Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Please join the meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/515345453
Dial In: 1-844-655-0022
Access Code: 738 811 844
March 13, 2020
9:30 am to 11:30 am

1. **Welcome Guests/Public Comment**

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

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

   - **Erik Krogh**
   - **Randy Hyrns**
   - **Tim Smith**

4. **Consent Agenda**

   - January 10, 2020 SWMBH Board Meeting Minutes (d) (pg.3)

5. **Operations Committee**

   a. Operations Committee Minutes December 18, 2019 (d) (pg.8)
   b. Operations Committee Minutes January 29, 2020 (d) (pg.11)

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

   a. *Fiscal Year 2019 Customer Satisfaction Survey Results (d) (J. Gardner) (pg.15)
   b. *SWMBH 2019 Health Services Advisory Group (HSAG) External Quality Review Compliance Monitoring Report (d) (J. Gardner) (pg.39)
   c. *Fiscal Year 2019 Performance Bonus Incentive Program Results (d) (J. Gardner) (pg.45)

7. **Board Actions to be Considered**

   a. Operations Committee Self-Evaluation (d) (D. Hess) (pg.53)
   b. Operating Agreement Revisions (d) (D. Hess and B. Casemore) (pg.57)

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

   - None scheduled

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

   - None scheduled

10. **Board Education**

    a. Final Fiscal Year 2019 Financial Statements (d) (T. Dawson) (pg.70)
    b. Fiscal year 2020 Year to Date Financial Statements (d) (T. Dawson) (pg.79)
    c. Fiscal Year 2019 Program Integrity Compliance Program Evaluation (d) (M. Todd) (pg.87)
    d. Fiscal Year 2019 HIPAA Privacy/Security Report (d) (M. Todd and N. Spivak) (pg.92)
    e. Integrated Care (d) (M. Kean) (pg.100)
    f. Michigan Health Endowment Fund (MHEF) Grant Update (M. Kean)
    g. Auditor Procurement (T. Dawson)
    h. System Reform Part 1 (attachment) (B. Casemore)

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

    a. Performance Bonus Incentive Program Fiscal Year 2019 Dollars (d) (T. Dawson) (pg.110)
    b. April 17, 2020 Public Policy Legislative Event (d) (pg.111)
    c. May 8, 2020 Board Retreat (d) (pg.112)
    d. Michigan Consortium for Healthcare Excellence (MCHE) MCG Invoice (d) (pg.115)
    e. 2019 Admissions Data and Prevention Outcomes Reports (d) (J. Smith) (pg.124)
    f. Mr. Meny Letter to DHHS (d) (E. Meny) (pg.140)
    g. 2020 Election Outlook (d) (pg.142)
    h. Federal Developments (d) (pg.146)
    i. Open Minds Article (d) (pg.155)
    j. Dr. Joneigh Khaldun Visit (d) (pg.159)
    k. Board Member Attendance Roster (d) (pg.160)
    l. April 10, 2020 Draft Board Agenda (d) (pg.161)
    m. President's and Governor's Fiscal Year 2021 Budget Proposals (d) (pg.163)
    n. April: Board Elections
    o. April: BG-006 Annual Board Planning
    p. April: BG-010 Board Committee Principles

12. **Public Comment**

13. **Adjournment**

Next SWMBH Board Meeting
April 10, 2020
9:30 am - 11:30 am
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
January 10, 2020
9:30 am-11:30 am
5250 Lovers Lane, Suite 200, Portage, MI 49002
Draft: 1/13/20

Members Present: Tom Schmelzer, Edward Meny, Susan Barnes, Robert Nelson, Moses Walker, Patrick Garrett

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Rhea Freitag, Behavioral Health Waiver & Clinical Quality Manager, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Deb Hess, Van Buren Community Mental Health; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Janet Bermingham, St. Joseph County; Richard Thiemkey, Barry County Community Mental Health; Mike Kenny, NAMI; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH

Welcome Guests

Tom Schmelzer called the meeting to order at 9:34 am, introductions were made, and Tom welcomed the group.

Public Comment

None

Agenda Review and Adoption

Motion	Edward Meny moved to accept the agenda as presented.
Second	Patrick Garrett
Motion Carried	

Financial Interest Disclosure Handling

Mila Todd stated that there was no financial interest disclosure to review.

Consent Agenda

Motion	Edward Meny moved to approve the December 13, 2019 Board meeting minutes as presented.
Second	Patrick Garrett
Motion Carried	

Operations Committee

Operations Committee Minutes November 20, 2019

Tom Schmelzer asked for comments or questions. Minutes accepted.

Ends Metrics

Autism Spectrum Disorder

Rhea Freitag reported as documented. Discussion followed.

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

Second Robert Nelson

Motion Carried

Tools Update

Moira Kean reported as documented. Discussion followed. Board agreed to move American Society of Addiction Medicine (ASAM) tool update to March Board meeting.

Motion Edward Meny moved that the Supports Intensity Scale (SIS) data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.

Second Susan Barnes

Motion Carried

Motion Moses Walker moved that the Levels of Care Utilization System (LOCUS) data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.

Second Edward Meny

Motion Carried

Motion Moses Walker moved that the Child and Adolescent Functional Assessments Scale (CAFAS) data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.

Second Susan Barnes

Motion Carried

Board Actions to be Considered

Fiscal Year 2020 Revised Budget

Tracy Dawson reported as documented, noting that SWMBH has been ranked 2nd in the State for lowest Medical Loss Ratio.

Motion Edward Meny moved to approved column G of the Fiscal Year 2020 Revised Budget as presented.

Second Patrick Garrett

Motion Carried

Credentialing of Behavioral Health Practitioners Policy

Mila Todd reported as documented.

Motion Patrick Garrett moved to accept the Credentialing of Behavioral Health Practitioners Policy as presented.

Second Moses Walker

Motion Carried

Credentialing of Behavioral Health Organizational Providers Policy

Mila Todd reported as documented.

Motion Robert Nelson moved to accept the Credentialing of Behavioral Health Organizational Providers Policy as presented.

Second Patrick Garrett

Motion Carried

2020 Quality Assurance and Performance Improvement Plan

Jonathan Gardner reported as documented.

Motion Edward Meny moved to accept the 2020 Quality Assurance and Performance Improvement Plan as presented.

Second Patrick Garrett

Motion Carried

Board Resolution

Susan Barnes read the Board Resolution as presented that formally recognizes SWMBH staff for their dedication, commitment and hard work to the success of SWMBH and more importantly to the consumers that are served throughout the region.

Motion Edward Meny moved to accept the Board Resolution as presented.

Second Patrick Garrett

Motion Carried

Board Policy Review

BG-001 Committee Structure

Tom Schmelzer reviewed the policy as presented.

Motion Susan Barnes moved that policy BG-001, the Board is in compliance and the policy does not need revision.

Second Patrick Garrett

Motion Carried

BG-004 Board Ends and Accomplishment

Tom Schmelzer reviewed the policy as presented.

Motion Edward Meny moved that policy BG-004, the Board is in compliance and the policy does not need revision.

Second Susan Barnes

Motion Carried

BG-007 Code of Conduct

Tom Schmelzer reviewed the policy as presented.

Motion Moses Walker moved that policy BG-007, the Board is in compliance and the policy does not need revision.

Second Patrick Garrett

Motion Carried

Executive Limitations Review

BEL-001 Budgeting

Tom Schmelzer read an email dated 1/9/2020 from Michael McShane that, although he could not attend today's Board meeting, he had reviewed the policy and pertinent documents and he would vote to approve adherence to this policy in its current form.

Motion Edward Meny moved that the Executive Officer is in compliance with BEL-001 Budgeting and the policy does not need revision.

Second Robert Nelson

Motion Carried

Board Education

Fiscal Year 2020 Utilization Management Plan

Anne Wickham reported as documented. Discussion followed.

Fiscal Year 2019 Customer Services Report

Sarah Ameter reported as documented. Discussion followed.

Annual Board Compliance Education

Mila Todd reported as documented.

Fiscal Year 2019 Program Integrity Compliance Report

Mila Todd reported as documented. Discussion followed.

Communication and Counsel to the Board

Fiscal Year 2020 Year to Date Financial Statements

Brad Casemore reported as documented noting that new revenues are coming soon.

Fiscal Year 2019 Medicaid Services Verification Report

Mila Todd reported as documented.

Board Member Attendance Roster

Brad Casemore reported as documented stating that the July through December 2019 attendance record will be mailed to each CMHSP Board Chair.

March 13, 2020 Draft Board Agenda

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

Public Policy Legislative Event

Brad Casemore noted that the draft agenda is included in the packet for the Board's review.

SWMBH Board Resignation

Brad Casemore reported that Karen Lohman of Cass County sent a letter of resignation from the SWMBH Board.

Death Audit

Brad Casemore reported as documented. Discussion followed.

May 2020 Board Retreat Draft Agenda

Brad Casemore noted that the draft agenda is included in the packet for the Board's review.

MDHHS Public Forums

Brad Casemore reported as documented and summarized the January 9th forum that he attended in Grand Rapids.

MDHHS Letter on SWMBH Risk Management Strategy

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

2020 Govern for Impact Forum

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

Healthcare Affordability State Policy Scorecard

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

Community Mental Health Association of Michigan Letter from MDHHS

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

Advocates and Community Mental Health Association of Michigan met to develop principles related to MDHHS system design proposal.

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

Public Comment

Mike Kenny commented that the for-profit companies are sneaking in the back door and thanked the Board and SWMBH for their continued hard work despite the threats coming.

Adjournment

Motion	Edward Meny moved to adjourn at 11:38am
Second	Robert Nelson
Motion Carried	

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: December 18, 2019
9:00am-2:00pm

Members Present via conference call – Debbie Hess, Jeannie Goodrich, Jeff Patton, Jane Konyndyk, Richard Thiemkey, Ric Compton, Bradley Casemore, Kris Kirsch, Kathy Sheffield, Sue Germann

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, QAPI Director, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Michelle Jorgboyan, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Pat Davis, Integrated Services of Kalamazoo

Call to Order – Debbie Hess began the meeting at 9:05 am.

Review and approve agenda – Agenda approved.

Review and approve minutes from 11/20/19 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 YTD Financials – Tracy Dawson stated that financials will be finished soon and should be emailed out by the end of the week. Tracy asked that each CMHSP review their Autism numbers to assess recent fluctuation.

Fiscal Year 2020 Performance Bonus Incentive Program (PBIP) and Performance Improvement (PI) Plan – Jonathan Gardner reported as documented, noting that SWMBH is finalizing and refining the metrics and targets. Milliman has not provided which BH TEDs fields will be utilized for rate setting and thus identified as "critical" yet. Brad Casemore noted that the PBIP metrics are imposed on SWMBH by the State, and the PI metrics participation is voluntary. PI metrics incentive money flows from the PBIP funds and thus if earned by a CMH would be considered local. A field for reporting date on each metric will be added to distinguish from measurement date. Send additional comments for consideration to Brad or Jonathan by January 3rd. PI metrics will be in a contract amendment coming out in mid January.

Public Policy Environment – Brad Casemore noted Director Gordon's Future of Behavioral Health presentation and encouraged everyone to participate in the scheduled townhalls. Discussion followed.

Cass Woodlands Authority Status – Kathy Sheffield updated the group on recent Woodlands updates. Discussion followed. Kathy Sheffield stated that her last day is 12/23/19. The Operations Committee thanked her for her years of service and commitment to Woodlands and the clients served.

Fiscal Year 2019 Encounters and Medicaid Utilization Net Cost (MUNC) – Tracy Dawson reported as documented, stated that SWMBH is waiting on December payment correction from the State and that the State did not provide any detail with the November payment.

Tableau Year to Date Encounters – Tracy Dawson reported as documented.

Fiscal Year 2019 Behavioral Health Treatment Episode Data Set – Natalie Spivak reported as documented noting that SWMBH is above the State compliant level.

Autism Alliance of Michigan Autism Spectrum Disorder Report – Brad Casemore reported as documented.

Cost Allocation Workgroup – Pat Davis reported as documented and recommended that Chief Financial Officers review costs and percentages to run through the costing model. Jeannie Goodrich stated that she is part of the CEO Cost Allocation Workgroup which will review the Cost Allocation Workgroups proposals and then review and provide feedback on proposed model.

Proposed Medicaid Policy – Brad Casemore reported that DHHS announced that Pharmacy will become a carve-out Fee For Service Medicaid benefit.

Psychiatric Residential Treatment Facilities (PRTF) – Moira Kean reported as documented, noting this document was reviewed at the Clinical Practices Committee. Any feedback on the concept paper should be sent to her.

Assessment Tools – Moira Kean reported as documented, adding that the American Society on Addiction Medicine (ASAM) data is being reviewed.

Autism Spectrum Disorder (ASD) Guidelines – Moira Kean reported as documented, highlighting the letter from the State that the ASD guidelines are not a requirement and therefore not in the contract. Moira stated that several SWMBH trainings have been conducted regarding ASD and a pilot group is forming to review and revise an ASD tool regarding levels of care.

Fiscal Year 2020 PIHP-DHHS Contract Development – Mila Todd shared that Amendment 2 is coming and PBIP feedback in January will facilitate another contract amendment.

Managed Care Functional Review Provider Network Management – Mila Todd stated that meetings have begun with Information Technology on a shared site for reviews and credentialing.

Data Use Agreement (DUA) Status – Mila Todd stated that the DUAs previously sent were incorrect. SWMBH drafted correct DUAs for CMHSP signature; most have been returned. Mila will follow up with any that have not been returned.

Fiscal Year 2019 Medicaid Service Verification Report – Mila Todd reported as documented noting that this report is a contract obligation and SWMBH met the standard.

Fiscal Year 2020 Utilization Management (UM) Plan – Anne Wickham reported as documented noting that the UM plan was reviewed by the Regional Utilization Management Committee with a due date for revisions by December 27th.

Fiscal Year 2019 Customer Services Report – Anne Wickham reported as documented. Discussion followed.

Opioid Health Homes (OHH) – Brad Casemore stated that development of OHH continues with providers and trips planned to visit existing PIHP and their Office-Based Opioid Treatment (OBOTs) and Opioid Treatment Programs (OTPs).

January SWMBH Board Agenda – Brad Casemore noted that a draft Board agenda is included in the packet for review.

Dr. Khaldun Visit – Brad Casemore reported that Dr. Joneigh Khaldun, Chief Medical Executive and Chief Deputy Director for Health, MDHHS, is scheduled to visit SWMBH on February 7, 2020.

United Health Care (UHC) Visit – Brad Casemore reported that he recently met with UHC Medicare Director and staff at their request to discuss mutually beneficial ideas.

Meridian Visit – Brad Casemore reported that SWMBH recently met with Meridian President and staff at their request to discuss Meridian-SWMBH MI Health Link ongoing partnership. Follow ups are planned.

Autism Alliance of Michigan (AAM) Visit – Brad Casemore reported that he recently met with Colleen Allen, CEO and President of AAM to discuss thoughts on ASD Guidelines, boilerplate development and lack of funding.

CMS Announcement – Brad Casemore stated that CMS announced that effective January 1, 2020 methadone would be a Medicare benefit.

Michigan Health Endowment Fund (MHEF) – Moira Kean shared that the enrollment phase of Kalamazoo Health Connections has started. Partnerships with Integrated Services of Kalamazoo and WMED continue.

Death Audit – Tracy Dawson shared that she was part of a conference call with the State regarding $43 million dollars paid state-wide for deceased individuals. The State will be recouping the dollars. Discussion followed.

Adjourned – Meeting adjourned at 11:00am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: January 29, 2020
9:00am-2:00pm

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

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, QAPI Director, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, SWMBH; Sarah Ameter, Costumer Services Manager, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Pat Davis, Integrated Services of Kalamazoo; Jane Konyndyk, Integrated Services of Kalamazoo

Call to Order – Debbie Hess began the meeting at 9:00 am.

Review and approve agenda – Agenda approved.

Review and approve minutes from 12/18/19 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 YTD Financials – Tracy Dawson stated that SWMBH is waiting on one CMHSP to complete the financial preparation and will email them out as soon as they are complete.

Fiscal Year 2020 Performance Incentive – Jonathan Gardner reported as documented. Discussion followed. This topic will return to the February meeting.

System Reform – Brad Casemore reported as documented. Group discussed recent calls with Community Mental Health Association of Michigan and MDHHS.
Brad Casemore proposed a follow up schedule regarding this topic as follows:

• February Operations Committee	Discussion, Plan, Draft
• March Operations Committee	Plan, Document, Board Presentation
• February and March	Brad to meet with internal and external stakeholders
• April Operations Committee	Plan, Document, Revisions, Board Education for May 8th
• May 8th Board Retreat	Attend with materials ready two weeks in advance
• June 12 Board Meeting	Extended 11:30am-1:00pm
• July Operations Committee	Brad Casemore out of office

Fiscal Year 2019 Encounters and Medicaid Utilization Net Cost (MUNC) – Tracy Dawson reported as documented noting that this is the first time that all but one CMHSP has submitted their CAP which will allow SWMBH to review and compile for 228 submission.

Rate Setting Update – Tracy Dawson stated that an April meeting has been scheduled.

Fiscal Year 2020 Encounters – Tracy Dawson reported that Tableau reports were not pulled this morning but reminded group that these reports are available for each CMHSP to utilize whenever they need.

Cost Allocation Workgroup – Pat Davis reported that the Rate Development Workgroup is reviewing all 26 service codes with modifiers and the 90837 template. Review and recommendations are scheduled to be complete by April. The Cost Allocation Workgroup is reviewing high level reporting and defining all services to clients. This is scheduled to be complete by April. Jeannie Goodrich reported on the CEO workgroup that overseas the Cost Allocation Workgroup. Discussion followed.

Death Audit Recoupments – Tracy Dawson reported that SWMBH IT is reviewing data and discovered $70,000 of State reported recoup has already been recouped or was never paid in the first place. The State expects the PIHPs to verify the data. SWMBH will research and review monthly recoup report/data from the State and will keep the group updated.

Operating Agreement Review – Brad Casemore stated that he recommends no changes to the Operating Agreement. Jeff Patton noted a name change needed from Kalamazoo Community Mental Health & Substance Abuse Services to Integrated Services of Kalamazoo. Michelle Jacobs to email the Operating Agreement to each CMH CEO for their review. Revisions should be sent to Michelle Jacobs prior to the February Operations Committee meeting for approval at the March Board meeting.

Operations Committee Self-Evaluation – Brad Casemore recommended no changes. Jonathan Gardner reported on last year's self-evaluation and presented possible new survey questions. Group agreed to keep the 5-point rating scale and the same questions. Jonathan Gardner to send a Survey Monkey to the group to be completed prior to the February Operations Committee meeting for approval at the March Board meeting.

Healthy Michigan Plan (HMP) Work Exempt & Non-exempt – Natalie Spivak and Sarah Ameter reported as documented. Discussion followed.

Encounter Quality Initiative (EQI) – Tracy Dawson and Natalie Spivak reported as documented. Discussion followed. Brad Casemore encouraged the group to respond to the department reminding them that EQI needs to go through PIHP and CMHSP General Fund contact negotiations be it can be implemented.

Community Mental Health Association of Michigan (CMHAM) Medicaid Revenue Analysis – Tracy Dawson reported as documented, noting State errors, and payment discrepancies. SWMBH continues to review and research.

Directors Forum minutes – Brad Casemore reported as documented.

PIHP-DHHS Contract Development – Mila Todd reported that contract language work continues in Compliance, Global Assessment of Individual's Needs, County of Financial Responsibility, Electronic Verification Visit, and Jail Diversion. The group is also reviewing policies for Person Centered Planning and Self Determination.

Managed Care Functional Review Provider Network Management – Mila Todd stated that a presentation from Optum was given at the last Provider Network Management Committee meeting regarding data management solutions. Group is reviewing other data management options while taking into consideration Health Services Advisory Group's feedback.

Data Use Agreement (DUA) Status – Mila Todd stated that all DUAs have been received.

Autism Spectrum Disorder (ASD) Guidelines Update – Moira Kean reported that SWMBH is meeting this Friday with Providers to review ASD Tool and assess providers that are interested and willing to implement the tool. Jeremy Franklin is meeting with CMHSP staff on Applied Behavioral Analysis (ABA) services. Moira Kean reminded group that new ABA processes and medically necessary criteria is starting March 1, 2020.

Michigan Health Endowment Fund (MHEF) Grant Update – Kalamazoo Health Connections (KHC) – Moira Kean reported that KHC currently has 9 participants. MDHHS approved a data use agreement that KHC can use to identify participants in Kalamazoo County.

Navigators Transitions from Hospitals – Moira Kean reported as documented. Discussion followed.

Health Services Advisory Group (HSAG) – External Quality Review (EQR) Compliance Report – Jonathan Gardner reported as documented noting that SWMBH is in communication with HSAG regarding findings.

Opioid Health Homes (OHH) – Joel Smith stated that development of OHH continues with Summit Pointe and Victory Clinic. SWMBH staff will be visiting Northern Michigan Regional Entity and their Office-Based Opioid Treatment (OBOTs) and Opioid Treatment Programs (OTPs) on January 30, 2020.

Medicare and Medicine Assisted Treatment (MAT) – Joel Smith stated that effective January 1, 2020 Medicare is covering opioid treatment. This impacts MI Health Link and dual eligibles.

Feedback from Substance Abuse and Mental Health Services Administration (SAMHSA) on Marijuana Attestation Requirement – Joel Smith reported as documented. Discussion followed.

Electronic Visit Verification (EVV) – Mila Todd stated that the State was granted an October 1, 2021 extension on Implementing EVV.

Veterans Affairs (VA) Medicaid Service Requests – Brad Casemore reported as documented. Discussion followed.

March SWMBH Board Agenda – Brad Casemore noted that a draft Board agenda is included in the packet for review.

Fiscal Year 2020 CMHSP Site Reviews – Mila Todd reported as documented. Discussion followed.

April 17, 2020 Public Policy Event – Brad Casemore reminded group of the April 17th Public Policy Event to be held at Cityscape in Kalamazoo. A hold the date invitation will be sent soon.

Adjourned – Meeting adjourned at 1:05pm

2019-2020 Board Ends Metric Status Report

March 13, 2020

Customer Satisfaction Survey Metric

2019 Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2018 results for the following categories:	**Begins October 2019**
• Metric Measurement Period: (1/1/19 - 9/30/19) • Board Report Date: March 13, 2020 A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning)* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes)*	MHSIP Improved Function 18=85.8% 19=89.7% **+3.9%** YSS Improved Outcomes 18=81.3% 19=83.3% **+2.0%**

How Did We Do?

MHSIP Results

- 2019 Aggregate Ave. Score: 93.09%
- 2018 Aggregate Ave. Score: 90.63%

+2.46% Percent Improvement over 2018 Scores (All Categories)

YSS Results

- 2019 Aggregate Ave. Score: 91.58%
- 2018 Aggregate Ave. Score: 91.28%

+30% Percent Improvement over 2018 Scores (All Categories)

Overall Response Rates

- 2019 Response Rate: 36.4%
- 2018 Response Rate: 37.3%

Overall Result

+2.76% Percent Overall Improvement (MHSIP + YSS)

***Suggested Motion:** The data is Relevant and Compelling; the Executive Officer is in Compliance and the Ends requires no further Revision.

2019 Customer Satisfaction Survey Analysis

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

Southwest Michigan BEHAVIORAL HEALTH

Results and Analysis of Each Survey Identified are Presented in this Report

1. Mental Health Statistics Improvement Program (MSHIP)
2. Youth Services Survey (YSS)
3. MI Health Link Member Satisfaction Survey (MHL)
4. Recovery Self Assessment in Recovery Survey (RSA-r)

To access the survey results listed above on the SWMBH Portal go to: SWMBH→QAPI→2018 Consumer Satisfaction Survey Results and Analysis (MHSIP,YSS, & RSA-r) Or Click Here CJ4

Mental Health Statistics Improvement Program (MSHIP) & Youth Services Survey (YSS) Surveys

Southwest Michigan
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Survey Process and Preparation

Preparation:

- Starts in September
- Consumers are selected based on a sample of those who have received three (3) or more services within the measurement period (April-August 2019).
- The goal is 1500 completed surveys by the end of the calendar year.

Validity:

- To guarantee data validity, SWMBH selects an outside vendor for administration and feedback collection.

Vendor Selection:

- Barnes Research
  - Over 25 years of experience
  - Works with a variety of healthcare organizations
  - Conduct surveys, focus groups, mystery shopping, etc.

Survey Process and Preparation

How the survey is conducted:

- Telephonically
- Using the following survey tools:
- Mental Health Statistics Improvement Program (MHSIP) – consumers 18 years + .
- Youth Services Survey (YSS) – under 18 years of age.

20

About the survey tools:

- Contractually obligated by MDHHS for SMWBH to utilize.
- Both offer a wide range of flexibility in the capturing of feedback.
- Offer comparison against other national and state results (currently implemented in 55 states).

Survey Process and Preparation

Goal:

- To gain valuable feedback.

What happens after the data is collected:

- SWMBH QAPI analyzes and constructs reports.
- Reports are then presented to various committees for review and feedback including:
  - Regional Consumer Advisory Committee
  - Regional Utilization Management Committee
  - Regional Operations Committee
  - Regional Compliance Committee
  - Regional Quality Management Committee

If you would like further information on the annual consumer satisfaction survey projects, please don't hesitate to contact the SWMBH Quality Assurance Department at: 269-488-8922 or via email at: jonathan.gardner@swmbh.org

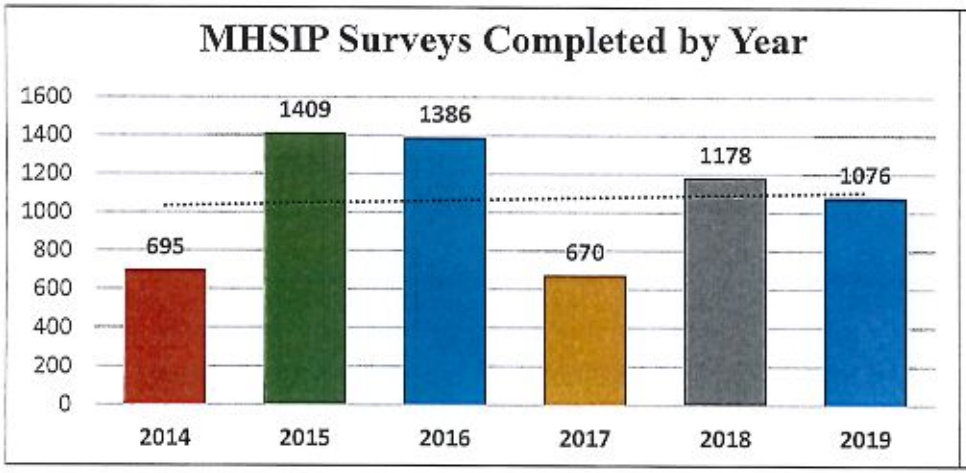
MHSIP Survey Information

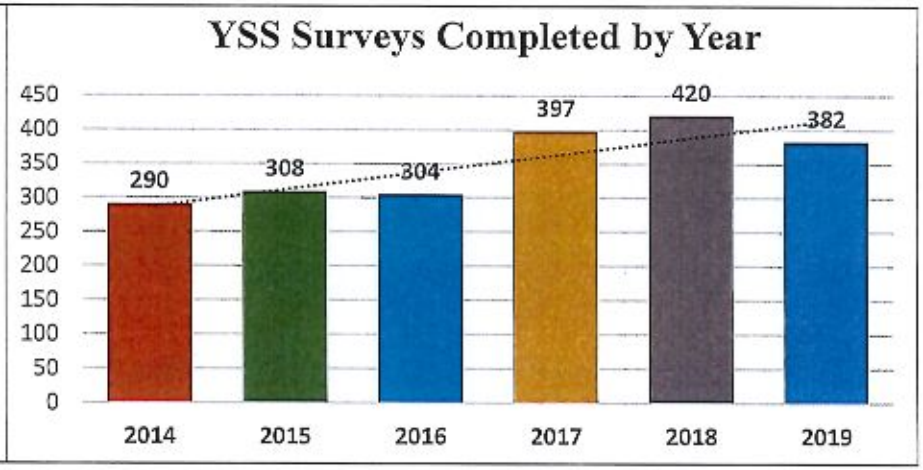
- The Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys measure concerns that are important to consumers of publicly funded mental health services in (7) different areas including:
  1. Access
  2. Quality/Appropriateness
  3. Outcomes
  4. General Satisfaction
  5. Social Connectedness
  6. Participation in Treatment Planning
  7. Functioning
- The MHSIP consists of 44 questions.
- Use of the MHSIP survey tool is a contractual requirement by MDHHS (42 CFR 438.230).

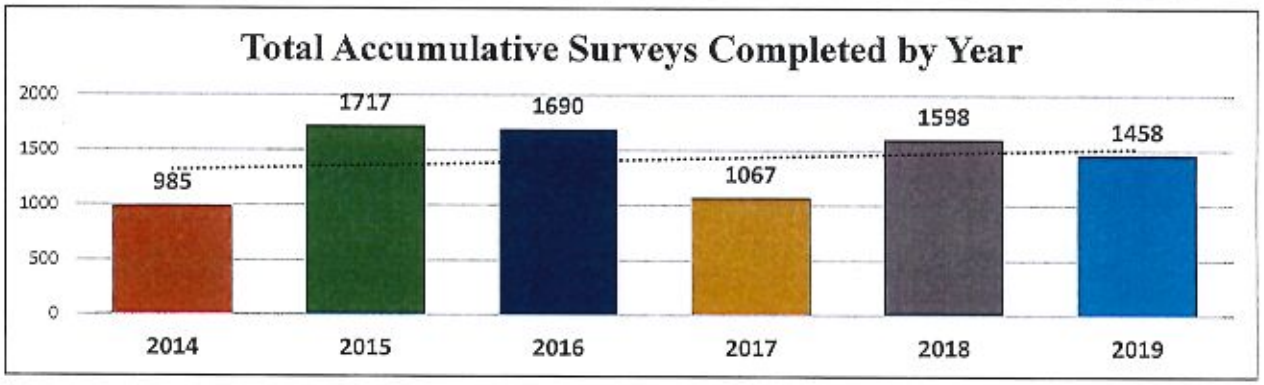
YSS-F Survey Information

- A modification of the MHSIP survey for adults, the Youth Services Survey for Family (YSS-F) assesses caregivers' perceptions of behavioral health services for their children aged 17 and under.
- The YSS creates (6) domains that are used to measure different aspects of customer satisfaction with public behavioral health services including:
  1. Access
  2. Appropriateness
  3. Outcomes
  4. Social Connectedness
  5. Cultural Sensitivity
  6. Participation in Treatment
- The YSS-F consists of 46 questions.

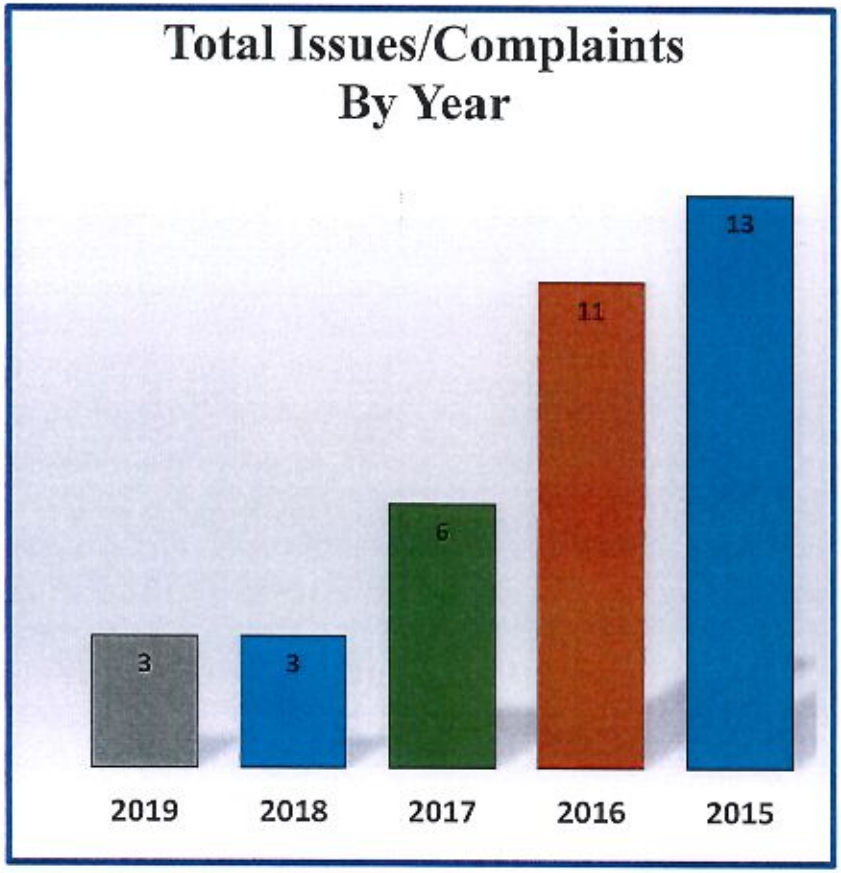
How Many Surveys Were Completed



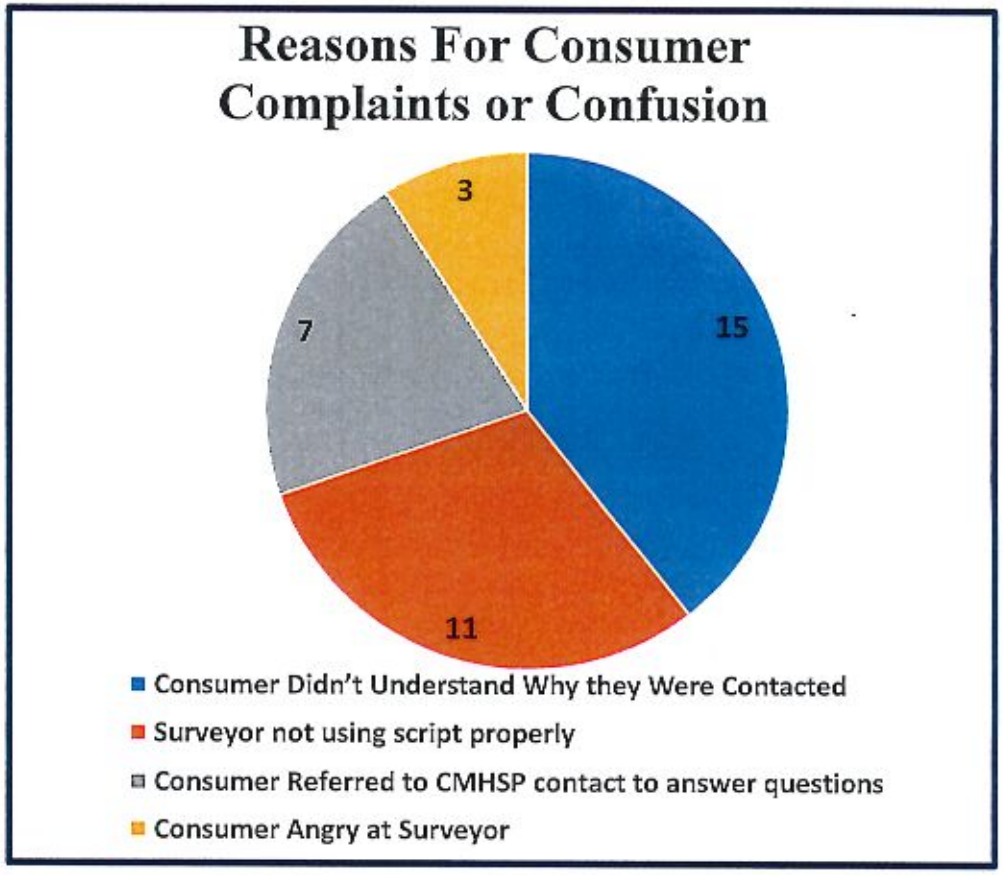




Consumer Issues and Complaints



(3) Complaints during 2019

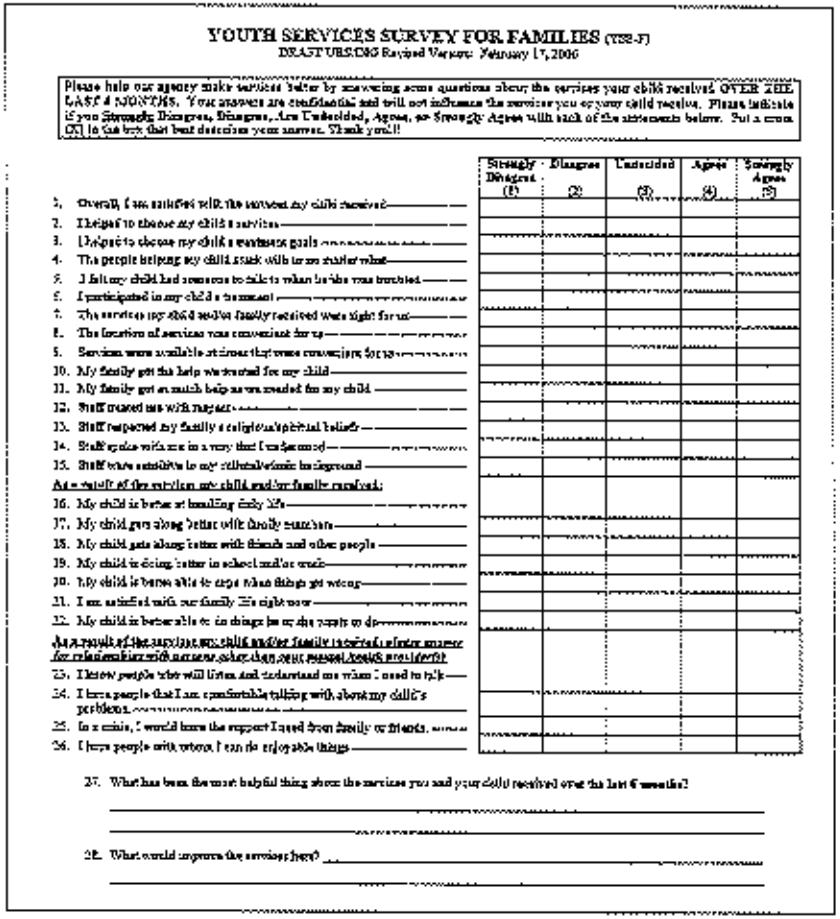


(36) Total Across All 5 Year's

Questions asked on the MHSIP Survey (44 Questions Total)

For each item, circle the answer that matches your view.		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
1.	I like the services that I received.	SA	A	N	D	SD	NA
2.	If I had other choices, I would still choose to get services from this mental healthcare provider.	SA	A	N	D	SD	NA
3.	I would recommend this agency to a friend or family member.	SA	A	N	D	SD	NA
4.	The location of services was convenient.	SA	A	N	D	SD	NA
5.	Staff were willing to see me as often as I felt it was necessary.	SA	A	N	D	SD	NA
6.	Staff returned my calls within 24 hours.	SA	A	N	D	SD	NA
7.	Services were available at times that were good for me.	SA	A	N	D	SD	NA
8.	I was able to get all the services I thought I needed.	SA	A	N	D	SD	NA
9.	I was able to see a psychiatrist when I wanted to.	SA	A	N	D	SD	NA
10.	Staff believed that I could grow, change and recover.	SA	A	N	D	SD	NA
11.	I felt free to complain.	SA	A	N	D	SD	NA
12.	I was given information about my rights.	SA	A	N	D	SD	NA
13	Staff encouraged me to take responsibility for how I live my life.	SA	A	N	D	SD	NA
14.	Staff told me what side effects to watch for.	SA	A	N	D	SD	NA
15.	Staff respected my wishes about who is and who is not to be given information about my treatment services.	SA	A	N	D	SD	NA
16.	Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	SA	A	N	D	SD	NA
17.	Staff helped me obtain the information I needed so that I could take charge of managing my illness or disability.	SA	A	N	D	SD	NA
18.	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	SA	A	N	D	SD	NA
19.	I felt comfortable asking questions about my treatment, services, and medication.	SA	A	N	D	SD	NA
20.	I, not staff, decided my treatment goals.	SA	A	N	D	SD	NA

Questions asked on the YSS-F Survey (46 Questions Total)



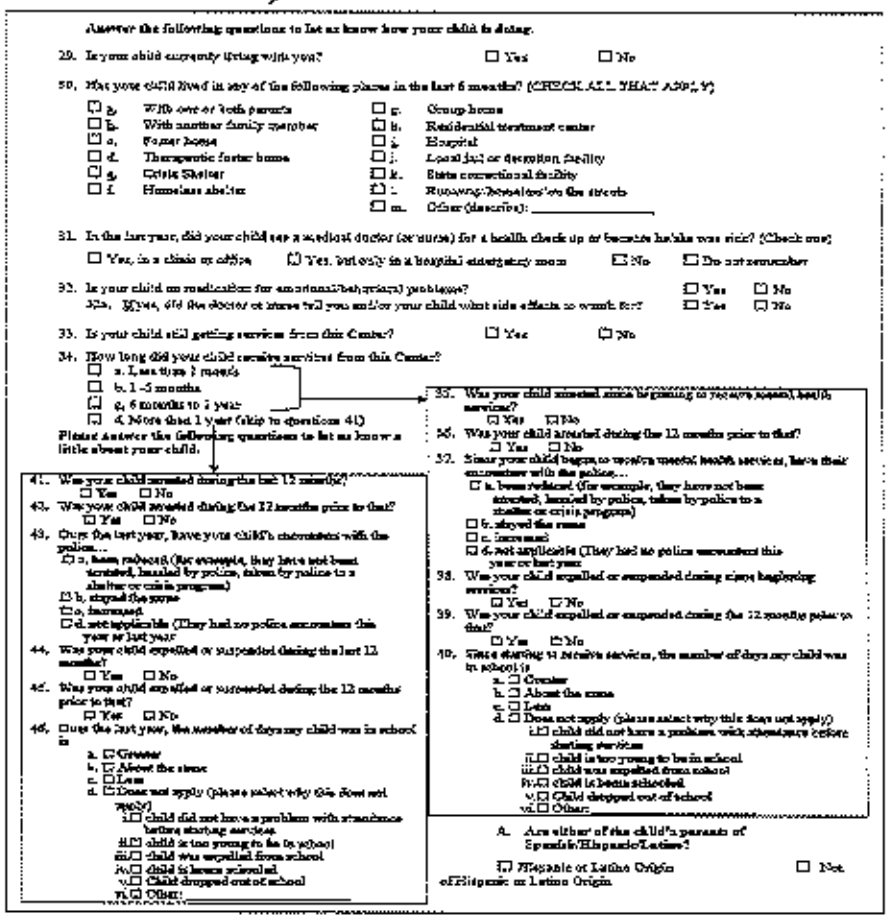
YOUTH SERVICES SURVEY FOR FAMILIES (YSS-F)
DRAFT VERSION Revised Version: February 17, 2006

Please help our agency make services better by answering some questions about the services your child received OVER THE LAST 6 MONTHS. Your answers are confidential and will not influence the services you or your child receive. Please indicate if you Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree with each of the statements below. Put a cross (X) in the box that best describes your answer. Thank you!!

	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services my child received					
2. I helped to choose my child's services					
3. I helped to choose my child's treatment goals					
4. The people helping my child stuck with us no matter what					
5. I felt my child had someone to talk to when he/she was troubled					
6. I participated in my child's treatment					
7. The services my child and/or family received were right for us					
8. The location of services was convenient for us					
9. Services were available at times that were convenient for us					
10. My family got the help we wanted for my child					
11. My family got as much help as we needed for my child					
12. Staff treated me with respect					
13. Staff respected my family's religious/spiritual beliefs					
14. Staff spoke with me in a way that I understood					
15. Staff were sensitive to my cultural/ethnic background					
As a result of the services my child and/or family received:					
16. My child is better at handling daily life					
17. My child gets along better with family members					
18. My child gets along better with friends and other people					
19. My child is doing better in school and/or work					
20. My child is better able to cope when things get wrong					
21. I am satisfied with our family life right now					
22. My child is better able to do things he or she wants to do					
As a result of the services my child and/or family received, I have someone for support/help with no one other than paid mental health providers:					
23. I know people who will listen and understand me when I need to talk					
24. I have people that I am comfortable talking with about my child's problems					
25. In a crisis, I would have the support I need from family or friends					
26. I have people with whom I can do enjoyable things					

27. What has been the most helpful thing about the services you and your child received over the last 6 months?

28. What would improve the services here?



Answer the following questions to let us know how your child is doing.

29. Is your child currently living with you? ☐ Yes ☐ No

30. Has your child lived in any of the following places in the last 6 months? (CHECK ALL THAT APPLY)

- ☐ a. With one or both parents
- ☐ b. With another family member
- ☐ c. Foster home
- ☐ d. Therapeutic foster home
- ☐ e. Crisis Shelter
- ☐ f. Homeless shelter
- ☐ g. Group home
- ☐ h. Residential treatment center
- ☐ i. Hospital
- ☐ j. Local jail or detention facility
- ☐ k. State correctional facility
- ☐ l. Runaway/homeless/on the streets
- ☐ m. Other (describe): _____

31. In the last year, did your child see a medical doctor (or nurse) for a health check up or because he/she was sick? (Check one)
☐ Yes, in a clinic or office ☐ Yes, but only in a hospital emergency room ☐ No ☐ Do not remember

32. Is your child on medication for emotional/behavioral problems? ☐ Yes ☐ No
32a. If yes, did the doctor or nurse tell you and/or your child what side effects to watch for? ☐ Yes ☐ No

33. Is your child still getting services from this Center? ☐ Yes ☐ No

34. How long did your child receive services from this Center?
- ☐ a. Less than 3 months
- ☐ b. 3 - 5 months
- ☐ c. 6 months to 1 year
- ☐ d. More than 1 year (skip to question 41)

Please answer the following questions to let us know a little about your child.

41. Was your child arrested during the last 12 months?
☐ Yes ☐ No

42. Was your child arrested during the 12 months prior to that?
☐ Yes ☐ No

43. Over the last year, have your child's encounters with the police...
- ☐ a. been reduced (for example, they have not been arrested, handled by police, taken by police to a shelter or crisis program)
- ☐ b. stayed the same
- ☐ c. increased
- ☐ d. not applicable (They had no police encounters this year or last year)

44. Was your child expelled or suspended during the last 12 months?
☐ Yes ☐ No

45. Was your child expelled or suspended during the 12 months prior to that?
☐ Yes ☐ No

46. During the last year, the number of days my child was in school is
- a. ☐ Greater
- b. ☐ About the same
- c. ☐ Less
- d. ☐ Does not apply (please select why the item not applies)
  - i. ☐ child did not have a problem with attendance before starting services
  - ii. ☐ child is too young to be in school
  - iii. ☐ child was expelled from school
  - iv. ☐ child is home schooled
  - v. ☐ Child dropped out of school
  - vi. ☐ Other: _____

47. Was your child arrested since beginning to receive mental health services?
☐ Yes ☐ No

48. Was your child arrested during the 12 months prior to that?
☐ Yes ☐ No

49. Since your child began to receive mental health services, have their encounters with the police...
- ☐ a. been reduced (for example, they have not been arrested, handled by police, taken by police to a shelter or crisis program)
- ☐ b. stayed the same
- ☐ c. increased
- ☐ d. not applicable (They had no police encounters this year or last year)

50. Was your child expelled or suspended during since beginning services?
☐ Yes ☐ No

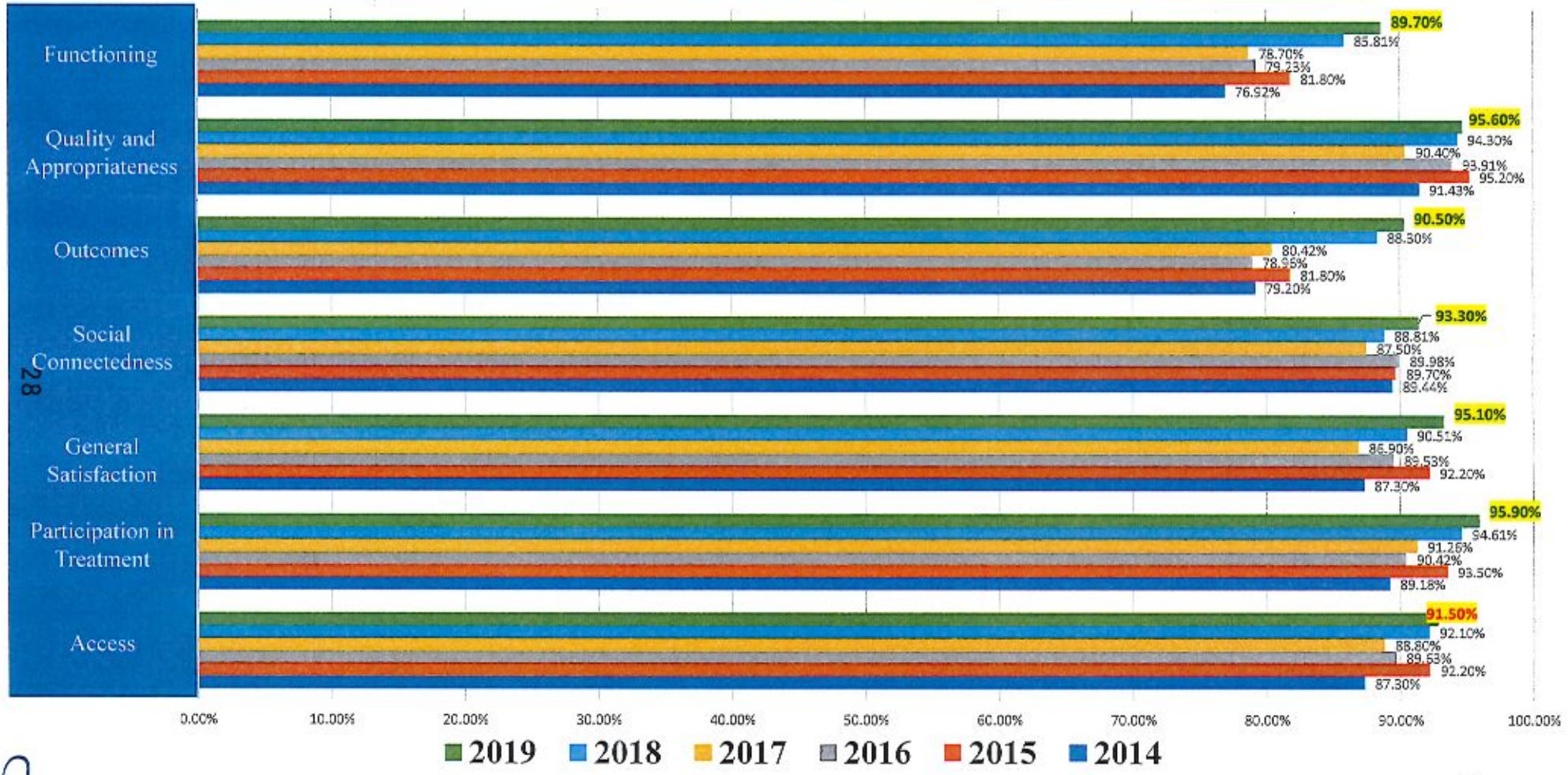
51. Was your child expelled or suspended during the 12 months prior to that?
☐ Yes ☐ No

52. Prior starting to receive services, the number of days my child was in school is
- a. ☐ Greater
- b. ☐ About the same
- c. ☐ Less
- d. ☐ Does not apply (please select why this does not apply)
  - i. ☐ child did not have a problem with attendance before starting services
  - ii. ☐ child is too young to be in school
  - iii. ☐ child was expelled from school
  - iv. ☐ child is home schooled
  - v. ☐ Child dropped out of school
  - vi. ☐ Other: _____

A. Are either of the child's parents of Spanish/Hispanic/Latino?

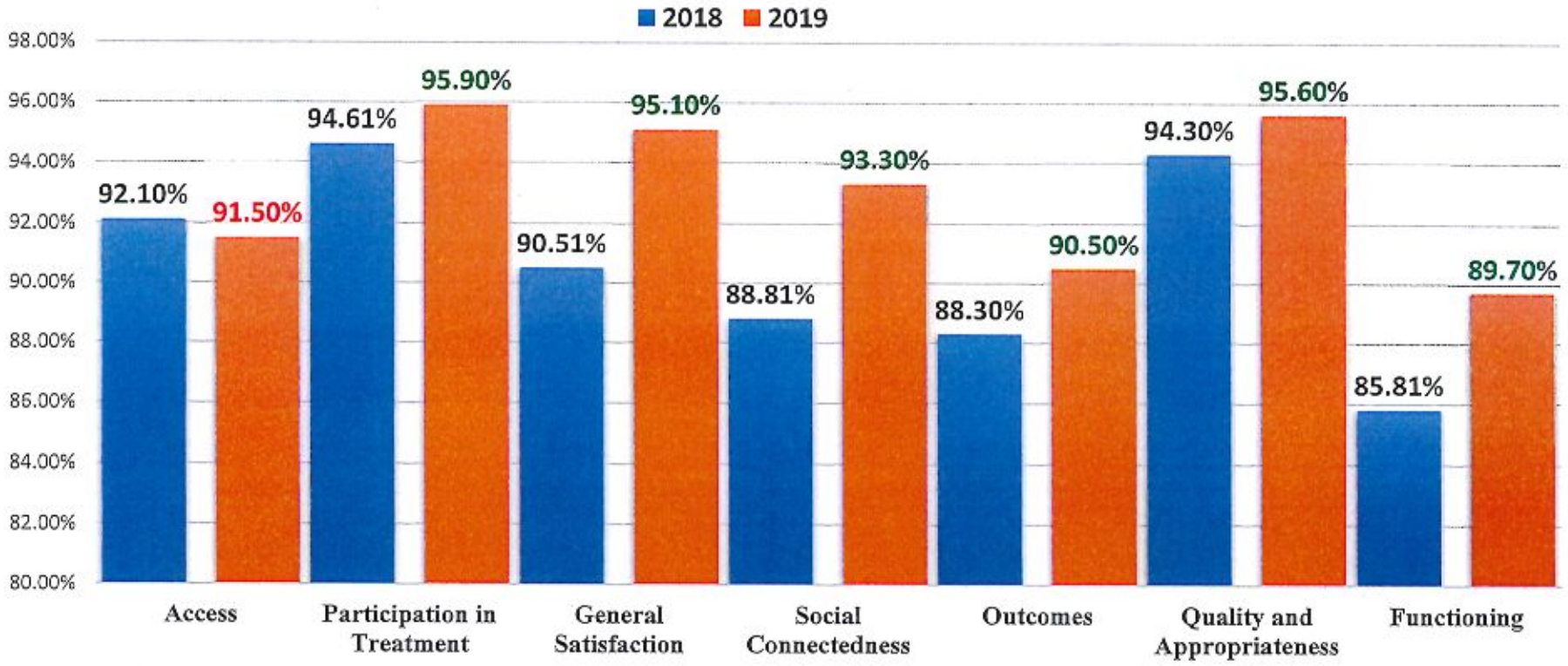
☐ Hispanic or Latino Origin ☐ Not of Hispanic or Latino Origin

Mental Health Statistics Improvement Program (MHSIP) Score Comparison By Year Analysis



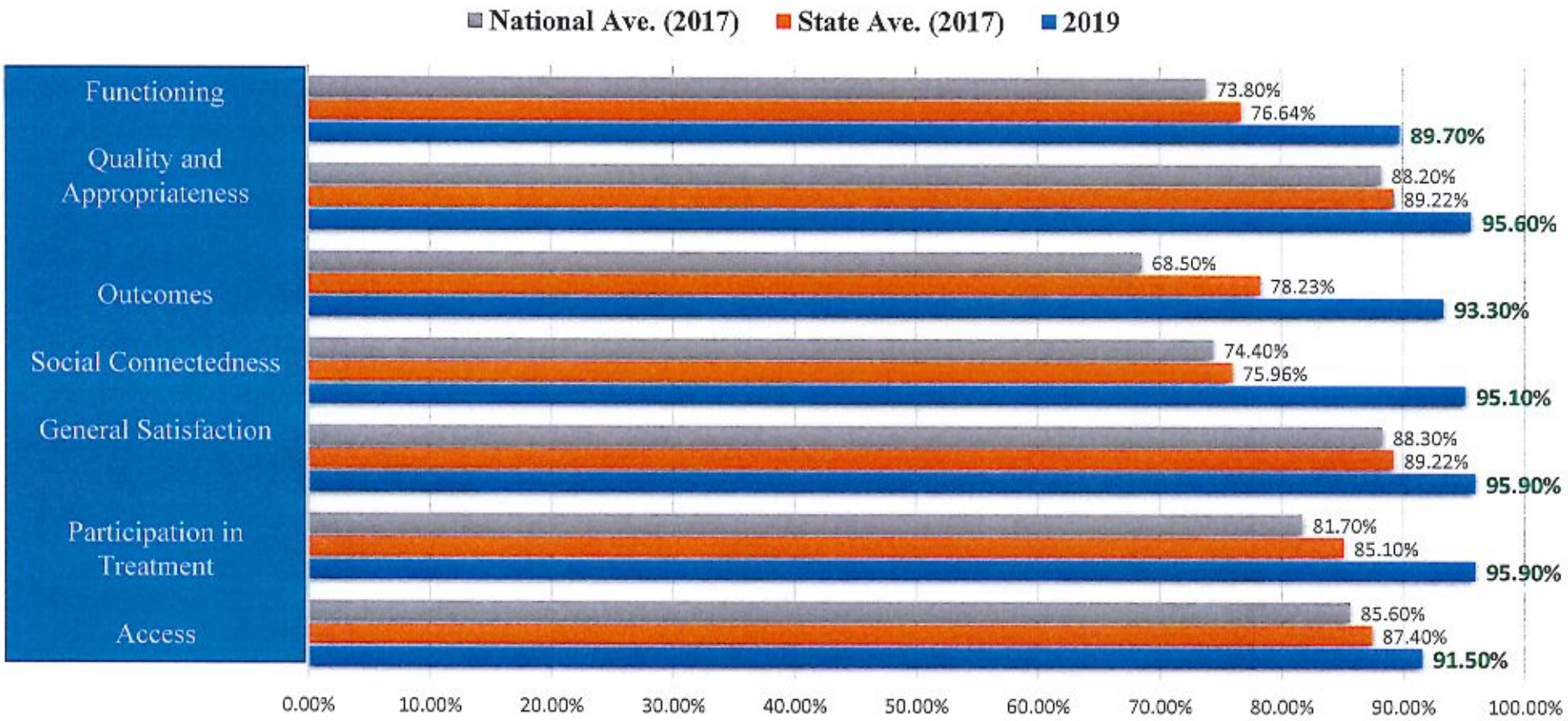
Green = Improvement in score compared to previous years results

MHSIP (Adult) Score Comparison
2018 vs. 2019

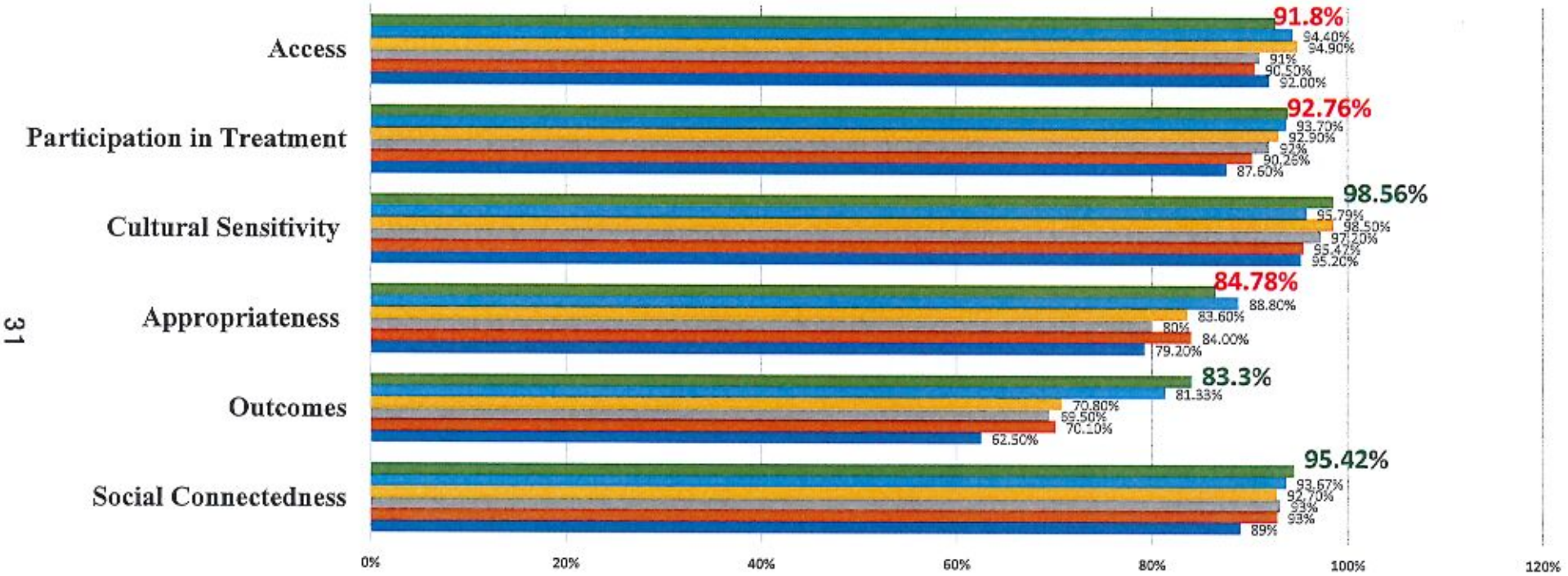


Green Highlighted Values Represent an Improvement Over the Previous Year's Results

2019 MHSIP State and National Comparisons

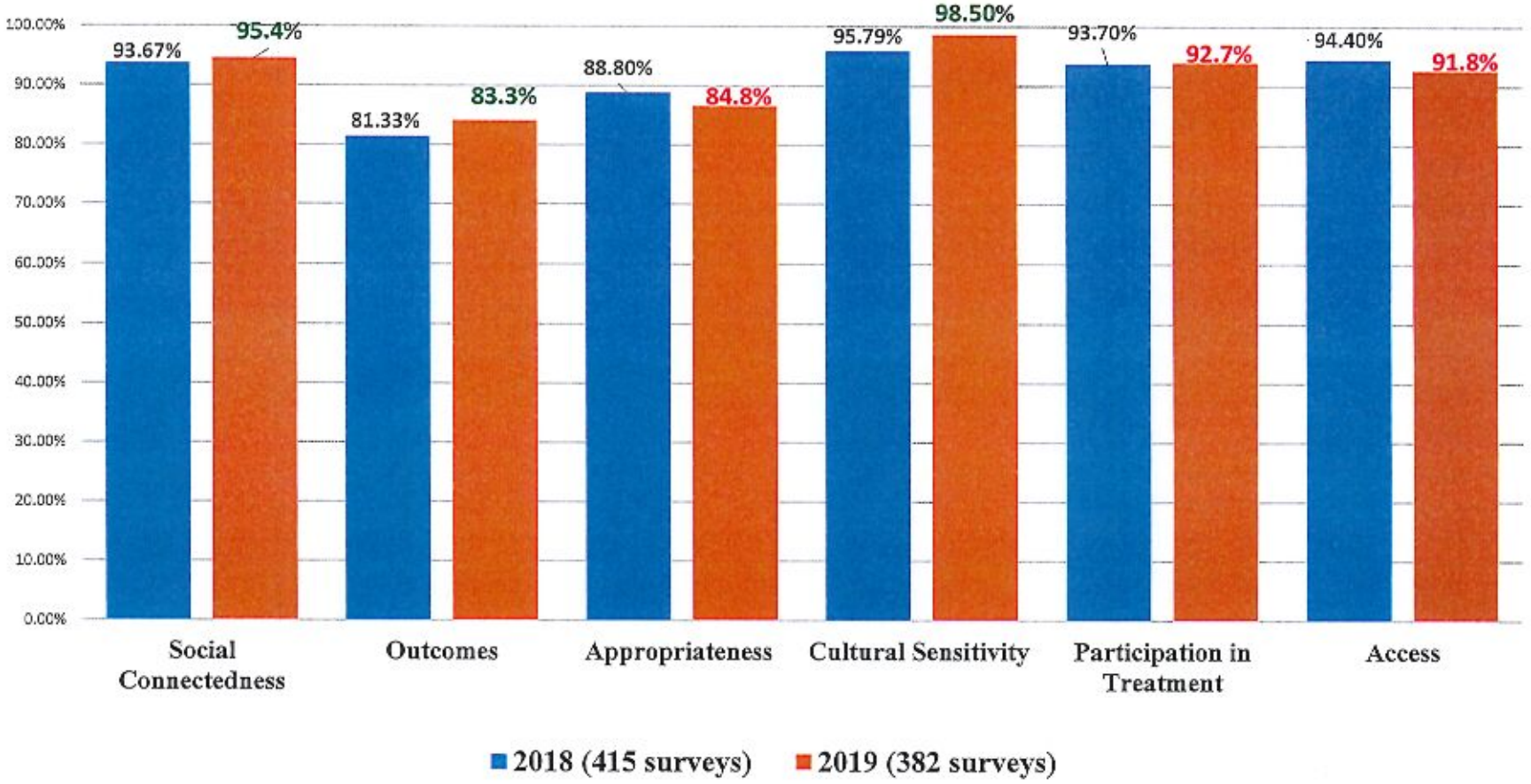


Youth Services Survey (YSS) - Score Comparison By Year



GREEN= Improvement in score compared to previous years results
RED= Decrease in score compared to previous year.

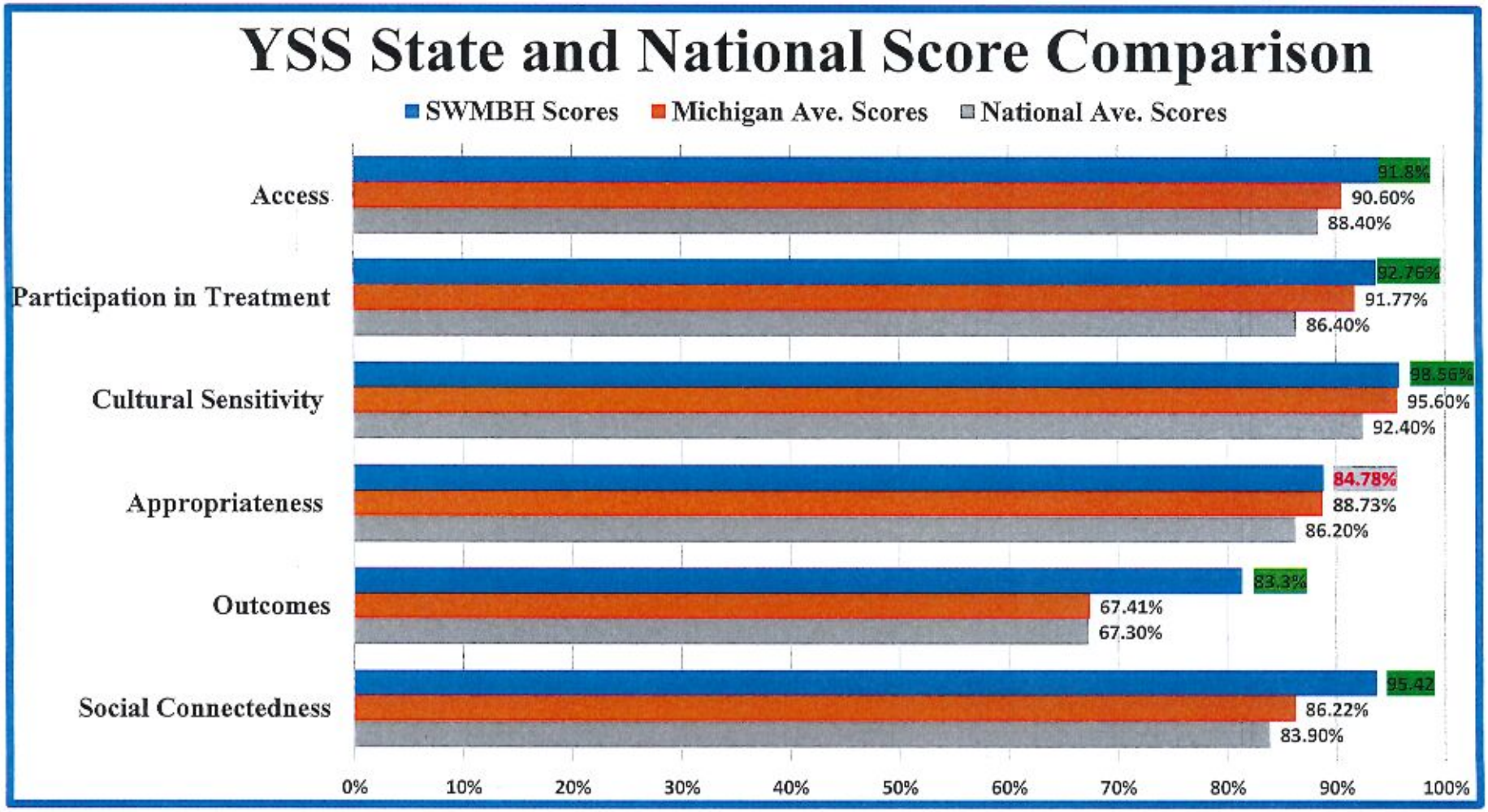
YSS 2018 vs 2019 Overall Percentage Comparison



GREEN= Yearly increase

RED= Yearly decrease

YSS State and National Score Comparison



How Did We Do?

MHSIP Results

- 2019 Aggregate Ave. Score: 93.09%
- 2018 Aggregate Ave. Score: 90.63%

+2.46% Percent Improvement over 2018 Scores (All Categories)

YSS Results

- 2019 Aggregate Ave. Score: 91.58%
- 2018 Aggregate Ave. Score: 91.28%

+.30% Percent Improvement over 2018 Scores (All Categories)

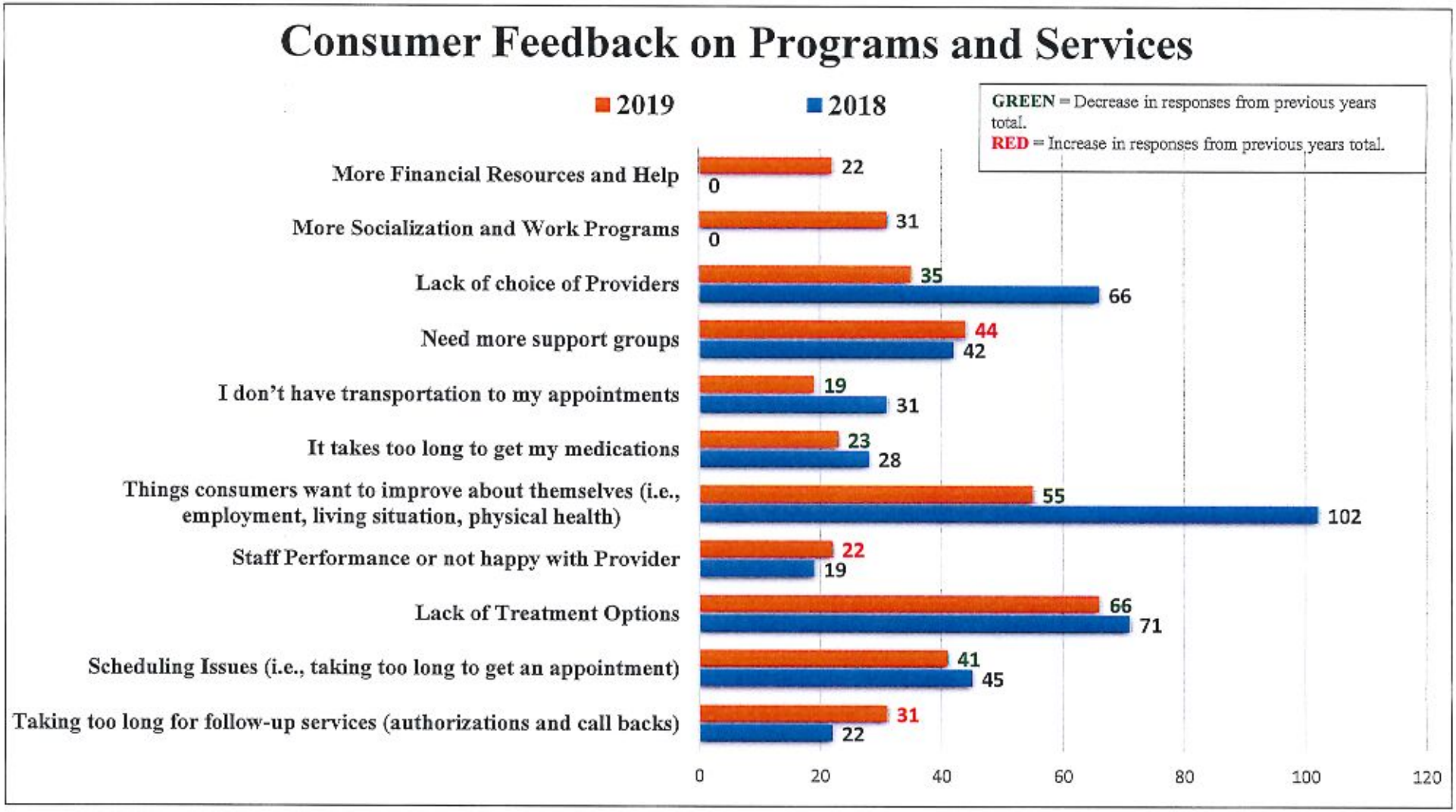
Overall Response Rates

- 2019 Response Rate: 36.4%
- 2018 Response Rate: 37.3%

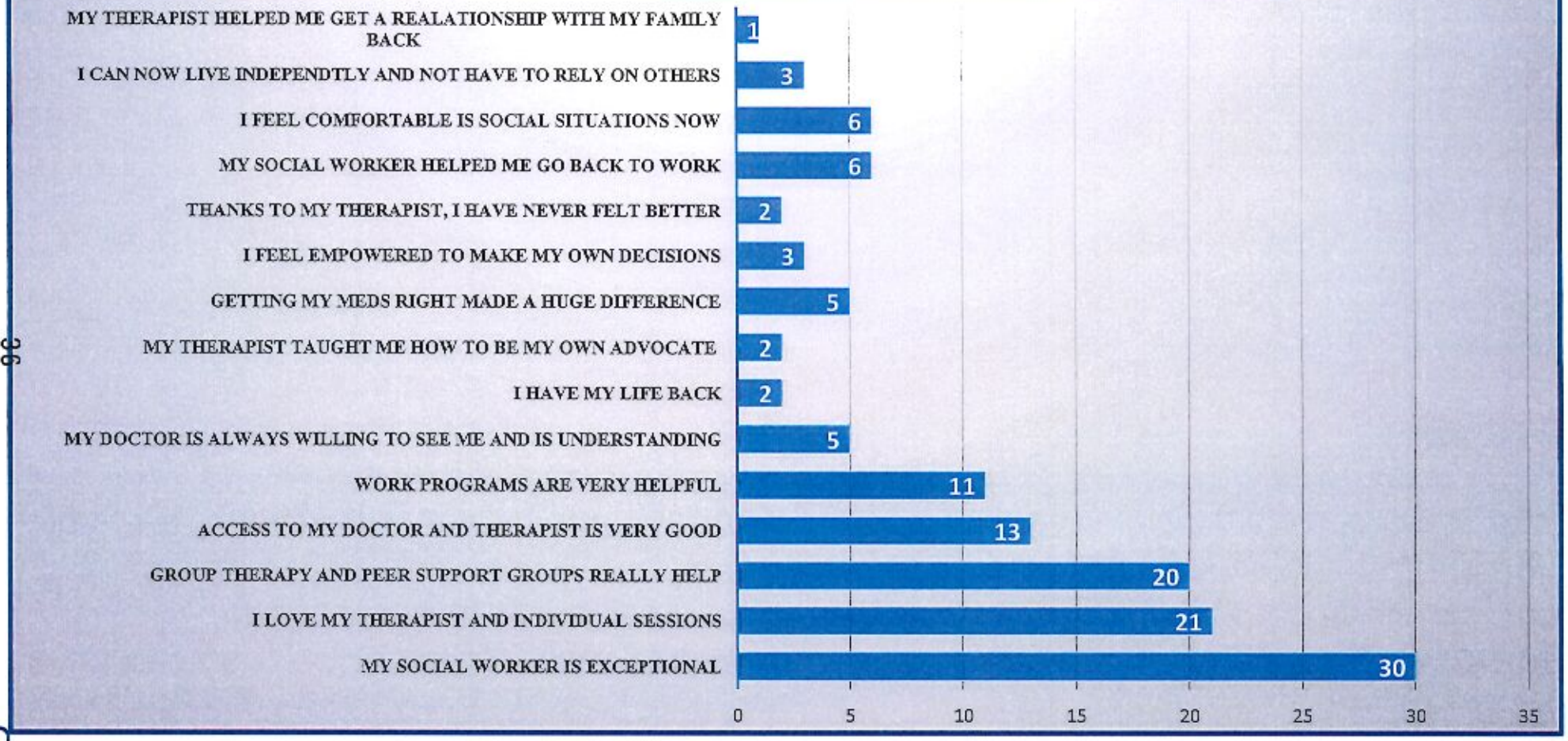
Overall Result

+2.76% Percent Overall Improvement (MHSIP + YSS)

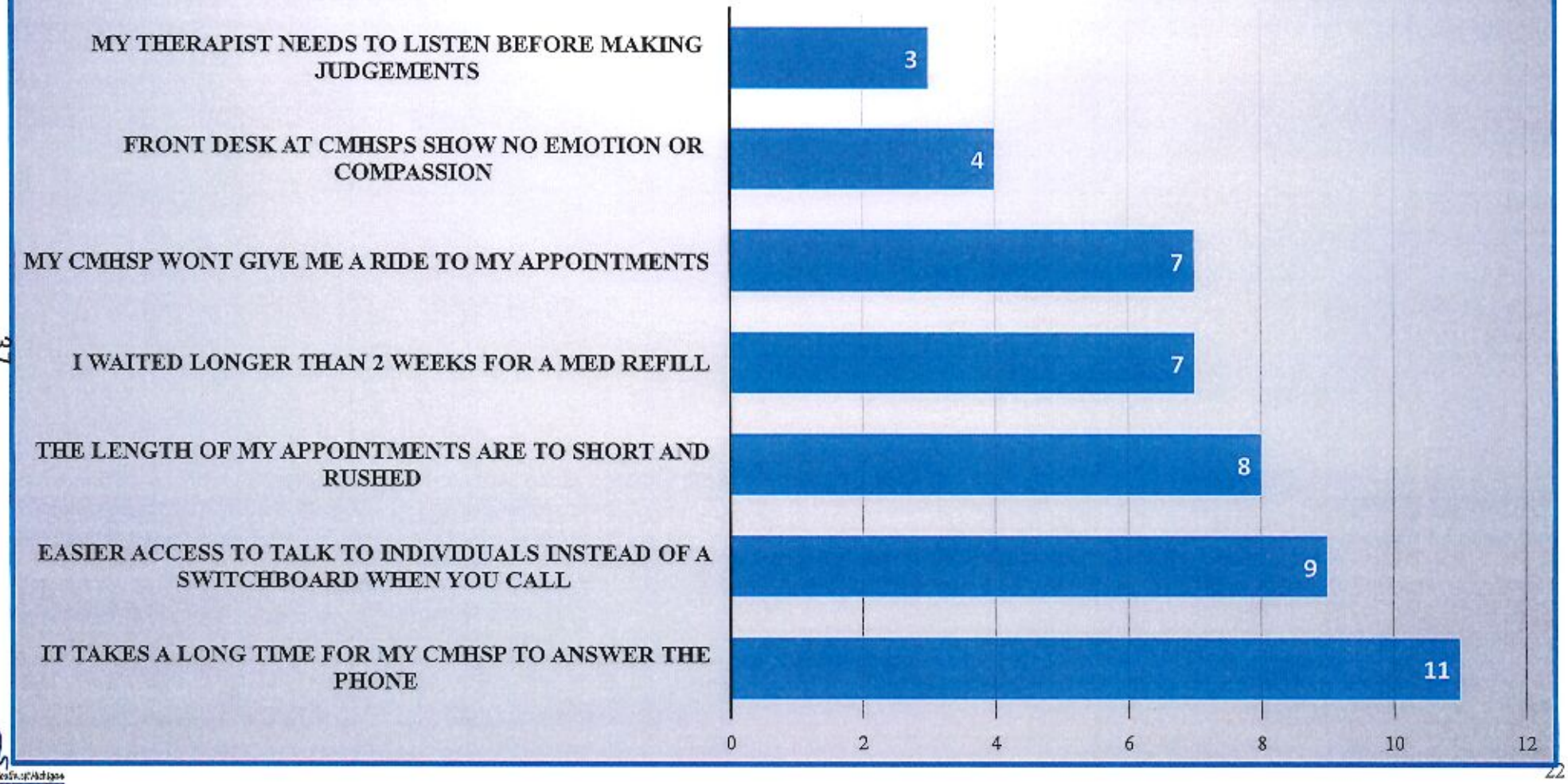
Consumer Feedback on Programs and Services



Positive Feedback From Consumers Regarding Improved Outcomes



Direct Service Consumer Feedback and Opportunities for Improvement



2019 Customer Satisfaction Survey
Analysis - Next Steps – Opportunities for Improvement

- Publish results widely (*i.e., newsletters, share with stakeholders and regional committees)*
- Develop CMHSP Specific Reports for all (8) Counties including; a causal analysis of results, and identify areas and opportunities for improvement.
- Per our 2019 Health Service Advisory Group (HSAG) External Quality Review (EQR) Report, it has been recommended that; SWMBH complete a comprehensive quantitative analysis of Consumer feedback, and select the category with the greatest opportunity for improvement as a Performance Improvement Project (PIP).
- Evaluate Improvement Strategies and Opportunities for Improvement through SWMBH led Regional Committees, such as; QM, RUM, CAC, and other Regional Committees. Committees will be instructed to deliberate and prioritize identified areas of improvement by May 29, 2020. A culminating report and action plan will be shared with the Operations Committee, by June 30, 2020.

Southwest Michigan
BEHAVIORAL HEALTH

2018–2019 External Quality Review Compliance Monitoring Report *for* Prepaid Inpatient Health Plans

Region 4 – Southwest Michigan Behavioral Health

Report Date: March 13, 2020

Report Highlights

Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS has elected to review the full set of standards over two review periods, as displayed in Table 2-1.

2017–2018	2018–2019
Standard VI—Customer Service	Standard I—QAPIP Plan and Structure
Standard VII—Grievance Process	Standard II—Quality Measurement and Improvement
Standard IX—Subcontracts and Delegation	Standard III—Practice Guidelines
Standard X—Provider Network	Standard IV—Staff Qualifications and Training
Standard XII—Access and Availability	Standard V—Utilization Management
Standard XIV—Appeals	Standard VIII—Members' Rights and Protections
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	Standard XI—Credentialing
Standard XVII—Management Information Systems	Standard XIII—Coordination of Care
	Standard XVI—Confidentiality of Health Information

This report presents the results of the 2018–2019 review period. MDHHS and the individual PIHPs use the information and findings from the compliance monitoring reviews to:

- Evaluate the quality and timeliness of and access to healthcare services furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Table 2-2—Scoring Methodology[2-2]

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk review documentation	October 1, 2018, through April 30, 2019
Information obtained through interviews	October 1, 2018, through the end of each PIHPs' on-site review
File review records	• Prior authorization denials closed between October 1, 2018, through April 30, 2019 • Providers who have completed the credentialing process between October 1, 2018, and April 30, 2019

Summary of Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	7	1	0	87%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	74	8	0	90%

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard

Southwest Michigan Behavioral Health achieved full compliance in six of the nine standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information. The remaining three standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to Quality Measurement and Improvement, Utilization Management, and Credentialing, as these areas received performance scores under 90 percent.

Southwest Michigan Behavioral Health demonstrated compliance in 74 of 82 elements, with an overall compliance score of 90 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out most required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Southwest Michigan Behavioral Health is required to submit to MDHHS a CAP for all elements scored *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the PIHP must identify the planned

interventions to achieve compliance with the requirement(s); the individual(s) responsible for each intervention; and the timeline, including planned dates of completion for each intervention.

HSAG has prepared a customized template to facilitate **Southwest Michigan Behavioral Health's** submission and MDHHS' review of corrective actions. The template includes each requirement for which HSAG assigned a performance score of *Not Met* and, for each requirement, HSAG's findings and recommendations to bring the organization's performance into full compliance with the requirement. Within 30 days after receipt of the final report, the CAP must be submitted to HSAG's secure file transfer protocol (SFTP) site, with an email notification to MDHHS and HSAG indicating that the CAP has been uploaded.

2019-2020 Board Ends Metric Status Report

March 13, 2020

2019 Health Service Advisory Group (HSAG) External Quality Review (EQR)

2019 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met").	**Audit Summary**
• Metric Measurement Period: (1/1/18 – 6/1/19) • Board Report Date: March 13, 2020 **Measurement:** Number of Element Sub-Sections "Met" Total Elements Evaluated	The 2019 HSAG EQR Review took place on September 17, 2019 SWMBH achieved 74/82 Standards evaluated achieving an overall score of 90.24%. SWMBH received the top score of all 10 PIHP's For all Standards receiving a designation of "Not Met" a comprehensive Corrective Action Plan will be developed and delivered to HSAG by 3/4/2020. Please see the complete overview report for more details.

Audit Results by Standard:

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	7	1	0	87%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	74	8	0	90%

***Suggested Motion:** The data is Relevant and Compelling; the Executive Officer is in Compliance and the Ends requires no further Revision.

2019-2020 Board Ends Metric Status Report

March 13, 2020

Performance Bonus Incentive Program

Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications.

- Metric Measurement Period: (10/1/18 - 11/15/19)
- Metric Report Date: March 13, 2020

A. Increased participation in patient-centered medical homes
B. Identification of enrollees who may be eligible for services through the Veteran's Administration
C. Additional Areas to be addressed include:
   1. Veterans Community Action Team attendance
   2. Co-location of CMH staff in primary care settings
   3. Involvement with FQHC's, SIM, MI Health Link
   4. Efforts to identify consumers without a primary care physician
D. Joint Care Management
E. Follow-up after Hospitalization for Mental Illness
F. Plan all-cause readmissions

Review Summary

The PBIP Narrative Report and Metrics were submitted for MDHHS evaluation on November 13, 2019

SWMBH was notified of award/results on 1/13/2020 and had until 2/1/2020 to contest findings

SWMBH achieved **98.20%** of possible bonus award earnings

FY19 Total .75 Performance Bonus Incentive		
	Total $ Available (.75 withhold)	**Total Withhold Unearned**
SWMBH	$ 1,799,741.93	$34,709.31

Follow-up after Hospitalization for Mental Illness within 30 days Scoring (50 points)								
	Scored 6-20 Combos	Scored 6-20 Combos Meeting Standard	Scored 21-65 Combos	Scored 21-65 Combos Meeting Standard	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	Score (maximum = 50)
SWMBH	2	2	5	4	7	7.14	6	43

PIHP Joint MHP Metric Score (100 points)				
	Score	Score Converted to Percentage	Joint Metric Total $ Available	Joint Metric Earned
SWMBH	93	93%	$485,930.32	$451,221.01

Joint Care Management Processes, PCR and FUA Narrative Scoring (50 points)				
	Joint care mgmt processes Yes = 35, No = 0	PCR Narrative Yes = 10, No = 0	FUA Narrative Yes = 5, No = 0	Score (maximum = 50)
SWMBH	35	10	5	50

PIHP-only Narrative Score (100 points)							
	Patient Centered Medical Home Participation Yes = 46, No = 0	Veterans' Needs and Services Yes = 46, No = 0	SSDAD Narrative Yes = 8, No = 0	Score	Score Converted to Percentage	Total Narrative $ Available	Narrative $ Earned
SWMBH	46	46	8	100.00	100%	$1,313,811.61	$1,313,811.61

*__Suggested Motion:__ The data is Relevant and Compelling; the Executive Officer is in Compliance and the Ends requires no further Revision.

R4 SWMBH

FY19 Pay for Performance on Integration of Behavioral Health and Physical Health Services

Shared Metrics Data Validation Narrative Score: 14

Feedback & Scoring Form

PIHPs are scored Pass/Fail for FY19 narratives. PIHPs earning 11.25 or more points will pass and earn full incentive dollars for the PCR and FUA narratives.

Shared Metrics Data Validation Narrative

☐ REVIEW
☒ FINAL

Plan All-cause Readmission (PCR) Deliverables: CY 2017 Rate: CY 2018 Rate:	**Point Allocation**	**Submission Points**
1. Describe any discrepancies found between health plan and MDHHS data for this measure, such as: dates of service differences (ex. last billing date versus discharge date); claims or provider specialty changes results; exclusion applicability (ex. hospice); and eligibility discrepancies (ex. change in health plan during measurement period).	***5***	5
2. Describe current strategies to improve performance on this measure, including utilizing ADTs or other forms of secure data exchange to coordinate care for patients. Identify goals, objectives and activities for improving performance on this measure, including coordination with partner plans.	***5***	4.5
Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) Deliverables: CY 2017 Rate: CY 2018 Rate:	**Point Allocation**	**Submission Points**
1. Describe any discrepancies found between health plan and MDHHS data for this measure, such as: dates of service differences (ex. last billing date versus discharge date); claims or provider specialty changes results; exclusion applicability (ex. hospice); and eligibility discrepancies (ex. change in health plan during measurement period).	***1.5***	1.5
2. Describe analysis of the FUA rate and data that you have done. Specifically, describe review by: Race/Ethnicity	***1.5***	1.5

(REQUIRED), Age, Gender, Providers, Geography, and/or Other.		
3. Describe current strategies to improve performance on this measure, including utilizing ADTs or other forms of secure data exchange in care coordination for patients. Describe how your health plan is monitoring ED utilization for alcohol and other drugs and what has been done to improve communication regarding ED visits for alcohol and other drugs. If not using ADTs, or if you have not taken other steps, explain why not and plans for the future. Identify goals, objectives and activities for improving performance on this measure, including coordination with partner plans.	***2.0***	1.5

TOTAL SCORE: 14/*15*

Plan All-Cause Readmission (PCR):

Question #1

At least two of the following items should be addressed in order to earn full points on the description of discrepancies:

1. Mentioned the data source(s) you used for your review.
2. State specific number of records you verified and how you verified them.
3. Provide the number of PIHP result flag = YES and the number of PIHP result flag = NO.
4. List the most common reasons behind the discrepancy between the PIHP result flag and the MDHHS result flag, such as readmission was greater than 30 days from discharge, beneficiary did not meet the eligibility criteria, or readmission was actually a next day transfer, etc.
5. Comparison of PIHP and state denominator.
6. Digging further for any factors that help predict whether there will be a readmission.

SWMBH's narrative addressed two or more of the above criteria and earned full points.

Question #2:

The following items should be addressed in order to earn full points on "How can performance be improved?"

1. How are ADTs are used and if not used, what data sharing process is used instead?
2. How is the PIHP/CMHSPs collaborating with MHPs to provide follow-up services?
3. Describe multiple strategies in use or being planned for that are expected to improve performance.
4. How is the PIHP/CMHSPs collaborating with local entities (like hospitals, clinics, SUD providers) to reduce readmissions?

SWMBH earned 4.5 points. Additional points could have been earned by explaining the data sharing process used instead of ADTs.

Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA):
Question #1: In ideal circumstances, a disparity analysis should involve a comparison of FUA rates for the sub-populations considered and a discussion of any disparities identified between MDHHS results and the PIHP results. However, MDHHS was not able to provide our results to the PIHPs due to confidentiality requirements. It was not possible for the PIHPs to complete a full disparity analysis. For this reason, a full disparities analysis with the full sub-population numerator data is not required for full points for FUA Question #1.

Question #2: To earn full points, disparities should be described based on follow-up rates. The PIHP contract stipulates that you answer this question:
Which Racial/Ethnic group is most/least likely to receive a follow-up service?
Other demographic stratifications that could be described, but are not mandatory include gender, county/CMH, age ranges.

SWMBH's narrative addressed the above criteria and earned full points.

Question #3: The following items should be addressed in order to earn full points on "How can performance be improved?"

1. How are ADTs are used and if not used, what data sharing process is used instead?
2. How is the PIHP/CMHSPs collaborating with MHPs to provide follow-up services?
3. Describe multiple strategies in use or being planned for that are expected to improve performance.
4. How is the PIHP/CMHSPs collaborating with local entities (like hospitals, clinics, SUD providers) to reduce readmissions?

SWMBH's narrative earned 1.5 point. Additional points could have been earned by providing more detail about multiple strategies in use or planned to improve performance.

SWMBH – Region 4
FY19 Pay for Performance

PIHP-only Measure and Narratives Score: 100

Feedback & Scoring Form

PIHPs are scored Pass/Fail for FY19 narratives. PIHPs earning 75 or more points will earn full incentive dollars for SSD-AD, Patient-centered and Veteran's narratives.

PIHP-only Narratives

☐ REVIEW
☒ FINAL

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Meds (SSD-AD) Deliverable:	**Point Allocation**	**Submission Points**
1. Describe findings from data validation activities. Note opportunities for improvement within subsets of the overall population based on differences in rates between age groups, FFS vs. MHP enrolled, CMHSPs, gender or ethnic groups, etc. Explain sources of data used for validation, and how the PIHP data collection process ensures that local data is valid and reliable. If there are local data integrity issues impacting the comparison, please explain.	***8***	8
Patient-centered Medical Home Participation and Veterans' Needs and Services Deliverables:	**Point Allocation**	**Submission Points**
1. Increased participation in patient-centered medical homes • Comprehensive Care • Patient-Centered • Coordinated Care • Accessible Services • Quality & Safety	***46***	46
2. Identification of enrollees who may be eligible for services through the Veteran's Administration • Outreach efforts and activities with Veterans, Veterans Advocate Groups, and/or Veterans Providers of any type • Level of CMH and other PIHP Provider involvement on TriCare Panel • Population Health and Integrated Care efforts with local VA Medical Centers and Clinics	***46***	46
TOTAL SCORE: 100/*100*		

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Meds (SSD-AD):

SWMBH's narrative addressed the above criteria and earned full points on this item.

Patient-centered Medical Home Participation

The narrative addressed the above criteria and earned full points. The Complex Case Management program shows much promise. BHDDA recognizes the efforts of SWMBH to embed recovery coaches in emergency departments, and at integrated care clinics.

Veterans' Needs and Services

The narrative addressed the above criteria and earned full points on this item. BHDDA recognizes progress made by the SWMBH Veteran's Navigator. It's clear from the narratives that broad efforts are underway at the CMH level to identify and connect veterans to the services they need.

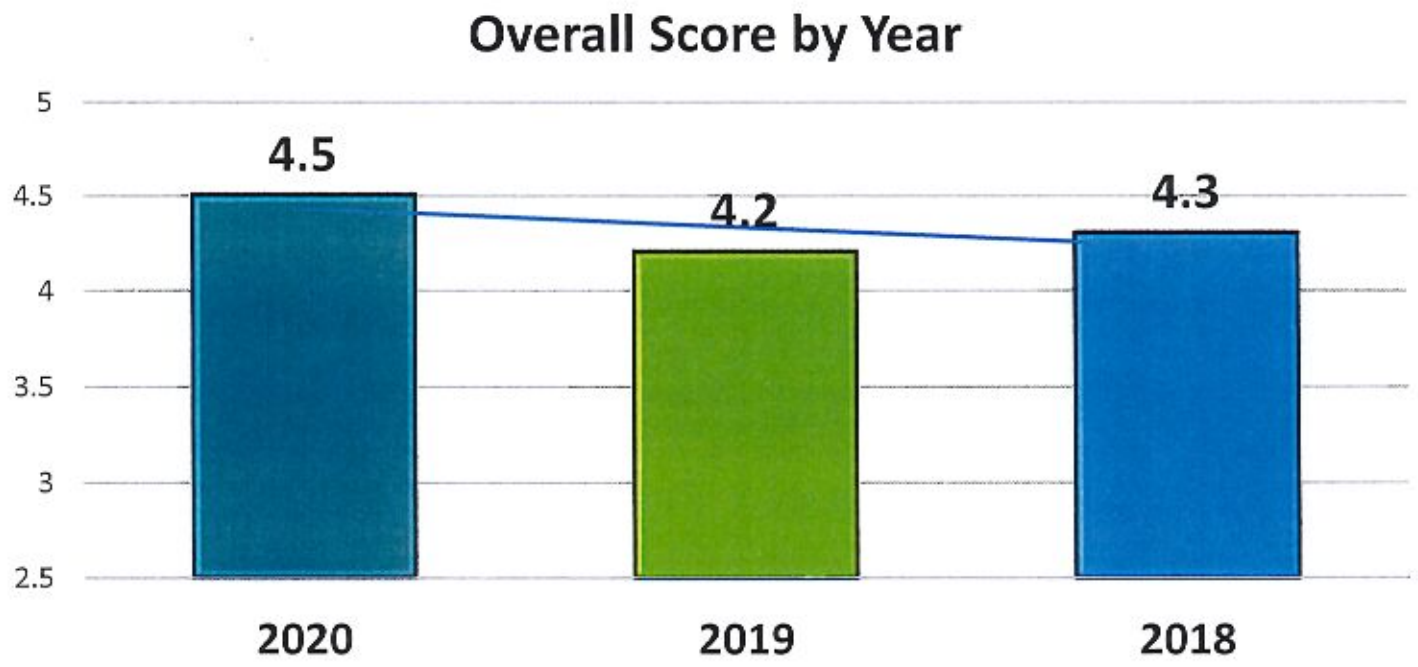
Southwest Michigan
BEHAVIORAL HEALTH

2020 Operations Committee Self-Evaluation Summary Report

March 13, 2020

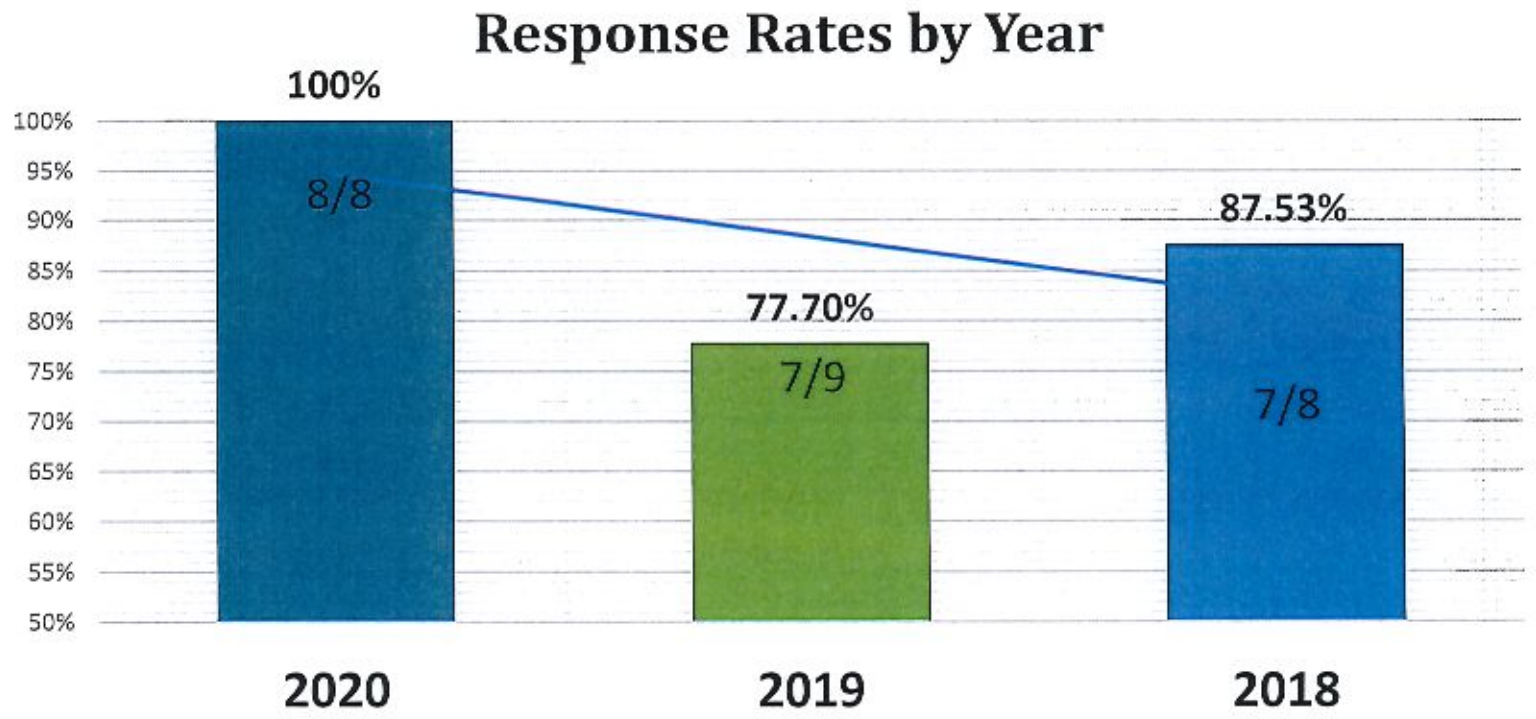
Operations Committee
Self Evaluation Summary Report

The Operations Committee performed its annual self-evaluation in February 26, 2020 by confidential score submissions. The Scoring system was a 5 point scale, with 5 being strongly agree and 1 being strongly disagree. The overall average score for 16 questions is shown below, as well as a comparison of the previous years overall score. The 2020 survey observed an average score of (4.5), which is a (+.30) improvement, across all questions, in comparison to the 2019 survey.



Operations Committee
Self Evaluation Summary Report

- 2020 Self Evaluation = 100% response rate (8/8)
- 2019 Self Evaluation = 77.7% response rate (7/9).
- 2018 Self Evaluation = 87.5% response rate (7/8).
- Cass County CEO was excluded from the 2020 calculation; as decided by the Operations Committee during their 1/29/20 meeting.



Operations Committee Evaluation General Trends and Observations

Although no questions represented a significant *negative* variance in comparison to 2019 results, these questions represent the highest ratio of in-agreement response changes:

- The length of our meetings is appropriate and respectful of the agenda. (-.19)
- Attendance at our meetings is consistent and members arrive on time. (-.11)

2020 survey questions with significant *positive* variance in comparison to 2019 results:

- There is alignment between SWMBH's Goals, Mission, Vision & Values, and the purpose, scope and deliverables taken and/or the decisions made by the committee. (+.83)
- As a general rule, when I speak I feel listened to and that my comments are valued. (+.72)
- We consistently use our meeting time well. Issues get the time and attention proportionate to their importance. (+.66)

Board Approved 3/8/19

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH OPERATING AGREEMENT

Table of Contents

PURPOSE

Pursuant to Michigan Law, an Operating Agreement is "an agreement among an organization's participant members to govern the organization's business, and the participant member's financial and managerial rights and duties." (MCL 450.4102(2)(r)).

Southwest Michigan Behavioral Health (SWMBH) Operating Agreement is established between SWMBH and its participant Community Mental Health Services Programs (CMHSPs). The Operating Agreement is approved by the regional SWMBH Board, which has as its membership representatives from each of the participant CMHSP Boards.

The primary purposes of this Operating Agreement are to:

- Declare that the Regional Entity is a separate legal entity from the participant CMHSP organizations;
- Augment specific sections of the SWMBH Bylaws, as referenced therein;
- Further define the governance and management structure of SWMBH that the participant CMHSPs have chosen for the organization;
- Clarify the business and operational relationships between SWMBH and its participant CMHSPs; and
- Clarify the provisions and understandings by which SWMHB will operate.

PREAMBLE

Southwest Michigan Behavioral Health (hereinafter referred to as "SWMBH") is a Regional Entity created pursuant to MCL 330.1204b of the Michigan Mental Health Code, 1974 PA 258. A Regional Entity is an independent public governmental entity, and is separate from the counties, authorities, or organizations that establish it. SWMBH operates under the authority of its own Board of Directors (the "SWMBH Board"), which consists of membership from each of the participant CMHSP boards, as delineated in the SWMBH Regional Entity Bylaws.

SWMBH was created with the filing of its Bylaws with Michigan's Office of the Great Seal. These Bylaws were approved by the following participant Community Mental Health Services Programs, which are organized and operated as community mental health authorities under Michigan's Mental Health Code (MCL 330.1001 et seq.)

- Barry County Community Mental Health Authority;
- Berrien Mental Health Authority d/b/a Riverwood Center;
- Branch County Community Mental Health Authority, d/b/a Pines Behavioral Health Services;
- Calhoun County Community Mental Health Authority; d/b/a Summit Pointe;
- Cass County Community Mental Health Authority d/b/a Woodlands Behavioral Healthcare Network;
- Kalamazoo County Community Mental Health Authority, d/b/a/ ~~Kalamazoo Community Mental Health and Substance Abuse Services~~ Integrated Services of Kalamazoo;
- Community Mental Health and Substance Abuse Services of Saint Joseph County; and
- Van Buren Community Mental Health Authority.

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As the Bylaws reference the Operating Agreement and require an annual review of this Operating Agreement with revisions subject to approval by the SWMBH Board, the Operating Agreement will be

filed by SWMBH with each County Clerk and the Office of the Great Seal when revisions occur.

SWMBH designated service area encompasses the following Michigan counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren. These counties are hereinafter known as the "Service Area" of SWMBH.

SWMBH was formed for the purpose of:

(i) carrying out the provisions of the Mental Health Code in its Department designated service area as they relate to: serving as a prepaid inpatient health plan, as defined in 42 CFR 438.2 ("PIHP");

(ii) managing the business lines for which SWMBH is the contractor to Michigan Department of Health and Human Services (MDHHS);

(iii) ensuring a comprehensive array of services and supports as provided in the contracts with MDHHS;

(iv) performing all the duties and responsibilities contained in the Department/Regional Entity Contract;

(v) Substance Abuse Coordinating Agency (CA) required functions for its service area, pursuant to MCL 333.6230 et seq. (PA 501 of 2012; Amendments to Public Health Code), and MCL 330.1100a et seq. (PA 500 of 2012, Mental Health Code);

(vi) contractual participation in the Department's MI Health Link (MIHL) demonstration project for its service area, serving persons with behavioral health needs who have both Medicare and Medicaid coverage; and finally

(vii) exercising the powers and authority set forth by the Bylaws and governed by the SWMBH Board.

OPERATIONAL STRUCTURE

The aforementioned eight Community Mental Health Services Programs (the "Participants") have joined together to create a jointly governed regional entity operating as a Prepaid Inpatient Health Plan ("PIHP") for the purpose of supporting and furthering the work of the Participants in their roles as Community Mental Health Service Programs ("CMHSPs") as applicable in the counties they serve.

Inherent in this action is the belief that the Participants are best suited to provide services well matched to the needs of the communities and citizens served. SWMBH is established for the purpose of meeting its regulatory and statutory requirements, and other services as mutually agreed, while not encumbering, but enhancing, the efforts of the Participant CMHSPs. In serving and representing the counties of Barry, Berrien, Branch, Cass, Calhoun, Kalamazoo, Saint Joseph, Van Buren, SWMBH shall be dedicated to ensuring that equality in voice and governance exists, and that the benefit to the person participating in services is uniform, person centered, and locally available.

SWMBH is founded on a shared governance structure, using standing committees to create avenues for input. Certain checks and balances are created to ensure that governance remains balanced and equal. SWMBH exists to support all Participants, and all Participants must work collaboratively to ensure that

SWMBH is successful in its core mission.

The SWMBH Board has final authority over governing SWMBH, as set forth in the Bylaws approved by the Participants and subject to those powers reserved to the Participants in the Bylaws. This Operating Agreement reinforces the responsibility for governance of the Regional Entity to the SWMBH Board, and management of the Regional Entity to its Executive Officer(EO).

The SWMBH Board will be best served by an EO who is an accomplished administrator and facilitator, capable of bringing many and varied voices together to achieve consensus. The EO must promote compliance, fiscal responsibility, quality programs, meaningful outcomes, and efficiencies that will funnel more resources to direct services. The SWMBH Board shall also be advised by an Operations Committee that brings management expertise, local perspectives, local needs, and greater vision to the operation of the PIHP.

ORGANIZATION

Formation and Qualification. SWMBH has been formed by the Participants pursuant to the authority granted under the Michigan Mental Health Code, MCL § 330.1204b and by filing Bylaws with the County Clerks of each of the eight counties and the Michigan Secretary of State, Office of the Great Seal.

Name. The business of SWMBH may be conducted under that name or, in compliance with applicable laws, any other name that the SWMBH Board deems appropriate or advisable. SWMBH shall file any certificates, articles, fictitious business name statements and the like, and any amendments and supplements thereto, as SWMBH considers appropriate or advisable.

Office. The principal office of SWMBH shall be at such place or places of business within the eight counties as the SWMBH Executive Officer may determine.

SCOPE AND AUTHORITY

The intention of this Operating Agreement is to provide a paradigm for decision-making, and a structure for effective communication among members of the SWMBH Board, the Participants, SWMBH administration and, potentially, provider representatives, persons in service, SWMBH staff, and stakeholders, that is inclusive, collegial, equal and responsive.

The Operations Committee participates meaningfully in the establishment of and alignment to regional, SWMBH, and common CMHSPs goals.

- Meetings. The Operations Committee shall meet as often as it deems necessary in order to perform its responsibilities. The Operations Committee may also meet by video and phone options and may act by unanimous written consent via e-mail in lieu of a meeting. Records of Operations Committee Meetings shall be kept.

- Annual Self-Evaluation. At least annually, the Operations Committee shall evaluate its own performance, and provide recommendations and conclusions to the Board.

- Standing Committees and Subcommittees. The Operations Committee may form and delegate authority to one or more Standing Committees made up of CEOs, or it may form self-populated subcommittees or workgroups as it deems appropriate from time to time under the circumstances. Such efforts will avoid duplication or role confusion.

SWMBH BOARD COMMITTEES AND OVERSIGHT BOARDS

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

- Operations Committee;

Operations Committee

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

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

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

Operations Committee Responsibilities and Authorities

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

A. Assure Participant CMHSP and community awareness of and alignment to SWMBH approved contracts, Participant subcontracts and related Plans, Policy and Procedures.
B. Assure its CMHSP personnel are constructively involved in SWMBH Committees and related activities.
C. Contribute to SWMBH and Participant CMHSP environmental awareness and SWMBH regional planning activities, including but not limited to strategic planning, Mission

development, operational and capital budgeting, growth, infrastructure, products and markets.

D. Seek to resolve boundary issues, differences and disputes.
E. On an ongoing basis consider possible administrative efficiencies where appropriate (Bylaws 11.2).

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

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

OPERATIONAL COMMITTEES AND POLICY BOARD COMMITTEES

SWMBH POLICY BOARDS AND COMMITTEES

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

Policy Board will be constituted as required under MCL 330.1100a et seq. (PA 500 of 2012; Mental Health Code) and shall advise the SWMBH on issues concerning services to persons with substance use disorders. The functions and responsibilities assigned to the Board under law will include:

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

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

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

SWMBH Standing Committees

Standing Operating Committees of SWMBH are:

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

The CMHSP CEOs will ensure representatives from participant CMHSPs on all SWMBH Standing Committees. Each Participant CMHSP shall identify their representative to each committee. The EO with CMHSP support and involvement will actively pursue customer representation on standing committees. Committee work plans and goals shall be reviewed by the Operations Committee annually and in the event of changes to ensure alignment with SWMBH and common CMHSP goals. At its discretion, the Operations Committee may request an in-depth committee report or update.

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

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

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

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

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

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

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

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

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

Responsibilities of SWMBH and Participants Regarding the Participants and Committees

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

A. Provide all parties, in a timely manner, copies of correspondence of a substantive nature to allow full consideration and deliberation prior to being called on to take action on such items.

This includes but is not limited to: 1) policy, 2) contracts, 3) funding, 4) State and federal mandates, 5) items requiring a parties action and 6) legislative initiatives;

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

DISPUTE RESOLUTION PROCESS

"The manner for adjudicating a dispute or disagreement among Participants shall be set forth in an Operating Agreement, approved by the Regional Entity Board and incorporated herein by reference." *(SWMBH Bylaws 3.G)*

Occasionally disputes may arise that cannot be resolved through amiable discussion. Any unresolved disputes between the Participants or one or more Participant and SWMBH will be resolved as follows:

1. The Participant CMHSP CEOs/Executive Directors will attempt to resolve the dispute through discussion with each other, or the SWMBH EO if the dispute is with SWMBH.
2. If the dispute remains unresolved, the Participant CMHSP CEOs/Executive Directors, or the SWMBH EO if the dispute is with SWMBH, will bring the matter to the Operations Committee no later than its next scheduled meeting, which will discuss the matter and render a decision within fifteen (15) calendar days of the meeting, or within agreed upon timeframe by involved parties.
3. If the dispute continues to be unresolved to the satisfaction of the Participant/s or SWMBH, all parties to the dispute will provide written descriptions of the issue in dispute and propose a solution to the SWMBH Board within fifteen (15) calendar days or within agreed upon timeframe by involved parties. The SWMBH Board will have thirty (30) calendar days or a mutually agreed upon timeframe to provide a written decision.
4. If the Participant/s or SWMBH remain dissatisfied, the Participant/s or SWMBH may seek

mediation, arbitration or legal recourse as provided by PIHP-CMHSP contract and law.

5. Participant sub-contracts will include a Dispute Resolution section congruous with this approach.

OPERATION OF SWMBH

A. Budget

The Finance Committee is charged with advising the EO and SWMBH CFO in the development of the regional annual operating and capital budget; Financial Management Plan, Cost Allocation Plan, and Financial Risk Management Plan, for review by the SWMBH Operating Committee prior to presentation and approval by the SWMBH Board as applicable.

From these plans, annual operating and capital budgets will be developed. The Participants play an integral part in the budget development via its representatives on the SWMBH Finance Committee.

Annual operating and capital budgets will be developed in accordance with the principles outlined in SWMBH Financial Management and Financial Risk Management Plan and Cost Allocation Plans which are incorporated herein by reference and considered a part of this Operating Agreement. The annual operating and capital budgets will be reviewed by the Operations Committee prior to presentation to the SWMBH Board.

The annual operating budget shall plan for adequate funds for projected supports and services to beneficiaries. Budgeting shall consider Participant CMHSPs needs for capital and operating costs, payments of principal and interest on obligations; prudent risk management; reinvestment of Medicaid savings to ensure benefit stabilization; Participant CMHSPs meeting local match obligations for Medicaid; equitable distribution of any surplus funds available after the completion of the Regional Entity's purpose, and operations efficiency and effectiveness across the region.

The SWMBH CFO and Finance Committee may recommend to the EO potential areas where functional consolidation and administrative efficiencies may be achieved. These in turn will be considered by the EO and the Operations Committee. After thorough review, a proposal may be presented to the SWMBH Board for approval if necessary.

Purchase of Services (POS)

Participant CMHSPs singly or in groups may purchase services from SWMBH. Such arrangements shall be documented in writing with mutual agreement as to specification and pricing.

Where there is a POS agreement between SWMBH and one or more Participants, only those Participants who are a party to the agreement will be subject to the terms and conditions of the agreement. Cost associated with any agreements shall be managed between SWMBH and applicable Participants, subject to request for review by the Operations Committee.

Nothing shall prohibit a Participant from withdrawing from an agreement established with SWMBH to provide a service on behalf of the Participant. However, the Participant, once a party to an agreement, will be bound by that agreement and may withdraw only according to the terms of the agreement.

The SWMBH CFO and Finance Committee will establish a financial management system sufficient to

monitor revenues and expenditures by funding source (Medicaid, HMP, General Fund, etc.) and the Participants. SWMBH shall maintain accounts and source records in which any and all revenues received and expenses incurred are ascertainable and verifiable and include date of receipt/payment and sources of funds. The SWMBH CFO has the responsibilities set forth in MCL § 330.1204b and will be responsible for receiving, depositing, investing, and disbursing SWMBH's funds in the manner authorized by SWMBH Bylaws, Board policy, and operational policy.

B. Planning

The SWMBH Board, in collaboration with the Operations Committee and the EO, will develop and publish a mission statement and vision statement consistent with the principles of SWMBH.

Per Board directive the EO will facilitate a planning session, involving the SWMBH Board and the Operations Committee to create, update, or modify the Long-Term Plan of SWMBH. The process will allow for broad input and is intended to meet all contractual and accreditation requirements. The SWMBH Board will approve the Long-term Plan prior to its publication.

C. Compliance

All parties recognize that SWMBH is a regional entity, and holds distinct and different legal status and responsibilities than the Participants. SWMBH is the Department designated PIHP and CA Office for the Southwest Michigan service area.

Throughout the implementation of this Operating Agreement, all parties enter into this arrangement in a spirit of good faith and cooperation. All parties recognize that SWMBH may need to, at the discretion and with the advanced approval of the SWMBH EO and his/her designee, conduct random audits and/or reviews of the Participants. Such activity would occur with timely notice to the Participant CEOs/Executive Directors and Participant Compliance Officer to communicate rationale for the review and findings. The Participants acknowledge that SWMBH is responsible for ensuring that covered services and administrative services furnished by and through the Participants are furnished and compensated in accordance with applicable laws and regulations. Accordingly, on behalf of itself and its providers, the Participants acknowledge that SWMBH has the right, responsibility and authority:

1. To detect and deter compliance violations by the Participants and their providers by any lawful means, including monitoring and announced audits; and
2. In conjunction with the Participant CMHSPs Compliance Officer to independently investigate alleged or suspected compliance violations by the Participants, a network provider, or an employee, owner, or governing body members of either.

The Participants acknowledge their obligation to submit all requested financial and quality data and reports within the timelines as found in subcontracts, MDHHS directives or as agreed upon. Should a Participant CMHSPs not submit requested financial and quality data and reports in a complete, valid and timely manner, SWMBH will be empowered to take corrective action, including agreed upon sanctions, in accordance with the terms of the SWMBH/CMHSP Contract.

D. Human Resources

SWMBH will directly employ the EO, CFO, and CIO. The Operations Committee may recommend to the

SWMBH EO the use of other hired staff, or the use of a contract to secure other established positions as required.

The SWMBH EO shall appoint, or contract with, an individual or an organization to perform Human Resources functions.

The employee handbook of SWMBH shall be made available upon request to the Operations Committee.

The SWMBH Board has sole responsibility for all hiring and retention decisions regarding the SWMBH EO. The Operations Committee shall assist the SWMBH Board in this process as requested. This may include screening candidates to ensure the SWMBH Board receives only qualified applicants to consider and participation in the interview and evaluation process

E. Policy Development

The SWMBH EO, making full use of the Operations committee and standing committees, shall develop policies, exclusive of SWMBH internal operational policies.

The SWMBH EO shall consult with the Operations Committee before rendering a formal policy interpretation that may materially or negatively affect the Participants where feasible.

F. Contracts

SWMBH shall contract with the Participants as its CMHSP providers.

SWMBH, consistent with regulatory requirements and funds availability may consider with review from Operations Committee providing Participants with pilot or startup funding. Nothing other than federal or state statutory or regulatory prohibition should inhibit or prohibit a Participant CMHSPs from participating in opportunities to provide integrated and accountable care to serve the Medicaid population in its CMHSP catchment area provided that they are consistent with SWMBH policies, financial plan, financial risk management plan and cost allocation plan.

Consistent with the SWMBH mission, vision, and principles, all grant applications submitted on behalf of SWMBH must be reviewed by the Operations Committee prior to being submitted. This may necessitate review outside the regularly scheduled Operations Committee meetings due to funding application grant timelines.

The SWMBH EO shall, in consultation with Operations Committee, determine what functions remain with SWMBH and which can be delegated to the Participants consistent with the Medicaid Managed Care Rules.

The Operating Committee shall be consulted regarding significant contract arrangements that involve SWMBH and Participant CMHSPs. Nothing herein prohibits the participant CMHSPs from entering into opportunities at the local level to provide services.

"2.4.1 The Regional Entity shall have no powers, rights or authority with respect to:

- the Participants' obligations under the Mental Health Code including those related to size, composition, and authority of the Participants' Board;
- the Participants' autonomous administrative, financial, or clinical operations; or

- the Participants' relationship with other providers unless the Regional Entity's involvement is so limited that it does not prevent the Participant from collaborating with other providers." (SWMBH Bylaws 2.4)

AMENDMENTS

This Operating Agreement shall be reviewed and an Operations Committee Self-Evaluation shall be performed by the Operations Committee on an annual basis, with a report to the Board on both. Any recommended changes to the Operating Agreement will be forwarded to the SWMBH Board for consideration. All revisions or amendments to the Operating Agreement shall be in writing and formally approved by the SWMBH Board.

	E	F	G	H	J	K	L	M	N	O	P	Q	R	S
1	**Southwest Michigan Behavioral Health**				Mos in Period									
2	For the Fiscal YTD Period Ended 6/30/2019			P12FYTD19	12									
3	*(For Internal Management Purposes Only)*													
4	**INCOME STATEMENT**			TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ABG Activities	Indirect Pooled Cost	
5														
6														
7	**REVENUE**													
16	Contract Revenue			284,392,500	204,044,388	33,222,453	12,003,180	3,563,941	9,533,786	2,024,753	-	-	-	
17	Incentive Payments			2,264,842	499,309	-	-	-	-	-	1,765,033	-	-	
18	Grants and Earned Contracts			705,517	-	-	-	-	628,935	-	76,582	-	-	
19	Interest Income - Working Capital			215,837	-	-	-	-	-	-	215,837	-	-	
20	Interest Income - ISF Risk Reserve			40,069	-	-	-	-	-	-	40,069	-	-	
21	Local Funds Contributions			2,163,020	-	-	-	-	-	-	2,163,020	-	-	
22	Other Local Income			7,345	-	-	-	-	-	-	7,345	-	-	
23														
24	**TOTAL REVENUE**			289,785,531	204,543,697	33,222,453	12,003,180	3,563,941	10,162,921	2,024,753	4,267,886	-	-	
25														
26	**EXPENSE**													
27	Healthcare Cost													
28	Provider Claims Cost			20,911,658	3,244,491	6,045,469	-	3,662,221	6,814,734	2,024,753	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			213,643,836	174,334,261	19,105,571	16,879,372	1,649,986	1,974,645	-	-	-	-	
30	Insurance Provider Assessment Witheld (IPA)			2,827,614	2,827,614	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			5,923,148	3,209,360	2,713,788	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	2,074,561	-	-	(2,074,561)	-	-	-			
33														
34	Total Healthcare Cost			243,508,465	186,690,477	27,864,828	16,879,372	3,267,666	7,889,379	2,024,753	-	-	-	
35	Medical Loss Ratio (HCC % of Revenue)			84.4%	90.5%	83.9%	140.6%	91.4%	77.8%	100.0%				
36														
37	Administrative Cost													
38	Purchased Professional Services			648,257	-	-	-	-	-	-	648,257	-	-	
39	Administrative and Other Cost			7,275,234	-	-	-	-	-	-	7,274,886	-	348	
40	Interest Expense			-	-	-	-	-	-	-	-	-	-	
41	Depreciation			110,119	-	-	-	-	-	-	110,119	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	128,432	-	(128,432)	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	348	-	(348)	
44	Delegated Managed Care Admin			16,214,816	13,396,117	1,469,622	1,281,300	127,877	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	5,941,543	841,620	564,761	178,408	269,265	-	(7,794,497)	-	-	
46														
47	Total Administrative Cost			24,248,626	19,277,660	2,311,242	1,846,060	306,286	398,697	-	110,680	-	-	
48	Admin Cost Rate (MCA % of Total Cost)			8.8%	9.4%	7.7%	9.9%	8.6%	4.8%	0.0%	2.9%			
49														
50	Local Funds Contribution			2,163,020	-	-	-	-	-	-	2,163,020	-	-	
51	PBIP Transferred to CMHPs			1,840,820	-	-	-	-	-	-	1,840,820	-	-	
52														
53	**TOTAL COST after apportionment**			271,658,931	204,968,137	30,176,071	18,725,432	3,563,941	8,288,076	2,024,753	3,914,820	-	-	
54														
55	**NET SURPLUS before settlement**			(1,870,300)	(424,440)	3,046,382	(5,722,252)	-	1,874,845	-	353,066	-	-	
56	Net Surplus (Deficit) % of Revenue			-0.7%	-0.2%	9.2%	-56.5%	0.0%	18.5%	0.0%	8.3%			
57														
58	Prior Year Savings			-	-	-	-	-	-	-	-			
59	Change in PA2 Fund Balance			-	-	-	-	-	-	-	-			
60	ISF Risk Reserve Abatement (Funding)			(40,069)	-	-	-	-	-	-	(40,069)			
61	ISF Risk Reserve Deficit (Funding)			4,100,211	4,100,211	-	-	-	-	-	-			
62	Settlement Receivable / (Payable)			(1,876,845)	(3,675,770)	(3,046,482)	5,722,252	-	(1,876,845)	-	-	-	-	
63	**NET SURPLUS (DEFICIT)**			313,297	-	-	-	-	-	-	313,297	-	-	
64	*HMP & Autism is settled with Medicaid*													
65	SUMMARY OF NET SURPLUS (DEFICIT)													
67	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
68	Current Year Savings			-	-	-	-	-	-	-	-			
69	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
70	Local and Other Funds Surplus/(Deficit)			313,297	-	-	-	-	-	-	313,297	-	-	
71														
72	**NET SURPLUS (DEFICIT)**			313,297	-	-	-	-	-	-	313,297	-	-	
73														

Southwest Michigan Behavioral Health

For the Fiscal YTD Period Ended 9/30/2019
(For Internal Management Purposes Only)

Mos in Period: 12
ok

INCOME STATEMENT

	Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Bentien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
Medicaid Specialty Services		HCC%	78.8%	76.8%	78.8%	74.2%	78.0%	83.7%	80.8%	81.1%	78.6%
Subcontract Revenue	204,044,366	15,578,521	188,465,867	7,614,422	37,304,939	9,878,887	34,967,492	10,073,716	57,659,422	12,643,571	16,123,415
Incentive Payment Revenue	499,309	35,649	463,660	24,902	34,000	31,828	130,715	5,343	184,819	36,090	15,964
Contract Revenue	204,543,697	15,614,170	188,929,527	7,639,324	37,338,939	9,910,715	35,098,207	10,079,061	57,844,241	12,679,661	16,139,380
External Provider Cost	131,360,472	3,244,491	128,115,981	4,026,433	24,434,235	6,459,888	23,439,494	6,278,933	45,490,050	7,851,859	10,133,095
Internal Program Cost	48,911,377	-	48,911,377	3,185,107	10,152,388	2,558,692	9,844,057	3,231,729	7,492,791	4,758,624	7,610,089
SSI Reimb, 1st/3rd Party Cost Offset	(1,043,111)	-	(1,043,111)	(58,254)	(247,582)	(51,916)	(214,888)	(14,285)	(327,816)	(32,335)	(94,647)
Insurance Provider Assessment Withhold (IPA)	8,037,174	8,037,174	-	-	-	-	-	-	-	-	-
MHL Cost in Excess of Medicare FFS Cost	296,688	296,688	-	-	-	-	-	-	-	-	-
Total Healthcare Cost	185,562,600	9,578,352	175,984,247	7,134,286	34,338,731	8,966,664	33,168,664	9,496,397	52,655,026	12,576,143	17,648,537
Medical Loss Ratio (HCC % of Revenue)	90.7%	61.3%	93.1%	93.4%	92.0%	90.5%	94.5%	94.2%	91.0%	97.8%	97.3%
Managed Care Administration	15,405,536	5,941,543	13,463,994	767,168	2,646,462	748,049	2,310,296	718,661	4,372,401	759,739	1,142,238
Admin Cost Ratio (MCA % of Total Cost)	8.5%	2.9%	6.6%	9.7%	7.2%	7.7%	6.5%	7.0%	7.7%	5.7%	6.1%
Contract Cost	204,968,137	15,519,896	189,448,242	7,901,444	36,984,193	9,714,614	35,478,960	10,215,058	57,027,427	13,335,882	18,790,775
Net before Settlement	(424,440)	94,274	(518,715)	(262,120)	354,756	196,101	(380,653)	(135,997)	816,814	(656,221)	(651,395)
Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-
Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
Contract Settlement / Redistribution	(3,675,770)	(4,194,485)	518,715	262,120	(354,756)	(196,101)	380,653	135,997	(816,814)	656,221	651,395
Net after Settlement	(4,100,211)	(4,100,211)	0	-	-	-	-	-	-	-	-
Eligibles and PMPM											
Average Eligibles	146,916	145,916	145,916	7,492	28,467	8,085	27,415	8,521	38,472	11,982	15,482
Revenue PMPM	$ 116.82	$ 8.92	$ 107.90	$ 84.97	$ 109.30	$ 102.15	$ 106.69	$ 98.57	$ 125.80	$ 88.58	$ 97.64
Expense PMPM	$ 117.06	$ 8.86	$ 108.19	$ 87.89	$ 108.27	$ 100.13	$ 107.85	$ 99.90	$ 123.53	$ 92.75	$ 101.14
Margin PMPM	$ (0.24)	$ 0.05	$ (0.30)	$ (2.92)	$ 1.04	$ 2.02	$ (1.16)	$ (1.33)	$ 1.77	$ (3.17)	$ (3.51)

Medicaid Specialty Services

Budget v Actual

Eligible Lives (Average Eligibles)											
Actual	145,916	145,916	145,916	7,492	28,467	8,085	27,415	8,521	38,472	11,982	15,482
Budget	148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
Variance - Favorable / (Unfavorable)	(2,491)	(2,491)	(2,491)	(29)	(505)	(352)	(498)	(29)	(651)	(240)	(187)
% Variance - Fav / (Unfav)	-1.7%	-1.7%	-1.7%	-0.4%	-1.7%	-4.2%	-1.8%	-0.3%	-1.7%	-2.0%	-1.2%
Contract Revenue before settlement											
Actual	204,543,697	15,614,170	188,929,527	7,639,324	37,338,939	9,910,715	35,098,207	10,079,061	57,844,241	12,679,661	16,139,380
Budget	204,068,849	17,242,038	186,826,811	7,396,977	37,196,138	9,989,229	34,283,103	9,762,361	57,765,210	12,640,970	17,903,422
Variance - Favorable / (Unfavorable)	474,848	(1,627,868)	2,102,716	242,947	142,801	(78,514)	815,104	326,700	79,031	338,690	235,957
% Variance - Fav / (Unfav)	0.2%	-9.4%	1.1%	3.3%	0.4%	-0.8%	2.4%	3.3%	0.1%	2.7%	1.3%
Healthcare Cost											
Actual	185,562,600	9,578,352	175,984,247	7,134,286	34,338,731	8,966,564	33,168,664	9,496,397	52,655,026	12,576,143	17,648,537
Budget	190,649,234	10,330,043	180,319,192	7,776,176	36,453,063	9,659,212	32,144,756	9,256,775	54,655,508	12,971,760	17,501,941
Variance - Favorable / (Unfavorable)	5,086,635	751,690	4,334,944	641,891	2,114,331	692,648	(1,023,908)	(239,622)	2,000,483	395,617	(146,596)
% Variance - Fav / (Unfav)	2.7%	7.3%	2.4%	8.3%	5.8%	6.2%	-3.2%	-2.6%	3.7%	3.0%	-0.8%
Managed Care Administration											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2019		12										
3	*(For Internal Management Purposes Only)*		ok										
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
56	Actual		19,405,538	5,941,543	13,463,994	767,168	2,645,452	748,049	2,310,298	718,861	4,372,401	759,739	1,142,238
59	Budget		20,585,764	6,967,929	13,617,834	579,053	2,717,287	798,312	2,319,936	709,287	4,594,528	609,923	1,089,510
60	Variance - Favorable / (Unfavorable)		1,180,226	1,026,386	153,840	(188,105)	71,834	50,262	9,640	(9,574)	222,127	60,184	(52,728)
61	% Variance - Fav / (Unfav)		5.7%	14.7%	1.1%	-32.5%	2.6%	6.3%	0.4%	-1.3%	4.8%	8.2%	-4.8%
62													
63	Total Contract Cost												
64	Actual		204,988,137	15,519,895	189,448,242	7,901,444	36,984,183	9,714,614	35,476,860	10,215,058	57,027,427	13,335,882	18,790,775
65	Budget		211,234,998	17,297,972	193,937,026	8,355,229	39,170,349	10,857,524	34,464,692	9,966,062	59,250,036	13,781,683	18,591,451
66	Variance - Favorable / (Unfavorable)		6,266,861	1,778,076	4,488,785	453,785	2,186,166	842,910	(1,014,168)	(248,996)	2,222,610	445,801	(199,324)
67	% Variance - Fav / (Unfav)		3.0%	10.3%	2.3%	5.4%	5.6%	8.2%	-2.9%	-2.5%	3.8%	3.2%	-1.1%
68													
69	Net before Settlement												
70	Actual		(424,440)	94,274	(518,715)	(282,120)	354,756	196,101	(380,653)	(136,997)	816,814	(456,221)	(651,395)
71	Budget		(7,166,149)	(55,933)	(7,110,216)	(958,862)	(1,974,211)	(369,295)	(181,589)	(213,701)	(1,484,926)	(1,240,713)	(888,029)
72	Variance - Favorable / (Unfavorable)		6,741,708	150,208	6,591,501	696,732	2,328,967	564,396	(199,064)	77,704	2,301,841	784,492	36,633
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 9/30/2019			12									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Bertien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	**Healthy Michigan Plan**			HCC%	9.6%	13.8%	7.0%	12.2%	11.0%	6.6%	7.4%	10.0%	6.7%
76	Contract Revenue		33,222,453	8,251,621	24,970,832	1,229,855	5,107,343	1,180,113	4,568,865	1,479,748	7,012,376	1,929,976	2,474,556
77													
78	External Provider Cost		16,514,972	6,045,469	10,469,503	561,662	1,516,700	865,376	2,209,954	329,308	3,714,622	650,446	622,439
79	Internal Program Cost		8,636,068	-	8,636,068	715,641	1,549,074	605,133	2,572,498	424,891	1,087,619	886,997	784,215
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	Total Healthcare Cost		25,151,041	6,045,469	19,105,571	1,277,304	3,064,773	1,470,509	4,782,452	754,197	4,802,240	1,547,442	1,406,654
82	*(Medical Loss Ratio (HCC % of Revenue)*		75.7%	73.3%	76.5%	103.9%	60.0%	124.6%	105.0%	51.0%	68.5%	80.2%	56.8%
83													
84	Managed Care Administration		2,311,142	841,520	1,469,622	137,350	236,110	122,679	333,113	57,076	398,771	93,483	91,041
85	Admin Cost Ratio (MCA % of Total Cost)		6.4%	9.1%	5.4%	9.7%	7.2%	7.7%	6.5%	7.0%	7.7%	5.7%	6.1%
86													
87	Contract Cost		27,462,183	6,886,989	20,575,194	1,414,654	3,300,883	1,593,188	5,115,565	811,273	5,201,012	1,640,925	1,497,695
88	Net before Settlement		5,760,270	1,364,632	4,395,638	(184,799)	1,806,460	(413,075)	(558,700)	668,476	1,811,365	289,051	976,861
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(3,046,482)	1,349,156	(4,395,638)	184,799	(1,806,460)	413,075	558,700	(668,476)	(1,811,365)	(289,051)	(976,861)
93	Net after Settlement		2,713,788	2,713,788	-	-	-	-	-	-	-	-	-
94													
96	Eligibles and PMPM												
96	Average Eligibles		49,641	49,641	49,641	2,474	10,164	2,376	8,977	2,961	13,902	3,840	4,949
97	Revenue PMPM		$ 55.77	$ 13.85	$ 41.92	$ 41.43	$ 41.87	$ 41.41	$ 42.30	$ 41.65	$ 42.03	$ 41.89	$ 41.67
98	Expense PMPM		46.10	11.56	34.54	47.66	27.06	55.91	47.48	22.63	31.16	35.61	25.22
99	Margin PMPM		$ 9.67	$ 2.29	$ 7.38	$ (6.23)	$ 14.81	$ (14.50)	$ (5.19)	$ 18.81	$ 10.86	$ 6.27	$ 16.45
100													
101	**Healthy Michigan Plan**												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
106	Actual		49,641	49,641	49,641	2,474	10,164	2,375	8,977	2,961	13,902	3,840	4,949
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		(1,929)	(1,929)	(1,929)	(38)	(246)	(56)	(192)	(14)	(1,150)	(77)	(154)
108	% Variance - Fav / (Unfav)		-3.7%	-3.7%	-3.7%	-1.5%	-2.4%	-2.3%	-2.1%	-0.5%	-7.6%	-2.0%	-3.0%
109													
110	Contract Revenue before settlement												
111	Actual		33,222,453	8,251,621	24,970,832	1,229,855	5,107,343	1,180,113	4,568,865	1,479,748	7,012,376	1,929,976	2,474,556
112	Budget		29,027,015	5,015,199	24,010,816	1,159,255	4,844,554	1,125,226	4,286,564	1,368,310	7,049,612	1,816,861	2,350,433
113	Variance - Favorable / (Unfavorable)		4,195,437	3,235,422	960,016	70,600	262,789	54,885	280,301	111,438	(37,235)	113,115	124,123
114	% Variance - Fav / (Unfav)		14.5%	64.5%	4.0%	6.1%	5.4%	4.9%	6.1%	8.1%	-0.5%	6.2%	5.3%
115													
116	Healthcare Cost												
117	Actual		25,151,041	6,045,469	19,105,571	1,277,304	3,064,773	1,470,509	4,782,452	754,197	4,802,240	1,547,442	1,406,654
118	Budget		25,127,724	5,813,027	19,314,697	1,380,764	2,888,453	1,265,829	4,763,800	982,435	5,128,279	1,166,313	1,739,834
119	Variance - Favorable / (Unfavorable)		(23,317)	(232,443)	209,126	103,460	(176,320)	(204,679)	(18,652)	228,238	326,039	(382,129)	333,180
120	% Variance - Fav / (Unfav)		-0.1%	-4.0%	1.1%	7.5%	-6.1%	-16.2%	-0.4%	23.2%	6.4%	-32.8%	19.2%
121													
122	Managed Care Administration												
125	Actual		2,311,142	841,520	1,469,622	137,350	236,110	122,679	333,113	57,076	398,771	93,483	91,041
124	Budget		2,405,657	950,562	1,455,095	102,818	215,311	105,712	348,811	75,278	431,101	72,759	108,306
125	Variance - Favorable / (Unfavorable)		94,515	109,042	(14,527)	(34,532)	(20,799)	(16,967)	10,698	18,202	32,329	(20,724)	17,265
126	% Variance - Fav / (Unfav)		3.9%	11.5%	-1.0%	-33.6%	-9.7%	-16.1%	3.1%	24.2%	7.5%	-28.5%	15.9%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 6/30/2019			12									
3	*(For Internal Management Purposes Only)*			OK									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Barrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CSN/HSAS	St Joseph CMHA	Van Buren MHA
5													
127													
128	Total Contract Cost												
129	Actual		27,462,183	6,886,869	20,575,194	1,414,654	3,300,883	1,590,168	5,115,565	811,273	5,201,012	1,640,926	1,497,695
130	Budget		27,533,381	6,763,588	20,769,793	1,483,571	3,103,766	1,371,542	5,107,611	1,057,712	5,559,379	1,238,072	1,848,141
131	Variance - Favorable / (Unfavorable)		71,196	(123,401)	194,599	68,918	(197,119)	(221,646)	(7,954)	246,440	358,368	(402,853)	350,446
132	% Variance - Fav / (Unfav)		0.3%	-1.8%	0.9%	4.6%	-6.4%	-16.2%	-0.2%	23.3%	6.4%	-32.5%	19.0%
133													
134	Net before Settlement												
135	Actual		5,760,270	1,364,632	4,395,638	(184,799)	1,808,460	(413,076)	(556,700)	688,476	1,811,365	289,051	976,851
136	Budget		1,493,634	(1,747,389)	3,241,023	(324,316)	1,740,739	(246,314)	(811,047)	310,598	1,490,232	578,789	502,292
137	Variance - Favorable / (Unfavorable)		4,266,636	3,112,021	1,154,615	139,518	65,670	(166,761)	252,347	357,878	321,132	(289,738)	474,559
138													
139		x											

Southwest Michigan Behavioral Health

For the Fiscal YTD Period Ended 9/30/2019

(For Internal Management Purposes Only)

Mos in Period: 12

OK

INCOME STATEMENT

	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
			7.6%	5.9%	9.9%	8.7%	7.2%	3.9%	6.4%	8.7%	10.6%
Autism Specialty Services		HCC%									
Contract Revenue	12,003,180	30,425	11,972,755	622,172	2,226,064	653,450	2,183,958	609,353	3,523,261	971,251	1,192,307
External Provider Cost	14,464,684	-	14,464,684	4,230	4,249,998	1,026,787	1,432,281	436,980	4,192,906	872,811	2,246,666
Internal Program Cost	2,414,688	-	2,414,688	544,478	2,477	26,332	1,693,171	3,989	-	12,276	131,963
Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-
Total Healthcare Cost	16,879,372	-	16,879,372	548,708	4,252,470	1,055,119	3,125,452	440,979	4,192,906	885,089	2,378,649
Medical Loss Ratio (HCC % of Revenue)	140.6%	0.0%	141.0%	88.2%	191.0%	161.5%	143.1%	72.6%	119.0%	91.1%	199.5%
Managed Care Administration	1,846,660	564,761	1,281,300	59,003	327,610	89,025	217,698	33,372	348,173	53,469	163,949
Admin Cost Ratio (MCA % of Total Cost)	9.9%	3.0%	8.8%	9.7%	7.1%	7.7%	6.5%	7.0%	7.7%	5.7%	6.1%
Contract Cost	18,726,432	564,761	18,160,671	607,711	4,580,080	1,143,144	3,343,149	474,351	4,541,079	938,559	2,532,598
Net before Settlement	(6,722,252)	(534,336)	(6,187,916)	14,461	(2,354,076)	(489,694)	(1,159,192)	126,002	(1,017,819)	32,692	(1,340,292)
Contract Settlement / Redistribution	6,722,252	534,336	6,187,916	(14,461)	2,354,076	489,694	1,159,192	(126,002)	1,017,819	(32,692)	1,340,292
Net after Settlement	-	0	-	-	-	-	-	-	-	-	-
			0.2%	0.3%	0.4%	0.4%	0.0%	0.5%	0.0%	0.7%	0.2%
SUD Block Grant Treatment		HCC%									
Contract Revenue	9,533,786	8,194,646	1,339,140	91,443	475,006	42,960	-	147,834	271,161	191,262	119,674
External Provider Cost	5,914,734	5,914,734	-	-	-	-	-	-	-	-	-
Internal Program Cost	465,926	-	465,926	27,278	185,870	42,454	-	57,092	4,814	108,445	39,972
Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-
Total Healthcare Cost	6,380,660	5,914,734	465,926	27,278	185,870	42,454	-	57,092	4,814	108,445	39,972
Medical Loss Ratio (HCC % of Revenue)	66.9%	72.2%	34.8%	29.8%	39.1%	98.8%	0.0%	38.7%	1.8%	56.7%	33.4%
Managed Care Administration	(232,138)	(232,138)	-	-	-	-	-	-	-	-	-
Admin Cost Ratio (MCA % of Total Cost)	-3.8%	-3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Contract Cost	6,148,522	5,682,596	465,926	27,278	185,870	42,454	-	57,092	4,814	108,445	39,972
Net before Settlement	3,385,264	2,512,050	873,214	64,165	289,136	506	-	90,642	266,347	82,817	79,702
Contract Settlement	(1,876,545)	(1,003,331)	(873,214)	(64,165)	(289,136)	(506)	-	(90,642)	(266,347)	(82,817)	(79,702)
Net after Settlement	1,508,719	1,508,719	-	-	-	-	-	-	-	-	-

	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 6/30/2019			12									
3	*(For Internal Management Purposes Only)*			ok									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		258,803,805	32,055,212	226,748,594	9,557,892	45,113,292	11,755,410	41,706,315	12,301,463	83,466,220	15,936,060	21,909,952
178	Incentive Payment Revenue		499,309	36,649	463,660	24,902	34,000	31,828	130,715	5,343	184,819	36,090	15,964
179	Contract Revenue		259,303,115	32,090,861	227,212,254	9,582,794	45,147,292	11,787,238	41,839,030	12,306,796	83,651,039	15,972,150	21,925,916
180													
181	External Provider Cost		166,254,862	15,204,694	150,050,168	4,594,325	30,199,928	8,354,050	27,081,729	7,045,229	53,397,678	9,375,109	13,002,221
182	Internal Program Cost		80,426,059	-	80,426,059	4,452,504	11,889,809	3,232,511	14,209,726	3,717,701	8,585,224	5,774,345	8,566,239
183	SSI Reimb, 1st/3rd Party Cost Offset		(1,043,111)	-	(1,043,111)	(59,254)	(247,892)	(51,916)	(214,866)	(14,286)	(327,616)	(32,335)	(94,847)
184	Insurance Provider Assessment Withhold (IPA)		6,037,174	6,037,174	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		295,666	295,666	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		233,973,572	21,539,566	212,436,116	8,987,575	41,841,845	11,534,646	41,076,468	10,748,665	61,654,986	15,117,119	21,473,612
187	Medical Loss Ratio (HCC % of Revenue)		90.2%	67.1%	93.5%	93.8%	92.7%	97.8%	98.2%	87.3%	89.8%	94.6%	97.9%
188													
189	Managed Care Administration		23,330,602	7,116,686	16,214,916	963,511	3,209,172	968,754	2,861,106	809,109	6,118,346	906,691	1,387,228
190	Admin Cost Ratio (MCA % of Total Cost)		9.1%	2.5%	6.3%	9.7%	7.1%	7.7%	6.5%	7.0%	7.7%	5.7%	6.1%
191													
192	Contract Cost		257,304,274	28,656,241	228,650,033	9,951,087	45,051,017	12,493,399	43,937,574	11,557,774	66,774,332	16,023,810	22,861,040
193	Net before Settlement		1,998,841	3,436,620	(1,437,779)	(368,293)	96,275	(706,162)	(2,098,544)	749,022	1,876,707	(51,660)	(935,124)
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(1,876,545)	(3,314,324)	1,437,779	368,293	(96,275)	706,162	2,098,544	(749,022)	(1,876,707)	51,660	935,124
198	Net after Settlement		122,296	122,296	0	0	0	(0)	0	-	0	0	(0)
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 9/30/2019			12									
3	(For Internal Management Purposes Only)			OR									
4	**INCOME STATEMENT**	Total SWMBH	SWMBH Central		CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
201	**State General Fund Services**			HCC%	4.8%	3.2%	4.0%	4.5%	5.9%	5.2%	5.4%	2.8%	4.1%
202	Contract Revenue				10,717,271	536,179	1,830,178	622,469	2,079,572	628,648	3,504,657	445,241	970,327
203													
204	External Provider Cost				4,001,316	71,074	507,714	190,855	570,805	310,549	2,032,241	245,550	72,433
205	Internal Program Cost				6,715,732	229,017	1,221,292	358,721	2,007,312	283,374	1,624,937	151,321	839,708
206	SSI Reimb, 1st/3rd Party Cost Offset				(160,028)	-	-	-	-	-	(160,026)	-	-
207	Total Healthcare Cost				10,557,021	300,091	1,729,006	549,577	2,578,217	593,918	3,497,201	396,871	912,142
208	Medical Loss Ratio (HCC % of Revenue)				98.5%	55.0%	94.5%	88.3%	124.0%	94.5%	97.0%	89.1%	94.0%
209													
210	Managed Care Administration				896,090	36,035	148,508	51,030	158,958	49,515	320,261	26,301	65,492
211	Admin Cost Ratio (MCA % of Total Cost)				7.8%	10.7%	7.9%	8.5%	7.2%	7.7%	8.4%	6.2%	6.7%
212													
213	Contract Cost				11,453,110	336,126	1,877,513	600,607	2,777,174	643,432	3,817,461	423,172	977,634
214	Net before Settlement				(735,839)	200,053	(47,335)	21,862	(697,602)	(14,784)	(212,804)	22,069	(7,297)
215													
216	Other Redistributions of State GF				(283,984)	(4)	-	-	(123,474)	-	(123,368)	-	(37,138)
217	Contract Settlement				(205,672)	(194,190)	-	(11,482)	-	-	-	-	-
218	Net after Settlement				(1,225,495)	5,858	(47,335)	10,380	(821,077)	(14,784)	(336,172)	22,069	(44,435)
219													

77

CMHSP's Variances from Interim Reporting

Medicaid*	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren	Total
Final (2/28/20)	(262,119.55)	354,755.66	196,101.09	(380,652.60)	(135,997.05)	816,814.34	(456,221.17)	(651,395.43)	(518,714.72)
Interim (11/12/19)	(158,742.11)	334,549.27	327,477.06	1,665,855.93	138,637.44	478,368.43	(582,016.25)	(605,065.35)	1,599,064.42
Net Change	(103,377.44)	20,206.39	(131,375.98)	(2,046,508.53)	(274,634.49)	338,445.91	125,795.07	(46,330.08)	**(2,117,779.14)**

Autism*	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren	Total
Final (2/28/20)	14,461.21	(2,354,076.49)	(489,693.67)	(1,159,191.50)	126,002.38	(1,017,818.70)	32,692.30	(1,340,291.75)	(6,187,916.22)
Interim (11/12/19)	993.44	(2,354,175.97)	(490,246.36)	(980,163.69)	33,639.00	(1,158,048.85)	52,193.76	(1,340,407.45)	(6,236,216.12)
Net Change	13,467.77	99.48	552.69	(179,027.81)	92,363.38	140,230.15	(19,501.46)	115.70	**48,299.90**

**Net Revenue and Expenses Reported*

	E	H	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**		Mos in Period								
2	For the Fiscal YTD Period Ended 1/31/2020	P04FYTD20	4								
3	(For Internal Management Purposes Only)										
4	**INCOME STATEMENT**	TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ABC Activities	Indirect Pooled Cost
5											
7	**REVENUE**										
16	Contract Revenue	53,149,718	37,941,086	10,611,394	5,574,561	1,194,836	2,428,057	199,775	-	-	-
17	DHHS Incentive Payments	301,609	301,609	-	-	-	-	-	-	-	-
18	Grants and Earned Contracts	502,788	-	-	-	-	502,788	-	-	-	-
19	Interest Income - Working Capital	69,845	-	-	-	-	-	-	69,845	-	-
20	Interest Income - ISF Risk Reserve	2,657	-	-	-	-	-	-	2,657	-	-
21	Local Funds Contributions	575,397	-	-	-	-	-	-	575,397	-	-
22	Other Local Income	64,167	-	-	-	-	-	-	64,167	-	-
23											
24	**TOTAL REVENUE**	89,876,181	68,242,695	10,611,394	5,574,561	1,194,836	2,930,845	199,775	721,886	-	-
25											
26	**EXPENSE**										
27	Healthcare Cost										
28	Provider Claims Cost	7,660,921	1,624,657	2,013,668	-	1,098,763	2,587,172	477,062	-	-	-
29	CMHP Subcontracts, net of 1st & 3rd party	73,350,913	60,085,812	6,844,812	5,694,919	508,046	226,429	-	-	-	-
30	Insurance Provider Assessment Withheld (IPA)	930,419	930,419	-	-	-	-	-	-	-	-
32	MHL Cost in Excess of Medicare FFS Cost	-	498,443	-	-	(498,443)	-	-	-		
33											
34	Total Healthcare Cost	81,942,256	63,039,530	8,857,680	5,694,919	1,108,366	2,783,601	477,062	-	-	-
35	Medical Loss Ratio (MCC % of Revenue)	92.8%	92.4%	83.5%	102.1%	92.8%	113.6%	239.0%			
36											
37	Administrative Cost										
38	Purchased Professional Services	221,137	-	-	-	-	-	-	221,137	-	-
39	Administrative and Other Cost	2,264,036	-	-	-	-	-	-	2,263,974	-	62
41	Depreciation	34,928	-	-	-	-	-	-	34,928	-	-
42	Functional Cost Reclassification	-	-	-	-	-	88,286	-	(88,286)	-	-
43	Allocated Indirect Pooled Cost	(0)	-	-	-	-	-	-	62	-	(62)
44	Delegated Managed Care Admin	5,491,778	4,526,992	502,919	424,584	37,303	-	-	-	-	-
46	Apportioned Central Mgd Care Admin	0	1,845,732	265,364	170,695	46,167	85,437	-	(2,415,395)	-	-
48											
47	Total Administrative Cost	8,011,876	6,372,723	768,283	595,179	83,470	173,722	-	16,608	-	-
48	Admin Cost Ratio (MCA % of Total Cost)	8.9%	9.2%	8.0%	9.5%	7.2%	5.9%	0.0%	2.7%		
49											
50	Local Funds Contribution	575,397	-	-	-	-	-	-	575,397	-	-
51											
52	**TOTAL COST after apportionment**	90,529,531	69,412,253	9,625,963	6,289,999	1,194,836	2,957,323	477,062	591,905	-	-
53											
54	**NET SURPLUS before settlement**	(653,350)	(1,169,346)	1,185,231	(715,428)	-	(6,476)	(277,287)	129,981	-	-
55	Net Surplus (Deficit) % of Revenue	-1.0%	-1.7%	11.0%	-12.8%	0.0%	-0.2%	-138.8%	18.0%		
56											
57	Prior Year Savings	-	-	-	-	-	-	-	-		
58	Change in PA2 Fund Balance	283,766	-	-	-	-	-	283,766	-		
59	ISF Risk Reserve Abatement (Funding)	(2,657)	-	-	-	-	-	-	(2,657)		
60	ISF Risk Reserve Deficit (Funding)	699,545	699,545	-	-	-	-	-	-		
61	Settlement Receivable / (Payable)	-	469,803	(1,185,231)	715,428	-	6,476	(6,476)	-		
62	**NET SURPLUS (DEFICIT)**	127,303	-	-	-	-	-	-	127,303	-	-
63	HMP & Autism is settled with Medicaid										
64											
65	SUMMARY OF NET SURPLUS (DEFICIT)										
66	Prior Year Unspent Savings	-	-	-	-	-	-	-	-		
67	Current Year Savings	-	-	-	-	-	-	-	-		
68	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-		
69	Local and Other Funds Surplus/(Deficit)	127,303	-	-	-	-	-	-	127,303	-	-
70											
71	**NET SURPLUS (DEFICIT)**	127,303	-	-	-	-	-	-	127,303	-	-
72											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	***Medicaid Specialty Services***			HCC%	78.4%	74.2%	75.9%	79.5%	74.1%	80.3%	81.5%	85.7%	77.4%
7	Subcontract Revenue		67,941,066	4,329,816	63,611,250	2,669,467	12,321,924	3,455,106	11,587,798	3,494,582	19,697,176	4,348,066	6,128,160
8	Incentive Payment Revenue		301,839	166,907	132,932	13,767	9,531	7,942	38,123	2,118	53,773	-	2,647
9	Contract Revenue		68,242,905	4,496,723	63,744,182	2,672,234	12,331,456	3,463,049	11,625,912	3,496,700	19,695,949	4,348,066	6,130,788
10													
11	External Provider Cost		45,511,342	1,524,857	43,986,486	1,488,019	8,737,896	2,237,297	7,276,256	2,088,452	15,845,908	3,299,169	3,283,689
12	Internal Program Cost		16,888,547	-	16,888,547	963,235	3,407,984	909,023	3,461,773	1,049,223	3,006,491	1,570,997	2,526,822
13	SSI Reimb, 1st/3rd Party Cost Offset		(280,061)	-	(280,061)	(6,790)	(51,317)	(15,993)	(68,379)	(2,861)	(101,888)	(7,806)	(25,016)
14	Insurance Provider Assessment Withhold (IPA)		930,419	930,419	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(47,906)	(47,906)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		63,000,341	2,407,369	60,592,972	2,384,463	12,094,364	3,130,417	10,669,650	3,134,815	18,549,411	4,862,357	5,767,494
17	Medical Loss Ratio (HCC % of Revenue)		92.3%	53.5%	95.1%	89.2%	98.1%	90.4%	91.8%	89.7%	94.2%	111.8%	94.1%
18													
19	Managed Care Administration		5,410,026	1,845,732	4,564,295	173,163	366,575	272,864	683,890	276,205	1,583,269	314,070	362,550
20	Admin Cost Ratio (MCA % of Total Cost)		8.2%	2.7%	8.8%	8.8%	6.7%	8.0%	6.0%	8.2%	7.9%	6.1%	6.2%
21													
22	Contract Cost		68,410,367	4,253,101	65,157,267	2,557,646	12,460,939	3,403,071	11,353,540	3,413,119	20,142,680	5,176,427	6,130,044
23	Net before Settlement		(1,167,462)	245,622	(1,413,084)	114,588	(629,484)	59,978	252,572	83,581	(446,731)	(828,341)	(19,247)
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		469,803	(943,231)	1,413,084	(114,588)	629,484	(59,978)	(252,572)	(83,581)	446,731	828,341	19,247
28	Net after Settlement		(697,659)	(697,659)	(0)	-	-	-	-	-	-	-	-
29													
30	Eligibles and PMPM												
31	Average Eligibles		146,760	146,760	146,760	7,497	26,380	8,134	27,781	8,703	38,566	12,177	15,520
32	Revenue PMPM	$	116.25	$ 7.66	$ 108.59	$ 89.11	$ 108.83	$ 106.44	$ 104.44	$ 100.45	$ 127.87	$ 89.27	$ 98.78
33	Expense PMPM	$	118.24	$ 7.24	$ 110.99	$ 85.29	$ 114.17	$ 104.59	$ 102.17	$ 98.04	$ 130.57	$ 106.27	$ 99.07
34	Margin PMPM	$	(1.99)	$ 0.42	$ (2.41)	$ 3.82	$ (5.55)	$ 1.84	$ 2.27	$ 2.40	$ (2.90)	$ (17.01)	$ (0.31)
35													
36	***Medicaid Specialty Services***												
37	Budget v Actual												
38													
39	Eligible Lives (Average Eligibles)												
40	Actual		146,760	146,760	146,760	7,497	26,380	8,134	27,781	8,703	38,566	12,177	15,520
41	Budget		148,407	148,407	148,407	7,521	26,972	8,437	27,913	8,660	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		(1,647)	(1,647)	(1,647)	(24)	(592)	(303)	(132)	153	(555)	(45)	(149)
43	% Variance - Fav / (Unfav)		-1.1%	-1.1%	-1.1%	-0.3%	-2.2%	-3.6%	-0.5%	1.8%	-1.4%	-0.4%	-1.0%
44													
45	Contract Revenue before settlement												
46	Actual		68,242,905	4,496,723	63,744,182	2,672,234	12,331,455	3,463,049	11,625,912	3,496,700	19,695,949	4,348,066	6,130,788
47	Budget		68,022,950	5,747,346	62,275,604	2,465,459	12,398,713	3,329,743	11,427,701	3,250,787	19,255,070	4,180,323	5,967,807
48	Variance - Favorable / (Unfavorable)		219,956	(1,248,623)	1,468,578	206,775	(67,258)	133,306	176,211	245,913	440,879	167,762	162,980
49	% Variance - Fav / (Unfav)		0.3%	-21.7%	2.4%	8.4%	-0.5%	4.0%	1.6%	7.6%	2.3%	4.0%	2.7%
50													
51	Healthcare Cost												
52	Actual		63,000,341	2,407,369	60,592,972	2,384,463	12,094,364	3,130,417	10,669,650	3,134,815	18,549,411	4,862,357	5,767,494
53	Budget		63,549,745	3,443,248	60,106,497	2,592,059	12,151,021	3,186,404	10,714,919	3,085,592	18,218,503	4,323,920	5,833,980
54	Variance - Favorable / (Unfavorable)		549,404	1,035,878	(486,575)	207,595	56,657	55,987	45,269	(49,223)	(330,908)	(538,437)	66,486
55	% Variance - Fav / (Unfav)		0.9%	30.1%	-0.8%	8.0%	0.5%	1.8%	0.4%	-1.6%	-1.8%	-12.5%	1.1%
56													
57	Managed Care Administration												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			ok									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Region CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
58	Actual		6,410,026	1,845,732	4,564,295	173,183	866,975	272,854	668,690	278,306	1,593,269	314,070	382,650
59	Budget		6,861,921	2,322,643	4,539,278	193,018	905,762	266,104	779,312	236,429	1,631,509	269,974	368,170
60	Variance - Favorable / (Unfavorable)		451,895	476,912	(25,017)	19,835	39,187	(6,550)	89,622	(41,876)	(61,759)	(44,095)	(18,360)
61	% Variance - Fav / (Unfav)		6.6%	20.5%	-0.6%	10.3%	4.3%	-2.5%	11.5%	-17.7%	-4.0%	-16.3%	-5.3%
62													
63	Total Contract Cost												
64	Actual		69,410,387	4,253,101	65,157,287	2,657,648	12,960,939	3,409,071	11,353,340	3,413,119	20,142,660	5,176,427	6,150,044
65	Budget		70,411,666	5,765,991	64,645,675	2,786,076	13,058,763	3,452,508	11,488,231	3,322,021	19,750,012	4,593,894	6,197,150
66	Variance - Favorable / (Unfavorable)		1,001,299	1,512,890	(511,591)	227,430	95,844	49,437	134,891	(91,099)	(392,668)	(582,533)	47,106
67	% Variance - Fav / (Unfav)		1.4%	26.2%	-0.8%	8.2%	0.7%	1.4%	1.2%	-2.7%	-2.0%	-12.7%	0.8%
68													
69	Net before Settlement												
70	Actual		(1,187,462)	246,622	(1,413,084)	114,585	(629,484)	59,978	252,572	83,681	(446,731)	(626,341)	(19,247)
71	Budget		(2,366,716)	(18,644)	(2,370,072)	(319,617)	(658,070)	(122,765)	(60,530)	(71,234)	(484,942)	(413,571)	(229,349)
72	Variance - Favorable / (Unfavorable)		1,221,254	264,267	956,987	434,205	28,586	182,743	313,101	154,914	46,211	(414,770)	210,098
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			of									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	**Healthy Michigan Plan**			HCC%	8.9%	14.2%	8.2%	6.8%	11.7%	6.6%	7.1%	8.6%	8.0%
76	Contract Revenue		10,911,394	1,934,431	8,976,963	427,777	1,954,276	414,500	1,620,539	548,112	2,529,915	716,458	865,364
77													
78	External Provider Cost		5,697,153	2,013,068	3,684,085	209,698	822,503	69,891	817,788	49,050	1,228,486	203,618	282,076
79	Internal Program Cost		3,160,727	-	3,160,727	246,068	640,579	196,447	871,709	206,706	388,417	296,825	313,976
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		8,857,880	2,013,068	6,844,812	455,966	1,463,082	266,139	1,689,475	255,756	1,617,903	500,439	596,051
82	Medical Loss Ratio (HCC % of Revenue)		81.9%	100.7%	76.2%	106.8%	74.8%	64.2%	104.3%	46.7%	64.0%	69.8%	68.9%
83													
84	Managed Care Administration		768,283	265,364	502,919	33,117	104,832	23,160	108,258	22,706	138,967	32,324	39,535
85	Admin Cost Ratio (MCA % of Total Cost)		8.0%	2.8%	5.2%	6.6%	6.7%	8.0%	6.0%	3.2%	7.9%	6.1%	6.2%
86													
87	Contract Cost		9,626,163	2,278,432	7,347,731	489,082	1,567,914	289,319	1,797,735	278,461	1,756,870	532,763	635,587
88	Net before Settlement		1,285,231	(444,001)	1,629,232	(61,305)	386,364	125,182	(177,196)	269,650	773,045	183,695	229,797
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(1,285,231)	444,001	(1,629,232)	61,305	(386,364)	(125,182)	177,196	(269,650)	(773,045)	(183,695)	(229,797)
93	Net after Settlement		0	0	-	-	-	-	-	-	-	-	-
94													
95	Eligibles and PMPM												
96	Average Eligibles		50,260	50,260	50,260	2,436	10,362	2,356	9,022	3,084	14,066	4,004	4,832
97	Revenue PMPM		$ 53.78	$ 9.12	$ 44.65	$ 43.91	$ 44.74	$ 43.99	$ 44.91	$ 44.44	$ 44.97	$ 44.74	$ 43.87
98	Expense PMPM		47.88	11.33	36.55	50.20	37.83	30.70	49.82	22.57	31.23	38.27	32.22
99	Margin PMPM		$ 5.90	$ (2.21)	$ 8.10	$ (6.28)	$ 6.91	$ 13.28	$ (4.91)	$ 21.86	$ 13.74	$ 11.47	$ 11.65
100													
101	**Healthy Michigan Plan**												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
105	Actual		50,260	50,260	50,260	2,436	10,362	2,356	9,022	3,084	14,066	4,004	4,832
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,169	2,976	16,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		(1,310)	(1,310)	(1,310)	(77)	(48)	(75)	(147)	109	(986)	87	(172)
108	% Variance - Fav / (Unfav)		-2.5%	-2.5%	-2.5%	-3.1%	-0.5%	-3.1%	-1.6%	3.7%	-6.6%	2.2%	-3.4%
109													
110	Contract Revenue before settlement												
111	Actual		10,911,394	1,934,431	8,976,963	427,777	1,954,276	414,500	1,620,539	548,112	2,529,915	716,458	865,364
112	Budget		9,675,672	1,872,066	8,003,605	386,418	1,614,851	375,076	1,432,188	466,103	2,349,671	605,620	783,478
113	Variance - Favorable / (Unfavorable)		1,135,722	162,364	973,358	41,358	239,427	39,424	188,351	92,009	180,245	110,838	81,908
114	% Variance - Fav / (Unfav)		11.7%	9.7%	12.2%	10.7%	14.8%	10.5%	13.2%	20.2%	7.7%	18.3%	10.5%
115													
116	Healthcare Cost												
117	Actual		8,857,880	2,013,068	6,844,812	455,966	1,463,082	266,139	1,689,478	255,756	1,617,903	500,439	596,051
118	Budget		8,375,906	1,937,676	6,438,232	460,251	962,818	421,943	1,667,933	327,478	1,709,426	388,438	579,945
119	Variance - Favorable / (Unfavorable)		(481,972)	(75,392)	(406,579)	4,286	(500,265)	155,805	(101,545)	71,722	91,523	(112,001)	(16,106)
120	% Variance - Fav / (Unfav)		-5.8%	-3.9%	-6.3%	0.9%	-52.0%	36.9%	-6.4%	21.9%	5.4%	-28.8%	-2.8%
121													
122	Managed Care Administration												
123	Actual		768,283	265,364	502,919	33,117	104,832	23,160	108,258	22,706	138,967	32,324	39,535
124	Budget		801,886	816,654	485,032	34,273	71,779	35,237	114,604	25,053	143,700	24,253	36,102
125	Variance - Favorable / (Unfavorable)		33,603	51,490	(17,887)	1,156	(33,061)	12,067	6,345	2,347	4,733	(8,071)	(3,433)
126	% Variance - Fav / (Unfav)		4.2%	18.3%	-3.7%	3.4%	-46.1%	34.2%	5.5%	9.5%	3.3%	-33.3%	-9.5%

	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 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			ok									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
127													
128	Total Contract Cost												
129	Actual		9,626,163	2,278,432	7,347,731	489,062	1,567,914	289,319	1,797,795	278,461	1,756,870	582,763	835,587
130	Budget		9,177,794	2,254,529	6,923,264	494,524	1,034,588	457,181	1,702,537	352,571	1,853,126	412,691	616,047
131	Variance - Favorable / (Unfavorable)		(448,369)	(23,903)	(424,467)	5,462	(533,326)	167,862	(95,198)	74,109	96,257	(120,073)	(18,540)
132	% Variance - Fav / (Unfav)		-4.9%	-1.1%	-6.1%	1.1%	-51.5%	36.7%	-5.6%	21.0%	5.2%	-29.1%	-3.2%
133													
134	Net before Settlement												
135	Actual		1,185,231	(444,001)	1,629,232	(81,306)	286,364	125,182	(177,196)	269,850	773,045	169,695	229,797
136	Budget		497,878	(582,463)	1,080,341	(108,106)	580,283	(82,106)	(270,349)	103,633	496,744	192,930	167,431
137	Variance - Favorable / (Unfavorable)		687,353	138,462	548,891	46,800	(293,898)	207,286	93,153	166,118	276,301	(9,235)	62,367
138													
139		X											

83

	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 1/31/2020			4									
3	(For Internal Management Purposes Only)			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
140	***Autism Specialty Services***			HCC%	7.4%	6.1%	19.4%	8.7%	7.3%	6.1%	6.1%	2.7%	9.4%
141	Contract Revenue		5,574,551	(0)	5,574,551	271,489	1,062,959	302,295	1,016,711	288,364	1,639,512	446,690	546,740
142													
143	External Provider Cost		5,016,824	-	5,016,824	-	1,650,928	339,295	677,514	297,788	1,990,246	150,756	670,098
144	Internal Program Cost		678,195	-	678,195	162,483	1,160	2,484	479,629	1,236	-	3,187	28,014
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	Total Healthcare Cost		5,694,819	-	5,694,819	162,483	1,652,088	341,779	1,057,143	299,025	1,990,246	153,943	698,112
147	Medical Loss Ratio (HCC % of Revenue)		102.2%	0.0%	102.2%	59.8%	155.4%	113.1%	104.0%	92.9%	86.6%	34.5%	127.7%
148													
149	Managed Care Administration		595,170	170,605	424,564	11,801	118,374	29,768	67,749	21,220	119,413	9,944	46,305
150	Admin Cost Ratio (MCA % of Total Cost)		9.5%	2.7%	6.7%	6.8%	6.7%	8.0%	6.0%	6.8%	7.9%	6.1%	6.2%
151													
152	Contract Cost		6,289,989	170,605	6,119,383	174,284	1,770,460	371,548	1,124,893	320,246	1,609,660	163,887	744,417
153	Net before Settlement		(715,428)	(170,605)	(544,823)	97,204	(707,501)	(69,342)	(108,171)	28,109	129,852	282,703	(197,677)
154	Contract Settlement / Redistribution		715,428	170,605	544,823	(97,204)	707,501	69,342	108,171	(28,109)	(129,852)	(282,703)	197,677
155	Net after Settlement		-	-	-	-	-	-	-	-	-	-	-
156													
157		X											
158	***SUD Block Grant Treatment***			HCC%	0.8%	0.1%	0.5%	0.8%	0.0%	0.7%	0.0%	0.9%	0.4%
159	Contract Revenue		2,428,057	1,985,010	443,047	39,481	157,869	11,553	-	49,211	90,387	63,754	39,891
160													
161	External Provider Cost		2,537,172	2,537,172	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		226,429	-	226,429	4,582	77,713	31,093	-	29,257	2,639	51,700	29,446
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	Total Healthcare Cost		2,763,601	2,537,172	226,429	4,582	77,713	31,093	-	29,257	2,639	51,700	29,446
165	Medical Loss Ratio (HCC % of Revenue)		113.8%	127.8%	51.1%	11.6%	49.2%	269.1%	0.0%	59.5%	2.9%	81.1%	73.8%
166													
167	Managed Care Administration		(329,066)	(329,066)	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		-13.5%	-13.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	Contract Cost		2,434,536	2,208,106	226,429	4,582	77,713	31,093	-	29,257	2,639	51,700	29,446
171	Net before Settlement		(6,479)	(223,096)	216,617	25,899	79,956	(19,439)	-	(19,955)	(87,748)	(12,054)	(10,445)
172	Contract Settlement		6,479	223,096	(216,617)	(25,899)	(79,956)	19,439	-	(19,955)	(87,748)	(12,054)	(10,445)
173	Net after Settlement		-	-	-	-	-	-	-	-	-	-	-
174													
175		X	-										

	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 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			*OK*									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		86,755,107	8,149,257	78,605,850	3,368,213	15,396,830	4,183,466	14,205,039	4,380,280	29,896,990	5,574,887	7,680,165
178	Incentive Payment Revenue		301,809	168,907	132,902	13,787	9,531	7,942	38,123	2,118	58,773	-	2,647
179	Contract Revenue		87,056,917	8,318,164	78,738,753	3,401,960	15,406,361	4,191,408	14,243,162	4,382,378	29,955,764	5,574,887	7,682,813
180													
181	External Provider Cost		58,762,291	6,075,096	52,687,196	1,647,916	11,211,125	2,646,283	8,671,538	2,376,291	18,295,642	3,663,536	4,215,863
182	Internal Program Cost		20,951,368	-	20,951,368	1,368,362	4,127,437	1,139,047	4,813,110	1,286,422	9,396,647	1,922,709	2,900,257
183	SSI Reimb, 1st/3rd Party Cost Offset		(280,081)	-	(280,081)	(6,790)	(51,317)	(15,908)	(68,379)	(2,881)	(101,938)	(7,806)	(25,016)
184	Insurance Provider Assessment Withhold (IPA)		930,419	930,419	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(47,906)	(47,906)	-	-	-	-	-	-	-	-	-
186	Total Healthcare Cost		80,315,641	6,957,608	73,359,032	3,007,494	15,287,245	3,769,426	13,416,269	3,658,852	27,590,201	5,578,439	7,091,104
187	Medical Loss Ratio (HCC % of Revenue)		92.3%	83.6%	93.2%	88.4%	99.2%	89.9%	94.2%	83.5%	92.0%	99.3%	92.3%
188													
189	Managed Care Administration		7,444,413	1,962,636	5,481,776	218,100	1,089,780	326,592	969,888	322,231	1,861,648	356,338	468,390
190	Admin Cost Ratio (MCA % of Total Cost)		8.5%	22%	6.9%	6.8%	6.7%	8.0%	6.8%	8.1%	7.9%	6.0%	6.2%
191													
192	Contract Cost		87,761,054	8,919,244	78,840,810	3,225,595	16,377,026	4,095,039	14,278,988	3,981,083	29,411,850	5,934,777	7,559,494
193	Net before Settlement		(704,137)	(592,079)	(112,058)	176,366	(970,666)	96,378	(32,796)	401,295	543,914	(349,889)	23,319
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		6,478	(105,580)	112,058	(176,366)	970,666	(96,378)	32,796	(401,295)	(543,914)	349,889	(28,319)
198	Net after Settlement		(697,659)	(697,659)	(0)	0	(0)	(0)	(0)	-	0	(0)	0
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 1/31/2020			4									
3	*(For Internal Management Purposes Only)*			OK									
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
201	***State General Fund Services***			NOC%	5.1%	6.5%	4.1%	4.5%	6.3%	0.3%	5.3%	1.8%	4.9%
202	Contract Revenue				3,684,008	240,738	641,576	229,000	662,628	172,064	1,226,206	198,190	313,612
203													
204	External Provider Cost				1,510,223	78,875	187,266	23,477	187,159	170,263	789,422	61,805	47,877
205	Internal Program Cost				2,472,103	129,062	462,243	146,073	808,586	74,681	479,121	56,559	315,660
206	SSI Reimb, 1st/3rd Party Cost Offset				(81,082)	-	-	-	-	-	(81,082)	-	-
207	Total Healthcare Cost				3,921,244	208,057	649,499	169,550	976,723	244,944	1,201,461	108,374	383,737
208	Medical Loss Ratio (HCC % of Revenue)				106.4%	86.4%	101.2%	74.0%	147.3%	142.3%	98.0%	54.7%	118.0%
209													
210	Managed Care Administration				326,072	16,647	51,771	16,484	69,435	23,739	113,393	7,834	26,869
211	Admin Cost Ratio (MCA % of Total Cost)				7.7%	7.4%	7.4%	8.9%	6.6%	8.8%	8.6%	6.7%	6.9%
212													
213	Contract Cost				4,247,316	224,603	701,270	186,034	1,045,169	268,683	1,314,854	116,208	390,606
214	Net before Settlement				(563,307)	16,133	(59,694)	42,966	(382,533)	(96,619)	(88,648)	81,982	(76,994)
215													
216	Other Redistributions of State GF				(30,808)	-	-	-	-	-	-	-	(30,808)
217	Contract Settlement				(127,866)	(14,956)	-	(40,384)	-	-	-	(72,526)	-
218	Net after Settlement				(721,981)	1,176	(59,694)	2,582	(382,533)	(96,619)	(88,648)	9,456	(107,802)
219													

Southwest Michigan
BEHAVIORAL HEALTH

FY19 Program Integrity & Compliance Program Evaluation

October 1, 2018 – September 30, 2019

03/13/2020

FY19 ROUTINE AUDIT ACTIVITIES

Audit	# Claims reviewed	# Invalid claims	Recoupments	Compliance Rate	Funding Stream
Medicaid Verification	1,860	62	$23,897.58	96.67%	Medicaid claims & encounters (Medicaid, HMP, MI Child)
MI Health Link (Duals) Audit	1,140	51	$2,720.87	95.5%	Claims paid by SWMBH with MI Health Link funds
SUD Coordination of Benefits Audit	120	13	$254.03	89.1%	Medicaid as secondary payor for SUD services
SUD Block Grant – Ability to Pay Audit	240	68	$2,993.05	71.67%	Community Block Grant funds

FY19 Investigations

- Twenty-seven (27) investigations opened by SWMBH PI/C
- Three (3) matters referred to the MI Office of Inspector General (OIG)
- One (1) referral received from the MI OIG for follow-up

Process Improvements Implemented in FY19

- Added SUD specific audits
  - Previously identified limited/minimal oversight of SUD provider billing practices
  - Implemented SUD Coordination of Benefits (COB) and SUD Block Grant Ability to Pay (ATP) audits
- Fully implemented on-going Data Mining
  - Reviewed and worked Overlapping Billing Report monthly
  - Created Place of Service Report
- Autism service reviews
  - Continued quarterly checks of Autism provider billing to ensure the billing modifier issue identified in FY18 was resolved
- Submitted Quarterly OIG Reports
  - Extensive coordination with Participant CMHSPs

Enhanced Regulator Relations

- MDHHS BHDDA
  - Involvement with MDHHS-PIHP contract negotiations on a monthly basis, including negotiating MI OIG Program Oversight related language
- MI OIG
  - Tri-annual meetings with the MI OIG and PIHP Compliance Officers
  - Open lines of communication between PIHP Compliance Officers and OIG
  - MI OIG requests for PIHP Contract language has allowed for more frequent contact and collaboration
- MI Attorney General's Office
  - Open lines of communication

Southwest Michigan
BEHAVIORAL HEALTH

Fiscal Year 2019 Privacy & Security Update

Mila C. Todd, Chief Compliance & Privacy Officer
Natalie Spivak, Chief Information & Security Officer

March 13, 2020

Privacy Officer Overview

Promote and ensure compliance with HIPAA, 42 CFR Part 2, and MI Mental Health Code including:

- Monitoring legal updates;
- Policies & Procedures;
- Staff trainings;
- Business processes surrounding PHI sharing (MIHIN, Standard Consent Form, ICT meeting communications, Record Requests, etc.);
- Responding to subpoenas for records and/or for staff to testify;
- Breach Risk Team Chair

Ensure compliance with other applicable laws that effect privacy (HIV, other communicable disease information, etc.)

Security Officer Overview

- Develop, enforce and maintain SWMBH's Information Security policies, procedures and standards. Conduct annual review of required HIPAA regulations and reports.
- Maintain appropriate security measures and mechanisms to guard against unauthorized access to electronically stored and /or transmitted PHI and protect against reasonably anticipated threats and hazards.
- Oversee and/or assist in performing on-going security monitoring, and recommend new information security technologies and counter-measures against threats to information or privacy.
- Ensure compliance through adequate training programs and periodic security audits (*see associated IT/QAPI Audit/Review Schedule*).

Security Program: Network Penetration Testing

Penetration testing* is the practice of testing a computer system, to find security vulnerabilities that an attacker could exploit.

Vulnerability Index = 0.063 – Low Risk

Results of June 2019 Penetration test:

- Solid firewall protection
- Internet/Web filtering
- Low physical security risk
- Anti-virus up-to-date on each system

4 Security Issues found and resolved

- Final Security Rating 8.5/10 = Secure & Protected

Regular Audits done to keep security practices up-to-date

*Testing performed by OST – Grand Rapids

Privacy Program

Prospective

- Business Associate and/or Qualified Service Organization Agreement execution and tracking
- Data Use Agreement execution and tracking
- Committee Confidentiality Statements
- MDHHS Standard Consent Form
- Training – at hire, annually electronically, annually in-person
  - What is PHI?
  - What are the governing regulations?
  - What is minimum necessary?
  - Where to direct questions/concerns?
- Role-based Training

Retrospective

- Breach Risk Team
- Walk through audits

Breach Risk Team

Responsibilities

- Investigate unauthorized uses/disclosures of PHI as reported/discovered;
- Meet monthly to review and complete a Risk Assessment to assess probability of compromise; and
- Determine if notification is necessary and if so, what kind(s).

Risk Assessment Standard

- 45 CFR 164.402(2) – "Except as provided in paragraph (1) of this definition, an acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment..."

- SWMBH Breach Risk Assessment Tool utilized to assess all reported incidences
  - Tool contains all the assessment factors articulated in 45 CFR 164.402

IS

Breach Risk Team: Standards

Notification Requirements

- Following a breach of unsecured PHI, covered entities must provide notification of the breach to the affected individuals, the Secretary, and, in certain circumstances, to the media.
  - Time constraints depend on the number of individuals affected by the breach;
  - Notification to the Secretary (OCR) is required for all breaches, however, it can be done annually if a breach affects less than 500 individuals.
- Business associates must notify the covered entity if a breach occurs at or by the business associate.
  - SWMBH Business Associate Agreements include provisions requiring Business Associates to promptly report breaches of PHI

Breach Risk Team: FY 2019 Summary

42 Incidents reported for Breach Risk Team review

- Nineteen (19) were determined to be a low probability of compromise and did not require notification;
- Thirteen (13) were determined to fall within and Exception;
- Eight (8) were determined to not be an unauthorized use or disclosure.

Summary of Outcomes – 2 reportable breaches

- Two of the reported incidences required reporting to the Office for Civil Rights (OCR).

Southwest Michigan
BEHAVIORAL HEALTH

Integrated Care

Presented by Moira Kean

SWMBH Board Meeting March 13, 2020

What is Integration?

- A coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.
- Goals
  - to enhance quality of care and quality of life,
  - consumer satisfaction, and
  - system efficiency
  - for patients with complex, long term problems cutting across multiple services, providers and settings.

Kodner and Spreeuwenberg, 2002

What is Care Coordination?

- ***Deliberately organizing consumer care activities*** and sharing information ***among all of the participants concerned with a consumer's care*** to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

Agency for Healthcare Research and Quality (2014)

Why Focus on Integrated Care?

- Life expectancy for persons with Severe Mental Illness (SMI) is 15-25 years shorter than general population
- SWMBH regional analysis found:
  - SMI 2X Hospitalizations and ED visits compared to non-SMI population
  - SMI twice as likely to have chronic health condition (61.3% vs. 29.4%)
  - 70% of Intellectually/Developmentally Disabled (IDD) population have at least one chronic medical condition
- Known negative impacts of Adverse Childhood Experiences (ACEs) on behavioral and physical health
- Known negative impacts of Social Determinants of Health (SDOH) on behavioral and physical health

SAMHSA Standard Framework for Integration

Coordinated		Co-Located		Integrated	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	In separate facilities.	In same facility not necessarily same offices.	In same space within the same facility.	In same space within the same facility (some shared space).	In same space within the same facility, sharing all practice space.

Integrated Care Activities at SWMBH

- Kalamazoo Health Connections (Michigan Health Endowment Fund grant)
- Opioid Health Homes (SUD Block Grant beginning 4/1/20)
- Inpatient Discharge Navigators (Mental Health Block Grant beginning 10/1/20)
- MHP/PIHP Collaborative Workgroup
- PIHP/Medicaid Health Plan Integrated Care Teams (monthly plan-to-plan care coordination on specific enrollees)
- Complex Case Management and Integrated Care Teams for MI Health Link enrollees
- Performance Improvement Project (improving diabetes screening rates for adults who are taking antipsychotics)
- Physical and Behavioral Health Care Coordination Survey

Integrated Care Activities around the Region

- Co-located primary care services within CMH
- FQHC partnerships and bi-directional referrals
- Certified Community Behavioral Health Clinics (CCBHCs) - current and future
- High ED utilizer collaboration with hospital systems
- Pharmacies and labs on-site at CMH
- Crisis Intervention Teams (CITs) and specialty courts
- Homelessness grants, partnerships, and initiatives
- Health information exchanges and log ins with hospital EHR systems
- Screening, Brief Intervention and Referral to Treatment (SBIRT) in Emergency Departments

Integration Challenges

- Relative lack of shared or integrated EHRs; health information available in CC360 is dated and incomplete
- Difficulties surrounding 42 CFR Part 2 and sharing of SUD-related information
- Inadequate incentives for care to be integrated
- Complexity of comorbid conditions and social needs
- Provider shortages; difficulties finding appropriate supports for individuals with multiple morbidities

Common themes for success

- Continuous investment toward cross-system relationship building and collaboration at all levels
- Staff education and buy-in
- Information availability to the right person at the right time
- An ounce of prevention is worth a pound of cure:
  - ACEs
  - Mental health first aid
  - SBIRT
  - Chronic disease prevention and screening
  - Social determinants of health

Thank you

- Questions or comments?

SWMBH FY19 PBIP Distribution

	FY19 Pool	Percentage Earned	*Dollars Earned*
PIHP **Joint**	$ 485,930.32	92.86%	*$ 451,221.01*
PIHP **Only**	$ 1,313,811.61	100.00%	*$ 1,313,811.61*
	$ 1,799,741.93	98.07%	***$ 1,765,032.62***
		SWMBH 10%	*$ 176,503.26*
		CMHs 90%	*$ 1,588,529.36*

Eligibles FY19	MCD	HMP	**Total**	% of Total	Distribute Per CMH
Barry	89,901	29,685	**119,586**	5.1%	$ 80,950.87
Berrien	341,605	121,967	**463,572**	19.8%	$ 313,803.93
Branch	97,024	28,495	**125,519**	5.3%	$ 84,967.07
Calhoun	328,985	107,719	**436,704**	18.6%	$ 295,616.29
Cass	102,246	35,532	**137,778**	5.9%	$ 93,265.51
Kalamazoo	461,667	166,828	**628,495**	26.8%	$ 425,444.60
St Joe	143,786	46,075	**189,861**	8.1%	$ 128,521.85
VanBuren	185,778	59,388	**245,166**	10.4%	$ 165,959.24

Total Eligibles	**1,750,992**	**595,689**	**2,346,681**	100%

Southwest Michigan
BEHAVIORAL HEALTH

Fifth Annual Regional Healthcare Policy Forum

Invitees: Community Mental Health Service Providers

Elected and Appointed State, County, Local Officials

Date: Friday, April 17, 2020

Location: Cityscape Event Centre
125 S. Kalamazoo Mall, Kalamazoo, MI

Panelists:

***Elizabeth Hertel, Chief Deputy Director**
Michigan Department of Health and Human Services

***Mary Whiteford, MI House Representative**
Chair, Health & Human Services Appropriations Subcommittee
Michigan House Representative

***Jeff Patton, Chief Executive Officer**
Integrated Services of Kalamazoo

***Jane Shank, Executive Director**
Association for Children's Mental Health

***Sherri Boyd, Executive Director**
The ARC Michigan

***Jay Rosen, President**
Health Management Associates

Purpose/Objectives
Looking to the Future . . .

- Exploring the Michigan Department of Health and Human Services Proposal and Plans for System Transformation in the Public Behavioral Health Care System
- Assessing the Implications and Ramifications for both Persons Served and Providers

Facilitator: Scott Dzurka, Vice President
Public Sector Consultants

Agenda

8:30--9:00 am	Registration and Continental Breakfast
9:00--9:15 am	Welcome & Introductions Scott Dzurka
9:15—12:00 noon	Discussion & Conversation with Panelists
12:00--12:30 pm	Light Hors D'oeuvres and Conversation

** Photographer Available **

** Parking Discount Vouchers Available **

Registration: https://swmbh-healthcarepolicyforum.eventbrite.com

vs 2/18/20

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting /Retreat

Date: Friday, May 8, 2020

Sherman Lake YMCA Event & Retreat Center

6225 North 39th St. Augusta, MI 49012

Draft Agenda

2/3/20

Objectives:

1) Environmental Scan
2) Implications and Ramifications of Environmental Scan
3) Identify Course of Action for SWMBH Regional Entity

Facilitator: Scott Dzurka, Public Sector Consultants

9:00 am-9:30 am	*Full Breakfast*
9:30 am–10:30 am	SWMBH Board Meeting
10:30 am-10:45 am	*Break*
10:45 am-11:00 am	Board Retreat Welcome, Introductions, and Session Objectives (Scott Dzurka)
11:00 am-12:00 noon	Environmental Scan Elizabeth Hertel, Chief Deputy Director of Administration Michigan Department of Health and Human Services • Overview of the state and regional healthcare policy landscape • MDHHS Reform Objectives, Imperatives, Status, and Process • Questions and Discussion

12:00 pm-12:45 pm	Lunch Break
12:45 pm – 1:30 pm	Alan Bolter, Associate Director Community Mental Health Association of Michigan • Overview of the state and regional healthcare policy landscape • Fiscal Year 2021 Executive Budget Highlights • Questions and Discussion
1:30 pm-2:30 pm	Jay Rosen, President Health Management Services • Overview of the evolving federal and state healthcare policy landscape • State Experiences: Arkansas, Arizona, North Carolina • Views on Specialty Integrated Plans • Questions and Discussion
2:30 pm-3:30 pm	Summary and Next Steps
3:30 pm	Adjourn

* * * * * * *

Participants:

* SWMBH Board and Board Alternates
* CMHSP CEOs
* SWMBH Chief Financial Officer, Chief Compliance & Privacy Officer, Chief Information Officer, Chief Administrative Officer, Director of Quality Assurance and Performance Improvement, Director of Clinical Quality, Director of SUD Services
* SWMBH Consumer Advisory Committee Chair/Vice Chair
* SWMBH Substance Use Disorder Oversight Policy Board Chair/Vice Chair
* NAMI Southwest Michigan

Materials: SAMHSA Strategic Plan FY2019-FY2023

NIHCM Foundation – Mental Health Trends & Future Outlook

FY 2021 Executive Budget Proposal Highlights

MDHHS letter to CMHAM – January 7, 2020

Capitol Line Federal Summary

Batch 3446
Ref 15880

INVOICE

MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE
C/O CMHPSM
3005 Boardwalk Suite 200
Ann Arbor, MI 48108

Invoice No : 7023
Date : 1/15/2020
Customer ID : SWMBH

Bradley
Casemore,
Southwest MI Behavioral Health - Region 4
5250 Lovers Lane
Portage, MI 49002
269-202-8398

Project	Payment Terms	Due Date
MCG Year 2	Due upon receipt	

Quantity	Description	Unit Price	Line Total
1	MCG Year 2	$52,230.72	$ 52,230.72

Received 1/16/2020

Subtotal	$ 52,230.72
	$ -
TOTAL	$ 52,230.72 ✓

Make all checks payable to MICHIGAN CONSORTIUM FOR HEALTHCARE EXCELLENCE.

Attn: Finance Department: Dana Darrow

8110 800

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
August 10, 2018
9:30 am-11:00 am
5250 Lovers Lane, Suite 200, Portage, MI 49002

Members Present: Susan Barnes, Nancy Johnson, Tom Schmelzer, Robert Nelson, Mary Myers, Patrick Garrett, Moses Walker, Tim Carmichael

Absent: Edward Meny, Anthony Heiser

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Director of Operations, SWMBH; Jonathan Gardner, Director of QAPI, SWMBH; Joel Smith, Manager of SUD Treatment and Prevention Services, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; Gale Hackworth, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Karen Lehman, Woodlands Board Alternate; Randall Hazelbaker, Branch County Commissioner; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Jeff Patton, Kalamazoo CMHSP; Kris Kirsch-St. Joseph CMHSP; Jeannie Goodrich, Summit Pointe.

Welcome Guests

Tom Schmelzer called the meeting to order at 9:30 AM and welcomed the group.

Public Comment

None

Agenda Review and Adoption

Motion	Tim Carmichael moved to accept the agenda with the movement of the Utilization Management Statewide Comparison topic to the September Board agenda.
Second	Patrick Garrett
Motion Carried	

Consent Agenda

Motion	Patrick Garrett moved to approve the 7-13-18 SWMBH Board Meeting Minutes.
Second	Mary Myers
Motion Carried	

Operations Committee

Operations Committee Minutes June 27, 2018

Tom Schmelzer asked for comments or questions. Questions were presented and answers were given. Minutes accepted.

Ends Metrics

Michigan Mission Based Performance Indicator System (MMBPIS)

Jonathan Gardner reported as documented.

Board Actions to be Considered

Utilization Management Solution via Michigan Consortium for Healthcare Excellence

Brad Casemore reviewed history, context, and Federal and State requirements regarding Utilization Management parity.

Motion Moses Walker moved that the EO may commit the objectively determined SWMBH share of MCG utilization management solution, subject to a contract satisfactory to him which is consistent with Board Executive Limitations. This approval shall apply to the duration of the MCG contract.

Second Patrick Garrett

Motion Carried

Motion Robert Nelson moved to amend the previous motion stating that the EO may commit the objectively determined SWMBH share of MCG utilization management solution, subject to a contract satisfactory to him which is consistent with Board Executive Limitations. This approval shall apply to the duration of the MCG contract and will be reviewed by the Board annually.

Second Susan Barnes

Motion Carried

Board Policy Review

BG-002 Management Delegation

Tom Schmelzer reviewed the policy.

Motion Susan Barnes moved that the Board is in compliance and the policy does not need any revision.

Second Mary Myers

Motion Carried

Executive Limitations Review

EO-003 Emergency Executive Officer Succession

Brad Casemore asked the Board for a 60 day extension to name additional emergency executive officer successors.

Motion Tim Carmichael moved that the Board grant Brad Casemore a 60 day extension to name additional emergency officer successors.

Second Robert Nelson

Motion Carried

Board Education

Fiscal Year 2019 Budget Preview

Tracy Dawson reported as documented.

Utilization Management Modernization Status
Anne Wickham reported status of the Implementation Workgroup and sub-workgroups regarding eligibility, access, processes, and level of care guidelines. Timelines and revisions are being determined.

Substance Abuse Disorder Treatment and Prevention Update
Joel Smith reported as presented.

Substance Use Disorder Oversight Policy Board (SUDOPB)
Randall Hazelbaker presented highlights from the last quarter's SUDOPB meetings.

Communication and Counsel to the Board

Consolidated Fiscal Year 2018 Year to Date Financial Statements 6/30/18
Tracy Dawson reported as documented.

Agency Vehicle
Tracy Dawson stated that the SWMBH company vehicle hit 93,200 miles and was at a point and best, most cost effective time, to trade in for a new vehicle.

Michigan Department of Corrections Community Based Substance Used Disorder Services Benefits Management Contract
Brad Casemore reported that the Michigan Department of Corrections Community Based Substance Used Disorder Services Benefits Management Contract is in negotiations with the final contract negotiation scheduled for September 20, 2018.

St. Joe Community Mental Health and Substance Abuse Services Freedom of Information Act
Mila Todd reported that SWMBH has responded to a subpoena and FOIA requests regarding the O'dell vs. St Joe CMH litigation. If the case goes to trial and SWMBH staff are called to testify, or are deposed, the SWMBH attorney would be present.

Erv Brinker Update
Brad Casemore stated that Erv Brinker is scheduled to be released from State prison on September 11, 2018. If the media attempts contact/inquiries with anyone regarding this please refer the media to Brad Casemore.

Lakeshore Regional Entity

Brad Casemore shared that Lakeshore Regional Entity issued a RFP for Managed Care Functions and Beacon Health Systems was awarded the RFP; they are in contract negotiations.

Annual Formal Fiduciary Retirement Reviews

Brad Casemore shared that SWMBH staff and Rose Street Advisors completed the annual fiduciary review of retirement plans and that Rose Street Advisors will attend and present at an upcoming Board meeting.

Board Member Attendance Roster

Brad Casemore reported as documented.

Public Comment

None

Adjournment

Motion Susan Barnes moved to adjourn at 11:00 AM.
Second Patrick Garrett
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
October 12, 2018
9:30 am-11:00 am
5250 Lovers Lane, Suite 200, Portage, MI 49002

Members Present: Tom Schmelzer, Edward Meny, Susan Barnes, Robert Nelson, Mary Myers, Moses Walker, Patrick Garrett, Timothy Carmichael

Absent: Anthony Heiser

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Jonathan Gardner, Director of QAPI, SWMBH; Rhea Freitag, Behavioral Health Waiver & Clinical Quality Manager, SWMBH; Moira Kean Director of Clinical Improvement, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Jeannie Goodrich, Summit Pointe; Debra Hess, VanBuren CMH; Jeff Patton, Kalamazoo Community Mental Health & Substance Abuse Services; Karen Lehman, Woodlands Board Alternate; Kris Kirsch, St. Joseph Community Mental Health & Substance Abuse Services; Mike Kenny, NAMI

Guests on phone: Richard Thiemkey, Barry County Community Mental Health

Welcome Guests

Tom Schmelzer called the meeting to order at 9:30 am and welcomed the group.

Public Comment

Jeannie Goodrich, CEO of Summit Pointe, addressed the Board reading a written statement regarding MDHHS audit findings. Mike Kenny of NAMI shared with the Board a new program titled Ending the Silence. The program, which is for High School students, is available to any county in the SWMBH region.

Agenda Review and Adoption

Motion — Edward Meny moved to accept the agenda with the following additions: MCHE update, October 19th Public Policy Event, and EO Evaluation.
Second — Tim Carmichael
Motion Carried

Consent Agenda

Motion — Edward Meny moved to approve the 9-14-18 SWMBH Board Meeting Minutes.
Second — Patrick Garrett
Motion Carried

Motion Edward Meny moved to approve the Customer Advisory Committee member appointments as presented.

Second Mary Myers

Motion Carried

Operations Committee

Operations Committee Minutes August 22, 2018

Tom Schmelzer asked for comments or questions. Minutes accepted.

Operations Committee Report

Deb Hess reported as documented.

Ends Metrics

Contractually Obligated Assessment Tools Update

Jonathan Gardner reported as documented. Return item for Board action in November.

SWMBH 2018 Health Services Advisory Group (HSAG) Performance Measurement Validation Review

Jonathan Gardner reported as documented.

Motion Tim Carmichael moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends Metric does not need revision.

Second Patrick Garrett

Motion Carried

Regional Habilitation Supports Waiver Slots

Rhea Freitag reported as documented.

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

Second Edward Meny

Motion Carried

Board Actions to be Considered

Fiscal Year 2019 Budget

Tracy Dawson reviewed as presented. Board discussed.

Motion Moses Walker moved "To approve the SWMBH Regional fiscal year 2019 budget Column H, as presented for the period October 1, 2018 through January 11, 2019. A fiscal year 2019 revised budget shall be presented to the Board for approval no later than January 11, 2019. "Management shall propose a fiscal year 2019 ending minimum ISF balance in dollars and as a percentage of maximum allowable. Complete depletion of ISF is not acceptable."

Second Patrick Garrett
Motion Carried

Holiday Gathering

Tom Schmelzer reminded the Board that the December Board meeting will be the annual holiday gathering luncheon.

Board Policy Review

EO-003 Emergency Executive Officer Succession

Brad Casemore reviewed the policy.

Motion Robert Nelson moved to accept Executive Officer plan as presented.
Second Edward Meny
Motion Carried

Executive Limitations Review

BEL-008 Communication and Counsel

Tom Schmelzer reviewed the policy.

Motion Tim Carmichael moved that the Executive Officer is in compliance and the policy does not need any revision.
Second Mary Myers
Motion Carried

BEL-010 RE 501 (c) (3) Representation

Moses Walker reviewed the policy.

Motion Moses Walker moved that the Executive Officer is in compliance and the policy with revisions noted in red are approved.
Second Edward Meny
Motion Carried

Michigan Consortium for Health Care Excellence (MCHE) and MCG Contract

Brad Casemore reviewed history and MCG Contract.

Motion Edward Meny moved that SWMBH may pay MCHE for State mandated software (MCG) not to exceed $80,000 in Fiscal Year 2019.

Board Education

Annual Board Compliance Education

Mila Todd reported as documented.

Fiscal Year 2018 Program Integrity Compliance Report

298 Unenrolled

Communication and Counsel to the Board

Consolidated Fiscal Year 2018 Year to Date Financial Statements 8/31/18
Tracy Dawson reported as documented.

Autism Spectrum Disorder Rates
Brad Casemore reported as documented.

Persons with Mild to Moderate Mental Health Disorders
Brad Casemore reported current plans.

Michigan Department of Corrections Community Based Substance Used Disorder Services Benefits Management Contract
Brad Casemore reported that SWMBH has withdrawn from the Michigan Department of Corrections Community Based Substance Used Disorder Services Benefits Management Initiative.

Board Member Attendance Roster
Brad Casemore reported as documented. Tim Carmichael stated that Anthony Heiser is stepping down as a SWMBH Board member and Tim will be moving from Board Alternate to Board member.

Fiscal Year 2019 Financial Interest Disclosure (FID) Statements
Mila Todd distributed folders containing FID forms to sign and return to her.

Public Comment
Mike Kenney of NAMI commended the SWMBH Board on their commitment and work.

Adjournment

Motion	Edward Meny moved to adjourn at 11:32 AM.
Second	Tim Carmichael
Motion Carried	

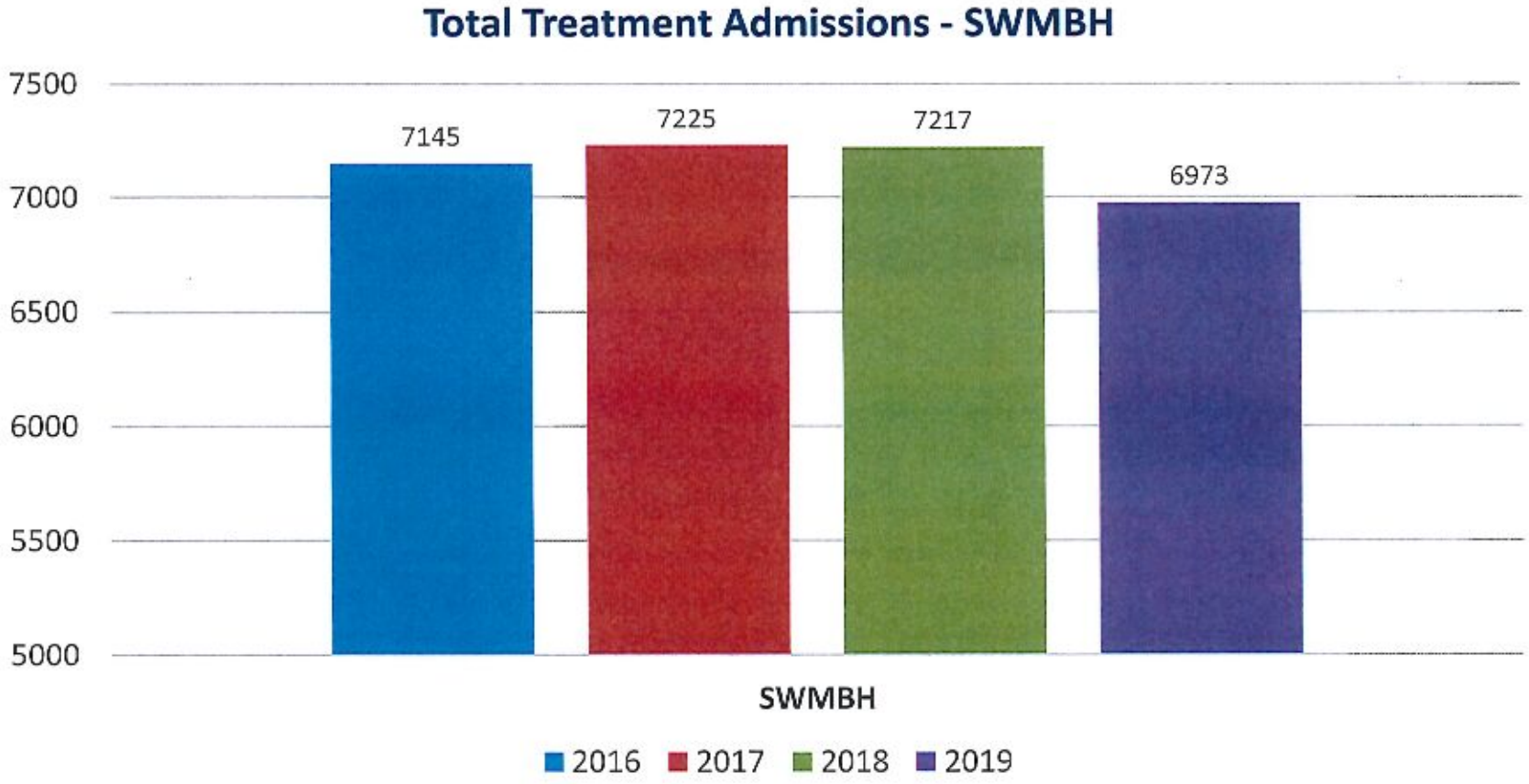
Behavioral Health Treatment Episode Data Set Admission Data: Fiscal Year 2019

SWMBH Board
March 13, 2020

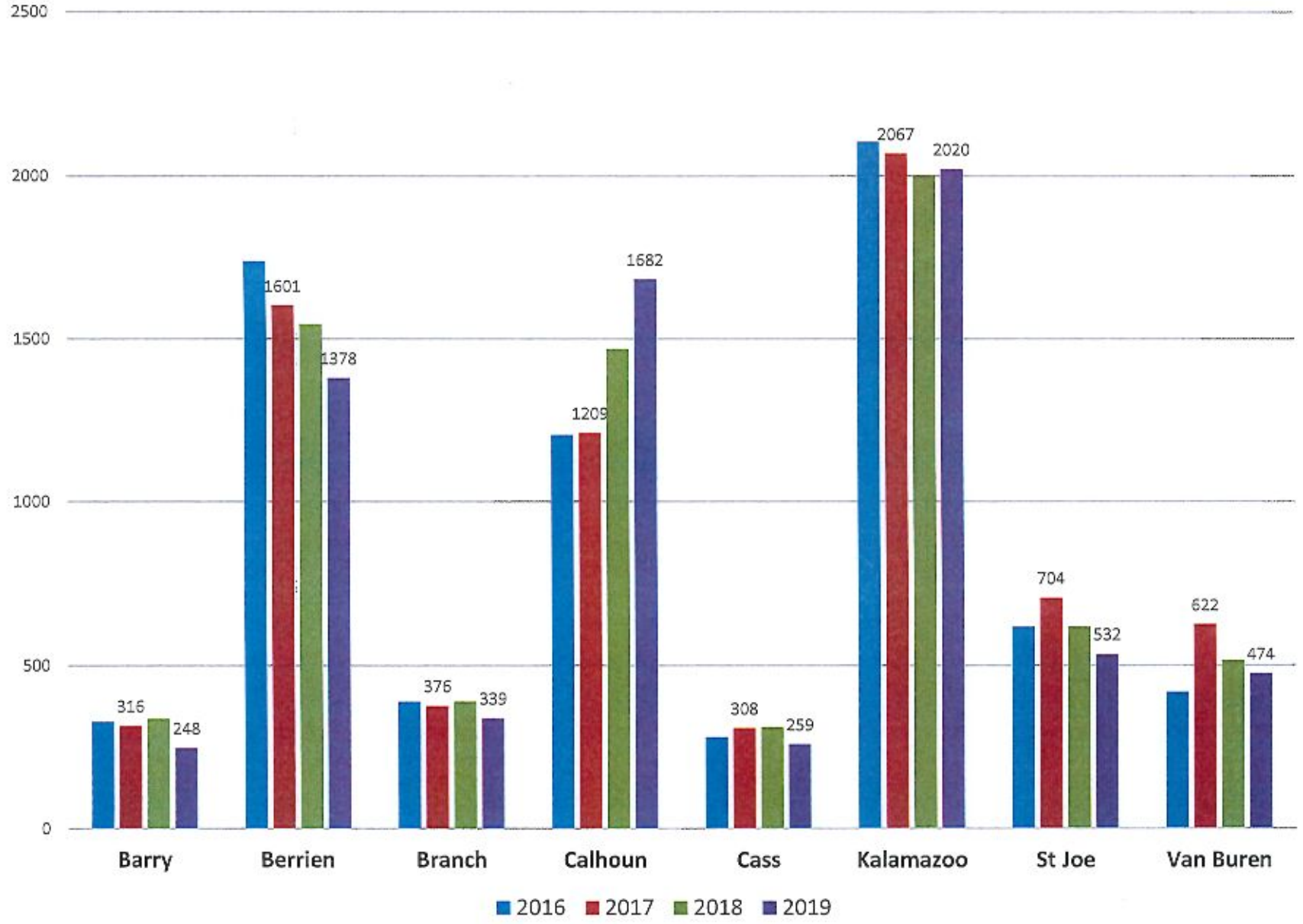
Southwest Michigan
BEHAVIORAL HEALTH

Overview:

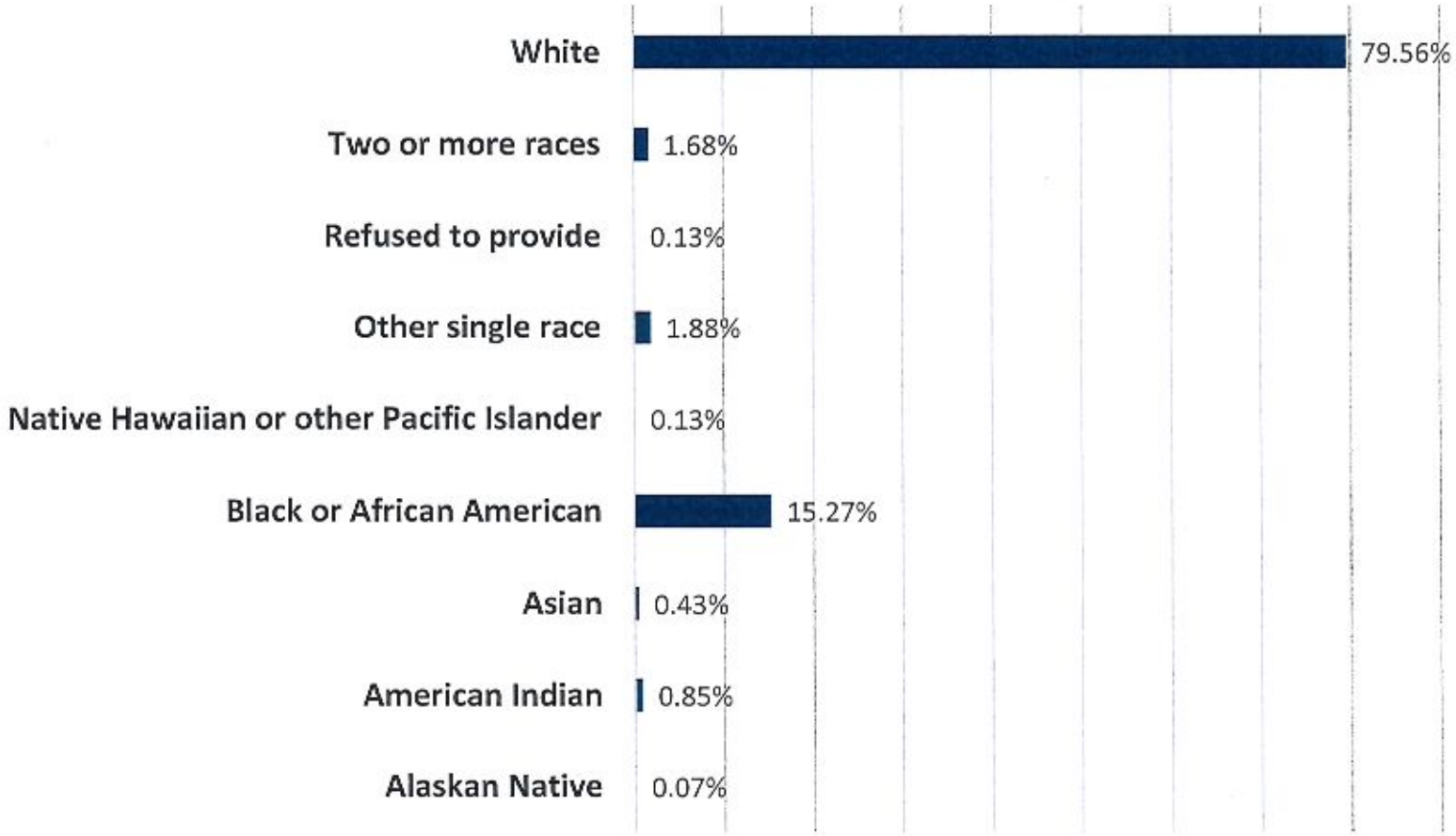
As required by the MDHHS contract, a Behavioral Health Treatment Episode Data Set (BH-TED) is completed for every admission to SUD treatment. In fiscal year (FY) 2019, the SWMBH region had ***6,973*** treatment admissions to service. This count includes all customers for all levels of care. For example, if a customer went to detoxification services first and then to outpatient services, they would be counted twice (two separate services).



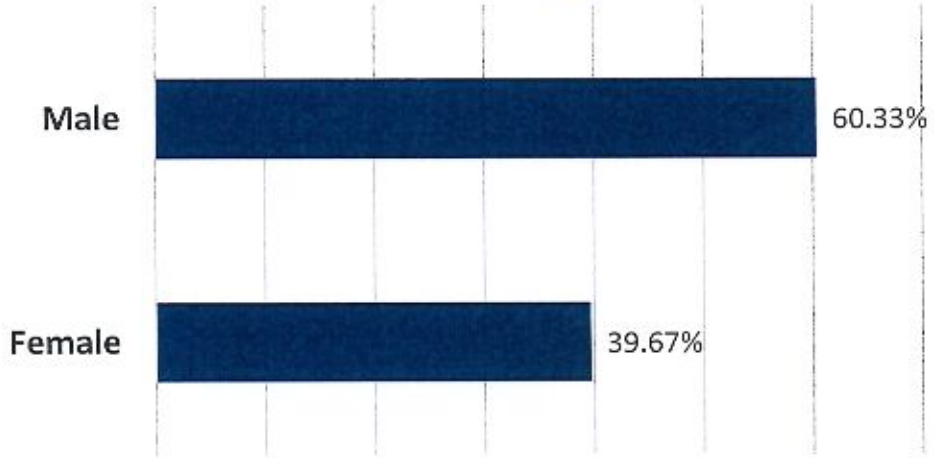
Treatment Admissions by County



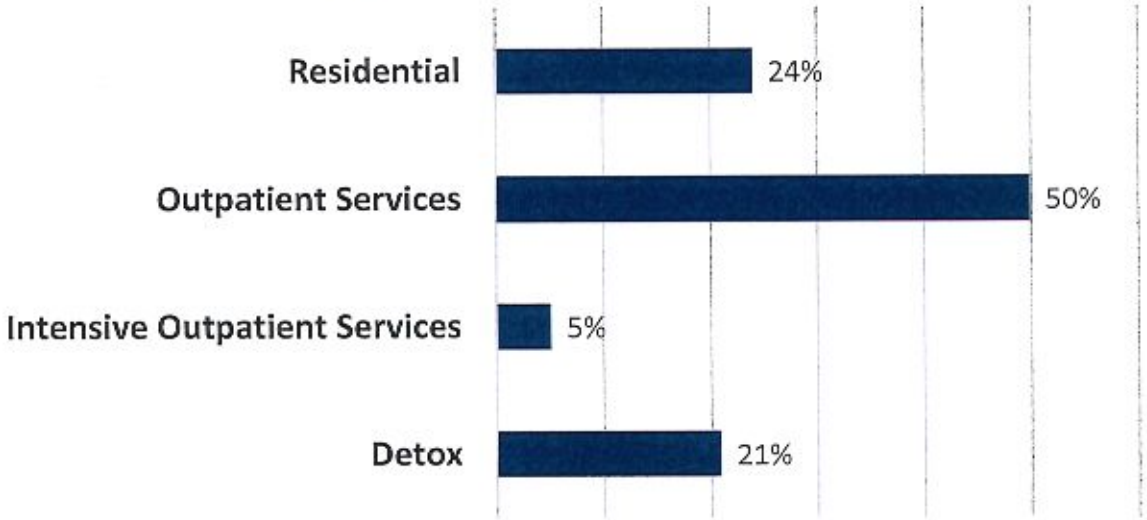
SWMBH Region: Race



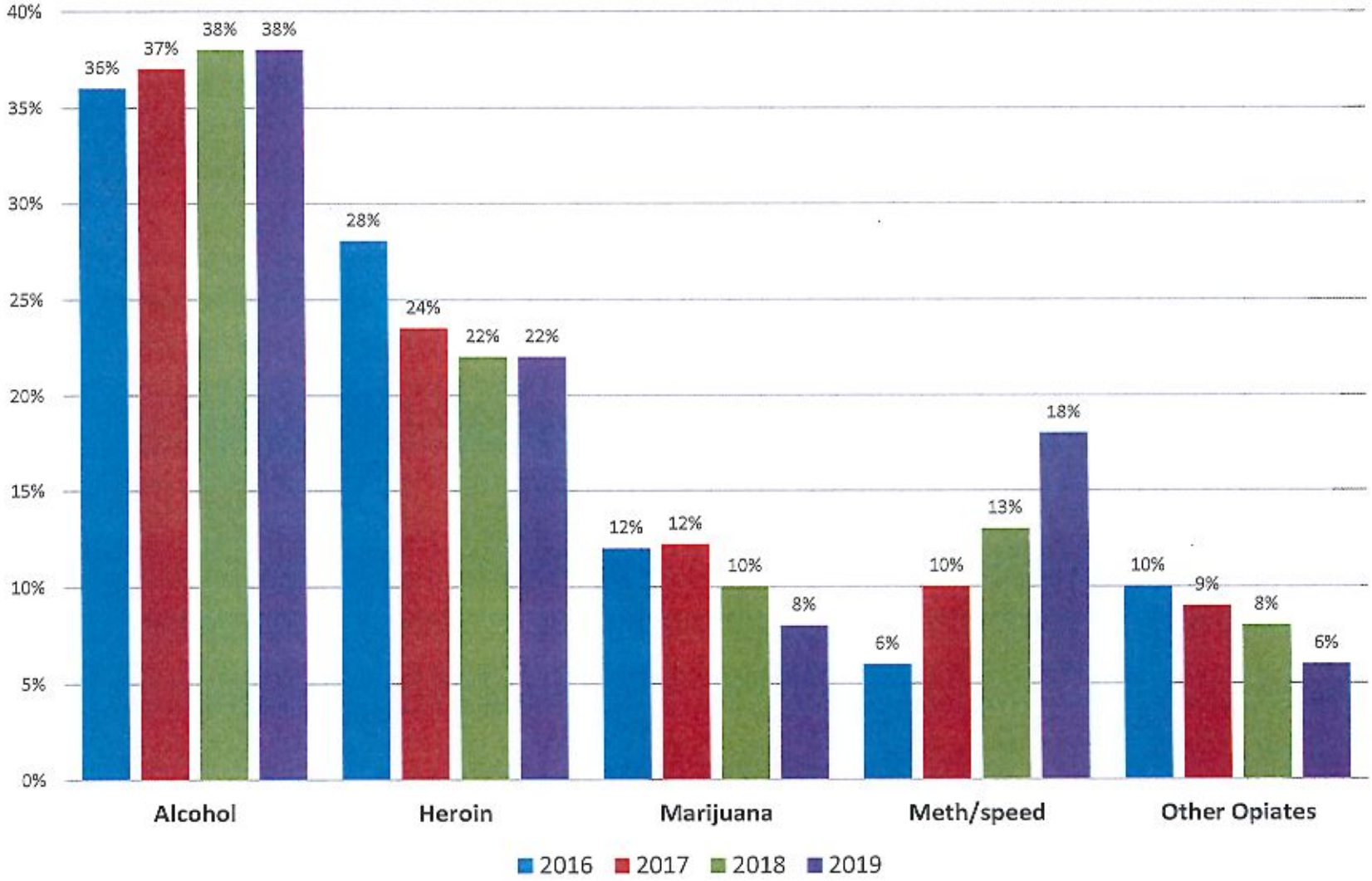
SWMBH Region: Gender



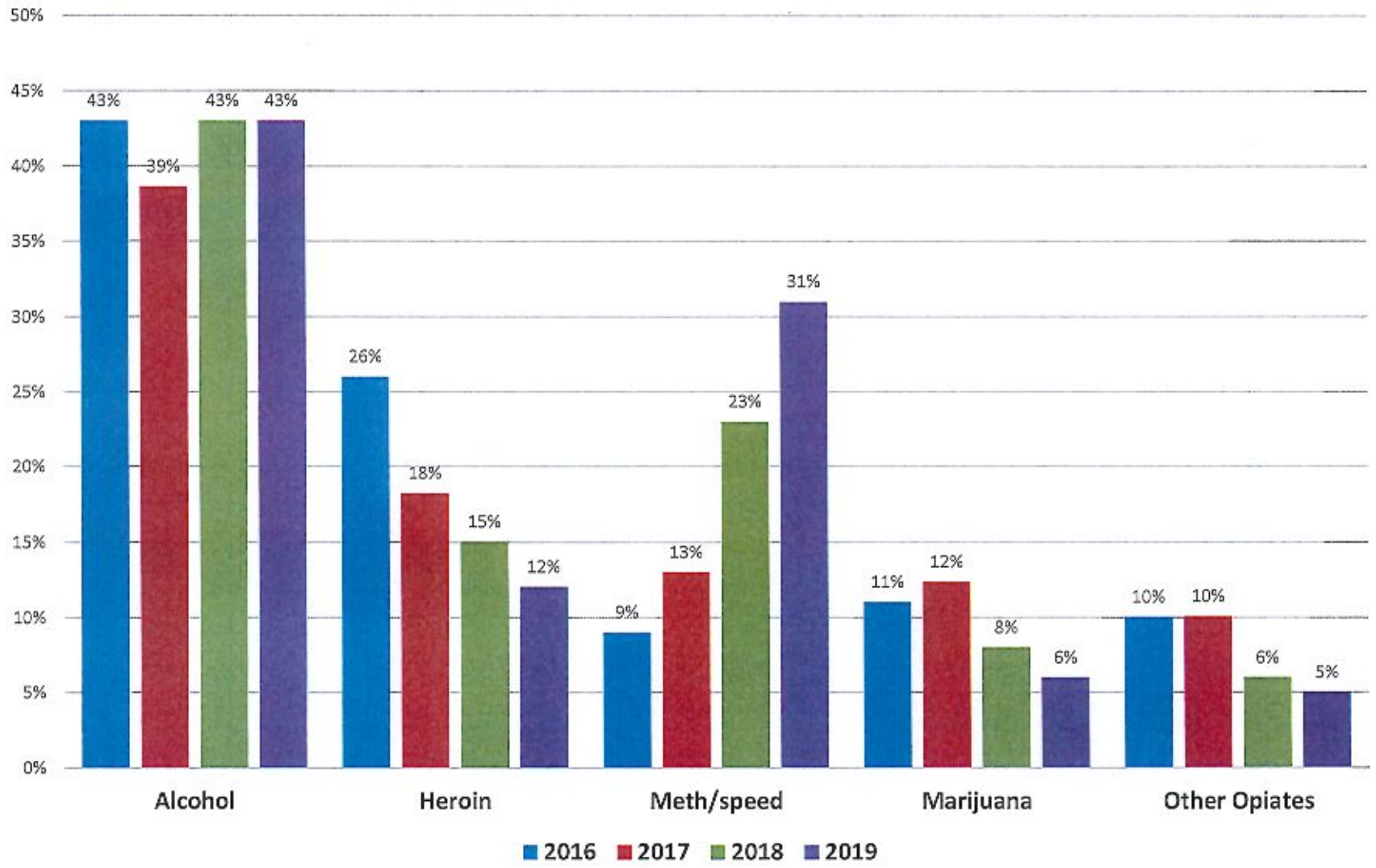
SWMBH Region: Treatment Service Setting



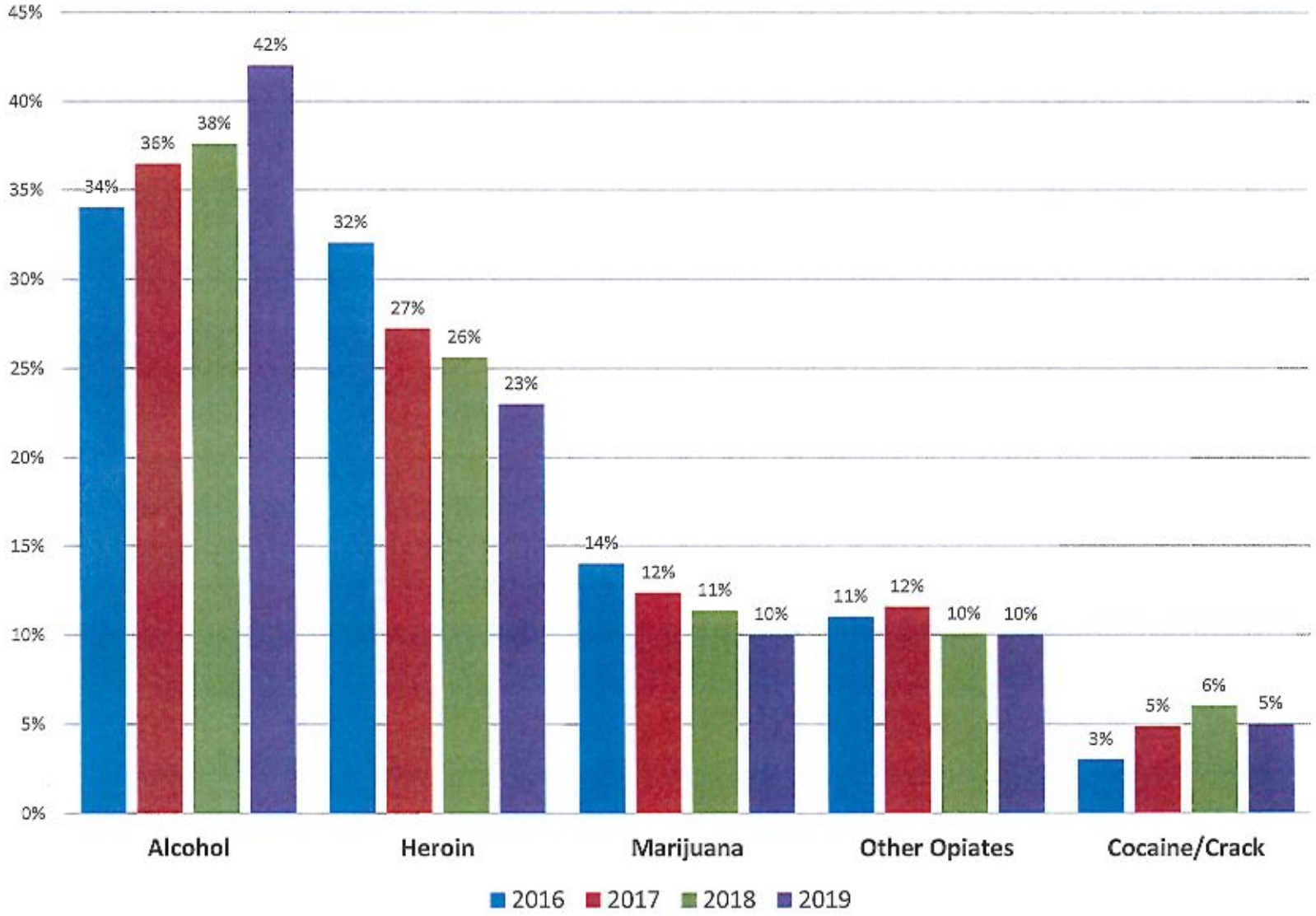
SWMBH Region
Primary Substance of Abuse at Admission



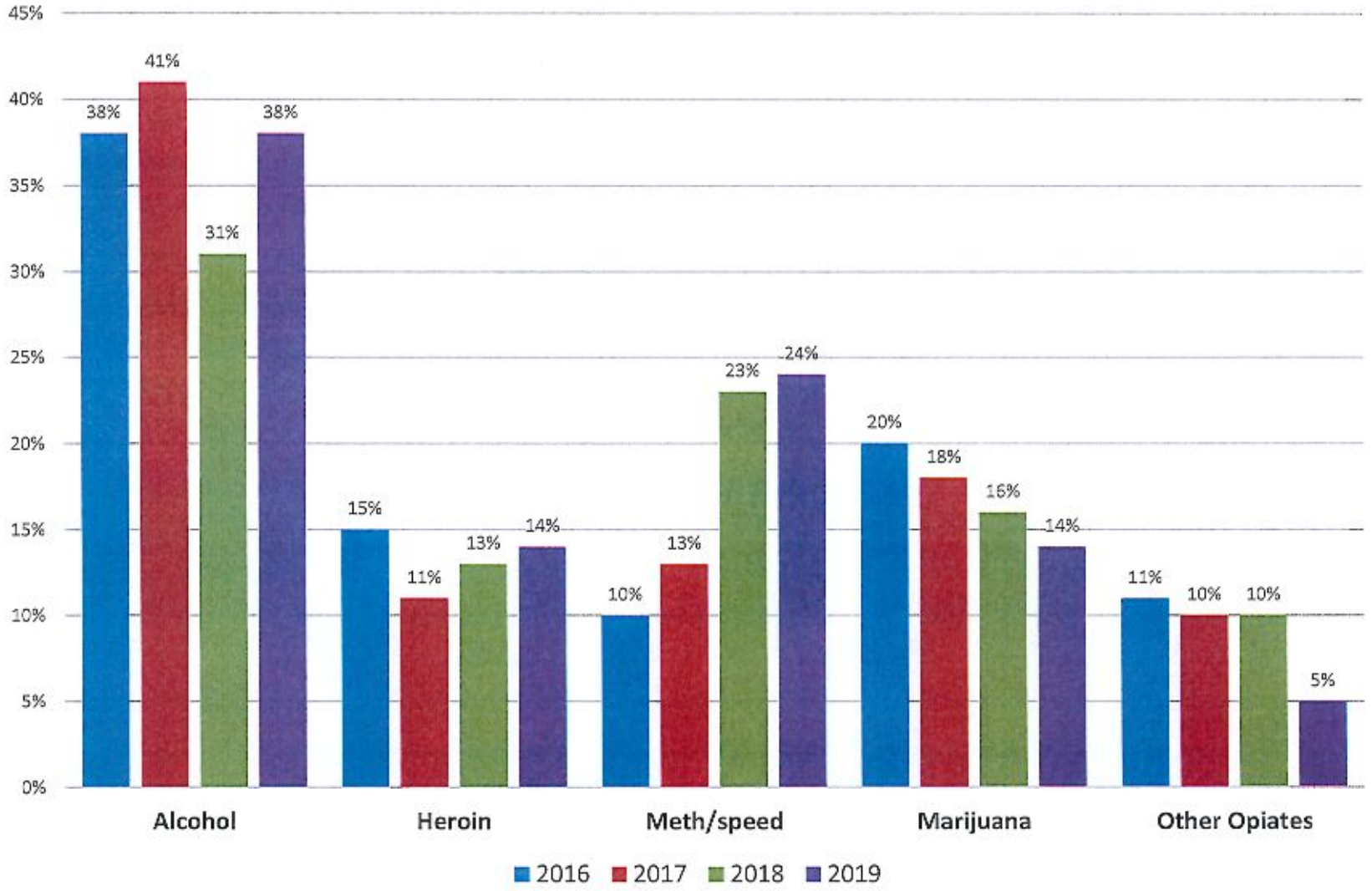
Barry County
Primary Substance of Abuse at Admission



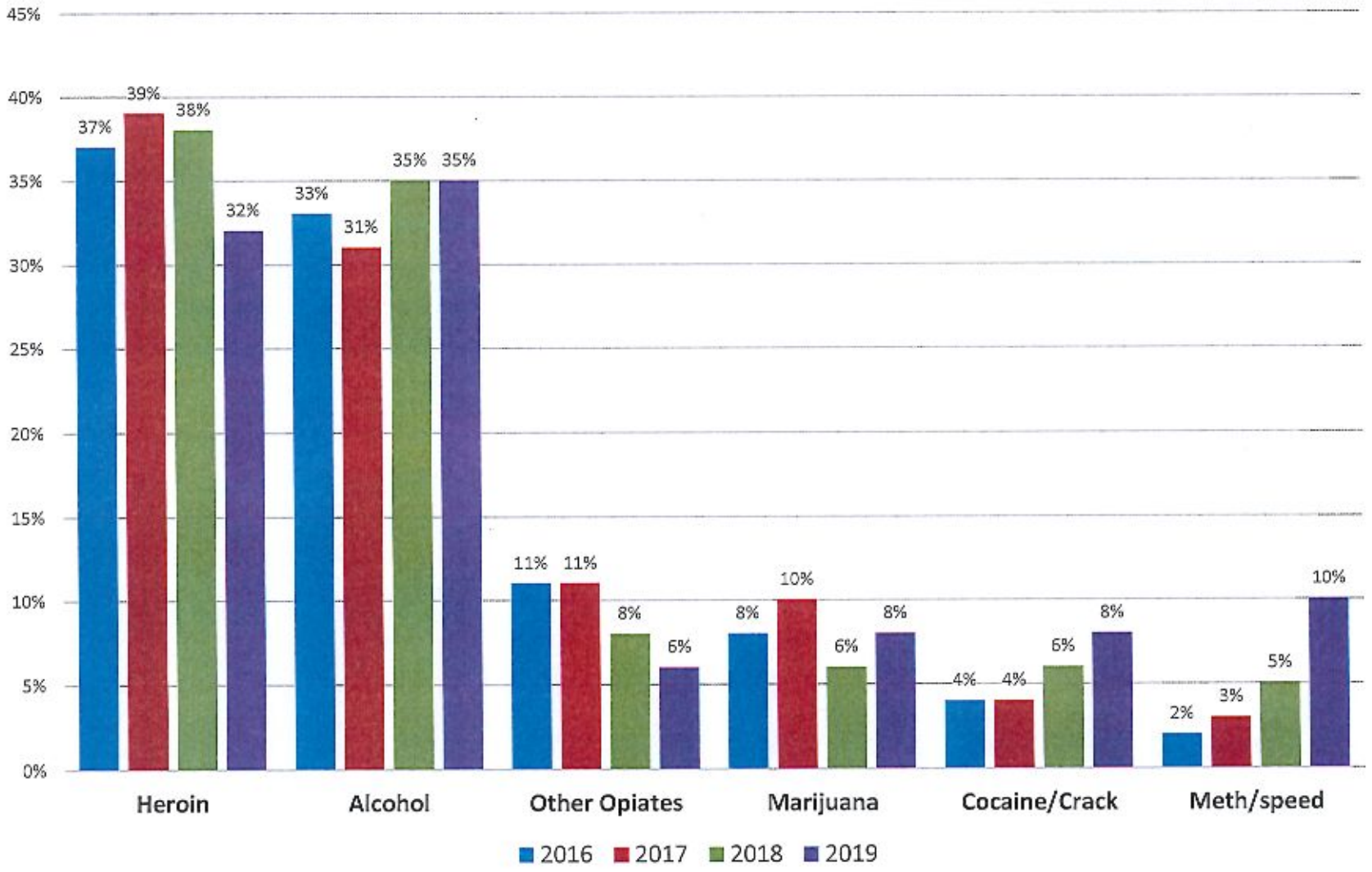
Berrien County
Primary Substance of Abuse at Admission



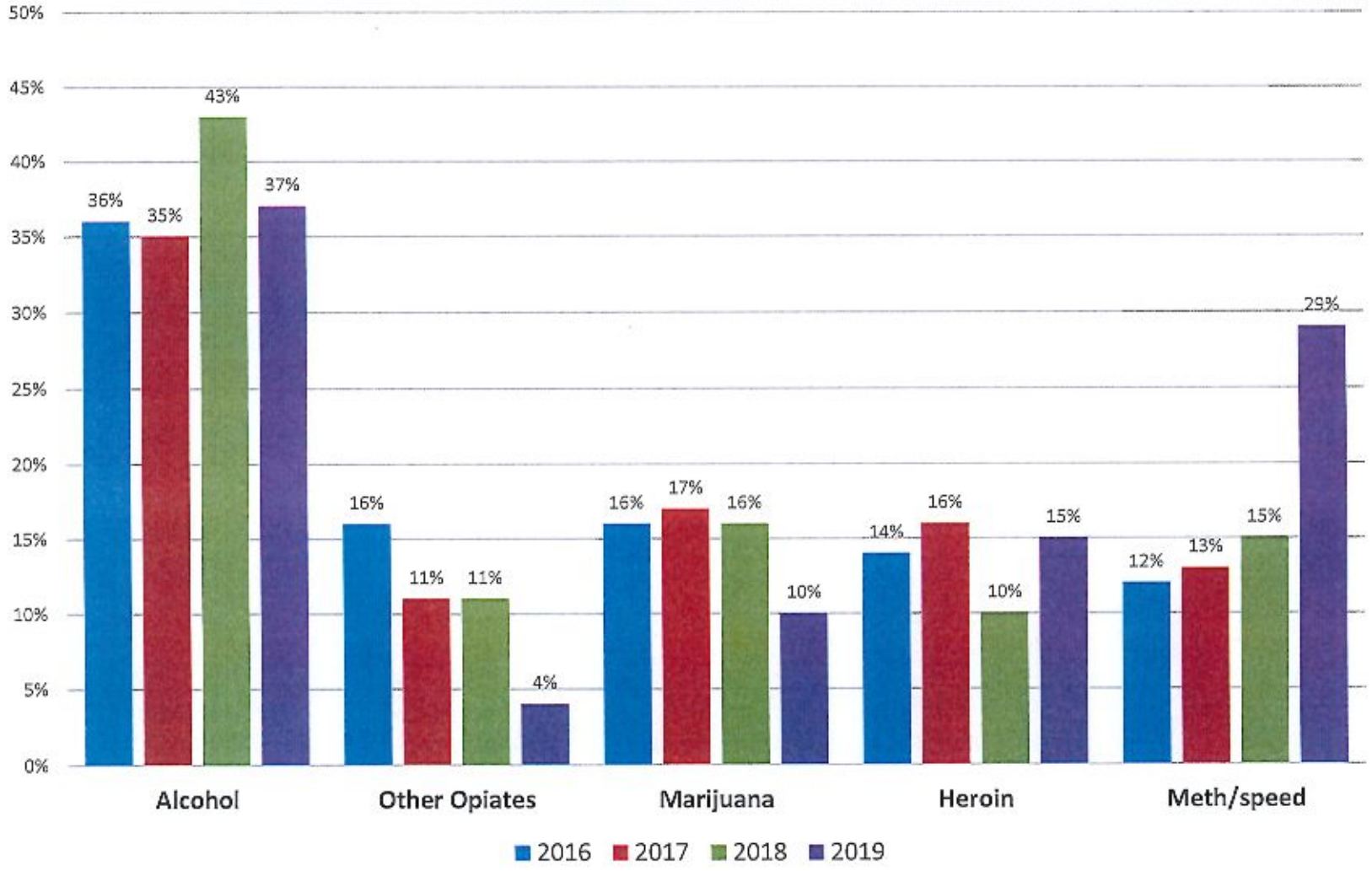
Branch County
Primary Substance of Abuse at Admission



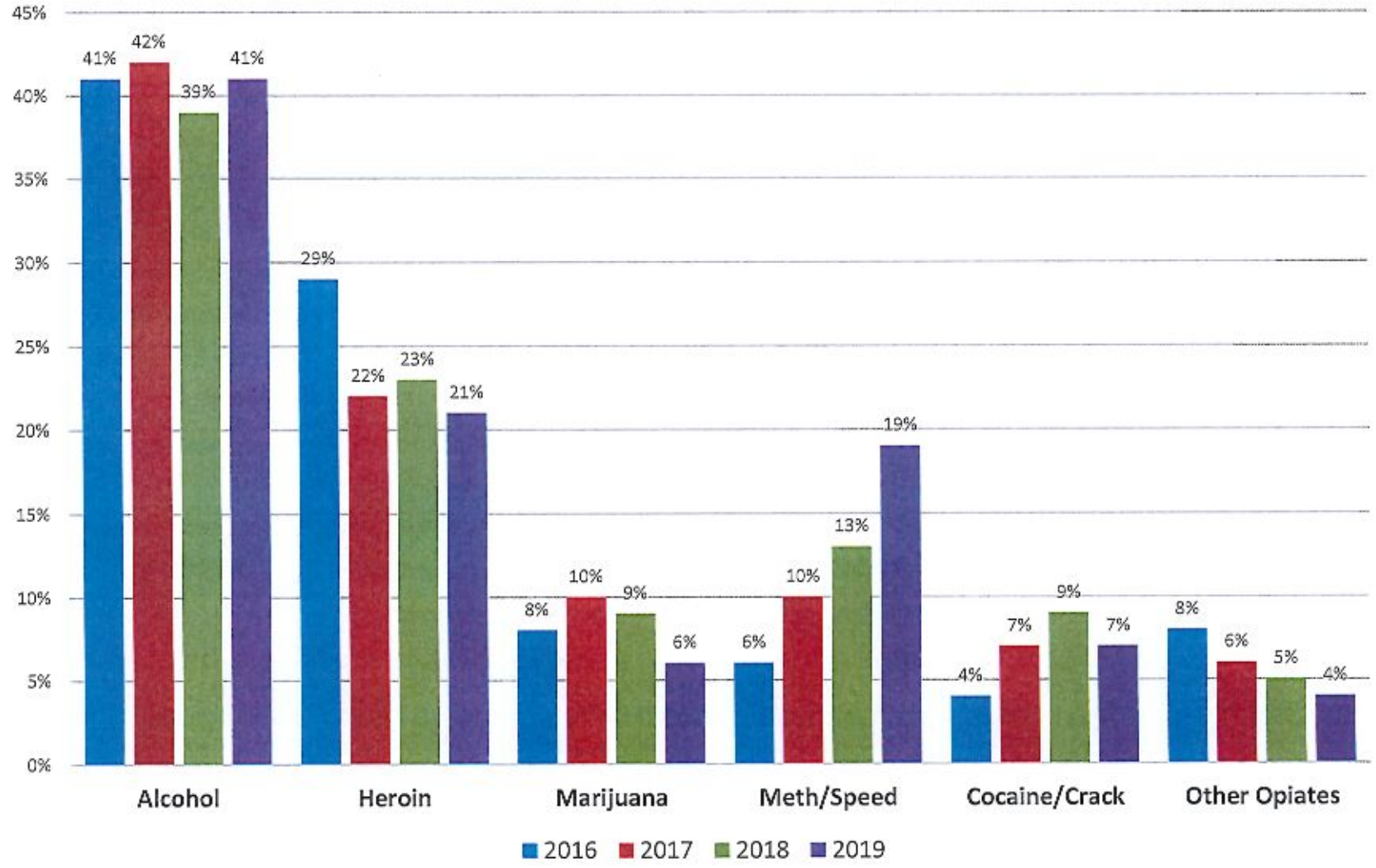
Calhoun County
Primary Substance of Abuse at Admission



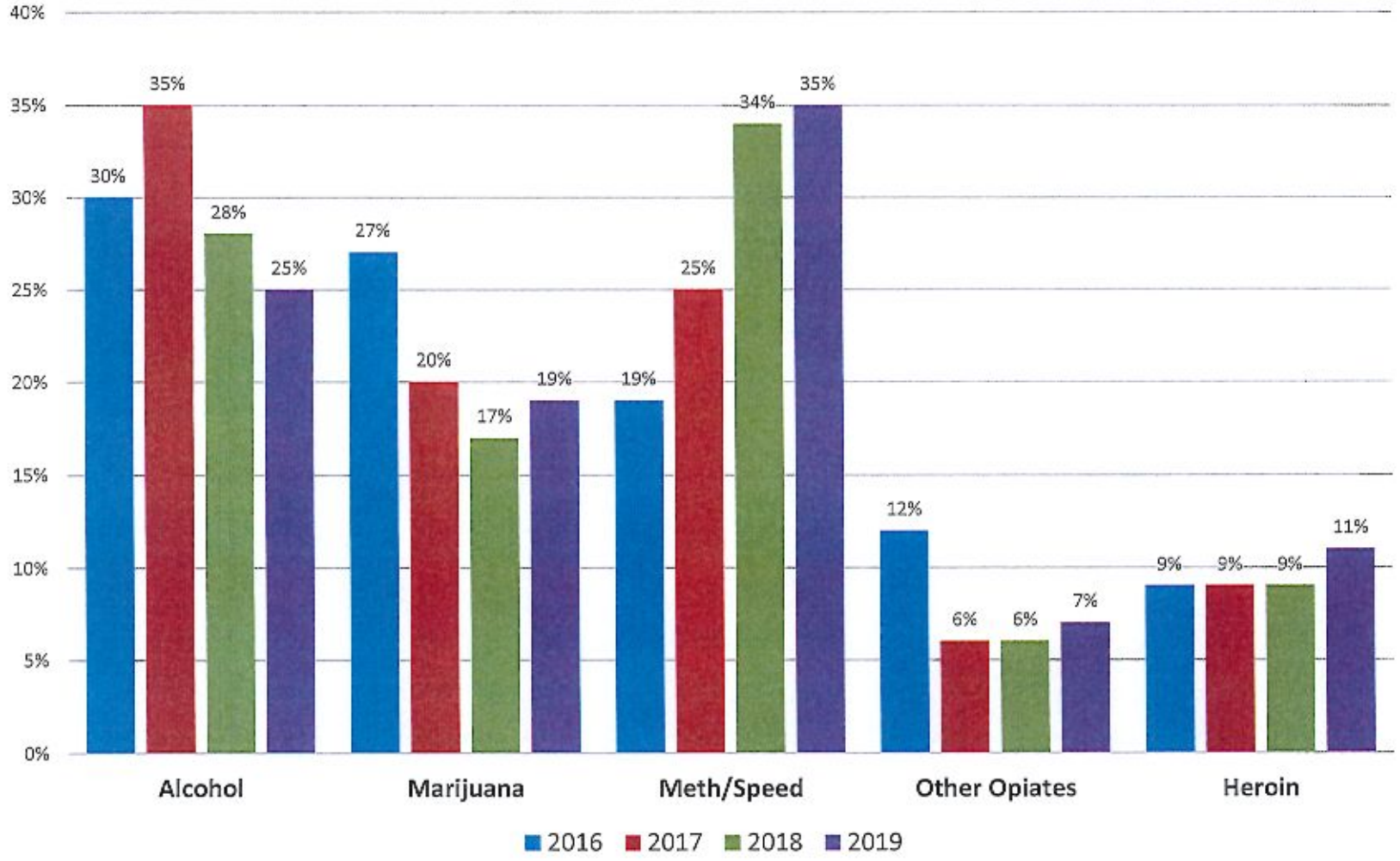
Cass County
Primary Substance of Abuse at Admission



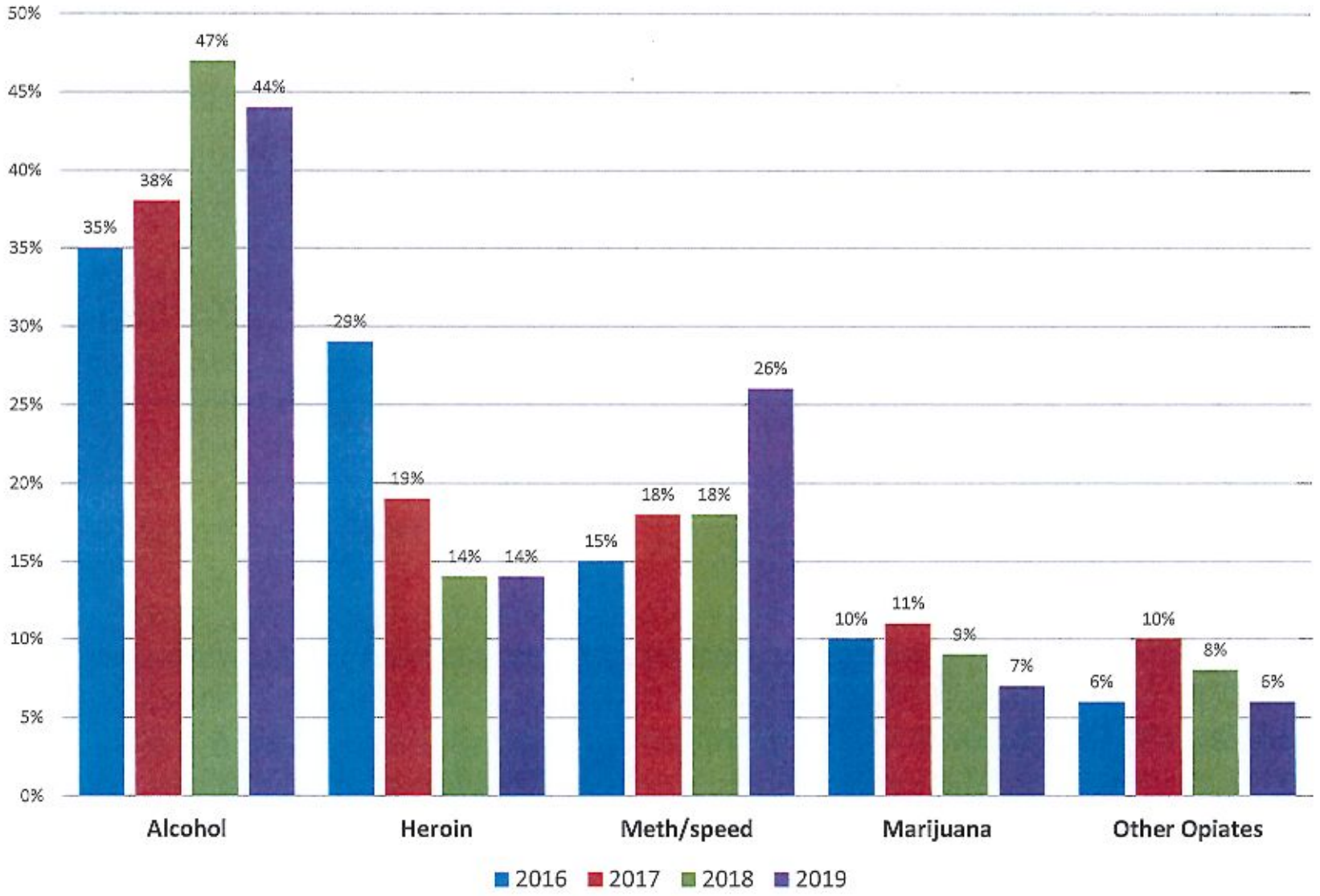
Kalamazoo County
Primary Substance of Abuse at Admission



St Joe County
Primary Substance of Abuse at Admission



Van Buren County
Primary Substance of Abuse at Admission



Prevention Outcome Measures Performance Report: Fiscal Year 2019

SWMBH Board
March 13, 2020

Southwest Michigan
BEHAVIORAL HEALTH

FY2019 SUD Prevention Outcome Measures Performance Report

Prevention Outcome Measure Domains	Domain Value (%)	Barry (BCCMHA)	Berrien (BCHD)	Branch (PBH)	Calhoun (SAC)	Calhoun (SAPS)**	Cass (WBHN)	Kazoo (CHC)	Kazoo (PW)	St. Joe (CMHSAS)	VB (CMH)
I - SUD Community Consequences Indicators a) HS Youth past 30-day use (Alcohol, Rx Drugs, MJ) b) Alcohol-related Traffic Fatalities/Accidents	3%	2.6%	2.3%	2.3%	2.6%	2.6%	2.0%	3.0%	3.0%	2.6%	2.3%
II - Pre/Post Test Scores	24%	24.0%	20.0%	21.6%	22.7%	24.0%	24.0%	23.0%	22.2%	21.0%	24.0%
III - Stakeholder Input Surveys	9%	9.0%	9.0%	9.0%	9.0%	19.0%	9.0%	7.9%	7.8%	6.0%	9.0%
IV - Problem ID. & Service Referral (Pre-screening)	9%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
V - Community Education Campaigns (RX Drugs, Under-Age Drinking, MJ/Kids, Other)	22%	22.0%	20.2%	22.0%	22.0%	21.0%	21.0%	22.0%	21.2%	18.7%	20.8%
VI - Alcohol & Tobacco Retailer Activities (Under-Age Drinking, tobacco access, E-Cigs)	10%	10.0%	9.2%	8.9%	10.0%	NA	10.0%	10.0%	9.4%	10.0%	7.7%
VII - Community-based Projects	15%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
VIII - Community-based Accomplishments	6%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	5.0%	6.0%	4.0%	6.0%
IX - Outputs Efficiency Indicators	2%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	0.0%	1.0%
Provider Performance Rating (Annual Goal: ≥ 85%)	95.7%	99.6%	92.7%	95.7%	98.4%	98.6%	98.0%	96.9%	95.7%	86.4%	94.8%
** Denotes Providers that do not have activities and Outcome Measures in all performance domains. Their performance scores are weighed & adjusted accordingly.											

Expired, Unused Med Collection Program	SWMBH	Barry	Berrien	Branch	Calhoun-SAC	Calhoun (SAPS)	Cass	Kazoo	St. Joe	Van Buren
lbs. (Actual)	21,397	1,290	534	802	1,135	110	620	14,738	207	1,962
lbs. (Annual Goal)	16,116	1,186	500	556	1,100	200	575	10,000	500	1,500
%	132.8%	108.8%	106.8%	144.3%	103.2%	55.0%	107.8%	147.4%	41.4%	130.8%

Edward Meny
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St Joseph, Michigan 49085
269-429-2025 (H)
269-930-4824 (C)
Edwardmeny0421@comcast.net

January 28, 2020

Robert Gordon, Director
State of Michigan Department of Health and Human Services
PO Box 30195
Lansing, Michigan 48909

Dear Director Gordon:

I will begin by introducing myself.

I am a 73-year-old married husband, father and grandfather. I have served on the Berrien County Community Health Authority DBA Riverwood Center Board for thirty years. I have served on the board of Southwestern Michigan Behavioral Health PIHP for three years and will become Board Chairperson in April. I am a St Joseph Charter Township Trustee, an elected position. I have been a licensed insurance agent for forty-two years and an insurance agency owner for much of that time.

The people who work for and in behavioral healthcare in Michigan are dedicated, educated, hard-working unselfish people, and we are extremely proud of the many things that we have accomplished under some very challenging conditions.

I guess I am part of the Public Sector. The Public Sector has a black eye that it does not deserve and frankly, I believe that many of the problems in Behavioral Health have been self-inflicted by state government. We have worked with and around crisis after crisis, change after change, for as long as I can remember. Privatization is just the latest iteration. Funding has been a head-scratcher for as long as I can remember.

So, thank you for honoring our "extraordinary work" that our members and staff "have done to establish a public safety net that serves all Michiganders". "So many states would love to create what you have built." Those are your words written to our Association on January 7th.

Integration of Physical and Behavioral Health has been our goal for some time now. We have experienced difficulties with the health plans. They have been problematical for our Mild to Moderate population and we have often had to backstop that. They have not had a consistent provider panel for behavioral health consumers.

Some time ago Michigan legislators said they traveled the state interviewing stakeholders for a project they called CARES. We were not interviewed or asked for our opinions. A significant problem involves term limited legislators having even a basic knowledge of what we do.

Please understand that I don't speak for anyone other than myself here. I believe that we have a system in place that works. Millions of dollars have been spent putting together several different configurations of the CMH/PIHP system. This obviously includes equipment, supplies and employees. We have what I believe are heroic employees who have weathered the storms of uncertainty, funding inconsistency and low pay. We have consumers who have remained patient while we have reacted and adapted, all the while attempting to provide excellent uninterrupted service.

You suggest that "piecemeal reforms" would add complexity. I suggest that your proposed plan, requiring changes to the Mental Health Code, with multiple types of organizations and multiple choices will add much greater complexity and confusion.

Please do not be unaware of or dismiss the many effective things the public system – including Riverwood Center and SWMBH do - at the Health Plan, Provider and Beneficiary levels to improve our client's physical health status and reduce avoidable healthcare utilization and expenses. Those activities are too numerous to detail in this letter. The planned Reform will significantly distract from and jeopardize those efforts as Plans and agencies adjust and spend even more required dollars on transition efforts rather than client care, just like moving from 18 PIHPs to 10 not so long ago.

As a businessman I am puzzled that you would advocate for tearing the entire house down to address a component we all are trying very hard to fix. It reminds me of watching Wal Mart abandon a perfectly good building only to build a much bigger building next door. Frankly, I think we have a fiduciary duty to our taxpayers to work smarter than that.

Transportation is a problem the Behavioral and Physical Health providers have had for the Medicaid population for years. This is particularly acute in Berrien County and many rural areas of Michigan. In many cases we can provide funds for transportation, but adequate transportation is not available or is unsatisfactory and not dependable. As an example, in Berrien County there are three separate public transportation providers. They do not work together, serve the same areas, and at least one has refused to even consider doing so. Consumers of both behavioral and physical health, in order to get from one end of Berrien County to the other, must secure three different rides. Often the schedules conflict. Often the consumer must wait up to two hours for a connection. It is very difficult to make appointments or get to a job. It is impossible to get to two appointments, especially if they are at different locations. It isn't unusual for a person to have to devote his or her entire day to make it to and from an appointment. This is stressful. This is a serious problem that will continue even if integration is successful. Ride services such as Uber often will not pick our clients up because of where they live or who they are. Those rides are too expensive as well.

As a taxpayer, I would ask you to look at your current system, build from the PIHPs and CMHPs that are doing the job efficiently and correctly, and use what is working well as a template.

As a board member at Southwestern Michigan Behavioral Health and Berrien County Community Mental Health I would ask you to come by and talk with our people.

Thank you for considering these comments. I am hopeful that we can move forward together.

Yours very truly,

Edward Meny

CC: Representative Pauline Wendzel
Senator Kim LaSata
Governor Gretchen Whitmer

2020 Federal Elections

(as of Jan. 2020)

Note that for the Congressional races the MI deadlines are:

- Candidate filing deadline - April 21, 2020
- Primary - August 4, 2020
- General - November 3, 2020

House

Competitive Michigan Races

MI-3 **Incumbent Justin Amash (I)** - This race is viewed as a toss-up. Given that Amash recently left the Republican party and is a registered Independent. Amash declared candidacy, but has not yet filed. The race is listed as leaning (R).

Republican primary candidates (registered and non-registered) include:

- Lynn Afendoulis
- Joe Farrington
- Andrew Jackson Willis
- Joel Langlois
- Peter Meijer
- Tom Norton
- Emily Rafi

Democratic primary candidates include:

- Nick Colvin
- Hillary Scholten

MI-6 **Incumbent Fred Upton (R)** - This race is seen as leaning R. Upton has a Republican primary challenger, Elena Ocike. There are three Democrats for the primary race: Jon Hoadley, Angelica Pastor-Diaz, and Jen Richardson.

MI-7 **Incumbent Tim Walberg (R)** - This race is seen as likely R. Walberg does not have a Republican challenger at this point. There are two Democratic primary candidates: Samuel Branscum and Gretchen Driskell.

MI-8 **Incumbent Elissa Slotkin (D)** - This race is seen as toss up to leaning D. Trump won this district in 2016. There are four Republican primary candidates: Mike Detmer, Paul Junge, Kristina Lyke and Nikki Snyder.

MI-11 **Incumbent Haley Stevens (D)** - This race is seen as leaning D/likely D. Trump won this district in 2016. There are currently three Republican primary candidates: Kerry Bentivolio, Eric Esshaki and Whittney Williams.

MI Open Seat

MI-10 Incumbent Paul Mitchell (R) is retiring, but the seat is considered a safe R. Republican primary candidates include Shane Hernandez, Lisa McClain and Doug Slocum. Democratic primary candidates include Kimberly Bizon and Kelly Noland.

SENATE

Incumbent Senator Gary Peters (D) is up for reelection in 2020. His seat is seen as a "safe" Democratic seat. Peters does not have a primary challenger.

There are two Republican primary candidates - Bob Carr and John James.

2020 FEDERAL ELECTIONS

Presidential Election Key Dates:

Feb. 3 – Iowa holds its presidential caucuses, officially kicking off the battle for the Democratic Party's presidential nomination and Trump's re-nomination as the Republican nominee.

Feb. 11 – New Hampshire holds its presidential primary, potentially winnowing the field of Democrats seeking the nomination.

Feb. 22 – Nevada* caucus

Feb. 29 – South Carolina* primary

March 3 – Super Tuesday - Alabama, Arkansas, California, Colorado, Maine, Massachusetts, Minnesota, North Carolina, Oklahoma, Tennessee, Texas, Utah, Vermont, Virginia* hold primaries or caucuses

March 10 – Idaho, Michigan, Mississippi, Missouri, North Dakota (primary – convention on MAR 27), Washington primaries

March 14 – Wyoming convention

March 17 – Arizona*, Florida, Illinois, Ohio primaries

March 24 – Georgia primary

March 27 – North Dakota convention

April 4 – Alaska*, Hawaii*, Louisiana primaries, Wyoming (caucus)

April 7 – Wisconsin primary

April 28 – Connecticut, Delaware, Maryland, New York, Pennsylvania, Rhode Island primaries

May 2 – Kansas* primary

May 5 – Indiana primary

May 12 – Nebraska, West Virginia primaries

May 19 – Kentucky, Oregon primaries

June 2 – District of Columbia, Montana, New Jersey, New Mexico, South Dakota primaries

July 13-16 –Democratic Convention (Milwaukee, WI)

Aug. 24-27 – Republican Convention (Charlotte, NC)

Sep. 29 –First presidential debate (South Bend, IN)

Oct. 7 – Vice Presidential Debate (Salt Lake City, UT)

Oct. 15 – Second Presidential Debate (Ann Arbor, MI)

Oct. 22 – Third Presidential Debate (Nashville, TN)

Nov. 3 – U.S. voters to go to the polls to select the next president

**No Contest: The Republican Party in each of these locations has canceled its 2020 primary or caucus. All delegates are expected to be allocated to President Trump.*

- *Alaska*
- *Arizona*
- *Hawaii*
- *Kansas*
- *Nevada*
- *South Carolina*
- *Virginia*

Sources:

- www.cookpolitical.com
- http://www.centerforpolitics.org
- www.realclearpolitics.com
- https://ballotpedia.org/

NACBHDD

2020 Legislative and Administrative Priorities and Positions

Medicaid as a Block Grant

Issue: A new CMS advisory encourages states to seek waivers to change the state Medicaid program *from an entitlement to a block grant*. The change would allow states to limit the amount, duration and scope of coverage, cap the number of people covered, disallow coverage for some and impose fees for coverage. It also enables states to skirt key ACA Medicaid expansion provisions.

Action: *Oppose* the Administration's proposal to allow states to change state Medicaid into a block grant. *Support* continuation of the 50-year-old Medicaid law as an entitlement program.

CCBHC Authorization/Appropriation

Issue: The authority and appropriations for the 8-state Certified Community Behavioral Health Center (CCBHC) demonstration expire on May 22, 2020, unless legislation enacted to keep the program alive. Some on the Hill hope to use the 'must pass" CCBHC (and FQHC) appropriations as a vehicle for adoption of drug cost reduction and/or surprise medical cost measures. House and Senate legislation would reauthorize CCBHCs for 2 more years and to expand them by 11 more states. (S. 824 and HR 1767, the excellence in Mental Health and Addiction Treatment Expansion Act).

Action: *Urge legislators to support* reauthorization and appropriation (funding) for CCBHCs beyond May 22, 2020, particularly if merging them with other measures may not succeed.

Regulatory Changes to SSDI/SSI Disability Insurance

Issue: The Social Security Administration has new rules for how often to conduct eligibility reviews for certain disabled individuals on the SSDI and SSI disability rolls. By reclassifying about 1.7 million SSDI/SSI recipients, their status would be scrutinized more frequently. The aim is cost savings. Many who would be affected (older adults, children ages 1-12 with ID/DDs, workers with multiple impairments) are people with mental disorders. Adding further burdens to an already complex process for these individuals is irresponsible, inappropriate and dangerous to their health. In the 1980s, a similar cost-cutting Reagan Administration effort was overturned by Congress.

Action: *Oppose* implementation of these SSA rules requiring more frequent SSI/SSDI health status reviews that disproportionately affects people with severe mental disorders and comorbid conditions now receiving SSDI/SSI.

Justice Involved Populations

Issue: Individuals in county and city jails lose Medicaid and other federal benefits the moment they are incarcerated. Many have behavioral disorders and need ongoing treatment during and following release, whether pre- or post-adjudication. S. 2626 and S. 2628, taken together, would ensure that people in custody prior to trial do not lose their Medicaid, Medicare, CHIP an VA benefits. Other legislation (HR 4141 and S. 2305) would repeal the Medicaid inmate exclusion altogether.

Action: *Support* legislation to repeal the so-called Medicaid inmate exclusion. This will continue federal Medicaid (and other healthcare) payments to people in city and county jails prior to adjudicated, during incarceration, and following release.

Saving the ACA

Issue: Legislative, regulatory and judicial efforts are ongoing to weaken, repeal or find the ACA unconstitutional. The Supreme Court will not consider the ACA case until after the 2020 election.

Action: *Support* continuation of the ACA as initially designed. *Oppose* lower court decisions in Texas vs. HHS. *Oppose* rules promoting "skinny" plans and other coverage changes that circumvent ACA requirements for services, parity, coverage for those with preexisting conditions, etc.

IMPROVING ACCESS TO MENTAL HEALTH CARE

Issue. Medicare currently recognizes psychiatrists, psychologists, clinical social workers and psychiatric nurses to provide covered mental health services. However, mental health counselors as well as marriage and family therapists (MFTs) (whose education is comparable to that of clinical social workers) are not eligible to be reimbursed by Medicare. Similarly, such individuals are not authorized to develop post-hospital discharge plans for patients about to be discharged from a hospital. The *Mental Health Access Improvement Act* (HR 3662, Rep. Mike Thompson (D-CA), S 286, Sen. John Barrasso (R-WY)) would make around 165,000 mental health counselors and MFTs eligible to serve and be reimbursed for independent care for Medicare beneficiaries.

Action: Urge members of the House and Senate to cosponsor and support adoption of both HR 3662 and S 286 to cover services provided by both mental health counselors and marriage and family therapists under Medicare.

STATE/LOCAL FLEXIBILITY IN FUNDING NON-FEDERAL MEDICAID SHARE

Issue: On November 18, 2019, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule—the *2019 Medicaid Fiscal Accountability Regulation (MFAR)*. MFAR would significantly change how states and counties are allowed to finance the non-federal share of their Medicaid programs. It would, for example, place new restrictions on intergovernmental transfers (IGTs), certified public expenditures (CPEs), provider taxes and other mechanisms. CMS would have new discretion to review both new and existing state and local financing arrangements, and to do so every 3 years. Moreover, MFAR also imposes significant new onerous reporting requirements. The National Association of Counties has strongly objected to these proposed new regulations (see attachment for detailed explanation of that objection).

Action: Consistent with NACo's position paper, urge members of the House and Senate to press the US Department of Health and Human Services to drop its proposed 2019 *Medicaid Fiscal Accountability Regulation* (MFAR). Note that *NACBIIDD joins NACo to encourage maximum flexibility for states and counties to finance the non-federal share of Medicaid. We also join NACo to oppose any new restrictions on that flexibility which could shift costs to state and local taxpayers, limit the ability to plan, and reduce access to essential health care services for low-income, uninsured and underinsured residents.*

2-10-20

Proposed Interim Policy Resolution on New Restrictions on State and Local Flexibility to Finance the Non-Federal Share of Medicaid

Issue: State and county flexibility to finance the non-federal share of Medicaid

Proposed Policy: Counties support the current rules that undergird the federal-state-local partnership for financing the Medicaid program, including disproportionate share hospital (DSH) payments and other supplemental payments. These rules permit using an array of public funds for intergovernmental transfers (IGTs), certified public expenditures (CPEs) and other financing mechanisms. *Counties encourage maximum flexibility for states and counties to finance the non-federal share of Medicaid. Counties oppose any new restrictions on that flexibility which could shift costs to state and local taxpayers, limit the ability to plan, and reduce access to essential health care services for low-income, uninsured and underinsured residents.*

Background: NACo policy has long supported the unique role of counties in Medicaid administration, finance and service delivery in partnership with the state and federal governments. Counties have worked with their state governments and with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) to develop financial arrangements to fund their Medicaid programs, approved pursuant to federal and state law and regulations, in order to meet their unique local needs.

On November 18, 2019 CMS published a proposed rule known as the 2019 Medicaid Fiscal Accountability Regulation (MFAR). MFAR would significantly change the ways that states and counties would be permitted to finance the non-federal share of their Medicaid programs, including new restrictions on IGTs, CPEs, provider taxes and other mechanisms. MFAR would also significantly expand CMS discretion to review both new and existing state and local financing arrangements. Moreover, these new reviews would be required every three years leading both to destabilizing uncertainty and regulatory burden. MFAR also imposes significant new onerous reporting requirements.

If these new restrictions are implemented, they could significantly reduce the funds available to states and counties to contribute to the non-federal share of Medicaid and draw down the federal match. The diminished resources could result in less Medicaid funding available to support local health care systems, including county hospitals, clinics, behavioral health programs and long-term care facilities. Further, under the proposed regime, times of maximum strain on finding resources (a contracting tax-base) would coincide with those of greatest need for Medicaid services (increasing unemployment).

The proposed rules not only undermine providers and patient care, they also constitute an intrusion of the federal government into local affairs, undermine provider incentives to wean themselves off of state funds and increase bureaucracy. As proposed, MFAR introduces so much ambiguity to the basic financing mechanisms underpinning county government Medicaid funding, it could make it increasingly difficult for localities to continue to budget and innovate strategically.

Fiscal/Urban/Rural Impact: According to the Government Accountability Office (GAO), in FY 2012 (the most recent data available) 31 states used IGT funding and 28 states and the District of Columbia used CPEs. On average, 26 percent of the non-federal share of Medicaid costs were financed by provider taxes (10.4 percent), and IGTs and CPEs (15.5 percent). These percentages are probably higher now, with more states likely relying on provider taxes. If states are unable to replace funding from providers and IGTs/CPEs with other sources (e.g. general revenues generated from higher taxes or from cuts to other parts of their budgets), they will have no choice but to reduce their spending on their Medicaid programs. Fewer state and local dollars spent on Medicaid will mean fewer federal Medicaid matching funds and more significant cuts to Medicaid and the individuals it serves overall. (See Health Affairs Blog, Jan. 16) According to a 2020 Manatt Health impact analysis of the proposed rule for the American Hospital Association, the Medicaid program nationwide would see cuts totaling between $37 and $49 billion per year, or 5.8 percent to 7.6 percent of total program spending. While MFAR's impact on individual states would vary widely, in almost all states it would result in cuts to Medicaid enrollment and services. In some states the effects could be catastrophic.

Sponsors: The County of Los Angeles, The Hon. Clay Jenkins, Dallas County Judge, The California State Association of Counties, The County Welfare Directors Association of California, The National Association of County Human Services Administrators, Harris County, Texas

PENDING BEHAVIORAL HEALTH LEGISLATION—116TH CONGRESS AND ADMINISTRATION PROPOSALS

(MARCH 2020)

STRENGTHENING PARITY

- *Mental Health Parity Compliance Act.* (HR 3165, Rep. Katie Porter (D-CA); S 1737, Sen. Chris Murphy (D-CT)). The bill would further strengthen parity in mental health and substance use disorder benefits, with improved monitoring and reporting features.
- *Parity Enforcement Act* (HR 2848, Rep. Donald Norcross (D-NJ)). The bill would allow the Labor Department to impose penalties against health insurers and plan sponsors for parity violations; protect issuers and sponsors that exercise "reasonable diligence" to comply and correct violations within 30 days of being known.
- *Behavioral Health Coverage Transparency Act* (HR 2874, Rep. Joseph P. Kennedy (D-MA); S 1576, Sen. Elizabeth Warren (D-MA)). The bill would strengthen enforcement of parity laws by increasing mandatory federal audits of health plans, requiring insurance companies to disclose how they make decisions on behavioral health care coverage, and establishing a Consumer Parity Portal, a one-stop shop where consumers could learn about their rights and submit complaints about their insurers.

WORKFORCE

- *Mental Health Professionals Workforce Shortage Loan Repayment Act* (HR 2431, Reps. John Katko (D-NY) Grace Napolitano (D-CA); S 2500, Sen. Kamala Harris (D-CA). The bill would amend the PHS Act to authorize loan repayments for mental health professionals to relieve workforce shortages, and for other purposes.
- *Defending Access to Mental Health Care Act* (S. 1668, Sen. John Tester (D-MT)). The bill expands the National Health Service Corps to include service in pediatric inpatient mental health facilities (such facilities may qualify as health professional shortage areas under the program).
- *Mental Health Access Improvement Act of 2019* (HR 945, Rep. Mike Thompson (D-CA); S 286, Sen. John Barrasso (R-WY)). This bill provides for coverage of marriage and family therapist services and mental health counselor services under Medicare. It also excludes such services from the skilled nursing facility prospective payment system and authorizes mental health counselors and marriage and family therapists to develop discharge plans for post-hospital services.

CCBHCS

- *Certified Community Behavioral Health Centers* (CCBHCs) expansion grants and grants to Federally Qualified Health Centers were reauthorized and funded *only through May 22, 2020*, rather than through September 30, 2020 (the end of the fiscal year) under the FY 2020 minibus appropriations bill signed into law late last year. The aim is to link these "must pass" bills with legislation on drug costs and/or surprise medical bills to assure they all are considered and enacted by Congress. Note that, since March 2019, the demonstration program and funding have been temporarily extended 6 times. While adopting measures to lowering drug costs and curb the threat posed by unanticipated high medical bills are important, the CCBHC and FQHC programs need continuing authority and funding through the entirety of FY 2020 and beyond.
- *Mental Health and Addiction Treatment Expansion Act* (S. 824, Sen. Debbie Stabenow (D-MI); HR 1767, Rep. Doris Matsui (D-III). The bills reauthorize CCBHCs for 2 additional years and to expand them by 11 more states.

JUSTICE-INVOLVED POPULATIONS

- *Restoring Health Benefits for Justice-involved Individuals Act of 2019* (S. 2626, Sen. Jeff Merkley (D-). The bill would ensure that people in jail prior to conviction (aka, pre-adjudication status) still have access to Medicare, CHIP and veterans' benefits.

- *Equity in Pretrial Medicaid Coverage Act* (S. 2628, Sens. Ed Markey (D-MA), Jeff Merkley (D, Sherrod Brown, Tina Smith, Dick Durbin). The bill would remove the limitation on an individual's eligibility Medicaid while the individual is in custody pending disposition of charges (aka pre-adjudication status).
- *Humane Correctional Health Care* Act. (HR 4141 Rep. Annie Kuster (D-NH); S. 2305 Sen. Corey Booker (D-NJ). The legislation would repeal the Medicaid inmate exclusion altogether.
- *The Medicaid Re-entry Act.* (HR 1329, Reps. Paul Tonko (D-NY), Michael Turner (R-OH)). The measure allows states to begin or restart benefits for Medicaid-eligible individuals for addiction treatment up to 30 days *before* release from jail or prison. The provisions apply equally to individuals with mental disorders and intellectual/developmental disabilities.

SUICIDE PREVENTION

- *National Suicide Hotline Designation Act.* (S. 2661, Senator Cory Gardner (R-CO); HR 4194, Rep. Chris Stewart (R-CO). The bill would require the Federal Communications Commission to *designate 9–8–8* as the universal telephone number for a national suicide prevention and mental-health crisis hotline. DHHS and the VA are to specify how to make the hotline operational and effective nationwide. While the FCC voted in December 2019 to move to the 988 number, it is important to keep the pressure on by supporting this legislation to ensure that the FCC follows through on its vote and that funds are appropriated.
- *Barriers to Suicide Act.* (HR 2599, Reps. Don Beyer (D-VA), John Katko (D-NY) and Grace Napolitano (D-CA)). The bill makes grants to state and local governments to fund nets and barriers on bridges, a practice shown to reduce suicide.
- *Suicide and Threat Assessment Nationally Dedicated to Universal Prevention (STANDUP) Act.* (HR 2599, Reps. Scott Peters (D-Ca), Gus Bilirakis (R-FL) and S 2492, Sens. Gardner (R-CO), Doug Jones (D-AL)) The House bill encourages section Project AWARE and other school-based suicide prevention grant recipients to implement student suicide prevention awareness and training policies and school threat assessment team policies. The Senate version addresses *only* student suicide prevention awareness and training policies. It does not include school threat assessment.
- *Increasing Access to Mental Health in Schools Act* (HR 2958, Rep. Judy Chu (D-CA); S 1642, Sen. John Tester (D-MT)). The bill would increase the recruitment and retention of school-based mental health services providers by low-income local educational agencies.
- *Mental Health Services for Students Act* (HR 1109, Rep. Grace Napolitano (D-CA); S 1122, Sen Tina Smith (D-MN)). The bill would add funds and expand the scope of the Project AWARE State Educational Agency Grant Program to provide access to more comprehensive school-based mental health services and supports, including universal evidence-based screening of children for potential emotional disorders, comprehensive staff development, for comprehensive training for families/caregivers to improve health and academic outcomes for children with, or at risk for, mental disorders.

ACCESS TO CARE/INSURANCE

- *Primary and Behavioral Health Care Access Act* (HR 5575, Rep. Lauren Underwood (D-IL). Under the bill, those with private insurance plans would be granted three annual primary care visits and three annual outpatient behavioral health care visits without incurring a copayment, coinsurance or deductible-related fee.

MIXED-TOPIC (DRUG COSTS/ACA SAFEGUARDS/SOCIAL DETERMINANTS) LEGISLATION

- *Elijah E. Cummings Lower Drug Costs Now* Act (HR 3, known as the Pelosi bill). The measure was adopted by the House in a 230-192 vote. Two Republicans voted in favor of the measure that, according to CBO estimates, would cut prescription drug prices by as much as 55% and save consumers $456 billion over the next 10 years. The bill has been pending in the Senate for several months now. A recently revised, separate Senate measure co-sponsored by Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking member, Senator Ron Wyden (D-OR) is

favored by the White House. The authors hope to attach their proposal to the CCBHC/FQHC reauthorizations and appropriations that must occur by May 22, 2020. However, recognizing both the Senate and House bills have more Democratic than Republican support, Majority Leader McConnell isn't likely to rush it to the floor at this time in the election cycle.

- *Utilizing National Data, Effectively Reforming Standards and Tools, to Address Negative Determinants of Health (UNDERSTAND) Act.* (S. 1323, Sens. Rob Porter (R-OH), Bob Casey (D-PA)). The bill would collect information under Medicare, Medicaid, and the Children's Health Insurance Program related to social determinants of health. Data would be collected from licensed health professionals and community health workers on topics including education and literacy; employment and unemployment; occupational exposure risks; housing and economic circumstances; social environment; family/primary support groups; civil or criminal convictions; and pregnancy. A report on the findings would be made to Congress within 5 years of enactment.

SAVING THE ACA

- *Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act* (S 1905, Sens. Tammy Baldwin (D-WI) and Bob Casey (D-PA)). The bill would restore $100 million in funding for the Navigator program that helps American families get the information and support they need to find a quality health care plan at a price they can afford. The measure is cosponsored by 20 or more Senate Democrats. A House companion has already been adopted.
- *State Allowance for a Variety of Exchanges (SAVE) Act.* (S 1400, Sens. Bob Menendez (D-NJ), Cory Booker (D-NJ); HR 1385, Rep. Andy Kim (D-NJ)). The bill would make $200 million in grants available to states choosing to establish their own state-based ACA marketplaces in lieu of remaining part of the federal marketplace program.

MEDICAL RECORD PRIVACY

- *Overdose Prevention and Patient Safety Act* (HR 2062, Reps. Earl Blumenauer (D-OR), Markwayne Mullin (R-OK)); *Protecting Jessica Grubb's Legacy Act* (S 1012 Sens. Joe Manchin (D-WV), Shelley Moore Capito (R-WV). The bipartisan bill would modify the federal statute requiring explicit patient consent before sharing substance use treatment records to align with Part 2 patient privacy protections permitting the medical community to use substance use disorder treatment records in the same manner as all other medical records. The bill incorporates language to safeguard against unauthorized invasion of patient privacy and discriminatory activity.

SUBSTANCE ABUSE TREATMENT PROGRAMS

- *Mainstreaming Addiction Treatment Act* (HR 2482, Rep. Paul Tonko (D-NY); S 2074, Sen. Margaret Hassan (D-NH)). The bill would increase access to buprenorphine treatment within our communities by eliminating separate registration requirement for dispensing narcotic drugs in schedule III, IV, or V (such as buprenorphine) for maintenance or detoxification treatment.
- *Family Support Services for Addiction Act* (HR 5572, Reps. David Trone (D-MD) and Dan Meuser (R-PA); Sens. Kirsten Gillibrand (D-NY) and Shelley Moore Capito (R-WV)). The bill would make $25 million available over 5 years to help community organizations and nonprofits build family support services and resources for families with loved ones struggling with addiction.

SURPRISE MEDICAL BILLS

- Shortly before the end of 2019, Senate HELP Committee Chairman Senator Lamar Alexander (R-TN), and the Chair and Ranking member of the House Energy and Commerce Committee, Representatives Frank Pallone (D-NJ) and Greg Walden (R-OR), announced a bipartisan solution to the issue of surprise medical bills. It included a compromise on how much insurance companies would pay out-of-network physicians for insured patient care, created by combining the different House and Senate approaches. Bills over $750 would be sent to arbitration; those under that figure would be paid at a benchmark price tied to in-network charges in the region. The hope was to attach the bill to the must-pass FY 2020 appropriations measure. That obviously did not happen.

That's because the Chair and Ranking member of the House Ways and Means Committee, respectively Richard Neal (D-MA) and Kevin Brady (R-TX), introduced a rival bill, resurfacing key divisions over the legislation. *Any compromise measure may well be considered as part of a package that includes reauthorization of FQHCs and CCBHCs sometime between now and May 22, 2020.*

STATE/LOCAL FLEXIBILITY IN FUNDING NON-FEDERAL MEDICAID SHARE

- On November 18, 2019, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule—the *2019 Medicaid Fiscal Accountability Regulation (MFAR).* MFAR would significantly change how states and counties are allowed to finance the non-federal share of their Medicaid programs. It would, for example, place new restrictions on intergovernmental transfers (IGTs), certified public expenditures (CPEs), provider taxes and other mechanisms. CMS would have new discretion to review both new and existing state and local financing arrangements, and to do so every 3 years. Moreover, MFAR also imposes significant new onerous reporting requirements. *The National Association of Counties and NACBHDD oppose these proposed new regulations. (See attachment for detailed discussion.)*

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from higher taxes or from cuts to other parts of their budgets), they will have no choice but to reduce their spending on their Medicaid programs. Fewer state and local dollars spent on Medicaid will mean fewer federal Medicaid matching funds and more significant cuts to Medicaid and the individuals it serves overall. (See Health Affairs Blog, Jan. 16) According to a 2020 Manatt Health impact analysis of the proposed rule for the American Hospital Association, the Medicaid program nationwide would see cuts totaling between $37 and $49 billion per year, or 5.8 percent to 7.6 percent of total program spending. While MFAR's impact on individual states would vary widely, in almost all states it would result in cuts to Medicaid enrollment and services. In some states the effects could be catastrophic.

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2-10-20

OPEN MINDS

No Common Language = No Data Sharing

February 24, 2020 | Monica E. Oss

After attending the session, Population Health Management For The Complex Consumer Market: How To Utilize Data To Coordinate Services Across The Care Continuum at the 2020 *OPEN MINDS* Performance Management Institute, I was reminded of the Biblical story of the Tower of Babel. In the story, the result was the wide array of human languages across the globe.

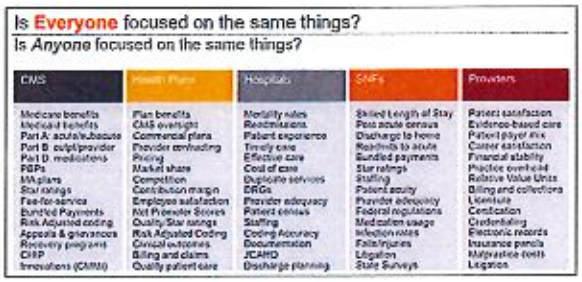
Cathy Lipton, M.D., National Medical Director, Institutional Programs, Optum

The session, featuring Cathy Lipton, M.D., National Medical Director, Institutional Programs at Optum; Dianne Shaffer, Director of Systems Development at Integrated Services of Kalamazoo; and Sarah Green, Senior Integrated Health Care Specialist of Southwest Michigan

Most Popular Resources In The *OPEN MINDS* Industry Library In

Behavioral Health, reminded the audience of the very disparate views of "value" among the stakeholders.

Dr. Lipton opened the session with an overview of the different health and human service system stakeholders' focus. Payers have a "mega focus" on the "Quadruple Aim." Health plans are looking for profitability and growth. Hospitals and skilled nursing facilities want consumers and clinical professionals want career satisfaction and stability. Consumers are looking for resolution of their problems and an easy health care system to navigate. Her underlying premise was that the only commonality among these stakeholders is that they define success in terms of clinical outcomes—and even those definitions vary.



Dianne Shaffer, Director of Systems Development, Integrated Services of Kalamazoo

This discussion speaks to the challenges of standardizing performance measures in value-based reimbursement contracts. It also highlights the difficulty for provider organization management teams to develop a "value proposition"

January

UnitedHealthcare Expands Initiative To Use Diagnostic Codes To Capture Social Determinants Of Health

New CMS IMD Rules Expand Medicaid Coverage Of Psychiatric Treatment Facilities

SAMHSA Proposes Changes To Addiction Treatment Privacy Rules

Social Determinants—The Next Frontier

Anthem To Acquire Beacon Health Options

that speaks to payers, health plans, and consumers simultaneously. "We're great at delivering services. What we aren't great at is telling our story of who we serve and putting ourselves at the forefront of being the solution for payers," said James Stewart, session moderator and Chief Executive Officer of Grafton Integrated Health Network.

Ms. Shaffer and Ms. Green presented a collaborative initiative between Southwest Michigan Behavioral Health, prepaid inpatient health plans (PIHPs) for eight counties, and Integrated Services of Kalamazoo, a community mental health provider organization, to coordinate care for "high needs" seniors in their market. From the start, the primary challenge they faced was obtaining consumer-specific data and then normalizing that data for use in care coordination. Michigan is unique in having a statewide data repository for Medicaid data so that data is available, but the collaborative has not been able to access the rest of the consumer data—including Medicare data. As a result, their care coordination program is missing fundamental information for both risk profiles and ongoing care management.

Recognizing that limitation, the discussion turned to why data sharing is so difficult and what to do about it. The reasons data sharing among stakeholders is difficult are well known. Different stakeholders in the field "speak" different languages, use different electronic health record systems, record different metrics, have little (or no) agreement on incentives and goals, and have a limited understanding of each other's capabilities.

Sarah Green, Senior Integrated Healthcare Specialist, Southwest Michigan Behavioral Health

The question is what to do about the current constraints to data sharing? This is a key strategic issue for any specialty provider organization. My key takeaway is to understand the priority of data needs and master the art of "small data" (see From Big Data To Small Data—From The Ideal To The Possible and Using Data Can Make Care Coordination More Efficient (& Effective). Even if you don't have "all the data," executive teams need to identify and prioritize the "highest value" data needed for optimal performance. This is a case where waiting for "the perfect" scenario is the enemy of progress.

For more on managing your data, check out these resources from *The OPEN MINDS Industry Library*.


02/07/2020

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

as of 1/10/20

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

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial In: 1-844-655-0022
Access Code: 738 811 844
April 10, 2020
9:30 am to 11:30 am
Alan Bolter, CMHAM 10:45am-11:30am
Draft: 2/26/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Fiscal Year 2019 Audit Report (d) (T. Dawson and D. Miller)**
5. **Consent Agenda**
   - March 13, 2020 SWMBH Board Meeting Minutes (d)
6. **Operations Committee**
   a. Operations Committee Minutes February 26, 2020 (d)
   b. Operations Committee Quarterly Report (d) (D. Hess)
7. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   - None scheduled
8. **Board Actions to be Considered**
   a. Board Officer Elections
   b. Revised Credentialing of Behavioral Health Practitioners Policy (d) (M. Todd)
   c. Revised Credentialing of Behavioral Health Organizational Providers Policy (d) (M. Todd)
   d. Summer Alternate Board Meeting Locations (B. Casemore)
   e. Strategic Imperatives Revised Descriptions (B. Casemore) (d)
9. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   a. BG-006 Annual Board Planning (d)
   b. BG-010 Board Committee Principles (d)
10. **Executive Limitations Review**
    Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
    - None scheduled

11. **Board Education**

    a. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson)
    b. Auditor Procurement (T. Dawson)
    c. Workplace Culture Program (d) (A. Wickham)
    d. System Reform Part 2 (d) (B. Casemore)

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

    a. Michigan Consortium for Healthcare Excellence (MCHE) Update (d) (B. Casemore)
    b. April 17, 2020 Public Policy Legislative Event (d) (B. Casemore)
    c. May 8, 2020 Board Retreat (d) (B. Casemore)
    d. Board Member Attendance Roster (d)
    e. May: BG-011 Governing Style
    f. May: BEL-004 Treatment of Staff (E. Meny)

13. **Public Comment**

14. **Adjournment**

Next SWMBH Board Meeting
May 8, 2020
9:30 am - 10:30 am
Sherman Lake YMCA Event & Retreat Center
Leadership Lodge
6225 North 39th St. Augusta, MI 49012

To be followed by Planning Session until 3:30pm

State Legislative Update:

FY21 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY'19 (final)	FY'20 (final)	FY'21 (exec rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$130,674,200
-Medicaid Mental Health Services	$2,319,029,300	$2,487,345,800	$2,566,704,100
-Medicaid Substance Abuse services	$67,640,500	$68,281,100	$76,957,600
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,956,200	$108,754,700	$107,133,400
-Autism services	$192,890,700	$230,679,600	$278,006,400
-Healthy MI Plan (Behavioral health)	$299,439,000	$371,843,300	$419,357,300
- Local Revenue (local match)	$25,475,800	$20,380,700	$25,475,800

Other Highlights of the FY21 Executive Budget:

$37.5 million for Healthy Moms, Healthy Babies ($17.6 million general fund) to reduce infant mortality rates and racial disparities in birth outcomes through expanded maternal and reproductive health services and home visiting programs. Funding will extend Medicaid family planning benefits to women of child-bearing age up to 200% of the poverty level, expand Medicaid postpartum coverage from 60 days to 12 months after birth, increase evidence-based home visiting services to high-risk mothers and vulnerable families, and expand psychiatric support services to perinatal providers.

$20.3 million for long-term care services and supports options counseling ($8.5 million general fund) through a network of independent, conflict-free providers. Services supported by this funding will provide beneficiaries with information on all long-term care options available to them, allowing them to seek the care best suited to their needs.

$11.7 million for Social Determinants of Health infrastructure ($7.1 million general fund) to invest in community-based systems and technological infrastructure to support data sharing across programs and providers and appropriately connect individuals to state and local services. Funding will establish a standard screening tool to determine health related social needs (e.g., food security and housing stability) and make referrals to community-based resources. Local partnerships across eight regions will coordinate services, identify gaps in community-based programs, and guide resource investment.

$12.3 million to expand DHHS's response to the opioid crisis (one-time, $10 million general fund). This funding will support initiatives involving data-driven quick response teams, a predictive analytics system, substance use disorder treatment outcomes monitoring, and a revolving loan fund for recovery housing providers. Funding will also support training for community providers and criminal justice diversion grants.

$5 million to increase psychiatric care staffing (general fund) to improve the quality of care and staff and patient safety at state psychiatric hospitals. Funding supports 63 new positions across four facilities. An additional $30 million in one-time general fund is recommended in the budget for the Department of Technology, Management and Budget to address a backlog of facility maintenance needs.

$86.5 million to expand the MiDocs medical residency program (one-time, $21.6 million general fund). This investment will improve access to critical services in rural and medically underserved areas of the state by providing loan forgiveness to physicians committed to serving in those areas. One-time funding when combined with base funding will support 48 residency slots within cohorts beginning residencies over the next five years.

$5.1 million for Non-Medicaid Community Mental Health Services programs (general fund) to enhance community-based services and supports for individuals with mental illness, serious emotional disturbance, and developmental/intellectual disabilities who do not meet Medicaid eligibility criteria. Around 52,000 Michigan residents currently access these services.

$2.5 million for first responder and public safety staff mental health (one-time general fund) to provide firefighters, police officers, paramedics, dispatchers, and corrections officers with services to support their mental health. This funding will provide greater resources to address post-traumatic stress disorder, suicidal ideation, and other mental health crises.

$5 million for behavioral health system redesign efforts ($3 million general fund) that support policy development and projects that will strengthen and improve the behavioral health system by protecting safety net programs and integrating physical and behavioral health payments and clinical services.

$5 million to create a Medicaid Transformation Office ($2.5 million general fund). Effective value-based payments are a powerful tool for states to increase the quality of Medicaid services while also containing state costs. Funding will support the development of innovative programs and payment mechanisms in Michigan's physical health and behavioral health managed care programs.

REDUCTIONS

$182.9 million from Medicaid pharmacy reimbursement reform ($45.8 million general fund) tied to implementation of a single, statewide Medicaid preferred drug list (PDL). The PDL will help maximize federal rebates and provide DHHS greater leverage in negotiating lower prices with drug manufacturers. Savings will be used, in part, to increase pharmacy reimbursement rates to further enhance access to provider networks throughout the state.

$5.1 million from Community Mental Health local match funds (general fund). Funding was included for fiscal year 2020 to offset county match requirements for Medicaid behavioral health and shift the costs to the state general fund. The Executive Budget instead redirects this funding to allow for expanded non-Medicaid behavioral health services.

Federal Update:

White House Releases FY 2021 Budget Request

On Monday the Trump Administration released its Fiscal Year (FY) 2021 budget request which totals $4.8 trillion. The proposal includes significant nondefense discretionary cuts including a nine percent cut to the Department of Health and Human Services (HHS) and its agencies. The proposed budget does, however, include $906 million to extend the Certified Community Behavioral Health Clinic (CCBHC) demonstration program as well as $225 million in CCBHC expansion grants. These funds would enable CCBHCs to continue offering the full range of required mental health and addiction treatment services. Despite the

positive signal of support for CCBHCs, the budget also includes major cuts to Medicaid and other critical behavioral health programs that would significantly harm Americans living with mental illness and addiction.

National Council for Behavioral Health President and CEO Chuck Ingoglia released a statement affirming that "We applaud the White House and bipartisan leaders in Congress for their continued efforts to expand access to high-quality addiction and mental health treatment. Much work remains to ensure that every American has access to life-saving treatment available at CCBHCs and we are grateful for the bipartisan support that has brought us this far."

It is important to remember that this is a proposal and represents President Trump and his Administration's goals and priorities but is not likely to be enacted into law as written. Congressional appropriators do not have an obligation to enact the President's budget and are considering their own priorities and calculations. Members of Congress are currently working on their budget by engaging with stakeholders, including the National Council, on their requests. We anticipate that appropriations committee hearings will be completed by the end of March and that subcommittee markups will begin in April.

Health care requests in the President's budget include:

- **Mental Health:** Although the President calls on the importance of addressing mental health in his budget, he is simultaneously proposing a cut of $139 million to the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition to the **$906 million to extend the CCBHC Medicaid demonstration, there is $225 million for CCBHC expansion**, an increase of $25 million over last Fiscal Year. The budget allocates $156 million, an increase of $2 million, for school-based mental health programs such as Project AWARE, Healthy Transitions, and Mental Health First Aid. The budget modifies the Medicaid Institutes for Mental Diseases (IMD) exclusion to provide targeted flexibility to states to provide inpatient mental health services to Medicaid beneficiaries with serious mental illnesses, as part of a comprehensive strategy that includes improvements to community-based treatment. Further, Qualified Residential Treatment Programs (QRTPs) would be exempt from the IMD exclusion, allowing children in foster care to have Medicaid coverage in these facilities.

- **Integrated care:** The President's budget proposes eliminating the Primary and Behavioral Health Care Integration (PBHCI) program "due to other funding sources available for integrated care." Discontinuing this program would disrupt progress in this area that has been building since it began in 2009 addressing the intersection between primary care and treatment for mental illness and co-occurring addiction.

- **Opioids:** State Targeted Opioid Response grants received a request increase of $85 million to support prevention, treatment, and recovery support services. States are also given flexibility to use these funds to address the emerging drug issue, which is the increasing number of overdoses related to psychostimulants, including methamphetamines.

- **Medicaid and Medicare:** The Administration proposes almost $1 trillion in cuts over ten years from its proposals to reform Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. The budget proposes cuts by instituting nationwide Medicaid work requirements and allowing asset tests for individuals who are eligible for Medicaid based on their modified adjusted gross income and for reducing the maximum allowable home equity for Medicaid eligibility. Additionally, the budget has proposed changes to Medicare including site-neutral payments and tying future funds available for Medicare payments for uncompensated care to FY 2019

uncompensated care funding levels. The budget does also propose prohibiting states from terminating Medicaid coverage for the first six months of a person's incarceration, and instead suspending that coverage during incarceration to ease individuals' transition back into the community upon release.

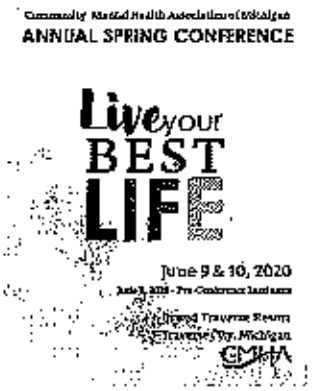
- **Drug Pricing:** The drug pricing proposals in the budget were left intentionally vague to allow continued negotiations in Congress. The Administration projects $135 billion in savings over ten years from potential drug pricing reforms, pointing to some of the estimated savings from plans in Congress. This number is similar to estimates for reforms proposed by Senate Finance Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) to restructure the Part D benefit and to place inflation caps on drug prices in Parts B and D. This proposal by Senators Grassley and Wyden includes a two year extension and 11 state expansion for CCBHCs.

- **Telehealth:** The budget calls for expanding the telehealth benefit in Medicare fee-for-service, permitting more providers to participate in telehealth.

Additional details on the President's HHS budget request are outlined in the Department's budget-in-brief document. Further policy details have yet to be released that would outline how the President proposes to achieve the level of cuts to public health care programs included in the proposal. The National Council will monitor the appropriations process and will continue to share updates in Capitol Connector.

Education Opportunities:

New! Call for Presentations: CMHA 2020 Annual Spring Conference



New Location for Annual Spring Conference: Grand Traverse Resort, Traverse City, Michigan! The conference will be held on:

2020 Annual Spring Conference
June 8, 2020: Pre-conference Institutes
June 9 &10, 2020
Grand Traverse Resort, Traverse City

Click Here to Download the Workshop Submission Form

Deadline to Respond to Call for Presentations: Friday, March 13, 2020

Conference Registration & Hotel Reservations are not available at this time.