation from all CMHSPs. During CAC meetings information is shared and feedback and discussion are requested and encouraged. CAC members also attend various regional committees which affords SWMBH the opportunity to involve beneficiaries in quality management and improvement efforts.

FY 2025 Quality Assurance and Performance Improvement Program Descriptions & Work Plan

A. Performance Measures

a) Michigan Mission Based Performance Indicator System (MMBPIS)

Description

SWMBH utilizes performance measures established by MDHHS in the areas of access, efficiency, and outcome measures. SWMBH is responsible for ensuring that its CMHSPs and SUD Providers are measuring performance through the MMBPIS per the contract with MDHHS. SWMBH maintains a dashboard tracking system to monitor individual CMHSP and Regional progress on each indicator throughout the year.

Each CMHSP is responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH via the SWMBH Commons by the 25th of every month for analysis. SWMBH promotes data integrity by using electronic controls within the spreadsheets used for reporting MMBPIS data. SWMBH has a Clinical Quality Specialist dedicated to reviewing the data to ensure it is complete and accurate, based on the MMBPIS PIHP Code Book, prior to submission to MDHHS. SWMBH submits the data to MDHHS quarterly as established in the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH requests the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). SWMBH Subject Matter Experts (SMEs) also review performance indicator compliance and are incorporated in approval of MMBPIS-related CAPs. The PIHP ensures the action plans are achieved and improvements are recognized. Status updates are given, and regional trends are identified and discussed at relevant committees such as QMC, RUM, RCP and Operations Committee for further planning and coordination. SWMBH also participates in the MDHHS Quality Improvement Council (QIC) and associated sub-workgroups and communicates any changes with indicator measurements or reporting to stakeholders.

SWMBH utilizes the QAPIP to assure it achieves minimum performance levels on performance indicators as established by MDHHS as defined in the contract and analyzes the causes of statistical outliers when they occur. Oversight and monitoring are conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. The administrative and delegated function CMHSP site reviews occur annually. The SWMBH Quality Management and Clinical Outcomes (QMCO) Department completes a review of MMBPIS Performance Indicator (PI) data, primary source verification documentation and protocols during this annual site audit, CAPs may be requested from any CMHSPs with a site review score of two or less for each PI related standard.

FY25 Goals

In late FY24, MDHHS introduced their plans for a quality overhaul- a three-year roll-out strategy to implement new behavioral health quality measures that align with other state and national requirements (termed BH Quality Transformation) and reported that MMBPIS will be sunset at the end of FY25. SWMBH goals will remain for the final year of MMBPIS measures, that the PIHP will meet or exceed the MDHHS-indicated benchmark for each of the access and follow-up MMBPIS performance measures in the table below. Benchmarks that became effective in FY24 for indicators 2 and 3 remain in place for one additional year. SWMBH continues the non-clinical PIP in FY25 related to increasing indicator 3 outcomes as this benchmark, and goal of the PIP, was not achieved in FY24.

MMBPIS Indicators	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QMCO	QMC	Quarterly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QMCO	QMC	Quarterly
Indicator 2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children (>=62%).	QMCO	QMC	Quarterly
Indicator 2e - Percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorders (>=68.2%).	QMCO, SUD	QMC, SUD Directors Workgroup	Quarterly
Indicator 3 - Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (>=72.9%).	QMCO	QMC	Quarterly

Indicator 4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QMCO	QMC	Quarterly
Indicator 4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QMCO	QMC	Quarterly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QMCO, SUD	QMC, SUD Directors Workgroup	Quarterly
Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (<=15%).	QMCO	QMC	Quarterly
Indicator 10b - Re-admission to Psychiatric Unit within 30 Days- Adults (<=15%).	QMCO	QMC	Quarterly

b) Performance Bonus Incentive Program (PBIP)

Description

Contract quality withholds are established by MDHHS to support initiatives as identified in the MDHHS Comprehensive Quality Strategy. The quality withhold program is called the Performance Bonus Incentive Program (PBIP). The Criteria for the PBIP payments will include, but is not limited to, assessment of performance in quality of care, access to care, and administrative functions. PBIP withhold monies will be distributed as follows:

- Contractor-only Pay for Performance Measures: 45% of withhold
- Contractor Narrative Report: 25% of withhold
- MHP/Contractor Joint Metrics: 30% of withhold

FY25 Measures

Contractor-only Pay for Performance (P4P) Measures

Measure	Description	Deliverable
Implement data driven outcomes measurement to address social determinants of health. (18% of the P4P Measures)	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BHTEDS record during the measurement period, look back to most recent prior update or admission record.	SWMBH will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31, 2025. Narrative must address beneficiary changes in employment and housing and actions taken to improve housing and employment outcomes.
Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD). (9% of the P4P Measures)	Percentage of adults aged 18 and older with Schizophrenia or Schizoaffective Disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	Region 4 will be measured against a minimum standard of 62%. Measurement period will be calendar year (CY) 2024.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). (18% of the P4P Measures)	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.	Region 4 will be measured against a minimum of 40% at initiation and 14% at engagement. Points will be divided evenly between Initiation and Engagement measures. Measurement period will be CY24.
PA 107 of 2013 Sec. 105d (18): Increased participation in patient centered medical homes. (25% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	SWMBH must submit a narrative report of no more than 10 pages by November 15th, 2025, summarizing prior FY efforts, activities, and achievements of SWMBH and CMHSPs to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

MHP/Contractor Joint Metrics

Measure	Description	Deliverable
Implementation of Joint Care Management Processes. (10% of the Joint Measures)	Collaboration between entities for the ongoing coordination and integration of services.	Each Medicaid Health Plan and SWMBH will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the SWMBH-MHP Collaboration Work Group in consultation with the State. SWMBH must demonstrate joint care planning specific to child and adult populations. SWMBH must document joint care plans in CC360 for at least 25% of qualified adult Enrollees.

Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS (Healthcare Effectiveness Data and Information Set) descriptions. (10% of the Joint Measures)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 days.	1. Region 4 must meet set standards for follow-up within 30 days for each rate (ages 6-17 and ages 18 and older). Region 4 will be measured against an adult minimum standard of 58% and a child minimum standard of 79%. Measurement period will be CY23. The points will be awarded based on MHP/SWMBH combination performance measure rates. 2. Data will be stratified by race/ethnicity and provided to plans. Region 4 will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of CY23 with CY24. The points will be awarded based on Region 4 performance measure rates. The points for overall standard (item 1 above) will be awarded based on MHP/ Region 4 combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or Region 4 performance over time. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons.
Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment. (5% of the Joint Measures)	Adult beneficiaries who had new SUD episodes that result in treatment initiation and engagement. 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit	1. Region 4 will be measured against an initiation (IET 14) minimum standard of 40% and an engagement (IET 34) minimum standard of 14%. Measurement period will be calendar year 2024. 2. Data will be stratified by race/ethnicity and provided to plans. Region 4 will be incentivized to reduce the disparity between the index population and at least on minority group (if necessary, minority groups will be combined to achieve a sufficient numerator/denominator). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024. The points for the overall standard (item 1 above) will be awarded based on MHP/PIHP combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or Region 4 performance over time. The total potential points will be the same regardless of

		the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons.
Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence. (5% of the Joint Measures)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence (AOD) that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to SWMBH. Region 4 will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of CY23 with CY24. The points will be awarded based on Region 4 performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for Region 4.

B. Performance Improvement Projects (PIPs)

Description

MDHHS requires SWMBH to conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Medicaid Managed Care rules, 42 CFR Part 438. According to the managed care rules, the quality of health care delivered to Medicaid beneficiaries in PIHPs must be tracked, analyzed, and reported annually. SWMBH's QAPIP includes affiliation-wide performance improvement projects that achieve thorough ongoing measurement and intervention, and demonstratable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that SWMBH serves.

Each year, one PIP is reviewed by the Health Services Advisory Group (HSAG). The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the Quality Improvement (QI) strategies and activities conducted by the PIHP during the PIP.

The following are steps used to identify, implement, and evaluate the progress of a PIP.

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

There are currently two primary Performance Improvement Projects that SWMBH has targeted for FY25:

1. Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). This is a high-risk service area, where improved continuity and coordination of care is needed; this project serves as the clinical PIP.
2. Increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (MMBPIS Indicator 3); this project serves as the non-clinical PIP.

The details of each of the two identified PIPs can be found below.

FY25 PIPs

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Performance Improvement Project #1 (Clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Goal: "To eliminate the statistically significant disparity between African American/Black and White rates of follow up after Emergency Department (ED) visits for alcohol and other drug use, from baseline (2021) to remeasurement 1 (2023) and 2 (2024), without a corresponding decrease in White follow up rates." Monitoring: Remeasurement 2 (2024) results will be available in June 2025. SWMBH will assess performance on the following measures to determine whether the region met the PIP goal for 2024: 1. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. In FY25, SWMBH will collaborate with the Project ASSERT teams in the three largest counties to increase referrals from EDs and to follow-up on referrals when individuals present to the ED for substance use needs, with specific attention to the Black/African American population.	QMCO	Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)	Bi-Annual

Performance Improvement Project #2 (Non-Clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (MMBPIS Indicator 3). Goal: In FY25, SWMBH and its provider network will continue efforts to increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. The goal is to reach the MDHHS set benchmark of 72.9%. Monitoring: Quarterly, the PIHP will complete continuous analysis of regional outcomes, reasons for non-compliance and the mean number of days to service per CMHSP-submitted MMBPIS data. By the end of FY25 Q1, SWMBH will complete individual meetings to discuss specific barriers and actions taken to improve access and timeliness with the 3 CMHSPs that had the lowest rates per FY24 Q4 outcomes. Best practices found in these consultations will be shared and discussed with the region during QMC/RCP meetings. By the end of FY25, the PIHP will review the data and evaluate the effectiveness of the interventions and improvement strategies suggested to determine if the goal was met, and in preparation for revised access measures included in the BH Quality Transformation.	QMCO	Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)	Annually and Quarterly

C. Critical Incident, Sentinel Event, and Risk Event Management

Description

SWMBH's process for identifying, reporting, and following up on incidents and events that put individuals at risk of harm is outlined in SWMBH policy - Incident Event Reporting and Monitoring. The five reportable critical incidents for beneficiaries are defined by MDHHS as suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrest. Hospitalization or EMT due to an injury is further classified to include whether the injury resulted from physical management or was due to a fall.

CMHSP Process

Specialized residential treatment providers prepare and file incident reports to the contracted CMHSP when incidents occur. The CMHSPs are responsible for reviewing and classifying the incident reports and submitting the reportable incidents to SWMBH as outlined in policy. SWMBH is then responsible for reporting qualifying

incidents to MDHHS in a timely manner, as defined in the contract language, via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). SWMBH is also responsible for ensuring that MDHHS requests for further information, details related to the remediation of an incident, or any other requests are responded to timely. Risk Event data is made available to MDHHS upon request. SWMBH delegates the responsibility of the process for the identification, review, and follow-up of immediate events, sentinel events (SEs), critical incidents (CIs), and risk events (REs) to its eight contracted CMHSPs.

SWMBH requires that CMHSPs notify SWMBH within 36 hours of an immediate event that is "newsworthy" and/or subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours of PIHP notification via the BH CRM. Following an immediate event notification, SWMBH additionally submits to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within 1 year of the individual's discharge from a State-operated service.

A sentinel event is an unexpected occurrence involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. A root cause analysis (RCA) (JCAHO) or investigation (per the Centers for Medicare and Medicaid Services (CMS) approval and MDHHS contractual requirements) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998). The CMHSPs have 3 business days after an incident occurs to determine if it is a sentinel event, and two subsequent business days to commence an RCA of the event if it determined to be a sentinel event. The CMHSPs work with the residential treatment provider, when applicable, to complete a root cause analysis. All unexpected deaths (UDs) are classified as SEs and are defined as deaths resulting from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect, for beneficiaries who at the time of their deaths were receiving specialty supports and services. SWMBH reviews a random sample of SEs during the annual administrative and delegated function CMHSP site reviews to ensure that all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, are reviewed and the review includes:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews. SWMBH ensures that individuals involved in the review of SEs have the appropriate credentials to review the scope of care (e.g. deaths or serious medical conditions involve a review by a physician or nurse).
- Documentation of the mortality review process, findings, and recommendations.
- Following completion of a RCA, or investigation, the CMHSP or SUD Provider developed and implemented either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event or documented the rationale of why corrective actions were not needed.
- Use of mortality information to address quality of care.

SWMBH analyzes CIs, SEs, and REs at least quarterly during the regional QMC meetings. The REs reviewed minimally include those that put individuals at risk of harm including actions taken by individuals who receive services that cause harm to themselves, actions taken by individuals who receive services that cause harm to others, and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or patterns of events are reviewed and

discussed to remediate the problem or situation and prevent the occurrence of similar additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes which are saved on the SWMBH Commons and available to all QMC members. It is the expectation that members that cannot attend the meetings will review the presentations and minutes, and that all members communicate information from the meetings to the appropriate people within their organizations.

SUD Residential Treatment Provider Process

SWMBH holds contracts with SUD residential treatment providers for the region. SWMBH delegates the responsibility of the process for the identification, review, and follow-up of SUD SEs to those providers. If an SUD SE occurs, the provider is required to notify SWMBH of the incident immediately. SWMBH then reports those events to MDHHS within 24 hours via email to mdhhs-bhdda-contracts-mgmt@michigan.gov and additionally reports the SE in the BH CRM.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will report any SUD Sentinel Event that occurs at a contracted residential treatment provider via email to MDHHS and in the BH CRM within 24 hours.	QMCO	Through submission to MDHHS via email and in the BH CRM	As SUD SEs Occur
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	QMCO	QMC	Quarterly
The rate for the region, per 1000 persons served, of unexpected deaths due to overdose will demonstrate a decrease from the previous year.	QMCO	QMC	Quarterly

D. Behavioral Treatment Review

Description

MDHHS requires data to be collected based on the definitions and requirements within the MDHHS Technical Requirement Behavioral Treatment Plans policy and the MDHHS Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans policy. Only techniques that are permitted by the Technical Requirement and have been approved during person-centered planning may be used. SWMBH delegates the responsibility for monitoring and collecting and analyzing data to each local CMHSP Behavior Treatment Review Committee (BTRC). Each BTRC reviews and approves or disapproves behavior treatment plans (BTPs) that propose the use of restrictive or intrusive interventions, as defined by the technical requirement. Each CMHSP is required to submit their BTRC data to SWMBH quarterly. SWMBH focuses on and analyzes data related to intrusive and restrictive techniques, physical management, and/or incidents resulting in 911 calls for emergency behavioral crisis. The data submitted includes the numbers of interventions and length of time the interventions were used per person. Monitoring this data is important for the oversight and protection of vulnerable individuals, including those receiving long term supports and services (LTSS). The data is made available to MDHHS upon request. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. Based on the analysis, SWMBH requests the behavior plans on an individual level as needed to review further. The criteria for further review may include, but is not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, etc. During the annual CMHSP Site Reviews SWMBH completes an audit of the data and a sample of behavior treatment plans to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete a quality review of at least 4 behavior treatment plans per CMHSP for FY24.	QMCO	QMC	Quarterly
The region will achieve 90% or higher on the Behavior Treatment Plan section of the non-SUD clinical file review tool for the annual CMHSP Site Review.	QMCO	CMHSP Administrative and Delegated Function Site Review, Clinical File Review Tool	Annually

E. Member Experience with Services

a) Customer Satisfaction Survey

Description

SWMBH's Quality Management and Clinical Outcomes Department administers an annual Customer Satisfaction Survey on behalf of the region. The primary objective of the survey is to identify opportunities for improvement at the CMHSP and PIHP levels, and to improve outcomes in comparison to the previous year results. SWMBH ensures the incorporation of beneficiaries receiving long-term supports or services (LTSS), case management services, CCBHC services, and Medicaid services into the review and analysis of the survey results obtained from quantitative and qualitative methods. Respondents are asked to identify the type of services and supports they, or the individual the respondent is completing the survey on behalf of, are receiving which allows for the identification of beneficiaries receiving LTSS. CMHSPs are also required to identify target populations (e.g. CCBHC) within their sample provided for the survey, and responses are tracked and analyzed based on that information.

SWMBH utilizes a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS), and the Experience of Care and Health Outcomes (ECHO) Survey. All adopted survey methods and categories are certified as best practice survey tools to gauge beneficiary experience of care and were approved by MDHHS. Prior to implementation, survey tools are evaluated to ensure required data is collected from beneficiaries and their guardians/family where appropriate. SWMBH's Consumer Advisory Committee members also provide feedback on the survey process, questions and content, and the distribution plan during standing committee meetings. During 2025, the SWMBH Quality Management and Clinical Outcomes Department plans to collect beneficiary survey responses throughout the year with the goal of achieving at least 2100 completed surveys. Surveys will be accessible electronically to beneficiaries via postings with quick-response (QR) codes and tablets in the CMHSP waiting/lobby areas, through the SWMBH website, by text message, and by email. Additionally, CMHSPs will offer the survey on paper if requested. CMHSPs are responsible for having a systematic approach to enter the paper survey responses they receive into the electronic survey collection tool.

The survey provides space for individuals completing it to provide comments on their services which allows for deeper analysis and qualitative assessment. Respondents have the option to request CMHSP follow-up within the survey, which generates an automated response to the applicable CMHSP, and CMHSP Customer Services staff are responsible to follow-up with those requests.

At the conclusion of the survey project, a full analysis report is produced, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The quantitative analysis includes a review of the numerical data, and the qualitative analysis includes a review of the comments and additional information respondents provide. Starting in 2025, SWMBH plans to provide further analysis of service delivery and health outcomes from year-to-year as anonymous IDs are now optionally assigned to each participant to track

respondents' answers over time. The results and survey analysis are shared with internal/external stakeholders which includes SWMBH's Regional Clinical Practices Committee, Utilization Management Committee, the Operations Committee, Customer Advisory Committee, Quality Workgroups, and the Board of Directors. The results are also shared via the SWMBH website, newsletters, within the annual QAPIP Evaluation, etc.

The QAPIP Evaluation outlines the results of the survey project, identifies any barriers, and provides recommendations for improvement for the following years' survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, are evaluated and discussed during the Regional QMC meeting. The survey analysis addresses issues of quality and availability of services. Sources of beneficiary dissatisfaction are identified and each CMHSP is required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps will be outlined to follow up on the findings.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1500 completed MHSIP surveys and 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QMCO	QMC	Annually
The FY25 MHSIP (adult) survey will see an improvement of the region's overall score for the lowest scoring domain in the FY24 survey (Outcomes and Functioning).	QMCO	QMC, RCP, CAC	Annually
The FY25 YSS (youth) survey will see an improvement of the region's overall score for the lowest scoring domain in the FY24 survey (Outcomes).	QMCO	QMC, RCP, CAC	Annually

b) Recovery Self-Assessment, Person in Recovery version (RSA-r) Survey

Description

SWMBH's Quality Management and Clinical Outcomes Department, in conjunction with the SUD Department, administers the Recovery Self-Assessment Survey, Person in Recovery version (RSA-r) to Medicaid and SUD Block Grant beneficiaries within the region. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement in SWMBH's recovery-oriented care. At the conclusion of the survey project, a full analysis report is produced, providing qualitative and quantitative analysis for each of the six subcategories measured (Life Goals, Involvement, Diversity of Treatment, Choice, Individually Tailored Services, Inviting Space). The results and survey analysis are shared with internal and external stakeholders including the SWMBH Consumer Advisory Committee, RCP, the Regional Operations Committee, QMC, and the SUD Program Director's Workgroup. Feedback strategies are implemented as appropriate. The results are also shared via SWMBH website, newsletters, the annual QAPIP Evaluation, and other SWMBH annual publications.

The Evaluation Report outlines the results of the survey project, identifies any barriers, and provides recommendations for improvement for the following year's survey project. The effects of activities implemented to improve satisfaction, from the previous year's recommendations, are evaluated and discussed during the QMC and the SUD Directors Subgroup meetings. The survey analysis addresses issues of quality and availability of care. Sources of beneficiary dissatisfaction are identified. SWMBH requests that participating SUD and CMHSPs review results internally and develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps are outlined to follow up on the findings.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase survey participation compared to the previous year, as evidenced by more participating providers and/or more completed surveys.	QMCO, SUD	QMC, SUD Directors Subgroup	Annually
Achieve at least 90% consumer satisfaction with SUD services as indicated by survey results.	QMCO, SUD	QMC, SUD Directors Subgroup	Annually

F. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance department performs the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to beneficiaries by its Participant CMHSPs, providers, and subcontractors. This review is performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performs this review after the end of each Fiscal Year Quarter, typically within 30 days depending on the accepted encounter volume, to have real time results and an opportunity to effectuate change quickly. SWMBH submits its findings from this process to MDHHS annually and provides follow up actions that were taken because of the findings. SWMBH also presents the findings to the Board of Directors.

For completing the fiscal year verification of sampled Medicaid claims, SWMBH uses the random number function of the Office of Inspector General's (OIG) statistical software package, RAT-STAS, and conducts quarterly audits of service encounters for each CMHSP and reviews claims from contracted substance use disorder (SUD) providers and non-SUD providers subcontracted with Participant CMHSPs. SWMBH utilizes a standardized verification tool, which includes the following elements against which all selected encounters and claims are evaluated:

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)?

FY25 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The overall Medicaid claims verification of services compliance rate for SWMBH will be above 90%.	Compliance	SWMBH Corporate Compliance Committee, Regional Compliance Committee	Monthly/Every Other Month

G. Provider Network

a) Provider Network Adequacy Evaluation

Description

SWMBH completes an evaluation of the adequacy of its current fiscal year's provider network during the first quarter of the applicable fiscal year, assessing provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The areas that are assessed include enrollee-to-provider ratios, crisis residential beds-to-enrollee ratios, time and distance standards, SUD services based on American Society of Addiction Medicine Level of Care (ASAM LOC), timely appointments, languages spoken, cultural competence, and physical accessibility. Each section contains a regional analysis and identifies opportunities for improvement that will be addressed throughout the fiscal year. The data from SWMBH's internal network adequacy analysis and opportunities for improvement report is then added to the MDHHS Network Adequacy Reporting Template and submitted to MDHHS by the required due date specified in Schedule E of the MDHHS-PIHP contract.

MDHHS contracts with HSAG to conduct the annual performance measures and included network adequacy validation activities, ensuring all reported performance indicator rates are calculated following the state's measure specifications and reporting requirements, and that network standards, as defined by the state, were met.

SWMBH also maintains the Provider Directory on behalf of the region, which is located on SWMBH website. The CMHSPs submit new/update/delete request forms through SWMBH Commons when there has been a change to their network providers and SWMBH makes the change to the directory within 30 days.

FY25 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	Provider Network	SWMBH Assessment of Medicaid Network Adequacy Report	Annually

b) Administrative and Delegated Function Site Reviews

Description

SWMBH either directly performs or ensures that its Participant CMHSPs perform annual monitoring of all providers in its network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality.

Participant CMHSP Site Reviews

SWMBH performs annual Site Reviews of its Participant CMHSPs. These reviews consist of a review of each CMHSP's administrative processes and procedures in the following functional areas: Access and Utilization Management, Claims, Compliance, Credentialing, Customer Services, Grievances & Appeals, Provider Network, Quality, Staff Training, and SUD EBP Fidelity and Administration.

In addition to reviewing administrative processes, the annual site review process also includes file reviews for the following administrative functions:

- Denial File Review (performed quarterly)
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review (performed quarterly)
- Appeals File Review (performed quarterly)
- MMBPIS and Critical Incident File Review
- Staff Training File Review

To monitor clinical service quality, SWMBH performs a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that is focused on a specific population or service (consistent across all Participant CMHSPs). The population or service focus is determined annually by SWMBH's Quality Management and Clinical Outcomes Department based on several factors which may include State or PIHP-audit results, beneficiary complaints, or other identified concerns. SWMBH also performs an SUD Clinical Quality clinical record review of CMHSP directly operated SUD services.

SUD Providers

SWMBH does not allow for subcontracting of SUD services, and therefore directly holds each contract with its network SUD Providers. SWMBH directly performs annual site reviews for each of its contracted SUD providers. These reviews consist of a review of each SUD Provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor SUD Provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered.

To monitor clinical service quality, SWMBH performs a clinical file review as part of the annual site review process.

Network Providers

For non-SUD network providers that are contracted with one or more of SWMBH's Participant CMHSPs, SWMBH ensures that monitoring is performed annually either directly by SWMBH or by a Participant CMHSP. SWMBH directly performs the annual site reviews for the following provider types:

- Autism Service Providers
- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)
- Financial Management Services (FMS) Providers

SWMBH's Participant CMHSPs perform annual monitoring of the remaining provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviews standardized network provider review tools which are used for completion of network provider site reviews to ensure consistency and foster reciprocity. The RPNMC also maintains a spreadsheet of all "shared providers", network providers that are contracted with more than one Participant CMHSP and assigns a responsible Participant CMHSP to perform the annual site review each year, to reduce the burden on shared providers. Completed reviews are uploaded to SWMBH's Portal so they are accessible to all Participant CMHSPs.

Network provider site reviews consist of a review of each provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY25 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete or ensure completion of site reviews for the region (for Participant CMHSPs, SUD Providers, and Network Providers), and areas of non-compliance will require a corrective action plan.	All SWMBH Departments; Participant CMHSPs	Site Review Tools and CAP Documents	Annually

H. Credentialing and Re-Credentialing

Description

SWMBH either directly performs or ensures that its Participant CMHSPs and network providers perform credentialing and re-credentialing in compliance with SWMBH's Credentialing and Re-credentialing Policies, which are annually approved by the SWMBH Board of Directors. The credentialing process (inclusive of re-credentialing) ensures that organizations, physicians, and other licensed health care professionals are qualified to perform their services. SWMBH utilizes standardized credentialing and re-credentialing applications throughout its Region to ensure consistent application of required standards. These applications are periodically reviewed by the Regional Provider Network Management Committee. SWMBH utilizes a checklist to assist in processing credentialing applications. The checklist includes, among other things, the following components for re-credentialing files:

- QI Data Check
  - Compliance fraud/waste/abuse (F/W/A) or other billing issues
  - Customer Services issues (in addition to formal Grievances/Appeals)
  - Utilization Management issues/concerns

SWMBH directly performs credentialing for the following in its network:

- Applicable SWMBH employees/contractors (individual credentialing)
- Participant CMHSPs (organizational credentialing)
- SUD Providers (organizational credentialing)
- Autism Service Providers (organizational credentialing on behalf of the Region)
- Financial Management Service Providers (organizational credentialing on behalf of the Region)
- Crisis Residential Providers (organizational credentialing on behalf of the Region)
- Inpatient Psychiatric Service Providers (organizational credentialing on behalf of the Region)
- Large Specialized Residential Providers – Beacon, Residential Opportunities Inc. (ROI), Turning Leaf, and Hope Network
  - SWMBH performs organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegates, under Delegation memorandum of understanding (MOUs), credentialing activities to its Participant CMHSPs for the following:

- CMHSP network providers, other than those listed above.

SWMBH includes credentialing requirements consistent with its policies in its subcontracts with its Participant CMHSPs, SUD providers, and network providers via the CMH-provider subcontract boilerplate, for the following:

- Compliance with SWMBH or CMH organizational re-credentialing activities, including provider timely submission of credentialing applications and proofs; and
- Provider completion of individual practitioner credentialing of directly employed/contracted staff.

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and its Participant CMHSPs monitor compliance with credentialing requirements through the annual site review process. Each site review includes a file review of a sample of the provider's credentialing files. See "Provider Network Monitoring" for additional information on the annual site review process. Additionally, SWMBH and its Participant CMHSPs require clinician information for any clinician to be listed as a "rendering provider" in the applicable agency's billing system. This is another way SWMBH and its Participant CMHSPs monitor to ensure licensed professionals are qualified to perform their services. While it is not "credentialing", when SWMBH receives a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performs basic screening checks including exclusions screening and licensure verification to ensure that the clinician is only assigned billing rights to service codes they are qualified to deliver.

Monitoring Activities – Non-licensed Providers

SWMBH and its Participant CMHSPs monitor non-licensed provider staff qualifications through the annual site review process. Standardized site review tools for all provider types include a Staff Training file review, which evaluates whether a sample of the provider's staff completed all required trainings within required timeframes. Standardized site review tools that are specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) include review elements that evaluate the provider's process for ensuring non-licensed direct care staff meet the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

Through the annual site review process SWMBH ensures, regardless of funding mechanism:

- Staff (licensed or non-licensed) possess the appropriate qualification as outlined in their job descriptions, including the qualifications for all the following:
  - Education background
  - Relevant work experience
  - Cultural competence
  - Certification, registration, and licensure as required by law (where applicable)

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network	RPNMC	Annually
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the Administrative and Delegated Function Site Reviews.	Provider Network	Delegated Admin Function Review Tool	Annually

I. Clinical Practice Guidelines

Description

SWMBH reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of the MDHHS Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its Medicaid subcontracted provider network have adopted these guidelines. SWMBH assures that information related to the guidelines is made available to beneficiaries and providers.

It is policy that the employees of SWMBH, the CMHSPs, and the provider network must assure that decisions with respect to utilization management, beneficiary education, coverage of services, and other areas are consistent with the guidelines found here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

SWMBH's Clinical Protocols and Practice Guidelines meet the following requirements:

- Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
- Consider the needs of SWMBH beneficiaries.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or the Director of Quality Management and Clinical Outcomes.
- Guidelines are disseminated to all applicable providers through provider orientation/the provider manual and to beneficiaries upon request.
- Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks.
- Implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
- Any decisions with respect to utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

SWMBH's adopted practice guidelines include:

- Inclusion Practice Guideline
- Person-Centered planning Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- Employment Works! Policy

Practices Guidelines are adopted, developed, and implemented by the Regional RCP Committee, which consists of representatives from SWMBH and the eight CMHSPs in Region 4. The group works together to decide which guidelines are most relevantly matched to the individuals in the region by eliciting responses from CMHSP representatives who are close to the issues. The group ensures that the essence and intention of these guidelines are filtered through the behavioral health system via meaningful discussion, policy, procedure, training, and auditing/monitoring. Practice guidelines are monitored and evaluated through SWMBH's Administrative and Delegated Function Site Review process to ensure Participant CMHSPs and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline during the Administrative and Delegated Function Site Reviews.	QMCO	Clinical Quality Review Tool	Annually
SWMBH, with the CMHSPs, will develop improvement strategies to address any deficiencies and identify goals to improve the Person-Centered Planning Process in FY25.	QMCO	RCP	Quarterly

J. Care Management Program

Description

SWMBH provides a robust care management program to all Medicaid beneficiaries with behavioral health needs who require intensive care management, including but not limited to, child and adult beneficiaries who have significant behavioral health issues and complex physical comorbidities.

The purpose of SWMBH's care management program is to help beneficiaries gain optimal health outcomes, improve functional capacity, and support whole-person recovery. Care management includes but is not limited to care planning, preventative health education, patient communication, medication management, risk stratification, and population management. Care coordination between behavioral and physical health providers is an essential competent of care management involving the organization, coordination, and communication of healthcare services for beneficiaries.

SWMBH works with the MHPs to own joint care management responsibilities with shared MHP beneficiaries, consistent with MDHHS policy and contractual direction. Monthly integrated care team (ICT) meetings are held with the MHPs represented in Region 4 to address the needs of beneficiaries with multiple or complex conditions as well as high ED use and inpatient (IP) admissions. Mutually shared beneficiaries are identified through risk stratification conducted in CareConnect 360 (CC360). An Integrated Healthcare Specialist provides comprehensive assessment of the beneficiary's condition, determination of available benefits and resources, and development and implementation of a care management plan with patient-centered goals, monitoring, and follow-up in conjunction with the MHP care management teams. An integrated care plan is created in CC360 to monitor care coordination activities and health outcomes.

Transition of care monitoring is a key component of care management that focuses on closely monitoring and supporting beneficiaries as they move between different care settings, such as moving from an inpatient admission to the community, ensuring a smooth transition and minimizing potential complications by providing coordinated care during a critical period in a beneficiary's care. Discharge planning is an integral part of treatment. Consideration of the continuum of care and long-term recovery needs of the member should direct transition planning. Transition of care monitoring intends to improve quality of care, improve outcomes and control costs by assuring plan coordination in which primary and specialty mental health, SUD, and healthcare providers inform each other regarding their treatment of an individual and collaboration regarding the needs of the beneficiary.

To further bolster performance measures including FUH and FUA, SWMBH employs grant funded Transition Navigators. The SWMBH UM department identifies beneficiaries not actively engaged in services with a CMHSP,

Certified Community Behavioral Health Clinic (CCBHC), or SUD treatment program that, if not otherwise engaged in aftercare, would have a high risk of readmission following an IP admit or ED visit. Transition Navigators conduct outreach to promote treatment engagement, eliminate barriers to engagement, link beneficiaries to resources as needed, and provide health education.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will create an audit system to track the number of complex cases identified by risk stratification delineated by MHP, the number of cases presented for discussion in monthly ICT meetings, and the volume of cases having a care plan in CC360. This will aid SWMBH to meet or exceed the benchmark expectation that 25% of complex beneficiaries identified through risk stratification will also have a joint care plan created or updated in CC360.	QMCO (Integrated Care)	ICT meetings, RCP, SWMBH Departmental Meetings	Quarterly
SWMBH will create a care coordination procedure detailing use of CC360 risk stratification to identify enrollees 18 and under, shared by both PIHP and MHP, who have significant behavioral health issues and complex physical care needs.	QMCO (Integrated Care)	RCP and shared via Provider Newsletter	Annually
SWMBH will establish a care coordination procedure to facilitate plan-level referrals between both PIHP and MHP which follows the agreed upon workflow created in the PIHP-MHP Referral Subgroup.	QMCO (Integrated Care)	RCP, RUM	Annually

K. Long-Term Services and Supports (LTSS)

Description

LTSS refers to services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).

LTSS are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; or
- Physical, cognitive, developmental, or chronic health conditions; or
- Other functional limitations that restrict their abilities to care for themselves; and
- Receive care in home and community-based settings or facilities such as nursing homes.

MDHHS identifies Medicare and Medicaid participants in its HCBS Waivers as recipients of LTSS. HCBS is defined as Home and Community Based Services which provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. SWMBH manages funding for Michigan's specialty behavioral

health Medicaid population through delegation and contracting with the eight CMHSPs and their provider networks in Region 4. SWMBH and its network serves beneficiaries receiving LTSS through the following HCBS Waivers:

- Children's Waiver Program (CWP)
- Waiver for Children with Serious Emotional Disturbances (SED)
- Habilitative Supports Waiver (HSW)
- 1915 (i)SPA

Additionally, SWMBH identifies beneficiaries who receive the following services as LTSS recipients:

- Care Coordination/Targeted Care Management
- Respite Services
- Community Living Supports (to promote participation in the community)
- Home Modifications
- Nursing Services
- Personal Emergency Response Systems
- Family and Non-Family Training
- Enhanced Pharmacy
- Overnight Health and Safety Supports

SWMBH is dedicated to ensuring the quality and appropriateness of care to all beneficiaries. People receiving LTSS are some of the region's most vulnerable individuals, therefore, additional analyses of the quality and appropriateness of care for the LTSS populations in Michigan are warranted by both quantitative and qualitative means. The quality, appropriateness, availability, and accessibility of care furnished to beneficiaries receiving LTSS is quantitatively and qualitatively assessed using an analysis of adult and youth (MHSIP and YSS) satisfaction surveys. SWMBH's Quality Management and Clinical Outcomes (QMCO) Department incorporated a question in the annual surveys to identify individuals who received LTSS in FY23. This has allowed for a separate analysis of the LTSS population.

The CMHSP Clinical Quality File Review Tool that is utilized in Region 4 annually, includes items to monitor the quality and appropriateness of care for beneficiaries receiving LTSS. For reference, some of the items from the SWMBH annual CMHSP site review tool are:

- In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the primary care physician.
- If the member is a recipient of LTSS, there is an assessment of care between settings.
- Needs, priorities, and a professional analysis of service needs and recommendations are documented.
    - All identified needs are included and addressed in the Individual Plan of Service (IPOS).
- Level of Care (LOC) is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment is completed annually and when there is significant change in individual's status.
- The IPOS is individualized based upon assessment of the beneficiary's needs and preferences. The plan (or assessment) describes their strengths, abilities, plans, hopes, interests, preferences and natural supports.
    - Health/safety risks are identified.
    - Beneficiary choice is documented.
    - Natural supports that will be used to assist the beneficiary in being able to accomplish goals and objectives are identified.

    - The plan contains clear, concise, and measurable statements of the objectives the beneficiary will be attempting to achieve.
- Individuals are provided with ongoing opportunities to provide feedback on supports and services they are receiving, perceived barriers or strengths during treatment, and their progress towards goal attainment.
    - May be documented in progress notes and/or periodic reviews.
- Services and interventions identified in the IPOS are provided as specified –
    - Goals and objectives are measurable.
    - The plan specifies the type, amount, scope, duration, frequency, and timeframe for implementing services.
    - The individual has received all services as authorized in the plan.
    - If services are not being utilized as planned, and an appropriate reason for the lack of service provision is not present in the documentation, the IPOS has been amended. (Lack of provider is not an acceptable reason for not providing a medically necessary service.)

Aggregated annual audit outcomes are regularly monitored and analyzed by the QMCO Department at both the CMHSP and PIHP levels. Results are used to inform annual provider training that is offered to the LTSS provider network. Additional quality improvement training is provided at the CMHSP-level as needed or required.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will use the Customer Satisfaction Survey results to assess the quality, appropriateness, availability, and accessibility of care of beneficiaries receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q4 of FY25.	QMCO	QMC, RCP	Annually
SWMBH will evaluate the number of Respite encounters utilized to establish a baseline of LTSS Respite service utilization. SWMBH will provide education to increase awareness of the benefit of Respite services through Regional Committees and using the member newsletter by providing a description of Respite services, and featuring a beneficiary success story from using Respite supports, by Q4 of FY25.	QMCO	RCP, RUM, RPNMC, and shared via Member Newsletter	Annually

L. Utilization Management (UM)

Description

The purpose of the UM Program is to maximize the quality of care provided to beneficiaries while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers, LTSS recipients (defined in LTSS section of the QAPIP), and SUD Community Grant resources

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

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

Utilization Management Activities

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

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

Determination of Medical Necessity

Treatment under the beneficiary's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, IDD, and substance abuse

supports and services and provider qualifications are found in the MDHHS Medicaid Provider Manual. For the purposes of utilization control, SWMBH ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in the MDHHS Medicaid criteria or professional qualifications requirements, and UM standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

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

Process Used to Review and Approve the Provision of Medical Services

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

<u>Review Process</u>

A Prospective Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service

delivery. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

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

Access Standards

- The percentage of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (MMBPIS #1, Standard = 95%)
- The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (MMBPIS #2, Standard = >62%)
- The percentage of new persons receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with a SUD. (MMBPIS #2e, Standard = 68.2%)
- The percentage of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MMBPIS #3, Standard = 72.9%)
- The percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (MMBPIS #4a, Standard = 95%)
- The percentage of discharges from a substance abuse withdrawal management (detox) unit who are seen for follow-up care within seven days. (MMBPIS #4b, Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less.

Level of Intensity of Service Determination

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

Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition	Within 1 hour of request

Coordination and Continuity of Care

SWMBH is committed to ensuring each beneficiary receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, and the ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a SUD. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the SIS (Supports Intensity Scale) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person- centered planning process with the beneficiary's participation and with consultation from any specialists providing care to the beneficiary.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.

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

determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

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

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

The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings. Should any performance area be below the established benchmark standard, the Utilization Review process requires that a CAP be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the CAPs. The outlier management process and subsequent reports to manage it, including Over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Outlier Management

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

1) Outlier Definition

"Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows: A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under- utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

2) Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative

patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3) Outlier Management Procedures

1. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.
2. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensure understanding of the utilization trends or patterns.
3. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion.

Data Management

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

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

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

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques through the Annual CMHSP Clinical Quality Site Review Process. SWMBH will identify and/or develop relevant UM Reports to share with the Region to help monitor utilization and uniform benefit using data informed practices.	UM, QMCO	RUM, RCP	Annually and Quarterly

SWMBH will ensure regional IRR audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. ▪ IRR monitoring will continue during the annual site review process to ensure it is being completed to ensure consistent application and use of the LOCUS. The LOCUS tableau report will be utilized to review trends by assessor by CMHSPs and discussed quarterly in Regional Committees	UM, QMCO	RUM, RCP	Annually and Quarterly
SWMBH will review Service Authorization Denial files for trends, ongoing through the end of FY25. ▪ Service authorization denial trends will be reviews quarterly. CMHSPs and SWMBH will complete quarterly denial monitoring meetings.	UM, Customer Services	RUM, Regional Customer Service Committee	Quarterly

M. Customer Services

Description

SWMBH's Customer Services Department provides a welcoming environment and orientation to services which includes providing information about benefits, available providers in network, how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Services assists beneficiaries with obtaining information about how to access their due process rights when services are denied, reduced, suspended, or terminated. That includes helping beneficiaries with the grievance and appeal (G&A) process. Customer Services is able to track and report patterns of problems for each organization, regionally, and evaluate over/under service utilization.

SWMBH delegates Customer Service functions including due process, grievances, and appeals to the CMHSPs. As such, a MOU between SMWBH and each CMHSP is implemented. The MOU specifies the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all beneficiaries have access to customer service rights. This ensures federal and state requirements are met, while ensuring the services are provided in a uniform manner throughout Region 4 for continuity of care.

SWMBH also employs a Veteran Navigator within the Customer Services Department, and their role is to listen, support, offer guidance, and help connect Veterans to services they need. The Veteran Navigator facilitates and attends community outreach events throughout the region to increase awareness and connection to services.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Regional Customer Service Committee will ensure all member facing materials meet state and federal requirements, including updates to 1557 by end of FY25. This will include but not limited to all brochures, SWMBH and CMH websites, informational materials, privacy practices, intake paperwork such as consent to treat, all letters and notices provided to members, and 1557 training.	Customer Services	Regional Customer Service Committee	Quarterly
Plan and implement Conflict-Free Access and Planning (CFAP) requirements to Customer Service such as notices and letters for members as well as any informational materials in FY25. ▪ Review guiding documents from MDHHS when released for customer service (member materials/documents), grievance appeal, veteran navigator, and access requirements. ▪ Identify any oversight and monitoring requirements and create and implement any tracking tools.	Customer Services	Regional Customer Service Committee	Quarterly
Committee will review Grievance and Appeal files for trends, ongoing through the end of FY25. ▪ Committee will review G&A trends quarterly. ▪ CMHSPs and SWMBH will complete quarterly G&A monitoring meetings. ▪ Review the Managed Care Program Annual Report (MCPAR) data for trends by the end of March 2025.	Customer Services	Regional Customer Service Committee	Quarterly

N. Integrated Health Initiatives

Description

Health Home models aim to improve the health and well-being of individuals served by using comprehensive and integrated approaches to care. In Region 4, the Certified Community Behavioral Health Clinic (CCBHC), Substance Use Disorder Health Home (SUDHH), and Behavioral Health Home (BHH) models are represented. Each of these models, though different, converge to provide comprehensive mental health and substance use disorder care, coordination between behavioral and physical health, as well as address areas of social need, support service delivery across the lifespan, and improve access to services through interdisciplinary care teams and flexible funding structures.

CCBHC

Effective 10/01/24, seven of the eight CMHSPs within Region 4 are participating as CCBHC demonstration sites. The CMS CCBHC Demonstration requires certified sites to provide nine core services and Michigan CCBHCs have twelve required and seven recommended evidence-based practices they must use. The 9 core services are:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.

3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for beneficiaries of the armed forces and veterans, particularly those beneficiaries and veterans located in rural areas.

CCBHC General Requirements

SWMBH must adhere to the CCBHC contractual and policy requirements from MDHHS. CCBHCs must meet the requirements indicated in CCBHC certification. SWMBH and the CCBHCs must adhere to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

PIHP Requirements

SWMBH shares responsibility with MDHHS for ensuring continued access to CCBHC services. SWMBH is responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring, reporting on CCBHC measures, and coordinating care for all populations served by the CCBHC sites in their region (regardless of payor). SWMBH developed a MOU with all CCBHCs in the region and ensure access to CCBHC services for their enrollees. Contracts with CCBHCs permit authorizing agreements with Designated Collaborating Organization (DCO) entities and reflect the CCBHC scope of services. They also ensure compensation for CCBHC services equates to clinic-specific Prospective Payment System (PPS-1) rates and do not limit the CCBHC's ability to serve all populations with behavioral health needs per CCBHC eligibility requirements. SWMBH is responsible for understanding the CCBHC certification process requirements, including DCO credentialing. MDHHS recommends that PIHPs provide training and support on this process and help potential CCBHC sites to become certified.

SWMBH distributes data requests from MDHHS for quality metrics, cost reports, level of care data, reconciliation templates, etc. and validates and evaluates CCBHC data as well as communicates any discrepancies to MDHHS prior to submission. SMWBH utilizes Michigan claims and encounter data for the CCBHC population, and provides support related to Health Information Technology (HIT) including the Waiver Support Application, CC360, the PIHP Electronic Health Record (EHR) and Health Information Exchanges (HIEs). SWMBH works with CCBHCs to establish timelines for MDHHS reporting deadlines.

SWMBH provides access to CCBHC services through providers certified as a CCBHC. SWMBH panels CCBHCs to provide SUD services or assist the CCBHC to develop a DCO agreement with a SUD provider already on the PIHP panel. SWMBH honors intake, access, screening, and authorization for CCBHC services completed by a CCBHC demonstration provider when an individual seeks services at a CCBHC (i.e., calling the CCBHC directly or walk-ins). Timely access is provided to new and established recipients according to the CCBHC Handbook and SWMBH pays the CCBHC the full PPS rate for any first encounter.
SWMBH collaborates with CCBHCs who conduct a warm handoff to the PIHP during instances when a CCBHC is required to refer individuals to the PIHP access center. This may include:

- Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO, including SUD services.
- Individuals seeking access to services a CCBHC does not provide.
- Individuals seeking access to services offered through the 1915(c) waivers or 1915(i) services.
- PIHPs cannot require any prior authorizations or additional screening requirements beyond those noted above before an individual can access CCBHC services.

It should be noted that PIHP utilization management of CCBHC services is limited to retrospective review of approved/rendered services to confirm that the care was medically necessary. SWMBH cannot delegate retrospective reviews for CCBHC services to a CCBHC or CMHSP.

SWMBH utilizes RUM, QMC, and RCP to cover CCBHC topics and current metric status. The full list of specific Core Measures and other federal requirements are included in the CCBHC Handbook and measures associated with the Quality Bonus Payment (QBP) program are included below.

Measure Name	State or Clinic Reported	Steward	Benchmark	Award Methodology
HBD-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	State	NCQA	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end for each sub-measure. HbA1c controlled HbA1c poorly controlled	10% of Eligible QBP
DEP-REM-6: Depression Remission at 6 months	Clinic	MN Community Measurement	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end.	5% of Eligible QBP
I-SERV: Time to Services	Clinic	SAMHSA	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end for each sub-measure: Time to Evaluation Time to Clinical Service Time to Crisis Response	15% of Eligible QBP
FUH-AD: Follow-Up After Hospitalization for Mental Illness, ages 18+	State	NCQA	30-day: 75% 7-day: 48%	15% of Eligible QBP
FUH-CH: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17	State	NCQA	30-day: 88% 7-day: 60%	15% of Eligible QBP
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State	NCQA	Initiation: 41% Engagement: 14%	10% of Eligible QBP
PCR-AD: Plan All-Cause Readmissions Rate	State	NCQA	10%	10% of Eligible QBP
SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment	Clinic	Mathematica	73%	10% of Eligible QBP
SRA-C: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic	Mathematica	57%	10% of Eligible QBP

SUDHH and BHH

Both the SUDHH and BHH models provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries eligible for SUDHH will have a qualifying diagnosis related to alcohol, stimulant, or opioid use disorder. Beneficiaries eligible for BHH must have a SMI or SED. The models are staffed with an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. Each model must provide six core health services:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Support Services

PIHP Requirements

PIHPs operating as the Lead Entity (LE), for both the SUDHH and BHH models, must:

- Have the capacity to evaluate, select, and support providers who meet the standards for Health Home Program (HHP)s including:
  - Identification of providers who meet the HHP standards
  - Provision of infrastructure to support HHPs in care coordination
  - Collecting and sharing member-level information regarding health care utilization and medications
  - Providing quality outcome protocols to assess HHP effectiveness
  - Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
- Maintain a network of providers that support the HHPs to service beneficiaries with a substance use disorder (SUDHH) or serious mental illness and serious emotional disturbance (BHH).
- Reimburse HHPs for providing health home services
- The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the SUDHH and BHH with providers; MDHHS will retain overall oversight and direct administration of the LE; the LE will also serve as part of the Health Homes team by providing care management and care coordination services.

FY25 SUDHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	State Baseline	Allocation % of P4P Budget
1	Initiation and engagement of alcohol and other drug (AOD) dependence treatment (0004), Initiation of AOD treatment within 14 days	NCQA	TBD	50%
2	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge	NCQA	TBD	30%
3	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	CMS	TBD	20%

FY25 BHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Allocation % of P4P Budget
1	Follow up After Hospitalization (FUH-7)	NCQA	50%
2	Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
3	Access to Preventative/Ambulatory Health Services	NCQA	30%

O. External Monitoring and Audits

Description

SWMBH is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from MDHHS, HSAG, CMS, and other organizations. Audit results are reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board of Directors, as appropriate. Regional and internal CAPs are developed for reviews/audits that do not achieve specified benchmarks or established targets.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will achieve an overall compliance score of >90% during the 2025 HSAG Compliance Review.	QMCO, SWMBH Senior Leaders	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >95% on the 2025 HSAG Performance Measure Validation (PMV) Audit.	QMCO, IT	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >90% during the 2025 HSAG Network Adequacy Validation (NAV) audit.	Provider Network	RPNMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will see a reduction in the number of repeat citations during the 2025 MDHHS Waiver Audit, compared to the 2023 audit results.	QMCO	QMC, RPC, other Regional Committees	Annually

P. Cultural Competency

Description

SWMBH is dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all beneficiaries. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment to cultural competence and demonstrate compliance with the MDHHS/PIHP contract, SWMBH has the following five components in place:

1. Community Assessment
2. Policy and Procedure

3. Service Assessment and Monitoring
4. Ongoing Training
5. Culturally Contextual Services/Supports

Community Assessment
SWMBH uses the annual regional Network Adequacy assessment and consumer satisfaction surveys to assess for a culturally competent provider network and consumer involvement throughout the region. Languages spoken throughout the provider network are gathered through the Region's credentialing process.

At the county level, MDHHS requires each CMHSP to conduct a nominal Needs Assessment at least every two years. Michigan also launched as a CCBHC Demonstration state in 2021, and MDHHS requires all local CCBHC sites to complete a Needs Assessment. These community health needs assessments provide current demographic data and involve extensive stakeholder surveys spanning both provider agencies and persons served. The CMHSPs analyze stakeholder survey responses alongside data points for a combined qualitative and quantitative view of cultural competence and needs in each county. These data points are discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments are used to create a foundational equity framework that is specific to the county level, complete with root cause analysis and subsequent strategic planning.

Policy and Procedure
SWMBH Policy - Cultural & Linguistic Competency and SWMBH Procedure - SWMBH Cultural Competency Plan reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network.

Service Assessment and Monitoring
SWMBH is fully dedicated to improving health equity within Region 4, as evidence by adding the Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. It is a grant funded position that will continue to plan and develop region wide programming to increase the access and participation of minority populations in behavioral health services in FY25. The position facilitates a Regional Health Equity Focus Group consisting of representation from all 8 counties in the Region 4. The workgroup meets quarterly and helps to identify regional and county barriers. Likewise, the workgroup participants bring advice from frontline partnerships for further coordination and support, provide feedback on trainings and anti-stigma campaign efforts. Cultural competency is further assessed and monitored through current PBIP, CCBHC, MMBPIS, and other metrics geared toward ensuring cultural competence and fairness in service delivery.

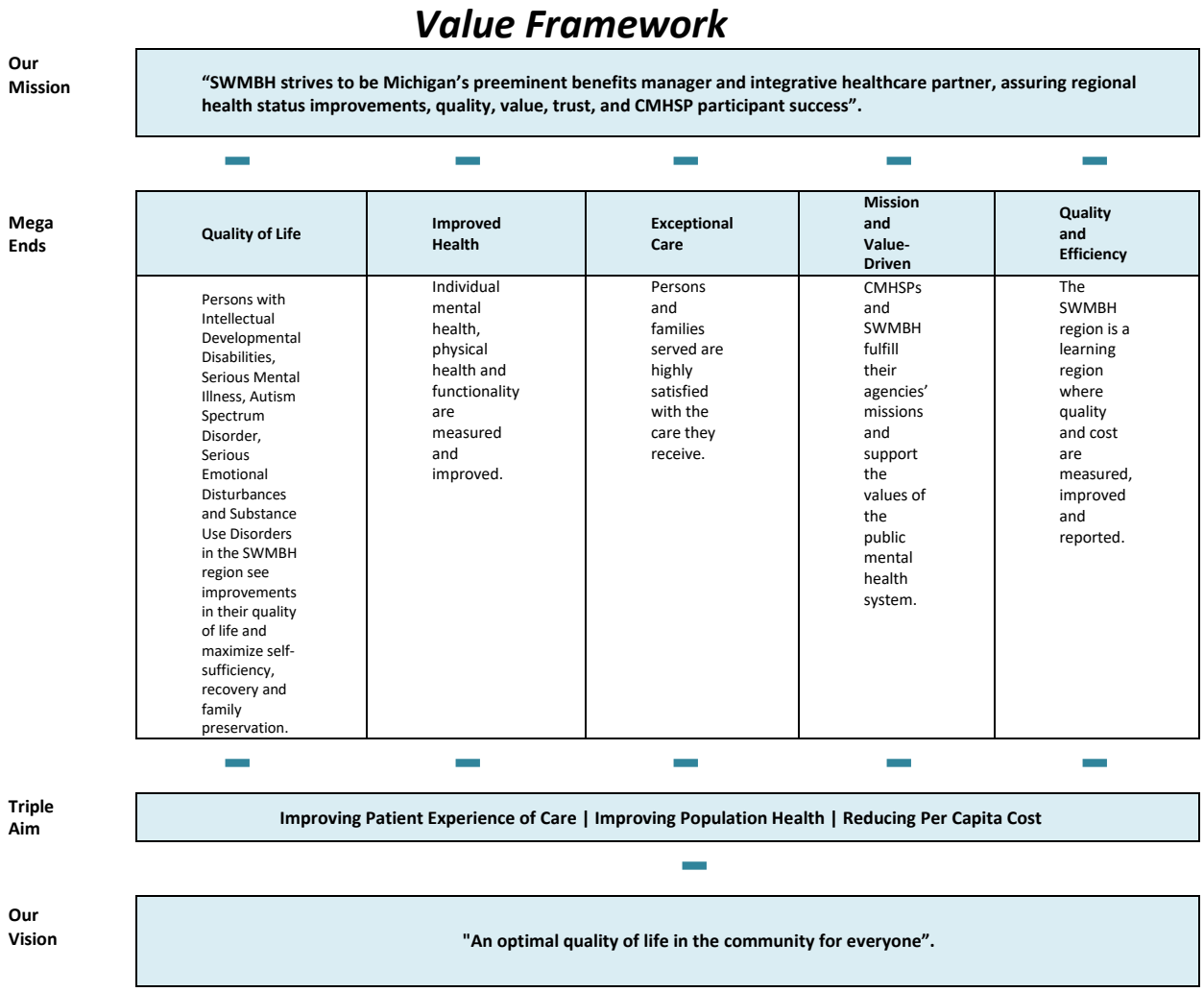
Training
SWMBH requires ongoing training to assure that staff are aware of, and able to effectively implement cultural competency policies and procedures. SWMBH requires all provider-level staff that are in-network to have cultural competency training and SWMBH reviews that requirement as part of the Staff Training File Review in the annual administrative and delegated function site review process. SWMBH Policy - Cultural & Linguistic Competency and SWMBH Procedure SWMBH Cultural Competency Plan are trained annually during a Quality Management Committee meeting. SWMBH has likewise begun offering the following trainings free of charge to all provider agencies in Region 4: Social work Ethics and Pain Management, Implicit Bias, and Human Trafficking.

Culturally Contextual Services/Supports
SWMBH strives to ensure that supports and services are provided within the cultural contexts for all beneficiaries. SWMBH's community-sponsored events are selected by the Community Outreach Committee, which is dedicated to finding opportunities to better reach underserved and minority populations.

FY25 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Further develop trainings in 2025 by adding a mixture of free-to-attend virtual trainings and in-person health equity conferences in the region.	QMCO (Integrated Care)	Integrated Care Team Meetings	Monthly
Promote continued education throughout the organization and 8-county region by participating in or contributing to local organizations and public events. Continue to seek culturally relevant, visible opportunities that attract minorities and their allies.	Customer Services	Regional Customer Services Committee, RPNMC, RCP	Annually
SWMBH will evaluate language spoken by network providers vs. enrollees for FY24. SWMBH believes capturing more Provider data regarding languages spoken, cultural competency, and physical accessibility of office space will assist the Provider Network Departments at each CMHSP in ensuring the Region's beneficiary's needs are being met in this capacity.	Provider Network	Regional Customer Services Committee, RPNMC, RCP	Annually

ATTACHMENT A – VALUE FRAMEWORK



ATTACHMENT B – SWMBH BOARD ROSTER

2025 Board of Directors Roster

Barry County

- Lorraine Lindsey
- Robert Becker (Alternate)

Berrien County

- Edward Meny
- Nancy Johnson (Alternate)

Branch County

- ***Tom Schmelzer, Vice-Chair***
- Jon Houtz (Alternate)

Calhoun County

- ***Sherii Sherban, Chair***
- Kathy-Sue Vette (Alternate)

Cass County

- Louie Csokasy
- Jeanne Jourdan (Alternate)

Kalamazoo County

- Erik Krogh
- Karen Longanecker (Alternate)

St. Joseph County

- ***Carol Naccarato, Secretary***
- Cathi Abbs (Alternate)

Van Buren County

- Tina Leary
- Angie Dickerson (Alternate)

Eleos Group Purchase Agreement

In August 2024, Eleos Health completed a demo of its Behavioral Health AI Solution for documentation at the Regional Operations Committee, at the invitation of Pivotal. Pivotal and other CMHs were already actively using or in discussions with Eleos for this documentation solution. There was a cost benefit (lower per user fee) under a group purchase arrangement, with SWMBH holding an overarching Membership Partnership Agreement and each CMH having a separate Member Service Agreement and Business Associate Agreement directly with Eleos.

All* CMHs indicated a desire to move forward with the group purchase arrangement. SWMBH indicated that the cost of the Eleos contract would be paid by SWMBH, including a portion allocated to Regional Local funds. SWMBH via Mila Todd worked with Eleos on and ultimately signed a three-year Agreement December 18, 2024.

The Eleos Invoice totals $566,534.67 for the first year for 7 of 8 participant CMHSPs. Invoices will be $529,000 for each year after the Implementation Year.

Pursuant to Board Policy BEL002, Section III(8), The Executive Officer may not:

> 8. Make a single purchase or commitment of greater than $100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.

This arrangement should have been brought before the SWMBH Board prior to execution of the Agreement in December 2024.

Requested Board Action: A Motion that the Board retroactively approve the execution of the Eleos Membership Partnership Agreement by SWMBH.

*While all 8 CMHs requested and supported pursuit of a group purchase arrangement, ISK holds a separate agreement with Eleos that predates the group purchase arrangement. ISK has indicated when its contract with Eleos is up for renewal, ISK intends to opt-in to the group purchase arrangement.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Accomplishment	Policy Number: BG-004	Pages: 1
Subject: Board Ends and Accomplishment	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
04.11.2014	2/9/24	12.12.14, 1/8/16, 1/13/17, 1/12/18,1/11/19, 1/10/20, 1/8/21, 1/14/22, 1/13/23

I. **PURPOSE:**

To clearly identify the role of Ends monitoring and define accomplishment for SWMBH

II. **POLICY:**

The SWMBH Board will provide clear direction by determining Ends, approving Interpretations and adopting Ends Metrics.

III. **STANDARDS:**

Accordingly, the SWMBH Board shall:

1. Identify areas of focus (Ends) for strategic monitoring.

2. Approve Interpretations of Ends. EO shall propose Interpretations.

3. Adopt Ends Metrics which are clear, succinct, results-oriented, achievable, realistic and objective. EO shall propose Ends Metrics.

4. Regularly review data related to focus (Ends) Metrics as planned in the Board-approved calendar, upon request of the Board, or at the initiation of the EO.

5. Revisit Ends, Interpretations and Metrics as it sees fit. The EO may propose to the Board additions or revisions to Ends, Interpretations and Metrics as the EO sees fit. No changes to these are permitted absent Board approval.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Management/Governance	Policy Number: BG-007	Pages: 2
Subject: Code of Conduct	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH Executive Officer (EO)		Required Reviewer: SWMBH Board
Effective Date: 01.10.2014	Last Review Date: 2/9/24	Past Review Dates: 1.09.15, 1/8/16, 1/13/17, 2/9/18,1/11/19, 1/10/20, 1/8/21, 1/14/22,2/10/23

I. **PURPOSE:**

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

II. **POLICY:**

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

III. **STANDARDS:**

1. Members will follow the SWMBH Conflict of Interest Policy

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

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

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

5. Members will be properly prepared for Board deliberation.

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

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

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

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

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

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

A key component of Board development is Board education planned and executed in a focused fashion. This serves to support the Board in its deliberations on 2025 Board education and to inform selection of materials to be covered during the Board's May day-long planning retreat.

- **SWMBH Bylaws**
- **Policy Governance**
- **Managed Care Functions**
- **Federal and State Policy Developments and Advocacy**
- **Plans and Policies required to be reviewed include:**
    - **Financial**: Management Plan, Cost Allocation Plan, Operating and Capital Budgets, Risk Management Plan
    - **Regional Entity Guiding Documents**: Quality Assurance and Performance Improvement Plan & Utilization Management Plan
    - **Clinical Programs and Services**
    - **Impact and Outcomes**

Board education topics may include many topics:

- **Board member recruitment**: A process for actively recruiting new members.
- **Board culture**: A board's culture can be a foundation for its effectiveness.
- **Board diversity**: Diverse boards have different opinions, approaches, and solutions, which can lead to better decisions.
- **Strategic action plans**: Think strategically to be more efficient and effective.
- **Assessing board performance**: Boards can establish norms to clarify their practices and behaviors.
- **Succession planning**: Boards should have a plan for choosing a successor if a board member steps down.
- **Governance trends**: Boards can learn about the top governance trends and issues that affect organizations.

Other Topics and Issues that Affect the Organization:

- **Cybersecurity**
- **Natural disasters and environmental issues**
- **Sustainability**
- **Technology**
- **Fundraising**
- **Social, economic, and political issues**

At a specially called meeting of the SWMBH Board of Directors on January 3, 2025, regarding the Dispute Resolution Step 3 proceedings between SWMBH/Summit Pointe & Pivotal, the SWMBH Board voted as follows:

> "The SWMBH Board refer the matter of the Pivotal and Summit Pointe dispute resolutions presented at the December 13, 2024 meeting of the SWMBH Board to the Operations Committee to develop a plan for allowing regional CMHs to become responsible for continuing stay reviews for psychiatric inpatient care for submission to the SWMBH Board at their February 14, 2025 meeting."

Mila Todd (SWMBH), Jeannie Goodrich (Summit Pointe), and Cameron Bullock (Pivotal) met on January 6, 2025 and reached a proposed resolution for presentation to the full Operations Committee. The Operations Committee offers the following general plan to the SWMBH Board for its consideration:

- SWMBH develops a Readiness Assessment Tool for acute care continuing stay reviews and provides the Tool to CMHs.
- CMH submits a written request to perform acute care continuing stay reviews.
- SWMBH and CMHs meet to review the readiness assessment tool and develop a mutually agreed upon timeframe for the assessment to occur.*
- CMHs provide all proofs required by the readiness assessment tool by the mutually agreed upon submission date.
- SWMBH reviews the submitted materials.
- The parties have any necessary dialogue and submit any additional proofs as may be necessary for SWMBH to complete the readiness assessment by the mutually agreed upon timeframe.
- SWMBH will work with CMHs on any continued deficiencies to ensure that CMHs are able and ready to perform CSRs.
- Based on the findings of the Readiness Assessment, SWMBH will submit an updated Delegation Memorandum of Understanding and request to MDHHS.**

*SWMBH and Participant CMHSPs will review SWMBH Policy 2.10 to codify general timeframes that allow for flexibility based on the circumstances of each unique request.

**The parties maintain disagreement as to whether this step is required, but have agreed to disagree and move ahead in good faith towards a resolution. SWMBH will contact its MDHHS contract manager and CC Summit Point and Pivotal to ascertain whether acute care continuing stay medical necessity determinations and authorizations are a function subject to the 90-day MDHHS approval under the MDHHS-PIHP Contract. Based on that answer, the parties will determine the final step in the procedure.

Quality Assurance and Performance Improvement Program (QAPIP) Fiscal Year 2024 Evaluation Report Summary

All SWMBH Medicaid Business Lines

Evaluation Period: October 1, 2023 - September 30, 2024

The Quality Assurance and Performance Improvement Program (QAPIP) 2024 Evaluation Report assesses the effectiveness of the 2024 QAPIP plan's goals and objectives. Each section contains a barrier analysis and highlights improvement efforts. The annual QAPIP evaluation helps inform the 2025 QAPIP Plan.

SWMBH has adopted a rating system to evaluate the key performance indicators and QAPIP Plan objectives. Throughout the evaluation, a five-point scoring rubric is used to rate each evaluated component as follows:

1. A score of 1 or "Poor" indicates a critically unmet need that requires immediate follow-up.
2. A score of 2 or "Subpar" is given to an area that markedly needs improvement but does not necessarily require urgent, immediate attention.
3. A score of 3 or "Acceptable" is indicative of an area that minimally meets that area's requirements.
4. A score of 4 or "Good" reflects an area that exceeds the acceptable requirements but may still contain room for minor improvements.
5. A score of 5 or "Excellent" is reserved for those areas that far exceed the acceptable requirements and need only very minor, if any, improvements.

Each year MDHHS reviews the QAPIP, and we receive a score of met or not met. In 2024 all areas were met with no additional recommendations. These are the sections evaluated:

- Performance Measures (MMBPIS Indicators)
- Performance Improvement Projects
- Critical Incident, Sentinel Event, and Risk Event Management
- Behavioral Treatment Review
- Member Experience with Services
- Practice Guidelines
- Credentialing and Re-Credentialing
- Verification of Services
- Utilization Management
- Provider Network (delegated function site reviews)
- Long-Term Services and Supports (LTSS)

2024 Results Performance Indicators:

Indicator	Where Progress was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Monthly	98.86%	99.67%	5	The goal was met, will stay the same and be monitored through FY25.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Monthly	98.88%	99.72%	5	The goal was met, will stay the same and be monitored through FY25.
2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adult, MI-child, IDD-adult, IDD-child (>=62%).	QMC	Monthly	66.85%	72.92%	3	This goal was met, will stay the same and be monitored through FY25.
2e - 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 (>=68.2%).	QMC	Monthly	66.83%	65.97% *	3	It is anticipated that this goal will be met; however, MDHHS calculates this indicator and Q4 outcomes were not available for this report. This goal will be monitored through the upcoming FY.
3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adult, MI-child, IDD-adult, and IDD-child) (>=72.9%).	QMC	Monthly	56.78%	59.21%	2	This goal was not met and will continue to be monitored through the upcoming FY. Due to low indicator performance, the non-clinical PIP to improve access and timeliness for new beneficiaries will continue through FY25.
4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QMC	Monthly	98.01%	97.35%	4	The goal was met, will stay the same and be monitored through FY25.
4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QMC	Monthly	96.98%	97.17%	4	The goal was met, will stay the same and be monitored through FY25.
4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QMC	Monthly	98.98%	98.11%	4	The goal was met, will stay the same and be monitored through FY25.
10a - Re-admission to Psychiatric Unit within 30 Days-Children (<=15%).	QMC	Monthly	3.37%	9.01%	4	The goal was met, will stay the same and be monitored through FY25.
10b - Re-admission to Psychiatric Unit within 30 Days-Adults (<=15%).	QMC	Monthly	9.50%	13.06%	4	The goal was met, will stay the same and be monitored through FY25.

2024 Results- Performance Improvement Projects (PIP):

Clinical PIP/FUA-30: There were increases in the rates of ED follow up in 2023 (remeasurement 1) compared to 2021 (the project's baseline), with an overall follow up rate of 38.07% in 2023 compared to 20.97% in 2021. However, the statistically significant disparity between the African American/Black and White populations remained, with an African American/Black population rate of 25.81% compared to 42.65% for the White population. Barriers exist with filling ED outreach position, encounter reporting, and information exchange from the Eds to the CMH when someone needs SUD follow up. Improvement efforts were focused on increasing peer services and getting credit for those, our Health Equity Grant Coordinator (focus groups, anti-stigma campaign, and provider trainings), meetings and data sharing with EDs. This PIP will continue in FY25.

Non-Clinical PIP/MMBPIS Indicator 3: The rate increased from 56.78% in FY23 to 59.21% in FY24, but it did not meet the 72.9% benchmark. Some of the identified barriers are due to member scheduling issues, high no-show rates for psychiatric appointments and staffing shortages. The region discussed many recommendations and the CMHs were asked to review and determine what strategies they could implement. This PIP will continue in FY25.

Goal	Where Progress was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
Performance Improvement Project #1 (Clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Monitoring: Remeasurement 1 (2023) results will be available in June 2024. We will assess our performance on the following measures to determine whether we have met the PIP goal for 2023. 1. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.	Regional Clinical Practices Committee and Regional Quality Management Committee	Bi-Annual	Did not meet the FY24 goal of eliminating the disparity from 2021 to 2023.	**3**	The disparity between Black/African American and White beneficiary follow-up from ED for AOD rates did not change significantly from 2021 to 2023.

2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.					
Performance Improvement Project #2 (Non-Clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (MMBPIS Indicator 3). Goals: ▪ Completion of a causal barrier analysis to evaluate factors contributing to the 2023 baseline of 56.78%. ▪ Development and implementation of interventions to address the barriers. ▪ Improve access to meet the MDHHS benchmark of 72.9%.	Regional Clinical Practices Committee and Regional Quality Management Committee	Annually and Quarterly	Partially Met	**2**	Goal was partially met as the causal barrier analysis completed and interventions were implemented in FY24. However, the FY24 overall Indicator 3 rate measures below 72.9% benchmark, at 59.21%. This was an improvement from FY23, and the PIP will continue in FY25.

FY24 Results- Critical Incidents: The rate of suicide deaths per 1,000 people served decreased. The rates of hospitalization, emergency medical treatment, and arrests increased compared to FY24. We expect to see those continue to increase in FY25 because MDHHS changed the reporting requirements to include more individuals. The region discusses the outcomes of the reviews of those significant incidents quarterly to try to mitigate them.

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	Through submission to MDHHS in the new CRM	As SEs Occur	None to Report	None to Report	**N/A**	No SUD Sentinel Events were reported in FY24. The process for reporting and the goal will remain the same for FY25.
The rate for the region, per 1000 persons served, of suicide deaths will	QMC	Quarterly	0.34	0.23	**5**	The goal was met and will stay the same. It will be monitored through FY25.

demonstrate a decrease from the previous year.						
The rate for the region, per 1000 persons served, of individuals who were hospitalized due to an injury or medication error will demonstrate a decrease from the previous year.	QMC	Quarterly	0.06	0.11	**3**	The goal was not met, but the rate did not increase significantly. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups.
The rate for the region, per 1000 persons served, of individuals who received emergency medical treatment (EMT) for an injury or medication error will demonstrate a decrease from the previous year.	QMC	Quarterly	1.33	1.59	**2**	The goal was not met. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups and the clarification of reporting requirements.
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	QMC	Quarterly	1.08	1.77	**2**	The goal was not met. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups.
The rate for the region, per 1000 persons served, of individuals who caused harm to themselves (risk event codes B9, B10, and B11) will demonstrate a decrease from the previous year.	QMC	Quarterly	B9- 0.65 B10- 3.39 B11- 0.56	B9- 0.60 B10- 5.81 B11- 0.77	**3**	A decrease was seen in self-harm resulting in injury, but an increase was seen in suicide threats and attempts. The data will continue in FY25, but the goal will be discontinued.
The rate for the region, per 1000 persons served, of individuals who caused harm to others (risk event codes B3, B4, B5, and B6) will demonstrate a decrease from the previous year.	QMC	Quarterly	B3- 0.83 B4- 1.70 B5- 0.00 B6- 0.92	B3- 0.20 B4- 1.62 B5- 0.03 B6- 0.63	**4**	Decreases were seen in physical aggression resulting in injury, homicide threats, and inappropriate sexual conduct. An increase was seen with 1 homicide attempt. The data will continue in FY25, but the goal will be discontinued.

FY24 Results- Behavioral Treatment Review:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will complete a quality review of at least 6 behavior treatment plans per CMHSP for FY24.	RCP and QMC	Quarterly	Partially Met. A total of 58 behavior treatment plans were reviewed across the region but not at least 6 per CMHSP.	**3**	The goal will remain the same for FY25. SWMBH will continue to request behavior treatment plans for review based on trends or other identified questions or concerns.
The region will achieve 90% or higher on the Behavior Treatment Plan section of the annual CMHSP audit.	RCP and QMC	Annually	Not Met. Regional average score in the Behavior Treatment Planning Section was 85.74%	**3**	The goal will remain the same for FY25. SWMBH will continue to provide technical assistance to the region on low scoring areas and request CAPs as needed.
SWMBH will implement a regional strategy to evaluate the BTRC's effectiveness by Q4 of FY24.	RCP and QMC	Annually	The BTRC Workgroup worked on this initiative, however, this requirement was removed from the newest version of the technical requirements.	**N/A**	This goal will be discontinued as MDHHS indicated that this is no longer a requirement.

FY24 Results- Member Experience with Services:

Customer Satisfaction Surveys- we had the highest number of surveys completed since we started the survey in 2014. The adult survey saw a statistically significant improvement in the outcomes and functioning construct and the youth survey had no statistically significant differences in any construct compared to FY24 results. The goals for FY25 are to improve the lowest scoring constructs (adults- outcomes and functioning, youth- outcomes)

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	Recommendations
Achieve at least 1500 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper.	QMC	Quarterly	1508 Completed Surveys	1583 Completed Surveys	5	This goal was met and will continue to be monitored in FY25.
Achieve at least 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QMC	Quarterly	395 Completed Surveys	644 Completed Surveys	5	This goal was met and will continue to be monitored in FY25.
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QMC, RCP, and CAC	Annually	Met	Met	4	This process will continue in FY25 but will not be identified as a goal.
Ensure CMHSPs develop improvement plans specific to their survey findings/results/analysis.	QMC and CAC	Annually	Met	Met	4	This process will continue in FY25 but will not be identified as a goal.
Present and receive feedback from the SWMBH Beneficiary Advisory Committee on survey process, questions, content, and distribution plan.	QMC and CAC	Annually	Met	Met (Scheduled review in January 2025)	5	This goal was met, and the process will continue in FY25.

FY24 Results- Verification of Medicaid Services:

Goal	FY23	FY24	Eval Score	Recommendations
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	92.03 %	95.05 %	5	Goal was met in FY24 and will continue in FY25.

FY24 Results- Credentialing and Re-Credentialing:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network Team Meeting Minutes	Annually	Met – Training occurred on 02/17/23, 03/17/23, and 10/20/23	Met – Training occurred on 10/20/24, 10/22/24, 10/28/24, and 10/30/24	**5**	SWMBH is planning to provide continued training to the region in FY25 related to the MDHHS policy updates and implementation of universal credentialing.
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated Site Reviews.	Site Review Tools	Annually	Combined Average from 8 FY23 CMHSP Site Reviews 98%	Combined Average from 8 FY23 CMHSP Site Reviews 96.3%	**5**	Continue to monitor.
SWMBH will develop and implement a quality performance improvement project designed to improve adherence to SWMBH and MDHHS credentialing requirements.	Site Review Tools, RPNMC	Annually	N/A	N/A	**N/A**	SWMBH decided to pursue a different non-clinical PIP in FY24, in anticipation of MDHHS changing the credentialing process.

FY24 Results- Provider Network:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	SWMBH Assessment of Medicaid Network Adequacy Report	Annually	Met	Met	**5**	Continue to monitor.

FY24 Results- Delegated Function Site Reviews:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will complete Site Reviews for the region (for Participant CMHSPs, SUD Providers, and Subcontracted Providers), and areas of non-compliance will require a corrective action plan.	Site Review Tools and CAP Documents	Annually	Met	5	Continue to monitor.

FY24 Results: Clinical Practice Guidelines:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline and develop improvement strategies to address any deficiencies in FY24.	QMC, RCP, Site Review Tools	Quarterly	Met	5	The Clinical Quality CMHSP site review tool was updated to better evaluate the effectiveness and implementation of the Person-Centered Planning process. Any deficiencies resulted in corrective action plan development. As this is an area that continues to need regional improvement, this goal will continue in FY25.

FY24 Results- Long-Term Services and Supports (LTSS):

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will use the Beneficiary Experience Satisfaction Survey results and the information from the Waiver Audit Interviews to assess the quality, availability, and accessibility of care of beneficiaries receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q3 of FY24.	QMC and RCP	Annually	Met	5	The Customer Satisfaction Survey results showed better scores in all constructs for adult and youth LTSS recipients compared to non-LTSS recipients. This goal will be kept in FY25 and SWMBH will continue to evaluate beneficiary satisfaction.

FY24 Results- Utilization Management:

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will create a Utilization management Plan per MDHHS guidelines.	RUM	Annually	Met	Met	**5**	The goal was met. This is recommended to be removed for a FY25 UM Department Goal. This is a required document and consistently met without any concern.
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques.	RUM and RCP	Monthly	Met	Met	**5**	Level of care thresholds were finalized for the MichiCANS implementation into CMHSP EHRs for the start of FY25. RUM will continue to review updated Tableau reports and work collaboratively with the SWMBH's Clinical Quality staff to assist with data validation, reviewing data, and resolving any identified concerns. This goal will be continued into FY25.
SWMBH will identify the levels of care and subsequent reports to manage utilization and uniform benefit.	RCP	Quarterly	Met	Met	**5**	SWMBH has reviewed and updated the LOC core service menu. Several reports have been developed to evaluate data related to UM practices in the region.
SWMBH will ensure regional inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	RUM	Annually	Met	Not Met	**2**	5 of SWMBH's 8 CMHSPs did not provide adequate documentation to show proof of LOCUS IRR implementation, as required for the FY24 Annual Site Review. Those not meeting the standard were placed on Corrective Action Plans to ensure staff were meeting the minimum standard of LOCUS IRR testing. IRR monitoring will continue to be reviewed during the annual site review process to ensure it is being completed to ensure consistent application and use of the LOCUS. This goal will be continued into FY25.

SWMBH will meet or exceed the standard for compliance with Adverse Benefit Determination notices completed in accordance with the 42 CFR 438.404 and verify compliance during Delegated Managed Care Reviews.	RUM and Regional Customer Service Committee	Quarterly, Annually	65.2%	62.5%	**3**	ABD Scores remained consistent across the region. Additional training was completed by SWMBH staff at the request of certain CMHSPs. Ongoing ABD monitoring will continue quarterly.
Emergent and non-emergent access to treatment will be periodically monitored to ensure compliance with timeliness standards.	RUM and Regional Customer Service Committee	Quarterly	Met	Met	**4**	The goal was met, the compliance and timeless standard were monitored throughout FY24 with a regional score of 87.5%
SWMBH will achieve a call abandonment rate of 5% or less.	Data submission to MDHHS	Quarterly	0.19%	0.13%	**5**	SWMBH's Call Center has consistently achieved call abandonment rates of less than 1%, well below the 5% required to meet NCQA standards.
SWMBH will achieve an average call answer time 30 seconds or less	Data submission to MDHHS	Quarterly	99.03%	99.49%	**5**	SWMBH's Call Center has continued to achieve call answer times of 30 seconds or less over 99% of the time, well above the NCQA timeliness standard required.
SWMBH will ensure a call center monitoring plan is in place and provide routine quality assurance audits.	QMC	Monthly	Met	Met	**5**	SWMBH Call Center Manager completed monthly staff call monitoring and provided staff feedback to anyone not scoring 100% for performance improvement efforts.
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	Site Review Tools	Annually	93.75%	Met	**4**	CMHSP Call reports are monitored as part of the annual administrative site review process. Any CMHSPs not obtaining abandonment rates of less than 5% or having call answer times of over 30 seconds less than 95% of the time were required to complete a root cause analysis as part of the require corrective action plan and monthly monitoring has continued to ensure the call time is improving and the deficiency is being remedied.