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
March 8, 2019
9:30 am to 11:30 am

Five Year Anniversary Celebration!
8:45-9:30am
Hot Breakfast with SWMBH Staff

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d) (pg.1)**
3. **Board Action: Financial Interest Disclosure – Conflict of Interest Handling (d) (M. Todd) (pg.3)**
   - J. Goodrich
4. **Consent Agenda**
   - January 11, 2019 SWMBH Board Meeting Minutes (d) (pg.4)
5. **Operations Committee**
   a. Operations Committee Minutes December 19, 2018 (d) (pg.9)
   b. Operations Committee Minutes January 23, 2019 (d) (pg.12)
6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   - 2018 Customer Satisfaction Survey Results (d) (J. Gardner) (pg.15)
7. **Board Actions to be Considered**
   a. SWMBH Board Bylaws Revisions Resolution (d) (B. Casemore) (pg.48)
   b. Board Directive ..."the SWMBH Executive Officer and Chief Financial Officer be charged with adjustments to cell H56 on the 2019 proposed Budget to reduce projected deficit with a report to the Board by March 2019." (d) (B. Casemore and T. Dawson) (pg.62)
   c. Fiscal Year 2018 Performance Bonus Incentive Characterization (d) (B. Casemore) (pg.70)
   d. Southwest Michigan Behavioral Health Operating Agreement (d) (pg.72)
   e. Southwest Michigan Behavioral Health Operations Committee Charter (d) (pg.86)
   f. SWMBH Board Retreat Planning – May 2019 (d) (B. Casemore) (pg.89)
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - None scheduled

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

- BEL-007 Compensation and Benefits (S. Barnes) (d) (pg.91)

10. **Board Education**

a. Final Fiscal Year 2018 Consolidated Financial Statements (d) (T. Dawson) (pg.95)
b. Fiscal year 2019 Year to Date Financial Statements (d) (T. Dawson) (pg. 104)
c. 2019 Utilization Management Plan (d) (A. Wickham) (pg.112)
d. Fiscal Year 2018 Program Integrity Compliance Program Evaluation (d) (M. Todd) (pg.134)
e. Fiscal Year 2018 HIPAA Privacy/Security Report (d) (M. Todd and R. Moerland) (pg.134)
f. Integrated Care Targeted Measures Status (d) M. Kean (pg.151)

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

a. Michigan Consortium for Healthcare Excellence (B. Casemore)
b. 2019 Public Policy Legislative Education Initiative (d) (B. Casemore) (pg.152)
c. Board Member Attendance Roster (d) (pg.156)
d. SWMBH Retirement Plans Follow Up (d) (pg.157)
e. Articles (d) (pg.158)
f. April: Board Elections
g. April: BG-010 Board Committee Principles
h. April: BEL-002 Financial Conditions (E. Meny)

12. **Public Comment**

13. **Adjournment**

Next SWMBH Board Meeting
April 12, 2019
9:30 am - 11:00 am
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

SWMBH BOARD OF DIRECTORS

Consideration and Process for SWMBH Financial Interest Disclosure Statements and SWMBH Conflict of Interest Waivers

For consideration and action at the Board's 03/08/2019 meeting

SWMBH BOARD OF DIRECTORS

SWMBH Operations Committee (Summit Pointe) – Jeannie Goodrich

- SWMBH Financial Interest Disclosure Statement completed and signed by Jean M. Goodrich on 11/08/2018, disclosing the following:
  - "My son is employed and receives compensation from Pine Rest. Summit Pointe contracts with Pine Rest, and those contracts are negotiated by SWMBH on behalf of Summit Pointe and other Region 4 CMHSPs. He is a direct care worker at Center Pointe."
- Considerations:
  - Summit Pointe's Board of Directors considered Ms. Goodrich's disclosed conflict of interest during its November 6, 2018 Board Meeting. It noted the following: 1) that Ms. Goodrich will need to maintain "an arms-length distance from this contractual relationship"; 2) that other Summit Pointe staff monitor the relationship and contract with this provider; and 3) that SWMBH negotiates this contract on behalf of its Participant CMHSPs. The Summit Pointe Board unanimously passed a motion to waive Ms. Goodrich's conflict of interest.

SWMBH Management Recommendation

SWMBH management recommends that the SWMBH Board determine as follows:

1. A conflict of interest exists;
2. The Board is not able to obtain a more advantageous arrangement from someone other than Ms. Goodrich;
3. Reasonable safeguards are already in place at Summit Pointe to ensure that the conflict disclosed is not likely to affect the integrity of the services that SWMBH may expect to receive from Ms. Goodrich; and
4. A conflict of interest waiver should be granted.

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
January 11, 2019
9:30 am-11:30 am
5250 Lovers Lane, Suite 200, Portage, MI 49002

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

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 QAPI, SWMBH; Mary Ann Bush, Senior Operations Specialist/Project Coordinator, SWMBH; Jon Houtz, Branch Alternate; Deb Hess, Van Buren Community Mental Health; Susan Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Richard Thiemkey, Barry County Community Mental Health; Mike Kenny, NAMI; Kathy Sheffield, Woodlands BH

Guests on phone: Nancy Johnson, Berrien Board Alternate

Welcome Guests

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

Public Comment

None

Agenda Review and Adoption

Motion	Tim Carmichael moved to accept the agenda as presented.
Second	Mary Myers
Motion Carried	

Consent Agenda

Motion	Susan Barnes moved to approve the December 14, 2018 Board Meeting minutes as presented.
Second	Robert Nelson
Motion Carried	

Motion	Edward Meny moved to approve the Customer Advisory Committee appointment as presented.
Second	Patrick Garrett
Motion Carried	

Operations Committee

Operations Committee Minutes November 14, 2018

Tom Schmelzer asked for comments or questions. Minutes accepted.

Operations Committee Quarterly Written Report

Debbie Hess presented the written report as documented. Tom Schmelzer asked for comments or questions. Report accepted.

Ends Metrics

2018 Aetna Claims Audit Results

Anne Wickham reported as documented and recognized SWMBH staff, Gina Martuge, for her work on the audit.

Motion Edward Meny moved that the 2018 Aetna Claims Audit Results is relevant and compelling, the Executive Officer is in compliance and the Ends Metric does not need revision.

Second Patrick Garrett

Motion Carried

Board Actions to be Considered

SWMBH Bylaws Revision Resolution

Brad Casemore reviewed history of Bylaws revisions. Robert Nelson shared discussion of SWMBH Bylaws revisions at the Barry Community Mental Health Authority Board meeting on January 10, 2019. Group reviewed Robert Nelson's email dated 1/10/19 at 1:48pm. Board agreed to table the SWMBH Bylaws Revision Resolution until feedback from each CMHSP Board is received.

2019 Fiscal Year Revised Budget

Tracy Dawson reported as documented and thanked each CMH CFO for their hard work in revising budgets and reducing expenses. Tracy Dawson noted that moving to State Autism rates will result in budget reductions of 4 million. Brad Casemore added that April 1, 2019 the State will be adding the direct care wage to State rates, which is an unknown favorable impact for us. Group discussed budget.

Motion Tim Carmichael moved that the 2019 Fiscal Year revised budget be accepted as presented.

Second Robert Nelson

Motion Carried

Motion Tim Carmichael moved that the SWMBH Executive Officer and Chief Financial Officer be charged with adjustments to cell H56 on the 2019 proposed Budget to reduce projected deficit with a report to the Board by March 2019.

Second Patrick Garrett

Motion Carried

2019 Compliance Plan

Mila Todd reported as documented.

Motion Tim Carmichael moved to accept the 2019 Compliance Plan as presented.

Second Patrick Garrett

Motion Carried

2019 Quality Assurance and Performance Improvement Plan

Jonathan Gardner reported as documented.

Motion Moses Walker moved to accept the 2019 Quality Assurance and Performance Improvement Plan as presented as required by 42 CFR Section 438-210.

Second Tim Carmichael

Motion Carried

2019-2020 Ends Metrics

Jonathan Gardner reported as documented.

Motion Edward Meny moved to accept the 2019-2020 Ends Metrics with the exclusion of #9, the 298 Unenrolled Initiative Metric.

Second Patrick Garrett

Motion Carried

Board Policy Review

BG-001 Committee Structure

Tom Schmelzer reviewed the policy.

Motion Edward Meny moved that regarding policy BG-001, the Board is in compliance and the policy does not need revision.

Second Tim Carmichael

Motion Carried

BG-004 Board Ends and Accomplishment

Tom Schmelzer reviewed the policy.

Motion Moses Walker moved that regarding policy BG-004, the Board is in compliance and the policy does not need revision.

Second Tim Carmichael

Motion Carried

BG-006 Annual Board Planning Cycle

Tom Schmelzer reviewed the policy.

Motion Edward Meny moved that regarding policy BG-006, the Board is in compliance and the policy does not need revision.

Second Tim Carmichael

Motion Carried

BG-007 Code of Conduct

Tom Schmelzer reviewed the policy.

Motion Tim Carmichael moved that regarding policy BG-007, the Board is in compliance and the policy does not need revision.

Second Moses Walker

Motion Carried

Executive Limitations Review

BEL-001 Budgeting

Patrick Garrett reviewed the policy and noted that no revisions are necessary.

Motion Patrick Garrett moved that regarding policy BEL-001 the Executive Officer is in compliance and the policy does not need revision.

Second Moses Walker

Motion Carried

Board Education

2018 Community Mental Health Site Visit Results

Mila Todd reported as documented. Group discussed.

Communication and Counsel to the Board

Consolidated Fiscal Year 2019 Year to Date Financial Statements

Tracy Dawson reported as documented noting that the Internal Service Funds Risk Reserve Deficit Funding is on a better trajectory than October of 2018 and that the Medical Loss Ratio is also lower. Group discussed.

SWMBH Retirement Plans Update

Anne Wickham introduced Carl Doerschler of Rose Street Advisors. Carl Doerschler distributed a handout reviewing services, plans, statistics and rates of returns. Group discussed and requested a report regarding data, fees, costs and comparisons of retirement plans be prepared and presented to the Board at the March SWMBH Board meeting.

BEL-003 Emergency Executive Succession Board Considerations

Brad Casemore reported as documented. Group approved and requested the document be added to the Board records.

Fiscal Year 2018 Medicaid Services Verification Report

Mila Todd reported as documented.

Michigan Consortium for Healthcare Excellence Written Report

Brad Casemore reported as documented.

Board Membership Roster and Board Members' Attendance Roster

Brad Casemore reported as documented noting that the 2018 report will be mailed to each CMHSP Board chair.

CMHSPs Bylaws Revisions Consideration Update

Brad Casemore reviewed his recent visits to Cass, Barry and Calhoun CMH Board meetings.

March 8, 2019 Draft Board Agenda

Brad Casemore reported as documented.

Public Comment

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

Adjournment

Motion	Tim Carmichael moved to adjourn at 12:02 pm.
Second	Susan Barnes
Motion Carried	

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: December 19, 2018
9:00am-2:00pm

Members Present – Debbie Hess – Chair, Richard Thiemkey, Sue Germann, Jeff Patton, Jane Konyndyk, Kris Kirsch, Jeannie Goodrich, and Bradley Casemore

Members Present via phone conference – Kathy Sheffield, and Ric Compton

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer; Moira Kean, Director of Clinical Improvement, SWMBH; Jonathan Gardner, Director of QAPI, SWMBH; Dr. Robert Hill, Clinical Consultant, SWMBH; Mary Ann Bush, Sr. Operations Specialist, SWMBH; Michelle Jorgboyan, Sr. Operations Specialist, SWMBH; and Brad Sysol, Summit Pointe Counsel.

Guests via phone conference – Pat Davis, KCMHSAS; Tina Boyer, VBCMH; Mike Reed, RWC; Roger Pierce, Woodlands; Kelly Jenkins, BCCMHA; David Balmer, Summit Pointe and Jill Bishop, BCCMH.

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

Review and approve agenda – Committee agreed to follow the agenda as presented.

Review and approve minutes from 11/14/18 Operations Committee Meeting – Minutes were approved by the Committee.

Revised Fiscal Year 2019 Budget – Tracy Dawson thanked the CMH CFOs for their tremendous work in development and reductions regarding the Fiscal Year (FY) 2019 Budget. The current draft FY2019 Budget will deplete the Internal Savings Fund to zero for 2020. Tracy Dawson stated that anymore 2019 Budget adjustments need to be submitted to her by close of business day on 1/2/19. Tracy Dawson shared a 2018 Spend down Data Report. Group discussed.

Fiscal Year 2019 YTD Financials – Tracy Dawson stated that November financials are not ready yet.

DHHS 298 Unenrolled– Brad Casemore stated that the RFP should be released sometime in January of 2019.

MCG Installation Update– Anne Wickham reviewed the memo as documented.

SWMBH Public Policy-Legislative Education Initiative Steering Committee Meeting Update– Brad Casemore stated that the next SWMBH Legislative Event is scheduled for April 2019. Mary Ann Bush to send Public Policy Committee Meeting minutes to group.

Delegated Functions Oversight & Monitoring– Mila Todd reviewed the document as presented.

Review of Operating Agreement– Brad Casemore stated that the annual review of the Operating Agreement will start at next month's Operations Committee meeting. Michelle Jorgboyan to email Operating Agreement to group for review prior to next month's meeting.

Review of Operations Committee Charter– Brad Casemore stated that the annual review of the Operations Committee Charter will start at next month's Operations Committee meeting. Michelle Jorgboyan to email Operations Committee Charter to group for review prior to next month's meeting.

Operations Committee Self-Evaluation– Brad Casemore stated that the Operations Committee Self-Evaluation documents will be included in next month's meeting for the groups review.

SWMBH Bylaws Revisions– Brad Casemore stated that the SWMBH Board unanimously approved the Bylaws revisions and that each CMH Board must approve those as well. Kathy Sheffield commented that Woodlands CMH Board felt rushed in approving SWMBH Bylaws revisions and did not vote, with reconsideration at their January Board meeting.

2019-2020 Board Ends Metrics– Jonathan Gardner reviewed the document as presented. Group discussed and provided feedback to Jonathan.

Fiscal Year 2019 Compliance Plan– Mila Todd reviewed the 2019 Compliance Plan as presented. Group discussed.

2019 Operations Committee Meetings Calendar Approval– Group reviewed, discussed, revised and approved the 2019 Operations Committee Meetings Calendar. Michelle Jorgboyan to email meetings to group. Jeannie Goodrich requested that for Operations Committee meetings in 2020 that the group approves the meetings earlier in 2019.

Regional Utilization Management Managed Care Functional Review – Anne Wickham reviewed the document as presented and added that a Substance Use Disorder (SUD) Workgroup will be starting soon to review SUD processes and flow charts.

Mild to Moderate Policy and Procedure – Moira Kean reviewed the documents as presented.

Revised Level of Care Guidelines – Moira Kean reviewed the document as presented.

Children's Intensive Crisis Stabilization Report – Moira Kean reviewed the memos from the State as presented.

Fiscal Year 2018 Encounter Submission Status– Rob Moerland stated that SWMBH is updating their warehouse with encounter data and is 90% completed.

278 Transaction Status– Rob Moerland stated that there is some outstanding development work with Streamline and PCE.

2019 Quality Assurance Performance Improvement Plan– Jonathan Gardner reviewed the document as presented.

Draft Integrated Care Strategic Plan – Dr. Robert Hill and Moira Kean reviewed the document as presented and asked the group for feedback. Michelle Jorgboyan to email plan to group.

Dr. Logan to January Clinical Programs and Provider Network Management Committee Meetings– Brad Casemore stated that Dr. Logan will be visiting the January Clinical Programs and Provider Network Management combined Committee meeting.

January SWMBH Board agenda – Draft SWMBH Board agenda was included in the packet for the group's review.

Adjourned – Meeting adjourned at 1:30 pm

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: January 23, 2019
9:00am-2:00pm

Members Present – Debbie Hess – Chair, Sue Germann, Jeff Patton, Jeannie Goodrich, and Bradley Casemore

Members Present via phone conference – Kathy Sheffield, Ric Compton, Kris Kirsch, Richard Thiemkey

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer; Moira Kean, Director of Clinical Improvement, SWMBH; Robert Moerland, Chief Information Officer, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; Mary Ann Bush, Senior Operations Specialist, SWMBH; and Kim Rychener, Summit Pointe.

Guests via phone conference – Heather Garcia, KCMHSAS; Tina Boyer, VBCMH; Mike Reed, RWC; Roger Pierce, Woodlands; Kelly Jenkins, BCCMHA; Robin Wilber, Pines BH; Greg Hintz, Woodlands; and Jill Bishop, BCCMH.

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

Review and approve agenda – Committee agreed to follow the agenda as presented.

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

Fiscal Year 2019 YTD Financials – Tracy Dawson reviewed financials as documented noting that Internal Savings Fund usage is improving a bit. Brad Casemore added that April 1, 2019 the State will be adding the direct care wage to State capitation rates, which is an unknown impact for us. Group discussed.

DHHS 298 Unenrolled – Brad Casemore shared that the State plans to release the Request for Proposal in January and that he has a meeting scheduled with the 298 CMHSPs in February.

CMH Bylaws Consideration Update – Brad Casemore updated the group on his recent visits to various CMH Board meetings and schedule for attending future meetings.

MCG Installation Update – Anne Wickham stated that MCG notified the PIHPs this morning that the project kick off meeting was cancelled and that the installation date is currently on hold.

SWMBH Public Policy-Legislative Education Initiative Steering Committee Meeting Update – Brad Casemore thanked the Committee for their work and reported as documented on the next Legislative

Event scheduled for May 17th at the VBISD Center. Mary Ann Bush will email information and documents to group.

Review of Operating Agreement – Brad Casemore and Debbie Hess reviewed Operating Agreement revisions as documented. A final red line revisions version will be reviewed at the February Operations Committee meeting.

Review of Operations Committee Charter – Brad Casemore reviewed Charter as documented. Group discussed and agreed to incorporate non-redundant items into the Operating Agreement and drop the Charter as most of the items are already listed in the Operating Agreement.

Operations Committee Self-Evaluation – Brad Casemore and Debbie Hess reviewed last year's Operations Committee Self-Evaluation as documented. Group discussed and agreed to add from page 5 of the Operating Agreement under *Operations Committee Responsibilities and Authorities* the first list of items marked A through E to this year's self-evaluation form. Jonathan Gardner to revise self-evaluation in Survey Monkey.

Access and Eligibility Clarification – Debbie Hess reviewed the DHHS memo as documented. Group discussed.

Medicaid Payments for Inmates Inpatient Services – Ric Compton discussed recent Riverwood Center example of Medicaid payment for inmate inpatient services and noted increased costs. Mila Todd reviewed federal and state definitions for clarification on Medicaid payments for inmates' inpatient services. Group discussed.

SWMBH Board Directive – Sue Germann reviewed her email as documented. Brad Casemore reviewed the Board directive from the January 11th meeting minutes which stated, "... the SWMBH Executive Officer and Chief Financial Officer be charged with adjustments to cell H56 on the 2019 proposed Budget to reduce projected deficit with a report to the Board by March 2019." Group discussed Board directive and financial situations. Tracy Dawson asked that each CMH CEO submit any expense and revenue ideas to her regarding the Board directive. Jeff Patton stated that there is a "structural deficit problem in the State," recommend that each CMH Board should look at their own bottom line and not SWMBH's bottom line, and each Board should draft a letter to be sent to their respective legislators. Group discussed PIHPs banding together to make a case to the State and legislators that PIHPs are underfunded. Brad Casemore will follow up with PIHPs.

Regional Utilization Management Managed Care Functional Review – Anne Wickham stated that project work continues and added that the SUD sub-work group met for the first time in January and a full managed care functional review will be completed.

FY2018 Program Integrity Compliance Program Evaluation – Mila Todd reported as documented. Group discussed.

DHHS Standard Consent Form – Mila Todd reported as documented. Group discussed.

Fiscal Year 2018 Encounter Submission Status – Rob Moerland stated that the files in the data warehouse are current, the files are good, and the interim encounter report is due soon. A BH TEDS

internal workgroup has been formed to discuss issues and clean up and BH TEDS extracts are being sent to CMHSPs.

278 Transaction Status – Rob Moerland stated that SWMBH IT is working with Streamline and PCE on issues and files transfers and that 278 transactions should be operational in February.

SWMBH Portal Access and Layout – Rob Moerland asked the group about any issues accessing the portal and reminded group to contact him directly if you are experiencing difficulties.

LOCUS 0s and 1s – Moira Kean reviewed LOCUS and Mild-Moderate reports in Tableau. Reports can be filtered by data sources, schedules, details and several other filters. The Regional Utilization Management Committee reviews these reports and a link to these reports will be sent to the Operations Committee soon. Group discussed.

FY2018 Performance Bonus Incentive Program (PBIP) Proceeds – Brad Casemore reviewed history of PBIP proceeds going to CMHSPs as local. He cannot permit that this year, given regional financial conditions. The SWMBH Board will have to rectify this per SWMBH-CMHSP agreements.

Annual Data Certification Declarations – Mila Todd stated that annual data certification declarations should be submitted to her.

Committee Goals and Strategic Imperatives – Brad Casemore reviewed Committee Goals and Strategic Imperatives in relation to Committee Goals. Group discussed and will review again at February's Operations Committee meeting.

March SWMBH Board agenda – Draft SWMBH Board agenda was included in the packet for the group's review. Brad Casemore noted that, in recognition of SWMBH's 5-year anniversary, a hot breakfast will be provided prior to the Board meeting for Board, Board Alternates, Operations Committee, and SWMBH staff. Also, Brad Casemore announced the SWMBH Board retreat coming up in May and group reviewed a proposed agenda (subject to determination and approval of the Board).

Adjourned – Meeting adjourned at 1:10 pm

2018 – 2019 SWMBH Board Ends Metrics
Fiscal and Calendar Year Metrics
Board Approved on: 12/8/2017

2018-2019 Board Ends Metrics Review and Approval Dates:

- *Mega Ends; Approved by SWMBH Board on: 3/11/2016*
- *Mega Ends; Endorsed by Operations Committee on: 3/2/2016*
- *Operations Committee Review and Endorsement on: 11/29/2017*
- *Utilization Management and Clinical Committee Review on: 11/13/2017*
- *Quality Management Committee Review on: 10/26/2017 & 11/30/2017*

Mega Ends:

1. **Quality of Life**: Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery and family preservation.
2. **Improved Health**: Individual mental health, physical health and functionality are measured and improved.
3. **Exceptional Care**: Persons and families served are highly satisfied with the care they receive.
4. **Mission and Value-Driven**: CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
5. **Quality and Efficiency**: The SWMBH region is a learning region, where quality and cost are measured, improved and reported.

Our Mission:

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Our Vision:

"An optimal quality of life in the community for everyone."

Our Triple Aim:

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Quality of Life

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

PROOFS	STATUS
Fully utilize contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Serious Mental Illness (SMI); Autism Spectrum Disorders (ASD) and Serious Emotional Disturbances (SED). A. 100% of assessment scores will be received as automated data file transfers to SWMBH at the domain and dimension level **(By: 1/30/18) COMPLETE** B. 85% of members who have had an encounter during FY18, receive the appropriate assessment within the required timeframe **(By: 9/30/18) COMPLETE** 1. LOCUS- Level of Care Utilization System Tool 2. SIS- Supports Intensity Scale Tool 3. CAFAS- Child/Adolescent Assessment Scale Tool 4. ASAM- American Society of Addiction Medicine Tool C. SWMBH will develop and make available; Regional assessment reports in Tableau, with appropriate filters/analysis for each assessment tool **(By: 5/31/2018) COMPLETE**	**COMPLETE 11.9.18 Board Mtg.** 100% of assessment , have received the scores are being received as automated data files 90.45% of members who have had an encounter appropriate assessment 72% was baseline measure on: 9.30.17 Regional assessment Reports that adhere to LOC tables are complete and available for view via Tableau Visual Analytics Tool.

Improved Health

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

PROOFS	STATUS
In an effort to ensure collaboration and integration between the Medicaid Health Plans and Pre-paid Inpatient Health Plan, the Department of Health and Human Services has developed the following joint expectations for the MHP and the PIHP to respond to. There are 100 points possible for this bonus metric in FY2018: 1. Quarterly, each MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities. a. The MHPs and PIHPs will work jointly to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS. b. MDHHS will select beneficiaries randomly and review their care plans within CC360. 2. Quarterly, each MHP and PIHP will participate, via the MHP-PIHP workgroup in reviewing and validating MDHHS reports that would include: a. Number of care coordination plans. b. Reasons for closing care coordination plans. c. Average length of time for active care coordination plans. 3. Follow-up after Hospitalization for Mental Illness within 30 days is calculated by MDHHS and verified by SWMBH annually. a. 70% ages (6-20) b. 58% ages (21 and older)	**ON TARGET** MDHHS PBIP Metrics 8.4.2.1 Amend #2 Very important for FY 18, the bonus will be awarded as a true bonus and not as a take back. Bonus potential of 0.75% on top of FY 18 negotiated contract. **FUH Current SWMBH Values:** ***Children*** SWMBH 77.40% State 74.0% ***Adults*** SWMBH 72.30% State 65.0% Possible 100pts. Standards 1&2 – 50pts. Standard 3 - 50pts.

Exceptional Care:

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

PROOFS	STATUS
Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2017 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey) measurement categories, utilizing the following survey tools: A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning)* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes)* (By: December 31, 2018) **Measurement: (MHSIP)** 2018 MSHIP Improved Functioning Score 2017 MSHIP Improved Functioning Score **Measurement: (YSS)** 2018 YSS Improved Outcomes Score 2017 YSS Improved Outcomes Score	**ON TARGET** Begin in October 2018
SWMBH will complete the indicated MDHHS Home and Community Based Service (HCBS) reporting obligations with 95% success rate. A. 95% of required Home and Community-Based Service (HCBS) Provider corrective action plans for the Habilitation Supports Waiver will be requested and approved by SWMBH. **(By: June 30, 2018) COMPLETE** B. SWMBH will validate and verify that 95% of (Hab Waiver) corrective action plans have been completed and implemented. **(By: December 31, 2018) COMPLETE** **Measurement:** Number of corrective action plans completed and submitted to MDHHS / Total number of provider corrective action plans issued	**COMPLETE 9.14.18 Board Mtg.** *100% of HCBS CAPs have been requested and approved by SWMBH. *96.5% of corrective action plans complete (includes those found to be compliant and those discharged)

Mission and Value Driven:

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

PROOFS	STATUS
92% of MMBPIS Indicators will be at or above the State benchmark for 3 quarters for FY 18. (October 17 – September 18) A. SWMBH will improve MMBPIS data collection process by designing and implementing a new data collection tool (By: 12/30/17) B. MMBPIS Indicator reports will be submitted to SWMBH on a monthly schedule via an automated method (By: 3/30/18) C. Reports/dashboards and performance indicator analysis will be developed and available on the portal (By: 6/30/18) **Measurement:** Total number of indicators that met State Benchmark / Total number of indicators measured (51)	**COMPLETE 11.9.18 Board Mtg.** **Q1= 17/17** Indicators met at State Benchmark **Q2= 17/17** Indicators met at State Benchmark **Q3= 17/17** Indicators met at State Benchmark First time ever, SWMBH has achieved 17/17 indicators at the MDHHS benchmark for (3) consecutive quarters!
Regional Habilitation Supports Waiver slots are full at 99% throughout the year. (October 17 - September 18) **Measurement:** (%) of waiver slot (months) filled x 12 / (#) of waiver slot (months) available *Special Note: (20) additional slots awarded to SWMBH by MDHHS in October, 2017. Oct – 100% Nov – 99.9% Dec – 100% Jan – 100% Feb – 99.9% March – 100% April – 100% May – 99.9% June – 100% July – 100% Aug – 100% Sept – 100%	**COMPLETE 10.12.18 Board Mtg.** 99.9% full FY 18 Oct-August 690 slots per month 8278 / 8280 99.9% full
In FY18, at least 48% of persons with Autism Spectrum Disorders who have an Individual Plan of Service (IPOS) which includes ABA services, will receive ABA services consistent with their plan (*>=75% units approved*). DHHS-defined family "inactivity periods" are excluded from the calculation. SWMBH will earn 1 point bonus credit toward the final 2018-2019 Board Ends Metrics calculations if at least 53% of persons with Autism Spectrum Disorders who have an IPOS which includes ABA services receive ABA services consistent with their plan (*>=75% units approved*). (By: December 31, 2018). A. SWMBH will develop measurements and analysis to show improvements in populations served 1. Report and visual analysis will be available on portal, to show current status **Measurement:** (%) of Autism consumers that received services consistent with IPOS / Total number of Autism consumers with an (IPOS)	**Below Target 11.9.18 Board Mtg.** Current Value: **36.00%** Goal: **48%**

The following Board End Metrics fall into multiple Mega End categories.	
Quality and Efficiency: The SWMBH region is a learning region, where quality and cost are measured, improved and reported.	**Mission and Value Driven:** CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
SWMBH will apply for and achieve no less than (One Year) NCQA MBHO Accreditation for the MI Health Link Duels Business Line. (By: April 2018) A. SWMBH will complete all necessary tools (ISS and IRT) during the accreditation process. B. SWMBH will plan and facilitate all necessary on-site and desk review requirements. C. SWMBH will achieve no less than (One-Year) accreditation with a score between (70-83) I. The organization's programs for quality improvement and consumer protection are well organized and established to meet the majority of NCQA standards. NCQA gives the organization a list of recommendations and within *15 months* reviews the organization Again to determine if it qualifies for Full Accreditation. D. If SWMBH achieves the level of (Full) Accreditation with a score between (84-100); SWMBH will earn 1pt of bonus credit toward the final 2018-2019 Board Ends Metrics calculation. II. The organization's programs for quality improvement and consumer protection exceed NCQA standards. The duration of accreditation status is valid for *36 months* from date of accreditation.	**COMPLETE** **4.13.18** **Board Mtg.** **Full Accreditation Achieved** **+ 1 point bonus credit**
2018 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met"). (By: September 30, 2018) **Measurement:** Number of Element Sub-Sections "Met" Total Elements Evaluated	**Missed** **167/187 = 89%** Review was Completed on June 5th and 6th 2018 – Waiting on Draft report expected in August – September 2018

2018 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") (By: September 30, 2018) **Measurement:** Number of Critical Measures that achieved "Met" Total number of Critical Measures Evaluated	**COMPLETE** **10.12.18** **Board Mtg.** Review Completed on: July 18, 2018 Draft Report/Results Received on August 28, 2018 • 3/3 – 100% Data Integration, Data Control and PI Elements were *"Accepted"* • 12/12 – 100% of PI evaluated were determined compliant *"Reportable"* full compliance • 13/13 – 100% of Data Control elements evaluated *"Met"* full compliance • 9/9 – 100% of PI numerator and denominator verification *"Met"* full compliance
FY 2018 Medicaid Administrative Loss Ratio for the region is (< or = to 9.5%) (By: September 30, 2018) **Measurement:** (Medicaid) Administrative and other Costs Total Medicaid Revenue	**PENDING**
SWMBH to implement and lead a multi-year, collaborative, systemic and systematic *Regional Values Outcome Project*, which primary objective will be to "*Improve Lives and Prove It*". A. A Steering Committee consisting of CMHSP and SWMBH functional leaders will be assembled to provide guidance on the following key categories of interest: 1) Improving Behavioral Health, 2) Improving Physical Health, 3) Improved Social Functioning, and 4) Reducing Avoidable Behavioral and Physical Health Service Utilization. (By: January 19, 2018) a. Conduct assessment of potential metrics that align with key categories of interest. b. Conduct assessment of current data availability and integrity of that data. c. Prioritize metrics for reporting based on value of metric(s) and data availability/integrity. (By: October 31, 2018) d. Implement regional reporting on prioritized metric(s). e. Analyze regional performance based on report data and qualitative analyses. f. Make recommendations for regional best practice models to improve performance where indicated.	**On Hold** New Metric Meeting scheduled with Steering Committee To discuss charter and focus metrics Operations Committee Meeting Update on April 25, 2018 Next Meeting on May 23rd. Committee Members to come back with selected metrics to prioritize. This will assist in the development of a short and long term work plan.

g. Implement best practice models. h. Re-measure performance to assess impact of best practices. i. Rotating process that will continue until all priority categories and metrics are completed (At least two complete improvement cycles complete by December 2019) B. Sharing interdepartmental and inter-organizational efforts through publications such as; newsletters, website, media campaigns and health fairs with our community partners, legislators, customers, team members, providers and other stakeholders. (By: December 31, 2019)	
SWMBH will achieve all quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts including: (By: December 31, 2018) a. 95% of claims per final reconciliation were received timely as monthly encounters. b. 95% of enrollees have a level II assessment completed within 15 days of their level I assessment. c. 80% of enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within (24 hours) of discharge to the facility or BH professional designated for follow-up care. d. 95% of enrollees have documented discussions regarding care goals. e. The PIHP will designate (2) members to serve on the advisory board.	**ON TARGET**
Per Board Directive: "Work with CMHs and contractors to assess and modify as appropriate regional managed care functions and roles to achieve greater efficiency and lower overall expenses." (By: March 30, 2019) 1. Revenue Maximization 2. Revenue Diversification **Measurement:**	**ON TARGET**

Financial Statements. Preliminary results December 2018 with final results March 2019.	
SWMBH to "Establish and implement an inclusive formal Regional public policy, legislative education program." (By: September 30, 2018) **Goal:** Michigan and federal legislative branch education and public policy involvement resulting in greater awareness of legislators about the values and results of the Michigan public behavioral health system and the SWMBH region and component CMHSPs. **Measurement:** Report deliverable detailing; types and numbers of events and contacts with elected officials and staff. Elected official qualitative assessment of Michigan public behavioral health system, SWMBH region, SWMBH Regional Entity, and SWMBH CMHSPs.	**ON TARGET** **11.9.18 Board Meeting**

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

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

Pending: proof could mean that;

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

Goal Not Met: proof could mean that;

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

Completed Goal:

- Evidence/proof exists that the metric has been successfully completed.

Southwest Michigan Behavioral Health
2018 Customer Satisfaction Survey Analysis

January 18, 2019

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)

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.

Survey Process and Preparation

SWMBH begins preparing for the annual consumer satisfaction survey process in September, with the goal of completing 2,000 surveys by the end of the year. To ensure the survey process is valid, SWMBH selects a vender to administer the surveys and collect feedback from consumers who have received 3 or more services within the measurement period (April – August 2018). Barnes Research was selected as the vender for the 2018 consumer satisfaction survey project. Barnes Research brings over 25 years of experience to the table, working with a variety of healthcare organizations to gain feedback from consumers using a variety of methods including: surveys, focus groups, mystery shopping and other types of consumer engagement techniques.

The 2018 consumer satisfaction surveys were completed using a telephonic process. The survey tools that were used include the Mental Health Statistics Improvement Program (MHSIP) survey for consumers 18 years of age and older and the Youth Services Survey (YSS) for consumers under the age of 18 years old. SWMBH is contractually obligated to utilize the MHSIP and the YSS survey tools, as they are required for use by the Michigan Department of Health and Human Services (MDHHS). The MHSIP and YSS survey tools offer a wide range of flexibility in capturing feedback from members with a variety of Mental Health disorders. The MSHIP and the YSS survey tools also offer comparisons against other State and National results. Currently the MHSIP and YSS surveys are being implemented in 55 States/Territories, so comparison data is easily obtainable. You will notice throughout the presentation, SWMBH provides comparisons against State and National results and has out preformed both State and National results in every category of its 2018 survey results.

The primary goal in completing the annual consumer satisfaction surveys is to gain valuable feedback from consumers on the services they have received. After the analysis of the survey scores and consumer feedback is completed, the SWMBH Quality Team presents the data to the primary Regional Committees including the: Regional Consumer Advisory Committee, Regional Utilization Management Committee, Regional Operations Committee, Regional Compliance Committee and the Regional Quality Management Committee, for review and feedback. SWMBH takes the consumer feedback they receive very seriously and works directly with providers and Community Mental Health Service Providers (CMHSP) to help improve Mental Health and Substance Abuse services and programs throughout the 8-county service region. SWMBH's survey preparation and processes have improved tremendously over the past 5 years and that can be directly attributed to the feedback received from the Regional Committees and Consumers we serve.
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

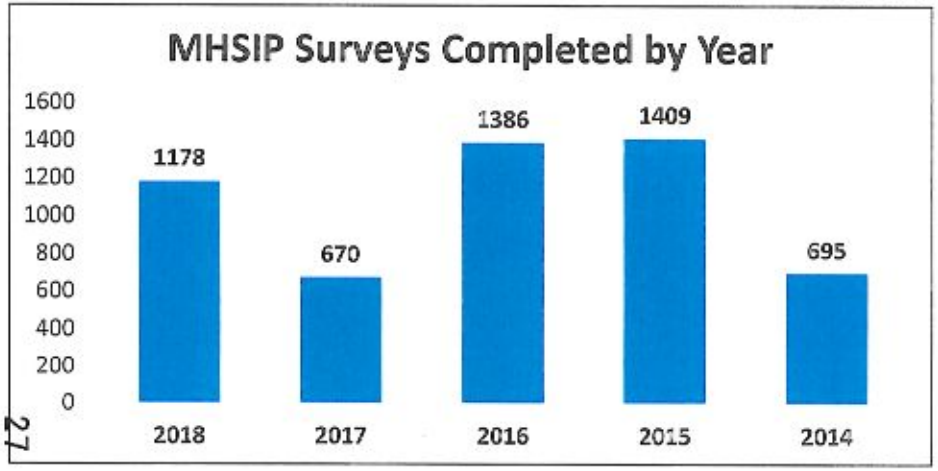
MHSIP Survey Information

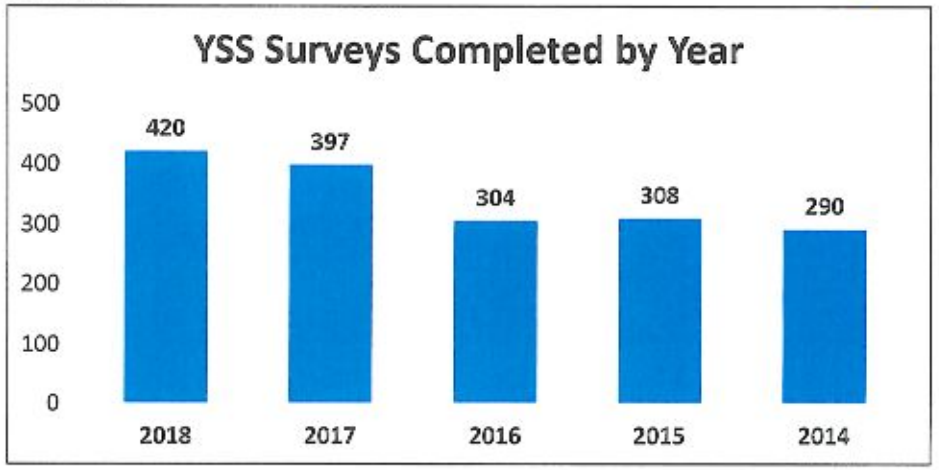
- The Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys measure concerns that are important to consumers of publicly funded mental health services in (7) different areas including:
  1. Access
  2. Quality/Appropriateness
  3. Outcomes
  4. General Satisfaction
  5. Social Connectedness
  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).

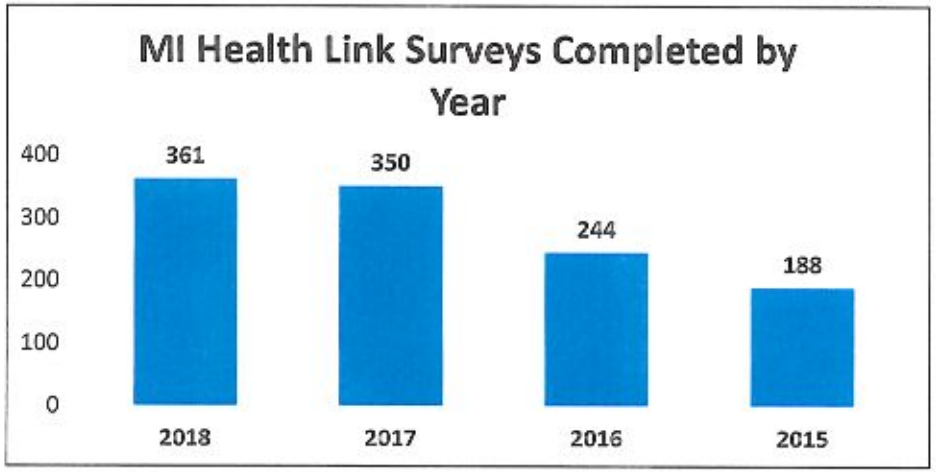
YSS-F Survey Information

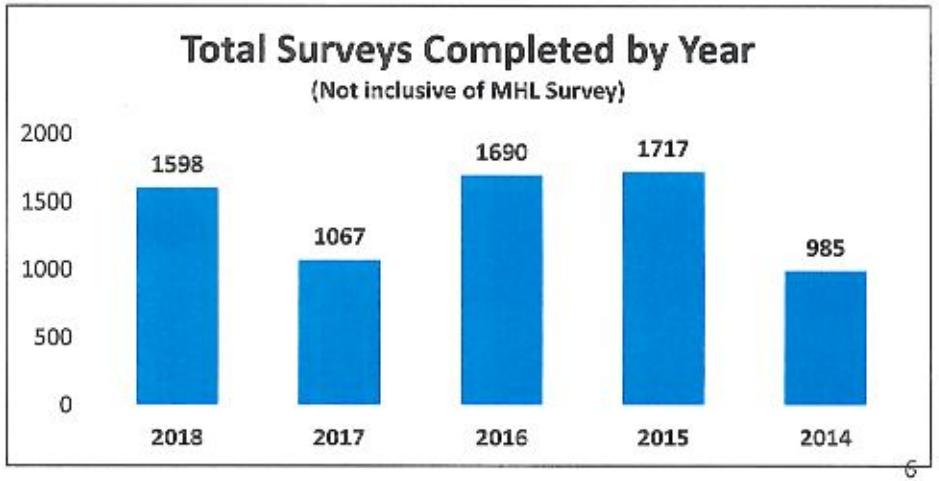
- A modification of the MHSIP survey for adults, the Youth Services Survey for Family (YSS-F) assesses caregivers' perceptions of behavioral health services for their children aged 17 and under.
- The YSS creates (6) domains that are used to measure different aspects of customer satisfaction with public 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

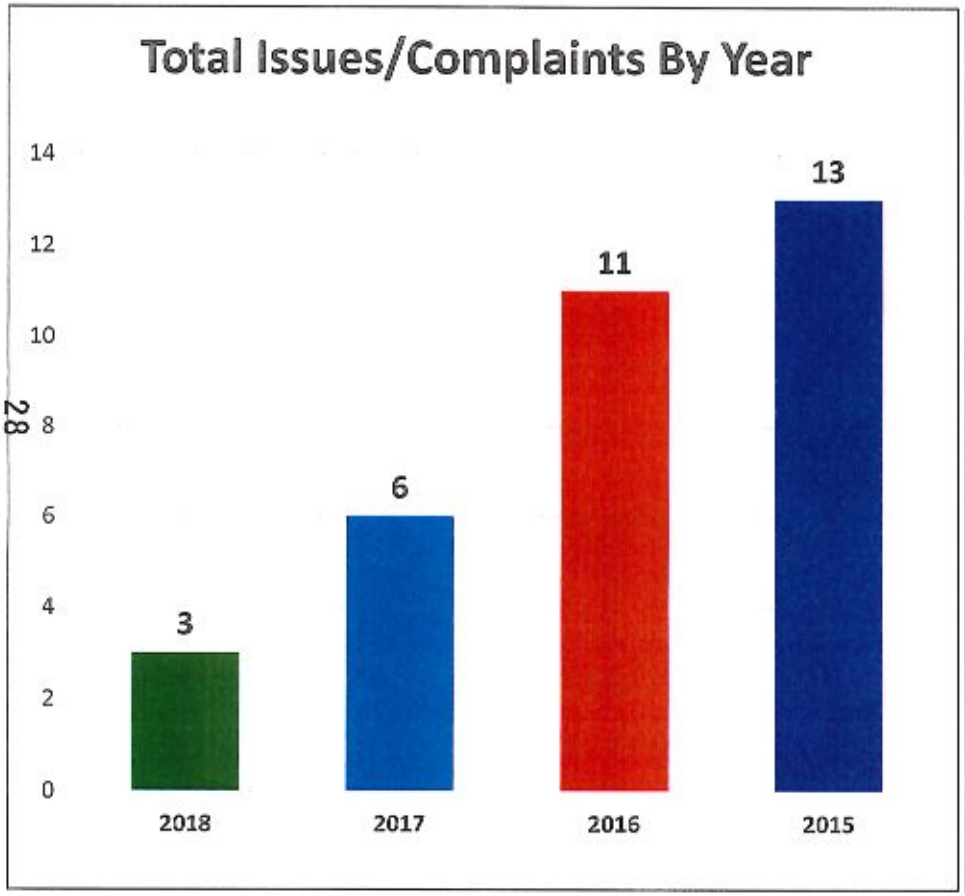




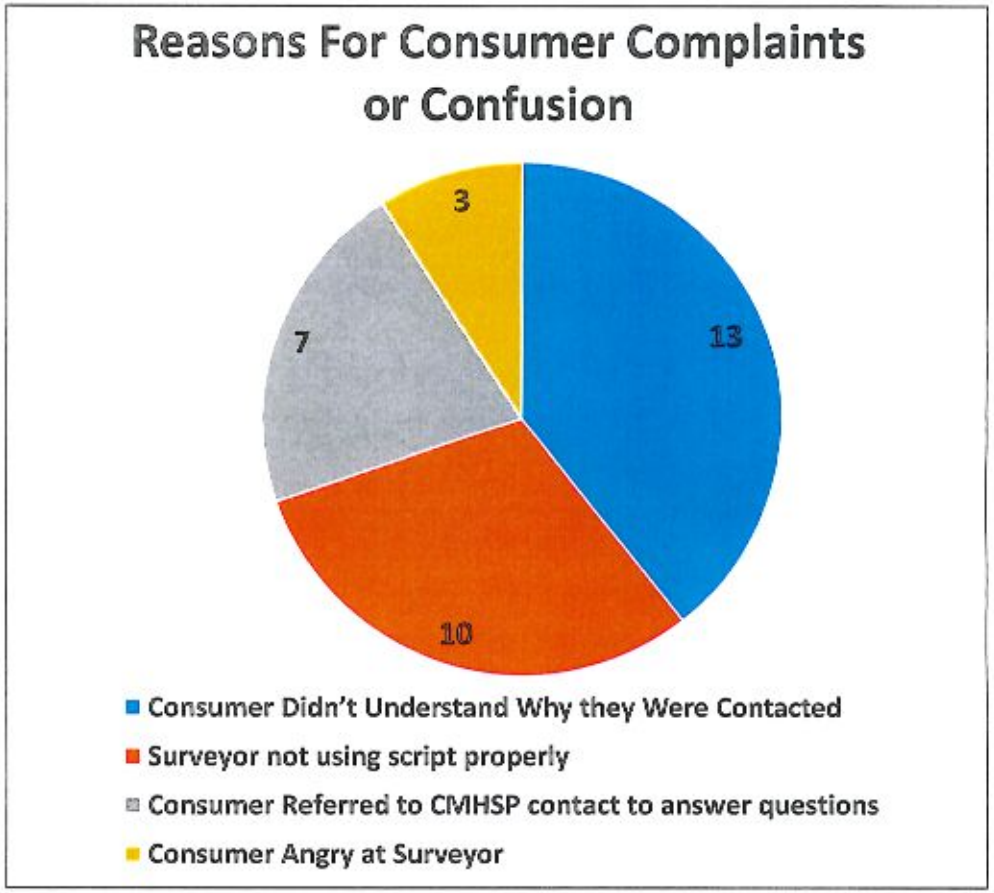




Consumer Issues and Complaints



33 Total Across All Year's

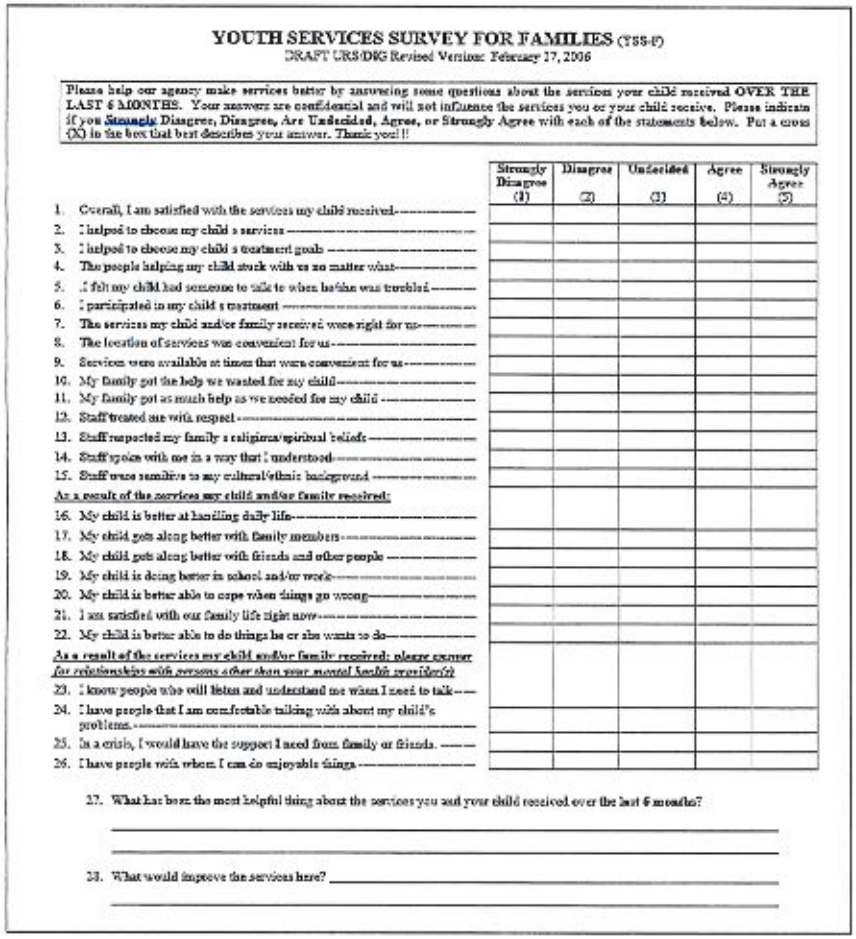


Questions asked on the MHSIP Survey (44 Questions Total)

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)



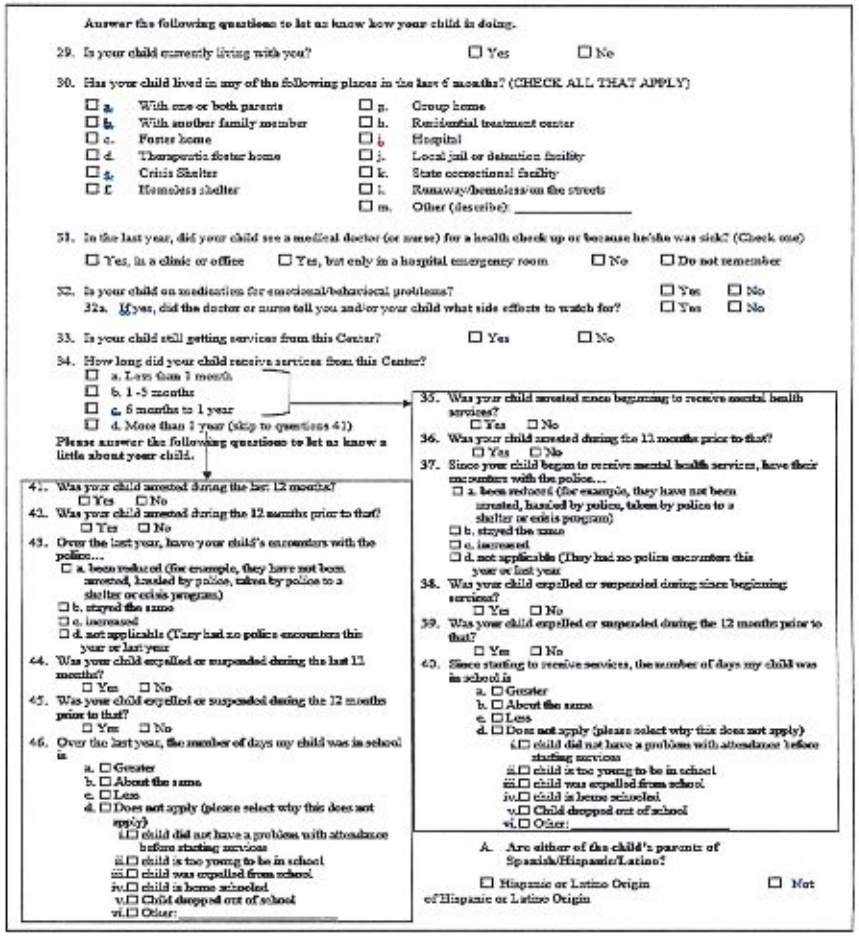
YOUTH SERVICES SURVEY FOR FAMILIES (YSS-F)
DRAFT URS/DIG Revised Version: February 17, 2006

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 go 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: please answer for relationships with persons other than your mental health provider(s)					
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 1 month
- ☐ b. 1 -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, headed 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

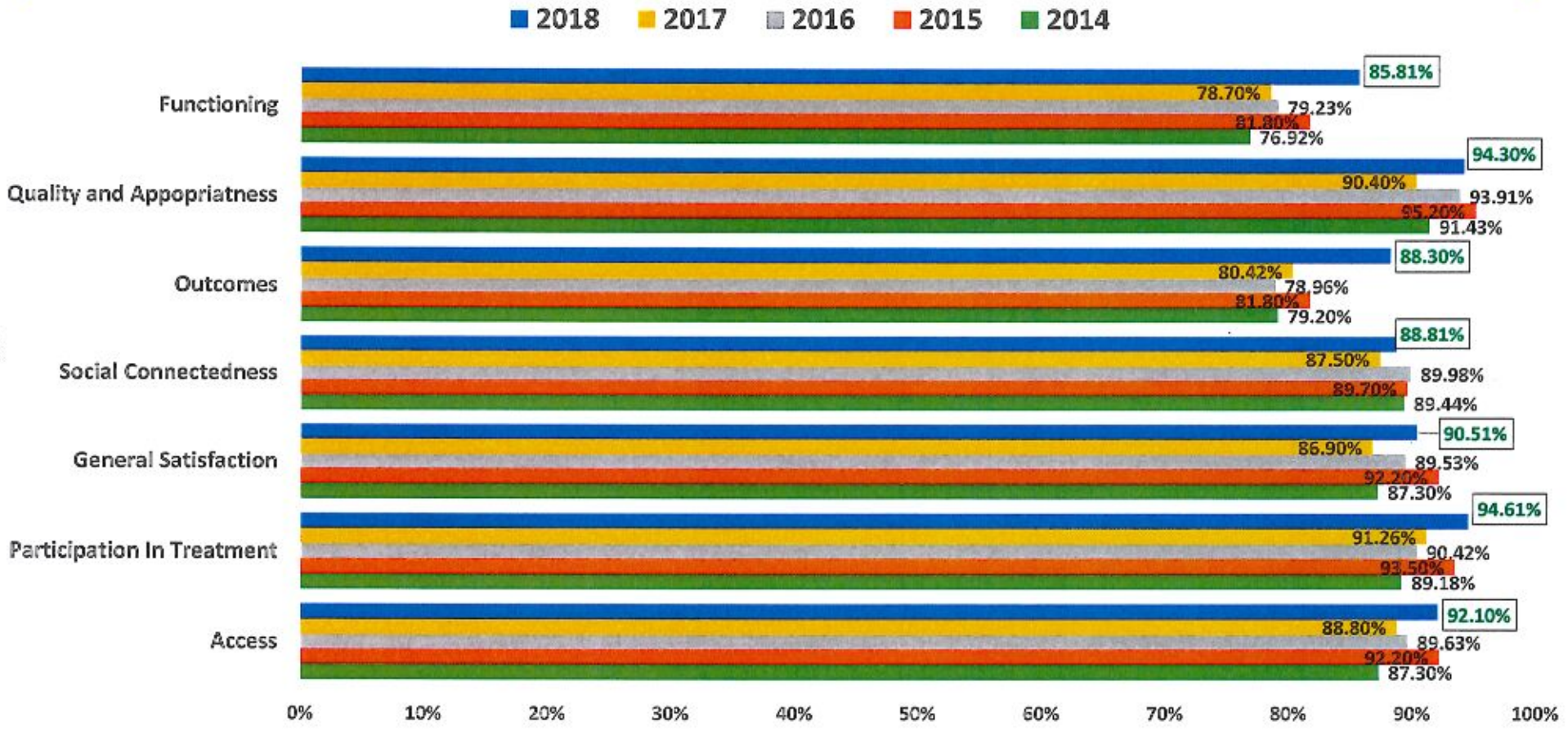
44. Was your child expelled or suspended during the last 12 months? ☐ Yes ☐ No
45. Was your child expelled or suspended during the 12 months prior to that? ☐ Yes ☐ No
46. Over the last year, the number of days my child was in school is
- a. ☐ Greater
- b. ☐ About the same
- c. ☐ Less
- d. ☐ Does not apply (please select why 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: _____

35. Was your child arrested since beginning to receive mental health services? ☐ Yes ☐ No
36. Was your child arrested during the 12 months prior to that? ☐ Yes ☐ No
37. 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, headed 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

38. Was your child expelled or suspended during since beginning services? ☐ Yes ☐ No
39. Was your child expelled or suspended during the 12 months prior to that? ☐ Yes ☐ No
40. Since 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: _____

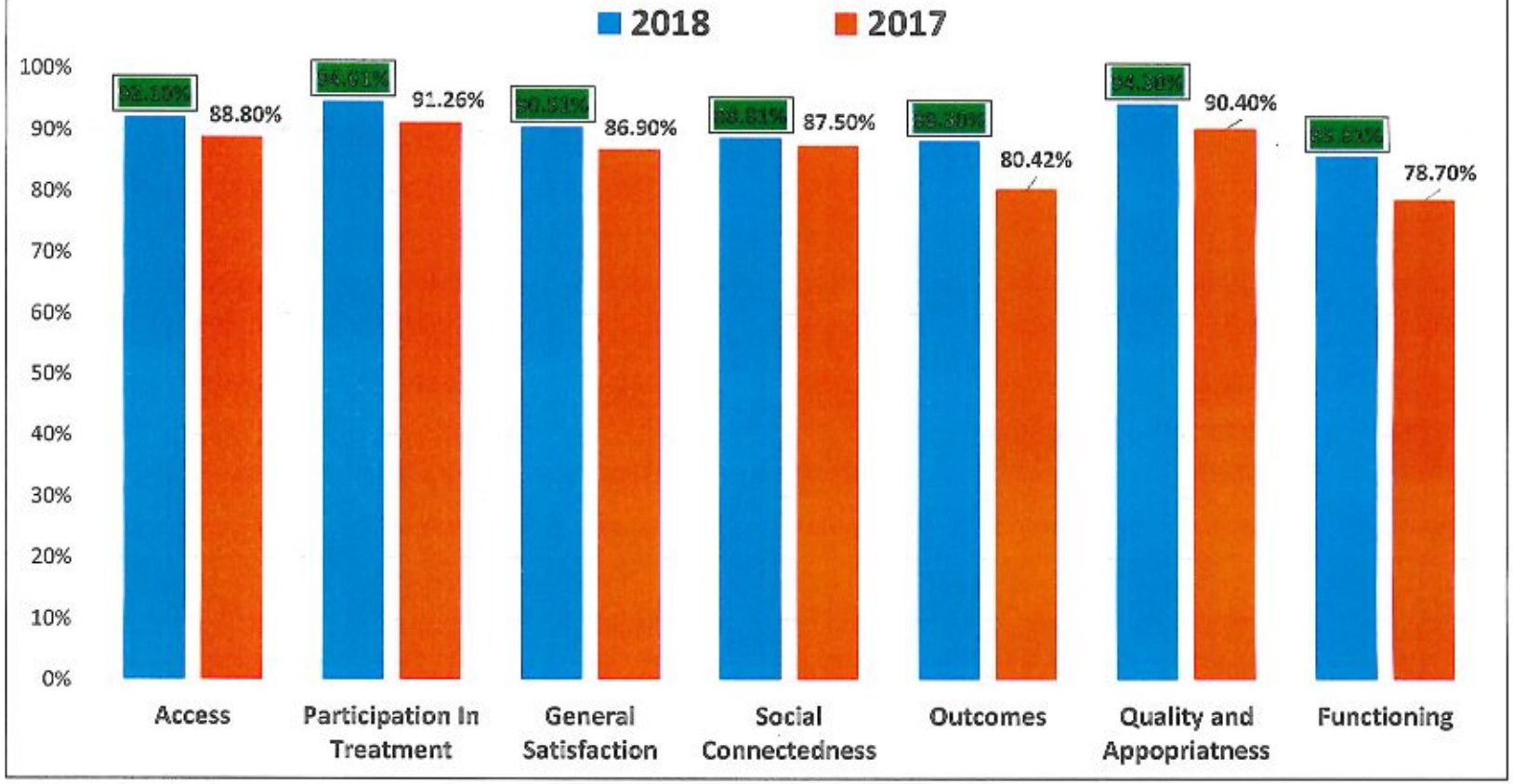
A. Are either of the child's parents of Spanish/Hispanic/Latino?
☐ Hispanic or Latino Origin ☐ Not of Hispanic or Latino Origin

MHSIP Score Comparison By Year Analysis



Green = Improvement in score compared to previous years results

MHSIP Score Comparison 2018 vs. 2017

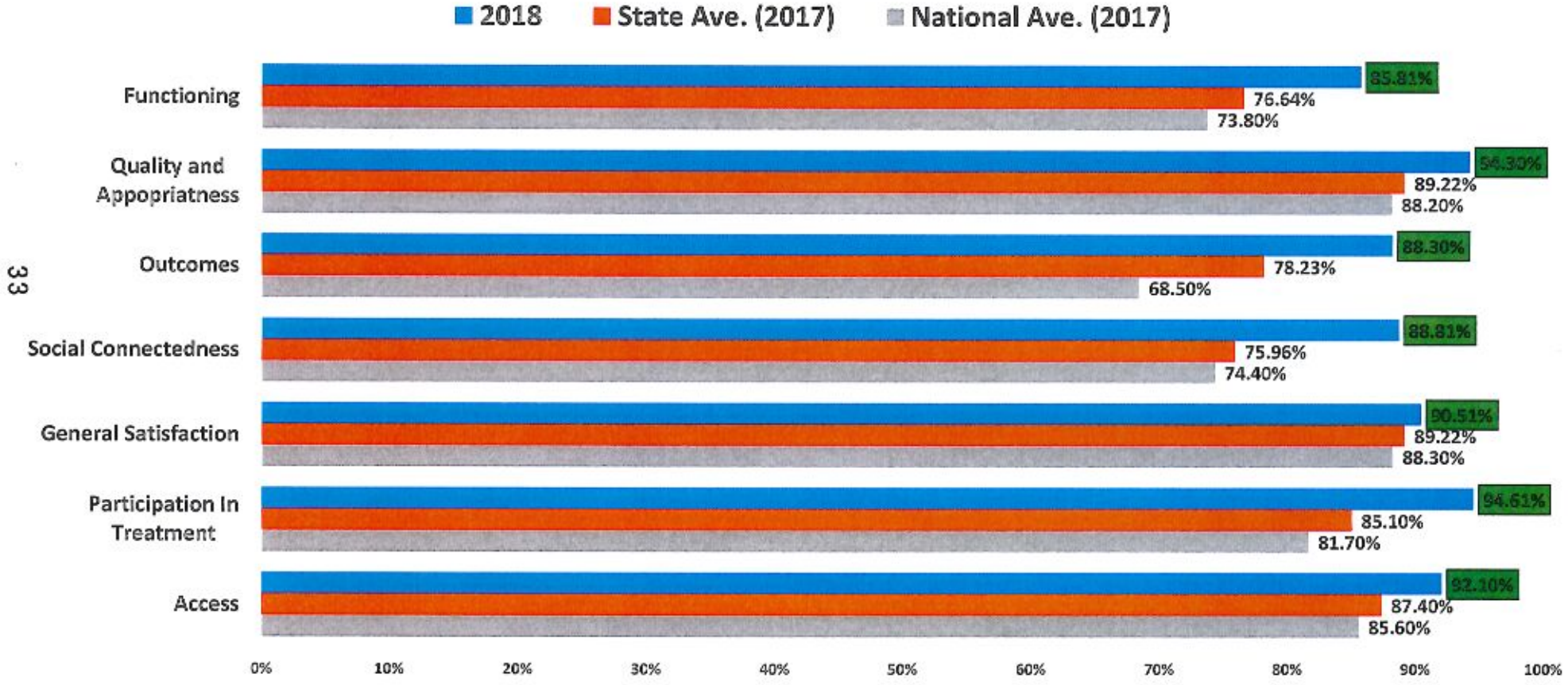


2018 Ave. Score = 90.63%
2017 Ave. Score = 86.20%

2018 = +4.43%

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

2018 MHSIP State and National Score Comparison

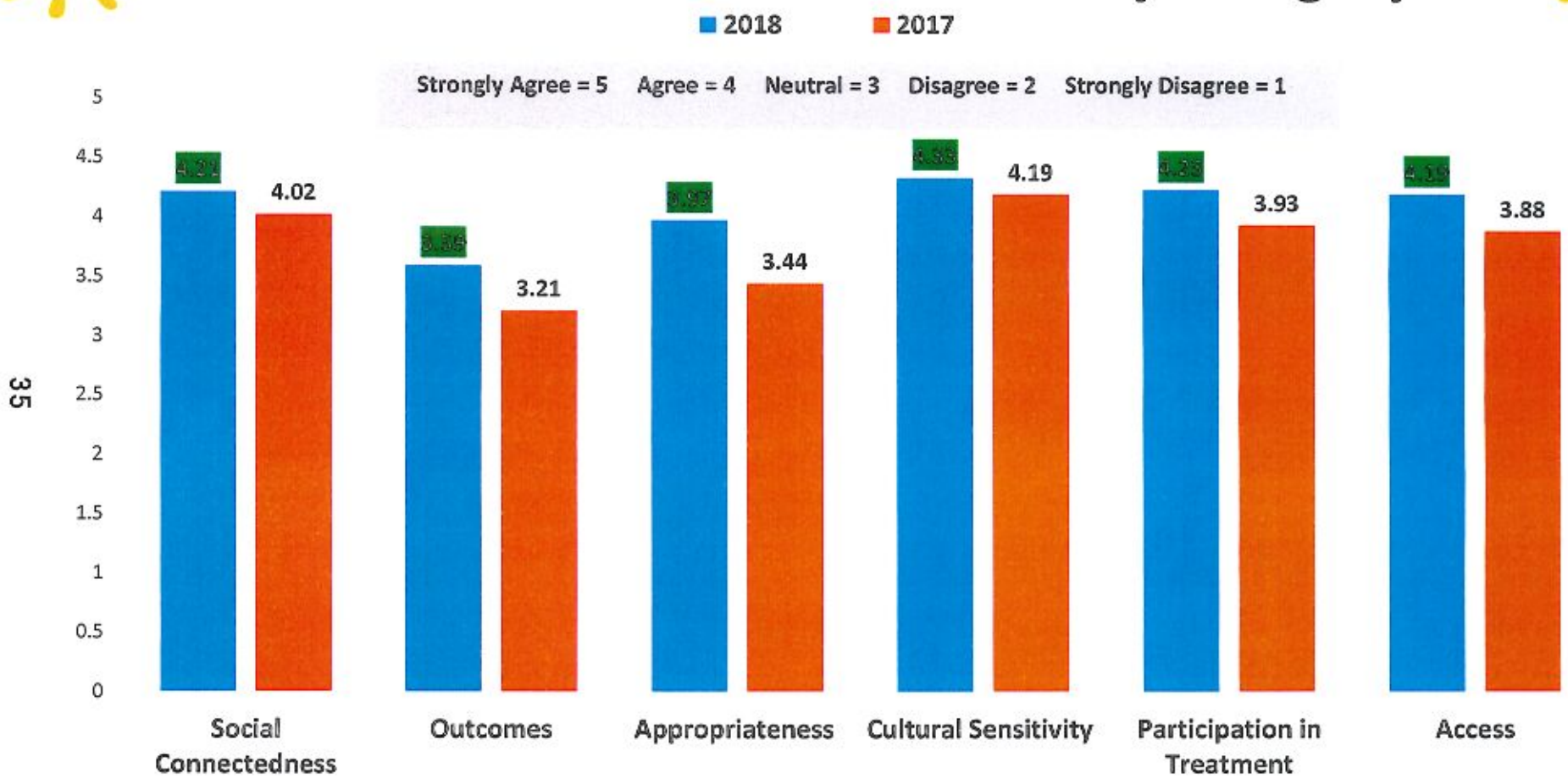


YSS Score Comparison By Year

2018 Ave. Score = 91.28%
2017 Ave. Score = 88.90%
2018 = +2.38% Improvement

Green = Improvement in score compared to previous years results
Red = Decrease in score compared to previous year.

2018 vs. 2017 YSS Mean Score By Category



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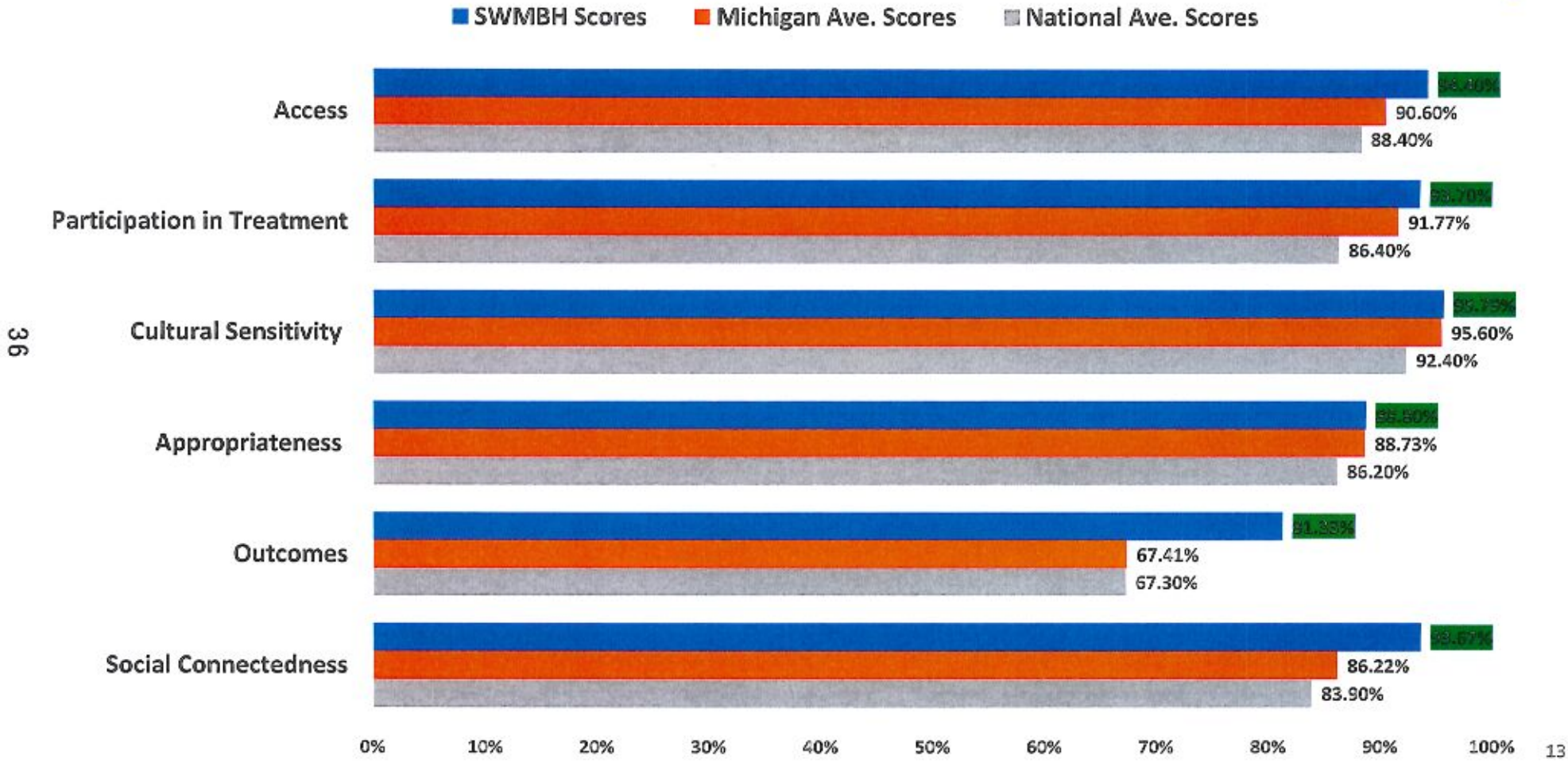
YSS State and National Score Comparison



How Did We Do?

MHSIP Results

- 2018 Aggregate Score: 90.63%
- 2017 Aggregate Score: 86.28%

+4.43% Percent Improvement over 2017 Scores

YSS Results

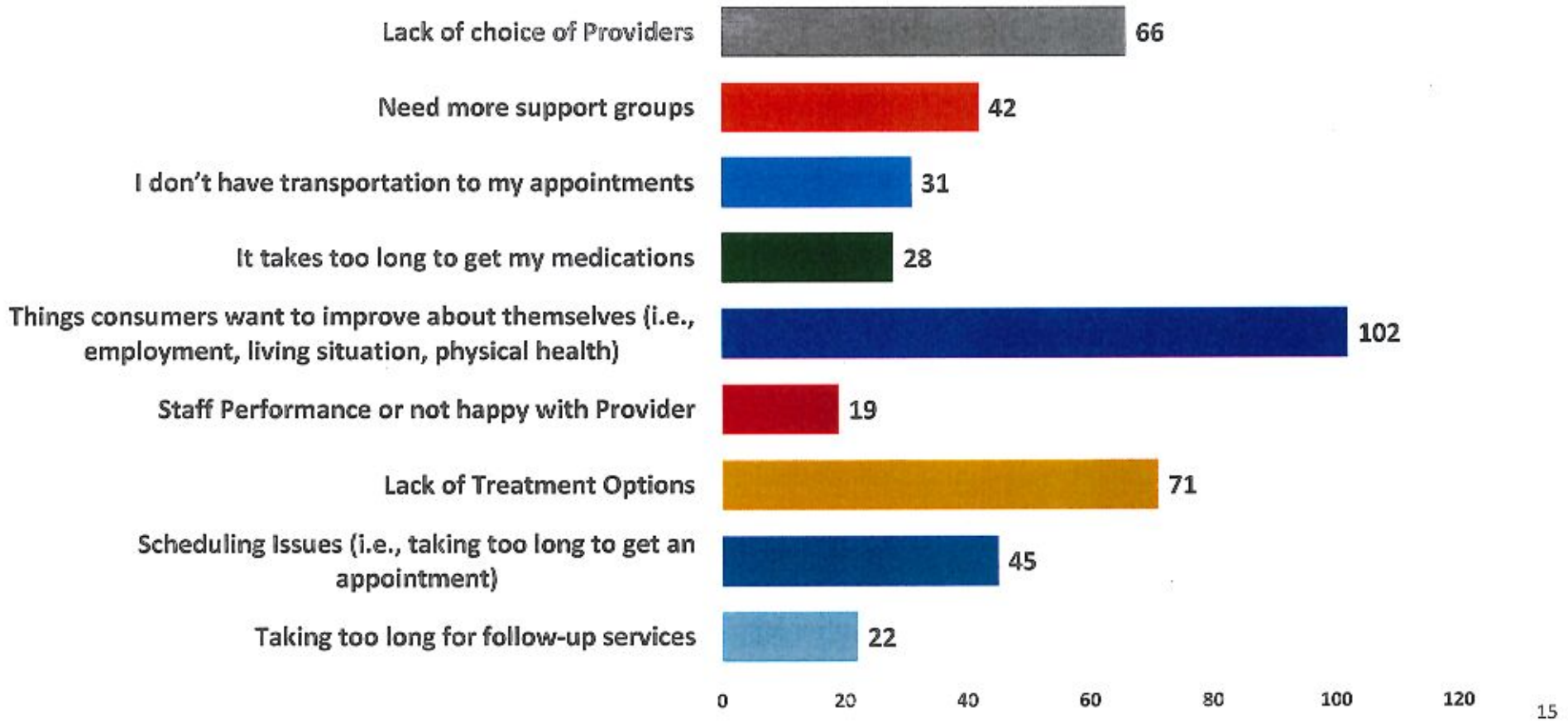
- 2018 Aggregate Score: 91.28%
- 2017 Aggregate Score: 88.90%

+2.38% Percent Improvement over 2017 Scores

Overall Result

+6.81% Percent Improvement

2018 Consumer Satisfaction Consumer Feedback



2018 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.
- Perform a Causal Analysis on Results for all (8) Counties.
- *Analysis and Evaluation of Comments Received by Customers.*
- Identify any Common Denominators or Patterns in Comments Received by Customers.
- Determine Course of Action to Address Customer Feedback and Concerns.
- Evaluate Improvement Strategies and Opportunities for Improvement through QM, RUMCP and other Regional Committees for the 2019 Customer Satisfaction Survey Process.

Southwest Michigan
BEHAVIORAL HEALTH

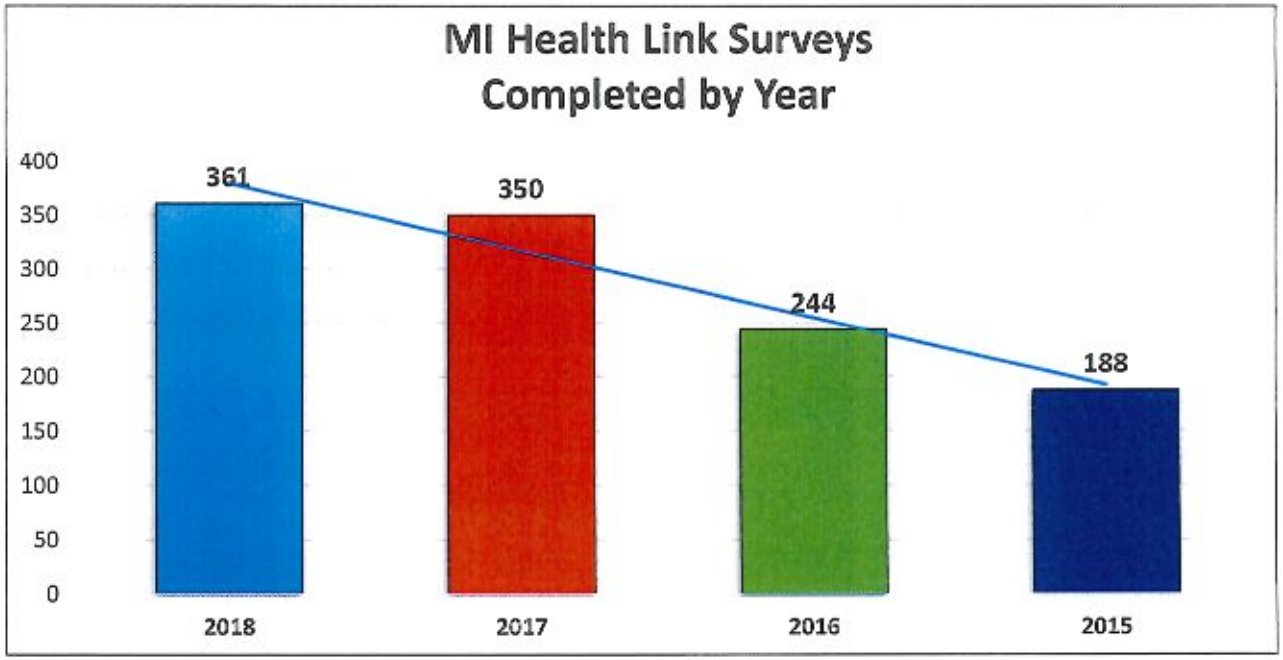
2018

MI Health Link Member Satisfaction Survey (MIHL)

MIHL Survey Information

- MI Health Link is a program that joins Medicare and Medicaid benefits, rules and payments into one coordinated delivery system, which began in March 2015.
- MI Health Link health plans provide Michigan Pre-paid Inpatient Health Plans (PIHPs) payments to provide covered services.
- SWMBH:
  - Region 4 consist of Southwest Michigan: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties.
- The MIHL survey was conducted by calling SWMBH MI Health Link consumers.
- The MIHL survey measures concerns that are important to consumers of MI Health Link Services including: Improved Functioning, Quality and Appropriateness, Outcomes, Social Connectedness, General Satisfaction, Participation in Treatment, and Access.
- Completing the survey is a core contractual deliverable to our Integrated Healthcare Partners (*Meridian Health Plan and Aetna Health Plan*)

How Many Surveys Were Completed



*841 calls made with 361 surveys completed = 42.9% response rate.

MIHL Survey Questions
(44 Questions Total/3 Additional Comment Sections)

- The first 36 questions are the same as the MHSIP Survey.
- The questions shown below are additional for MI Health Link Members.

Please answer the following questions to let us know how you are doing.

37. Are you currently (still) getting mental health services from this Provider? ☐ Yes ☐ No

38. How long have you received mental health services from this Provider?
    - ☐ a. Less than a year (less than 12 months) *(continue to Question 39)*
    - ☐ b. 1 year or more (at least 12 months) *(Skip to Question 42 on page 5)*

43

39. Were you arrested since you began to receive mental health services?
    ☐ Yes ☐ No
40. Were you arrested during the 12 months prior to that?
    ☐ Yes ☐ No
41. Since you began to receive mental health services, have your encounters with the police…
    - ☐ a. been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
    - ☐ b. stayed the same
    - ☐ c. increased
    - ☐ d. not applicable (I had no police encounters this year or last year

42. Were you arrested during the last 12 months?
    ☐ Yes ☐ No
43. Were you arrested during the 12 months prior to that?
    ☐ Yes ☐ No
44. Over the last year, have your encounters with the police…
    - ☐ a. been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
    - ☐ b. stayed the same
    - ☐ c. increased
    - ☐ d. not applicable (I had no police encounters this year or last year

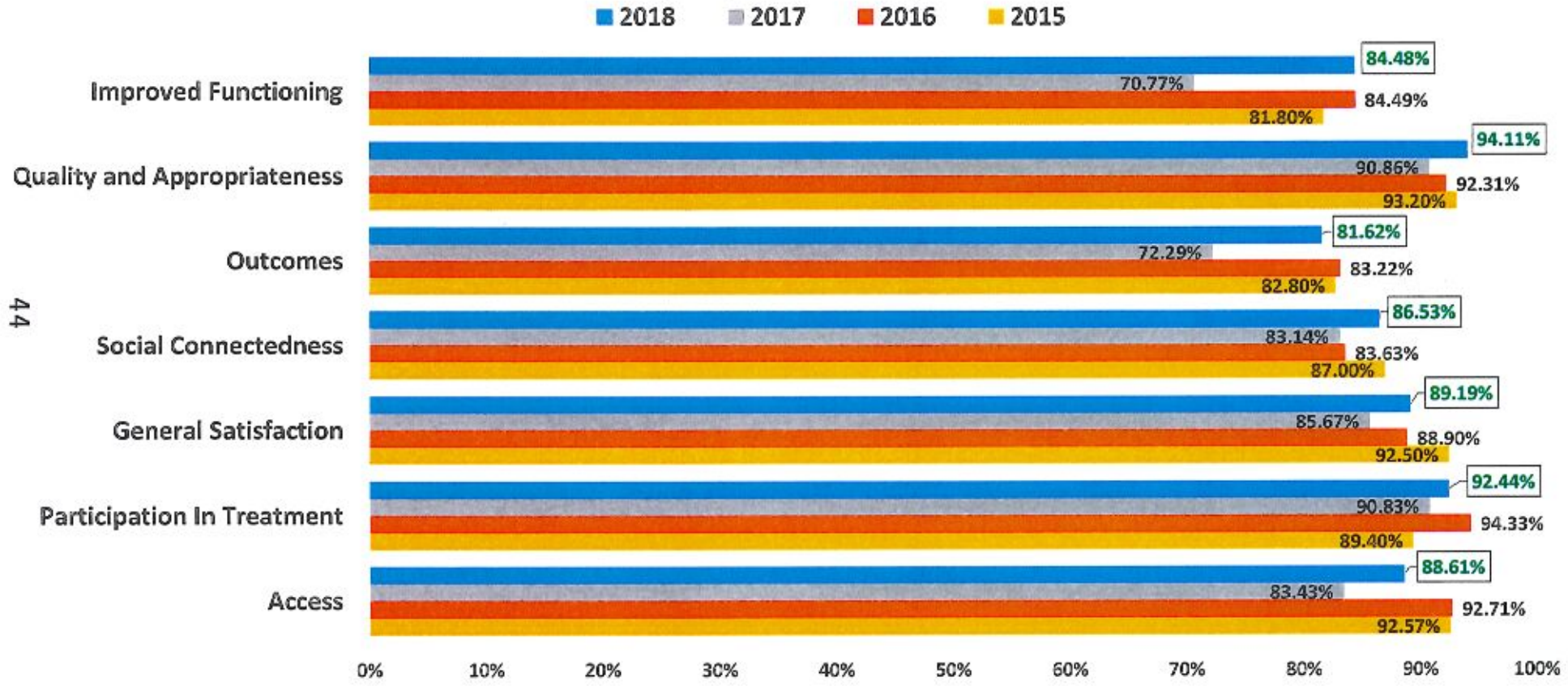
ADD COMMENT (VERBATIM):

A) Regarding your service experiences, has there been anything that has been particularly beneficial for you (describe in detail)?

B) Has there been anything you would like to improve?

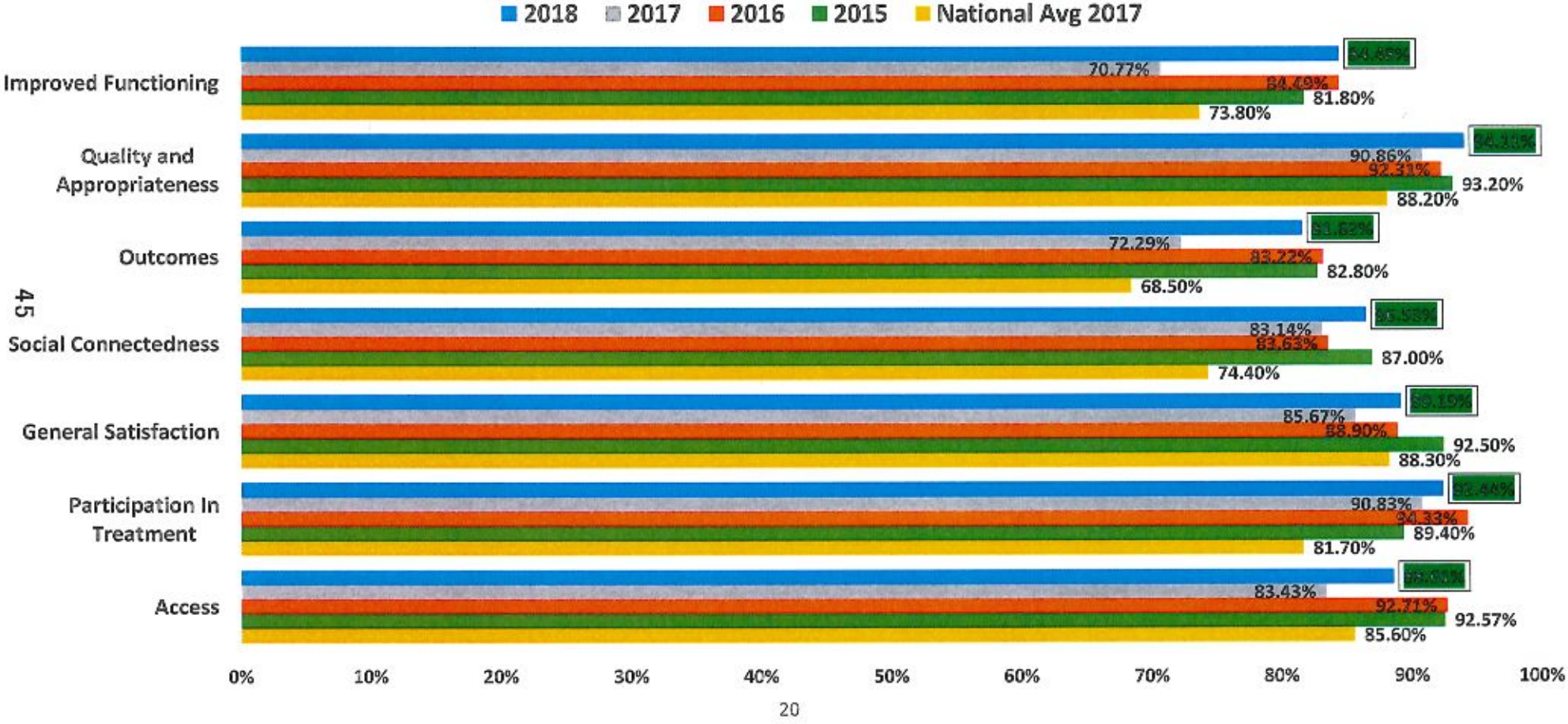
C) Anything else you would care to add?

MIHL Consumer Satisfaction Survey Score Comparison By Year



Improvement over previous years scores in all (7) categories

MI Health Link Consumer Satisfaction Survey Score By Year Against National Average



How Did We Do?

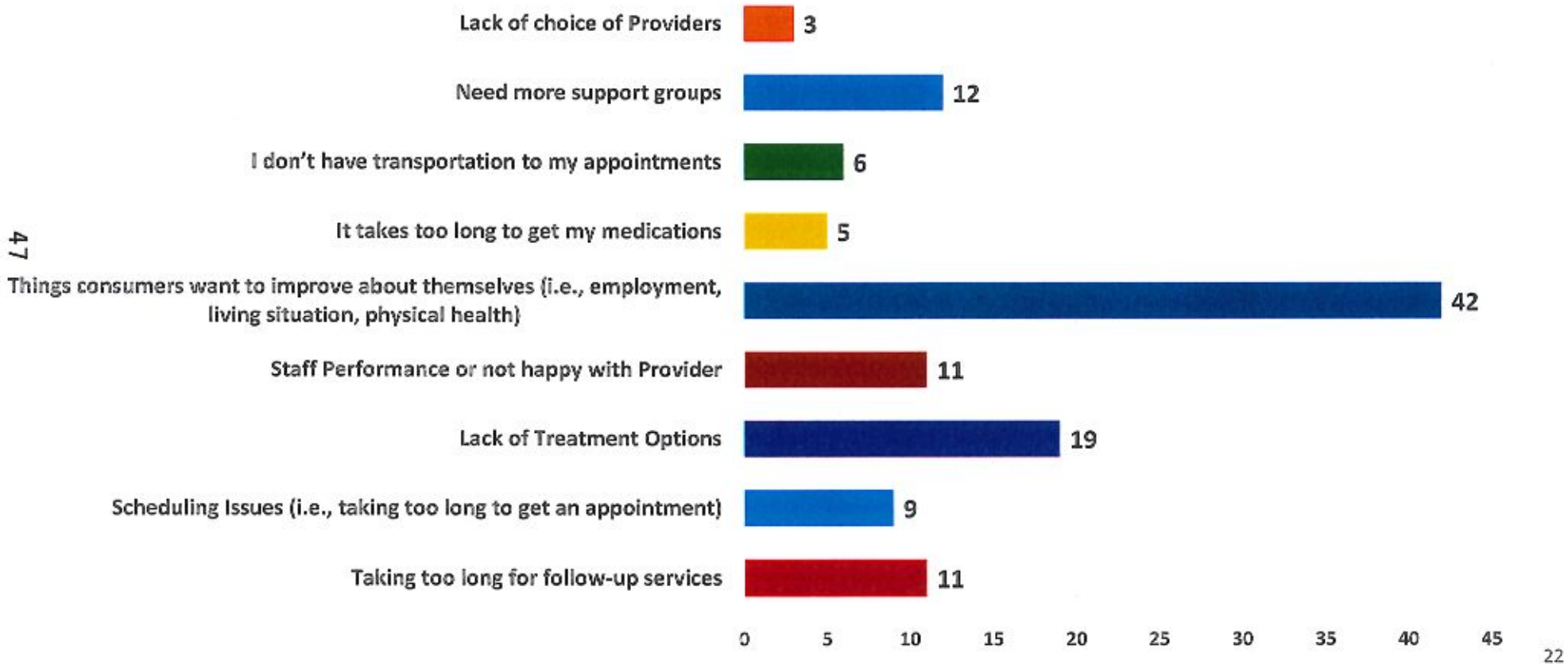
MIHL Results

- 2018 Aggregate Score: 88.14%
- 2017 National Ave Score: 80.07%
- 2017 Aggregate Score: 82.43%

+5.71% Percent Improvement over 2017 Scores

+8.07% Percent Improvement Over National Ave Scores

2018 MI Health Link
Consumer Satisfaction Constructive Criticism



RESOLUTION OF THE BOARD OF SOUTHWEST MICHIGAN BEHAVIORAL HEATH

WHEREAS, Southwest Michigan Behavioral Health Regional Entity ("SWMBH") was created under MCL 330.1204b of the Mental Health Code with the adoption and filing of SWMBH Bylaws by the 8 Participant community mental health services programs named in Section 1.1 of the Bylaws;

WHEREAS, the SWMBH Board has been presented with and has review proposed amendments to the Bylaws which will allow SWMBH to expand its Service Area, subject to the approval of the SWMBH Board, without amending the Bylaws and without obtaining approval of all Participant Boards in the future (Amendments);

THEREFORE BE IT RESOLVED that the SWMBH Board has reviewed and considered the Amendments to the Bylaws and hereby approves those Amendments in substantially the same form as presented;

THEREFORE BE IT RESOLVED that pursuant to Article XIII of the Bylaws any amendments to the Bylaws must be approved and adopted by the Boards of all Participants;

THEREFORE BE IT RESOLVED that pursuant to MCL 330.1204b(l) and Article XIV of the Bylaws any Amendments to the Bylaws are only effective after being duly adopted by the Boards of each Participant and subsequently filed with the clerk of each county in which the Participants are located and with the Michigan Secretary of State (Office of the Great Seal); and

THEREFORE BE IT RESOLVED that the Executive Officer of SWMBH is hereby authorized to arrange for such filings, upon receipt of resolutions from all Participant boards approving and adopting the Amendments.

RESOLUTION DECLARED ADOPTED

By: _____
Susan Barnes
SWMBH Board Secretary

I hereby certify the foregoing is a true and complete copy of the Resolution duly adopted by Southwest Michigan Behavioral Health Board at a meeting duly called on ---------- 2019, at which a quorum was present, and that said meeting was conducted and public notice of said meeting was given pursuant to and in full compliance with the Open Meetings Act, 1976 PA 267, and that minutes of said meeting were kept and will be or have been made available as required by said Act.

~~April 3 DRAFT FOR DISCUSSION PURPOSES ONLY OCTOBER 30, 2018~~

12-14-18 Board Revisions and Approval to the October 30, 2018 Draft

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FIRST
AMENDEDAND RESTATED
BYLAWS
(Southwest Michigan Behavioral Health)

ARTICLE I FORMATION

1.1 **Establishment of Entity**. The Southwest Michigan Behavioral Health Regional Entity (the " Regional Entity") ~~is hereby~~ was created pursuant to MCL 330.1204b of the Michigan Mental Health Code, 1974 PA 258, MCL 330.1001 *et seq* (the "Mental Health Code") with the adoption of ~~these~~ Bylaws by the following Participant community mental health services programs which are organized and operated as community mental health authorities under the Mental Health Code:

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

i.e., (the "Participants").

~~1.3~~1.2 **Form of Entity**. Pursuant to MCL § 330.1204b(3), the Regional Entity is a public governmental entity separate from the counties, authorities, or organizations that ~~establish~~ established it.

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~~1.41.3~~ **Service Area**. The Regional Entity's ~~designated~~ service area encompasses the following Michigan counties: Barry, Berrien, Branch, ~~Cass,~~ Calhoun, Cass, Kalamazoo, ~~St.~~ Saint Joseph ~~and~~, Van Buren ~~("Service Area "). "),~~

Any future additions to the Service Area shall not require amendments to the Bylaws or approval of the Participants' boards.

ARTICLE II
PURPOSES AND POWERS

2.1 **Purpose**. The Regional Entity is formed for the purpose of carrying out the provisions of the Mental Health Code in the Service Area as they relate to, including without limitation: serving as a prepaid inpatient health plan, as defined in 42 CFR 438.2 ("PIHP"), to manage the Medicaid Specialty ~~Support~~ Supports and Services Concurrent 1915(b)/(c) Waiver Programs ~~("Medicaid") and the~~ . The Healthy Michigan ~~ABW NON Pregnant Childless Adults~~ Program, the Flint 1115 Waiver ~~(Adult Benefits Waiver) Section 1115 Demonstration program ("ABW");~~and Substance Use Disorder Community Grant Programs; ensuring a comprehensive array of services and supports as provided in the ~~PIHP Medicaid and ABW~~ contracts with ~~MDCH~~the Michigan Department of Health and Human Services (MDHHS) and any other Michigan department or agency or any other duly constituted legal entity; and exercising the powers and authority set forth in these Bylaws. Additional purposes may be added by the Regional Entity Board.

2.2 **Powers**. Except as otherwise stated in these Bylaws, the Regional Entity has all of the following powers provided under MCL 330.1204b(2~~):~~) as well as the following:

2.2.1 The power, privilege, or authority that the Participants share in common and may exercise separately under the Mental Health Code, as specified in these Bylaws or as granted by the Regional Entity Board under subsection 2.2.8;

~~2.2.2~~ The power to contract with the State to serve as the Medicaid specialty service PIHP for the Service Area~~;~~ and the power to contract with other Michigan departments and agencies or any other duly constituted legal entity;

2.2.3 The power to contract with a state, federal, local, and/or commercial organization(s).

~~2.2.4~~ The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the State or a State department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the Regional Entity, and from a private, or civic source;

~~2.2.5~~ The power to enter into a contract with a Participant for any service to be performed for, by, or from the Participant; and

-2.6 The power to create a risk pool and take other actions as necessary to reduce the risk that the Participants otherwise bear individually.

2.2.7 The power to calculate, assess, and collect from the Participant payments attributable to their designated share of the Regional Entity's costs and expenses.

2.2.8 Other powers granted by the Regional Entity Board that the Participants share in common and may exercise separately under the Mental Health Code.

2.3 **Regional Entity Actions**. The manner by which the Regional Entity's purposes will be accomplished and powers will be exercised shall be through the actions of the Participants as provided in Article III of these Bylaws and through the actions of the Regional Entity Board as set forth in these Bylaws, or as delegated by the Regional Entity Board to officers, committees or other agents.

2.4 **Participant Retained Powers**. The Participants shall retain all powers, rights and authority afforded community mental health services programs, organized and operated as county mental health authorities, agencies or organizations under the Mental Health Code. Only the powers and authority specifically delegated to the Regional Entity under these Bylaws and as further defined under an Operating Agreement, are transferred to the Regional Entity. An Operating Agreement shall be approved by the Regional Entity Board and incorporated herein by reference.

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.

ARTICLE III THE PARTICIPANTS

3.1 **Participants**. The Participants shall be those community mental health authorities listed in section 1.1.

3.2 **Participant Vote**. Each Participant will designate members of the Regional Entity Board, as provided in Section 4.2.

3.3 **Withdrawal of the Participant**. Any Participant may withdraw from participation with the Regional Entity effective upon providing to the Executive Director of the Regional Entity written notice (minimum notice of 6 months before the beginning of the fiscal year). Upon the effective date of such withdrawal, the Participant will have no further rights or benefits of the Participant of the Regional Entity. The withdrawing Participant is responsible for meeting all of its obligations prior to the withdrawal. The Regional Entity Board position(s) and other positions appointed by the withdrawing Participant shall terminate upon the effective date of withdrawal of the Participant and no replacement shall be appointed nor vacancy be deemed to occur by reason of the Participant's withdrawal and termination of positions.

3.4 **Removal of the Participant**. The Participants cannot be removed from the Regional Entity.

3.5 **New Participants**. New Participants may be admitted by unanimous vote of the Participants~~a~~. ~~simple majority vote of the Participants.~~ At any time that the new Participant is admitted and enters into an Operating Agreement to participate in the Regional Entity, the new Participant shall be entitled to the entire Participants' rights of governance and obligations provided in these Bylaws.

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3.6 **Dispute Resolution**. 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.

3.7 **Participant Reserved Powers**. Each Participant shall possess the powers and rights retained and reserved to the Participants under Section 2.4 of these Bylaws and this Section 3.7, which shall include the power to approve the following:

3.7.1 all amendments, restatements or the adoption of new bylaws;

3.7.2 a plan of merger, consolidation or joint venture;

3.7.3 the sale, transfer or other disposition of substantially all the assets of the Regional Entity; and

3.7.4 the dissolution of the Regional Entity and distribution of assets and liabilities, if any.

3.8 **Participants' Exercise of Reserved Powers**. The Participants shall exercise their reserved powers through duly adopted written resolutions from their respective boards. The Participants Boards will unanimously 100% approve all reserved powers listed in section 3.7.

3.9 **The Participant Payment of Designated Share of the Regional Entity's Costs and Expenses**. The manner of equitably allocating costs and expenses and how they will be

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assessed shall be set forth in the Regional Entity's annual Financial Management Plan, which shall be approved by the Regional Entity Board and incorporated herein by reference.

ARTICLE IV REGIONAL ENTITY BOARD

4.1 **General Powers**. The business, property, and affairs of the Regional Entity shall be managed by the Regional Entity Board in accordance with the Policy Governance Model as made explicit by Dr. John Carver www.carvergovernance.com.

4.2 **Number and Composition**. The composition of the Regional Entity Board shall be consistent with all applicable statutory requirements. Each of the Participant Community Mental Health Services Program (CMHSP) Boards shall have one representative on the Regional Entity Board, who shall be an active member of the Participants' CMHSP Board. If the Regional Entity is a department-designated community mental health entity, as defined in Section 100a(22) of 2012 PA 500, the composition of the Regional Entity Board shall also consist of representatives of mental health, developmental or intellectual disabilities and substance use disorder services as required under 2012 PA 500. The Regional Entity Board shall also include consumer representation. Each Participant CMHSP Board shall appoint one member to the Regional Entity Board. The Regional Entity Board shall determine whether all of the required categories of board members are represented on the Regional Entity Board. Each CMH shall appoint one member with one vote if there are a total of 8 Board Members. If additional members are needed to be appointed to represent all of the required categories, the Participant CMHSPs will jointly agree on and appoint additional individuals as necessary. There shall be no more than two members from any one Participant CMHSP on the Regional Entity Board. There will be no more than 2 total votes for each Participant CMHSP on the Regional Entity Board. Participant CMHSPs in which two individual board members reside will have one vote assigned to each of those members and Participant CMHSPs in which one board member resides will have two votes assigned to that member.

4.3 **Appointment**. The Participant CMHSP Boards shall appoint members of the Regional Entity Board. At any time the Participant CMHSP Boards may appoint, remove, or replace its appointee to the Regional Entity Board.

4.4 **Term**. All Regional Entity Board members shall continue to serve on the Regional Entity Board until their Participant CMHSP Board appoints a different representative.

4.5 **Removal**. The Participant CMHSP Boards may remove its appointee to the Regional Entity Board at any time. The Regional Entity Board is responsible for informing the relevant Participant board if there is a lack of participation or attendance by the Participant's appointed Board members.

4.6 **Resignation**. Any Regional Entity Board member may resign at any time by providing written notice to the Regional Entity. The resignation will be effective on receipt of the notice or at a later time designated in the notice. A successor will be appointed as provided in Section 4.3 of these Bylaws.

4.7 **Regional Entity Board Vacancies.** A vacancy on the Regional Entity Board shall be filled by the Participant CMHSP Board that originally filled the person's vacated position.

4.8 **Regular Meetings**. The Regional Entity Board shall establish a regular schedule of meetings at the beginning of each fiscal year. Notice in writing of each meeting shall be given to Regional Entity Board members and posted to the public.

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

4.10 **Meeting by Remote Communication**. A Regional Entity Board member may participate in a meeting by conference telephone or any similar communication equipment through which all persons Participant in the meeting can hear each other. Participation in a meeting pursuant to this Section constitutes presence in person at the meeting.

4.11 **Quorum and Voting**. A majority of the Regional Entity Board members then in office constitutes a quorum for the transaction of any business at any meeting of the Regional Entity Board. Actions voted on by a super majority (75% of attendees) of Regional Entity Board members present at a meeting where a quorum is present shall constitute authorized actions of the Regional Entity Board.

4.12 **Conflict of Interest Policy**. The Regional Entity Board shall adopt and adhere to a conflict of interest policy. All Regional Entity Board members will annually disclose any conflicts of interest while serving on the Regional Entity Board.

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

4.14 **Alternates/Designees.** The Participant CMHSP Boards may appoint official designees to serve in place of their appointed Regional Entity Board member in the event that a Regional Entity Board member is unable to attend a regularly scheduled meeting.

This designee shall have full voting rights for the purpose of the meeting he/she is designated to attend.

4.15 **Per Diem and Travel Expenses**: The Regional Entity does not pay Per Diem or travel expenses of Regional Entity Board members that are part of regular Regional Entity Board activities.

ARTICLE V COMMITTEES

5.1 **Powers**. The Regional Entity Board may form committees from time to time, as it deems appropriate. A committee designated by the Regional Entity Board may exercise any powers of the Regional Entity Board in managing the Regional Entity's business and affairs that are within the committee's jurisdiction, to the extent provided by resolution of the Regional Entity Board.

5.1.1 Operations Committee: An Operations Committee will be formed consisting of the CEOs of the Participants or their designees. The Operations Committee will have the responsibilities and authorities assigned by the Board and outlined in the Operating Agreement.

5.2 **Meetings**. Committees shall meet as directed by the Regional Entity Board; minutes shall be recorded at each committee meeting and shall be available to the Regional Entity Board.

ARTICLE VI OFFICERS

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

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

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

6.4 **Vacancies**. A vacancy in an officer position shall be filled by a majority vote of the Regional Entity Board.

6.5 **Removal**. The Regional Entity Board will be able to remove any Regional Entity Board Officer by a super majority (75% of attendees) vote of Regional Entity Board

members present at a meeting where a quorum is present and shall constitute an authorized action of the Regional Entity Board.

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

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

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

ARTICLE VII STAFF POSITIONS

7.1 **Executive Officer**. The Regional Entity shall have at a minimum an Executive Officer, and a Fiscal Officer. The Regional Entity Board shall hire the Executive Officer; and the Executive Officer shall hire and supervise the Fiscal Officer. Both positions shall have direct access to the Regional Entity Board.

7.2 **Fiscal Officer**: The Fiscal Officer shall serve as the fiscal officer as defined in MCL 330.1204b and shall (a) have charge and custody over corporate funds and securities; (b) keep accurate books and records of corporate receipts and disbursements; (c) deposit all moneys and securities received by the Regional Entity at such depositories in the Regional Entity's name that may be designated by the Regional Entity Board. The Fiscal Officer has the responsibilities set forth in MCL 330.1204b and will be responsible for receiving, depositing, investing, and disbursing the Regional Entity's funds in the manner authorized by these Bylaws and Regional Entity Board in accordance with the Regional Entity's Operating Agreement and other duties as assigned by the Executive Officer.

ARTICLE VIII
ADVISORY BODIES:

8.1 **Advisory Bodies**. The Regional Entity Board may establish Advisory Bodies.

8.2 **Purpose**. The Regional Entity Board shall define the purpose and longevity of any advisory bodies in the document creating an Advisory Body.

8.3 **Membership**. The Regional Entity Board shall define membership in each establishing agreement for each Advisory Body.

8.4 **Officers**. Officers will be elected by a majority vote of the Advisory Body members.

8.5 **Meetings**. Each Advisory Body shall establish a regular schedule of meetings at the beginning of each fiscal year. Notice in writing of each meeting shall be given to the Regional Entity Board.

ARTICLE IX REPORTS

The Regional Entity must provide an annual report of its activities to each Participant.

ARTICLE X IMMUNITY

10.1 **Governmental Immunity**. All the privileges and immunities from liability and exemptions from laws, ordinances, and rules provided under MCL § 330.1205(3)(b) of the Mental Health Code granted to county community mental health services programs and their Regional Entity Board members, officers, and administrators, and county elected officials and employees of county government are retained by the Regional Entity and the Regional Entity's Board members, Officers, agents, and employees, as provided in MCL § 330.1204b(4).

10.2 **LIABILITY.** Except as required by law, these Bylaws, or any agreement between the Participants or the Participants and the Regional Entity, the Participants shall not be responsible for the acts, omissions, debts or other obligations and responsibilities of the Regional Entity or any other Participant or the Board members, employees, agents and representatives of the Regional Entity or the other Participants, whether acting separately or jointly under these Bylaws or pursuant to any such agreements. The Participants shall only be bound and obligated as expressly agreed to by each Participant and no Participant may otherwise obligate any other Participant.

10.2.1 All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Regional Entity shall be the sole and non-transferrable responsibility of the Regional Entity, and not the responsibility of the Participant, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act by the Regional Entity, its Board members, officers, employees or representatives; provided that nothing herein shall be construed as a waiver of any governmental or other immunity that has been provided to the Regional Entity or its Board members, officers, employees or representatives, by statute or court decisions.

1022 All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by the Participant shall be the sole and non-transferrable responsibility of the Participant and not the responsibility of the Regional Entity, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act by the Participant, its Board members, officers, directors, employees and authorized representatives; provided that nothing herein shall be construed as a waiver of any governmental or other immunity that has been provided to the Participant or its Board members, officers, employees or representatives, by statute or court decisions.

1023 Each Participant and the Regional Entity will obtain its own legal counsel, and will bear its own costs, including judgments, in any litigation which may arise out of its activities to be carried out pursuant to its obligations under these Bylaws or any agreement between the Participants or the Participants and the Regional Entity. It is specifically understood that no indemnification will be provided in such litigation.

1024 In the event that liability to third parties, loss or damage arises as a result of activities conducted jointly under these Bylaws or any agreement between the Participants or the Participants and the Regional Entity, such liability, loss or damages shall be borne by each party in relation to each party's responsibilities under the joint activities, provided that nothing herein shall be construed as a waiver of any governmental or other immunity granted to any of said parties as provided by applicable statutes and/or court decisions.

1025 Under these Bylaws, it is the intent that each of the Participants and the Regional Entity shall separately bear and shall be separately responsible for only those financial obligations related to their respective duties and responsibilities.

103 **INSURANCE.** The Regional Entity may purchase and maintain insurance on behalf of any person who is or was a Board member, officer, employee or representative of the Regional Entity, against any liability asserted against the person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the Regional Entity would have power to indemnify the person against such liability under these Bylaws or the laws of the State of Michigan.

ARTICLE XI ADMINISTRATION

11.1 **Allocation of Assets and Liabilities.** The Regional Entity shall allocate its assets and liabilities to each Participant in the following manner:

11.1.1 **Revenues**. The Regional Entity will equitably allocate Medicaid (including ABW) revenues to the Participants utilizing a sub-capitation methodology based on the number of Medicaid beneficiaries in each county using regional capitation rates. The specific methodology used to allocate revenues will be provided in the annual Financial Management Plan, approved by the Regional Entity Board and incorporated herein by reference.

The allocation of other revenues derived from a federal or state grant or loan, a gift, bequest, grant, or loan from a private source, or an insurance payment or service fee shall be approved by the Regional Entity Board on a case by case basis. The specific methodology for the allocation of other revenues will be provided in the annual Financial Management Plan approved by the Regional Entity Board and incorporated herein by reference.

11.1.2 **Capital and Operating Costs**. The Regional Entity will deduct and retain, from the total capitation revenue, the cost of any required State and Federal Payments (for example HRA or Claims Tax). The Regional Entity will deduct capital and operating costs, payments to reserve funds authorized by law, and payments of principle and interest on obligations as approved by Board. The deductions for capital and operating costs, reserve funds, payments of principle and interest on obligations should be allocated as delineated in the Financial Management Plan.

11.1.3 **Other Assets**. The Regional Entity Board shall approve the allocation of other Regional Entity assets, on a case by case basis. The specific methodology for such allocation will be provided in the annual Financial Management Plan, approved by the Regional Entity Board and incorporated herein by reference.

11.1.4 **Surplus Funds**. Any surplus funds available after the completion of the Regional Entity's purpose will be returned to the Participants in the proportion based on the amount of sub capitation revenues in the last year of Regional Entity operations.

11.1.5 **Special Fund Account**. Each Participant may elect to create a special fund account under Section 226A of the Mental Health Code. Money in the special fund account represents local funds of each Participant. Each Participant will pay the Regional Entity its share of local matching fund obligation for Medicaid funding. Each Participant may use its special fund account or other local funds to meet the local matching fund obligations for Medicaid funding.

11.1.6 **Accountability of Funds**. The Regional Entity will maintain an accounting and financial reporting system in accordance with Generally Accepted Accounting Principles (GAAP). The accounting procedures and internal financial controls of the Regional Entity shall conform to Generally Accepted Accounting Principles (GAAP) for governmental units. The Regional Entity 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 Regional Entity shall engage a certified public accounting firm to perform an annual independent financial audit in conformance with the American Institute of Certified Public Accountants Guide to assess compliance with the appropriate standard accounting practices and procedures and MDCH contract requirements.

11.1.7 **Contracts**. The Regional Entity Board shall designate the positions of the Regional Entity that will have authority to enter into contracts on behalf of the Regional Entity with third parties, including contracts involving the acquisition, ownership, custody, operation, maintenance, lease or sale of real or personal property and the disposition, division or distribution of property acquired through the execution of the contract.

11.1.8 **Risk Management**. The Regional Entity shall have a Financial Risk Management Plan that is approved by the Regional Entity Board.

11.1.9 **Participants Failure to Pay:** Addressed in 3.9, 11.1.2, and 11.1.5

11.2 **Other Administration Activities**. The Regional Entity Board and/or its Operations Committee will, on an ongoing basis, consider possible administrative efficiencies where appropriate.

ARTICLE XII FISCAL YEAR

The fiscal year of the Regional Entity shall end on September 30 of each calendar year.

ARTICLE XIII AMENDMENTS

These Bylaws may be amended altered, changed, added to or repealed by a uniform resolution approved by each Participant CMH Board. No amendment to these Bylaws shall be effective until filed as provided in Article XIV.

ARTICLE XIV FILING BYLAWS

These Bylaws, including any amendment, shall be effective only after it has been duly adopted in accordance with MCL 330.1204b(1) and subsequently filed with the clerk of each county in which the Participant is located and with the Michigan Secretary of State.

ARTICLE XV TERMINATION

The Participants may terminate the Regional Entity by a vote of super majority (75%) vote of the Participants, after distributing any surplus funds to the Participants as provided in Section 11.1.4 of these Bylaws.

SUMMIT POINTE
Certificate of Adoption of Resolutions by Board of Directors

WHEREAS, Southwest Michigan Behavioral Health ("SWMBH") was created pursuant to Section 204b of the Mental Health Code with the adoption and filing of SWMBH's Bylaws by the eight (8) Participant community mental health services programs named in Section 1.1 of the SWMBH Bylaws (the "Participant/s");

WHEREAS, Calhoun County Community Mental Health Authority, operating as Summit Pointe ("Summit Pointe"), is one of the Participants; and

WHEREAS, the Summit Pointe Board has been presented with and has reviewed proposed amendments to the SWMBH Bylaws that would allow SWMBH to expand its Service Area, subject to the approval of the SWMBH Board, without amending the SWMBH Bylaws and without obtaining approval of the Participants' Boards in the future (Amendments).

NOW, THEREFORE, BE IT RESOLVED, that the Summit Pointe Board has reviewed and considered the Amendments to the SWMBH Bylaws as attached hereto, and hereby:

Have determined that with no actual Request for Proposal from MDHHS related to the "unenrolled population" under the Section 298 Initiative; no response from SWMBH to an RFP; and no other expanded Service Area proposed with specificity, the Board lacks sufficient information to make a reasonably informed decision concerning the Amendments, and therefore does NOT approve, adopt or accept the Amendments. Summit Pointe, however, would be willing to reconsider, including calling a special meeting if necessary, either the proposed Amendments or another proposed amendment upon receipt of and an opportunity to review and analyze all material information related to any expansion of the Service Area beyond the Participants' geographical areas.

****

I, Deborah Davis, Secretary of the Board of Directors of Summit Pointe, hereby certify that the above is a true and correct copy of a Resolution adopted by the Board of Directors of Summit Pointe at a Regular Meeting of the Board duly called and held on the 5th day of February, 2019.

Deborah Davis, Secretary

Southwest Michigan Behavioral Health

Memo

To: SWMBH Board

From: Bradley P. Casemore, Executive Officer

cc: T. Dawson

Date: March 1, 2019

Re: Fiscal Year 2019 Budget Margin and Internal Service Fund

Introduction

At the January SWMBH Board meeting, discussion occurred regarding regional financial status, expense management and the Internal Service Fund (ISF) risk reserve balance. Specifically, the Board *"charged the SWMBH Executive Officer and Chief Financial Officer with adjustments to cell H56 on the 2019 proposed Budget to reduce projected deficit with a report to the Board by March 2019."* Cell H56 is the bottom line fiscal year 2019 margin, a product of revenues minus expenses. Please see Board-approved fiscal year 2019 budget, **attached** at end of this document. This report was discussed with Operations Committee on February 27, resulting in revisions. The final content are views of SWMBH, as the Board instructed.

Overview

The current budget projects fiscal year 2019 an ending ISF balance at 09/30/19 of $948,696, just .52% of maximum permissible ISF of $18,312,207.

Revenues are projected at $258,778,818, expenses at $265,480,440, of that with $239,472,729, medical loss and $23,844,691 administrative loss, and a negative margin of ($6,701,622).

It is important to note that the financial status of the entire system has suffered over the last three years driven by both Revenue and Expense issues. At least 7 of 10 PIHPs spent more than they received in fiscal year 2018, at least 3 had year-end funding infusions from DHHS for fiscal year 2018, and fiscal year 2019 looks even more bleak state-wide. All ten PIHPs have agreed to prepare and present to executive and legislative branch leaders a multi-year revenue, expense and margin graphic which clearly illustrates the structural deficit of the public mental health system. Revenues have been lessened by the state (e.g., artificial caps on autism applied behavior analysis service unit rates, and stale data used for actuarial work), while demand for services increases (opioid epidemic, autism prevalence, etc.), and DHHS demands for unfunded mandates expand (e.g., GAIN, MCG Criteria, etc.).

There is some indication that a fiscal year Medicaid behavioral health supplemental appropriation will be made, but this in not a certainty. It appears that the fiscal 2020 Medicaid PIHP capitation revenue rates formula will be materially altered. It is unclear if this will be a favorable, unfavorable or neutral outcome for a. the system and b. SWMBM. We must expect the worst and hope for the best.

As a region and a system, we must not solve the state's fiscal issues on the backs of our beneficiaries. Medically necessary, effective services must be provided, and the wishes of persons served honored. We must not suffer in silence accepting function after function, task after task - almost always without additional resources – while we are both criticized and taking up slack for under-performance of other parts of the public behavioral health and healthcare systems.

Several significant steps on the revenue and expense sides have occurred in prior years and in this fiscal year. The Board's question is what more can be done. That is the focus of this communication.

Of total projected expenses, $21,941,001 (77.1%) healthcare cost and $8,670,650 (3.3%) managed care administration are at the PIHP, with $212,682,714 (95.5%) healthcare cost and $15,998,863 (6.2%) managed care administration at the CMHSPs.

SWMBH and CMHSPs are separate legal entities with independent management and Boards. While SWMBH has contracts with each of our CMHSPs for services and delegated managed care functions, SWMBH's unilateral authority is limited by roles, boundaries, guiding documents, and Agreements. We are fortunate that we have developed a functional shared deliberation and decision-making process, allowing successful change management efforts.

Revenues

Revenues are under constant review, with attempts at maximization by SWMBH management. We participate actively in system-wide and independent revenue maximization policy advocacy initiatives. We budget revenues conservatively. We have been successful in securing or maximizing system revenues and/or regional revenues. One example is the advocacy in 2018 resulting in a $57 million state-wide Medicaid supplemental, which benefited us approximately $6,000,000. Medicaid revenue development for the region is largely a SWMBH-led and CMHSP-supported activity. CMHSPs are encouraged to and supported by SWMBH, when asked, to develop additional General Fund, Grants, etc. Generally speaking, such non-Medicaid revenues have no impact – favorable or unfavorable – on CMHSP Medicaid expenses. In 2018 we assembled a Revenue Maximization Team led by SWMBH CFO Tracy Dawson. Focus areas identified have included moving the region to the state ABA rates, a reduction in expense for most CMH's; and reducing duplicative reviews and sharing physician time when available. In addition, we have instituted a more objective screening process for persons with mild to moderate mental illness, as well as improved processes on how these services are financially handled in CMHSP systems.

Expenses

An important fact to remember is that we are based upon a cost-reimbursement commitment to CMHSPs. SWMBH must cover all legitimate Medicaid program and administration expenses at CMHSPs. While we work together to compare costs across our CMHSPs and to other PIHPs when available, all specific adjustments of a binding nature (e.g., ASD ABA provider rate, including for CMHSPs), have been by mutual agreement of the nine agencies. This necessitates deep and broad CMHSP management and Board inquiry into cost structures at the CMHSPs, as we continue to work together to find individual CMHSP, multi-

CMHSP or all-CMHSP expense reductions in addition to SWMBH expense reductions. SWMBH will be increasingly inquisitive in this regard as well as serving as a change management facilitator.

The lion's share of internal SWMBH and CMHSPs costs regionally is in employed staff; it is through highly trained clinicians that we achieve our results in individual and aggregate health and functional improvements. Highly trained and experienced managers fulfill administrative burdens and protect the agencies and our beneficiaries. When contracted provider service expenses are reduced, there is an immediate favorable financial impact. Where service demand and/or revenue does not support current or past internally provided services, the only mechanism to address this is reductions in force, aka layoffs. Otherwise, fixed costs simply move to other line items; the costs don't disappear.

Advocates and some legislators espouse potential future significant cost-savings of CMHSP mergers. Said savings are often over-stated, and transition costs ignored. Cost-benefit analyses and return on investment is typically lengthy and involves outside expertise. SWMBH does not claim to be expert in this nor to have the resources to evaluate such matters. This is an option whose consideration is reserved to the CMHSPs, not to SWMBH or the SWMBH Board.

Some agencies, including SWMBH have placed a senior executive review process on new and vacant positions. At a minimum, this is a recommended practice to assess changing circumstances before committing to a long-term expense load of additional FTEs. If one assumes a conservative average annual salary of $48,000 and a 30% benefits load of $14,400, the following Table reflects varying scenarios for FTE adjustment impact (at any of the nine agencies).

Number of FTEs	Base at $48,000	Benefits at $14,400	Cumulative Annual Impact
4	$192,000	$57,600	$249,600
8	$384,000	$115,200	$499,200
12	$576,000	$172,800	$748,800
16	$768,000	$230,400	$998,400

Medical Loss

Medicaid and Healthy Michigan supports and services are entitlements, *when medically necessary.* SWMBH is obligated to maintain uniformity of benefit across the region and has instituted a region-wide highly delegated utilization management function. In 2018 we instituted a regional managed care functional review of utilization management, led by SWMBH Chief Administrative Officer Anne Wickham. That review resulted in several changes, some of which are yet to be implemented. This results in a higher level of automation, as well as more consistent types/amounts/durations of services reducing both over- and under-utilization.

SWMBH negotiates provider rates for its own providers (substance use disorder and MI Health Link Medicare), while CMHSPs negotiate rates for their providers. It is probable that unified provider rate negotiations could result in overall lower provider rates. In addition, unified contract provider performance contracting could also result in better clinical outcomes and reduced provider expense loads. Diminishment of access and quality must be avoided.

Recently, collectively we normalized rates for autism service applied behavioral analysis providers, resulting in an approximate annual savings of $3 million. Other provider type rate joint efforts are being considered. A financial impact analysis is underway of the impact of all CMHSPs moving to the lowest rate accepted by the same Provider for the same service. In addition, the fiscal year 2018 Service Use Evaluation (SUE) development commences in March, its third iteration.

For CMHSPs and contract providers, clinical productivity is a major driver of expense structure. While it is true that clinicians have a material paperwork administrative burden, maximizing client contact time improves volume (encounters), unit cost and aggregate cost. More client contact also enhances the satisfaction, treatment adherence and outcomes for persons served. Clinical productivity improvement remains a CMHSP effort. We have encouraged and supported CMHSPs in their unilateral and multi-lateral efforts to address this topic, including endorsing external resources to assist at times.

Of the regional medical loss expense $212,682,714 (95.5%) are spent at CMHSPs, with $21,941,001 (77.1%) at SWMBH or CMHSP external providers. Of the CMH medical loss spend, $64,294,357, 27.0% are internal services and $170,329,358, 73.0% at external providers. Thus, management of CMHSP expenses is key. SWMBH has regular unit cost and aggregate review cost activities with our CMHSPs, and the Board has seen summary data from our Service Use Evaluation (SUE). Where it exists, we secure and analyze state-wide PIHP and CMHSP cost data.

CMHSP management and Board are responsible for understanding and improving their own expenses. CMHSPs cannot unilaterally and independently apply local utilization management criteria to Medicaid supports and services.

CMS, DHHS, SWMBH and CMHSPs are getting more sophisticated, regulated and objective in uniform and standard approaches to assessment and utilization management, e.g. LOCUS, ASAM, SIS, MCG Criteria, etc. Our region must accelerate the proper use an frequency of screening and assessment tools, make electronic reporting easier and more frequent, and make analysis and feedback reporting more timely, as well. This is the key intervention to assure 1.) proper patient placement and retention; 2.) admission/discharge/transfer accuracy and consistency; and 3.) objective and defensible proofs of PIHP contract fulfillment and avoidance of improper use of PIHP funds.

In January 2019 we instituted a regional approach to identifying persons with mild to moderate mental illness in care at CMHSPs and moving them to the appropriate Medicaid Health Plan Provider Network. We also instituted a regional approach to early screening for persons with mild to moderate mental illness (a responsibility of the MHPs), generally before CMHSP face to face services begin. This has several benefits including freeing access point resources and avoiding specialty services resources for persons with mild to moderate mental illness, a Medicaid Health Plan responsibility. Moving CMHSPs away from serving persons with mild to moderate mental illness – without MHP contracts – should produce material savings, provided that CMHSPs reduce staff and fixed expenses accordingly. Some CMHSPs have contracts with Medicaid Health Plans for these services, while others do not.

Administrative Loss

Significant progress has been made region-wide in reducing overall administrative expenses. In FY 2014 regional administrative expenses were $14,585,760 (9.2%). In FY 2018 administrative expenses were $23,240,242 (8.7%). Note that administrative expenses include all managed care administrative expenses (central and delegated) as well as CMHSP Board administrative expenses. CMHSPs are responsible for management of Board administrative

expenses, while managed care administrative expense management is a shared responsibility, with SWMBH as the leader. CMHSP specific Board administration costs and percentages are available locally at CMHSPs.

Some have made arguments for a more centralized – i.e., "less delegated" - approach to fulfilling mandatory managed care functions. SWMBH EO and CFO believe that our Delegation Model, while imperfect, has evolved in a sound manner, is working, and is defensible. Unwinding that now would be disruptive, expensive in the short term and true savings, if achievable, would be largely dependent upon reductions in force. This does not mean that we avoid scrutinizing managed care functions to achieve more automation, fewer FTEs overall, greater normalcy, and scalability and replicability. We have always supported CMHSPs considering relinquishing delegated managed care functions back to SWMBH, or in sharing delegated managed care functions. Both require prior informed consent of SWMBH.

There are savings gains from automation of business processes, data exchanges and analytics. Thus, this continues to be a goal, where possible. There is always a short-term cost to automate, and our environment with deep and broad change orders by MDHHS make this less attractive than in other more self-directed environments, e.g., Walgreens or Wal-Mart.

One method to urge reductions in administrative expenses would be to limit the dollars and/or percentages of funds allocated to Medicaid at CMHSPs, regardless the true administrative expense amount. This has negative tactical ramifications in that reporting artificially reduced Medicaid expenses places additional burden on local CMHSP local funds and has a suppressive effect on future SWMBH Medicaid rebasing. Thus, we don't recommend this.

Regarding administrative functions not related to managed care functions, there is often a certain appeal or assumed benefit to considering centralizing universal administrative functions such as IT, Finance, Payroll, Claims Management, HR, Purchasing and the like. Again, remembering the independent status, management and governance of the nine related agencies, centralization is generally more complicated and expensive to implement than when first conceived. It also tends to blur lines of authority, responsibility and culpability, and savings, if any, come later through reductions in force and or staff attrition. For potential cost-savings in these areas for CMHSPs to consider, SWMBH has no role, except upon invitation, and even then, our resources are limited for these efforts. CMHSPs could consider sharing Recipient Rights, and other functions, or multi-agency purchasing of accounting software, payroll services, etc. Cost-savings estimates in these areas would be generated by CMHSPs, not SWMBH.

CMHSPs have more in common with each other than with SWMBH, thus inter-CMHSP opportunities could be explored there. Given the tenuous nature of the PIHP lifespan, centralizing at a Regional Entity, if it becomes extinct, would necessitate an expensive reversal of the effort, absent regional support for an Administrative Services organization (ASO) role for SWMBH, in the event of a carve-in.

A critical consideration is *net savings*. If we save $100,000 at SWMBH and cost CMHSPs $101,000 we have disrupted business activity for a negative aggregate financial return. The converse is also true. There are always direct and indirect costs to major structural changes, many of which become apparent only after initiation of the change.

Another critical consideration is CMHSPs valuation of value-added SWMBH activity. Fulfillment of PIHP obligations by SWMBH to DHHS is non-negotiable, as is fulfillment of CMHSP obligations to SWMBH. However, identification, costing and revising other non-core supports to CMHSPs could be initiated, at Board direction.

High expectations and greater resource needs travel together. Our Board has always endorsed SWMBH being among the top PIHPs, and we have delivered. Similarly, our CMHSPs take their roles and performance very seriously, and compare very favorably to their peers. SWMBH EO could be directed to reduce expenses based upon a redirection to reduced expectations for SWMBH and CMHSP performance and thus supports and focusing more inward and less outward. Be aware that this approach would significantly diminish our strategic positioning stance, jeopardize future opportunities, demoralize staff and initiate a SWMBH staff exodus.

Conclusions

- It is proper for the Board to be concerned and active in setting budgetary parameters. Board and SWMBH management should continue to revise FY 2019 and FY 2020 regional margin expectations to prospectively stated, achievable levels.
- This situation helps focus Board on refining What Results for What Beneficiaries With What Resources, and management on achieving those results.
- SWMBH Board members and CMHSP CEOs can serve an important role in educating CMHSP Board members about regional budgetary issues, and local responsibilities.
- SWMBH regularly initiates collective and individual CMHSP efforts to improve access, quality, and cost structures, and will continue to do so.
- CMHSP Peer to Peer feedback and support would be beneficial.

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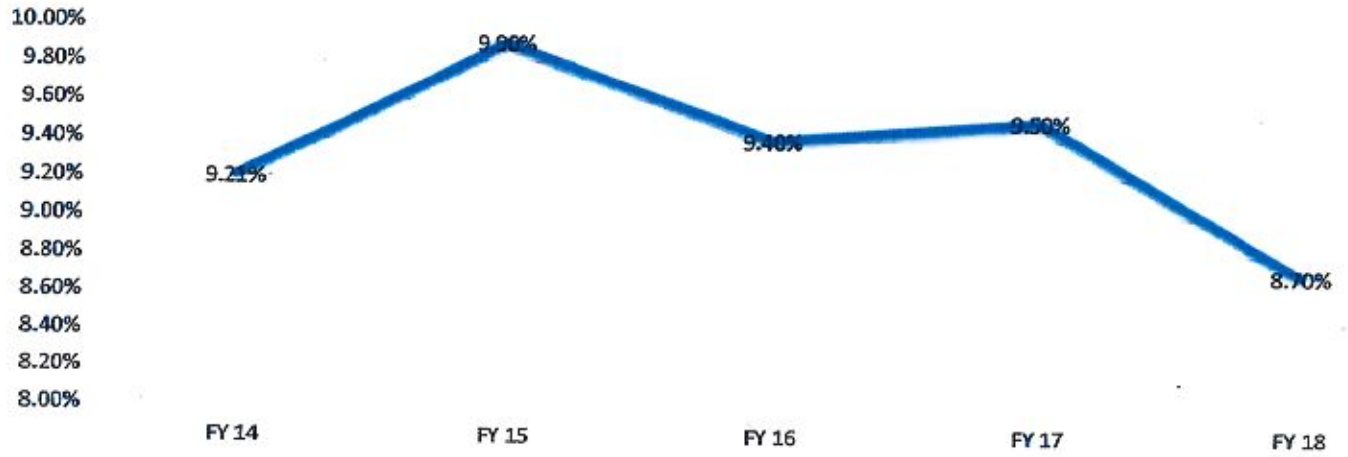
<END>

Approved 1/11/19

	E	F	G	H	I	J	K	L
1	**Southwest Michigan Behavioral Health**							
2	For the Fiscal YTD Period Ended 9/30/2019			FY19 Budget				
3	*(For Internal Management Purposes Only)*			**DRAFT**				
4	***INCOME STATEMENT***			As Proposed for Board Approval	FY19 Budget Current Status	FY18 Interim	Change FY19B v FY18 Interim Fav / (Unfav)	FY19 Budget
5								
6								
7	**REVENUE**							
8	**Contract Revenue**							
9	Medicaid Capitation			202,968,849	202,968,849	197,138,494	5,830,355	191,710,000
10	Healthy Michigan Plan Capitation			29,027,015	29,027,015	29,274,126	(247,111)	28,100,000
11	Autism Services Capitation			11,066,907	11,066,907	11,003,184	63,723	11,400,000
12	Dual Eligibles Demonstration Project			3,200,000	3,200,000	3,509,983	(309,983)	3,437,136
13	SA Block Grant Funding			7,005,139	7,005,139	9,871,743	(2,866,604)	7,000,711
14	SA PA2 Funding			1,871,835	1,871,835	1,812,428	59,407	2,502,808
15								
16	Contract Revenue			255,139,745	255,139,745	252,609,958	2,529,787	244,150,655
17	DHHS Incentive Payments			1,100,000	1,100,000	705,810	394,190	1,124,501
18	Direct Care Worker Revenue			-	-	-	-	4,800,000
19	Grants and Earned Contracts			132,695	132,695	104,022	28,672	66,000
20	Interest Income - Working Capital			139,752	139,752	134,178	5,574	69,000
21	Interest Income - ISF Risk Reserve			103,319	103,319	102,915	404	69,612
22	Local Funds Contributions			2,163,020	2,163,020	2,163,020	0	2,163,020
23	Other Local Income			88	88	166,176	(166,088)	-
24								
25	**TOTAL REVENUE**			**258,778,818**	**258,778,818**	**255,986,079**	**2,792,739**	**252,444,788**
26								
27	**EXPENSE**							
28	**Healthcare Cost**							
29	Provider Claims Cost			20,822,854	20,822,854	23,655,985	2,833,131	18,530,952
30	Direct Care Worker Cost			-	-		-	4,800,000
31	CMHP Subcontracts, net of 1st & 3rd party			212,682,714	212,682,714	215,100,740	2,418,026	203,656,830
32	HICA and Use Tax Expense			2,231,189	2,231,189	2,400,319	169,130	2,304,000
33	Medicaid Hospital Rate Adjustments			3,735,971	3,735,971	3,729,831	(6,140)	3,620,364
35								
36	**Total Healthcare Cost**			**239,472,729**	**239,472,729**	**244,886,875**	**5,414,146**	**232,911,238**
37	Medical Loss Ratio (HCC % of Revenue)			93.5%	93.5%	96.7%	3.2%	95.0%
38								
39	**Administrative Cost**							
40	Purchased Professional Services			924,500	924,500	1,347,158	422,658	1,556,893
41	Administrative and Other Cost			7,945,281	7,945,281	6,220,445	(1,724,835)	7,239,615
43	Depreciation			176,048	176,048	160,397	(15,650)	188,887
46	Delegated Managed Care Admin			14,798,863	15,998,863	15,512,242	(486,622)	15,341,511
48								
49	**Total Administrative Cost**			**23,844,691**	**25,044,691**	**23,240,242**	**(1,804,449)**	**24,328,906**
50	Admin Cost Ratio (MCA % of Total Cost)			9.1%	9.5%	9.7%	-0.8%	9.5%
51								
52	Local Funds Contribution			2,163,020	2,163,020	2,163,020	(0)	2,163,020
53								
54	**TOTAL COST after apportionment**			**265,480,440**	**266,680,440**	**270,290,137**	**3,609,696**	**259,403,162**
55								
56	**NET SURPLUS before settlement**			**(6,701,622)**	**(7,901,622)**	**(14,304,058)**	**6,402,436**	**(6,958,375)**
57	Net Surplus (Deficit) % of Revenue			-2.6%	-3.1%	-5.6%	-2.5%	-2.8%
58								
59	Prior Year Savings			-	-	6,473,810	(6,473,810)	7,102,777
60	Prior Year Public Act 2 Fund Balance			-	-	377,173	(377,173)	
61	ISF Risk Reserve Abatement (Funding)			103,319	(103,319)	(102,915)	(404)	(69,612)
62	ISF Risk Reserve Deficit Funding			6,822,000	7,874,011	9,284,897	(1,410,886)	-
63	Settlement Receivable / (Payable)			-	(0)	(1,448,672)	1,448,672	(5,790)
64	**NET SURPLUS (DEFICIT)**			**223,697**	**(130,930)**	**280,235**	**(411,165)**	**69,000**

Southwest Michigan Behavioral Health
Regional Adminstrative Cost Ratio



Southwest Michigan Behavioral Health
Internal Service Fund

Southwest Michigan Behavioral Health

Memo

To: SWMBH Board

From: Bradley P. Casemore

cc: T. Dawson, M. Todd

Date: March 1, 2019

Re: Fiscal Year 2018 Performance Bonus Incentive Program Proceeds

---

The SWMBH-DHHS Agreement Section 8.4.2.1 addresses the Performance Bonus Incentive Program. In short, DHHS withholds .075 % of our revenue along with an expectation to achieve various performance measures. We have been informed that we have earned 100% of the possible withhold, or **$1,789,245.66.** We also received an additional **$33,999.16** from the state-wide PBIP Pool due to other PIHPs not meeting their required thresholds, for a total of **$1,823,244.82**.

Fiscal Year 2018 and 2019 SWMBH-CMHSP Agreements govern distribution of the above-referenced funds, as outlined in the excerpt below:

> *Section XVI., Subpart S, Paragraph 7: "Unless prohibited by law, DHHS policy, or SWMBH Board action, PBIP earnings to Provider shall be considered restricted local funding, utilized only for the benefit of the public behavioral health system in Provider's county."*

We are in a difficult financial situation this year, with no lapse, no savings and a materially depleted Internal Service Fund. Thus, I cannot endorse treating these funds as local funds to CMHSPs; they must be retained by SWMBH for funding of supports & services entitlements in our region for Medicaid and Healthy Michigan Plan beneficiaries. For me to do so would be a breach of my fiduciary duty and would also violate SWMBH Board Executive Limitations Policies BEL-001 Budgeting III.4 "*May not endanger the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends,*" and BEL-002 Financial Conditions III.3 "*May not use any designated reserves other than for established purposes.*"

I discussed this topic with the Operations Committee on January 23, 2019 and on February 27, 2019.

The way our CMHSP Agreement is written, the SWMBH Board must make this decision not to apply as local funds to Participant CMHSPs, not me. I must call to your attention the glaring conflict of interest situation this places you in. As a SWMBH Board Member making this decision, your duties of Care, Loyalty and Obedience are to SWMBH. Given that, I see no way a SWMBH

Board Member could vote to provide these funds as local to CMHSPs. Please see our proposed Board Motion for your consideration.

I regret including this language in our CMHSP Agreement and placing you in this situation.

<END>

~~Board Approved 4/13/18~~ Operations Committee 2/27/19 Formatted: Font color: Red

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH OPERATING AGREEMENT

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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;
- Community Mental Health and Substance Abuse Services of Saint Joseph County; and
- Van Buren Community Mental Health Authority.

As the Bylaws reference the Operating Agreement and require an annual review of this Operating

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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

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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.

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~~*Board Approved 4/13/18 Operations Committee 2/27/19*~~

- ~~Charter. The Operations Committee and EO shall annually review and reassess the adequacy of this Charter and recommend any proposed changes to the Board for approval.~~
- 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.

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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

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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 sustaina 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

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

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

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

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

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

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

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

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

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

Regional Compliance Coordinating Committee consists of both SWMBH Chief Compliance Officer and

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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.

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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 3.6)*

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

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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.

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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.

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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

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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.

☒ SWMBH Committee: SWMBH Operations Committee ☐ SWMBH Workgroup: _____

Duration: ☒ On-Going ☐ Deliverable Specific Charter Effective Date: SWMBH Board Approved: 03.14.14

Revised: 07.11.14

04.10.15

Purpose:	The purpose of the Operations Committee is to assist the SWMBH Board and management in assessing matters of major strategic interest for the growth and development of the SWMBH regional organization and business lines. The Operations Committee is identified in the SWMBH Bylaws: 5.1.1 Operations Committee: "An Operations Committee will be formed consisting of the CEOs of the Participants or their designees. The Operations Committee will have the responsibilities and authorities assigned by the Board and outlined in the Operating Agreement. The Committee shall have the authority to undertake such other duties as the Board may authorize in writing and by formal action or request from time to time."
Accountability:	The Operations Committee shall function with a large degree of independence in the discharge 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.
Committee Purpose:	As listed throughout the Operating Agreement the Operations Committee does the following: • Advises both the EO and SWMBH Board. • Participates in the development of the vision, mission, and long-term plans of SWMBH. • 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. • Reviews the Quality Assurance and Program Improvement Program (QAPIP) prior to presentation and approval by the SWMBH Board. • Reviews the Utilization Management Program (UM Plan) prior to presentation to the SWMBH Board. • Advises the EO in advance of, and throughout, engaging in any meaningful discussion with other entities that may impact the operations or decision of parties' Boards. • Attempts to resolve disputes between the Participants or one or more Participants and SWMBH at step 2 in the process. • Assists the SWMBH Board in hiring and retention decisions regarding the SWMBH EO in a manner consistent with Board policy, and as requested. • Responds to the EO's consultation before the EO renders a formal policy interpretation that may materially or negatively affect the Participants - where feasible. • Reviews all appropriate grant applications submitted on behalf of SWMBH prior to being submitted. • 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.

	• 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
Relationship to Other Committees:	Each CMH contributes staff and resources to regional management-level Standing Committees of SWMBH. Review and advises Standing Committee Charter revisions. Standing Committees include as listed in the Operating Agreement but are not limited to: • Finance Committee • Quality Management Committee • Utilization Management Clinical Practices Committee • Provider Network Management Committee • Regional Information Technology Committee • Customer Services Committee • Regional Compliance Coordinating Committee The CMH CEOs will ensure representatives from participant CMHSPs on all SWMBH Standing Committees. Each Participant CMH shall identify their representative to each committee. The EO will also actively pursue customer representation on all standing committees. An annual Self-Evaluation shall be completed by each respective Committee, inclusive of annual meeting attendance, and shared with the Operations Committee on an annual basis.
Membership:	**Operations Committee** is comprised of the Participant CEOs/Executive Directors 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, in a manner consistent with Board directive. 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 CMH CEO is charged with assuring that its CMH complies with applicable federal and state standards and regulations. SWMBH staff shall support the Committee in logistics, materials, preparations, and transmissions.
Decision Making Process:	The Operations Committee is advisory to both the EO and SWMBH Board. <u>Quorum</u> • A quorum is a majority of Participant CEOs/designees. Absent a quorum, business may still be discussed but no votes taken. <u>Designees</u> • A CEOs designee shall have full voting rights. • The Process for specifying a CEO's designee shall be: o Contingent on prior approval from the CMH CEO and satisfaction of the Conflict of Interest requirements prescribed by SWMBH o If more than one staff member from a CMH is present, no one can vote without the CEO having communicated to SWMBH staff in advance of the meeting that a specific person is their alternate for that meeting or on an ongoing basis. <u>Voting</u>

	• Any items requiring approval from the Operations Committee requires a super majority (75% of present members) vote.
Deliverables:	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. Charter. The Operations Committee and EO shall annually review and reassess the adequacy of this Charter. 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.

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting /Retreat

Date: May 10, 2019

Sherman Lake YMCA Event & Retreat Center

6225 North 39th St. Augusta, MI 49012

Draft: 2/4/19

Proposed Agenda

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 (B. Casemore)
11:00 am-12:30 pm	Environmental Scan (B. Casemore) (Robert Gordon, Director MDHHS, Director BHDDA, Senator Mike Shirkey or TBD?) • Overview of the evolving federal, state, and regional healthcare policy landscape • Questions and Discussion
12:30 pm-1:15 pm	*Lunch Break – Room TBD*
1:15 pm – 1:45 pm	Interactive Discussion and Polling
1:45 pm-2:30 pm	Strategic Imperatives Discussion
2:30 pm-3:00 pm	Summary and Next Steps (B. Casemore)
3:00 pm	Adjourn

Southwest Michigan
BEHAVIORAL HEALTH

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
- SWMBH Consumer Advisory Committee Chair -- TBD
- SWMBH Substance Use Disorder Oversight Policy Board Chair -- TBD
- CMHSP Board Chairs?

Objectives:

1) Environmental Scan

2) Implications and Ramifications of Environmental Scan

3) Reaffirm or Modify Strategic Imperatives

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy Executive Limitations	Policy Number: BEL-007	Pages: 1
Subject: Compensation and Benefits	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 05.09.2014	Last Review Date: 2/9/18	Past Review Dates: 11/13/15, 1/13/17

I. **PURPOSE:**
To clearly define the parameters for compensation and benefits for SWMBH staff.

II. **POLICY:**
With respect to employment, compensation and benefits to employees, consultants, contract workers, Interns and volunteers, the Executive Officer (EO) shall not cause or allow jeopardy to financial integrity or to public image. SWMBH shall be at or near the 75th percentile on compensation and benefits and at or near the 85th percentile on agency culture and employee satisfaction.

III. **STANDARDS:**
Accordingly, The EO will not:

1. Change the EO's own compensation and benefits.

2. Promise permanent or guaranteed employment. Time-limited Executive Employment and Professional Services Agreements with termination clauses are permissible.

3. Establish current compensation and benefits which:
   a. Deviate materially from the geographic and professional market for the skills employed.
   b. Create obligations over a longer term than revenues can be safely projected, in no event longer than one year and in all events subject to losses in revenue.
   c. Fail to solicit or fail to consider staff preferences.

4. Establish or change retirement benefits so the retirement provisions:
   a. Cause unfunded liabilities to occur or in any way commit the organization to benefits that incur unpredictable future costs.
   b. Provide less than some basic level of benefits to all full-time employees. Differential benefits which recognize and encourage longevity are not prohibited.
   c. That are instituted without prior monitoring of these provisions.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance

Policy Number: BEL007
Policy Name: Compensation and Benefits
Board and Report Date: March 8, 2019
Assigned Reviewer: Sue Barnes

Purpose: To clearly define the parameters for compensation and benefits for SWMBH staff.

Policy: With respect to employment, compensation and benefits to employees, consultants, contract workers, Interns and volunteers, the Executive Officer (EO) shall not cause or allow jeopardy to financial integrity or to public image. SWMBH shall be at or near the 75th percentile on compensation and benefits and at or near the 85th percentile on agency culture and employee satisfaction.

Standards: Accordingly, The EO will not:

1. **Change the EO's own compensation and benefits.**

   EO Response: The EO has not and cannot change his own compensation and benefits as these are determined by a written Employment Agreement.

2. **Promise permanent or guaranteed employment. Time-limited Executive Employment and Professional Services Agreements with termination clauses are permissible.**

   EO Response: No promises of permanent or guaranteed employment have been made. The SWMBH Employee Manual carries language specifically referring to employment as "at-will.", as follows, "this handbook is intended to describe what is expected of employees and what employees can expect from SWMBH. It does not create an express or implied contract between SWMBH and any employee. While we hope our employment relationship will be long term, either you or SWMBH can end the relationship at any time, with or without notice, with or without reason consistent with "at will" employment status." In addition, professional services contracts include language that allows for cancellation with 15 days written notice for "any reason or no reason" where appropriate.

3. **Establish current compensation and benefits which:**
   a. **Deviate materially from the geographic and professional market for the skills employed.**
   b. **Create obligations over a longer term than revenues can be safely projected, in no event longer than one year and in all events subject to losses in revenue.**
   c. **Fail to solicit or fail to consider staff preferences.**

EO Response:

a. Significant geographic professional marketplace study was undertaken by SWMBH using external experts in Summer 2016. In June 2018 Salary grades were adjusted upward 3% to account for increase in COL since the marketplace study. Several staff (primarily masters level clinicians) were found to be below market grade and salary adjustments were made accordingly.
b. No employment or contract obligations have been established which create obligations over a longer term than revenues can be safely projected, none for longer than one year, and all are subject to revision based on reductions in SWMBH revenue.
c. Staff preferences on compensation and benefits were/are considered during monthly staff meetings and through interactions with Human Resources. In addition SWMBH is conducting a year long cultural insights survey project which asks among other things staff satisfaction with compensation and benefits. An small increase in satisfaction with Total Compensation was noted from June to November 2018. Senior Leaders are continuing to address staff concerns and suggestions for improvement throughout 2019.

4. **Establish or change retirement benefits so the retirement provisions:**
   a. **Cause unfunded liabilities to occur or in any way commit the organization to benefits that incur unpredictable future costs.**
   b. **Provide less than some basic level of benefits to all full-time employees. Differential benefits which recognize and encourage longevity are not prohibited.**
   c. **That are instituted without prior monitoring of these provisions.**

EO Response:

a. No unfunded liabilities exist; all employer contributions to health insurance and retirement benefits are made directly to carriers and retirement accounts at the time of their obligation. There are no unpredictable costs as Retirement Plans are explicit about eligibility, vesting, employer obligations and a prospective Board-approved budget.
b. There is a package of full-time employee benefits which rises above a "basic level" description. Differential benefits such as

increased PTO by length of service exist; these are common and were approved by the Board ad hoc Committee at inception.

c. All employee compensation and benefits were established against this Policy and its parameters. All amendments to the Retirement plans were reviewed by SWMBH Labor Counsel, Varnum LLP, and subsequently approved by the SWMBH Board as necessary.

Attachments:
2019 Employee Manual
HRM Cultural Insights Assessment June 2019
HRM Cultural Insights Pulse Survey November 2019
FY2019 New Employee Benefit Summary

-END

	E	F	G	H	I	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 9/30/2018			P12FYTD18		12									
3	*(For Internal Management Purposes Only)*														
4	***INCOME STATEMENT***			TOTAL		Medicaid Contract	Healthy Michigan Contract	AutSam Contract	MI Health Link	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	ASO Activities	Indirect Pooled Cost	
5															
6															
7	**REVENUE**														
8	**Contract Revenue**														
9	Medicaid Capitation			196,991,800		196,991,800	-	-	-	-	-	-	-	-	
10	Healthy Michigan Plan Capitation			29,273,799		-	29,262,301	11,498	-	-	-	-	-	-	
11	Autism Services Capitation			11,003,133		(0)	-	11,003,133	-	-	-	-	-	-	
12	Dual Eligibles Demonstration Project			3,509,983		-	-	-	3,509,983	-	-	-	-	-	
13	SA Block Grant Funding			9,871,743		-	-	-	-	9,871,743	-	-	-	-	
14	SA PA2 Funding			2,033,195		-	-	-	-	-	2,033,195	-	-	-	
15															
16	Contract Revenue			252,683,653		196,991,800	29,262,301	11,014,631	3,509,983	9,871,743	2,033,195	-	-	-	
17	DHHS Incentive Payments			583,498		583,498	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			122,401		-	-	-	-	63,530	-	58,872	-	-	
19	Interest Income - Working Capital			147,662		-	-	-	-	-	-	147,662	-	-	
20	Interest Income - ISF Risk Reserve			94,571		-	-	-	-	-	-	94,571	-	-	
21	Local Funds Contributions			2,169,020		-	-	-	-	-	-	2,169,020	-	-	
22	Other Local Income			172,518		-	-	-	-	-	-	172,518	-	-	
23															
24	**TOTAL REVENUE**			266,967,324		197,575,299	29,262,301	11,014,631	3,509,983	9,935,273	2,033,195	2,636,643	-	-	
25															
26	**EXPENSE**														
27	Healthcare Cost														
28	Provider Claims Cost			21,757,021		3,709,598	5,740,385	-	4,687,737	5,669,036	1,550,266	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			215,585,603		177,106,842	19,854,195	14,880,421	1,828,774	1,614,442	502,930	-	-	-	
30	HICA and Use Tax Expense			2,262,624		1,969,886	292,738	0	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			3,729,831		3,729,831	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-		2,732,892	-	-	(2,732,892)	-	-	-			
33															
34	Total Healthcare Cost			243,335,079		189,249,039	25,887,317	14,880,421	3,781,629	9,283,478	2,053,195	-	-	-	
35	Medical Loss Ratio (MCC % of Revenue)			91.1%		95.8%	88.4%	135.1%	90.6%	94.1%	100.9%				
36															
37	Administrative Cost														
38	Purchased Professional Services			1,327,018		-	-	-	-	-	-	1,327,018	-	-	
39	Administrative and Other Cost			6,442,776		-	-	-	-	-	-	6,438,889	-	3,888	
40	Interest Expense			-		-	-	-	-	-	-	-	-	-	
41	Depreciation			180,295		-	-	-	-	-	-	180,295	-	-	
42	Functional Cost Reclassification			-		-	-	-	-	98,861	-	(98,861)	-	-	
43	Allocated Indirect Pooled Cost			(0)		-	-	-	-	-	-	3,888	-	(3,888)	
44	Delegated Managed Care Admin			15,621,886		12,989,418	1,446,432	1,070,068	189,987	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0		5,942,719	941,192	492,467	194,367	276,152	-	(7,736,896)	-	-	
46															
47	Total Administrative Cost			23,561,976		18,912,137	2,289,626	1,562,566	328,354	375,012	-	94,293	-	-	
48	Admin Cost Ratio (MCA % of Total Cost)			8.8%		9.1%	8.1%	9.5%	8.6%	4.0%	0.0%	2.8%			
49															
50	Local Funds Contribution			2,169,020		-	-	-	-	-	-	2,169,020	-	-	
51															
52	**TOTAL COST after apportionment**			269,066,076		208,161,176	28,176,942	16,232,976	3,509,983	8,878,490	2,033,195	2,257,313	-	-	
53															
54	**NET SURPLUS before settlement**			(13,082,752)		(10,585,877)	1,085,359	(5,218,345)	-	1,256,782	-	379,330	-	-	
55	Net Surplus (Deficit) % of Revenue			-5.1%		-5.4%	3.7%	-47.4%	0.0%	12.6%	0.0%	14.4%			
56															
57	Prior Year Savings			6,473,810		5,102,623	1,371,188	-	-	-	-	-			
58	Prior Year Public Act 2 Fund Balance			4,518,166							4,518,166				
59	ISF Risk Reserve Abatement (Funding)			(94,571)		-	-	-	-	-	-	(94,571)			
60	ISF Risk Reserve Deficit Funding			8,245,054		8,245,054	-	-	-	-	-	-			

	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 9/30/2018			P12FYTD18	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 General	ASO Activities	Indirect Pooled Cost	
5														
6														
61	Settlement Receivable / (Payable)			(1,256,782)	(2,761,799)	(2,456,546)	5,218,345	-	(1,256,782)	-	-			
62	**NET SURPLUS (DEFICIT)**			4,802,925	-	-	-	-	-	4,518,166	284,759	-	-	
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			4,518,166	-	-	-	-	-	4,518,166	-			
69	Local and Other Funds Surplus/(Deficit)			284,759	-	-	-	-	-	-	284,759	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			4,802,925	-	-	-	-	-	4,518,166	284,759	-	-	
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 9/30/2018			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													
6	**Medicaid Specialty Services**			HCC%	79.7%	76.2%	93.0%	75.4%	76.1%	85.8%	82.5%	62.8%	78.3%
7	Subcontract Revenue		196,991,800	15,665,185	181,326,615	7,226,652	36,054,130	9,638,344	33,380,201	9,435,330	55,779,767	12,363,243	17,493,948
8	Incentive Payment Revenue		583,499	244,868	338,631	8,911	-	12,581	141,583	7,339	149,920	18,347	-
9	**Contract Revenue**		197,575,299	15,913,053	181,662,246	7,237,563	36,054,130	9,650,925	33,471,733	9,442,669	55,929,687	12,381,590	17,493,948
10													
11	External Provider Cost		133,041,708	9,709,598	123,332,110	4,138,716	25,870,300	6,380,107	21,522,396	6,441,417	47,440,765	7,821,130	9,717,278
12	Internal Program Cost		50,891,803	-	50,891,803	3,254,880	10,508,483	2,995,608	9,867,686	3,177,660	8,583,446	4,776,479	7,726,782
13	SSI Reimb, 1st/3rd Party Cost Offset		(1,290,297)	-	(1,290,297)	(57,277)	(440,649)	(85,934)	(198,675)	(29,864)	(297,883)	(47,987)	(154,248)
14	HICA & Use Tax, HRA		5,699,717	5,699,717	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		772,141	772,141	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		189,115,072	16,181,456	172,933,616	7,336,120	35,939,135	9,289,781	31,193,388	9,589,213	55,726,547	12,549,621	17,289,812
17	Medical Loss Ratio (HCC % of Revenue)		95.7%	84.0%	95.5%	101.4%	99.7%	96.5%	93.2%	101.6%	99.6%	101.4%	98.8%
18													
19	Managed Care Administration		19,046,104	5,942,719	13,103,385	652,091	2,636,541	701,805	2,267,416	675,843	4,441,406	775,095	1,001,190
20	Admin Cost Ratio (MCA % of Total Cost)		9.1%	2.0%	6.8%	7.0%	6.8%	7.0%	6.7%	6.8%	7.4%	5.8%	5.5%
21													
22	Contract Cost		208,161,175	16,124,175	192,037,001	7,988,210	38,577,675	10,011,586	33,460,803	10,265,055	60,167,953	13,324,715	18,291,002
23	**Net before Settlement**		(10,585,877)	(211,122)	(10,374,755)	(750,647)	(2,523,545)	(360,661)	20,930	(822,386)	(4,238,266)	(943,126)	(797,054)
24													
25	Prior Year Savings		5,102,623	5,102,623	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(2,761,799)	(13,136,555)	10,374,756	750,647	2,523,545	360,661	(20,930)	822,386	4,238,266	943,126	857,054
28	**Net after Settlement**		(8,245,054)	(8,245,054)	-	-	-	-	-	-	-	-	-
29													
30	Eligibles and PMPM												
31	Average Eligibles		148,371	148,371	148,371	7,529	28,964	8,407	27,900	8,540	39,094	12,183	15,754
32	Revenue PMPM		$ 110.97	$ 8.94	$ 102.03	$ 80.11	$ 103.75	$ 95.66	$ 99.98	$ 92.14	$ 119.22	$ 84.69	$ 92.54
33	Expense PMPM		$ 116.91	$ 9.06	$ 107.86	$ 87.31	$ 110.99	$ 99.24	$ 99.91	$ 100.17	$ 126.25	$ 91.14	$ 97.07
34	Margin PMPM		$ (5.95)	$ (0.12)	$ (5.83)	$ (7.20)	$ (7.26)	$ (3.58)	$ 0.06	$ (8.02)	$ (9.03)	$ (6.45)	$ (4.53)
35													
36	**Medicaid Specialty Services**												
37	Budget v Actual												
38													
39	Eligible Lives (Average Eligibles)												
40	Actual		148,371	148,371	148,371	7,529	28,964	8,407	27,900	8,540	39,094	12,183	15,754
41	Budget		149,940	149,940	149,940	7,309	29,119	8,559	28,052	8,523	39,920	13,012	15,466
42	Variance - Favorable / (Unfavorable)		(1,569)	(1,569)	(1,569)	220	(155)	(152)	(152)	17	(826)	(829)	288
43	% Variance - Fav / (Unfav)		-1.0%	-1.0%	-1.0%	3.0%	-0.5%	-1.8%	-0.5%	0.2%	-2.1%	-6.4%	1.9%
44													
45	Contract Revenue before settlement												
46	Actual		197,575,299	15,913,053	181,662,246	7,237,563	36,054,130	9,650,925	33,471,733	9,442,669	55,929,687	12,381,590	17,493,948
47	Budget		197,584,501	16,204,154	179,480,347	6,663,958	35,211,259	9,777,552	33,358,873	8,870,864	56,023,470	12,620,220	16,913,061
48	Variance - Favorable / (Unfavorable)		(59,203)	(2,291,101)	2,231,898	583,605	842,871	(126,907)	111,860	572,015	(93,783)	(238,629)	580,887
49	% Variance - Fav / (Unfav)		0.0%	-12.8%	1.2%	8.8%	2.4%	-1.3%	0.3%	6.4%	-0.2%	-1.9%	3.4%
50													
51	Healthcare Cost												
52	Actual		189,115,072	16,181,456	172,933,616	7,336,120	35,939,135	9,289,781	31,193,388	9,589,213	55,726,547	12,549,621	17,289,812
53	Budget		189,820,690	16,255,526	173,565,164	7,493,854	34,149,744	9,526,288	32,060,061	9,175,733	57,120,982	13,085,142	16,943,371
54	Variance - Favorable / (Unfavorable)		705,608	74,070	631,539	157,734	(1,789,391)	216,488	866,672	(413,479)	1,394,435	545,520	(346,441)
55	% Variance - Fav / (Unfav)		0.4%	0.7%	0.4%	2.1%	-5.2%	2.3%	2.7%	-4.5%	2.4%	4.2%	-2.0%
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 8/30/2018			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 CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
58	Actual		19,046,104	5,942,719	13,103,385	552,091	2,836,641	701,805	2,257,415	675,843	4,441,406	775,095	1,061,190
59	Budget		21,107,875	7,122,408	13,985,469	512,804	3,056,323	715,199	2,389,185	474,202	4,874,531	898,731	1,062,494
60	Variance - Favorable / (Unfavorable)		2,061,771	1,179,687	882,084	(39,287)	419,782	13,394	131,770	(201,641)	433,125	123,636	1,304
61	% Variance - Fav / (Unfav)		9.8%	16.6%	6.3%	-7.7%	13.7%	1.9%	5.5%	-42.5%	8.9%	13.8%	0.1%
62													
63	Total Contract Cost												
64	Actual		208,161,175	16,124,175	192,037,001	7,888,210	36,577,675	10,011,586	33,460,803	10,285,066	60,167,953	13,324,716	16,351,002
65	Budget		210,928,555	17,377,932	193,550,624	8,006,658	37,208,067	10,241,468	34,449,246	9,649,935	61,995,513	13,993,878	16,005,865
66	Variance - Favorable / (Unfavorable)		2,767,379	1,253,757	1,513,622	118,447	(1,369,609)	229,882	988,442	(635,120)	1,827,560	669,157	(345,137)
67	% Variance - Fav / (Unfav)		1.3%	7.2%	0.8%	1.5%	-3.7%	2.2%	2.9%	-6.4%	2.9%	4.8%	-1.9%
68													
69	Net before Settlement												
70	Actual		(10,585,877)	(211,122)	(10,374,756)	(660,647)	(2,528,546)	(360,661)	20,930	(822,366)	(4,238,286)	(943,128)	(857,054)
71	Budget		(13,294,054)	826,222	(14,120,276)	(1,362,699)	(1,996,308)	(453,636)	(1,099,873)	(779,261)	(6,972,042)	(1,379,663)	(1,092,783)
72	Variance - Favorable / (Unfavorable)		2,708,177	(1,037,344)	3,746,521	702,052	(526,737)	102,975	1,110,803	(43,105)	1,733,777	430,528	235,730
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos to Period									
2	For the Fiscal YTD Period Ended 9/30/2018			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%	8.8%	13.4%	8.8%	10.7%	12.5%	7.5%	7.4%	8.1%	8.1%
76	Contract Revenue		29,262,301	4,896,695	24,365,606	1,177,623	4,923,847	1,141,796	4,387,041	1,399,859	7,090,047	1,846,773	2,396,720
77													
78	External Provider Cost		18,476,540	6,740,385	10,736,155	466,306	1,439,136	540,150	2,891,788	273,665	3,577,873	660,071	847,366
79	Internal Program Cost		6,118,040	-	6,118,040	807,875	1,827,188	785,034	2,290,286	552,378	1,404,928	709,056	931,292
80	HICA & Use Tax		292,736	292,736	-	-	-	-	-	-	-	-	-
81	Total Healthcare Cost		25,887,317	6,033,123	19,854,195	1,294,182	3,066,325	1,325,184	5,182,074	836,044	4,982,802	1,369,127	1,778,658
82	Medical Loss Ratio (HCC % of Revenue)		88.5%	123.2%	81.5%	109.9%	62.3%	116.1%	118.1%	59.7%	70.3%	75.2%	74.2%
83													
84	Managed Care Administration		2,289,625	841,192	1,448,432	97,396	225,120	99,887	375,018	66,924	397,113	65,796	109,168
85	Admin Cost Ratio (MCA % of Total Cost)		8.1%	3.0%	5.1%	7.0%	6.8%	7.0%	6.7%	6.8%	7.4%	6.8%	5.8%
86													
87	Contract Cost		28,176,942	6,874,316	21,302,627	1,391,577	3,291,445	1,425,081	5,557,092	894,967	5,379,715	1,474,923	1,887,826
88	Net before Settlement		1,085,359	(1,977,620)	3,062,979	(214,054)	1,632,402	(283,285)	(1,170,051)	504,892	1,710,332	371,850	510,894
89													
90	Prior Year Savings		1,371,188	1,371,188	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,456,546)	606,433	(3,062,979)	214,054	(1,632,402)	283,285	1,170,051	(504,892)	(1,710,332)	(371,850)	(510,894)
93	Net after Settlement		0	0	-	-	-	-	-	-	-	-	-
94													
95	Eligibles and PMPM												
96	Average Eligibles		51,349	51,349	51,349	2,512	10,403	2,432	9,185	2,979	14,659	3,902	5,098
97	Revenue PMPM		$ 47.49	$ 7.95	$ 39.54	$ 39.07	$ 39.44	$ 39.13	$ 39.88	$ 39.16	$ 39.76	$ 39.44	$ 39.21
98	Expense PMPM		45.73	11.16	34.57	46.17	26.37	48.84	50.62	25.04	30.17	31.50	30.85
99	Margin PMPM		$ 1.76	$ (3.21)	$ 4.97	$ (7.10)	$ 13.08	$ (9.71)	$ (10.84)	$ 14.12	$ 9.59	$ 7.94	$ 8.35
100													
101	***Healthy Michigan Plan***												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
105	Actual		51,349	51,349	51,349	2,512	10,403	2,432	9,185	2,979	14,659	3,902	5,098
106	Budget		57,015	57,015	57,015	2,719	11,544	2,617	10,493	3,293	16,146	4,413	5,796
107	Variance - Favorable / (Unfavorable)		(5,666)	(5,666)	(5,666)	(202)	(1,142)	(186)	(1,327)	(314)	(1,287)	(511)	(698)
108	% Variance - Fav / (Unfav)		-9.9%	-9.9%	-9.9%	-7.4%	-9.9%	-7.1%	-12.6%	-9.5%	-8.0%	-11.6%	-12.0%
109													
110	Contract Revenue before settlement												
111	Actual		29,262,301	4,896,695	24,365,606	1,177,623	4,923,847	1,141,796	4,387,041	1,399,859	7,090,047	1,846,773	2,396,720
112	Budget		28,100,000	5,657,396	22,442,604	1,082,223	4,545,410	1,041,349	4,227,793	1,294,666	6,177,090	1,755,411	2,318,642
113	Variance - Favorable / (Unfavorable)		1,162,301	(760,701)	1,923,002	95,401	378,437	100,447	159,248	105,173	912,957	91,362	80,077
114	% Variance - Fav / (Unfav)		4.1%	-13.4%	8.6%	8.8%	8.3%	9.6%	3.8%	8.1%	14.8%	5.2%	3.5%
115													
116	Healthcare Cost												
117	Actual		25,887,317	6,033,123	19,854,195	1,294,182	3,066,325	1,325,184	5,182,074	836,044	4,982,802	1,369,127	1,778,658
118	Budget		22,589,996	4,082,904	18,507,092	1,328,640	3,267,618	1,132,131	4,222,868	970,146	5,202,217	910,431	1,469,051
119	Variance - Favorable / (Unfavorable)		(3,297,322)	(1,950,218)	(1,347,103)	34,459	191,294	(193,053)	(959,216)	134,102	219,615	(478,696)	(296,607)
120	% Variance - Fav / (Unfav)		-14.6%	-47.8%	-7.3%	2.6%	5.9%	-17.1%	-22.7%	13.8%	4.2%	-52.6%	-19.9%
121													
122	Managed Care Administration												
123	Actual		2,289,625	841,192	1,448,432	97,396	225,120	99,887	375,018	66,924	397,113	65,796	109,168
124	Budget		2,362,108	878,567	1,473,540	92,956	299,719	87,473	322,256	51,362	460,695	64,052	95,088
125	Variance - Favorable / (Unfavorable)		62,483	37,375	25,108	(4,440)	74,598	(12,425)	(52,762)	(7,562)	63,521	(21,744)	(14,080)
126	% Variance - Fav / (Unfav)		2.7%	4.8%	1.7%	-4.8%	24.9%	-14.2%	-16.4%	-14.7%	13.8%	-33.9%	-14.8%

	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 9/30/2018			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													
127													
128	Total Contract Cost												
129	Actual		28,176,942	6,874,315	21,302,627	1,391,577	3,291,445	1,425,081	5,557,092	894,967	5,379,715	1,474,923	1,887,826
130	Budget		24,942,104	4,961,472	19,980,632	1,421,596	3,557,337	1,219,603	4,545,114	1,021,506	5,682,851	974,483	1,578,139
131	Variance - Favorable / (Unfavorable)		(3,234,838)	(1,912,843)	(1,321,995)	30,019	265,892	(205,478)	(1,011,978)	126,540	283,136	(500,440)	(309,687)
132	% Variance - Fav / (Unfav)		-13.0%	-38.6%	-6.6%	2.1%	7.5%	-16.8%	-22.3%	12.4%	5.0%	-51.4%	-19.6%
133													
134	Net before Settlement												
135	Actual		1,085,359	(1,977,620)	3,062,979	(214,054)	1,632,402	(283,269)	(1,170,051)	504,892	1,710,382	371,850	510,894
136	Budget		3,157,896	695,924	2,461,972	(339,373)	966,073	(176,255)	(317,321)	273,179	514,239	780,928	740,603
137	Variance - Favorable / (Unfavorable)		(2,072,536)	(2,673,544)	601,008	125,320	644,329	(106,031)	(852,730)	231,713	1,196,083	(409,078)	(229,709)
138													
139													

100

	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 9/30/2018			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													
140	***Autism Specialty Services***			HCC%	8.5%	5.8%	8.4%	9.4%	5.2%	2.8%	5.9%	9.2%	8.9%
141	Contract Revenue		11,014,531	565,617	10,448,914	530,252	1,889,942	518,219	1,818,886	514,841	3,210,050	919,900	1,046,724
142													
143	External Provider Cost		12,521,843	-	12,521,843	41,151	3,777,849	1,137,697	586,959	307,608	3,963,250	782,735	1,924,293
144	Internal Program Cost		2,158,578	-	2,158,578	516,147	1,790	21,433	1,574,064	7,935	-	6,536	30,673
145	HICA & Use Tax		0	0	-	-	-	-	-	-	-	-	-
146	Total Healthcare Cost		14,680,421	0	14,680,421	557,298	3,779,639	1,159,430	2,161,023	315,543	3,963,250	789,271	1,954,966
147	Medical Loss Ratio (HCC % of Revenue)		133.3%	0.0%	140.5%	105.1%	200.0%	223.7%	118.8%	61.3%	123.5%	85.8%	186.8%
148													
149	Managed Care Administration		1,552,656	482,487	1,070,068	41,940	277,489	87,402	156,390	22,239	315,871	48,747	119,969
150	Admin Cost Ratio (MCA % of Total Cost)		9.6%	3.0%	6.6%	7.0%	6.8%	7.0%	6.7%	6.5%	7.4%	5.8%	5.8%
151													
152	Contract Cost		16,232,976	482,487	15,750,489	599,238	4,057,128	1,246,832	2,317,413	337,782	4,279,121	838,019	2,074,936
153	Net before Settlement		(5,218,345)	83,330	(5,301,675)	(68,986)	(2,167,186)	(728,613)	(498,527)	177,059	(1,069,072)	81,881	(1,028,231)
154	Contract Settlement / Redistribution		5,218,345	(83,330)	5,301,675	68,986	2,167,186	728,613	498,527	(177,059)	1,069,072	(81,881)	1,028,231
155	Net after Settlement		0	0	-	-	-	-	-	-	-	-	-
156													
157		x											
158	***SUD Block Grant Treatment***			HCC%	0.3%	0.8%	0.7%	0.3%	0.0%	0.5%	0.0%	0.9%	0.5%
159	Contract Revenue		9,871,743	8,606,941	1,264,802	90,695	450,561	34,756	-	145,536	227,338	191,007	124,717
160													
161	External Provider Cost		6,691,934	6,689,036	2,898	2,898	-	-	-	-	-	-	-
162	Internal Program Cost		777,072	-	777,072	62,094	332,892	34,756	-	55,309	17,514	143,198	111,309
163	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
164	Total Healthcare Cost		7,469,006	6,689,036	779,970	64,992	332,892	34,756	-	55,309	17,514	143,198	111,309
165	Medical Loss Ratio (HCC % of Revenue)		75.7%	77.7%	61.7%	95.5%	73.9%	100.0%	0.0%	38.0%	7.7%	75.0%	89.2%
166													
167	Managed Care Administration		311,483	311,483	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		4.0%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	Contract Cost		7,780,488	7,000,519	779,970	64,992	332,892	34,756	-	55,309	17,514	143,198	111,309
171	Net before Settlement		2,091,255	1,606,422	484,832	5,903	117,669	0	-	90,229	209,824	47,809	13,408
172	Contract Settlement		(1,266,782)	(771,950)	(494,832)	(5,903)	(117,659)	(0)	-	(90,229)	(209,824)	(47,809)	(13,408)
173	Net after Settlement		824,472	834,472	-	-	-	-	-	-	-	-	-
174													
175		x	834,472										

	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 9/30/2018			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													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		247,140,475	29,737,638	217,402,837	9,027,329	43,318,470	11,333,115	39,536,128	11,495,568	66,307,202	15,320,922	21,064,109
178	Incentive Payment Revenue		583,498	244,868	338,631	8,911	-	12,581	141,533	7,339	149,920	18,347	-
179	Contract Revenue		247,723,973	29,982,506	217,741,468	9,036,234	43,318,470	11,345,696	39,677,660	11,502,907	66,457,122	15,339,270	21,064,109
180													
181	External Provider Cost		188,732,024	16,139,018	152,593,006	4,669,071	31,087,286	9,058,253	25,001,145	7,022,690	64,961,668	9,283,936	12,488,957
182	Internal Program Cost		82,945,492	-	82,945,492	4,660,797	12,471,353	3,636,631	13,732,016	3,803,282	10,005,888	5,635,269	8,900,056
183	SSI Reimb, 1st/3rd Party Cost Offset		(1,290,297)	-	(1,290,297)	(67,277)	(440,649)	(55,994)	(196,675)	(29,864)	(297,883)	(47,887)	(154,248)
184	HICA & Use Tax, HRA		5,992,455	5,992,455	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		772,141	772,141	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**237,151,815**	**22,903,614**	**214,248,201**	**9,272,591**	**43,117,990**	**11,629,180**	**38,536,486**	**10,796,108**	**64,669,913**	**14,871,218**	**21,134,746**
187	Medical Loss Ratio (HCC % of Revenue)		95.7%	76.4%	98.4%	102.6%	99.5%	104.3%	97.1%	93.9%	97.3%	96.9%	100.3%
188													
189	**Managed Care Administration**		**23,199,767**	**7,577,881**	**15,621,886**	**691,426**	**3,141,160**	**889,105**	**2,786,823**	**757,006**	**5,154,391**	**969,638**	**1,290,347**
190	Admin Cost Ratio (MCA % of Total Cost)		8.9%	25%	6.8%	6.9%	6.8%	7.1%	6.7%	6.5%	7.4%	6.9%	5.8%
191													
192	**Contract Cost**		**260,351,583**	**30,481,495**	**229,870,087**	**9,964,017**	**46,259,141**	**12,718,286**	**41,325,309**	**11,553,114**	**69,844,304**	**15,780,856**	**22,425,093**
193	**Net before Settlement**		**(12,627,610)**	**(498,990)**	**(12,128,620)**	**(927,783)**	**(2,940,671)**	**(1,372,589)**	**(1,647,648)**	**(50,207)**	**(3,387,182)**	**(441,586)**	**(1,360,983)**
194													
195	Prior Year Savings		6,473,810	6,473,810	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(1,256,782)	(13,385,402)	12,128,620	927,783	2,940,671	1,372,589	1,647,648	50,207	3,387,182	441,586	1,360,983
198	**Net after Settlement**		**(7,410,582)**	**(7,410,582)**	**(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 9/30/2018			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													
201	***State General Fund Services***			HCC%	4.8%	3.7%	4.0%	4.2%	7.3%	3.3%	4.2%	2.1%	4.3%
202	**Contract Revenue**				10,118,465	419,871	1,926,626	567,832	2,489,573	499,037	3,040,692	305,916	869,918
203													
204	External Provider Cost				3,634,066	50,238	322,183	109,819	774,185	128,512	1,896,880	173,371	78,618
205	Internal Program Cost				6,658,085	305,443	1,467,081	408,123	2,244,277	242,976	962,090	140,197	868,900
206	SSI Reimb, 1st/3rd Party Cost Offset				(153,078)	-	-	-	-	-	(153,078)	-	-
207	**Total Healthcare Cost**				10,140,093	355,681	1,789,263	517,742	3,018,462	371,488	2,627,872	314,067	945,518
208	Medical Loss Ratio (HCC % of Revenue)				100.2%	84.7%	92.9%	91.2%	121.2%	74.4%	93.0%	102.7%	108.7%
209													
210	**Managed Care Administration**				827,910	29,792	144,676	43,558	242,076	28,881	252,661	21,702	84,564
211	Admin Cost Ratio (MCA % of Total Cost)				7.5%	7.7%	7.5%	7.8%	7.4%	7.2%	8.8%	6.5%	8.4%
212													
213	**Contract Cost**				10,968,003	385,473	1,933,940	561,300	3,260,536	400,368	3,080,533	335,769	1,019,082
214	**Net before Settlement**				(849,538)	34,398	(6,314)	6,532	(770,965)	98,669	(39,841)	(29,853)	(149,264)
215													
216	Other Redistributions of State GF				(154,424)	(90)	(7,958)	-	(89,057)	-	(96,115)	-	(21,204)
217	Contract Settlement				(147,920)	(13,814)	(10,000)	(8,286)	-	(85,822)	(10,000)	(10,000)	(10,000)
218	**Net after Settlement**				(1,151,882)	20,494	(26,272)	(1,653)	(860,022)	12,847	(135,956)	(39,853)	(171,467)
219													

103

	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 1/31/2019			P04FYTD19	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	ASO Activities	Indirect Pooled Cost	
5														
7	**REVENUE**													
16	Contract Revenue			84,249,841	66,311,861	10,342,379	4,035,205	1,102,668	1,848,851	609,057	-	-	-	
17	DHHS Incentive Payments			193,793	193,793	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			992	-	-	-	-	-	-	992	-	-	
19	Interest Income - Working Capital			37,988	-	-	-	-	-	-	37,988	-	-	
20	Interest Income - ISF Risk Reserve			30,214	-	-	-	-	-	-	30,214	-	-	
21	Local Funds Contributions			180,252	-	-	-	-	-	-	180,252	-	-	
22	Other Local Income			-	-	-	-	-	-	-	-	-	-	
23														
24	**TOTAL REVENUE**			84,693,980	66,505,474	10,342,379	4,035,205	1,102,668	1,848,851	609,057	249,446	-	-	
25														
26	**EXPENSE**													
27	Healthcare Cost													
28	Provider Claims Cost			8,993,211	1,209,251	1,686,314	-	963,666	2,298,581	606,491	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			70,635,216	58,358,316	8,159,343	5,341,288	582,492	194,787	-	-	-	-	
30	HICA and Use Tax Expense			691,105	691,102	3	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	563,881	-	-	(563,881)	-	-	-			
33														
34	Total Healthcare Cost			78,414,487	60,927,606	8,043,660	5,341,288	1,002,166	2,493,377	606,491	-	-	-	
35	Medical Loss Ratio (HCC % of Revenue)			92.6%	91.6%	77.8%	132.4%	90.9%	134.9%	99.6%				
36														
37	Administrative Cost													
38	Purchased Professional Services			282,241	-	-	-	-	-	-	282,241	-	-	
39	Administrative and Other Cost			2,518,233	-	-	-	-	-	-	2,516,672	-	1,561	
41	Depreciation			37,217	-	-	-	-	-	-	37,217	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	37,979	-	(37,979)	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	1,561	-	(1,561)	
44	Delegated Managed Care Admin			5,366,365	4,446,434	467,005	406,586	44,369	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			(0)	2,134,349	288,210	191,382	56,113	90,700	-	(2,760,754)	-	-	
46														
47	Total Administrative Cost			8,184,055	6,582,783	755,215	597,918	100,502	128,679	-	18,958	-	-	
48	Admin Cost Ratio (MCA % of Total Cost)			9.5%	9.5%	8.6%	10.1%	9.1%	4.8%	0.0%	3.2%			
49														
50	Local Funds Contribution			180,252	-	-	-	-	-	-	180,252	-	-	
51														
52	**TOTAL COST after apportionment**			86,778,794	67,510,387	8,798,875	5,939,207	1,102,668	2,622,056	606,491	199,209	-	-	
53														
54	**NET SURPLUS before settlement**			(2,085,713)	(1,004,913)	1,543,504	(1,904,001)	-	(773,205)	2,567	50,237	-	-	
55	Net Surplus (Deficit) % of Revenue			-2.5%	-1.5%	14.9%	-47.2%	0.0%	-41.8%	0.4%	20.1%			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			770,639	-	-	-	-	-	770,639	-			
59	ISF Risk Reserve Abatement (Funding)			(30,214)	-	-	-	-	-	-	(30,214)			
60	ISF Risk Reserve Deficit Funding			1,365,311	1,365,311	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	(360,498)	(1,543,504)	1,904,001	-	773,205	(773,205)	-			
62	**NET SURPLUS (DEFICIT)**			20,022	-	-	-	-	-	-	20,022	-	-	
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)			20,022	-	-	-	-	-	-	20,022	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			20,022	-	-	-	-	-	-	20,022	-	-	
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 1/31/2019			4									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Berry CMHA	Borgess CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			HCC%	79.4%	77.4%	80.8%	76.3%	76.8%	81.3%	80.8%	81.5%	77.9%
7	Subcontract Revenue		66,311,681	4,185,569	62,126,112	2,524,409	12,323,286	3,281,112	11,512,659	3,279,234	19,052,409	4,217,422	5,935,582
8	Incentive Payment Revenue		193,793	193,793	-	-	-	-	-	-	-	-	-
9	**Contract Revenue**		66,505,474	4,379,362	62,126,112	2,524,409	12,323,286	3,281,112	11,512,659	3,279,234	19,052,409	4,217,422	5,935,582
10													
11	External Provider Cost		43,841,968	1,209,251	42,632,715	1,389,903	8,482,392	2,285,654	7,380,928	2,007,243	15,560,004	2,752,927	2,779,726
12	Internal Program Cost		16,672,051	-	16,672,051	1,124,700	3,525,662	971,029	3,194,952	1,004,681	2,724,648	1,580,788	2,545,590
13	SSI Reimb, 1st/3rd Party Cost Offset		(363,968)	-	(363,968)	(22,588)	(75,066)	(14,627)	(90,776)	(37,991)	(85,341)	(10,157)	(27,421)
14	HICA & Use Tax, HRA		796,057	796,057	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(62,991)	(62,991)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		60,883,116	1,942,317	58,940,798	2,486,015	11,932,928	3,242,056	10,485,102	2,973,932	18,199,313	4,323,557	5,297,895
17	Medical Loss Ratio (HCC % of Revenue)		91.5%	44.4%	94.9%	98.5%	96.8%	98.8%	91.1%	90.7%	95.5%	102.5%	89.3%
18													
19	**Managed Care Administration**		5,627,172	2,134,349	4,492,824	203,210	922,258	259,405	756,039	237,897	1,479,622	255,590	378,603
20	Admin Cost Ratio (MCA % of Total Cost)		8.5%	3.2%	6.7%	7.6%	7.2%	7.4%	6.7%	7.4%	7.5%	5.6%	6.7%
21													
22	**Contract Cost**		67,510,287	4,076,666	63,433,621	2,689,225	12,855,186	3,501,461	11,241,141	3,211,830	19,678,934	4,579,147	5,676,497
23	**Net before Settlement**		(1,004,813)	302,696	(1,307,510)	(164,817)	(531,900)	(220,349)	271,518	67,404	(626,525)	(361,725)	259,084
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(380,498)	(1,668,007)	1,307,510	164,817	531,900	220,349	(271,518)	(67,404)	626,525	361,725	(258,884)
28	**Net after Settlement**		(1,385,311)	(1,365,311)	0	-	-	-	-	-	-	-	-
29													
30	Eligibles and PMPM												
31	Average Eligibles		146,750	146,750	146,750	7,621	28,680	8,173	27,574	8,517	38,686	12,009	15,540
32	Revenue PMPM	$	113.30	$ 7.46	$ 105.84	$ 82.81	$ 107.61	$ 100.36	$ 104.38	$ 96.26	$ 123.12	$ 87.80	$ 95.49
33	Expense PMPM	$	115.01	$ 6.94	$ 108.06	$ 88.22	$ 112.25	$ 107.10	$ 101.92	$ 94.28	$ 127.17	$ 95.33	$ 91.32
34	Margin PMPM	$	(1.71)	$ 0.52	$ (2.23)	$ (5.41)	$ (4.64)	$ (6.74)	$ 2.46	$ 1.98	$ (4.05)	$ (7.58)	$ 4.16
35													
36	**Medicaid Specialty Services**												
37	Budget v Actual												
38													
39	Eligible Lives (Average Eligibles)												
40	Actual		146,750	146,750	146,750	7,621	28,680	8,173	27,574	8,517	38,686	12,009	15,540
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		(1,657)	(1,657)	(1,657)	100	(342)	(264)	(339)	(33)	(437)	(213)	(129)
43	% Variance - Fav / (Unfav)		-1.1%	-1.1%	-1.1%	1.3%	-1.2%	-3.1%	-1.2%	-0.4%	-1.1%	-1.7%	-0.8%
44													
45	Contract Revenue before settlement												
46	Actual		66,505,474	4,379,362	62,126,112	2,524,409	12,323,286	3,281,112	11,512,659	3,279,234	19,052,409	4,217,422	5,935,582
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)		(1,517,476)	(1,367,984)	(149,492)	58,950	(75,427)	(48,631)	84,958	28,447	(202,660)	37,098	(32,226)
49	% Variance - Fav / (Unfav)		-2.2%	-23.8%	-0.2%	2.4%	-0.6%	-1.5%	0.7%	0.9%	-1.1%	0.9%	-0.5%
50													
51	Healthcare Cost												
52	Actual		60,883,116	1,942,317	58,940,798	2,486,015	11,932,928	3,242,056	10,485,102	2,973,932	18,199,313	4,323,557	5,297,895
53	Budget			#VALUE!	60,106,397	2,592,059	12,151,021	3,186,404	10,714,919	3,085,532	18,218,503	4,323,920	5,833,980
54	Variance - Favorable / (Unfavorable)		#VALUE!	#VALUE!	1,165,599	106,043	218,093	(55,652)	229,817	111,599	19,190	363	536,086
55	% Variance - Fav / (Unfav)		#VALUE!	#VALUE!	1.9%	4.1%	1.8%	-1.7%	2.1%	3.6%	0.1%	0.0%	9.2%
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 1/31/2019			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													
58	Actual		6,627,172	2,134,349	4,492,824	203,210	922,256	259,405	756,039	237,897	1,479,622	255,690	378,903
59	Budget		6,861,921	2,322,643	4,539,278	193,018	905,762	286,104	773,312	236,429	1,531,509	269,974	363,170
60	Variance - Favorable / (Unfavorable)		234,749	188,295	46,455	(10,192)	(16,496)	6,699	17,273	(1,468)	51,887	14,285	(15,633)
61	% Variance - Fav / (Unfav)		3.4%	8.1%	1.0%	-5.3%	-1.8%	2.5%	2.2%	-0.6%	3.4%	5.3%	-4.3%
62													
63	**Total Contract Cost**												
64	Actual		67,510,287	4,076,666	63,433,621	2,589,226	12,855,186	3,501,461	11,241,141	3,211,830	19,678,934	4,579,147	5,676,697
65	Budget		#VALUE!	#VALUE!	64,646,675	2,785,076	13,058,783	3,452,508	11,488,231	3,322,021	19,750,012	4,593,994	6,197,150
66	Variance - Favorable / (Unfavorable)		#VALUE!	#VALUE!	1,212,054	95,851	201,597	(48,953)	247,090	110,191	71,078	14,748	520,453
67	% Variance - Fav / (Unfav)		#VALUE!	#VALUE!	1.9%	3.4%	1.5%	-1.4%	2.2%	3.3%	0.4%	0.3%	8.4%
68													
69	**Net before Settlement**												
70	Actual		(1,004,813)	302,696	(1,307,510)	(164,817)	(531,900)	(220,349)	271,518	67,404	(626,525)	(361,725)	256,684
71	Budget		#VALUE!	#VALUE!	(2,370,072)	(319,817)	(558,070)	(122,765)	(60,530)	(71,234)	(494,942)	(413,571)	(229,343)
72	Variance - Favorable / (Unfavorable)		#VALUE!	#VALUE!	1,062,562	154,800	126,170	(97,584)	332,047	138,638	(131,583)	51,846	486,227
73													
74													

106

Southwest Michigan Behavioral Health

For the Fiscal YTD Period Ended 1/31/2019

(For Internal Management Purposes Only)

Mos in Period 4

OR

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
Healthy Michigan Plan											
Contract Revenue	10,342,379	1,866,116	8,476,263	421,759	1,740,934	398,239	1,547,667	497,514	2,376,628	649,426	844,076
		HCC%	9.3%	12.2%	6.3%	9.9%	10.4%	7.6%	7.5%	9.4%	7.5%
External Provider Cost	4,946,479	1,885,314	3,061,159	122,942	356,808	183,861	569,841	120,184	1,305,439	197,459	202,527
Internal Program Cost	3,097,183	-	3,097,183	269,759	574,325	236,995	850,129	158,749	393,540	303,437	310,249
HICA & Use Tax	3	3	-	-	-	-	-	-	-	-	-
Total Healthcare Cost	8,043,660	1,885,317	6,158,343	392,701	933,131	420,957	1,419,970	278,933	1,698,979	500,896	512,776
Medical Loss Ratio (HCC % of Revenue)	77.8%	101.0%	72.7%	93.1%	53.6%	105.7%	91.7%	56.1%	71.5%	77.1%	60.8%
Managed Care Administration	755,215	288,210	467,005	32,100	72,119	33,682	102,388	22,313	136,129	29,611	36,664
Admin Cost Ratio (MCA % of Total Cost)	8.6%	3.3%	5.3%	7.6%	7.2%	7.4%	6.7%	7.4%	7.5%	6.8%	6.7%
Contract Cost	8,798,875	2,173,527	6,625,348	424,801	1,005,249	454,639	1,522,359	301,246	1,837,108	530,507	549,440
Net before Settlement	1,543,504	(307,411)	1,850,915	(3,042)	735,685	(56,399)	25,328	196,268	539,521	118,919	294,636
Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-
Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
Contract Settlement / Redistribution	(1,543,504)	307,411	(1,850,915)	3,042	(735,685)	56,399	(25,328)	(196,268)	(539,521)	(118,919)	(294,636)
Net after Settlement	(0)	(0)	-	-	-	-	-	-	-	-	-
Eligibles and PMPM											
Average Eligibles	50,426	50,426	50,426	2,539	10,376	2,398	9,130	2,986	14,091	3,864	5,043
Revenue PMPM	$ 51.28	$ 9.25	$ 42.02	$ 41.54	$ 41.94	$ 41.53	$ 42.36	$ 41.56	$ 42.17	$ 42.02	$ 41.85
Expense PMPM	43.62	10.78	32.85	41.84	24.22	47.41	41.69	25.29	32.69	34.33	27.24
Margin PMPM	$ 7.65	$ (1.52)	$ 9.18	$ (0.30)	$ 17.72	$ (5.88)	$ 0.69	$ 16.44	$ 9.57	$ 7.70	$ 14.61

Healthy Michigan Plan

Budget v Actual

Eligible Lives (Average Eligibles)											
Actual	50,426	50,426	50,426	2,539	10,376	2,398	9,130	2,986	14,091	3,864	5,043
Budget	51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
Variance - Favorable / (Unfavorable)	(1,144)	(1,144)	(1,144)	26	(33)	(33)	(38)	11	(962)	(54)	(61)
% Variance - Fav / (Unfav)	-2.2%	-2.2%	-2.2%	1.0%	-0.3%	-1.4%	-0.4%	0.4%	-6.4%	-1.4%	-1.2%
Contract Revenue before settlement											
Actual	10,342,379	1,866,116	8,476,263	421,759	1,740,934	398,239	1,547,667	497,514	2,376,628	649,426	844,076
Budget	9,675,672	1,672,066	8,003,605	388,418	1,614,851	375,076	1,432,188	456,103	2,349,871	605,620	783,478
Variance - Favorable / (Unfavorable)	666,707	194,049	472,657	33,341	126,083	23,163	116,499	41,410	26,758	43,805	60,598
% Variance - Fav / (Unfav)	6.9%	11.6%	5.9%	8.1%	7.8%	6.2%	8.1%	8.1%	1.1%	7.2%	7.7%
Healthcare Cost											
Actual	8,043,660	1,885,317	6,158,343	392,701	933,131	420,957	1,419,970	278,933	1,698,979	500,896	512,776
Budget	8,375,908	1,937,676	6,438,232	460,251	962,818	421,943	1,587,933	327,478	1,709,426	388,438	579,945
Variance - Favorable / (Unfavorable)	332,248	52,359	279,890	67,550	29,687	986	167,963	48,545	10,447	(112,458)	67,169
% Variance - Fav / (Unfav)	4.0%	2.7%	4.3%	14.7%	3.1%	0.2%	10.6%	14.8%	0.6%	-29.0%	11.6%
Managed Care Administration											
Actual	755,215	288,210	467,005	32,100	72,119	33,682	102,388	22,313	136,129	29,611	36,664
Budget	801,886	316,854	485,032	34,278	71,770	35,237	114,604	25,093	143,700	24,253	36,102
Variance - Favorable / (Unfavorable)	46,671	28,644	18,027	2,178	(348)	1,556	12,215	2,780	5,572	(5,358)	(562)
% Variance - Fav / (Unfav)	5.8%	9.0%	3.7%	6.3%	-0.5%	4.4%	10.7%	11.1%	3.9%	-22.1%	-1.6%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			Mos in Period									
2	For the Fiscal YTD Period Ended 1/31/2019			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													
127													
128	Total Contract Cost												
129	Actual		8,798,875	2,173,527	6,625,348	424,801	1,005,249	454,639	1,522,359	301,246	1,837,106	530,507	549,440
130	Budget		9,177,794	2,254,529	6,923,264	494,524	1,034,588	457,181	1,702,637	352,571	1,853,126	412,891	616,047
131	Variance - Favorable / (Unfavorable)		378,919	81,002	297,916	69,723	29,339	2,542	180,178	51,325	16,019	(117,616)	66,607
132	% Variance - Fav / (Unfav)		4.1%	3.6%	4.3%	14.1%	2.8%	0.6%	10.6%	14.6%	0.9%	-28.5%	10.8%
133													
134	Net before Settlement												
135	Actual		1,543,504	(307,411)	1,850,916	(3,042)	735,685	(56,399)	25,328	196,266	539,521	118,919	294,638
136	Budget		497,878	(582,468)	1,080,341	(106,105)	580,263	(82,105)	(270,349)	103,533	496,744	192,930	167,431
137	Variance - Favorable / (Unfavorable)		1,045,626	275,052	770,574	105,064	155,422	25,706	295,677	92,735	42,777	(74,011)	127,205
138													
139		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 1/31/2019			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													
140	***Autism Specialty Services***			HCC%	7.2%	6.4%	9.8%	9.5%	6.5%	4.0%	5.8%	5.9%	9.2%
141	**Contract Revenue**		4,035,205	32,926	4,002,279	210,912	739,160	223,363	715,613	204,098	1,186,047	329,970	399,126
142													
143	External Provider Cost		4,570,933	-	4,570,933	-	1,452,217	394,790	365,916	145,361	1,307,371	312,866	592,471
144	Internal Program Cost		770,355	-	770,355	205,526	1,055	6,385	617,856	-	-	1,758	36,795
145	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		5,341,288	-	5,341,288	205,526	1,453,272	401,095	983,772	145,361	1,307,371	314,625	628,266
147	Medical Loss Ratio (HCC % of Revenue)		132.4%	0.0%	133.5%	97.4%	196.6%	180.5%	123.6%	71.2%	110.8%	95.3%	157.4%
148													
149	**Managed Care Administration**		597,918	191,382	406,536	16,800	112,319	32,253	63,725	11,628	106,291	18,599	44,921
150	Admin Cost Ratio (MCA % of Total Cost)		10.1%	3.2%	6.8%	7.6%	7.2%	7.4%	6.7%	7.4%	7.6%	5.6%	6.7%
151													
152	**Contract Cost**		5,939,207	191,382	5,747,824	222,326	1,565,590	435,347	947,498	156,989	1,413,662	333,224	673,187
153	**Net before Settlement**		(1,904,001)	(158,456)	(1,745,545)	(11,415)	(826,440)	(211,984)	(231,885)	47,109	(233,615)	(3,254)	(274,061)
154	Contract Settlement / Redistribution		1,904,001	158,456	1,745,545	11,415	826,440	211,984	231,885	(47,109)	233,615	3,254	274,061
155	**Net after Settlement**		-	0	-	-	-	-	-	-	-	-	-
156													
157		X											
158	***SUD Block Grant Treatment***			HCC%	0.2%	0.4%	0.5%	0.4%	0.0%	0.5%	0.0%	0.9%	0.3%
159	**Contract Revenue**		1,848,851	1,405,804	443,047	30,481	157,669	11,663	-	49,211	90,387	63,764	39,891
160													
161	External Provider Cost		2,298,591	2,298,591	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		194,787	-	194,787	13,475	69,327	17,324	-	23,566	1,913	46,296	22,887
163	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		2,493,377	2,298,591	194,787	13,475	69,327	17,324	-	23,566	1,913	46,296	22,887
165	Medical Loss Ratio (HCC % of Revenue)		134.9%	163.5%	44.0%	44.2%	44.0%	148.7%	0.0%	47.9%	2.1%	72.6%	57.4%
166													
167	**Managed Care Administration**		128,679	128,679	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		4.9%	4.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	**Contract Cost**		2,622,056	2,427,270	194,787	13,475	69,327	17,324	-	23,566	1,913	46,296	22,887
171	**Net before Settlement**		(773,205)	(1,021,466)	248,260	17,006	88,342	(5,671)	-	25,646	88,474	17,468	17,005
172	Contract Settlement		773,205	1,021,466	(248,260)	(17,006)	(88,342)	5,671	-	(25,646)	(88,474)	(17,468)	(17,005)
173	**Net after Settlement**		-	-	-	-	-	-	-	-	-	-	-
174													
175		X	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
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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		82,538,115	7,490,415	75,047,700	3,187,560	14,961,039	3,914,368	13,775,958	4,030,057	22,699,472	5,260,572	7,218,675
178	Incentive Payment Revenue		193,793	193,793	-	-	-	-	-	-	-	-	-
179	**Contract Revenue**		**82,731,909**	**7,684,208**	**75,047,700**	**3,187,560**	**14,961,039**	**3,914,368**	**13,775,958**	**4,030,057**	**22,699,472**	**5,260,572**	**7,218,675**
180													
181	External Provider Cost		55,657,969	5,393,155	50,264,808	1,506,845	10,293,355	2,864,346	8,316,569	2,272,786	16,172,814	3,269,252	3,574,725
182	Internal Program Cost		20,734,376	-	20,734,376	1,613,460	4,170,369	1,233,713	4,562,937	1,186,996	3,120,102	1,932,279	2,914,520
183	SSI Reimb, 1st/3rd Party Cost Offset		(363,968)	-	(363,968)	(22,586)	(76,066)	(14,627)	(90,776)	(37,991)	(85,341)	(10,157)	(27,421)
184	HICA & Use Tax, HRA		796,060	796,060	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(62,991)	(62,991)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**76,761,441**	**6,126,225**	**70,635,216**	**3,097,717**	**14,388,657**	**4,083,432**	**12,788,844**	**3,421,792**	**21,207,576**	**5,185,374**	**6,461,823**
187	Medical Loss Ratio (HCC % of Revenue)		92.8%	79.7%	94.1%	97.2%	96.2%	104.3%	92.8%	84.9%	93.4%	98.6%	89.5%
188													
189	**Managed Care Administration**		**8,108,984**	**2,742,620**	**5,366,365**	**262,110**	**1,106,695**	**325,339**	**922,153**	**271,838**	**1,724,041**	**303,800**	**460,388**
190	Admin Cost Ratio (MCA % of Total Cost)		9.6%	3.2%	6.3%	7.8%	7.1%	7.4%	6.7%	7.4%	7.5%	5.5%	6.7%
191													
192	**Contract Cost**		**84,870,425**	**8,868,845**	**76,001,580**	**3,349,827**	**15,495,352**	**4,408,771**	**13,710,998**	**3,693,630**	**22,931,617**	**5,489,174**	**6,922,211**
193	**Net before Settlement**		**(2,138,516)**	**(1,184,637)**	**(953,880)**	**(162,267)**	**(534,313)**	**(494,403)**	**64,961**	**336,427**	**(232,145)**	**(228,602)**	**296,463**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		773,205	(180,674)	953,880	162,267	534,313	494,403	(64,961)	(336,427)	232,145	228,602	(296,463)
198	**Net after Settlement**		**(1,365,311)**	**(1,365,311)**	**0**	**(0)**	**-**	**-**	**(0)**	**(0)**	**0**	**0**	**-**
199													
200													

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3	*(For Internal Management Purposes Only)*			ok									
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5													
201	***State General Fund Services***			HCC%	4.9%	3.5%	3.1%	3.9%	6.4%	6.5%	5.9%	2.2%	4.9%
202	Contract Revenue				3,572,413	217,059	610,058	207,488	693,188	209,548	1,201,552	148,412	285,108
203													
204	External Provider Cost				1,278,529	18,491	46,691	30,225	118,600	145,045	834,686	74,054	10,638
205	Internal Program Cost				2,387,886	94,898	416,108	134,364	750,235	91,851	531,889	44,120	324,420
206	SSI Reimb, 1st/3rd Party Cost Offset				(39,991)	-	-	-	-	-	(39,991)	-	-
207	**Total Healthcare Cost**				**3,626,525**	**113,389**	**463,000**	**164,589**	**868,835**	**236,896**	**1,326,584**	**118,174**	**335,057**
208	Medical Loss Ratio (HCC % of Revenue)				101.5%	52.2%	75.9%	79.3%	125.3%	113.1%	110.4%	79.6%	117.5%
209													
210	Managed Care Administration				311,506	10,373	40,517	14,629	69,752	20,941	126,929	7,814	26,552
211	Admin Cost Ratio (MCA % of Total Cost)				7.9%	8.4%	8.0%	8.2%	7.4%	8.1%	8.4%	6.2%	7.3%
212													
213	**Contract Cost**				**3,938,030**	**123,762**	**503,517**	**179,217**	**938,587**	**257,837**	**1,447,513**	**125,988**	**361,609**
214	**Net before Settlement**				**(365,617)**	**93,298**	**106,541**	**28,271**	**(245,399)**	**(48,289)**	**(245,961)**	**22,424**	**(76,501)**
215													
216	Other Redistributions of State GF				(59,625)	18,794	(1,752)	-	(14,836)	-	(46,129)	-	(15,642)
217	Contract Settlement				(209,947)	(92,114)	(74,453)	(24,878)	-	-	-	(15,170)	(3,333)
218	**Net after Settlement**				**(635,190)**	**19,918**	**30,336**	**3,393**	**(260,234)**	**(48,289)**	**(292,090)**	**7,254**	**(95,476)**
219													

Southwest Michigan Behavioral Health

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

FY 2019 (January 1, 2019 – September 30, 2019)

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Introduction

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

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

Purpose

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and

uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Values

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

Authority and Structure

Program Oversight

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director. Additionally, the Regional Utilization Management Committee shall serve in a critical role involving deliberation, consultation and proof of performance realms. The SWMBH Medical Officer is accountable for management of the PIHP's Utilization Management Program. Jointly with the board-certified Medical Officer, the Chief Administrative Officer and Manager of UM and Call Center provides clinical and operational oversight and direction to the UM program and staff and ensures that SWMBH has qualified staff accountable to the organization for decisions affecting customers.

Committee

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

Staffing

The RUM is a PIHP Committee consisting of cross collaborative leadership representation from SWMBH including the Chief Administrative Officer and the Director of Clinical Quality, a regional customer representative, and each of the eight Community Mental Health Service Programs. Quarterly collaboration occurs with the Quality Management Committee (QMC). Ongoing consultation and ad hoc representation from the SWMBH Medical Director, Customer Services, QMC, Finance, IT, Provider Network and Outcomes is available to the committee. RUM clinical representatives are experienced clinical professionals with specialty representation for Child and Adolescent Serious Emotional

Disturbance, Adults and Children with Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Adults and Children with Substance Use Disorders. The committee members are designated by the CEOs and empowered to make policy decisions for their CMHSP's as required by the scope of the committee in the area of Utilization Management. Furthermore, members ensure that pertinent information from the committee is shared with their respective CMHSP. The RUM committee meets at a minimum 10 times per year.

Roles of the Committee

The RUM is charged with the following

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

Standards and Philosophy

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

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

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

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

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

Access to SWMBH Behavioral Health Services

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

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

Access Standards

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

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

Level of Intensity of Service Determination

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

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-

specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

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

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

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

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

model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions. The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, EQRO, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

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

Review Activities

Utilization Management

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and most CMHSP's are delegated UM functions for a limited sc0ope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone. Based upon the UM Program review, annual audits and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers or SWMBH departments.

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

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid

criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

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

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
3. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
4. Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
7. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Use of Incentives

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

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

The expectation for service provision is that intensity of service will be aligned with severity of illness. For each population served (adults with mental illness, youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders), SWMBH utilizes a standardized functional assessment to identify level of need at initiation of services and at established intervals throughout service provision. SWMBH and its participant CMHs have established regional Levels of Care that correspond to needs identified through the functional assessment process, which are based on severity of illness and intensity of need. The Levels of Care and Core Service Menus for adults with mental illness were updated in 2018, with implementation on January 1, 2019. The Levels of Care and Core Service menus for youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders are in the process of being updated for 2019 implementation. The levels and service menus that were developed in 2016 are being used for those population areas until the updates are complete.

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

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

Levels of Care for Mental Health Specialty Services

Levels of Care for each of the SWMBH population areas are described below. Core service menus with recommended authorization thresholds for all levels of care (except for children with intellectual and developmental disabilities) have been developed and can be provided upon request.

PIHP Service Eligibility

Not all Medicaid-eligible persons with mental illness or emotional disturbances are eligible for PIHP services. For adults with mental illness and youth with emotional disturbance, thresholds for meeting eligibility for PIHP services are denoted below Level of Care descriptions that follow. Behavioral health services for persons with mild to moderate mental illness or emotional disturbances are provided through Medicaid health plans. All Medicaid behavioral health services for persons with substance use disorders and intellectual and developmental disabilities are provided through the PIHP.

Crisis Services

Crisis services are considered a benefit for any SWMBH customer or anyone who is physically in a county of the SWMBH region who needs urgent intervention. Crisis services are not considered a Level of Care

and do not require prior authorization. Appropriately trained and qualified CMHSP behavioral health practitioners with sufficient clinical experience who meet the qualifications for a preadmission unit pursuant to Michigan Mental Health Code 330.1409 Sec 409 provide prescreening services and authorization of 1-3 days of psychiatric inpatient or crisis residential, and any appropriate diversion and/or second opinion services.

Levels of Care for Adults (18 years or older) with Serious Mental Illness or Co-occurring MI and Substance Use Disorders. Level Of Care Utilization System (LOCUS) The LOCUS is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level VI- Intensive High Need/Acute (Medically Managed Residential)
Customers receiving services at this level of care are adults with a LOCUS score typically of 28 or higher including a score of 4 on dimension I and who present as a persistent danger to self or others. Treatment is typically provided in an inpatient setting and is aimed at ensuring safety and minimizing danger to self and others and alleviating the acute psychiatric crisis.

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

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

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

Level II – Low Need (Low Intensity Community Based Need)
Customers receiving services at this level of care are adults with a LOCUS score typically of 14-16 who present with ongoing treatment needs however have a low impairment of functioning in most areas, low to minimal risk of harm to self or others, able to reside independently in the community. Minimal assistance with linking/coordinating actively utilizing self-improvement and treatment skills acquired. Treatment is provided in the community and is typically clinic based.

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

Level 0 -- Basic Services

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

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

Eligible for PIHP Medicaid Services (Severe need):

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

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

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

Levels of Care for Children (ages 7 – 18) with Serious Emotional Disturbance or Co-occurring SED and Substance Use Disorders. The Child and Adolescent Functional Assessment Scale (CAFAS) is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level V Acute Need

Customers in this level of care are children (7-18) with a CAFAS score of 140 or higher who require total assistance and present with inability to function in most areas, persistent danger to self and others, at significant risk of institutionalization or placement out of the home, involved in numerous provider systems (criminal justice, mental health, department of human services, school). High risk difficulties in school/day care setting or substance use dominates life or is out of control.

Level IV – High Need

Customers in this level of care are children (7-18) with a CAFAS score of 140 or higher with inability to function in most areas, persistent danger to self and others, at moderate to significant risk of institutionalization or placement out of the home, likely involved in numerous provider systems (criminal justice, mental health, department of human services, school). Significant difficulties in school/day care setting. Treatment needs likely beyond home based services.

Level III – Moderate Need

Customers in this level of care are children (7-18) with a CAFAS score of 100-139 with moderate to significant inability to function in many areas, instability in living environment, multiple service needs, family requires regular support, crisis intervention services needed. Likely at risk for out of home placement, displays disruptive behavior.

Level II – Low Need

Customers in this level of care are children (7-18) with a CAFAS score of 60-99 with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention not needed or infrequently need.

Level I – Minimal Need

Customers in this level of care are children (7-18) with a CAFAS score of 59 and below with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention services not needed or needed infrequently. Children ages Infant-7 are typically placed in the Level I category for utilization management purposes with needed services authorized based upon medical necessity. It is anticipated that the PECFAS and potentially the DECA will be incorporated into the EMR at a future date to provide for the ability to determine levels for children younger than 8.

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

Eligible for PIHP Medicaid Services (Severe need):

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

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

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

Levels of Care for Adults (ages 18 and older) Intellectual and Developmental Disabilities (The Supports Intensity Scale (SIS) is utilized to identify level of support needs for adults with intellectual and developmental disabilities. Levels of care for adults with I/DD yet to be determined)

Level VI- Acute

Customers receiving services at this level of care are adults (18 years or older) and demonstrate extraordinary behavioral need typically provided in an acute care setting or a nursing home

Level V – Intense Need

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate extraordinary medical needs and/or extensive behavioral needs
and require total assistance on a daily basis may require 1:1 or higher level of staffing
Poorly managed, volatile; needs supports, frequent interventions/monitoring necessary
Low impulse control, active safety risk to self or others

Level IV – High Need

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate substantial behavioral needs and require multiple daily reminders to engage or complete activities and personal support which may include enhanced staffing (up to & including physical assistance); frequent hands-on assistance Safety risks to self or others and/or need for environmental accommodations

Level III – Moderate Need

Customers receiving services at this level of care are adults (18 years or older) and typically require frequent prompts/reminders, coaching, and/or training to engage or complete

activities (less than daily/more than weekly) or physical support, or some hands-on physical support/guidance. Moderate behavioral issues may be present with or without the need for a Behavior Plan. May experience physical health issues that require increased supports.
Safety risks may be present that need to be addressed or monitored; includes safety to self and safety in the community.

Level II – Low Need

Customers receiving services at this level of care are adults (18 years or older) and typically require occasional verbal prompts/reminders, coaching, and/or training to engage or complete activities (weekly or less) and monitoring of support needs with changes as situation dictates. Mild/moderate behavioral issues without the need for a Behavior Management Plan. Minimal safety risk

Level I – Minimal Need

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

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

Level V – Intense Need

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

Level IV – High Need

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

Level III – Moderate Need

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

Level II – Low Need

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

Level I – Minimal Need

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

Levels of Care for Substance Use Treatment Services for Adults and Adolescents. The American Society of Addiction Medicine - Patient Placement Criteria (ASAM) are utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level 0.5 – Early Intervention

Services include assessment and education for those who are at risk, but do not currently meet the diagnostic criteria for a substance-related disorder. Customers who are determined to have this level of need are typically referred to available community resources including support

groups and prevention activities. Customer is screened for co-occurring mental health issues and referred to appropriate levels of care to meet identified needs. Per definition, early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

Level 1.0 – Outpatient Services

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

Level 2.1 – Intensive Outpatient

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

Level 2.5 – Partial Hospitalization

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

Level 3.1 – Clinically-Managed Low-Intensity Residential

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

Level 3.3 – Clinically-Managed Medium-Intensity Residential

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

Level 3.5 – Clinically Managed High Intensity Residential

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

Level 3.7 – Medically-Monitored Intensive Inpatient

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

Level 4 – Medically-Managed Intensive Inpatient

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

Level I-D – Detoxification

Detoxification – Nursing care with services provided by a licensed hospital 24-hours per day only to address medical or psychiatric needs.

Level OMT – Opioid Maintenance Therapy

Opioid medication and counseling available daily or several times per week to maintain multidimensional stability for those with opioid dependence. Opioid maintenance therapy is considered to be an appropriate and effective treatment for opiate addiction for some

customers, particularly customers who have completed other treatment modalities without success and are motivated to actively engage in the treatment necessary in OMT.

Review Process

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

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

Outlier Management

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

1. Outlier Definition
   "Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:
   - A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.
2. Outlier Identification
   Multiple tools are available to SWMBH for monitoring, analyzing and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures
   A. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.

B. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.

C. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion. Corrective action plans might include:
   1. Brief description of the finding(s) and supporting information;
   2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps;
   3. A description of the monitoring to be performed to ensure that the steps are taken;
   4. A description of the monitoring to be performed that will reflect the resolution of the situation.
   5. Following initial review and efforts for resolution at a desk audit level, the disposition can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;
   6. Following consultation, recommendations are reviewed by the Director of Clinical Quality and/or the Medical Director for disposition determination. The MD and/or Director of Clinical Quality will review the recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.

D. The MD and Director of Clinical Quality will take into consideration the outlier severity in determining recommended remedies. The following options available at this level include:
   1. Acceptance of PIHP recommendations.
   2. Direction for additional PIHP staff and provider action(s),
   3. Clinical Peer Review -The Peer Review consists of review, consultation, and recommendations for resolution.
   4. Render final disposition.
   5. Provide recommendations for action for remediation to the SWMBH CEO

E. If the utilization trends or patterns are determined to be systemic or regional in nature, collaborative corrective action is jointly discussed at the regional committee level with defined timelines for completion. Corrective action includes:
   1. Brief description of the finding(s) and supporting information;
   2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps at the PIHP and CMHSP/Provider level;
   3. A description of the monitoring to be performed to ensure that the steps are taken;
   4. A description of the monitoring to be performed that will reflect the resolution of the situation.
   5. Following initial review and efforts for resolution, the review findings can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;

F. The spectrum of remedies available to the PIHP in relation to its provider panels stems from the authority of the PIHP Board. Subject to PIHP CEO's approval, possible remedies can include but are not limited to:
   1. Non-payment for case.

2. Plan member switch to new provider.
3. Provider loss of "Delegated Benefit Management" status.
4. Loss of credential for specified service(s).
5. Pro-rata payback on class of cases.
6. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
7. Removal from provider panel.

Data Management

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

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

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

Communication

UM Program Plan

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

Availability of Utilization Management Staff

SWMBH UM staff are available by telephone (toll free) from 8:00 a.m. to 8:00 p.m. Monday through Friday of each normal business day. Utilization Review staff respond to email and telephonic communications within one business day during provider's normal business hours. UM staff identify themselves by name, ~~title,~~ and organization during correspondence. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, SWMBH provides the opportunity for the requesting

customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

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

Peer Clinical Review

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

Evaluation

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

Definitions

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

Screening: Telephonic, face-to-face or computer-assisted process for determining financial* and clinical eligibility (including level of care needed) using a population-specific level-of-care tool where available, for specialty supports and services resulting in referral to CMHSP, other PIHP providers, Medicaid Health Plans or other community resources. *Financial eligibility does not apply to individuals requesting I/DD or DCCA services

Assessment: A face-to-face comprehensive clinical evaluation completed by an appropriately licensed and credentialed professional that obtains appropriate and necessary information about each individual seeking public behavioral health services. The assessment includes clinical consideration of the individuals' needs and informs the goals and treatment plan through the person-centered planning process. The information obtained in the assessment is used to match an individual's need with the appropriate care setting, care level and service intervention

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

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

SWMBH Role: Perform Central Care Management per UM Plan and Policy. Oversee and monitor delegated Local Care Management per UM Plan and Policy. Provide regular UM analytic management reports for SWMBH and CMHs. Regularly identify trends and material variations.

Shared Role (Director of Clinical Quality, Local Care Manager designees and RUM Committee): Regularly review UM analytic management reports. Identify trends and variations, including gaps in completeness, timeliness and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications as necessary. Adjust business process and/or decision trees as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

References/Additional Guiding Documents

SWMBH Level of Care Guidelines publish date 12.21.18

Plan Review and Approval

Medical Director: _____
Signature/date of review

Chief Administrative Officer: _____
Signature/date of review

Director of Clinical Quality: _____
Signature/date of review

Southwest Michigan
BEHAVIORAL HEALTH

FY18 Program Integrity & Compliance Program Evaluation

October 1, 2017 – September 30, 2018

03/08/2019

FY18 ROUTINE AUDIT ACTIVITIES

Audit	# Claims reviewed	# Invalid claims	Recoupments	Compliance Rate	Funding Stream
Medicaid Verification	1,734	65	$20,806.30	96.25%	Medicaid claims & encounters (Medicaid, HMP, MI Child)
MI Health Link (Duals) Audit	540 (Q1-Q2)	20	$1,367.73	96.3%	Claims paid by SWMBH with MI Health Link funds

FY18 Investigations

- Twenty (20) investigations opened by SWMBH PI/C
- Resulted in $82,345.55 in takebacks
  - Crisis Residential provider – insufficient documentation ($16,769)
  - Provider misuse of ABA billing modifiers ($35,889.95+)
  - General AFC providing CLS ($25,620)
- Four (4) matters referred to the MI Office of Inspector General (OIG)
- Two (2) referrals received from the MI OIG for follow-up

FY18 Investigations

- Provider misuse of ABA billing modifiers
  - Of the $35,889.95 in recoupments identified through SWMBH-direct review, all services could be rebilled with the appropriate code/modifier combination for a potential appropriate reimbursement amount of $32,572.22. This results in $3,287.73 in sustained recoupments.
    - Appropriate rebilling will reduce SWMBH's FY18 recoupment total to $46,455.60.
  - This investigation resulted in a request to ABA providers to review their billing practices and correct inappropriately coded services. The "ripple effect" resulted in identification of $276,297.56 in inappropriately coded services. To date, $226,858.32 has been identified as rebillable with the appropriate code/modifier combination. This results in $49,439.24 in sustained recoupments.

Process Improvements Implemented in FY18

- Improved Audit Efficiency
  - Continued Audit universe stratification to allow for review of a larger number of providers while reducing the number of duplicate reviews of the same providers (unless necessary)
- Implemented and Monitored Organizational Risk Assessment Internal Work Plan
  - Complementary to the Audit & Monitoring Plan's external focus
  - Worked with applicable SWMBH Departments to implement and/or change processes to manage and mitigate identified risks
- Prepped for Data Mining
  - Worked with SWMBH QAPI to develop overlapping billing report
  - Created business processes for implementation and use of report

Process Improvements Implemented in FY18

- Drafted and reviewed progressive remediation procedures for unauthorized uses and/or disclosures of PHI

- Held the first MI Health Link provider meeting
  - Education, resources, answer questions

2018 Department Goals

Audit Efficiency - Completed

- Coordinate and improve audit efficiency across departments to reduce duplication

Data Mining Reports – Completed

- Identified areas of risk, coordinated with other SWMBH departments for creation of data report, and developed business processes for regular scheduled reviews

Process Improvements Planned for FY19 Implementation

- New Audits
  - SUD Providers - Coordination of Benefits audits
  - SUD Net Cost Contract audits
- Data Mining
  - Business processes developed for routine use of the new Overlapping Billing Report
    - Outpatient services billed on same dates of service and per diem services
- Analyze and implement MI OIG and MDHHS BHDDA contractual expectations of PIHPs
  - First OIG Quarterly Report submitted in February 2019
  - Reviewing contract obligations in relation to OIG requests for information

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 2018 Privacy & Security Update

Mila C. Todd, Chief Compliance & Privacy Officer
Robert Moerland, Chief Information & Security Officer

March 8, 2019

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, 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*).**

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

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 2018 Summary

29 Incidents reported for Breach Risk Team review

- Sixteen (16) were determined to be a low probability of compromise and did not require notification;
- Six (6) were determined to fall within and Exception;
- Seven (7) were determined to not be an unauthorized use or disclosure.

Summary of Outcomes – 0 reportable breaches

- None of the reported incidences require reporting to the Office for Civil Rights (OCR).

IT/QAPI Audit/Review Schedule

Audit/Review	Date	Frequency	Lead	Notes
Online Access Review	March	Monthly	Rob / Andy	Review of access to online systems. Sampling of systems and accounts to ensure proper permissions: CMT, CC360, LOCUS, MCG, WSA/DSA, CHAMPS, FILE TRANSFER SERVICE, DEG
AD Account Access Audit	First month of each quarter	Quarterly	Rob / Randy	Automatic account locking after 45 days of of no use Review SWMBH Staff and External Users access permissions (File Server, Portal, Tableau)
Hardware Inventory Audit	Second month of each quarter	Quarterly	Rob / Randy	Randomly select asset tags to verify hardware is where expected
SQL Server Access	April / October	Bi-Annual	John	Audit/Review of user access to SQL Server (via Security Groups) Audit/Review Security Groups against SQL Server data Audit/Review of SQL Server logins
HSAG EQR	September	Annual	JG	HSAG EQR Audit, now bi-annual with the next audit scheduled for 2018
HSAG PMV	June-July	Annual	JG/Rob	HSAG PMV Audit
Aetna Customer Service Audit	May	Annual	JG	As Per the Aetna contract
Meridian Customer Service Audit	July/August	Annual	JG	As per the Meridian Contract
Aetna Claims Audit	August	Annual	JG / Anne	
Meridian Administration Audit	September	Annual	JG / UM	
Vendor SOC Audit	November	Annual	Rob / Secant	Third party security audit of our IT vendor
Security Test (Pen/permiter test)	November	Annual	Rob / Secant	Penetration testing and perimiter security audit of our IT Vendor
Backup/Restore Audit	December	Annual	John / Andy	Annual review of backup and restore procedures for SQL Server with successful test confirmation
Backup/Restore Audit	December	Annual	Rob / Secant	1. Annual review of backup and restore procedures for everything other than SQL Server with successful test confirmation 2. Annual review of backup and restore procedures for Virtual Servers with successful test confirmation
MDHHS SUD Administrative	June 5 - July 14 2019	Annual	JG	Annual SUD Administrative audit by MDHHS.
NCQA	Feb 2021		JG	NCQA Accreditation process and related audits. Accreditation is good for 3 years.

SWMBH FY19 Targeted Integrated Care Metrics. *March 2019 SWMBH Board Meeting*

MDHHS Performance Bonus Incentive Program (PBIP) Metrics. Data Source - CareConnect360 (CC360)
Rates for All Medicaid Enrollees in PIHP Region 4

Measure abbreviation	DHHS Contract Section	Description	Region 4 3/31/2018	Region 4 6/30/18	Region 4 9/30/2018	Impact	MI Rate 6/30/2018	End of FY19 Goal	Goal Status
SSD	8.4.2.1. Performance Bonus Incentive Program (PBIP)	**Diabetes Screening Behavioral Health measure:** Members 18 to 64 years of age with schizophrenia or bipolar disorder taking an antipsychotic medication who were screened for diabetes with a blood glucose or HbA1c test during the report period. Members diagnosed with diabetes prior to the report period are excluded.	77.81% (N=2249)	78.07% (N=2271)	no data	0.3%	79.88% (N=31,148)	83% (EQR* Performance Improvement Target)	
FUH - 30AD	8.4.2.1 PBIP	**Follow-Up after Hospitalization for Mental Illness - Adult (30 days):** Percentage of discharges for enrollees age 21-64 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.	74.05% (N=713)	73.46% (N=874)	no data	-0.6%	65.68% (N=13,955)	>/= 58% (MDHHS standard)	
FUH - 30CH	8.4.2.1 PBIP	**Follow-Up after Hospitalization for Mental Illness - Child (30 days):** Percentage of discharges for enrollees age 6-20 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.	78.29% (N=175)	79.44% (N=214)	no data	1.2%	76.97% (N=4,469)	>/= 70% (MDHHS standard)	
PCR	8.4.2.1 PBIP	**Plan All-Cause Readmission:** For members 18-64, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	15.81% (N=5060)	15.51% (N=5189)	no data	-0.3%	17.43% (N=83,315)	N/A: Baseline & Data Validation Period	N/A
FUA	8.4.2.1 PBIP	**Follow-Up after ED Visit for AOD:** Patient(s) 13 years and older with an ED visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	29.7% (N=1596)	29.04% (N=1615)	no data	-0.7%	23.91% (N=18,358)	N/A: Baseline & Data Validation Period	N/A

Additional Targeted Metric. Data Source - Pro-Act application (AKA CMT)
Rates for All Medicaid Enrollees in PIHP Region 4

Measure abbreviation	DHHS Contract Section	Description	Region 4 3/31/2018	Region 4 6/30/18	Region 4 9/30/2018	Impact	MI 50th Percentile 9/30/2018	End of FY19 Goal	Goal Status
973	7.4 Integrated Physical and Mental Health Care	**Adults' Access to Preventive/Ambulatory Health Services (AAP):** The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	42%	41% (N=186123)	40% (N=196128)	-1.0%	61.10%	50%	

* EQR: External Quality Review. Federal Medicaid managed care regulations require annual validation of a health plan performance improvement project by an EQR. Michigan contracts with Health Services Advisory Group (HSAG) for EQR validation.

Southwest Michigan
BEHAVIORAL HEALTH

Hold the Date!

May 17, 2019

2019 Regional Healthcare Policy Forum

Time: 8:30 am – Registration
9:15 am to 12:00 noon – Program

Location: Van Buren Intermediate School District Conference Center
490 S. Paw Paw St., Lawrence, MI 49064

Who: State & Federal Legislators, County Commissioners & Administrators, Community Mental Health-Substance Abuse Prevention & Treatment Professionals, Health & Human Services Stakeholders, & Judicial/Law Enforcement Stakeholders

Join us for discussion and interaction

- *Elected Official Comments*
- *Challenges for Public Mental Health System*

light refreshments will be served

RSVP to: Info@SWMBH.org – Subject: Healthcare Symposium

SWMBH is a Regional Entity/Prepaid Inpatient Health Plan

Riverwood Center
Summit Pointe
Community Mental Health & Substance Abuse Services
Kalamazoo Community Mental Health & Substance Abuse Services
Pines Behavioral Health
"Life should be enjoyed...not endured"
Barry County Community Mental Health Authority
Van Buren Community Mental Health
Woodlands

MI Representatives 1-2-19
POBox 30014, Lansing 48909

First Name	Last Name	Work Address 2	Work Phone	Work Fax No	Email Address	Contact	Party	Distri	Term	County
Eric	Leutheuser	992 House Office Bldg.	(517) 373-1794	(517) 373-5768	ericleutheuserz@house.mi.gov		R	58	1	Branch
Aaron	Miller	993 House Office Bldg.	(517) 373-0832	(517) 373-5763	aaronmiller@house.mi.gov		R	59	1	St. Joe
Jon	Hoadley	994 House Office Bldg.	(517) 373-1785		jonhoadley@house.mi.gov		D	60	1	Kazoo
Brandt	Iden	372 Capitol Bldg.	(517) 373-1774		brandtiden@house.mi.gov		R	61	1	Kazoo
Jim	Haadsma	N 996 House Office Bldg.	(517) 373-0555		jimhaadsma@house.mi.gov		D	62	1	Cal-BC
Matt	Hall	N0997 House Office Bldg.	(517) 373-1787	(517) 373-9119	MattHall@house.mi.gov		R	63	1	Kazoo/Cal
Beth	Griffin	S 1085 House Office Bldg.	(517) 373-0839		bethgriffin@house.mi.gov		R	66	1	VanBuren
Brad	Paquette	1097 House Office Bldg.	(517) 373-1796	(517) 373-5918	BradPaquette@house.mi.gov		R	78	1	Cass/St. J
Pauline	Wendzel	N 1098 House Office Bldg.	(517) 373-1403		PaulineWendzel@house.mi.gov		R	79	1	SJ/Berrien
Julie	Calley	1191 House Office Bldg.	(517) 373-0842		Juliecalley@house.mi.gov		R	87	1	Barry
1/24/2019										

First Name	Last Name	Work Address 2	Work Phone	Work Fax No	Email Address	ScheduleContac	Party	Distri	Term	County
John	Bizon	P.O. Box 30036	(517) 373-2426	(517) 373-2964	Senjbizon@senate.michigan.gov		R	19	1	Cal/Barry
		P.O. Box 30036								
Kim	LaSata	P.O. Box 30036	(517) 373-6960	(517) 373-0897	Senklasata@senate.michigan.gov		R	21	1	Cs/SJ/Berr
		P.O. Box 30036								
Sean	McCann	P.O. Box 30036	(517) 373-5100		sensmccann@senate.michigan.gov		D	20	1	Kazoo
Aric	Nesbitt	P.O. Box 30036	(517) 373-0793	(517) 373-5607	Senanesbitt@senate.michigan.gov		R	26	1	Van Buren
		P.O. Box 30036								
Mike	Shirkey - Maj Ldr	P.O. Box 30036	(517) 373-5932	(517) 373-5944	senmshirkey@senate.michigan.gov		R	16	2	Branch
1/18/2019										

2019 Michigan Committee Assignments

Senate Standing Committees	Senator
Appropriations	Bizon LaSata Nesbitt McCann
Energy & Technology	LaSata Nesbitt McCann
Families, Seniors, & Veterans	Bizon -- Chair
Finance	Nesbitt -- Vice Chair
Government Operations	Shirkey -- Chair Nesbitt
Health Policy & Human Services	Bizon -- Vice Chair LaSata
Insurance & Banking	LaSata Nesbitt
Natural Resources	McCann
Regulatory Reform	Nesbitt -- Chair
Transportation & Infrastructure	LaSata -- Vice Chair

Senate Appro. Subcommittees	
Agriculture & Rural Development	McCann
Capital Outlay	Bizon McCann
Community Health/Human Serv.	Bizon -- Vice Chair LaSata
Licensing & Regulatory Affairs (LARA)	Nesbitt – Chair
Matira; Respirces & Environ. Quality	McCann
Universities & Community Colleges	LaSata -- Chair Bizon

2019 MI Committee Assignments

House Standing C. Representative	
Agriculture	Wendzel
Appropriations	Hoadley -- Min. VC Miller -- Vice Chair Whiteford
Commerce & Tourism	Wendzel -- Vice Chair Hope
Education	Paquette -- Vice Chair Hall
Elections & Ethics	Calley -- Chair Paquette Hope
Energy	Wendzel -- Vice Chair Haadsma
Health Policy	Calley Whiteford
Insurance	Paquette
Local Gvmt & Local Municipal Finance	Calley Paquette Hope
Natural Res./Outdoor Recreation	Calley
Oversight	Hall -- Chair
Regulatory Reform	Hall Wendzel
Tax Policy	Hall
Transportation & Infrastructure	Haadsma
Ways & Means	Iden -- Chair Leutheuser Griffin

House Standing C. Representative	
Fiscal Governing Committee	Hoadley
Legislative Council	Whiteford

House Appro. Subcommittees	
General Government	Hoadley
Health & Human Services	Whiteford -- Chair Hoadley
Higher Education & Community Coll.	Hoadley
Joint Capitol Outlay	Whiteford
School Aid/Dept. of Education	Miller -- Chair
Transportation	

2019 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)												
Mary (Mae) Myers (Cass)												
Moses Walker (Kalamazoo)												
Timothy Carmichael (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Karen Lehman (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 1/11/19

James Blocker (Calhoun)	
Anthony Heiser (St. Joe)	

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

Southwest Michigan Behavioral Health

Memo

To: SWMBH Board

From: Anne Wickham

cc: Brad Casemore

Date: March 8, 2019

Re: Rose Street Advisors

As you requested, this memo serves to provide information regarding Rose Street Advisors fees associated with SWMBH retirement plans. Below are the comprehensive disclosure fees provided to me by Carl Doerschler of Rose Street Advisors.

- The Asset Base Charge for the SWMBH relationship (including all plans) is 0.62%.
  - The Asset Base Charge encompasses fees for the Rose Street Advisors, Nationwide, and Beene Garter.
- In addition to the Asset Base Charge, a participant would also be responsible for the cost of the investments, called Gross Expense Ratios.
  - Gross Expense Ratios range from 0.04% to 0.85%

I hope that this information is helpful to you.

SFY 2018, SFY 2019 and (SFY 2020 Executive Budget Recommendations) Comparisons

Budget Item	SFY 2018	SFY 2019	SFY 2018 & SFY 2019 Difference	Percent Change	Governor's Executive Budget Recommendation SFY 2020	SFY 2019 & SFY 2020 Difference	Percent Change
Medicaid Mental Health Services	$ 2,315,608,800	$ 2,319,029,300	$ 3,420,500	0.1%	$ 2,478,086,100	$ 159,056,800	6%
Medicaid Substance Abuse Services	$ 52,408,500	$ 67,640,500	$ 15,232,000	23%	$ 66,200,100	$ (1,440,400)	-2%
Healthy Michigan Program (ACA Expansion)	$ 288,655,200	$ 299,439,000	$ 10,783,800	4%	$ 346,548,100	$ 47,109,100	14%
Autism Services	$ 105,097,300	$ 192,890,700	$ 87,793,400	46%	$ 221,718,600	$ 28,827,900	13%
Children's Waiver Home Care Program	$ 20,241,100	$ 20,241,100	$ -	0%	$ 20,241,100	$ -	0%
Children's with Serious Emotional Disturbance Waiver	$ 10,000,000	$ 10,000,000	$ -	0%	$ 10,000,000	$ -	0%
Health Homes	$ 3,369,000	$ 3,369,000	$ -	0%	$ 3,369,000	$ -	0%
Total Medicaid	**$ 2,795,379,900**	**$ 2,912,609,600**	**$ 117,229,700**	**4%**	**$ 3,146,163,000**	**$ 233,553,400**	**7%**
CMH Non-Medicaid Services	$ 120,050,400	$ 125,578,200	$ 5,527,800	4%	$ 125,578,200	$ -	0%
Community Substance Use Disorder Prevention, Education and Treatment	$ 76,530,000	$ 76,530,000	$ -	0%	$ 107,754,700	$ 31,224,700	29%
Federal Mental Health Block Grant	$ 20,573,800	$ 20,573,800	$ -	0%	$ 20,573,800	$ -	0%
Nursing Home PAS/ARR-OBRA	$ 12,291,300	$ 12,291,300	$ -	0%	$ 12,291,300	$ -	0%
State Disability Assistance Program	$ 2,018,800	$ 2,018,800	$ -	0%	$ 2,018,800	$ -	0%
Civil Service Charges	$ 399,300	$ 399,300	$ -	0%	$ 399,300	$ -	0%
Total Non-Medicaid	**$ 231,863,600**	**$ 237,391,400**	**$ 5,527,800**	**2%**	**$ 268,616,100**	**$ 31,224,700**	**12%**
GRAND TOTAL	$ 3,027,243,500	$ 3,150,001,000	$ 122,757,500	4%	$ 3,414,779,100	$ 264,778,100	8%

Community Mental Health Association of Michigan

FY20 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY' 18 (final)	FY'19 (final)	FY'20 (executive budget)
-CMH Non-Medicaid services	$120,050,400	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,315,608,800	$2,319,029,300	$2,478,086,100
-Medicaid Substance Abuse services	$52,408,500	$67,640,500	$66,200,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,530,000	$76,956,200	$107,754,700
-Children's Waiver Home Care Program	$20,241,100	$20,241,100	$20,241,100
-Autism services	$105,097,300	$192,890,700	$221,718,600
-Healthy MI Plan (Behavioral health)	$288,655,200	$299,439,000	$346,548,100

Other Highlights of the FY20 Executive Budget:

- $10.0 million for Healthy Michigan Plan (HMP) work supports (general fund) to ensure that HMP beneficiaries impacted by new work requirements have access to needed employment supports and to provide resources to the department to help beneficiaries address the new requirements.

- $2.2 million for the Center for Forensic Psychiatry (general fund) to meet the growing demand for forensic evaluations and restoration treatment for adults deemed incompetent to stand trial and reduce current wait lists for these services. On a typical day, roughly 115 defendants wait in jail or while released on bond for an available bed to receive services to restore their competency. The wait lists strain local jails that are sometimes forced to provide behavioral health services to these defendants.

- $75.1 million for the Healthy Michigan Plan (general fund). The Executive Budget fully supports the health coverage needs of enrollees in the Healthy Michigan Plan and includes funding to cover increased state match requirements, which will move from 7 percent to a permanent rate of 10 percent starting in January 2020. The Administration is committed to working with the Legislature to make improvements

to current work requirement provisions scheduled to become effective in 2020 in order to support and encourage work for enrollees while simplifying procedures and reducing compliance burdens.

- $74.4 million to meet state match requirements within traditional Medicaid and Children's Health Insurance Program (CHIP) (general fund). Annual federal adjustments in Michigan's share for Medicaid expenditures will increase state Medicaid costs, while a more significant state cost in CHIP is recognized due to enhanced federal matching funds expiring in fiscal year 2020 and fiscal year 2021.

- $7.0 million for the State Innovation Model (SIM) (general fund). One-time funding will continue support for five Community Health Innovation Regions (CHIRs) initially developed under the federal SIM grant which expires in January 2020. Each CHIR provides a community-based structure for engaging critical community partners in identifying and addressing local health challenges with the goal of reducing intensive use of medical and social services. This bridge funding will maintain the CHIR infrastructure established with federal grant funds while an evaluation of the model is completed.

Boilerplate Sections Included:

Section 298 – retains language from FY19.

Section 928 – retains local match draw down requirement from past years.

Section 924 – Autism Reimbursement Limit – From the funds appropriated in part 1 for autism services, for the purposes of actuarially sound rate certification and approval for Medicaid behavioral health managed care programs, the department shall maintain a fee schedule for autism services reimbursement rates for direct services. Expenditures used for rate setting shall not exceed those identified in the fee schedule. The rates for behavioral technicians shall be maintained at the hourly rate in place in the previous fiscal year.

Section 961 – department shall allocate $150,000 to administer an electronic inpatient psychiatric bed registry consistent with the requirements in section 151 of the 19 mental health code, 1974 PA 258, MCL 330.1151.

Section 1009 – Direct Care Workers – From the funds appropriated in part 1 for Medicaid mental health services and Healthy Michigan plan - behavioral health, the department shall maintain the hourly wage for direct care workers from the previous fiscal year.

Section 1010 – Court Ordered Treatment – From the funds appropriated in part 1 for behavioral health program administration, up to $2,000,000.00 shall be allocated to address the implementation of court-ordered assisted outpatient treatment as provided under chapter 4 of the mental health code, 1974 PA 258, MCL 330.1400 to 330.1490.

Boilerplate Sections NOT included in Executive Recommendation:

Removed: Section 925 – Non-Medicaid Dollars – From the funds appropriated in part 1 for community mental health non-Medicaid services, each CMHSP is allocated not less than the amount allocated to that CMHSP during the previous fiscal year.

Removed: Section 959 – Medicaid Autism Benefit Cost Containment – The department shall establish a workgroup in collaboration with the chairs of the house and senate appropriations subcommittees on the DHHS budget or their designees, CMHSP members, autism service provider clinical and administrative staff, community members, Medicaid autism services clients, and family members to make recommendations to ensure appropriate cost and service provision, including but not limited to, the following:

a. Ways to prevent fraud and overdiagnosis.
b. Comparison of Medicaid rates for autism services to commercial insurance rates.
c. Comparison of diagnosis process between Medicaid, Tricare, and commercial insurance.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house DHHS subcommittees, the house and senate fiscal agencies, and the state budget office.

Removed: Section1696 NEW Language – Traditional Medicaid to HMP Migration Restriction – It is the intent of the legislature that, beginning in the fiscal year beginning October 1, 2019, if an applicant for Medicaid coverage through the Healthy Michigan Plan received medical coverage in the previous fiscal year through traditional Medicaid, and is still eligible for coverage through traditional Medicaid, the applicant is not eligible to receive coverage through the Healthy Michigan Plan.

Additional FY20 budget details

below are the main line items from the 2020 budget, we highlighted a few lines that saw a decent jump in funding.

Specific Mental Health/Substance Abuse Services Line items

	FY' 18 (final)	FY'19 (final)	FY'20 (executive budget)
-CMH Non-Medicaid services	$120,050,400	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,315,608,800	$2,319,029,300	$2,478,086,100
-Medicaid Substance Abuse services	$52,408,500	$67,640,500	$66,200,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$76,530,000	$76,956,200	$107,754,700
-Children's Waiver Home Care Program	$20,241,100	$20,241,100	$20,241,100
-Autism services	$105,097,300	$192,890,700	$221,718,600
-Healthy MI Plan (Behavioral health)	$288,655,200	$299,439,000	$346,548,100

I reached out to the Senate Fiscal agency and asked if the increases were new money for services or increased Medicaid taxes (like last years supplemental budget) or something else, below is the response:

> It's a combination of base funding, IPA (HICA tax replacement), and actuarial soundness. Autism got 5.75% ($13.8M Gross), behavioral health got 2.75% ($7.3M HMP, $66.0 million regular Medicaid, $2.0 million SUD), physical health Medicaid got 2.0%, so those are the increases. The autism cost containment policies are continuing, the rest of the adjustment is tied to base/caseload.
>
> The Community substance abuse increase is due to a new Federal opioid grant of about $30 million. There was money appropriated last year by Congress, so it's now flowing through.

Principal Office: 5250 Lovers Lane, Suite 200, Portage, MI, 49002
P: 800-676-0423
F: 269-883-6670

January 9, 2019

Kristine Kirsch
Executive Director
Community Mental Health and Substance Abuse Services of St. Joseph County
677 E. Main St.
Centreville, MI 49032
Via email to kkirsch@stjoecmh.org

Re: Compliance Program Effectiveness
Subcontract Citation: Section V, subpart E. Compliance Plan

Dear Ms. Kirsch,

History and Context

On February 15, 2018, SWMBH notified you of CMHSAS of St. Joseph County's contractual obligations as it relates to the operation of an effective compliance program, including operationalizing the Office of Inspector General's Seven Elements of an Effective Compliance Program. At that time, SWMBH performed a review of the structure and effectiveness of CMHSAS-SJC's Compliance Program. An initial review consisted of a review of relevant documentation and on-site staff interviews which occurred April 9, 2018. In a letter dated June 14, 2018, SWMBH presented to you its findings and requested a Corrective Action Plan from CMHSAS-SJC, which was provided and accepted. On November 30, 2018, SWMBH performed follow-up monitoring of CMHSAS-SJC's submitted CAP as well as its Compliance Program, which consisted of a documentation review and on-site staff interviews. Overall, substantial improvements were noted in documentation sufficiency and staff understanding and support of the Compliance Program. These findings were summarized in a letter dated December 14, 2018, which also indicated that SWMBH would "continue to monitor the culture of compliance concerning the Seven Elements of an Effective Compliance Program, Federal and Michigan Statutes regarding Whistleblower Protection, Retaliation, and efforts being made by the organization to develop an ethical culture."

Current Issue

It has been reported to SWMBH that the behavior of the CMHSAS-SJC Board Chairman, Tim Carmichael, toward CMHSAS-SJC staff has been inappropriate and perceived as intimidating, particularly surrounding Compliance related investigations. It has been reported that Mr. Carmichael interjects himself into Compliance related investigations without invitation of CMHSAS-SJC staff and seemingly without having an appropriate

purpose or expertise for his involvement in such investigations. Furthermore, it has been reported that Mr. Carmichael has attempted to dictate how Compliance investigations are resolved, including on one occasion ordering the Compliance Officer to pay a provider. We acknowledge that these reports are not based on our direct observations, however, we are duty bound to put you on notice of our Compliance related concerns. This type of behavior undermines the effectiveness of the organization's Compliance Program overall and, at the very minimum, gives the appearance that CMHSAS-SJC's Compliance Program is unsupported and therefore ineffective at the Board of Directors' level.

Within ten (10) business days of the date of this letter, please provide to me the following:

- CMHSAS-SJC's Code of Conduct for Board Members, including Board Member attestations acknowledging receipt (OIG Element #1);
- Evidence of the most recent Board Compliance Education, including its content as well as Board Member attestations (or equivalent documentation to show who participated) (OIG Element #3);
- Any Board policies that govern Board Member interaction with or relationship to the Compliance Officer (OIG Element #2).

Additionally, by March 1, 2019, please provide the following:

- Because the identified issues are at the Board level, a Board-approved Plan of Action for how CMHSAS-SJC intends to address the culture of Compliance at its Board of Director level. Should you require additional time to accomplish this, please contact me.

CMHSAS-SJC did a satisfactory job addressing deficiencies in the effectiveness of its Compliance Program as it relates to staff. I look forward to working with you to accomplish the same improvements at all levels of your organization. We are happy to provide technical assistance and/or Board education upon request. Thank you.

Regards,

Mila C. Todd

Mila C. Todd, Esq., CHC, CHPC
Chief Compliance & Privacy Officer
Provider Network Management
P: (269) 488-6794
F: (269) 488-8270

Cc: Brad Casemore

Three Rivers Commercial News

2/27/19

Carmichael quits CMH board
Decries oversight actions

BY:
RICK CORDES, C-N CORRESPONDENT

CENTREVILLE – In a fiery address to the St. Joseph County Community Mental Health and Substance Abuse Services board, Tim Carmichael, board chairperson, assailed those who prepared a compliance policy complaint against him, then announced he was stepping down.

"Effective at the end of this board meeting I will be tendering my resignation," Carmichael said.

A Jan. 9 letter to Kristine Kirsch, CMHSAS board executive director, from Mila C. Todd, chief compliance and privacy officer of SWMBH (CMHSAS' oversight agency) stated that, "It has been reported that the behavior of CMHSAS Board Chairperson, Tim Carmichael, toward CMHSAS staff has been inappropriate and perceived as intimidating, particularly surrounding Compliance related investigations."

Further, the letter stated that, "....Carmichael interjects himself into compliance related investigations without invitation," and, "...that Mr. Carmichael has attempted to dictate how compliance investigations are resolved."

Todd instructed CMHSAS to provide its code of conduct for board members, provide evidence of board member education and provide a plan of action on how to address the "culture of compliance at the board level."

Carmichael said that the issue arose from a payment concern raised by a provider of services to his son, and that he was attempting to be certain that that provider received due compensation.

"I don't care whose fault it was," Carmichael told the board. "This woman went four weeks without being paid."

Speaking fervently, Carmichael said, "Nothing I do on this board will limit my ability to advocate for my son!" He then condemned Brad Casemore, CEO of SWMBH (who was in attendance) and also condemned SWMBH.

Kirsch, later in the session, told the board that meeting the immediate compliance demands of SWMBH would be a time-consuming process, and that an extension of a March 1 deadline would be asked for. Carmichael added, "I'm suggesting that one issue of compliance is solved because I won't be here."

Board member Rick Shaffer expressed gratitude for Carmichael's service. "We've known each other a long time," Shaffer said. "You're very passionate. I recognize how you helped turn this ship around. I appreciate all you've done for this board." Board member Kathy Pangle said that she echoed that sentiment.

Rick Cordes is a former Commercial-News staff writer who still enjoys contributing to the paper.

Behavioral Health Integration

The current system using partial-risk Prepaid Inpatient Health Plans (PIHPs) to manage a siloed behavioral health benefit for the Medicaid population is failing. 8 of 9 PIHPs reported spending more on Medicaid services than the state had budgeted for them for FY 18 (Medicaid/HMP expenditures were greater than Medicaid/HMP revenue). Three 'one-time" bail outs have occurred in supplementals in the last two years and there is a need for more.

Managed Care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with Managed Care Organizations (MCOs) to provide all or some physical health benefits for beneficiaries.

166

States are seeking better ways to coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. A reasonable timetable should be planned for statewide behavioral health integration with the designated "298 pilot" areas moving first.

Network Adequacy standards and a state fee schedule should be developed and enforced. A risk corridor to prohibit profiteering should be created. Health Plans should be required to contract with all Community Mental Health Service Providers within their area of service. Health Plans should be allowed to contract with behavioral health service providers outside of the CMHSPs network in order to enhance access to care.

mahp
Michigan Association of Health Plans

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite 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, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

DISABILITYnetwork
Southwest Michigan

Disability Network Southwest Michigan's Position Statement:
Mental Health Privatization

Disability Network Southwest Michigan opposes current efforts to privatize the mental health care system in Michigan.

The State of Michigan is currently moving toward privatizing the publicly funded mental healthcare system. Through the section 298 initiative, three pilot projects have been designated to test integration of behavioral and physical health service provision. Under this plan, current Medicaid Healthcare Providers (MHP's) would expand services to include provision of mental/behavioral health care for their customers, removing these services and the associated funding from local Community Mental Health Boards (CMH's). CMH's would continue to be contracted with to provide "specialty services" to people with developmental disabilities and severe and persistent mental illness. In theory integration of physical and mental health services could deliver better, streamlined care for customers and lead to greater cost efficiency for the overall system. Instead, we believe this would devastate the current mental health system by allowing MHP's to provide limited mental health services to only the least costly customers. CMH's would continue to be required to provide services to those with the most persistent, intensive needs, and the highest care costs, while leaving them with significantly less funding to do so.

Our concerns extend beyond the loss of funding for local CMH's. As currently designed, section 298 also has significant program delivery and transparency issues, including:

- No commitment to community wide collaboration—law enforcement, courts, schools, public health shelters, recreation, housing, transportation, food banks, employee assistance programs, ACT, case meetings, club houses, and drop ins.
- Currently communities rely on CMH for programs such as Jail diversion and Kevin's Law (court ordered treatment).
- MHPs have had no experience linking and coordinating ancillary services: housing, transportation, recreation, supported employment and have had little experience with severe mental health disorders or mental health concepts to encourage recovery like person-centered planning; consumer self-determination; and social supports.
- Private MHPs do not have to comply with FOIA and open meetings. Whereas CMHSPs are public entities (connected to the government) and have greater accountability and transparency.
- In a prior test project for duel Medicare – Medicaid enrollees in four regions of Michigan. People that were eligible were automatically enrolled in MHP type of entities but had the option to leave. After 2 years over 60% of those automatically enrolled had left the MHP type of programs.

While we appreciate the honorable intentions behind desiring to integrate physical and behavioral health services, we do not believe Section 298 honors those intentions. We urge decision makers to find alternative methods to achieve better health outcomes for citizens with disabilities.

2/15/19

There were a number of significant developments at recent PIHP executive committee meeting with MDOC.

Over the last few months MDOC has paused work on the SUD project in order to make a key policy decision regarding how to deliver services in the 4 geographic areas managed by the PIHPs that elected to leave the project, as well as considerations involving leadership transitions in the Governor's Office and at MDOC. As you know, the MDOC Director, Heidi Washington, will remain in her post in the new administration.

While a number of other options were considered, ***Director Washington has decided that MDOC will only support and pursue a single state-wide model.*** The single, statewide model is intended to ensure that parolees/probationers may consistently access substance use disorder treatment services as entitled under the Medicaid/Healthy Michigan/SAPT Block Grant. MDOC reported that the decision has been made to add these responsibilities to all MDHHS/PIHP Contracts. As envisioned by MDOC, this model involves PIHPs managing Medicaid/HMP/SAPT Block Grant as currently required, and MDOC providing funding for MDOC services (Criminogenic Services or MARS).

MDOC values SUD work of the PIHPs and believes SUD services to parolees and probationers will be strengthened under this model. Based on discussions with MDHHS, MDOC believes that administrative and reporting requirements will decrease under this option. MDOC remains committed to ensuring that ALL additional costs, *including* administrative costs that PIHPs incur in serving this population, are covered in the proposed arrangement.

While many inter-departmental details are yet to be worked out, it was reported that Governor Whitmer's office has given this direction and will continue to be directly engaged with both departments to ensure this moves forward.

Next steps:

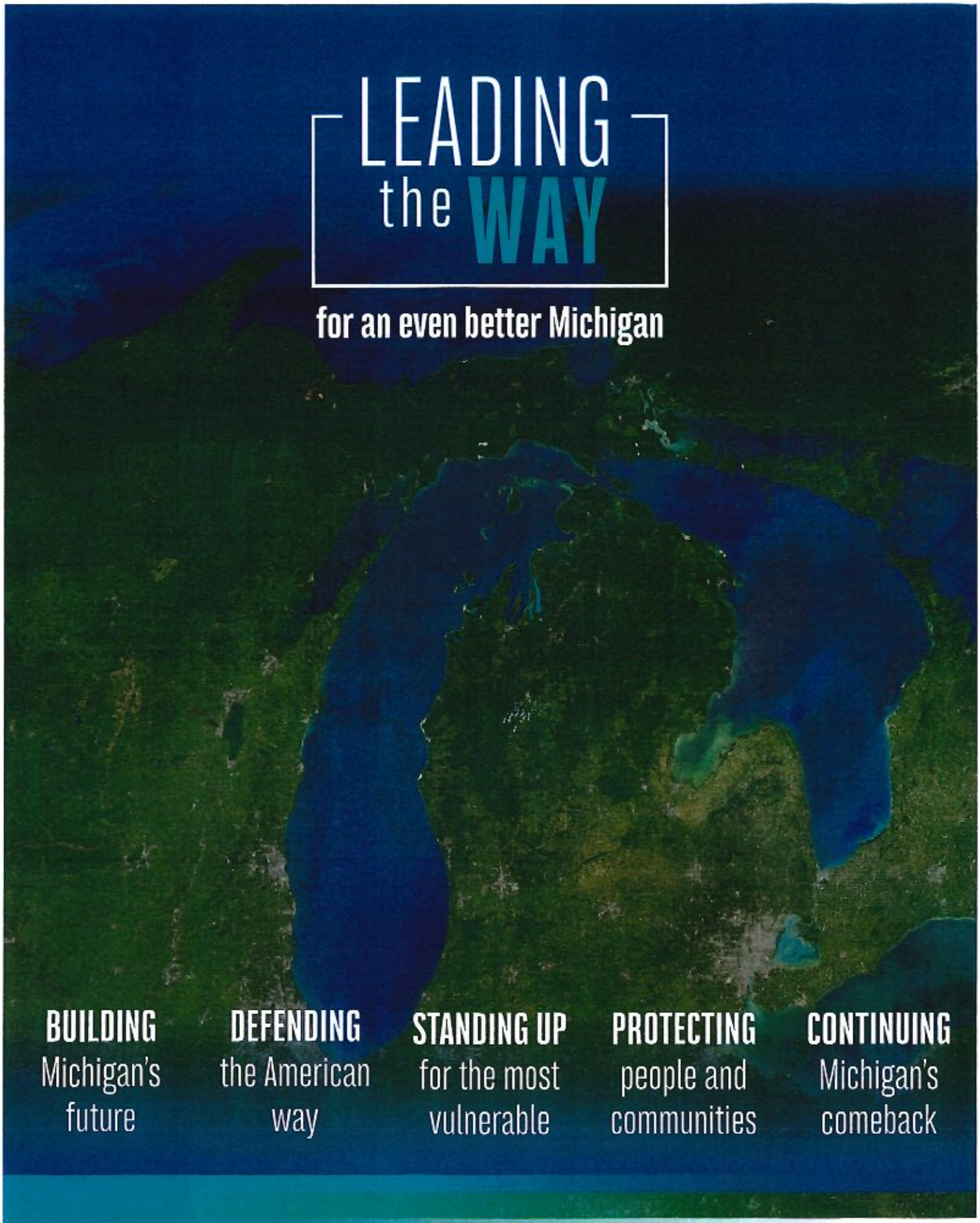
- We envision the Statement of Work we have been negotiating, in some way, will be incorporated into the MDHHS/PIHP contract. During this temporary pause, TBD Solutions has continued to work toward a mutually acceptable Statement of Work, has completed review and editing, and has proposed alternative language for future consideration.

- The PIHP Executive Committee will meet with MDOC in early March to complete negotiations to finalize the SoW. This will first be sent to the six engaged PIHPs for input before it is finalized by MDOC. A final version will then be sent to all PIHPs given the direction we learned this is taking as of yesterday.

- While MDOC is speculating the Standard Contract Terms will no longer be necessary, they are taking steps to confirm this.

- Given MCHE funds for TBD Solutions' support of this project have now been fully expended, this is our final update. Going forward, Joe Sedlock will be the point of contact for the PIHPs and MDOC. TBD Solutions has provided Joe with a detailed transition plan (attached) so that all remaining tasks are clearly identified.

Thanks to our group effort, a large under-served, often overlooked population will have access to the same quality services as other citizens. Remi joins me in thanking you so much for the opportunity to assist with this important work!


LEADING
the WAY
for an even better Michigan
BUILDING
Michigan's
future
DEFENDING
the American
way
STANDING UP
for the most
vulnerable
PROTECTING
people and
communities
CONTINUING
Michigan's
comeback

LEADING the WAY

for an even better Michigan

2019 | ACTION PLAN

Leading the way for an even better Michigan

Dear Michigan residents:

The past eight years have been good ones here in Michigan. We've made incredible strides to improve the economy and protect our way of life, with momentum you can feel from Monroe to Marquette.

And we want to see that success continue and expand to everyone who lives in the Great Lakes State. That is why the Michigan House Republicans, for the fifth consecutive legislative term, are pleased to publicly outline their priorities to help improve transparency. The 2019-20 Action Plan – Leading the Way – provides a blueprint to help make our state an even better place to live, work and raise a family.

Why commit to this plan so publicly? Because we work for you, and we want you to hold us accountable. The opportunity to review and respond to this action plan is part of that commitment. You deserve a state government that is always working in your best interests, which means being open and transparent in every way.

That's why – on the very first day of the 2019-20 legislative session – we introduced a plan to make the governor and Legislature subject to public disclosure laws. It's one of the pillars upon which our action plan is built.

Other priorities include reducing car insurance costs for Michigan drivers, improving the roads we all drive on, lowering taxes for residents (especially retirees), protecting property rights through civil asset forfeiture reform, and fighting to detect and remove PFAS contamination in our water supply. The common theme: Continuing Michigan's momentum and building a better state not only for today, but for our kids and grandkids.

There is a new dynamic at the state Capitol this year, with a Republican-led Legislature and a Democratic governor's administration sharing responsibility for the future of our state. In no way should this slow down Michigan's comeback. This isn't Washington, D.C. – and we're not going to become Washington, D.C. Here in the Great Lakes State, we will work together to deliver the meaningful results our residents demand and deserve.

We must not settle for our recent success. We must find ways to do even better – and that's what this action plan is all about.

Thank you for taking the time to review this document. As always, we welcome your feedback as we work on ways to make Michigan an even better place than it is today.

Sincerely,

Lee Chatfield
Speaker of the House

Representative Aaron Miller
Chair, Policy Action Plan Committee

Building Michigan's future

"We rely on this state's infrastructure to deliver goods to people and make a living. Our roads must be fixed on time and on budget for our families and job providers to continue to grow. Money is being spent, but more needs to be done to address this huge challenge and keep us moving."

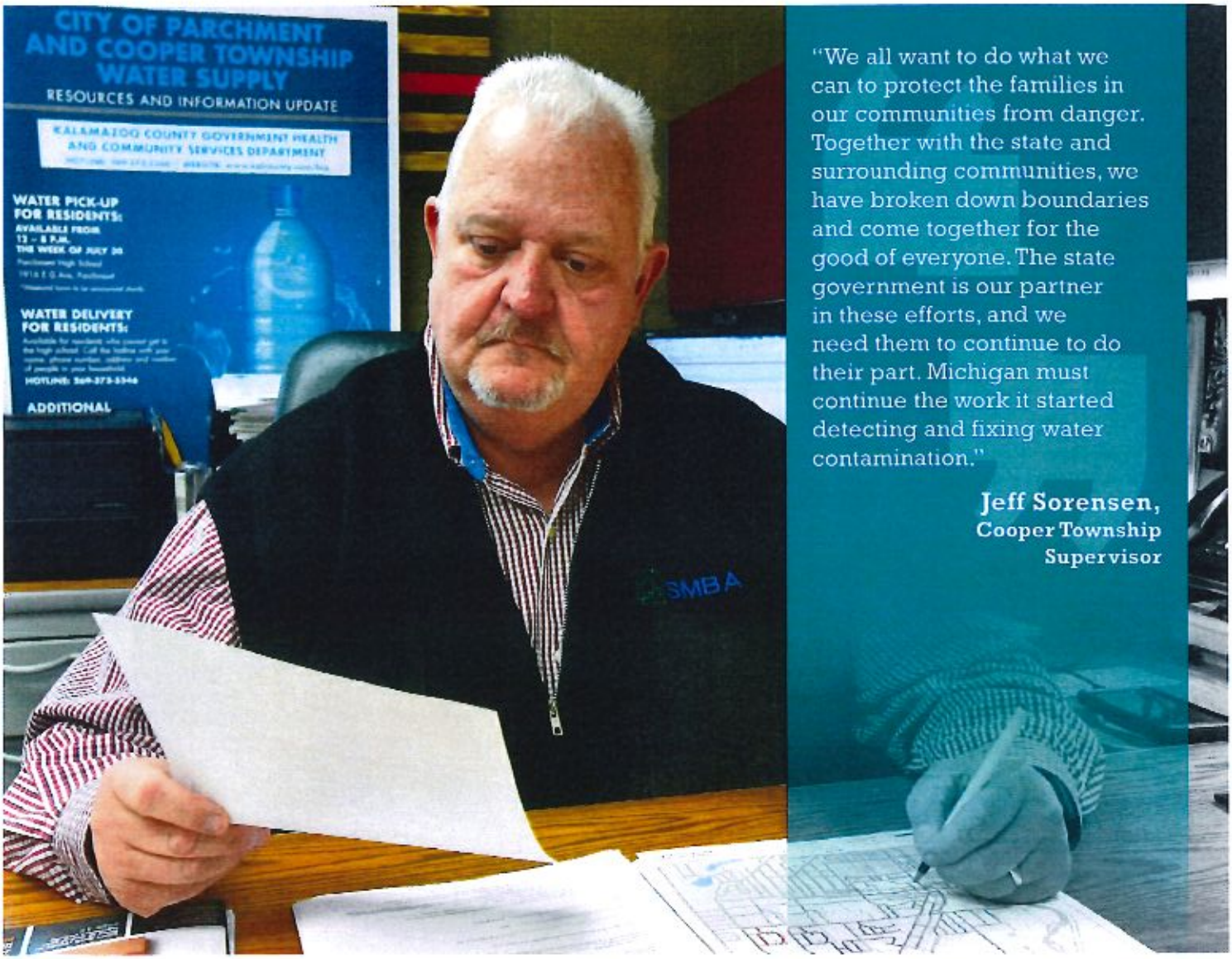
Carla Wardin,
Essex Township Supervisor

Continuing to fix our roads and bridges

Michigan drivers deserve better roads and bridges, and our plan is to continue improving them with a record-high investment in repairs. Some Michigan communities see this increased commitment paying off already, while others will notice improvements soon. We will continue this effort with smart, thoughtful budgeting and prioritization to improve our roads and bridges. Taxpayers deserve to get what they pay for, so we will continue to hold Michigan's road repair program accountable. We will take steps to ensure projects are done on time and on budget, with strengthened warranties to ensure quality. It took a long time for Michigan roads and bridges to fall into disrepair, and it will take time to fix them. We are on the right path and will stay on it moving forward.

Ensuring safe and clean drinking water

Michigan's abundant lakes and rivers are more than tourist destinations – they are the source of our state's fresh drinking water supply. We have taken the lead on fixing water delivery systems and improving natural resource protection in Michigan. This important work must continue as we face new and evolving challenges. In 2017, Michigan launched the first-in-the-nation multi-agency action team, backed by more than $60 million in state dollars, to respond to reports of PFAS contamination. This panel of experts has continued to work with our local communities to ensure the safety of public drinking water. The people of this state deserve more than a cleanup crew. They deserve smarter planning backed by cutting-edge research to build better systems to help avert another disaster. Increased investments in our water infrastructure have resulted in steady improvement in Flint residents' water supply and preempted problems across Michigan. We will continue to work with top experts to study and improve existing systems and regulations, and combat emerging threats. We will make responsible, targeted investments that will make our state a safe and enjoyable place to live, work and raise a family.



"We all want to do what we can to protect the families in our communities from danger. Together with the state and surrounding communities, we have broken down boundaries and come together for the good of everyone. The state government is our partner in these efforts, and we need them to continue to do their part. Michigan must continue the work it started detecting and fixing water contamination."

Jeff Sorensen,
Cooper Township Supervisor

Improving opportunities in schools and expanding broadband access

All Michigan students deserve a chance to succeed. That's why we'll continue to create better skilled trade opportunities that prepare students for high-skilled careers and enhance learning by continuing to expand broadband access. Challenges remain with getting students, residents and businesses the high-speed access they need. It is important to work on plans that will assist underserved areas. Without a fast and reliable internet connection that some parts of the state enjoy, certain communities are at a disadvantage keeping and attracting jobs. A common hurdle to clear is the return on investment (ROI) through supplying rural areas with broadband. We should shift this outlook from ROI for providers to ROI for the state – working to remove regulatory and financial barriers for providers. In addition, high-speed internet in the classroom is an effective educational tool to help build future generations and keep Michigan on the cutting edge. When prospective job providers can move into technologically competitive areas all over the state, it benefits every Michigan worker and allows our state to flourish.

Supporting the proposed tunnel under the Straits and protecting our Great Lakes and waterways

The Great Lakes and our inland waterways are crucial to our way of life in Michigan. Our families drink, fish and swim in this water, and we must protect these resources. Constructing a new underground infrastructure corridor in the Straits of Mackinac is the best solution to protect our beautiful Great Lakes and ensure Michigan families continue to have the resources they need to affordably heat their homes and keep their businesses running. By establishing the Mackinac Straits Corridor Authority, we created an independent watchdog to oversee the tunnel project and provide proper and necessary oversight, including a public, transparent process for ongoing operation of the tunnel. We will continue to support the tunnel and develop reforms to further protect our Great Lakes.

Defending our Constitution and the American way

Protecting religious freedoms

Our founders understood that the right to religious freedom is universal and must be protected for the benefit of all. Yet religious freedom is under attack in America, and people of faith continue to face a host of threats that seek to undermine their fundamental rights. Because of this, religious freedom is one of the most important issues of our time. We must make sure government does not stand in the way of free practice of faith. We will be vigilant in our promise to guard against the reaches of big government and will diligently protect all Michigan faithful in their places of worship.

Protecting Second Amendment rights

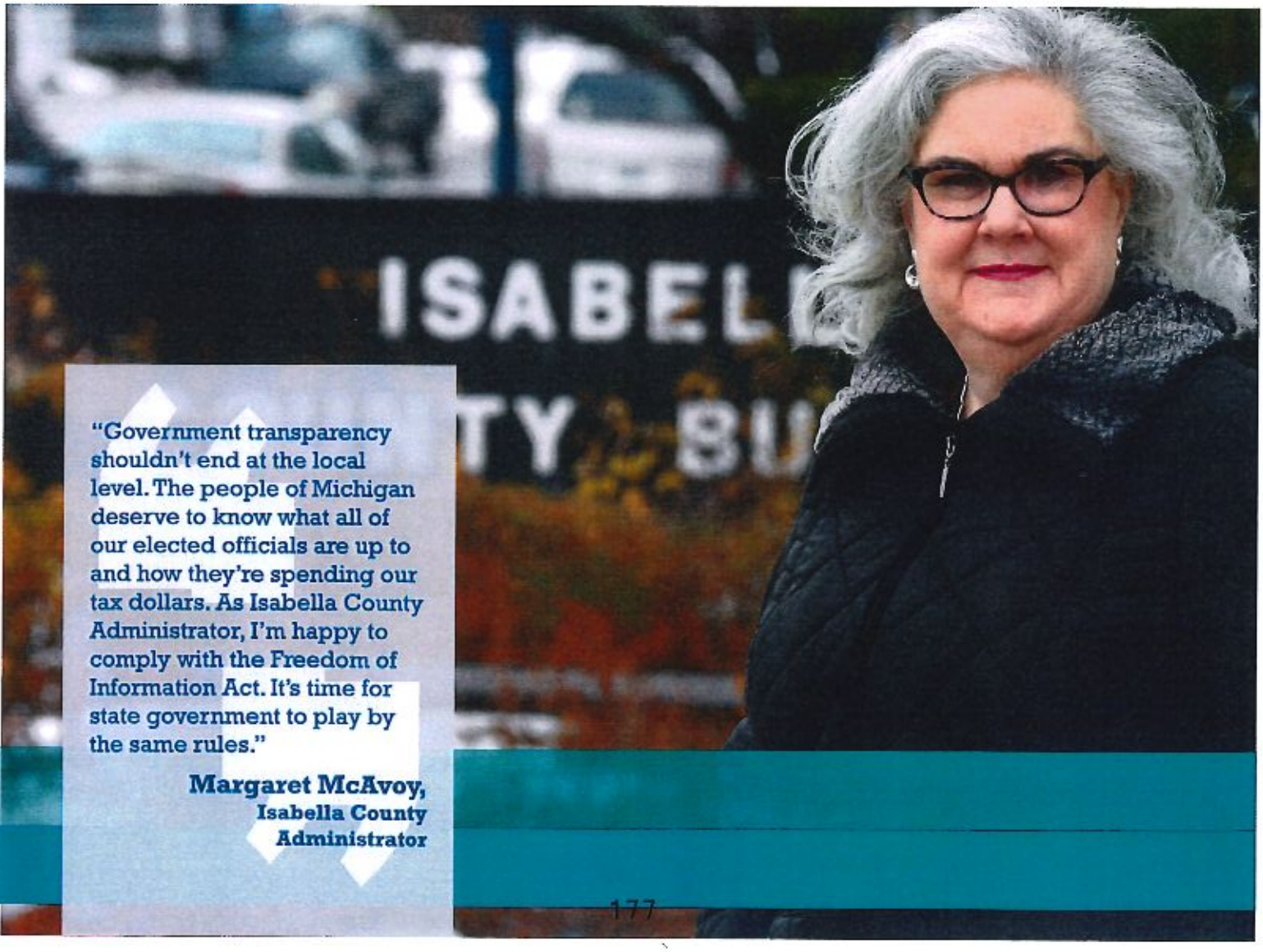
The right to bear arms is fundamental. It is prominently written into our Michigan and U.S. constitutions – the documents upon which our society is built. Sadly, this essential principle is constantly under attack by those who want to limit the right of law-abiding citizens to protect themselves, their families and their property. We will continue to protect this constitutional right from unfair restrictions. We will continue to defend law-abiding gun owners and protect the safety of all Michigan residents.

Helping Michigan veterans

While we will never be able to fully repay our brave men and women in uniform for their selfless service, we must honor veterans by ensuring they receive the best possible care and services after serving our country. Whether it's expanding access to adequate health care, helping navigate through benefits programs or opening up career training opportunities, we remain committed to making resources available to our military heroes and helping them utilize the benefits they've earned.

Increasing government transparency

Accountability is key to good government. The Michigan Freedom of Information Act (FOIA) was established in 1976 to provide the public with access to most records of public bodies. Historically, the Legislature, governor and lieutenant governor have been exempt from FOIA, but Michigan is now one of just two states where this exemption remains. We must do more to give the people of Michigan the transparency they expect from all of their elected officials. Not only are people throughout Michigan interested in how their state government works, they deserve access. People have a right to monitor the work done by their government and examine how their public tax dollars are spent. Our government will be stronger when all elected state officials are open and accountable to the people of Michigan.



"Government transparency shouldn't end at the local level. The people of Michigan deserve to know what all of our elected officials are up to and how they're spending our tax dollars. As Isabella County Administrator, I'm happy to comply with the Freedom of Information Act. It's time for state government to play by the same rules."

Margaret McAvoy,
Isabella County Administrator

Standing up for the most vulnerable

Protecting the unborn

Among the first words of our Michigan Constitution are those affirming the rights of all people, commanding that "no person shall be denied the equal protection of the laws." We take up this pledge, especially as it pertains to those with no voice to speak: the unborn. We are ready to stand up for the sanctity of life with respect and care from beginning to end. We'll guard against policies that chip away at the protections afforded to our unborn children and stand strong against attempts to weaken our state's strong safeguards for its most vulnerable residents.

Improving the lives of the mentally ill

We remain committed to providing better care to people by improving Michigan's broken mental health care system. By continuing to craft solutions based on the recommendations of the House Community Access Resources Education and Safety (C.A.R.E.S.) Task Force, we can improve local delivery of mental health services, combat the rise in substance use disorders, and make necessary improvements to our criminal justice system. Together we can work to ensure Michigan residents live happy, healthy and independent lives regardless of mental health challenges.

Supporting victims of opioid addiction

Opioid addiction and overdose have become an epidemic across the nation, and Michigan has not been immune. Because of the increase in strength and availability of opiates on the market, the likelihood of addiction and overdose continues to rise. By communicating with local law enforcement, addiction specialists, and those affected by this growing health concern, we will develop effective strategies to combat the opioid crisis. We remain committed to preventing dependence and abuse, and supporting people who need help.

"People with mental health, substance use needs and intellectual/developmental disabilities can thrive when offered the right individualized treatment, support and opportunities. By providing the best treatment options and support systems, we can work together to help those in need reach their fullest potential."

Connie Conklin,
Executive Director
Livingston County CMH

Protecting people and communities

Continuing impactful criminal justice reform

Many people in prison will one day return home. It is important for offenders to be reintegrated into society in a positive and productive fashion upon release. Successful reintegration reduces crime, lessens the burden placed on taxpayers, and benefits the entire state. By creating avenues for employment, we can give offenders a chance to achieve self-sustainability. Employment allows those with past criminal histories to provide for themselves or their families and reduce the likelihood they will turn back to crime to make ends meet. Michigan's prison population has risen from approximately 14,000 in the 1970s to more than 39,000 now. As a result, corrections spending has increased from 3 percent of the state budget general fund to roughly 20 percent. This soaring trajectory is unsustainable. Working to hinder the chances of an offender becoming a repeat offender will alleviate costs to the state – which ultimately fall on the taxpayer. We must also work to establish consistency with criminal penalties so that our state's justice system is just and fair. In addition, we should generally treat 17-year-old offenders as juveniles, instead of automatically charging them as adults and sending them to prison. By joining the vast majority of states that have raised the age for criminal prosecution from 17 to 18, we can work to turn 17-year-old offenders' lives around and remove them from the dangerous cycle of recidivism. This is a smart, forward-thinking policy that will help troubled youth, taxpayers and local communities for the long term.

Supporting law enforcement and protecting the rule of law

Our law enforcement officers put their lives on the line each and every day to protect and serve us all. At every opportunity, we must support our first responders and give them the tools they need to protect the public and properly enforce the law. No one should try to circumvent the important role our first responders play or try to dictate which laws they enforce. We will do everything we can to protect the rule of law and ensure law enforcement officers are not exploited for political purposes.

Reforming civil asset forfeiture

We must do more to protect the private property rights of people in Michigan. The government's ability to seize the private property of citizens was always intended to be a measure of last resort.

We will review and reform civil asset forfeiture laws to better protect the civil liberties of every single Michigan resident. Civil asset forfeiture is a serious step taken to punish criminals and ensure they don't profit from their crimes. It's time to implement sensible safeguards to better protect families and ensure innocent people aren't treated like criminals when it comes to civil asset forfeiture.

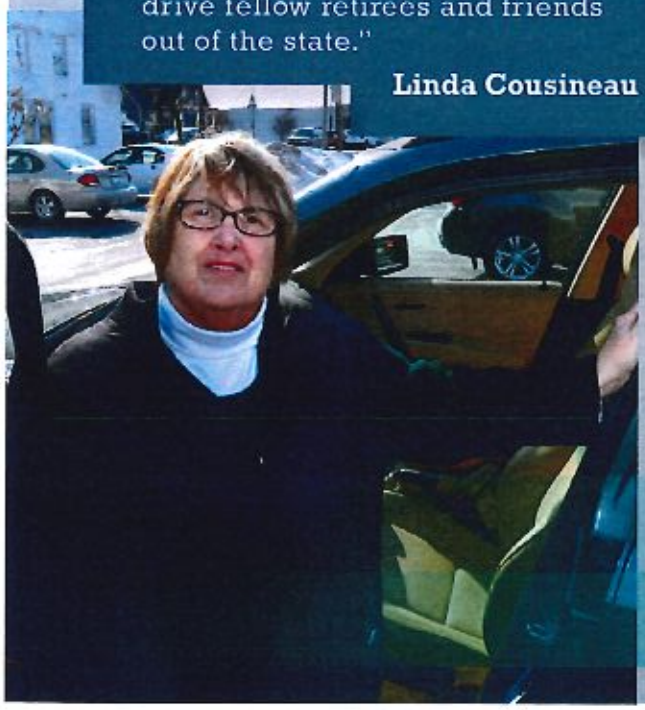
Continuing Michigan's comeback

Reducing car insurance rates for Michigan drivers

Michigan – the automotive capital of the world – is also home to the highest car insurance rates in the nation, and it's hurting our state. Skyrocketing insurance costs force some families to choose between putting food on the table and insuring their vehicles as mandated by state law. Drivers demand and deserve reforms to lower their bills. While there are a number of factors contributing to these out-of-control rates, one thing remains clear – it's well past time to stop playing politics and move our state forward with real reform. We're so committed to this important issue that we've created a special House committee solely focused on reforming our car insurance system. Michiganders deserve a more efficient and fair car insurance system, and we will take real, measurable steps to craft a solution that drives down costs while protecting drivers and their families.

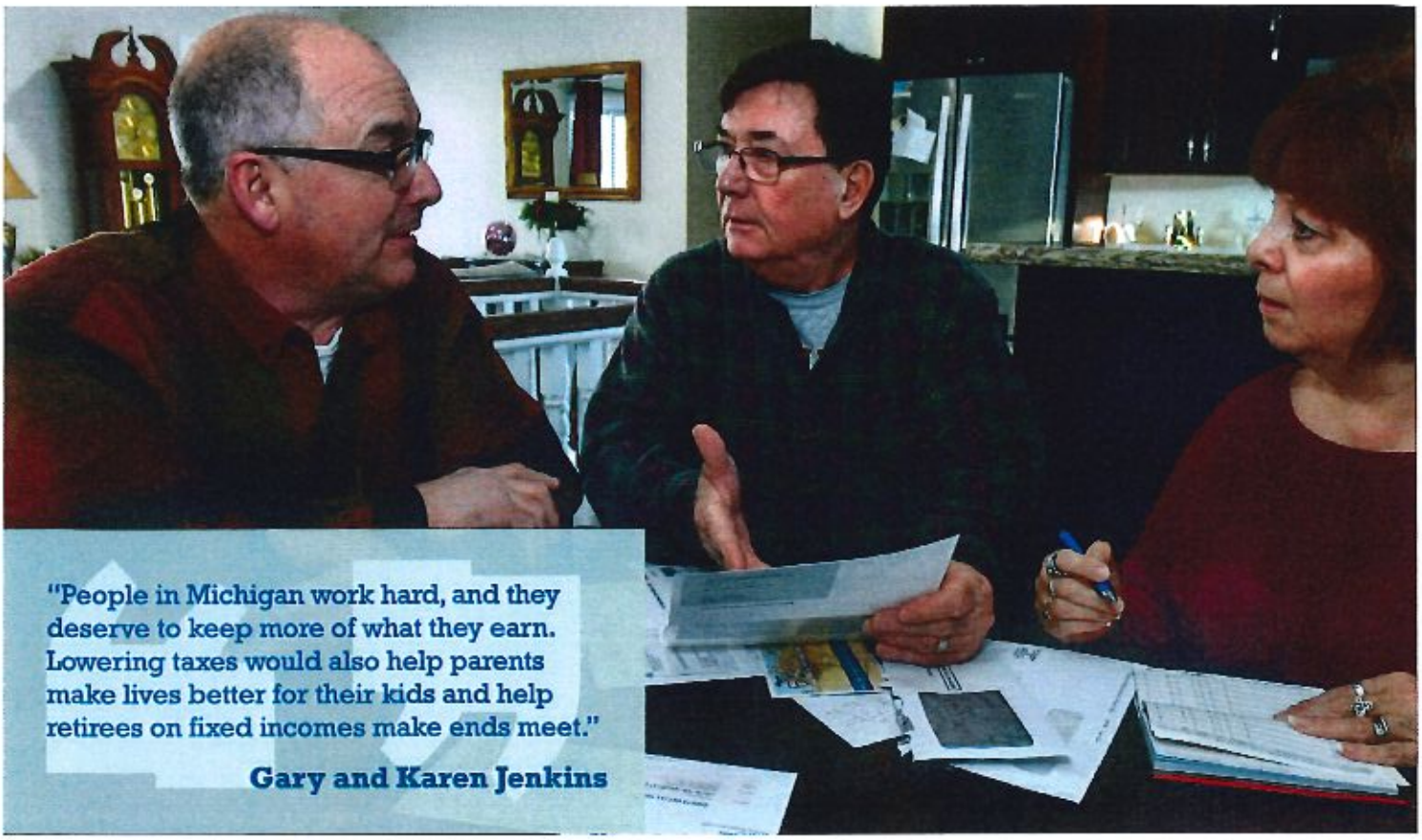
"The high cost of auto insurance is ridiculous and unfair. If I lived just 30 minutes south in Ohio, my car insurance premium would be drastically reduced. As a senior I've watched Michigan's skyrocketing car insurance rates drive fellow retirees and friends out of the state."

Linda Cousineau



"Being a mother of teen drivers makes Michigan's highest-in-the-nation car insurance rates even more painful. Just our monthly premium alone is a huge financial burden. We need car insurance reform now."

Kim Ayres



"People in Michigan work hard, and they deserve to keep more of what they earn. Lowering taxes would also help parents make lives better for their kids and help retirees on fixed incomes make ends meet."

Gary and Karen Jenkins

Helping people get to work and keep more of what they've earned

House Republicans have enacted several reforms to create a better tax system in the past eight years. Lower taxes help create jobs while enabling people to hang onto more of their hard-earned money. The proof of our success is an improved economy that's welcoming to job providers and workers alike. In addition, Republicans have been diligent in paying off debt and will continue to be responsible with taxpayer money and not saddle future generations with our debt.

While there has been substantial improvement, there's also more work to be done. Continued action is needed to lower the tax burden and improve the lives of every worker and retiree in Michigan, thereby helping more people participate in and benefit from our state's economic resurgence. We will consider plans to improve Michigan's tax system focused on reducing personal income taxes for workers and retirees. We will examine ways to simplify and clarify the tax system for individuals and job providers. It's one of our top priorities – because taxes remain one of the heaviest financial burdens shouldered by Michigan families, individuals and employers. The people of Michigan work hard for their money, and we will work just as hard to protect it.

Helping farmers and strengthening our agricultural economy

Agriculture is the second-largest sector of our state's economy, and is among the most diverse in the nation. A strong food production economy depends on an infrastructure to get commodities from farm to table. It requires quality roads, a skilled workforce ready for the high-tech demands of today's agriculture and cooperative regulatory policies. We must clear the way for our robust farming industry and keep Michigan's farms growing.

We'd like to thank the following Policy Action Plan Committee members for their work on the 2019-20 Action Plan:

Rep. Aaron Miller, Chair

Rep. Julie Alexander

Rep. Sue Allor

Rep. Ryan Berman

Rep. Ann Bollin

Rep. Diana Farrington

Rep. Beth Griffin

Rep. Matt Hall

Rep. Roger Hauck

Rep. Michele Hoitenga

Rep. Steve Johnson

Rep. Beau LaFave

Rep. Matt Maddock

Rep. Daire Rendon

Rep. Michael Webber

LEADING the WAY

for an even better Michigan

You are invited...

Policy Governance® Boot Camp

Hosted and facilitated by Partners in Policy Governance®, Eric Craymer, MBA, and Sue Radwan, MEd

Looking for a thorough understanding of Policy Governance® (PG) as a model for Boards of Directors?

Partners in Policy Governance® has created a two full day event focused on Policy Governance Theory--what it is and why it works.

During the session, you will learn:

- ✓ The essential elements and concepts that are *critical* to understanding what is and is NOT PG
- ✓ The important concepts that contribute to why the system works
- ✓ How elements of the PG model compare with other methods of governance
- ✓ How the 10 principles of PG change how governing is done
- ✓ What benefits and value adopting a model of governance can bring to your organization

We conducted research to discover what people found valuable in intensive education on Policy Governance. We have designed this event around our findings. We have discovered that the theory and understanding of why the theory works, overlaid with a mix of different sector Boards attending together brings a huge value. When you can talk about how the principles are interpreted in different organizational settings you gain deeper insight into how Boards apply the principles in different contexts. This leads to a new level of model understanding. **Because of the importance of this type of networking, we strongly encourage all attendees to plan on participating in group dinners planned for Day 1.**

Location: **Amway Grand Plaza**
A Curio Collection Hotel by Hilton®
Grand Rapids, Michigan

Date: **April 25-26, 2019**
These sessions are limited to 20 participants

The overall schedule for both days will be:

7:30 Continental Breakfast
8:00 Session begins
10:15-10:30 Morning Break
10:30 Session continues
12:00-1:00 Group Lunch
1:00 Session continues
2:45-3:00 Afternoon break
3:00-4:45 Session continues
Day 2, Session ends at 3:30.

Day 1 only - 6:00 p.m. Group dinners at local restaurant for deeper networking. *Not included in registration fee.* **We highly encourage your participation in the group dinner.**

PG Bootcamp Registration Fee
(includes lunch & e-publication for pre-reading)
Early bird: **$825** before Mar 10 2018
Regular rate: **$875** between Mar 11-Apr 15
Last minute rate: **$925** after Apr 16

Hotel Room Rate: $179/night. Reserve your room by Mar 26 online at https://book.passkey.com/e/49703757 or call (800) 253-3590. Let the hotel know you are with the Partners in Policy Governance event.

Cancellation Policy:
Registrations are transferable to individuals inside your organization.

- ➢ Full refund if cancelled before Mar 15
- ➢ 50% refund if cancelled between Mar 16-Apr 10
- ➢ No refund if cancelled after Apr 10 or a no show.

To register:

1. Register and pay online at http://www.PGbootcamp.net.event OR
2. Send your **commitment to attend** to susan.radwan@policygovernanceconsulting.com.
   You can send your registration fee in advance to 302 E Jefferson, Grand Ledge, MI 48837.

Please let us know if you have any specific food allergies that might influence our lunch menu.

PARTNERS IN POLICY GOVERNANCE®