Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
REMOTE MEETING ONLY – SWMBH OFFICES CLOSED
Mute Phones Do Not Place on Hold
Join the meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/515345453
Dial In: 1-844-655-0022
Access Code: 738 811 844
April 10, 2020
9:30 am to 11:00 am
Draft: 4/2/20

1. **Welcome Guests/Public Comment**
2. **Chairman Read Public Meeting Statement**
3. **Agenda Review and Adoption (d)**
4. **Financial Interest Disclosure Handling (M. Todd)**
   - Janet Bermingham – St. Joseph County
5. **Fiscal Year 2019 Audit Report (Derek Miller of Roslund, Prestage) (d) p. 3**
6. **Consent Agenda**
   - March 13, 2020 SWMBH Board Meeting Minutes (d) p. 35
7. **Operations Committee**
   a. Operations Committee Minutes February 26, 2020 (d) p. 42
   b. Operations Committee Quarterly Report (D. Hess) (d) p. 45
8. **10:30am Environmental Scan (Alan Bolter, Associate Director, Community Mental Health Association of Michigan) (d) p. 46**
9. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   - Assessment Tools: American Society of Addiction Medicine (ASAM) (M. Kean) (d) p. 71
10. **Board Actions to be Considered**
    a. Board Officer Elections (d) p. 72
    b. 2020-2024 Strategic Imperatives (B. Casemore) (d) p. 73
    c. May 8 Board Planning Session
11. **Board Policy Review**
    Is the Board in Compliance? Does the Policy Need Revision?
    a. BG-006 Annual Board Planning (d) p. 78
    b. BG-010 Board Committee Principles (d) p. 80

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

- None scheduled

13. Board Education

a. SWMBH COVID-19 Business Continuity (A. Wickham)
b. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 81
c. Auditor Procurement (T. Dawson)
d. Fiscal Year 2019 Quality Assurance, Performance Improvement and Utilization Management Annual Evaluation Report (J. Gardner) (d) p. 89
e. Workplace Culture Program (A. Wickham) (d) p. 326
f. System Reform Part 2 (B. Casemore) (d) p. 336

14. Communication and Counsel to the Board

a. Michigan Consortium for Healthcare Excellence (MCHE) Update (B. Casemore) (d) p. 350
b. April 17, 2020 Public Policy Legislative Event Canceled
c. Board Member Attendance Roster (d) p. 355
d. Regional Entities/PIHPs Unenrolled Complex Care Management Proposal to MDHHS (B. Casemore) (d) p. 356
e. May: BEL-004 Treatment of Staff (E. Meny)

15. Public Comment

16. Adjournment

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

To be followed by Planning Session until 3:30pm

Southwest Michigan Behavioral Health

Financial Statements
September 30, 2019

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

Southwest Michigan Behavioral Health
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September 30, 2019

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditor's Report

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

Report on the Financial Statements
We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Southwest Michigan Behavioral Health (the Entity), as of and for the year ended September 30, 2019, and the related notes to the financial statements, which collectively comprise the Entity's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions
In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the Entity, as of September 30, 2019, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information
Accounting principles generally accepted in the United States of America require that the required supplementary information, as identified in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in

the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report on March 30, 2020, on our consideration of the Entity's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Entity's internal control over financial reporting and compliance.

Sincerely,

Roslund, Prestage & Company, P.C.

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

March 30, 2020

MANAGEMENT'S DISCUSSION AND ANALYSIS

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH (SWMBH)

MANAGEMENT DISCUSSION & ANALYSIS FISCAL YEAR 2019

FOR THE PERIOD October 1, 2018 – SEPTEMBER 30, 2019

The following narrative offers readers of Southwest Michigan Behavioral Health's external audit a narrative overview and analysis of its operational and financial activities for the 12-month period ended September 30, 2019.

The information contained in management's discussion and analysis (MD&A) should be considered in conjunction with financial statements.

BACKGROUND:

Southwest Michigan Behavioral Health (SWMBH) is a Michigan public body, created as a Regional Entity under 330.1204(b) of the Michigan Mental Health Code. SWMBH became the regional Prepaid Inpatient Health Plan (PIHP) for Medicaid Specialty Services and Supports and other related payer contracts on January 1, 2014. SWMBH became the Substance Abuse Coordinating Agency for the eight county[i] region on February 1, 2014. SWMBH is a participating PIHP in the MI Health Link Demonstration for dual eligibles. This began March 1, 2015 and continues through 12/31/2020.

SWMBH has its own governing board comprised of one appointee from each Participant Community Mental Health Services Program (CMHSP) Board[ii]. SWMBH is a separate legal entity from the CMHSPs. Additionally, Per MCL 300.1100a (22), an Inter-governmental Agreement was executed on December 10, 2013 and a Substance Abuse Oversight Policy Board established on January 20, 2014. This agreement was renewed in 2017.

SWMBH is responsible for managing a range of publicly funded behavioral health benefits in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren. SWMBH holds both capitated and cost-based reimbursement contracts with the Michigan Department of Health and Human Services (MDHHS) for Medicaid Managed Specialty and Support Services, Medicaid and MiChild (state program name), Autism Benefits under an iSPA, Healthy Michigan Plan, Habitation Supports Waiver, Block Grant & and PA2 Substance Abuse Prevention and Treatment. SWMBH contracts with and funds each Participant CMH in a sub-capitation style, interim payment, cost-settlement model for most of these contracts, though not all. SWMBH is the risk-bearer for these contracts. SWMBH also maintains a provider network for selected services and supports with other providers on a per-diem or fee-for-service contracts.

SWMBH's duties include:

- Enter into contracts to provide services to plan members;
- Fulfillment of its benefits management PIHP role to MDHHS, including assuring delegated managed care functions are sound,
- Manage all mental health and substance abuse funds provided to the organization either directly or via sub-contract;
- Manage many of the primary and specialty medical care dollars;
- Assure that plan members are satisfied with their health care services;
- Assure that the State is satisfied with the performance of SWMBH;
- Remove barriers to seeking behavioral and primary care services;
- Uniformity of benefit (access, severity of illness-intensity of service, etc.)
- Assure plan members are aware of services and those who seek services are seen at or above stated standards;
- Assure plan members utilizing services experience improvements in their quality of life;
- Assure administrative and service efficiencies are achieved;
- Assure compliance to all applicable regulatory and contractual requirements for itself, its participant CMHs and its contracted providers.

Using This Annual Report

The annual report consists of four parts:

1. Management's Discussion & Analysis (MD&A)
2. Basic Financial Statements
3. Notes to the Financial Statements

The MD&A provides management's view of the current performance and financial results and expectations about the future.

The financial statements include the Statement of Net Position (often referred to as the Balance Sheet) which reflects the balance in the assets, liabilities and net position of SWMBH as of September 30, 2019. The net position is the result of the assets minus the liabilities, reflecting the financial health or position of the organization.

The Statement of Revenues, Expenses, and Changes in Net Position reflects the revenues, expenses and increase or decrease in the net position of SWMBH as a result of its activities during the period of time being reported.

The Statement of Cash Flows shows the sources from which funds were received, and how they were used over the course of the time period being reported.

SWMBH uses the accrual method of accounting, meaning that all of the period's revenues and expenses are taken into account regardless of when cash is actually received or paid. Revenues are recognized when earned, and expenses are recognized when incurred, absent instructions to the contrary from MDHHS or GAAP.

FINANCIAL HIGHLIGHTS

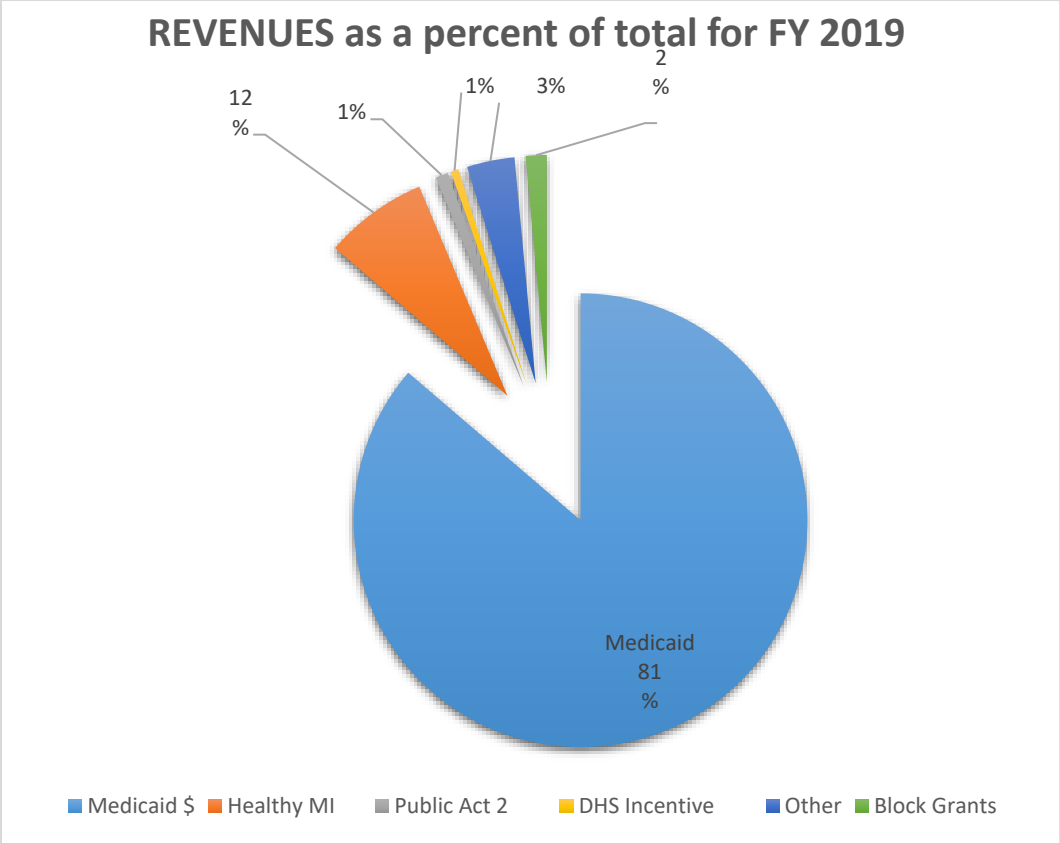
SWMBH's financial review will focus on the current year's results. Total assets at September 30, 2019 were $31,152,608 and total liabilities were $28,598,028. The difference between total assets and liabilities reflects the net revenue from activities of $2,554,580, interest income on ISF funds of $215,836 and Medicaid savings income of $40,069.

Total program revenue for the Regional Entity for the period October 1, 2018 through September 30, 2019 was as follows:

State Funding:	$	256,157,553
Federal Grants:		7,234,172
Local Funding		4,187,773
Other Revenues		76,682
Total Revenues:	$	267,656,180

Specialty Managed Care Services Internal Service (Risk Reserve) Fund (ISF) is below the 7.5%, as of 9/30/2019,

ANALYSIS OF FINANCIAL POSITION & OPERATING RESULTS:



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Revenue by program is reflected in the chart above and as follows:

State & Local Funding:

Medicaid	$	216,054,913	81%
Healthy MI		33,222,453	12%
Public Act 2		2,024,753	1%
Incentive Payments		2,264,342	1%
Other		8,425,122(MI Health Link, Local, Grants)	3%

Federal Grants:

Block Grants	$	5,664,597	2%

Total Revenue: $ 267,656,180

ANALYSIS OF BALANCES & TRANSACTIONS OF INDIVIDUAL FUNDS:

SWMBH receives funds from the federal and state governments and contracts with local Community Mental Health Service Providers (CMHSPs) and other providers to provide services for eligible beneficiaries. Additionally, each participant CMHSP provides to SWMBH delegated managed care functions within their county service area. The funds are maintained for the following programs:

- Medicaid Specialty Supports and Services including Habitation Supports Waiver (HSW)
  These programs provide a comprehensive array of specialty mental health and substance abuse services for eligible beneficiaries.
- Substance Abuse/Block Grant/PA2
  Provides for the administration and coordination of substance use disorder (SUD) services.
- Healthy Michigan Plan
  Provides for medically necessary services based on modified gross income eligibility. Autism benefits, provides for the coordination of services to children diagnosis of autism, these funds are not included in the monthly capitation payment from MDHHS.

CAPITAL ASSET & LONG-TERM DEBT ACTIVITY:

Southwest Michigan Behavioral Health does not own the land or the buildings from which it operates. It also has no long-term debt.

As of September 30, 2019, SWMBH has the following capitalized assets which consist of:

Vehicles:	$ 28,613
Managed Care Software	796,755
Accumulated Depreciation	(701,898)
Total (Net) Capital Assets	$123,470

There was no long-term debt incurred during the past year.

CURRENTLY KNOWN FACTS, DECISIONS OR CONDITIONS:

Michigan is experiencing a steady economic recovery. Therefore, we see a downward trend in Medicaid eligible participants, and thus revenues, especially for TANF persons in the Specialty Supports and Services program. We expect this downward trend to continue in a magnitude as yet unknown. It does not follow necessarily that need and demand (and thus services and expenses) goes down at the same levels as eligibles and revenue. In fact, experience suggests that need/demand/services/expenses does NOT decline in related proportions, if at all. Some of this activity and revenue has been replaced by Michigan's Medicaid expansion, Healthy Michigan which has a lower reimbursement rate.

As for Medicare, conversations with Integrated Care Organizations (ICOs) from whence that capitation revenue emerges will continue; there are contractual commitments to reviewing and performing actuarial analyses and capitation revisions. There will be cost settlements with the ICO's for FY's 18.

FORWARD OUTLOOK

Fiscal Year 2020 has already been challenging with respect to current year capitation revenue receipts, tracking and reconciliation. The numerous revisions MDHHS and Milliman have made to rate-setting along with prior year adjustment issues have yet to be clarified as of this writing. Yet, our financial position is more favorable that at least four (4) PIHPs who have already been in the state's risk corridor through fiscal year 2019 and several others thought to already be in the state's risk corridor for fiscal year 2020. We are conversing with the MI Health Link (duals) Integrated Care Organizations Aetna and Meridian regarding reconciliation, contract re-negotiation and their plans for January 1 2021 as the Demonstration ends 12/31/20.

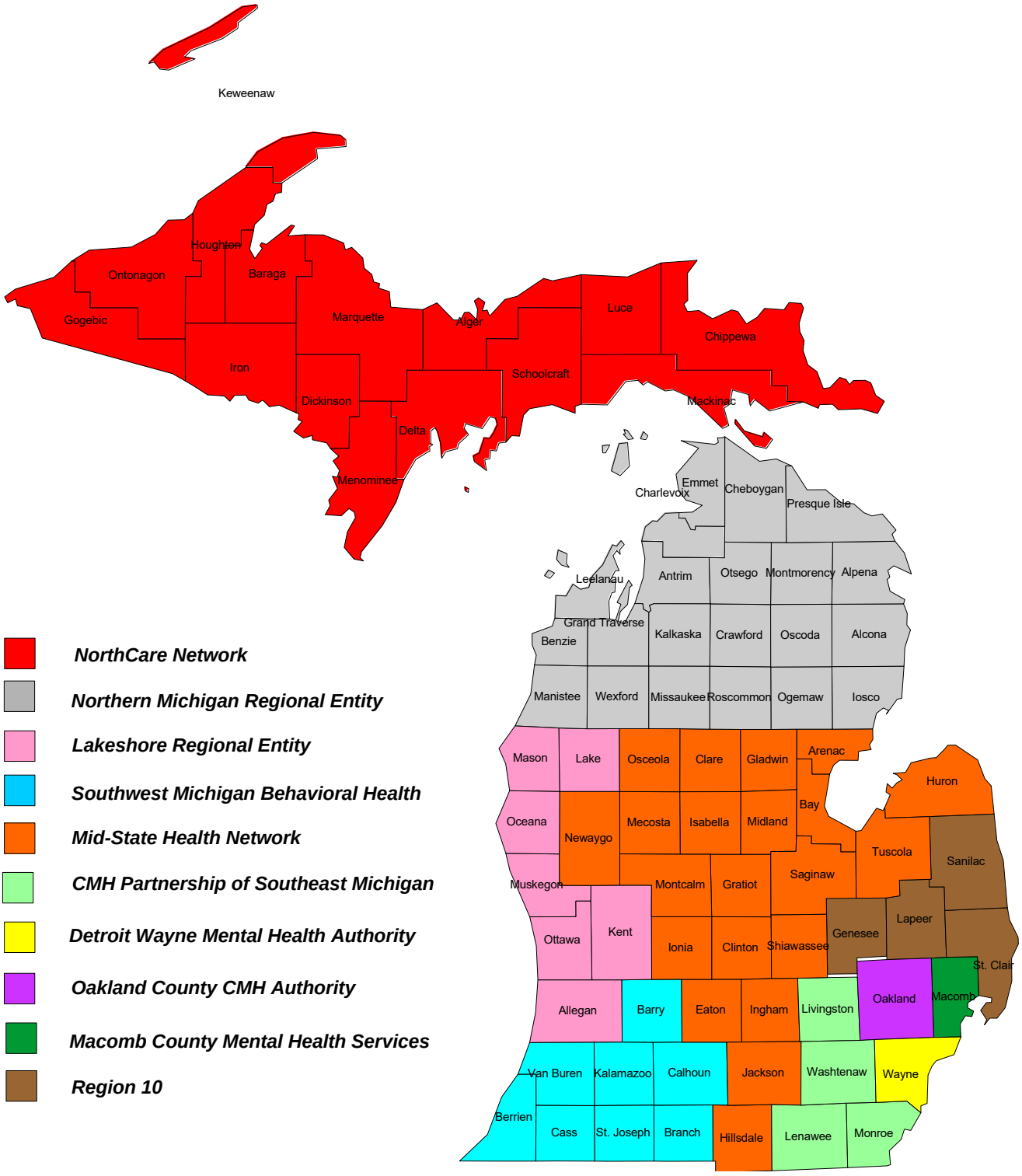
The current global pandemic will assuredly have an effect on the remainder of 2020 and beyond with many uncertainties. SWMBH is here to support the system and to ensure the beneficiaies get the services needed to continue to thrive.

Given that 2020 is a Presidential election year healthcare policy discussions at the federal and state levels are particularly active. Medicaid Expansion "community involvement" work rules have been implemented in Michigan with an executive branch ask of lower courts to overturn the state statute mandating it here. Medicaid Block Grants have been proposed by the President as a state option. Most importantly MDHHS public behavioral system reform plans call for the cessation of PIHPs at 10/1/22. Management has already begun discussions with the Board regarding the direction they wish this Regional Entity to take at that time. There may be opportunities for the SWMBH to continue to operate without a PIHP contract and bring value to the CMH Participants through clinical and administrative services to them and/or Administrative Service Organization offerings to other agencies including but not limited to the Specialty Integrated Plans, Medicaid Health Plans, organized Provider Groups, and the like.

Regardless of the environment our Board, management and CMHSPs maintain our focus on exemplary access, quality, effectiveness and cost considerations.

[i] Map of Michigan's Regional Entities
[ii] 2019 SWMBH Board Member Roster

Michigan PIHP Map



Updated 03/03/2016

Southwest Michigan
BEHAVIORAL HEALTH

2019 Board Member Roster

Barry County

- Robert Nelson
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Vice-Chair
- Nancy Johnson (Alternate)

Branch County

- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County

- Patrick Garrett
- Kathy-Sue Vette (Alternate)

Cass County

- Michael McShane
- Karen Lehman (Alternate)

Kalamazoo County

- Moses Walker
- Patricia Guenther (Alternate)

St. Joseph County

- Angie Price
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

BASIC FINANCIAL STATEMENTS

Southwest Michigan Behavioral Health
Statement of Net Position
September 30, 2019

	Enterprise Fund	Internal Service	
	Mental Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Current assets			
Cash and cash equivalents - unrestricted	$ 23,980,716	$ -	$ 23,980,716
Cash and cash equivalents - restricted	198,089	1,768,550	1,966,639
Accounts receivable	29,905	-	29,905
Due from other governmental units	6,745,438	-	6,745,438
Due from other funds	-	3,244,208	3,244,208
Prepaid expenses	74,990	-	74,990
Total current assets	31,029,138	5,012,758	36,041,895
Noncurrent assets			
Capital assets being depreciated, net	123,470	-	123,470
Total assets	31,152,608	5,012,758	36,165,365
Current liabilities			
Accounts payable	1,405,067	-	1,405,067
Accrued payroll and benefits	240,632	-	240,632
Due to other governmental units	18,168,806	-	18,168,806
Due to other funds	3,244,208	-	3,244,208
Incurred but not reported claims liability	1,024,324	-	1,024,324
Unearned revenue	4,316,902	-	4,316,902
Compensated absences, due within one year	29,713	-	29,713
Total current liabilities	28,429,652	-	28,429,652
Noncurrent liabilities			
Compensated absences, due beyond one year	168,376	-	168,376
Total liabilities	28,598,028	-	28,598,028
Net position			
Net investment in capital assets	123,470	-	123,470
Restricted for Medicaid risk management	-	3,019,834	3,019,834
Restricted for Healthy Michigan risk management	-	1,992,924	1,992,924
Restricted for Performance Bonus Incentive Pool	1,765,033	-	1,765,033
Unrestricted	666,077	-	666,076
Total net position	$ 2,554,580	$ 5,012,758	$ 7,567,337

The notes to the financial statements are an integral part of this statement.

Southwest Michigan Behavioral Health
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2019

	Enterprise Fund	Internal Service	
	Mental Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues			
State funding			
Medicaid	$ 216,054,913	$ -	$ 216,054,913
Healthy Michigan	33,222,453	-	33,222,453
Incentive payments	2,264,342	-	2,264,342
Medicare-Medicaid capitated revenue	3,563,941	-	3,563,941
State grant revenue	1,051,904	-	1,051,904
Total State funding	256,157,553	-	256,157,553
Federal grants			
Block grants	5,664,597	-	5,664,597
Partnerships for Success	131,652	-	131,652
Opioid State Targeted Response	937,098	-	937,098
State Opioid Response	500,825	-	500,825
Total federal grants	7,234,172	-	7,234,172
Local funding			
Public Act 2 funding	2,024,753	-	2,024,753
Local match drawdown	2,163,020	-	2,163,020
Total local funding	4,187,773	-	4,187,773
Other operating revenues	76,682	-	76,682
Total operating revenues	267,656,180	-	267,656,180
Operating expenses			
Funding for affiliate partners			
Barry County Community Mental Health	10,197,889	-	10,197,889
Kalamazoo Community Mental Health	66,954,732	-	66,954,732
Pines Behavioral Health	12,784,096	-	12,784,096
Riverwood Center	45,074,531	-	45,074,531
St. Joseph Community Mental Health	16,254,527	-	16,254,527
Summit Pointe	43,937,574	-	43,937,574
Van Buren Community Mental Health	23,204,399	-	23,204,399
Woodlands Behavioral Healthcare Network	11,751,004	-	11,751,004
PBIP funding for affiliate partners	1,640,920	-	1,640,920
Total funding for affiliate partners	231,799,672	-	231,799,672
Contract expenditures			
Contractual services	20,911,668	-	20,911,668
IPA and HRA taxes	8,750,962	-	8,750,962
Local match drawdown	2,163,020	-	2,163,020
Total contract expenditures	31,825,650	-	31,825,650
Administrative expenses			
Salaries and contracted personnel	4,329,160	-	4,329,160
Fringe benefits	1,267,863	-	1,267,863
Board expenses	9,200	-	9,200

Southwest Michigan Behavioral Health
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2019

	Enterprise Fund	Internal Service	
	Mental Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Community education	$ 44,471	$ -	$ 44,471
Depreciation expense	110,119	-	110,119
Furniture and small equipment	320,227	-	320,227
Insurance	34,094	-	34,094
IT and Consulting services	991,276	-	991,276
Lease expense	229,122	-	229,122
Legal and professional	209,972	-	209,972
Maintenance and custodial	28,230	-	28,230
Meeting and training expense	178,327	-	178,327
Membership and dues	44,010	-	44,010
Other operating expenses	11,055	-	11,055
Staff development and travel	95,374	-	95,374
Supplies	42,675	-	42,675
Utilities	54,437	-	54,437
Total administrative expenses	7,999,612	-	7,999,612
Total operating expenses	271,624,934	-	271,624,934
Operating income (loss)	(3,968,754)	-	(3,968,754)
Non-operating revenues (expenses)			
Investment income	215,836	40,069	255,905
Non-operating local expense	(33,998)	-	(33,998)
Total non-operating revenues (expenses)	181,838	40,069	221,907
Transfers			
Transfer in (out) - Medicaid	4,100,216	(4,100,216)	-
Total transfer in (out)	4,100,216	(4,100,216)	-
Change in net position	313,300	(4,060,147)	(3,746,847)
Net position, beginning of year	2,241,279	9,072,905	11,314,184
Net position, end of year	$ 2,554,580	$ 5,012,758	$ 7,567,337

Southwest Michigan Behavioral Health
Statement of Cash Flows
For the Year Ended September 30, 2019

	Enterprise Fund	Internal Service	
	Mental Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Cash flows from operating activities			
Receipts from the State and other governments	$ 267,441,239	$ -	$ 267,441,239
Payments to employees	(5,537,221)	-	(5,537,221)
Payments to affiliates and other governments	(262,602,973)	-	(262,602,973)
Payments to suppliers and providers	(3,185,965)	-	(3,185,965)
Net cash provided by (used in) operating activities	(3,884,920)	-	(3,884,920)
Cash flows from noncapital financing activities			
Payments from/to other funds	16,150,212	(16,150,212)	-
Payments for non-operating local expense	(33,998)	-	(33,998)
Net cash provided by (used in) noncapital fin. activities	16,116,214	(16,150,212)	(33,998)
Cash flows from investment activities			
Investment income	215,836	40,069	255,905
Net cash provided by (used in) investment activities	215,836	40,069	255,905
Net increase in cash and cash equivalents	12,447,130	(16,110,143)	(3,663,013)
Cash and cash equivalents, beginning of year	11,731,675	17,878,693	29,610,368
Cash and cash equivalents, end of year	$ 24,178,805	$ 1,768,550	$ 25,947,355
Reconciliation of operating income to net cash provided by (used in) operating activities:			
Operating income (loss)	$ (3,968,754)	$ -	$ (3,968,754)
Depreciation expense	110,119	-	110,119
Changes in assets and liabilities:			
Accounts receivable	(10,818)	-	(10,818)
Due from other governmental units	(5,408,280)	-	(5,408,280)
Prepaid expenses	119,769	-	119,769
Accounts payable	(1,013,264)	-	(1,013,264)
Due to other governmental units	6,430,628	-	6,430,628
Accrued payroll and benefits	23,311	-	23,311
Incurred but not reported claims liability	-	-	-
Unearned revenue	(204,124)	-	(204,124)
Compensated absences	36,492	-	36,492
Net cash provided by (used in) operating activities	$ (3,884,920)	$ -	$ (3,884,920)

NOTES TO THE
FINANCIAL STATEMENTS

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements of Southwest Michigan Behavioral Health (the Entity) have been prepared in conformity with U.S. generally accepted accounting principles (GAAP) as applicable to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The following is a summary of the significant accounting policies used by the Entity.

Reporting Entity

The Entity was formed by the CMHSP Participants to serve as the prepaid inpatient health plan ("PIHP") beginning on January 1, 2014 for the 8 counties designated by the Michigan Department of Health and Human Services as Region 4. The CMHSP Participants include Barry County Community Mental Health, Pines Behavioral Health (Branch Community Mental Health), Riverwood Center (Berrien Community Mental Health), Woodlands Behavioral Healthcare Network (Cass County Community Mental Health), Kalamazoo County Community Mental Health, Summit Pointe (Calhoun Community Mental Health), St. Joseph County Community Mental Health, and Van Buren Community Mental Health Authority.

Southwest Michigan Behavioral Health is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it.

Financial Statement Presentation

Under GASB 34, the Entity is considered a special purpose government and has elected to present the basic statements as an Enterprise Fund (a type of proprietary fund) which is designed to be self-supporting. Enterprise Funds distinguish operating revenues and expenses from nonoperating items. The principal operating revenues of the Entity are charges related to serving its customers (including primarily "per member per month" capitation and state and county appropriations). Operating expenses for the Entity include cost of services, administrative expenses, and depreciation on capital assets. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses including investment income and interest expense.

As a general rule, the effect of interfund activity has been eliminated when presenting total proprietary fund activity.

All amounts shown are in U.S. dollars.

Fund Accounting

The accounts of the Entity are organized on the basis of funds, each of which is considered a separate accounting entity. The operations of each fund are accounted for with a separate set of self-balancing accounts that comprise its assets, deferred outflows of resources, liabilities, deferred inflows of resources, net position, revenue, and expenses, as appropriate. Government resources are allocated to and accounted for in individual funds based upon the purposes for which they are to be spent and the means by which spending activities are controlled.

The Entity reports the following major enterprise fund:

Mental Health Operating – This fund is used to account for those activities that are financed and operated in a manner similar to private business relating to revenues earned, costs incurred, and/or net income. This fund of the Entity accounts for its general operations.

In addition, the Entity reports the following major internal service fund:

Medicaid Risk Reserve – This fund is used to cover the risk of overspending the Medicaid Managed Care Specialty Services Program Contract within the established risk corridor. This contract provides for the use of Department of Health and Human Services funding for the establishment of Internal Service Funds. Expenses from this fund will occur when, in any one fiscal year, the Entity finds it necessary to expend more to provide services to carry out the contract requirements than revenue provided by the contract.

Basis of Accounting and Measurement Focus

Basis of accounting refers to when revenue and expenses are recognized in the accounts and reported in the

financial statements. The proprietary funds are accounted for using the full accrual basis of accounting. Their revenues are recognized when they are earned, and their expenses are recognized when they are incurred. The proprietary funds are accounted for on a cost of services or economic resources measurement focus. This means that all assets and all liabilities associated with their activity are included on the statement of net position.

Estimates
The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents
The Entity's cash and cash equivalents are considered to be cash on hand, money market funds, demand deposits, and certificates of deposit.

Investments
Investments for the Entity are reported at fair value (generally based on quoted market prices).

Accounts Receivable/Payable
Accounts receivable/payable in all funds report amounts that have arisen in the ordinary course of business. Accounts receivable is stated net of allowances for uncollectible amounts, if any.

Due from/Due to Other Governmental Units
Due from/due to other governmental units consist primarily of amounts due from/to the CMHSPs Participants and the State of Michigan.

Inventories
The Entity does not recognize supplies inventory as an asset. The cost of these supplies is considered immaterial to the financial statements and the quantities are not prone to wide fluctuation from year to year. The costs of such supplies are expensed when purchased.

Prepaid Expenses
Certain payments to vendors reflect costs applicable to future accounting periods and are recorded as prepaid items in the financial statements. The cost of prepaid items is recorded as an expense when consumed rather than when purchased.

Capital Assets
Capital assets are defined by the Entity as individual assets with an initial cost equal to or more than $5,000 and an estimated useful life in excess of one year. Such assets are recorded at historical cost or estimated historical cost if purchased or constructed. Donated capital assets are recorded at estimated acquisition cost at the date of donation.

The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are not capitalized. Major outlays for capital assets and improvements are capitalized as projects are constructed.

Capital assets of the Entity are depreciated using the straight-line method over the following estimated useful lives:

Assets	Years
Computers and software	3
Vehicles	5

The Entity reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value. If it is determined that an impairment loss has occurred, the asset is written down to its net realizable value and a related expense is recognized in the current year.

Accrued Payroll and Benefits
Accrued payroll and benefits relate to salaries and wages earned in September but not paid until October.

Unearned Revenue
The Entity reports unearned revenue when revenue does not meet either the "measurable" and "available" criteria for recognition in the current period, or when resources are received by the Entity before it has a legal claim to them, such as when grant money is received prior to the incurrence of qualifying expenses. In subsequent periods, when both revenue recognition criteria are met, or when the Entity has legal claim to the resources, the liability for unearned revenue is removed and the revenue is recognized.

Incurred But Not Reported (IBNR) Liability
The amounts recorded in liabilities include amounts for incurred inpatient, residential and community provider claims liability based on management's estimate. The Entity may not be billed for these until several months after the date of service. The actual cost may vary from the estimated amount for a variety of reasons that include, but are not limited to, retroactive consumer eligibility or cost recovery from other third-party payers.

The methodology used in estimating reserves considers factors such as historical data adjusted for payment patterns, cost trends, service and benefit mixes, seasonality, utilization of health care services, internal processing changes, the amount of time it took to pay claims from prior periods, changes in the past few months in the claims adjudication procedures, changes in benefits, events that would lead to excessive claims, large increases or decreases in membership, and other relevant factors.

Compensated Absences
The Entity's policy permits employees to accumulate earned but unused vacation and sick benefits, which are eligible for payment upon separation from the Entity's service. The liability for such leave is reported as incurred in the financial statements. The liability for compensated absences includes salary related benefits, where applicable.

Deferred Outflows/Inflows of Resources
In addition to assets, the statement of net position will sometimes report a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position that applies to a future period(s) and so will not be recognized as an outflow of resources (expense) until then. The Entity has no items that qualify for reporting in this category.

In addition to liabilities, the statement of net position will sometimes report a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. The Entity has no items that qualify for reporting in this category.

Net Position
Net investment in capital assets
This category consists of capital asset balances, net of accumulated depreciation, less outstanding balances of debt related to those assets.

Restricted
Net position in this category is reported as restricted when constraints placed on net position use is either:
- Externally imposed by creditors, grantors, contributors, or laws or regulations of other governments, or
- Imposed by law through constitutional provisions or enabling legislation.

Unrestricted
If net position does not meet the criteria for the above categories, it is reported as unrestricted.

In addition, the Entity will first use restricted resources when an expense is incurred for purposes for which either restricted or unrestricted net position is available.

MDHHS Revenue
The Entity serves as the Pre-Paid Inpatient Health Plan for the area that includes Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren Counties. The Entity contracts directly with the Michigan Department

of Health and Human Services (MDHHS) to administer mental health and substance abuse revenues for covered services provided to eligible residents of these counties.

Restrictions on Net Position

Mental Health Operating

A portion of the net position has been restricted to fund the net uninsured exposure of potential shortfalls of contract revenues. As of September 30th, this amount was $0 for Medicaid Savings and $0 for Healthy Michigan Savings.

Another portion of the net position has been restricted in the Mental Health Operating fund in accordance the requirements of the Performance Bonus Incentive Pool (PBIP). These PBIP funds must be used for the benefit of the public behavioral health system. As of September 30th, the amount of this restriction was $1,765,003.

Internal Service Fund

A portion of the net position has been restricted in the internal service fund to fund the net uninsured exposure of potential shortfalls of contract revenues. As of September 30th, this amount was $3,019,816 for Medicaid risk management and $1,992,922 for Healthy Michigan risk management.

Internal Service Fund

The Entity authorized the establishment of an internal service fund. This fund is used to cover the risk of overspending the Managed Care Specialty Services Program Contract within the established risk corridor. This contract provides for the use of MDHHS funding for the establishment of Internal Service Funds.

Expenses from this fund will occur when, in any one fiscal year, the Entity finds it necessary to expend more to provide services to carry out the contract requirements than revenue provided by the contract.

NOTE 2 – CASH, CASH EQUIVALENTS AND INVESTMENTS

Cash and Cash Equivalents

Michigan's statutory authority allows governmental entities to invest in the following investments:

- Bonds, securities, other obligations and repurchase agreements of the United States, or an agency or instrumentality of the United States.
- Certificates of deposit, savings accounts, deposit accounts or depository receipts of a qualified institution.
- Commercial paper rated at the time of purchase within the 2 highest classifications established by not less than 2 standard rating services and that matures not more than 270 days after the date of purchase.
- Bankers' acceptances of United States banks.
- Obligations of the State of Michigan and its political subdivisions that, at the time of purchase are rated as investment grade by at least one standard rating service.
- Mutual funds registered under the Investments Company Act of 1940 with the authority to purchase only investment vehicles that are legal for direct investment by a public corporation.
- External investment pools as authorized by Public Act 20 as amended through December 31, 1997.

At September 30th the carrying amount of the Entity's cash and cash equivalents are as follows:

Description	Amount
Cash and cash equivalents - unrestricted	23,980,716
Cash and cash equivalents - restricted	1,966,639
Total cash and cash equivalents	25,947,355

Cash and Cash Equivalents - Restricted

The Entity has charged to MDHHS for the vested portion of compensated absences as of September 30th. The Entity holds, in a separate bank account, funds restricted for the payment of the compensated absences as they come due.

Cash and cash equivalents have been restricted in the Internal Service Fund for the expected future risk corridor requirements of the MDHHS contract.

Description	Amount
Restricted for Compensated Absences	198,089
Restricted for Internal Service Fund	1,768,550
Total	1,966,639

Interest Rate Risk
State law limits the allowable investments and the maturities of some of the allowable investments as identified in the summary of significant accounting policies. The Entity's investment policy does not have specific limits in excess of state law on investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

Credit Risk
State law limits investments to specific government securities, certificates of deposits and bank accounts with qualified financial institutions, commercial paper with specific maximum maturities and ratings when purchased, bankers' acceptances of specific financial institutions, qualified mutual funds and qualified external investment pools as identified in the summary of significant accounting policies. The Entity's investment policy does not have specific limits in excess of state law on investment credit. The ratings for each investment are identified above for investments held at year-end.

Custodial Credit Risk
Custodial credit risk is the risk that in the event of a bank failure, the Entity's deposits may not be returned. State law does not require and the Entity does not have a policy for deposit custodial credit risk. As of year-end, $507,434 of the Entity's bank balance $27,362,914 was exposed to custodial credit risk. FDIC insured balances are held in bank, CDARS and Sweep accounts.

Due to the timing of when funds are received (from MDHHS) and when they are remitted (to the CMHSPs), it is not operationally feasible to have all deposits covered by FDIC insurance coverage. The Entity typically remits payments to the CMHSPs within 2 business days from when the payment details are received from MDHHS.

The Entity evaluated the remaining financial institutions where the remaining funds will be held and the risk of the institution has an acceptable estimated risk level and deemed appropriate. To help reduce custodial credit risk, management has chosen to invest in repurchase agreements, as seen below.

Description	**Fair Value**	**Weighted average maturity (in years)**	**%**
First National Bank - Insured Cash Sweep	$24,664,650	.0027	100%
1 day maturity equals approximately .0027 years.			

Concentration of Credit Risk
State law limits allowable investments but does not limit concentration of credit risk as identified in the summary of significant accounting policies. The Entity's investment policy does not have specific limits in excess of state law on concentration of credit risk.

NOTE 3 – ACCOUNTS RECEIVABLE

The Entity believes that the accounts receivable will be collected in full and therefore the receivable balance has not been offset by an allowance for doubtful accounts.

NOTE 4 - DUE FROM OTHER GOVERNMENTAL UNITS

Due from other governmental units as of September 30th consists of the following:

Description	Amount
MDHHS	3,655,424
Kalamazoo CMH	1,679,804
Pines Behavioral Health	14,465
Riverwood Center	82,987
St. Joseph County CMH	22,314
Summit Pointe	349,363
Van Buren County CMH	32,112
Woodlands Behavioral Healthcare Network	908,969
Total	6,745,438

NOTE 5 - CAPITAL ASSETS

A summary of changes in capital assets is as follows:

	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets being depreciated					
Computers and software	796,755	-	-	-	796,755
Vehicles	28,613	-	-	-	28,613
Total capital assets being depreciated	825,368	-	-	-	825,368
Accumulated depreciation					
Computers and software	(590,825)	(104,397)	-	-	(695,222)
Vehicles	(954)	(5,722)	-	-	(6,676)
Total accumulated depreciation	(591,779)	(110,119)	-	-	(701,898)
Capital assets being depreciated, net	233,589	(110,119)	-	-	123,470

NOTE 6 - DUE TO OTHER GOVERNMENTAL UNITS

Due to other governmental units as of September 30th consists of the following:

Description	Amount
Department of Treasury	719,869
MDHHS	8,898,216
Barry County CMH	475,431
Kalamazoo CMH	433,403
Pines Behavioral Health	759,779
Riverwood Center	964,578
St. Joseph County CMH	186,365
Summit Pointe	2,238,264
Van Buren County CMH	795,942
Others	2,696,959
Total	18,168,806

NOTE 7 - UNEARNED REVENUE

The amount reported as unearned revenue represents revenues received in advance of the period earned as follows:

Description	Amount
PA2 revenues	4,314,042
Other unearned revenues	2,860
Total	4,316,902

NOTE 8 - LONG-TERM LIABILITIES

The changes in the long-term liabilities are as follows:

Description	Beginning Balance	Additions	Reductions	Ending Balance	Due within one year
Compensated absences	161,597	60,731	(24,240)	198,089	29,713

NOTE 9 - NET INVESTMENT IN CAPITAL ASSETS

As of September 30th, the composition of net investment in capital assets was comprised of the following:

Net investment in capital assets	Amount
Capital asset being depreciated, net	123,470
Net investment in capital assets	123,470

NOTE 10 – RETIREMENT AND OTHER POST EMPLOYMENT BENEFIT PLANS

Defined Contribution Retirement Plan – 401(a)

Plan Description

The Entity offers all employees a retirement plan created in accordance with the Internal Revenue Code, Section 401(a). The assets of the plan were held in trust for the exclusive benefit of the participants (employees) and their beneficiaries. Nationwide acts as the custodian for the plan and holds the custodial account for the beneficiaries of this Section 401(a) plan.

The assets may not be diverted to any other use. The Administrators are agents of the employer for purposes of providing direction to the custodian of the custodial account from time to time for the investment of the funds held in the account, transfer of assets to or from the account and all other matters. Plan balances and activities are not reflected in the Entity's financial statements.

Plan provisions are established or amended by Board resolution. This plan is funded solely by employer contributions.

Eligibility
All employees are eligible.

Contributions
The Entity contributes a match of 50% of the employee deferral (into the 457 plan) up to the maximum of 5.0% of wages. The Entity may also make discretionary contributions.

Normal Retirement Age & Vesting
Retirement age as defined by the plan is 59 ½ years of age. Contributions are vested 33% per year and 100% vested after 3 years of vesting service (1,000 hours in a plan year). All participants are fully vested upon death, disability and retirement.

Forfeitures
Forfeitures of contributions are reallocated as an employer discretionary contribution.

For the year ended September 30th, employer contributions (net of $455 in forfeitures) amounted to $131,041. No discretionary contributions were made during the fiscal year. The outstanding liability to the plan at year-end was $0.

Deferred Compensation Retirement Plan – 457(b)
Plan Description
The Entity offers all employees a deferred compensation plan created in accordance with the Internal Revenue Code, Section 457. The assets of the plan were held in trust, as described in IRC Section 457(b) for the exclusive benefit of the participants (employees) and their beneficiaries. Nationwide acts as the custodian for the plan and holds the custodial account for the beneficiaries of this plan.

The assets may not be diverted to any other use. The Administrators are agents of the employer for purposes of providing direction to the custodian of the custodial account from time to time for the investment of the funds held in the account, transfer of assets to or from the account and all other matters. In accordance with the provisions of GASB Statement 32, plan balances and activities are not reflected in the Entity's financial statements.

Plan provisions are established or amended by Board resolution. Under the plan, employees may elect to defer a portion of their wages, subject to Internal Revenue Service limits. This plan is funded solely by employee contributions.

Eligibility
All employees are eligible.

Contributions
Pre-tax employee deferrals and catch up contributions are allowed (up to maximum allowed by law). Rollovers are allowed from all participants.

Normal Retirement Age & Vesting
Retirement age as defined by the plan is 59 ½ years of age. All contributions are 100% vested immediately.

Forfeitures
Contributions are 100% vested immediately therefore there are no forfeitures.

Funding
For the year ended September 30th, contributions by employees amounted to $289,772. The outstanding liability to the plan at year-end was $0.

NOTE 11 - OPERATING LEASES

The Entity has entered into various operating leases for the use of real and personal property. Operating leases do not give rise to property rights or lease obligations, and therefore, the results of the lease agreements are not reflected in the financial statements. Lease expense for the fiscal year was approximately $190,996.

The future minimum lease obligations as of September 30th, were as follows:

Year Ending September 30th	Amount
2020	190,749
2021	193,994
2022	197,305
2023	200,681
2024	152,221

NOTE 12 - RISK MANAGEMENT

MMRMA
The Entity is exposed to various risks of loss related to theft of, damage to, and destruction of assets; errors and omissions; injuries; and natural disasters. The Entity participated in the public entity risk pool – Michigan Municipal Risk Management Authority (MMRMA) for auto and general liability, property and crime and vehicle physical damage coverage.

MMRMA, a separate legal entity, is a self-insured association organized under the laws of the State of Michigan to provide self-insurance protection against loss and risk management services to various Michigan governmental entities.

As a member of this pool, the Entity is responsible for paying all losses, including damages, loss adjustment expenses and defense costs, for each occurrence that falls within the member's self-insured retention. If a covered loss exceeds the Entity's limits, all further payments for such loss are the sole obligation of the Entity. If for any reason MMRMA's resources available to pay losses are depleted, the payment of all unpaid losses of the Entity is the sole obligation of the Entity. Settled claims have not exceeded the amount of coverage in any of the past three years.

The Entity's coverage limits are $10,000,000 for general and public officials' liability, $1,500,000 vehicles, and $1,519,135 for buildings and personal property.

Medicaid Risk Reserve
The Entity covers the costs up to 105% of the annual Medicaid and Healthy Michigan contract. The Entity and MDHHS equally share the costs between 105% to 110% of the contract amounts. Costs in excess of 110% of the contract are covered entirely by MDHHS.

The Entity has established a Medicaid Risk Reserve Fund, in accordance with MDHHS guidelines, to assist in managing any potential operating shortfalls (as noted above) under the terms of its contract with the MDHHS.

NOTE 13 – CONTINGENT LIABILITIES

Under the terms of various federal and state grants and regulatory requirements, the Entity is subject to periodic audits of its agreements, as well as a cost settlement process under the full management contract with the regional entity and the state. Such audits could lead to questioned costs and/or requests for reimbursement to the grantor or regulatory agencies. Cost settlement adjustments, if any, as a result of compliance audits are recorded in the

year that the settlement is finalized. The amount of expenses which may be disallowed, if any, cannot be determined at this time, although the Entity expects such amounts, if any, to be immaterial.

NOTE 14 – ECONOMIC DEPENDENCE

The Entity receives over 95% of its revenues directly from the State of Michigan.

NOTE 15 – TRANSFERS

The Medicaid Risk Reserve Fund transferred $4,100,216 to the Mental Health Operating Fund during the year to cover overspending of the Medicaid Managed Care Specialty Services Program Contract.

NOTE 16 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 84, Fiduciary Activities, was issued by the GASB in January 2017 and will be effective for the Entity's 2019-2020 fiscal year. The objective of this Statement is to improve guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. This Statement establishes criteria for identifying fiduciary activities for all state and local governments. The focus on the criteria generally is on (1) whether a government is controlling the assets of the fiduciary activity and (2) the beneficiaries with whom a fiduciary relationship exists. An activity meeting the criteria should be reported in a fiduciary fund in the basic financial statements. Entities with activities meeting the criteria should present a statement of fiduciary net position and a statement of changes in fiduciary net position.

GASB Statement No. 87, Leases, was issued by the GASB in June 2017 and will be effective for the Entity's 2020-2021 fiscal year. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities.

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Southwest Michigan Behavioral Health (the Entity), as of and for the year ended September 30, 2019, and the related notes to the financial statements, which collectively comprise the Entity's basic financial statements, and have issued our report thereon dated March 30, 2020.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Entity's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control. Accordingly, we do not express an opinion on the effectiveness of the Entity's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Entity's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
March 30, 2020


RPC
Roslund Prestage & Company
Certified Public Accountants

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
March 13, 2020
9:30 am-11:30 am
5250 Lovers Lane, Suite 200, Portage, MI 49002
Draft: 3/17/20

Members Present: Tom Schmelzer

Members Present via phone: Edward Meny, Susan Barnes, Robert Nelson, Michael McShane, Pat Garrett, Robert Becker, Pat Guenther, Jon Houtz, and Janet Bermingham

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Joel Smith, Director of SUD Treatment and Prevention Services, SWMBH; Deb Hess, Van Buren Community Mental Health; Sue Germann, Pines Behavioral Health; Kris Kirsch, St. Joseph Community Mental Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Richard Thiemkey, Barry County Community Mental Health; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Mary Ann Bush, Senior Operations Specialist and Project Coordinator, SWMBH; Patrick Hawthorne, GVSU Graduate Student

Welcome Guests

Tom Schmelzer called the meeting to order at 9:30 am, introductions were made, and Tom welcomed the group. Tom Schmelzer asked for a moment of silence to honor the late Moses Walker and his contributions to the Behavioral Health field. A moment of silence was observed, and Tom Schmelzer commented that Moses Walker was "a Kalamazoo icon," he was honored to have known Moses, may he be remembered and rest in peace.

Public Comment

Patrick Hawthorne introduced himself and discussed his education and background. Patrick Hawthorne is job shadowing Brad Casemore for the day. The Board welcomed him.

Agenda Review and Adoption

Motion	Edward Meny moved to accept the agenda as presented.	
Second	Robert Becker	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

Financial Interest Disclosure Handling

Mila Todd reviewed the Financial Interest and Conflict of Interest statements from Erik Krogh.

Motion	Edward Meny moved that a conflict of interest exists, the Board is not able to obtain a more advantageous transaction or arrangement from someone other than Erik Krogh, the Financial Interest disclosed by Erik Krogh on the SWMBH Financial Interest Disclosure Statement is not so substantial as to be likely to affect the integrity of services SWMBH may expect to receive from Erik Krogh, and the conflict should be waived.	
Second	Susan Barnes	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes
Motion Carried		

Mila Todd reviewed the Financial Interest and Conflict of Interest statements from Randy Hyrns.

Motion	Robert Becker moved that a conflict of interest exists, the Board is not able to obtain a more advantageous transaction or arrangement from someone other than Randy Hyrns, the Financial Interest disclosed by Randy Hyrns on the SWMBH Financial Interest Disclosure Statement is not so substantial as to be likely to affect the integrity of services SWMBH may expect to receive from Randy Hyrns, and the conflict should be waived.	
Second	Edward Meny	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes
Motion Carried		

Mila Todd reviewed the Financial Interest and Conflict of Interest statements from Tim Smith.

Motion	Susan Barnes moved that a conflict of interest exists, the Board is not able to obtain a more advantageous transaction or arrangement from someone other than Tim Smith, the Financial Interest disclosed by Tim Smith on the SWMBH Financial Interest Disclosure Statement is not so substantial as to be likely to affect the integrity of

	services SWMBH may expect to receive from Tim Smith, and the conflict should be waived.	
Second	Michael McShane	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes
Motion Carried		

Consent Agenda

Motion	Edward Meny moved to approve the January 10, 2020 Board meeting minutes as presented.	
Second	Susan Barnes	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes
Motion Carried		

Operations Committee

Operations Committee Minutes December 18, 2019 and January 29, 2020

Tom Schmelzer asked for comments or questions. Minutes accepted.

Ends Metrics

Fiscal Year 2019 Customer Satisfaction Survey Results

Jonathan Gardner reported as documented. Discussion followed.

Motion	Pat Garrett moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.	
Second	Edward Meny	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

SWMBH 2019 Health Services Advisory Group (HSAG) External Quality Review Compliance Monitoring Report

Jonathan Gardner reported as documented. Discussion followed.

Motion	Edward Meny moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.	
Second	Robert Becker	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

Fiscal Year 2019 Performance Bonus Incentive Program Results

Jonathan Gardner reported as documented. Discussion followed.

Motion	Edward Meny moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.	
Second	Pat Garrett	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

Board Actions to be Considered

Operations Committee Self-Evaluation

Brad Casemore reported as documented. Discussion followed.

Motion	Pat Garrett moved to acknowledge the report as presented.	
Second	Susan Barnes	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes

	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

Operating Agreement Revisions

Brad Casemore reported as documented. Discussion followed.

Motion	Edward Meny moved to accept the revised Operating Agreement as presented.	
Second	Pat Guenther	
Roll call vote	Edward Meny	yes
	Pat Garrett	yes
	Michael McShane	yes
	Robert Becker	yes
	Susan Barnes	yes
	Pat Guenther	yes
	Tom Schmelzer	yes

Motion Carried

Board Policy Review

None scheduled

Executive Limitations Review

None scheduled

Board Education

Final Fiscal Year 2019 Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Fiscal Year 2019 Program Integrity Compliance Program Evaluation

Mila Todd reported as documented. Discussion followed.

Fiscal Year 2019 HIPPA Privacy/Security Report

Mila Todd and Natalie Spivak reported as documented. Discussion followed.

Integrated Care

Moira Kean reported as documented. Discussion followed.

Michigan Health Endowment Fund (MHEF) Grant Update

Moira Kean reported status and recent activities. Discussion followed.

Auditor Procurement

Tracy Dawson stated that SWMBH will be issuing an RFP within the next 30 days. Four to five auditing firms have been identified.

System Reform Part 1

Mary Ann Bush stated that binders containing documents and information will be distributed and/or mailed to each Board member. New documents and information will be sent out to add to the binders. These binders are to be used to educate and inform the Board on proposed State reforms to behavioral health. Please take some time to read through the information.

Communication and Counsel to the Board

Performance Bonus Incentive Program Fiscal Year 2019 Dollars

Tracy Dawson reported as documented, noting that funds will be distributed locally as soon as the funds are received from the State. Discussion followed.

April 17, 2020 Public Policy Legislative Event

Brad Casemore and Mary Ann Bush reported that the event has been postponed until further notice. Brad asked each county to share with their respective stakeholders.

May 8, 2020 Board Retreat

Brad Casemore and Mary Ann Bush reported as documented.

Michigan Consortium for Healthcare Excellence (MCHE) MCG Invoice

Brad Casemore reported as documented. There were no questions from the Board.

2019 Admissions Data and Prevention Outcomes Reports

Joel Smith reported as documented. Discussion followed.

Mr. Meny Letter to DHHS

Edward Meny reported as documented and stated that he received a response from Senator LaSata and also met with her. Edward Meny shared that Representatives seem to require education about behavioral health reform proposals. Discussion followed.

2020 Election Outlook

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

Federal Developments

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

Open Minds Article

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

Dr. Joneigh Khaldun Visit

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

Board Member Attendance Roster

Tom Schmelzer noted the document is in the packet for the Board's review.

April 10, 2020 Board Agenda

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

President and Governor's Fiscal Year 2021 Budget Proposals

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

COVID 19 Update

Brad Casemore updated the Board on SWMBH COVID 19 responses to date as follows:

SWMBH Duties:

Our Beneficiaries
Our Staff
Our Calls
Our Providers
Our ICOs
Our Building

Governor Whitmer declared State of Emergency and all Public Schools are closed
SWMBH has:

- Made all meetings phone and webinar-at least through the end of March
- Asked non-staff not to visit our office- at least through the end of March
- Service Master cleaning on 3/14
- Social distancing required
- Lysol treatment to all office areas on 3/7
- Advised staff to stay home if sick (or will be sent home)
- Consulted with staff RN

Oakland Community Health Network

Brad Casemore announced that he is one of three finalists for the open CEO position at Oakland Community Health Network (OCHN). The OCHN Board is planning to make a final decision at their 3/26/20 Board meeting. Brad Casemore will keep the SWMBH Board informed as decision are made.

Public Comment

None

Adjournment

Motion Edward Meny moved to adjourn at 11:35am
Second Robert Becker
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: February 26, 2020
9:00am-2:00pm

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

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, QAPI Director, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Jane Konyndyk, Integrated Services of Kalamazoo; Mary Ann Bush, Senior Operations Specialist and Project Coordinator

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

Review and approve agenda – Agenda approved.

Review and approve minutes from 1/29/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 YTD Financials – Tracy Dawson stated financials are not ready as one CMHSP has not submitted their numbers. Tracy Dawson will send the financials as soon as they are ready. Tracy Dawson shared that the State took back the double payments for unenrolled and that the HSW payments are not correct yet. Discussion followed.

Fiscal Year 2019 Encounters/MUNC – Tracy Dawson reported as documented.

Rate Setting Update – Tracy Dawson stated that a March or April meeting has been discussed but no date confirmed.

Fiscal Year 2020 Encounters – Tracy Dawson reported as documented.

Cost Allocation Workgroup – No updates to report.

Death Audit Recoupments – Tracy Dawson reported that the State announced no recoupment for February or March. Discussion followed.

Operating Agreement Review – Brad Casemore noted that only one change was made to the Operating Agreement. The change was Kalamazoo Community Mental Health and Substance Abuse Services changed to Integrated Services of Kalamazoo.

Kris Kirsch moved that the revised Operating Agreement be approved as presented. Role call vote as follows:

Jeff Patton	yes	Debra Hess	yes
Ric Compton	yes	Kris Kirsch	yes
Sue Germann	yes	Tim Smith	yes
Jeannie Goodrich	yes	Richard Thiemkey	yes

Motion Carried

Operations Committee Self-Evaluation – Brad Casemore reported as documented. Group discussed and selected four slides to present at the March Board meeting.

Advocates Wishes – Brad Casemore reported as documented. Discussion followed. Michelle Jacobs to email documents from packet to Operations Committee.

Strategic Imperative Descriptions – Brad Casemore reported as documented. Discussion followed and group would like to get feedback from their CMHSPs and review again at the March Operations Committee meeting.

Fiscal Year 2019 Performance Bonus Incentive Program – Tracy Dawson reported as documented.

Planning Schedule – Brad Casemore distributed a handout for consideration, review and discussion asking for CMHSP feedback for April Board meeting.

PIHP-DHHS Contract Development – Mila Todd reported that February's meeting was cancelled, and a new boilerplate contract will be discussed at the March meeting. Mila Todd also shared that the State overturned their decision regarding Behavioral Tech employment. Discussion followed.

Managed Care Functional Review Provider Network Management – Mila Todd stated that the group is working on overlapping site reviews and universal credentialing.

Fiscal Year 2019 Customer Satisfaction Survey Results – Jonathan Gardner reported as documented. Discussion followed.

Opioid Health Homes (OHH) – Brad Casemore stated that there is nothing new to report.

Medicaid Block Grant – Brad Casemore noted the materials in the packet for review. Jeff Patton added that Mental Health Block Grant can be used for jail services. A letter was distributed. Michelle Jacobs to email the letter to the group.

Dr. Khaldun Visit – Brad Casemore shared that there were no follow ups from Dr. Khaldun's visit. SWMBH sent her information and accomplishment from the region.

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

April 17th Public Policy Event Agenda – Mary Ann Bush reported as documented, noting the Eventbrite link and distributed save the date cards. Mary Ann Bush will email a format for each CMHSP to use when inviting constitutes and stakeholders.

May 8th SWMBH Board Retreat Draft Agenda – Mary Ann Bush reported as documented.

Fiscal Year 2020 Voluntary Performance Incentive – Brad Casemore stated that this has become too complex and will be dropped for this year.

House Bill 5178 – Brad Casemore noted the documented included in the packet for review.

Department of Health and Human Services Incentive Payment (**DHIP) Annual Reporting –** Brad Casemore noted the documented included in the packet for review.

Preadmission Screening and Resident Review – Brad Casemore noted the documented included in the packet for review.

Out of State Hospitalization – Mila Todd stated that the Attorney General is working on processes for patients receiving services in hospitals outside the state of Michigan.

Corrective Action Plans – Kris Kirsch discussed multiple corrective action plans received from SWMBH. Discussion followed.

Adjourned – Meeting adjourned at 12:45pm

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for January, February, March 2019
Board Date 4/10/20

Action items:

- Reviewed and approved Operating Agreement revisions
- Conducted Self-Evaluation, reviewed, discussed and approved report for Board
- Reviewed and discussed COVID 19 Responses including ongoing sharing among the CEOs of resources, plans and support

Discussion items:

- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some of the topics from this quarter included:
    - Reviewed year to date financial reports, actions being taken to decrease expenditures, and reviewed state level actions which impact financials
    - Reviewed Budget Assumptions and SWMBH/CMHSPs visits
    - Reviewed Fiscal Year 2020 Contract Status/Updates
    - Reviewed Performance Bonus Incentive Program Fiscal Year 2019 and 2020
    - Reviewed Public Policy Committee Status/Updates
    - Reviewed Michigan Mission Based Performance Indicator System (MMBPIS) Results and New Standards
    - Reviewed Fiscal Year 2019 Encounters and Year 2020 Encounters
    - Reviewed Individuals with Developmental Disabilities (I/DD) Level of Care (LOC) Guidelines
    - Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status and review
    - Reviewed Autism Spectrum Disorder Services reports and recommended guidelines
    - Reviewed Grant Updates
    - Reviewed and discussed various State and Milliman rate setting documents and Cost Allocation Workgroup updates
    - Reviewed various SWMBH Policies
    - Reviewed 2020-2021 Board Ends Metrics – Strategic Imperatives
    - Reviewed Fiscal Year 2020 Utilization Management Plan
    - Reviewed Fiscal Year 2019 Customer Services Report
    - Reviewed Fiscal Year 2019 Customer Satisfaction Survey Results
    - Reviewed Fiscal Year 2019 Medicaid Services Verification Report
    - Reviewed Managed Care Functional Review Provider Network Management Recommendations
    - Reviewed State death audit recoupments and various delays and issues regarding these recoupments
    - Reviewed of System Reform to Behavioral Health Services
    - Reviewed 2020-2022 SWMBH Strategic Imperative Descriptions and Priorities

Community Mental Health Association of Michigan

Winter 2020 Public Policy Update

System Redesign Overview

- Values and Goals of system redesign
- Specialty Integrated Plans (SIP) – Medicaid Benefit
- Safety Net Services
- Timeline
- Next Steps

Core Elements

Core elements of the proposed system

1. **Strong public safety net**
2. **Specialty Integrated Plans**

Values and Goals of system redesign

- Values
  - Person-centered, self-determined, community-based, recovery-oriented, evidence-based, culturally competent
- Goals
  - Broaden access to quality care
  - Improve coordination & cut red tape
  - Increase behavioral health investment and financial stability

Challenges People Face

Challenges people face

Specialty services not available for early intervention

Referral delays to CMH

Emergency department boarding

Provider shortages

Inconsistency in services across the system

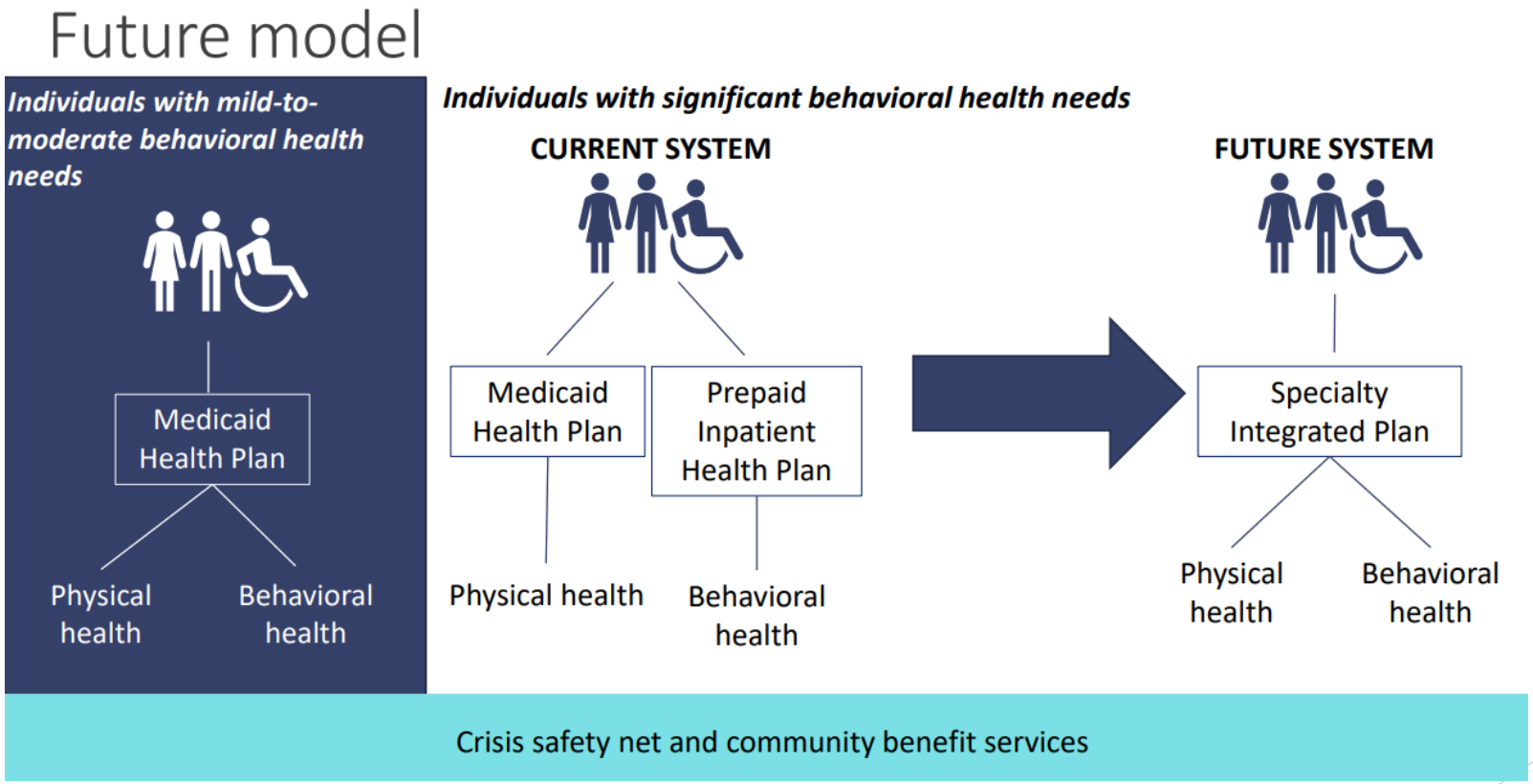
Navigating two systems to access support services

Staff turnover

Complex care coordination

Lack of coordination with primary care

DHHS Proposal – Specialty Integrated Plan



DHHS Proposal – Specialty Integrated Plan

Specialty Integrated Plans

Support from a specialized care team

Strong provider network

Choice for who manages your care

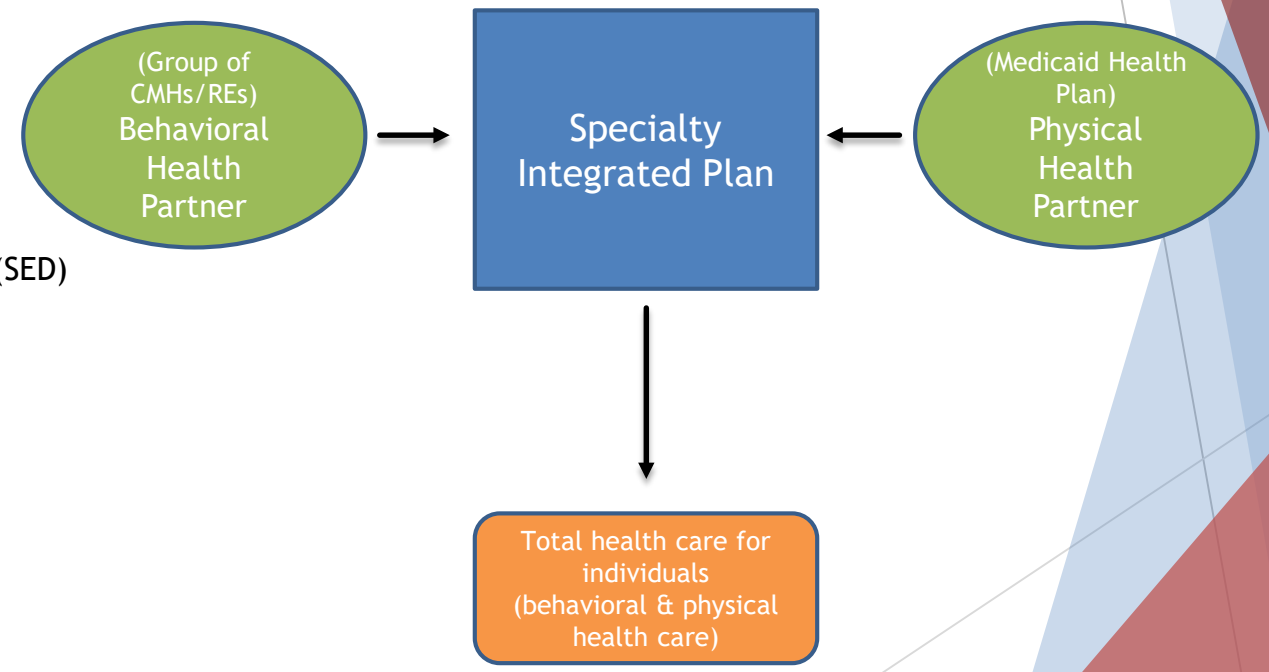
Whole-person plan with a full range of services

One place to go for help

What does a Specialty Integrated Plan look like?

- Who is in SIP?
- Medicaid & HMP beneficiaries:
  - Serious Mental Illness
  - Intellectual / developmental disabilities
  - Substance Use Disorder
  - Children w/ severe emotional disturbances (SED)
- Who is not included in SIP?
  - Unenrolled / Duals
  - Mild / moderate
  - SUD non-Medicaid

Population Carve Out for individuals with significant behavioral health needs



Options for SIPs

Specialty Integrated Plans

Will include at least one:

Public-led

- Could be led by statewide association of CMHs or other public entities
- Managed care and provider partners as needed

Additional options could include any of the following:

Plan-led

- Led by Medicaid Health Plan
- BH and provider partners as needed

Provider-led

- Led by association of providers and a hospital system
- Managed care partners as needed

Public/ private partnership

- Led by partnership among a Medicaid Health Plan, CMHs, FQHCs, and regional providers

- Led vs Partner/partnership
- Not a true public option

SIP Requirements

- All plans must meet certain requirements:
  - Fully-licensed and meets insurance regulatory requirements
  - Adequately capitalized and risk-bearing
  - Strong networks for health & specialty care
  - Typical health plan administrative infrastructure
  - Specialized care planning and management

DHHS Key components to SIP Proposal:

- Risk Bearing – transfer risk from state to SIPs
- Competition – how to make all stakeholders happy
- Financial Integration – directly related to risk bearing
- Statewide – preference but not deal killer

Impact on people receiving services

What people receiving services should expect

Most things will stay the same

- Benefits
- Person centered planning and self determination
- Mental Health Code protections and rights
- Able to get services at your CMH if you want
- Safety net there if you need it

A few things will change

- One care team to help you manage all your needs
- Providers more likely to coordinate your care
- Access to statewide provider network
- Ability to pick your plan (including a public-led option if you want)

Potential Impact on CMHs

What to expect as CMHs

Your role in the future

- Continue serving as the safety net for all Michiganders
- Part of the provider network of all SIPs
- Opportunity for expanded role as leader of public SIP(s), managing both behavioral and physical health needs

Changes you'll need to make

- Form new partnerships to serve as managed care entities
- Build new networks, clinical expertise, capital reserves, managed care functions
- Adjust accounting and billing

CMHA thoughts & concerns

1. Design element: Public Specialty Integrated Plan (SIP) formed as joint venture between Michigan's public mental health system and one private physical health plan

CMHA recommendations: A public SIP holds promise for system design success with the following components:

- Strong role of the public system in governance with over 50% of the governance seats are filled by public system representatives: persons served, advocates, CMHs, Regional Entities
- Strong role for the public system partner in operations
- DHHS takes an active role with changes to state statute (Mental Health Code and Insurance Code), state rules and regulations, and federal Medicaid waivers in the formation of this public/quasi-governmental SIP.
  - DHHS bring in KEY subject matter experts in development of entities – behavioral health, managed care, legal etc.

2. Design element: Fragmentation of Michigan's public behavioral health system by fostering the development of a number of private SIPs in addition to the public SIP.

CMHA recommendations: That the behavioral health safety net and population health focus of the state's public mental health system be strengthened, and its fragmentation be prevented through the development of a single SIP (statewide or single SIP per region) and that this SIP be designated the public SIP.

- The notion of competition causes an unnecessary set of complications:
  - Fragmentation of benefit
  - Loss of public resources
  - Barrier for public system to attract health plan partner
  - adverse selection / real choice

CMHA thoughts & concerns, cont.

3. Design element: Medicaid capitation payments to the public SIP based on the enrollment of the specialty population with the public SIP and not full Medicaid nor Healthy Michigan enrollment

CMHA recommendations: This payment structure, based on the enrollment of the specialty population with the public SIP and not full Medicaid nor Healthy Michigan enrollment, should be retained in the system design.

4. Design element: Provider network of public SIP not defined.

CMHA recommendations: That the CMH/Regional Entity and its provider network, should be the exclusive behavioral health provider network of the public SIP, with the exception of primary care providers providing prescription psychotropic medications.

- Others can be added and removed to the network through a mutual agreement of the SIP membership.

5. Design element: Payment method to be used by the SIP to its CMHs is not defined

CMHA recommendations: A sub-capitated payment structure, CMHs, paid via capitation, should be allowed to retain any savings generated within their sub-capitation, to meet the mental health and related social determinant needs of Medicaid enrollees and those without Medicaid coverage in their communities.

6. Design element: Party responsible for the management of the mild to moderate mental health benefit.

CMHA recommendations: Enrollees with mild to moderate mental health needs should be allowed to select enrollment in the public SIP or the benefit managed by the state's Medicaid Health Plans.

Details to be filled in

There are lots of details still to be filled in

- Management of the unenrolled and Medicare-Medicaid Duals population
- SUD funding and care delivery system
- Regional vs statewide design
- Safety net services vs SIP services and blended funding model
- Requirements to serve as a SIP
- SIP procurement process
- Care management model in SIPs
- Quality metrics and performance monitoring
- Rate structure
- Eligibility criteria for SIPs
- Enrollment and transition process for consumers
- Recipient rights structure in SIPs
- And many more…

Safety Net

Secure our safety net through the CMHs

- Uniform floor of statewide responsibilities
- Flexibility above floor
- Separate budgeting for non-Medicaid services

- Jail diversion
- 24/7 hotlines
- Community training
- Coordination with schools, police, corrections

Set of services and resources outside of Medicaid Specialty Integrated Plans

CMHA thoughts & concerns – Safety Net

Design element: Establishment of defined functions with earmarked General Fund and, potentially, Medicaid dollars, to CMHs, for fulfilling their safety net and community benefit functions

CMHA recommendations: This is a very strong component of the design and should be retained in the design. It is key that these General Fund and Medicaid dollars be built around the full set of safety net and community benefit roles played by the state's CMH system (organizer of care, community conveners and collaborators, advocates, and sources of guidance and expertise).

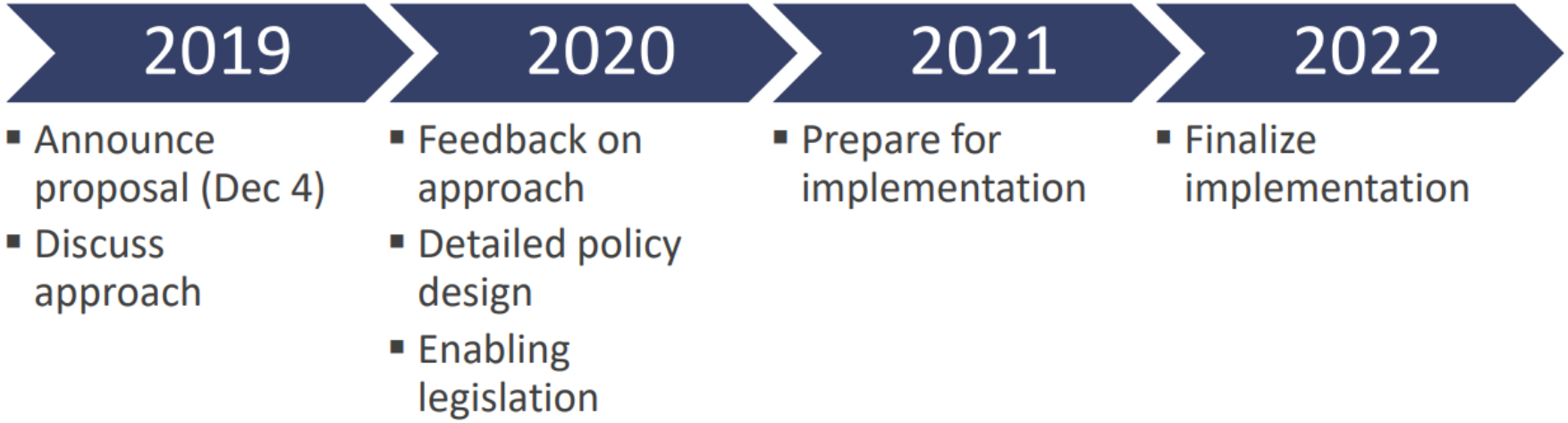
The nine essential functions contained in the federal Certified Community Behavioral Health (CCBHC) initiative, in the Michigan Mental Health Code, and the community leadership and convening roles of Michigan's CMHs provide a good start for identifying those roles and functions.

- Crisis mental health services – Screening, assessment and diagnosis, including risk assessment – Patient-centered treatment planning – Outpatient mental health and substance use services – Primary care screening and monitoring of key health indicators/health risk – Targeted case management – Psychiatric rehabilitation services – Peer support and family supports – Intensive, community-based mental health care for members of the armed forces and veterans

- How will this be funded? Most safety net services are comingled between GF & Medicaid.

Timeline

Proposed next steps: Timeline



Next Steps

- Statewide forums:
  - **Detroit** on January 8
  - **Grand Rapids** on January 9
  - **Marquette** on January 22
  - **Saginaw** on January 30
  - **virtual forum** on February 6
  - Grayling on February 21

- CMHA will:
  - develop recommendation through the system redesign work group.
  - Partner with statewide advocacy groups
  - Partner and recruit other stakeholders – MAC, Sheriffs, probate judges etc.
  - Reach out to Governor's office and start identifying potential legislative champions and influencers
- **Other options:**
  - Status quo not a viable option
  - DHHS is committed to plan – probably as far left as they will go
  - Legislative leaders are very skeptical of proposal – feel it is far too complicated (easier ways to do this)

FY21 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

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

FY21 Executive Budget Proposal

Other Highlights of the FY21 Executive Budget:

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

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

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

FY21 Executive Budget Proposal

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

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

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

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

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

FY21 Executive Budget Proposal

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

REDUCTIONS

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

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

What else is going on?

- State of the State – January 29
- Governor's FY21 Executive budget presentation – February 6

- Legislative Issues
  - HB 5178 – Universal credentialing
  - SB 672 & 673 – Certificate of need
  - HB 5043 – Mediation
  - FY19 Supplemental - $20.6 million
  - Pre-screening units – draft
  - CCBHC expansion grants ($2 million per year – 2 years)

Contact Information

Community Mental Health Association of Michigan

Alan Bolter

Associate Director

abolter@cmham.org

(517) 374-6848

American Society of Addiction Medicine (ASAM) Functional Assessment Tool Metric

FY19 Year-End Final Report

Metric Language: 95% of Functional Assessment tool detailed sub-element scores (LOCUS, ASAM, CAFAS, SIS) are received electronically by SWMBH from CMHSPs (By: 10/1/19)

- Intellectual Developmental Disabilities (Supports Intensity Scale - SIS)
- Substance Use Disorders (ASAM)
- Serious Mental Illness (Level of Care Utilization System - LOCUS)
- Serious Emotional Disturbances (Child and Adolescent Functional Assessments Scale – CAFAS and Preschool and Early Childhood Functional Assessment Scale - PECFAS)

ASAM Status – Not Met: The overall rate of assessment ASAM completeness was 94.1%, which was below the metric goal of 95%.

FY 2019	ASAM
Assessed	7057
Eligible	7503
Percent	94.1%

2020 Board Member Roster

Barry County

- Robert Nelson
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Vice-Chair
- Randy Hyrns (Alternate)

Branch County

- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County

- Patrick Garrett
- Kathy-Sue Vette (Alternate)

Cass County

- Michael McShane
- Vacant

Kalamazoo County

- Erik Krogh
- Patricia Guenther (Alternate)

St. Joseph County

- Janet Bermingham
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

Updated 3/13/20

2020-2022 Strategic Imperative Descriptions & Priorities

Proposed to SWMBH Board March 13, 2020. Revisions based on Environmental Scan. V 1/17/2020

Reviewed with Operations Committee on 2/26/20 and 3/25/20

- **1) Public Policy Legislative Education**
  - Inform legislators of Michigan statutory changes necessary for publicly led Specialty Integrated Plan
  - Inform executive branch of Michigan regulatory changes necessary for publicly led Specialty Integrated Plan
  - Inform legislators of potential negative impacts of Reforms on CMHSPs.
  - Inform Legislators of key Behavioral Health and SUD issues
  - Hold public policy & legislative education events

- **2) Uniformity of Benefits**
  - Ensure that persons served receive objectively appropriate services across all specialty populations
  - Automate Level of Care Guidelines and Utilization Management processes

  - **Use Level of Care Guidelines (LOCG) for service authorization consistency**
    - Consistent use, attached to Assessment Tool scores
    - Embedded in EMR and MCIS
    - Update LOCG Tables and business processes as necessary and indicated

  - **Consistent Use of Assessment Tools**
    - CMHSPs and Providers submit scores in detail as discrete data fields
    - Real-time, accessible analytics and reporting
    - Identification of outliers and trends for over- and under-utilization monitoring

- **3) Integrated Health Care**
  - Michigan Health Endowment Fund Grant success
  - Extend MI Health Link with Integrated Care Organizations beyond 12/31/2020
  - Multi-agency Performance Improvement Projects
  - Improve CMHSP and PIHP communications with primary physical health providers
  - Improve SWMBH communications with Medicaid Health Plans

- **4) Revenue Maximization/Diversification**
  - Assure capture of Performance Bonus Incentive Pool funds
  - Continue assertive efforts internally and externally to maximize regional capitation funds
  - Assess SWMBH opportunities for Grants, alternative funding streams, and expanded or new business lines
  - Assess CMHSP opportunities for Grants, alternative funding streams, and expanded or new business lines, upon request

  - **Cost reductions in Medical Loss Ratio and Administrative Loss Ratio**
    - Support CMHSP cost reduction strategies, upon request

- **5) Improve Healthcare Information Exchange, Analytics and Business Intelligence**
  - Improve Health Information Exchange systems
  - Improve healthcare data analytics capabilities

- Regional individual access to industry standard management information tools

- **6) Managed Care Functional Review**
  - Build consistency, replicability and scalability for all managed care functions

- **7) Proof of Value and Outcomes**
  - Create, monitor and publish proofs of clinical and administrative performance
  - Maintain NCQA MBHO Accreditation
  - Consider other NCQA Accreditations and/or Certifications
  - Assure Program Integrity

2020-2022 Strategic Imperative Descriptions & Priorities

Proposed to SWMBH Board March 13, 2020. Revisions based on Environmental Scan. V 1/17/2020

- **1) Public Policy Legislative Education**
  - **Inform legislators of Michigan statutory changes necessary for publicly led Specialty Integrated Plan**
  - **Inform executive branch of Michigan regulatory changes necessary for publicly led Specialty Integrated Plan**
  - **Inform legislators of potential negative impacts of Reforms on CMHSPs.**
  - Inform Legislators of key Behavioral Health and SUD issues
  - Hold public policy & legislative education events

- **2) Uniformity of Benefits**
  - Ensure that persons served receive objectively appropriate services across all specialty populations
  - Automate Level of Care Guidelines and Utilization Management processes

  - **Use Level of Care Guidelines (LOCG) for service authorization consistency**
    - Consistent use, attached to Assessment Tool scores
    - Embedded in EMR and MCIS
    - Update LOCG Tables and business processes as necessary and indicated

  - **Consistent Use of Assessment Tools**
    - CMHSPs and Providers submit scores in detail as discrete data fields
    - Real-time, accessible analytics and reporting
    - Identification of outliers and trends for over- and under-utilization monitoring

- **3) Integrated Health Care**
  - Michigan Health Endowment Fund Grant success
  - Extend MI Health Link with Integrated Care Organizations beyond 12/31/2020
  - Multi-agency Performance Improvement Projects
  - Improve CMHSP and PIHP communications with primary physical health providers
  - Improve SWMBH communications with Medicaid Health Plans

- **4) Revenue Maximization/Diversification**
  - Assure capture of Performance Bonus Incentive Pool funds
  - Continue assertive efforts internally and externally to maximize regional capitation funds
  - Assess SWMBH opportunities for Grants, alternative funding streams, and expanded or new business lines
  - Assess CMHSP opportunities for Grants, alternative funding streams, and expanded or new business lines, upon request

  - **Cost reductions in Medical Loss Ratio and Administrative Loss Ratio**
    - Support CMHSP cost reduction strategies, upon request
    -

- **5) Improve Healthcare Information Exchange, Analytics and Business Intelligence**
  - Improve Health Information Exchange systems
  - Improve healthcare data analytics capabilities
  - Regional individual access to industry standard management information tools

- **6) Managed Care Functional Review**
    - Build consistency, replicabiliuty and scalability for all managed care functions
- **7) Proof of Value and Outcomes**
    - Create, monitor and publish proofs of clinical and administrative performance
    - Maintain NCQA MBHO Accreditation
    - Consider other NCQA Accreditations and/or Certifications
    - Assure Program Integrity

2019 Strategic Imperative Descriptions & Priorities

- **1) Public Policy Legislative Education**
  - Inform Legislators of key Behavioral Health and SUD issues
  - Hold public policy & legislative education/coordination sessions

- **2) Uniformity of Benefits**
  - Ensuring consumers are receiving fair and consistent services across all service determinations
  - Automated wherever possible
  - CMHSP Peer Case Reviews & Site Visits
  - Will use to modify LOCG Tables and fiscal year 2019 budgets

  - **Use of Level of Care Guidelines (LOCG) for service authorization consistency**
    - Consistent use, attached to Assessment Tool scores
    - Embedded in EMR and MCIS
    - Update LOCG Tables and business processes to state wide approach

  - **Consistent Use of Assessment Tools**
    - Scores submissions, detail, discrete data
    - Analytics and reporting
    - Identification of outliers and trends
    - Data available for decision making

- **3) Population Health Management**
  - Collaborative relationships with our Integrated Healthcare partners
  - Shared Performance Improvement Projects
  - Improve communications between Physical and Mental Health providers

- **4) Revenue Maximization/Diversification**
  - Performance Bonus Pools
  - Grants and other alternative funding streams/business lines
  - Cost Sharing
  - Contract Services

  - **Cost reductions in Medical Loss Ratio and Administrative Loss Ratio**
    - CMHSP cost reduction strategies
    - Service consistency reviews

- **5) Improved Analytics and Business Intelligence**
  - Improve Information Exchange systems
  - Access to cutting edge data resources/tools
  - Access and ability to act on real-time information

- **6) Managed Care Functional Review**
  - Building consistency within the Regional Utilization Management Processes

- **7) Proof of Value Outcomes**
  - Accreditations
  - Assure Program Integrity
  - Integrated Care Measures
  - Performance Improvement Projects

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Board Governance/Management	Policy Number: BG-006	Pages: 1
Subject: Annual Board Planning Cycle	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 01.10.2014	**Last Review Date**: 4/12/19	**Past Review Dates**: 1.09.15, 2/12/16, 2/10/17, 1/12/18, 1/11/19

I. **PURPOSE:**

To organize the timing, process, content and outcomes of an annual planning process.

II. **POLICY:**

To accomplish its job, the Board will adopt an annual calendar which (a) completes a thorough review of Accomplishments/Ends annually, (b) continually improves its performance through attention to Board education and deliberation, (c) formally reviews all Board Policies, and (d) sets primary strategic imperatives for a following 12-18 month period.

III. **STANDARDS:**

a. Completes a thorough review of Accomplishments/Ends annually;

   Ends, Ends Interpretations and Ends Metrics are handled on both calendar years and fiscal years. Ends, Ends Interpretations and prospective Ends Metrics are proposed to Board no later than November and December of each year. They are first reviewed with the Operations Committee for advice and support.

   Ends Metrics status and final reports are provided to the Board throughout the year, based upon a Board-approved reporting calendar. Ideally a majority of Ends Metrics are reported before or at the November Board meeting.

b. Continually improves its performance through attention to Board education and deliberation;

c. Formally reviews all Board Policies annually. [Please note, Board can make some or all policies more or less frequent.]

   A prospective Board-approved calendar year events & activities calendar is proposed to the Board each December. It shall include: Board review calendar with Board Member assignments; required Board actions; Board-determined Board action; Ends Metrics Reporting; Executive Limitations, and Board-Staff Relationship Policy review.

d. Sets primary strategic imperatives for a following 12-18 month period.

January- May Preparatory Strategic Planning Work

April-May: Environmental Scan and Strategic Imperatives Review with Board.

May- Board Retreat

July- 24-month Strategic Plan draft

- Mission
- Capital
- Market
- Growth
- Products
- Alliances

September- Budget Board review and approval.

Attachment: Calendar Year Board Calendar.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-010	Pages: 1
Subject: Board Committee Principles	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 03.14.2014	**Last Review Date**: 4/12/19	**Past Review Dates**: 03.13.15, 04.10.15, 4/8/16, 4/14/17, 4/13/18

I. **PURPOSE:**
To define SWMBH Board committee principles.

II. **POLICY:**
Board committees, when used, will be assigned so as to reinforce the wholeness of the Board's job and to not interfere with delegation from the Board to the EO.

III. **STANDARDS:**
Accordingly the Committees shall:

1. Assist the Board by preparing policy alternatives and implications for Board deliberation. In keeping with the Board's broader focus, Board committees will normally not have direct dealings with current staff operations.

2. Not speak or act for the Board except when formally given such authority for specific and time-limited purposes.

3. Not exercise authority over staff.

4. Be used sparingly and ordinarily in an ad hoc capacity.

5. This policy applies to any group that is formed by Board action, whether or not it is called a committee and regardless of whether the group includes Board members. It does not apply to committees formed under the authority of the EO.

	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 2/29/2020			P05FYTD20	5									
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			113,237,928	86,285,569	14,227,765	6,981,460	1,487,157	3,257,104	998,874	-	-	-	
17	DHHS Incentive Payments			301,809	301,809	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			658,306	-	-	-	-	658,306	-	-	-	-	
19	Interest Income - Working Capital			68,353	-	-	-	-	-	-	68,353	-	-	
20	Interest Income - ISF Risk Reserve			3,220	-	-	-	-	-	-	3,220	-	-	
21	Local Funds Contributions			719,247	-	-	-	-	-	-	719,247	-	-	
22	Other Local Income			105,288	-	-	-	-	-	-	105,288	-	-	
24	**TOTAL REVENUE**			**115,094,151**	**86,587,378**	**14,227,765**	**6,981,460**	**1,487,157**	**3,915,411**	**998,874**	**896,108**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			10,084,314	1,810,174	2,659,868	-	1,785,393	3,256,400	572,480	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			91,125,506	74,405,065	8,452,221	7,202,134	634,347	431,739	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			1,174,246	1,174,246	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			1,423,884	1,423,884	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,052,785	-	-	(1,052,785)	-	-	-	-	-	
34	**Total Healthcare Cost**			**103,807,949**	**79,866,153**	**11,112,089**	**7,202,134**	**1,366,955**	**3,688,139**	**572,480**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**91.4%**	**92.2%**	**78.1%**	**103.2%**	**91.9%**	**113.2%**	**57.3%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			215,869	-	-	-	-	-	-	215,869	-	-	
39	Administrative and Other Cost			2,934,060	-	-	-	-	-	-	2,928,773	-	5,287	
41	Depreciation			42,322	-	-	-	-	-	-	42,322	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	111,827	-	(111,827)	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	5,287	-	(5,287)	
44	Delegated Managed Care Admin			6,827,212	5,615,487	625,219	539,817	46,689	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	2,315,461	337,591	218,805	73,513	115,445	-	(3,060,815)	-	-	
47	**Total Administrative Cost**			**10,019,462**	**7,930,947**	**962,810**	**758,622**	**120,202**	**227,272**	**-**	**19,608**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**8.8%**	**9.0%**	**8.0%**	**9.5%**	**8.1%**	**5.8%**	**0.0%**	**2.7%**			
49														
50	Local Funds Contribution			719,247	-	-	-	-	-	-	719,247	-	-	
52	**TOTAL COST after apportionment**			**114,546,658**	**87,797,101**	**12,074,899**	**7,960,756**	**1,487,157**	**3,915,411**	**572,480**	**738,855**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**547,494**	**(1,209,723)**	**2,152,866**	**(979,296)**	**-**	**(0)**	**426,394**	**157,253**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**0.5%**	**-1.4%**	**15.1%**	**-14.0%**	**0.0%**	**0.0%**	**42.7%**	**17.5%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(426,393)	-	-	-	-	-	(426,393)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,220)	-	-	-	-	-	-	(3,220)			
60	ISF Risk Reserve Deficit (Funding)			36,153	36,153	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	1,173,570	(2,152,866)	979,296	-	0	(0)	-			
62	**NET SURPLUS (DEFICIT)**			**154,033**	**-**	**-**	**-**	**-**	**-**	**-**	**154,033**	**-**	**-**	
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)			154,033	-	-	-	-	-	-	154,033	-	-	
71	**NET SURPLUS (DEFICIT)**			**154,033**	**-**	**-**	**-**	**-**	**-**	**-**	**154,033**	**-**	**-**	
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 2/29/2020			5									
3	*(For Internal Management Purposes Only)*			ok									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			*HCC%*	78.3%	76.4%	75.4%	78.6%	75.1%	80.4%	80.9%	85.9%	76.9%
7	Subcontract Revenue		86,285,569	6,297,381	79,988,187	3,355,771	15,560,486	4,340,094	14,504,442	4,414,613	24,688,318	5,415,493	7,708,971
8	Incentive Payment Revenue		301,809	180,616	121,193	13,767	-	7,942	38,123	(60)	58,773	-	2,647
9	**Contract Revenue**		**86,587,378**	**6,477,998**	**80,109,380**	**3,369,537**	**15,560,486**	**4,348,037**	**14,542,566**	**4,414,553**	**24,747,091**	**5,415,493**	**7,711,618**
10													
11	External Provider Cost		56,439,019	1,810,174	54,628,845	1,732,839	10,687,389	2,719,155	9,523,096	2,600,698	19,290,648	3,988,368	4,086,652
12	Internal Program Cost		20,702,470	-	20,702,470	1,201,377	4,206,378	1,105,851	4,287,534	1,282,472	3,675,628	1,923,621	3,019,609
13	SSI Reimb, 1st/3rd Party Cost Offset		(296,000)	-	(296,000)	(8,350)	(5,482)	(19,177)	(83,187)	(2,861)	(133,909)	(10,616)	(32,419)
14	Insurance Provider Assessment Withhold (IPA)		2,598,130	2,598,130	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		371,749	371,749	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**79,815,368**	**4,780,052**	**75,035,315**	**2,925,865**	**14,888,285**	**3,805,830**	**13,727,443**	**3,880,309**	**22,832,367**	**5,901,373**	**7,073,842**
17	**Medical Loss Ratio (HCC % of Revenue)**		**92.2%**	**73.8%**	**93.7%**	**86.8%**	**95.7%**	**87.5%**	**94.4%**	**87.9%**	**92.3%**	**109.0%**	**91.7%**
18													
19	**Managed Care Administration**		**7,977,637**	**2,315,461**	**5,662,176**	**218,066**	**1,064,583**	**333,508**	**895,330**	**334,515**	**1,970,228**	**389,709**	**456,237**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.1%**	**2.6%**	**6.4%**	**6.9%**	**6.7%**	**8.1%**	**6.1%**	**7.9%**	**7.9%**	**6.2%**	**6.1%**
21													
22	**Contract Cost**		**87,793,004**	**7,095,513**	**80,697,491**	**3,143,931**	**15,952,869**	**4,139,338**	**14,622,773**	**4,214,825**	**24,802,596**	**6,291,082**	**7,530,079**
23	**Net before Settlement**		**(1,205,626)**	**(617,515)**	**(588,111)**	**225,606**	**(392,383)**	**208,699**	**(80,207)**	**199,728**	**(55,505)**	**(875,588)**	**181,539**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		1,173,570	585,459	588,111	(225,606)	392,383	(208,699)	80,207	(199,728)	55,505	875,588	(181,539)
28	**Net after Settlement**		**(32,056)**	**(32,056)**	**(0)**	-	-	-	-	-	-	-	-
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		147,569	147,569	147,569	7,554	28,501	8,182	27,959	8,747	38,795	12,221	15,610
32	Revenue PMPM		$ 117.35	$ 8.78	$ 108.57	$ 89.21	$ 109.19	$ 106.28	$ 104.03	$ 100.94	$ 127.58	$ 88.63	$ 98.80
33	Expense PMPM		$ 118.99	$ 9.62	$ 109.37	$ 83.24	$ 111.95	$ 101.18	$ 104.60	$ 96.37	$ 127.86	$ 102.96	$ 96.48
34	Margin PMPM		$ (1.63)	$ (0.84)	$ (0.80)	$ 5.97	$ (2.75)	$ 5.10	$ (0.57)	$ 4.57	$ (0.29)	$ (14.33)	$ 2.33
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		147,569	147,569	147,569	7,554	28,501	8,182	27,959	8,747	38,795	12,221	15,610
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)		(838)	(838)	(838)	33	(471)	(255)	46	197	(328)	(1)	(59)
43	% Variance - Fav / (Unfav)		-0.6%	-0.6%	-0.6%	0.4%	-1.6%	-3.0%	0.2%	2.3%	-0.8%	0.0%	-0.4%
44													
45	**Contract Revenue before settlement**												
46	Actual		86,587,378	6,477,998	80,109,380	3,369,537	15,560,486	4,348,037	14,542,566	4,414,553	24,747,091	5,415,493	7,711,618
47	Budget		85,028,687	7,184,183	77,844,505	3,081,824	15,498,391	4,162,179	14,284,626	4,063,484	24,068,837	5,225,404	7,459,759
48	Variance - Favorable / (Unfavorable)		1,558,691	(706,185)	2,264,876	287,713	62,095	185,858	257,939	351,069	678,254	190,089	251,859
49	% Variance - Fav / (Unfav)		1.8%	-9.8%	2.9%	9.3%	0.4%	4.5%	1.8%	8.6%	2.8%	3.6%	3.4%
50													
51	**Healthcare Cost**												
52	Actual		79,815,368	4,780,052	75,035,315	2,925,865	14,888,285	3,805,830	13,727,443	3,880,309	22,832,367	5,901,373	7,073,842
53	Budget		79,437,181	4,304,184	75,132,997	3,240,073	15,188,776	3,983,005	13,393,648	3,856,990	22,773,128	5,404,900	7,292,476
54	Variance - Favorable / (Unfavorable)		(378,187)	(475,868)	97,681	314,208	300,491	177,175	(333,794)	(23,320)	(59,239)	(496,473)	218,633
55	% Variance - Fav / (Unfav)		-0.5%	-11.1%	0.1%	9.7%	2.0%	4.4%	-2.5%	-0.6%	-0.3%	-9.2%	3.0%
56													
57	**Managed Care Administration**												
58	Actual		7,977,637	2,315,461	5,662,176	218,066	1,064,583	333,508	895,330	334,515	1,970,228	389,709	456,237
59	Budget		8,577,402	2,903,304	5,674,098	241,272	1,132,203	332,630	966,640	295,536	1,914,387	337,468	453,962
60	Variance - Favorable / (Unfavorable)		599,765	587,843	11,922	23,206	67,620	(878)	71,310	(38,979)	(55,841)	(52,241)	(2,275)

	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 2/29/2020			5									
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													
61	% Variance - Fav / (Unfav)		7.0%	20.2%	0.2%	9.6%	6.0%	-0.3%	7.4%	-13.2%	-2.9%	-15.5%	-0.5%
62													
63	**Total Contract Cost**												
64	Actual		87,793,004	7,095,513	80,697,491	3,143,931	15,952,869	4,139,338	14,622,773	4,214,825	24,802,596	6,291,082	7,530,079
65	Budget		88,014,583	7,207,488	80,807,094	3,481,346	16,320,979	4,315,635	14,360,288	4,152,526	24,687,515	5,742,368	7,746,438
66	Variance - Favorable / (Unfavorable)		221,578	111,976	109,603	337,414	368,110	176,297	(262,484)	(62,299)	(115,081)	(548,714)	216,359
67	% Variance - Fav / (Unfav)		0.3%	1.6%	0.1%	9.7%	2.3%	4.1%	-1.8%	-1.5%	-0.5%	-9.6%	2.8%
68													
69	**Net before Settlement**												
70	Actual		(1,205,626)	(617,515)	(588,111)	225,606	(392,383)	208,699	(80,207)	199,728	(55,505)	(875,588)	181,539
71	Budget		(2,985,895)	(23,306)	(2,962,590)	(399,522)	(822,588)	(153,456)	(75,662)	(89,042)	(618,678)	(516,964)	(286,679)
72	Variance - Favorable / (Unfavorable)		1,780,269	(594,210)	2,374,479	625,128	430,205	362,155	(4,545)	288,770	563,173	(358,625)	468,217
73													
74													

83

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 2/29/2020			5									
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													
75	**Healthy Michigan Plan**			*HCC%*	8.8%	10.3%	9.7%	7.2%	11.6%	6.4%	7.4%	8.4%	7.5%
76	**Contract Revenue**		**14,227,765**	**3,017,623**	**11,210,142**	**535,312**	**2,317,196**	**520,104**	**2,026,484**	**662,903**	**3,174,419**	**890,759**	**1,082,965**
77													
78	External Provider Cost		7,294,660	2,659,868	4,634,792	159,467	1,122,098	112,398	1,052,451	64,020	1,597,195	214,781	312,382
79	Internal Program Cost		3,817,429	-	3,817,429	236,242	788,250	237,424	1,076,326	243,772	490,900	364,642	379,873
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**11,112,089**	**2,659,868**	**8,452,221**	**395,709**	**1,910,348**	**349,822**	**2,128,777**	**307,792**	**2,088,095**	**579,423**	**692,254**
82	**Medical Loss Ratio (HCC % of Revenue)**		**78.1%**	**88.1%**	**75.4%**	**73.9%**	**82.4%**	**67.3%**	**105.0%**	**46.4%**	**65.8%**	**65.0%**	**63.9%**
83													
84	**Managed Care Administration**		**962,810**	**337,591**	**625,219**	**29,492**	**136,599**	**30,655**	**138,843**	**26,534**	**180,184**	**38,263**	**44,648**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.0%**	**2.8%**	**5.2%**	**6.9%**	**6.7%**	**8.1%**	**6.1%**	**7.9%**	**7.9%**	**6.2%**	**6.1%**
86													
87	**Contract Cost**		**12,074,899**	**2,997,459**	**9,077,440**	**425,201**	**2,046,947**	**380,478**	**2,267,620**	**334,327**	**2,268,279**	**617,686**	**736,902**
88	**Net before Settlement**		**2,152,866**	**20,164**	**2,132,702**	**110,111**	**270,250**	**139,627**	**(241,136)**	**328,576**	**906,140**	**273,073**	**346,063**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,152,866)	(20,164)	(2,132,702)	(110,111)	(270,250)	(139,627)	241,136	(328,576)	(906,140)	(273,073)	(346,063)
93	**Net after Settlement**		**0**	**0**	-	-	-	-	-	-	-	-	-
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		50,685	50,685	50,685	2,454	10,447	2,379	9,089	3,112	14,217	4,017	4,969
97	Revenue PMPM		$ 56.14	$ 11.91	$ 44.23	$ 43.63	$ 44.36	$ 43.73	$ 44.59	$ 42.60	$ 44.66	$ 44.35	$ 43.59
98	Expense PMPM		47.65	11.83	35.82	34.66	39.19	31.99	49.90	21.49	31.91	30.75	29.66
99	Margin PMPM		$ 8.50	$ 0.08	$ 8.42	$ 8.98	$ 5.17	$ 11.74	$ (5.31)	$ 21.12	$ 12.75	$ 13.60	$ 13.93
100													
101	**Healthy Michigan Plan**												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		50,685	50,685	50,685	2,454	10,447	2,379	9,089	3,112	14,217	4,017	4,969
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		(885)	(885)	(885)	(59)	37	(52)	(79)	137	(835)	100	(134)
108	% Variance - Fav / (Unfav)		-1.7%	-1.7%	-1.7%	-2.3%	0.4%	-2.2%	-0.9%	4.6%	-5.5%	2.6%	-2.6%
109													
110	**Contract Revenue before settlement**												
111	Actual		14,227,765	3,017,623	11,210,142	535,312	2,317,196	520,104	2,026,484	662,903	3,174,419	890,759	1,082,965
112	Budget		12,094,590	2,090,083	10,004,507	483,023	2,018,564	468,845	1,790,235	570,129	2,937,338	757,025	979,347
113	Variance - Favorable / (Unfavorable)		2,133,175	927,540	1,205,635	52,289	298,632	51,259	236,249	92,773	237,081	133,733	103,618
114	% Variance - Fav / (Unfav)		17.6%	44.4%	12.1%	10.8%	14.8%	10.9%	13.2%	16.3%	8.1%	17.7%	10.6%
115													
116	**Healthcare Cost**												
117	Actual		11,112,089	2,659,868	8,452,221	395,709	1,910,348	349,822	2,128,777	307,792	2,088,095	579,423	692,254
118	Budget		10,469,885	2,422,094	8,047,791	575,314	1,203,522	527,429	1,984,917	409,348	2,136,783	485,547	724,931
119	Variance - Favorable / (Unfavorable)		(642,204)	(237,773)	(404,430)	179,605	(706,826)	177,607	(143,860)	101,555	48,687	(93,876)	32,677
120	% Variance - Fav / (Unfav)		-6.1%	-9.8%	-5.0%	31.2%	-58.7%	33.7%	-7.2%	24.8%	2.3%	-19.3%	4.5%
121													
122	**Managed Care Administration**												
123	Actual		962,810	337,591	625,219	29,492	136,599	30,655	138,843	26,534	180,184	38,263	44,648
124	Budget		1,002,357	396,067	606,290	42,841	89,713	44,047	143,254	31,366	179,625	30,316	45,128
125	Variance - Favorable / (Unfavorable)		39,547	58,476	(18,929)	13,348	(46,886)	13,392	4,412	4,831	(559)	(7,947)	480
126	% Variance - Fav / (Unfav)		3.9%	14.8%	-3.1%	31.2%	-52.3%	30.4%	3.1%	15.4%	-0.3%	-26.2%	1.1%
127													
128	**Total Contract Cost**												
129	Actual		12,074,899	2,997,459	9,077,440	425,201	2,046,947	380,478	2,267,620	334,327	2,268,279	617,686	736,902

	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 2/29/2020			5									
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													
130	Budget		11,472,242	2,818,162	8,654,080	618,155	1,293,235	571,476	2,128,171	440,713	2,316,408	515,863	770,059
131	Variance - Favorable / (Unfavorable)		(602,657)	(179,297)	(423,359)	192,954	(753,712)	190,998	(139,449)	106,387	48,129	(101,823)	33,157
132	% Variance - Fav / (Unfav)		-5.3%	-6.4%	-4.9%	31.2%	-58.3%	33.4%	-6.6%	24.1%	2.1%	-19.7%	4.3%
133													
134	**Net before Settlement**												
135	Actual		2,152,866	20,164	2,132,702	110,111	270,250	139,627	(241,136)	328,576	906,140	273,073	346,063
136	Budget		622,348	(728,079)	1,350,426	(135,132)	725,329	(102,631)	(337,936)	129,416	620,930	241,162	209,288
137	Variance - Favorable / (Unfavorable)		1,530,518	748,243	782,276	245,243	(455,079)	242,257	96,800	199,160	285,210	31,911	136,774
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 2/29/2020			5									
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%*	7.5%	5.2%	10.3%	9.6%	6.4%	5.8%	6.7%	2.6%	10.7%
141	**Contract Revenue**		**6,981,460**	**19,874**	**6,961,586**	**340,339**	**1,328,232**	**380,001**	**1,272,444**	**340,903**	**2,056,179**	**559,951**	**683,537**
142													
143	External Provider Cost		6,348,022	-	6,348,022	-	2,029,415	464,672	578,487	277,843	1,886,177	177,809	933,618
144	Internal Program Cost		854,112	-	854,112	197,865	2,068	2,486	598,748	-	-	4,258	48,688
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**7,202,134**	**-**	**7,202,134**	**197,865**	**2,031,483**	**467,158**	**1,177,235**	**277,843**	**1,886,177**	**182,067**	**982,307**
147	**Medical Loss Ratio (HCC % of Revenue)**		**103.2%**	**0.0%**	**103.5%**	**58.1%**	**152.9%**	**122.9%**	**92.5%**	**81.5%**	**91.7%**	**32.5%**	**143.7%**
148													
149	**Managed Care Administration**		**758,622**	**218,805**	**539,817**	**14,747**	**145,261**	**40,937**	**76,781**	**23,952**	**162,760**	**12,023**	**63,355**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.5%**	**2.7%**	**6.8%**	**6.9%**	**6.7%**	**8.1%**	**6.1%**	**7.9%**	**7.9%**	**6.2%**	**6.1%**
151													
152	**Contract Cost**		**7,960,756**	**218,805**	**7,741,951**	**212,612**	**2,176,743**	**508,095**	**1,254,016**	**301,795**	**2,048,937**	**194,090**	**1,045,662**
153	**Net before Settlement**		**(979,296)**	**(198,931)**	**(780,365)**	**127,727**	**(848,511)**	**(128,095)**	**18,428**	**39,108**	**7,242**	**365,860**	**(362,125)**
154	Contract Settlement / Redistribution		979,296	198,931	780,365	(127,727)	848,511	128,095	(18,428)	(39,108)	(7,242)	(365,860)	362,125
155	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.4%	3.8%	0.6%	0.8%	0.0%	0.8%	0.0%	1.0%	0.3%
159	**Contract Revenue**		**3,257,104**	**2,725,571**	**531,533**	**38,101**	**197,086**	**14,567**	**-**	**49,211**	**112,984**	**79,693**	**39,891**
160													
161	External Provider Cost		3,256,400	3,256,400	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		431,739	-	431,739	144,608	108,615	37,739	-	39,628	3,002	66,751	31,397
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**3,688,139**	**3,256,400**	**431,739**	**144,608**	**108,615**	**37,739**	**-**	**39,628**	**3,002**	**66,751**	**31,397**
165	**Medical Loss Ratio (HCC % of Revenue)**		**113.2%**	**119.5%**	**81.2%**	**379.5%**	**55.1%**	**259.1%**	**0.0%**	**80.5%**	**2.7%**	**83.8%**	**78.7%**
166													
167	**Managed Care Administration**		**(431,034)**	**(431,034)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-13.2%**	**-13.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**3,257,105**	**2,825,366**	**431,739**	**144,608**	**108,615**	**37,739**	**-**	**39,628**	**3,002**	**66,751**	**31,397**
171	**Net before Settlement**		**(0)**	**(99,794)**	**99,794**	**(106,507)**	**88,471**	**(23,172)**	**-**	**9,584**	**109,981**	**12,942**	**8,495**
172	Contract Settlement		0	99,794	(99,794)	106,507	(88,471)	23,172	-	(9,584)	(109,981)	(12,942)	(8,495)
173	**Net after Settlement**		**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175		x	0										

	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 2/29/2020			5									
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		110,751,897	12,060,450	98,691,447	4,269,523	19,403,000	5,254,766	17,803,370	5,467,630	30,031,899	6,945,895	9,515,363
178	Incentive Payment Revenue		301,809	180,616	121,193	13,767	-	7,942	38,123	(60)	58,773	-	2,647
179	**Contract Revenue**		**111,053,707**	**12,241,066**	**98,812,641**	**4,283,290**	**19,403,000**	**5,262,708**	**17,841,494**	**5,467,570**	**30,090,673**	**6,945,895**	**9,518,011**
180													
181	External Provider Cost		73,338,100	7,726,441	65,611,659	1,892,306	13,838,902	3,296,226	11,154,034	2,942,562	22,774,020	4,380,958	5,332,652
182	Internal Program Cost		25,805,750	-	25,805,750	1,780,091	5,105,311	1,383,500	5,962,608	1,565,872	4,169,530	2,359,271	3,479,567
183	SSI Reimb, 1st/3rd Party Cost Offset		(296,000)	-	(296,000)	(8,350)	(5,482)	(19,177)	(83,187)	(2,861)	(133,909)	(10,616)	(32,419)
184	Insurance Provider Assessment Withhold (IPA)		2,598,130	2,598,130	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		371,749	371,749	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**101,817,729**	**10,696,320**	**91,121,409**	**3,664,047**	**18,938,731**	**4,660,549**	**17,033,455**	**4,505,572**	**26,809,642**	**6,729,613**	**8,779,800**
187	**Medical Loss Ratio (HCC % of Revenue)**		**91.7%**	**87.4%**	**92.2%**	**85.5%**	**97.6%**	**88.6%**	**95.5%**	**82.4%**	**89.1%**	**96.9%**	**92.2%**
188													
189	**Managed Care Administration**		**9,268,035**	**2,440,823**	**6,827,212**	**262,305**	**1,346,443**	**405,101**	**1,110,954**	**385,002**	**2,313,172**	**439,995**	**564,240**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.2%**	**6.1%**	**6.7%**	**6.6%**	**8.0%**	**6.1%**	**7.9%**	**7.9%**	**6.1%**	**6.0%**
191													
192	**Contract Cost**		**111,085,763**	**13,137,142**	**97,948,621**	**3,926,352**	**20,285,174**	**5,065,649**	**18,144,409**	**4,890,574**	**29,122,814**	**7,169,609**	**9,344,040**
193	**Net before Settlement**		**(32,057)**	**(896,076)**	**864,019**	**356,938**	**(882,174)**	**197,059**	**(302,915)**	**576,995**	**967,859**	**(223,713)**	**173,971**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		0	864,020	(864,019)	(356,938)	882,174	(197,059)	302,915	(576,995)	(967,859)	223,713	(173,971)
198	**Net after Settlement**		**(32,056)**	**(32,056)**	**(0)**	**-**	**-**	**0**	**(0)**	**-**	**0**	**(0)**	**(0)**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 2/29/2020			5									
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%*	4.9%	4.3%	4.1%	3.8%	6.8%	6.6%	5.0%	2.1%	4.5%
202	**Contract Revenue**				**4,601,868**	**300,921**	**801,970**	**286,250**	**832,866**	**229,419**	**1,532,758**	**225,669**	**392,015**
203													
204	External Provider Cost				1,818,102	53,837	232,532	17,666	277,184	211,725	885,335	70,279	69,546
205	Internal Program Cost				2,952,291	111,893	571,224	165,626	972,127	107,133	606,573	70,662	347,054
206	SSI Reimb, 1st/3rd Party Cost Offset				(80,886)	-	-	-	-	-	(80,886)	-	-
207	**Total Healthcare Cost**				**4,689,508**	**165,730**	**803,755**	**183,292**	**1,249,311**	**318,859**	**1,411,022**	**140,940**	**416,599**
208	**Medical Loss Ratio (HCC % of Revenue)**				**101.9%**	**55.1%**	**100.2%**	**64.0%**	**150.0%**	**139.0%**	**92.1%**	**62.5%**	**106.3%**
209													
210	**Managed Care Administration**				**389,936**	**13,581**	**63,867**	**18,022**	**90,309**	**29,990**	**133,959**	**10,418**	**29,789**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.7%**	**7.6%**	**7.4%**	**9.0%**	**6.7%**	**8.6%**	**8.7%**	**6.9%**	**6.7%**
212													
213	**Contract Cost**				**5,079,443**	**179,311**	**867,622**	**201,314**	**1,339,620**	**348,849**	**1,544,981**	**151,358**	**446,388**
214	**Net before Settlement**				**(477,576)**	**121,610**	**(65,652)**	**84,936**	**(506,754)**	**(119,430)**	**(12,223)**	**74,311**	**(54,373)**
215													
216	Other Redistributions of State GF				(35,747)	-	-	-	-	-	-	-	(35,747)
217	Contract Settlement				(275,954)	(120,139)	-	(83,591)	-	-	-	(72,223)	-
218	**Net after Settlement**				**(789,276)**	**1,470**	**(65,652)**	**1,345**	**(506,754)**	**(119,430)**	**(12,223)**	**2,087**	**(90,120)**
219													

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Quality Assurance & Performance Improvement
Utilization Management
2019 Program Evaluation

All SWMBH Business Lines

Evaluation Period: Medicaid (October 1, 2018- September 30, 2019)
Evaluation Period: MI Health Link (January 1, 2019 – December 31, 2019)

Reviewed by:

SWMBH Quality Management Committee: 2/27/2020
SWMBH Regional Utilization Management Committee: 2/10/2020
SWMBH MI Health Link Committee: 2/20/2020
SWMBH Board Education: 4/10/2020

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I. Introduction

Quality Assurance Improvement Program

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 (BBA) as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically Attachment P.6.7.1.1.

As part of Southwest Michigan Behavioral Health's (SWMBH) benefit management organization responsibilities, the SWMBH QAPI Department conducts an annual QAPI Evaluation to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities.

This annual review will include (1) Improvement initiatives undertaken by SWMBH from October 2018 through September 2019 for Medicaid Services and from January 2019 to December 2019 for MI Health Link Services (2) Resources used by the QAPI department and (3) The status of QAPI Plan objectives. The formulation of the QAPI goals and objectives includes incorporating numerous federal, state, and accreditation principles, including; BBA standards, National Committee for Quality Assurance (NCQA) standards, MDHHS contract requirements, and best practice standards. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, along with other departmental plans. SWMBH's QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The QAPIP is reviewed and approved annually by the SWMBH Board. The authority of the QAPI department and the Quality Management Committee (QMC) is granted by SWMBH's Executive Officer (EO) and Board. SWMBH's Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPI Effectiveness Review/Evaluation throughout the year.

II. Reporting Period

This evaluation period considered is from October 1, 2018 through September 30, 2019 (Medicaid) and January 1, 2019 to December 31, 2019 (MHL) and provides summaries of activities and performance results for each of the QAPI Program/Plan and UM Program/Plan annual goals and objectives.

III. Overview of Resources

In continuing the development of a systematic improvement system and culture, the goal of this evaluation is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. This analysis also examined the current relationships and structures that exist to promote performance improvement goals and objectives.

Communication

The QAPI Department interacts with all other departments within SWMBH as well as our partner Community Mental Health Service Programs (CMHSPs). The communication and relationship between SWMBH's different departments and CMHSPs is a critical component to the success of the QAPI Department. The QAPI Department works to provide guidance on project management, technical assistance, and support data analysis to other departments and CMHSPs.

Sharing of information with internal and external stakeholders through our Managed Information Business Intelligence system; through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real-time status and analysis to the end-user.

Internal Staffing of the QAPI Department

The SWMBH QAPI Department is charged to develop and manage its program. This program plan outlines the current relationships and structures that exist to promote performance improvement goals and objectives.

The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement, which oversees the QAPI Department (including two full-time staff). The QAPI Department also may utilize outside contract consultant for specialty projects and preparation for accreditation reviews. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Committee (RUM), and the Regional Clinical Practices Committee (RCP).

The QAPI Department staff works in conjunction with two Business Data Analyst positions. The Business Data Analyst plays a pivotal role in the QAPIP, providing internal and external data analysis, management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations, including developing and maintaining databases, consultation, and technical assistance. In guiding the QAPI studies, the Business Data Analyst will perform complex analyses of data. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, and conducting factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to assess relationships between variables. Based on the data, the Business Data Analyst will develop reports, summaries, recommendations, and visual representations.

SWMBH staff will include a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner, as needed, will provide supervisory and oversight of all SWMBH clinical functions to include; Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment, and other clinical initiatives. The designated behavioral health care practitioner will also provide clinical expertise and programmatic consultation and will collaborate with QAPI Director to ensure complete, accurate, and timely submission of clinical program data, including Jail Diversion and Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management Committee (QMC).

Adequacy of Quality Management Resources

The following chart is a summary of the positions currently included in the QAPI Department, their credentials, and the percentage of time allocated to quality management activities. Additionally, the outside departmental staff is listed with the percentage of their time allocated to quality activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) Quality Assurance Specialist	QAPI	100%
Business Data Analyst I	QAPI	50%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management and Call Center	UM	20%

Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	20%
Senior Systems Architect	IT	20%
Customer Service Manager	UM	15%
Behavior Health Waiver and Clinical Quality Manager	CQ	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PN	20%
Chief Compliance and Administrative Officer	Com/Ops	15%

QAPI = Quality Assurance and Performance Improvement
PNM = Provider Network Management
UM = Utilization Management
IT = Information Technology
CQ= Clinical Quality

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MIChild, Autism Waiver, MI Health Link (MHL) & Duals, SUD Block Grant, PA 2 funds, and additional grant funding. To complete these functions, needed resources include but are not limited to:

- Access to regional data
- Software and tools to analyze data and determine statistical relationships

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient, and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

The QAPI Department collaborates with the Quality Management Committee (QMC) and the SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/venders like Streamline Solutions and the Health Service Advisory Group (HSAG) to review data collection procedures. These relationships are communicated with the EO and the SWMBH Board as needed. Other roles include:

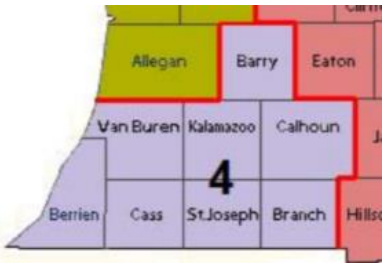
- Reviewing and submitting data to the state
- Creating and maintaining QAPI policies, plans, evaluations, and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development of the Boards Ends Metrics and other Key Performance Indicators
- Communications and Reporting to our Integrated Care Organizations
- Analysis of reports and data; to determine trends and recommendations for process improvements

Leadership involvement
Another significant strength of the QAPI program is the continuing involvement of SWMBH Senior Leadership at the highest level. The CEO and members of the Senior Leadership team are all active participants in the day to day operations of the QAPI Program. Their active involvement provides a clear message to all SWMBH and CMHSP team members regarding the importance of the active participation and support of the activities. Newly hired team members are quickly introduced to the quality culture of SWMBH and to the central role that quality and data play in decision making, strategic planning, and defining tactical objectives throughout the Region.

Practitioner Involvement
The QAPI has strong, active involvement of providers and Clinical Director involvement in the program. They attend Quality Management Committee meetings, MIHL Committee Meetings, Regional Utilization Management, and Clinical Practice Committee meetings and are available as needed to the QAPI team. They are instrumental in establishing measures and setting goals for Regional performance targets.

Physical Resources: Phones/Computers/Equipment
Due to the diverse geographical region, the phone system and internet/network capacities are essential to the day-to-day operations of the SWMBH. Document management is also a crucial business practice that promotes effective workflow. As such, SWMBH has developed and redesigned a portal for both internal and external entities to collaborate and access essential Regional information and data. Tableau, dashboard visualization, and analysis software have become a critical part of our information and data sharing process with both external and internal stakeholders. This software allows access to real-time data, which is very important in our performance-based environment. The use of Go-to-Meeting or WebEx technology is offered to Regional Committee members, internal, and external stakeholders if they are not able to attend meetings in person.
It is important to note that during the reporting period, SWMBH transitioned its telecommunications and IT vendor from ITP to Secant Technologies. The transition will provide significant cost savings, increased phone/call analytics data, improved security, and additional on-site support.

Service Population and Eligibles Served:
The SWMBH region (4) has served nearly **26,489** unique consumers from October 1, 2018 to September 30, 2019



Persons served Include:

- Adults with SPMI (Severe Persistent Mental Illness)
- Adults with Developmental Disabilities
- Adults with Substance Use Disorders
- Children with SED (Severe Emotional Disturbance)
- Children with Developmental Disabilities

Medicaid or Healthy Michigan Plan (HMP) Eligible in the region (FY'19): 258,912

IV. Evaluation of Quality Management Committee Structure

Quality Management (QMC) Committee Structure
SWMBH has established the QMC to provide oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. Moreover, SWMBH values the input of all stakeholders in the improvement process. QMC spearheads the improvement process by fostering participant communication, ensuring mission alignment, and acting as subject matter experts to SWMBH. QMC allows regional input to be gathered regarding the development and management of processes and policies related to quality. QMC is

responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC is required of all participants, customers, and providers. QMC representatives are selected by their CMHSPs and required to communicate any information discussed during meetings or included in meeting minutes back to their CMHSPs.

To assure a responsive system, the needs of those that use or oversee the resources, (e.g., active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever possible. Training on performance improvement techniques and methods, along with technical assistance, is provided as requested or as necessary.

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, a representative(s) from the SWMBH Customer Advisory Committee (CAC), and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed and include provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. All QMC members are required to participate; however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

***QMC Committee Commitments include*:**

1. Everyone participates
2. Be passionate about the purpose
3. All perspectives are professionally Expressed and Heard
4. Support Committee and Agency Decisions
5. Celebrate Success

Decision Making Process

Quality Management is one of the core functions of the PIHP. The QMC is tasked with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. Quarterly, QMC collaborates with the Regional Clinical Practices (RCP) and Regional Utilization Management (RUM) Committees on clinical and quality goals and contractual tasks.

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the QMC charter. *(Please see Attachment L – QMC Charter for more details)*.

QMC Roles and Responsibilities

- QMC will meet regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.
- Members of the committee will act as liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. It is expected that committee members attend all meetings by phone or in person. If members are not able to participate in meetings, they should notify the QMC Chair Person as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures, including the Board, the Management team, other SWMBH committees, and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.

- The primary task of the QMC is to review, monitor, and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.
- To ensure CMHSP's have developed and are maintaining a performance improvement program within their respective organizations.
- Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC.

Quality Management Committee Key Accomplishments

The QMC met monthly during FY 2019. All meeting materials are accessible on the SWMBH portal before and after each meeting. The focus and oversight of QMC during this review period was on the continued review of Quality activities, including Board Ends Metrics and Performance Improvement Projects. The QMC uses NCQA approved and best practice measures to track action items and follow-up's identified during meetings.

2019 Quality Management Committee Goals

SWMBH took a different approach to the Department and Committee goal setting in 2019. Each Department and Regional Committee worked together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 11, 2019. These (7) Strategic Imperatives replaced the 2019 Regional Committee Goals. The following represent a list of those Strategic Imperatives: *(Please see attachment C for more details on completion of Strategic Imperatives)*

1. Public Policy and Legislative Education
2. Uniformity of Benefit
3. Integrated Health Care
4. Revenue Maximization and Diversification
5. Managed Care Functional Review
6. Improved Healthcare Information Exchange, Analytics and Business Intelligence
7. Proof of Value and Outcomes

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons jointly enrolled in Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan. As such, SWMBH is held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS), CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements outlined in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment, and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD, and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

The MHL Committee is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows input to be gathered regarding the development and management of processes and policies related to quality.

The committee is one method of participant communication, alignment, and advice to SWMBH.

The committee tasks are determined by the SWMBH Executive Officer, committee chair and members, member needs, MI Health Link demonstration guidelines, including the Three-Way Contract, ICO-PIHP Contract, and NCQA requirements. The MHL Committee is accountable to the SWMBH EO. It is responsible for assisting SWMBH Leadership in meeting the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The Committee must provide evidence of review and thoughtful consideration of changes in its policies, procedures, work plan, and changes to its policies as needed. The Committee analyzes and evaluates the results of QM activities to identify required actions and make recommendations related to efficiency, improvement, and effectiveness. The Committee will meet regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.

MI Health Link Committee Membership

The MHL Committee shall consist of the QAPI Department staff, a designated behavioral health care practitioner, and ICO representatives. This designated behavioral health care practitioner shall have oversight of any clinical metrics and participate in advising the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and may be a medical director, clinical director, or participating practitioner from the organization or affiliate organization. All other ad-hoc members shall be identified as needed and could include provider representatives, IT support staff, Coordinating Agency staff, and medical director and clinical representation. Members of the committee are required to participate; however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

Members of the committee will act as liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that members will share information and concerns with SWMBH QAPI staff. As liaisons, it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bring challenges from their sites to the attention of the SWMBH committee for possible project creation.

Decision Making Process

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the MHL QMC charter. *(Please see Attachment F – MHL Committee Charter for more details)*. The MHL Committee is responsible for maintaining contact with other committees as well as identifying people, organizations, or departments that can further the aims of both the QAPI Department and the Committee. The MHL QAPI section of the Committee coordinates with the UM and Provider Network MHL Committees. The QAPI Director is a member of both the UM and Provider Network MHL Committees. The QAPI Director may call on other QAPI team members or CMHSP partners to participate in MHL Committee meetings as necessary.

MI Health Link Quality Committee Key Accomplishments during 2019 include:

- ✓ Preparations toward Achieving NCQA-MBHO Re-Accreditation
- ✓ Review Quarterly MHL enrollee statistics
- ✓ Completed and Ongoing QI Activities that address the quality and safety of clinical care and quality of service
- ✓ Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- ✓ Analysis and evaluation of the overall effectiveness of the QAPI program, including progress toward influencing network safe clinical practices
- ✓ Enhancing Practitioner Involvement with Quality initiatives and fundamental performance measures.
- ✓ Monthly Analysis and reporting on Call Center Metrics (*abandonment rate, average answer time, total calls per line, and call volume analysis).*
- ✓ Quarterly Review and analysis of Critical Incidents to help identify trends.

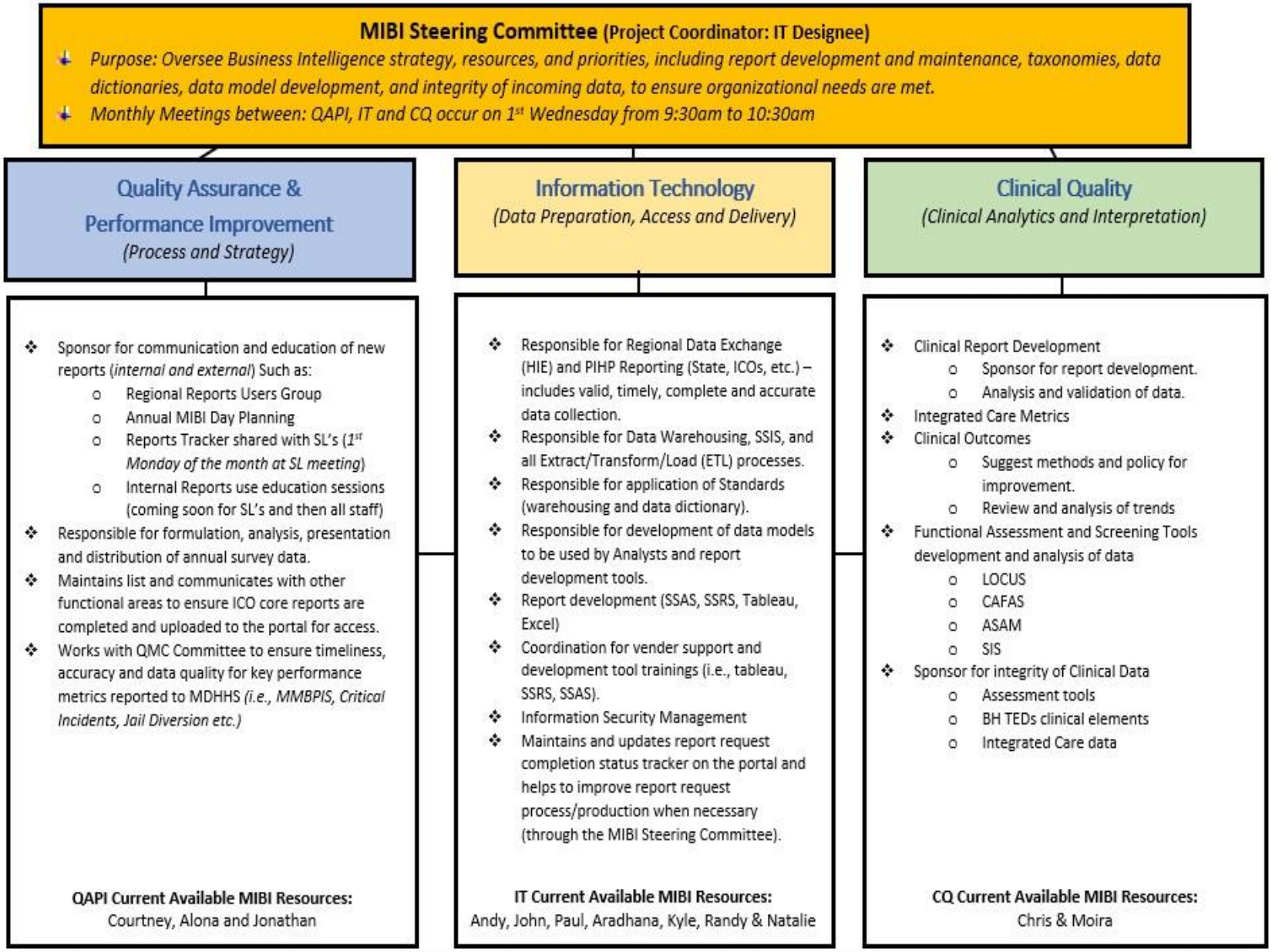
- ✓ Quarterly Review and analysis of grievances, appeals, and denials.
- ✓ Analysis of BH/PH Provider Communications Survey and Opportunities for improvement.
- ✓ Communication on critical findings from ICO/SWMBH audits and reviews.
- ✓ Review and understanding of NCQA-MBHO accreditation standards and elements.
- ✓ Monthly updates and discussion on MIHL enrollment and eligibility data.

Functional Area	Objectives	Lead Staff	Review Date
Committee	Approve last month's MHL Committee Meeting minutes.	All Committee Members	Monthly
UM	Grievances and Appeals	Customer Service Manager	Quarterly
Credentialing	Review and approval of MI Health Link policies and procedures.	Director of Provider Network	As needed
	Medical Director, Clean File Review Approvals Four clean file reviews since the last meeting	Provider Network Specialist, or Director of Provider Network	Monthly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Monthly
	Practitioner Complaints	Provider Network Specialist, or Director of Provider Network	Quarterly
Quality	Policy and Procedure Review and Updates.	Director of QAPI or designated QAPI Specialist	As needed
	Annual Work plan Review (Quarterly).	Director of QAPI or designated QAPI Specialist	Quarterly, as indicated by QAPI work plan
	Annual Reviews/Audits (Recommendations for Improvement and review of results).	Director of QAPI or designated QAPI Specialist	As needed
	Practitioner Participation and Clinical Practice Guideline Review.	Director of QAPI or designated QAPI Specialist	Quarterly
	Performance Measures for Site Audit	Director of QAPI or designated QAPI Specialist	As needed
	Causal Analysis	Director of QAPI or designated QAPI Specialist	Quarterly

	Call Center Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly
UM/Clinical	Collaborative Initiatives Meridian ICT Update	Manager of Utilization Management and Integrated Care Specialist	Monthly
	Complex Case Management	Manager of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Manager of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Manager of Utilization Management	As needed

Managed Information Business Intelligence Roles and Structure:

The MIBI Steering Committee was created in early 2019 to oversee business intelligence strategy, resources, and priorities. Monthly meetings occur, which include the Chief Information Officer, Director of Quality Assurance and Performance Improvement, and the Director of Clinical Quality. The (3) departments work very closely together, so key meeting objectives include data quality, data accuracy, data validation, report development, and prioritizing data related development projects and needs for SWMBH. The columns below describe the responsibilities of each functional area:


MIBI Steering Committee (Project Coordinator: IT Designee)
Purpose: Oversee Business Intelligence strategy, resources, and priorities, including report development and maintenance, taxonomies, data dictionaries, data model development, and integrity of incoming data, to ensure organizational needs are met.
Monthly Meetings between: QAPI, IT and CQ occur on 1st Wednesday from 9:30am to 10:30am
Quality Assurance & Performance Improvement (Process and Strategy)
Information Technology (Data Preparation, Access and Delivery)
Clinical Quality (Clinical Analytics and Interpretation)
Sponsor for communication and education of new reports (internal and external) Such as:
Regional Reports Users Group
Annual MIBI Day Planning
Reports Tracker shared with SL's (1st Monday of the month at SL meeting)
Internal Reports use education sessions (coming soon for SL's and then all staff)
Responsible for formulation, analysis, presentation and distribution of annual survey data.
Maintains list and communicates with other functional areas to ensure ICO core reports are completed and uploaded to the portal for access.
Works with QMC Committee to ensure timeliness, accuracy and data quality for key performance metrics reported to MDHHS (i.e., MMBPIS, Critical Incidents, Jail Diversion etc.)
QAPI Current Available MIBI Resources:
Courtney, Alona and Jonathan
Responsible for Regional Data Exchange (HIE) and PIHP Reporting (State, ICOs, etc.) – includes valid, timely, complete and accurate data collection.
Responsible for Data Warehousing, SSIS, and all Extract/Transform/Load (ETL) processes.
Responsible for application of Standards (warehousing and data dictionary).
Responsible for development of data models to be used by Analysts and report development tools.
Report development (SSAS, SSRS, Tableau, Excel)
Coordination for vender support and development tool trainings (i.e., tableau, SSRS, SSAS).
Information Security Management
Maintains and updates report request completion status tracker on the portal and helps to improve report request process/production when necessary (through the MIBI Steering Committee).
IT Current Available MIBI Resources:
Andy, John, Paul, Aradhana, Kyle, Randy & Natalie
Clinical Report Development
Sponsor for report development.
Analysis and validation of data.
Integrated Care Metrics
Clinical Outcomes
Suggest methods and policy for improvement.
Review and analysis of trends
Functional Assessment and Screening Tools development and analysis of data
LOCUS
CAFAS
ASAM
SIS
Sponsor for integrity of Clinical Data
Assessment tools
BH TEDs clinical elements
Integrated Care data
CQ Current Available MIBI Resources:
Chris & Moira

Southwest Michigan
BEHAVIORAL HEALTH

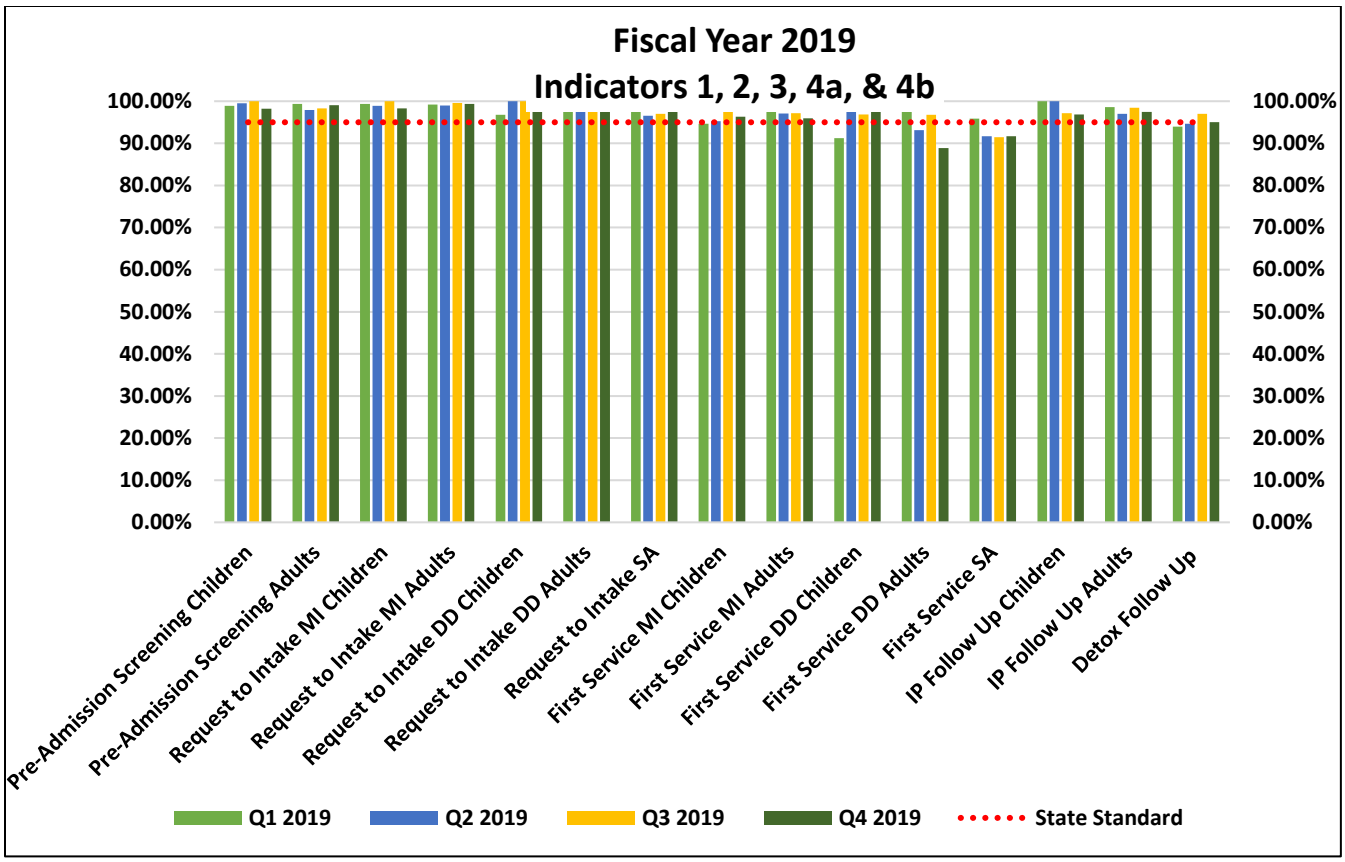
Quality Assurance Improvement Program Evaluation

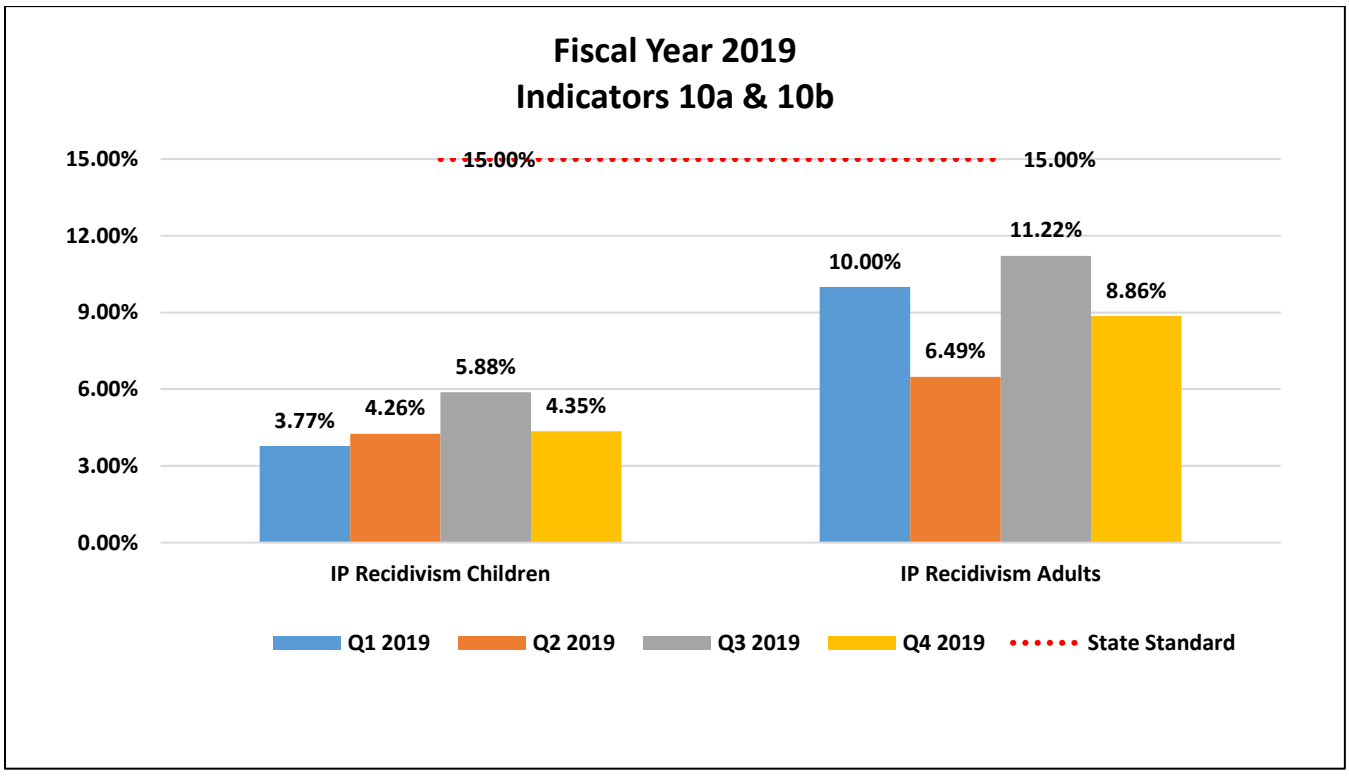
V. Quality Assurance Improvement Program Plan Evaluation

The following sections represent the outcomes, from the categories included in the 2019 QAPI and UM Plans

2019 Michigan Mission-Based Performance Indicator System Results (MMBPIS)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures reported to State.	✓ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ✓ Report indicator results to MDHHS quarterly. ✓ Status updates to relevant Committees such as QMC, RUM, RCP, and Operations Committee. ✓ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ✓ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated benchmark. ✓ Ensure CMSHP Corrective Action Plans are achieved, and improvements are recognized.	October 2018 – December 2019	QAPI Director QAPI Specialist Clinical Quality Director SUD Director	Quarterly Submissions to MDHHS: *Q1 - 3/31/19 *Q2 - 6/30/19 *Q3 - 9/30/19 *Q4 - 1/2/20 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs occur in April-May 2020.


Fiscal Year 2019
Indicators 1, 2, 3, 4a, & 4b
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Pre-Admission Screening Children
Pre-Admission Screening Adults
Request to Intake MI Children
Request to Intake MI Adults
Request to Intake DD Children
Request to Intake DD Adults
Request to Intake SA
First Service MI Children
First Service MI Adults
First Service DD Children
First Service DD Adults
First Service SA
IP Follow Up Children
IP Follow Up Adults
Detox Follow Up
Q1 2019
Q2 2019
Q3 2019
Q4 2019
State Standard


Fiscal Year 2019
Indicators 10a & 10b
15.00%
12.00%
9.00%
6.00%
3.00%
0.00%
15.00%
15.00%
3.77%
4.26%
5.88%
4.35%
10.00%
6.49%
11.22%
8.86%
IP Recidivism Children
IP Recidivism Adults
Q1 2019
Q2 2019
Q3 2019
Q4 2019
State Standard

Performance Indicator Measurement Period: October 1, 2018 through September 30, 2019

Objective:
State defined indicators that are aimed at measuring access, quality of service, and provide benchmarks for the state of Michigan and all (10) PIHPs.

Target Goals:
The MDHHS benchmark for access and follow-up performance indicators is set at 95%. The SWMBH Board Ends Metric target was set at 92% for all performance indicators to achieve the MDHHS established benchmark for (4) quarters during FY 2019.

Results:
59/68 or 86.7% of total Performance Indicators in 2019 met the State Standard of 95%:

- 1st Quarter = 14/17
- 2nd Quarter = 14/17
- 3rd Quarter = 16/17
- 4th Quarter = 15/17

MMBPIS Performance Indicator	*State Standard*	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Pre-Admission Screening Children	95.00%	98.93%	99.49%	100.00%	98.25%
Pre-Admission Screening Adults	95.00%	99.36%	97.90%	98.28%	99.08%
Request to Intake MI Children	95.00%	99.35%	98.87%	100.00%	98.26%
Request to Intake MI Adults	95.00%	99.21%	98.97%	99.55%	99.37%
Request to Intake DD Children	95.00%	96.77%	100.00%	100.00%	100.00%
Request to Intake DD Adults	95.00%	100.00%	100.00%	100.00%	100.00%
Request to Intake SA	95.00%	98.39%	96.55%	97.02%	97.58%
First Service MI Children	95.00%	94.61%	95.26%	97.72%	96.36%
First Service MI Adults	95.00%	97.91%	97.11%	97.16%	95.96%
First Service DD Children	95.00%	91.23%	100.00%	96.83%	100.00%
First Service DD Adults	95.00%	100.00%	93.10%	96.77%	88.89%
First Service SA	95.00%	95.83%	91.70%	91.43%	91.67%
IP Follow Up Children	95.00%	100.00%	100.00%	97.14%	96.88%
IP Follow Up Adults	95.00%	98.62%	97.01%	98.44%	97.49%
Detox Follow Up	95.00%	93.98%	94.64%	97.04%	95.05%
IP Recidivism Children	15.00%	3.77%	4.26%	5.88%	4.35%
IP Recidivism Adults	15.00%	10.00%	6.49%	11.22%	8.86%
Overall Results		14/17	14/17	16/17	15/17

Identified Barriers:
Many CMHSP's struggled with staffing issues throughout the year, which led to missed performance indicators (i.e., opportunities to schedule inside of a 14-day window are lost due to not having staff available to take on the assessment or service). Some CMHP's switched EMR's which hindered the ability to communicate information to SWMBH on a timely basis.

SWMBH distributed Corrective Action Plans (CAP's) asking for the identification of action to correct the missed indicator and turned them away if they did not include show proofs. When two or more indicators are missed, SWMBH implements a higher level of scrutiny, which requires the CMHSP's to submit monthly (and sometimes weekly) reports on their progress. CMHSPs are required to submit the MMBPIS tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter.

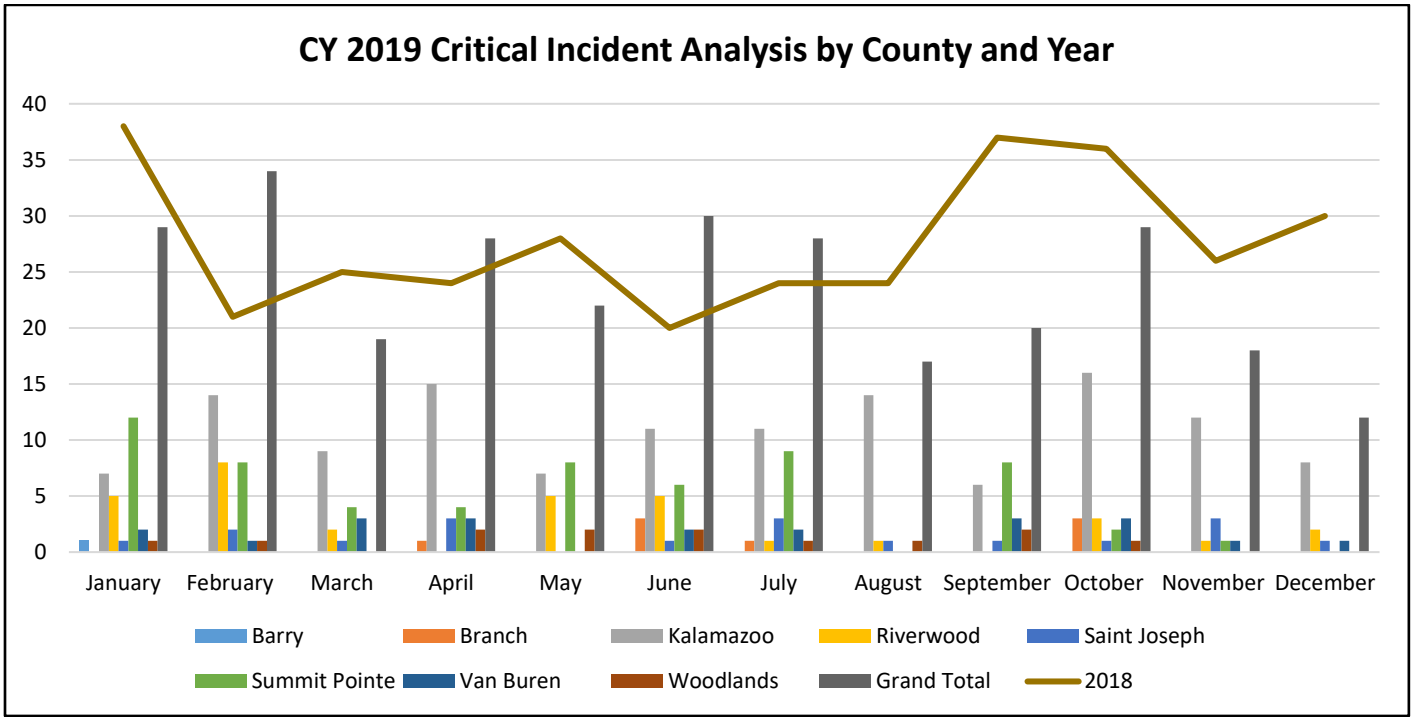
Improvement Efforts:
SWMBH sends CMHSP's appreciation letters upon meeting 100% of the State's performance indicators, which are directed at their CEO and shared at the Board meetings. SWMBH has also increased the frequency of analysis during QMC meetings, igniting conversation, and sharing best practices across the region. This process has helped identify trends early on. SWMBH has also developed dashboards in the tableau analytics system, that allow CMHSP's to access and flag cases that are approaching the end of the follow-up period.

Recommendations:
CMHSPs are required to submit the MMBPIS tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter. MDHHS will be changing reporting specifications for indicators 2b, 3, and 4 in the 3rd Quarter of 2020. One of the primary changes will be the elimination of the exclusions and acceptations for the said indicators.

2019 Event Reporting

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Event Reporting (Critical Incidents, Sentinel Events, and Risk Events)	➢ Event Reporting- trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualifying events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	✓ Event Reporting Quarterly reports to QMC, RUM, RCP, and MHL committees as part of the process. ✓ Quarterly Reports of any qualified events to MDDHS including: ▪ Suicide ▪ Non-Suicide Death ▪ Emergency Medical Treatment Due to medication error ▪ Hospitalization due to injury or medication error ▪ The arrest of a consumer that meets population standards	October 2018 – September 2019	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for analysis.

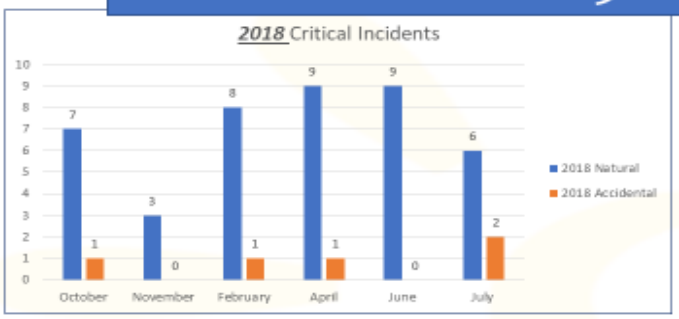
2019 Critical Incidents

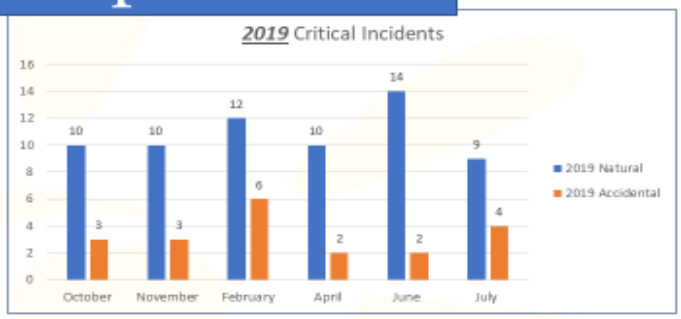


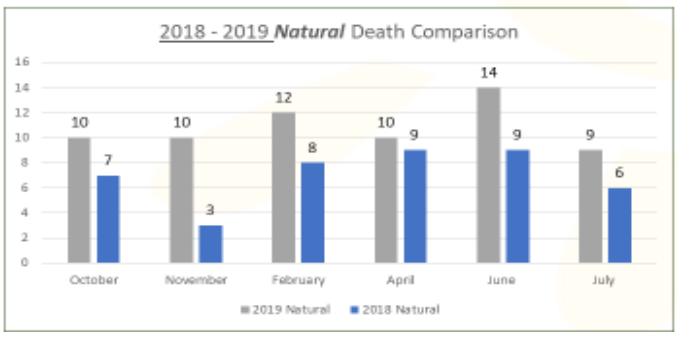
- ❖ Overall, for calendar year 2019 there were 287 critical incidents.
- ❖ The highest CI category being non-suicide death (141); the next top CI category is EMT due to injury/medication error (77).
- ❖ The lowest number of critical incidents was due to Suicide (8).

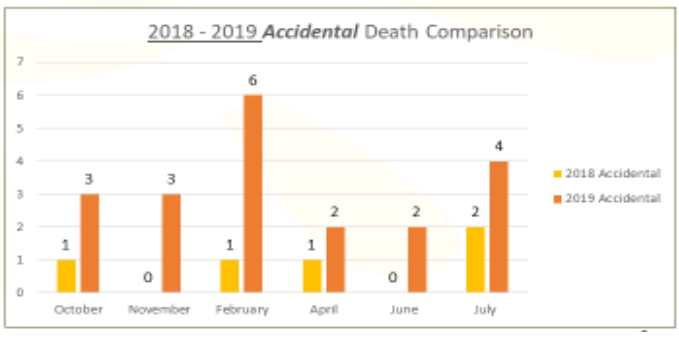
	FY 2019 - Q2			FY 2019 - Q3			FY 2019 - Q4			FY 2020 - Q1			Grand Total
	January	February	March	April	May	June	July	August	Septemb..	October	November	December	
Arrest	3	6	2	3	5	5	7	3	4	5	2	3	48
EMT due to Injury/Medication Error	6	7	9	12	6	8	6	8	4	6	4	1	77
Hospitalization due to Injury/Medication Er..	2	3	0	1	1	1	2	1	0	1	1	0	13
Non-Suicide Death	17	17	7	12	9	14	12	4	12	17	11	9	141
Suicide	1	1	1	0	1	2	1	1	0	0	0	0	8
Grand Total	29	34	19	28	22	30	28	17	20	29	18	13	287

2018 vs 2019 Comparison





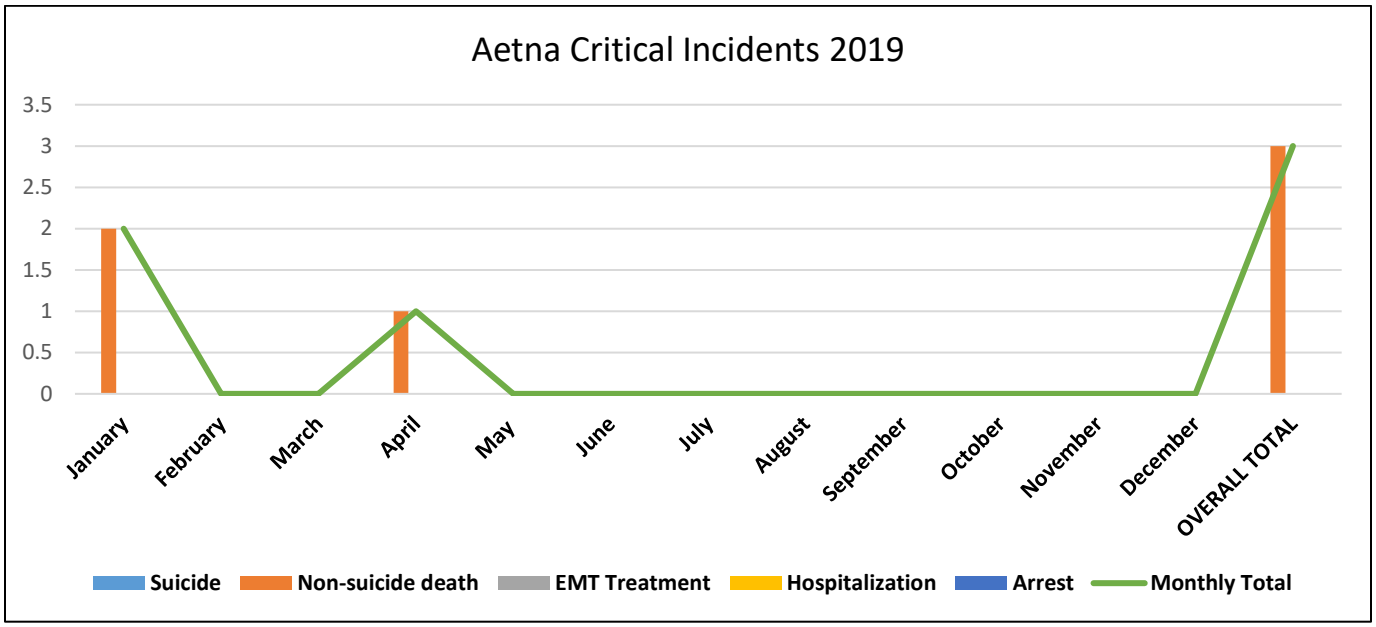




- ❖ The above data reflects months in which Natural and Accidental Deaths occurred, as well as a comparison by year.
- ❖ 2019 showed an increase of 23 Natural Deaths over the 2018 results.
- ❖ 2019 showed an increase of 15 Accidental Deaths over the 2018 results.

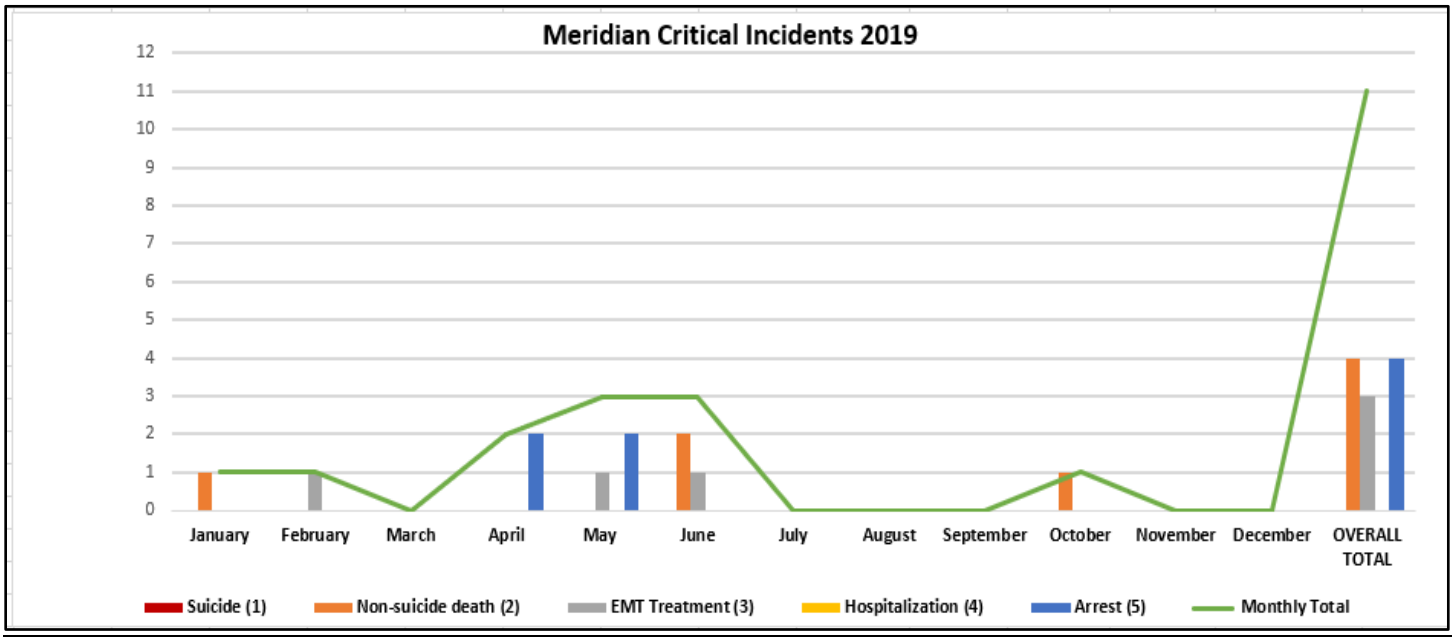
MI Health Link (Duals Demonstration Project) Critical Incidents

Aetna Health Plan



	2019-Q1			2019-Q2			2019-Q3			2019-Q4			
	January	February	March	April	May	June	July	August	September	October	November	December	OVERALL TOTAL
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death	2	0	0	1	0	0	0	0	0	0	0	0	3
EMT Treatment	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly Total	2	0	0	1	0	0	0	0	0	0	0	0	3

- Analysis: In CY 2019 there was a total of (3) critical incidents reported to SWMBH for enrolled Aetna Members.
- A new reporting template will be implemented in 2020. The new template will allow both SWMBH and Aetna complete additional analysis, using the detailed data they receive.
- No significant trends were noted for the 2019 reporting period.



	2019-Q1			2019-Q2			2019-Q3			2019-Q4			
	January	February	March	April	May	June	July	August	September	October	November	December	OVERALL TOTAL
Suicide (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death (2)	1	0	0	0	0	2	0	0	0	1	0	0	4
EMT Treatment (3)	0	1	0	0	1	1	0	0	0	0	0	0	3
Hospitalization (4)	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest (5)	0	0	0	2	2	0	0	0	0	0	0	0	4
Monthly Total	1	1	0	2	3	3	0	0	0	1	0	0	11

- Analysis: In CY 2019 there was a total of 11 critical incidents reported to SWMBH for enrolled Meridian Members.
- A new reporting template will be implemented in 2020. The new template will allow both SWMBH and Aetna to complete additional analysis, using the detailed data they receive.
- No significant trends were noted for the 2019 reporting period.

Objective:
Collecting, reporting, and reviewing all deaths and unusual events or incidents of persons served.

Results:
Improved reporting from CMHSPs—increase in events reported in FY2019 due to the newly implemented process.

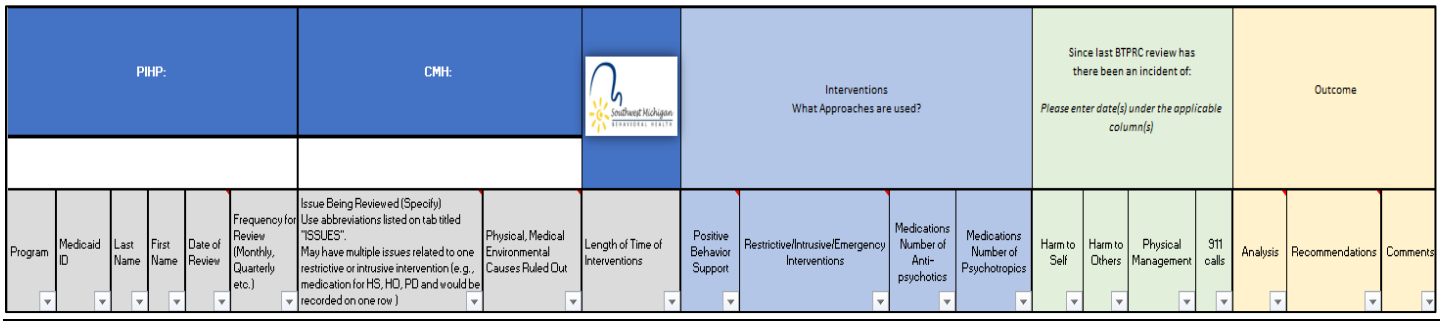
Identified Barriers:
Per a recent Health Service Advisory Group (HSAG) External Quality Audit, it was determined that risk event analysis needs to be conducted on a more frequent basis during the Quality Management Committee (QMC) meetings. Also, a new policy regarding Sentinel event timeliness needs to be employed and communicated to SWMBH CMHSP partners.

Recommendations:

CMHSPs must fill out and send their Event Reporting Submission sheets to the SWMBH Event Reporting Inbox (eventreporting@swmbh.org) each month for reportable critical incidents and risk events. If there are no reportable events, then please document this in the Event Reporting Submission sheet each month and send it to the Event Reporting Inbox. Critical Incident reporting has significantly improved since FY 18. A CISE (Critical Incident & Sentinel Event) workgroup was created to update any current CISE training materials and also to add new helpful materials for new Providers, employees, etc. These documents are all housed in a central location on the new SWMBH Portal under Partners, Reporting Tools and Resources, Critical Incidents Educational Resources, and Tools. Documents include CISE Reporting Template, Critical Incidents Presentation, a webinar training with the Critical Incidents Presentation, Critical Incidents Process Map, Event Reporting Handbook, Risk Events Information, and Reporting Requirements by Service handout. Furthermore, with an updated risk event system, the QAPI department should develop an analysis methodology. We currently created a dashboard on Tableau, but the analysis and improvement still need to occur.

2019 Behavioral Treatment Review Committee Data

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Behavioral Treatment Review Committee Data	➢ SWMBH collects information from CMHs and makes it available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify opportunities for improving care.	✓ The QMC Committee will review the data collected from CMHs for trends and outliers quarterly. ✓ If trends are identified, the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ✓ The QMC Committee will formulate methods for improving the care of "vulnerable" people.	October 2018 – September 2019	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly



PIHP:						CMH:			Interventions What Approaches are used?				Since last BTPRC review has there been an incident of: *Please enter date(s) under the applicable column(s)*				Outcome		
Program	Medicaid ID	Last Name	First Name	Date of Review	Frequency for Review (Monthly, Quarterly etc.)	Issue Being Reviewed (Specify) Use abbreviations listed on tab titled "ISSUES". May have multiple issues related to one restrictive or intrusive intervention (e.g., medication for HS, HD, PD and would be recorded on one row)	Physical, Medical Environmental Causes Ruled Out	Length of Time of Interventions	Positive Behavior Support	Restrictive/Intrusive/Emergency Interventions	Medications Number of Anti-psychotics	Medications Number of Psychotropics	Harm to Self	Harm to Others	Physical Management	911 calls	Analysis	Recommendations	Comments

Objective:

The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency. Data shall include numbers of interventions and length of time the interventions were used per person. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. Collected by SWMBH from the affiliates and available for review. The information fields on the spreadsheet did not include the length of time that interventions were used per person. Attachment P7.9.1 requires that the BTRCs review the numbers of interventions and length of time the interventions were used per person. Similarly, PIHP Contract Attachment P1.4.1 establishes elements that the BTRC committee must track and analyze, which includes No. 8, the length of time of each intervention.

Results:

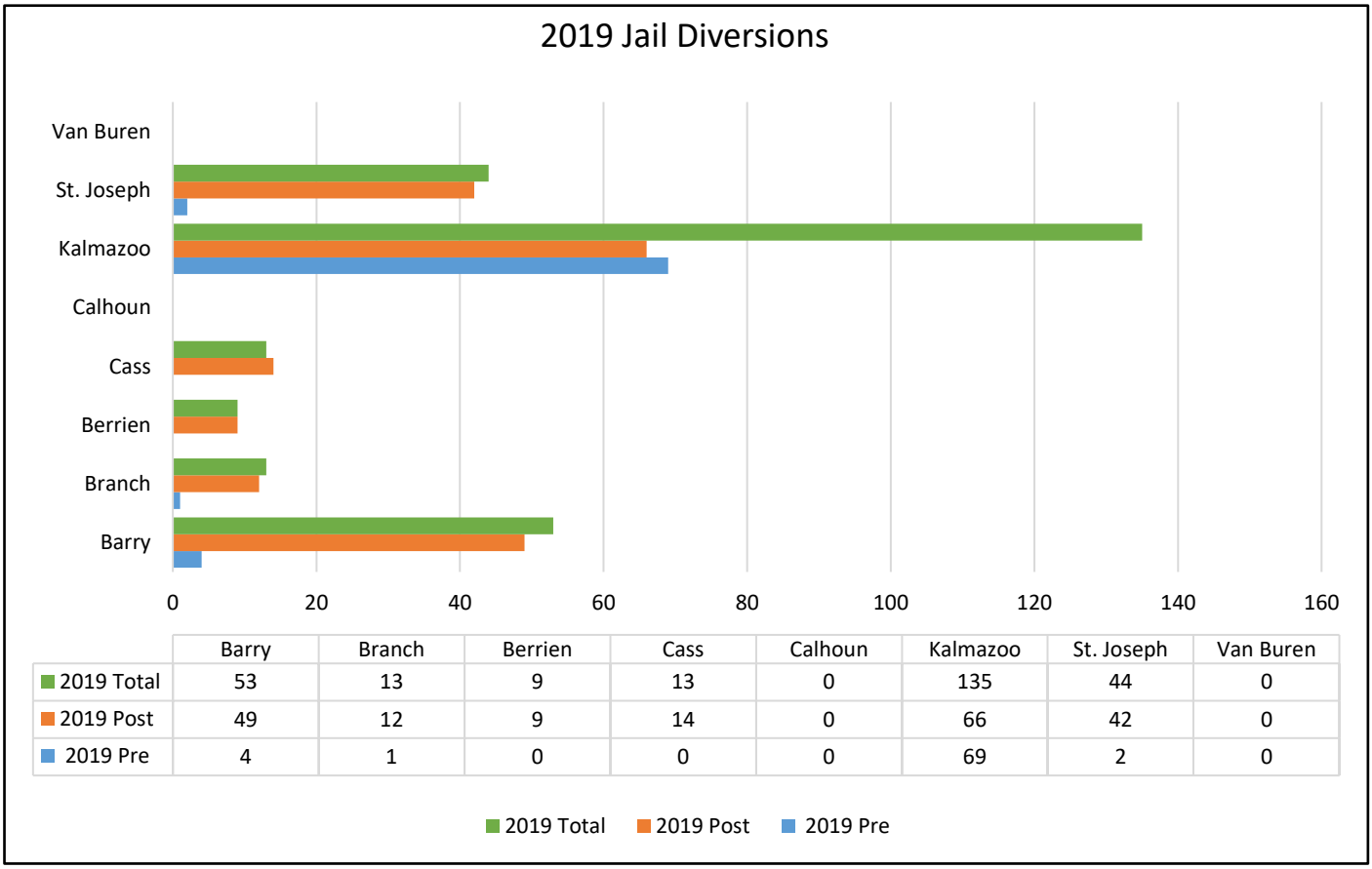
The SMMBH Quality Management Committee (QMC) minutes documented that the PIHP ensured that each affiliate submitted BTRC data via the BTPRC Data Spreadsheet. The SWMBH Operating Policy 3.3, Behavior Treatment Review Committee, listed the information required to be entered in the form. This information is reviewed quarterly during QMC meetings, and selected cases are selected for review during CMHSP site audits. The SWMBH clinical team reviews the appropriateness of interventions and length of service standards.

Identified Barriers:
CMHSPs are not reporting for non-waiver beneficiaries. A process has been established to begin collecting this information from CMHSP's during FY 2020.

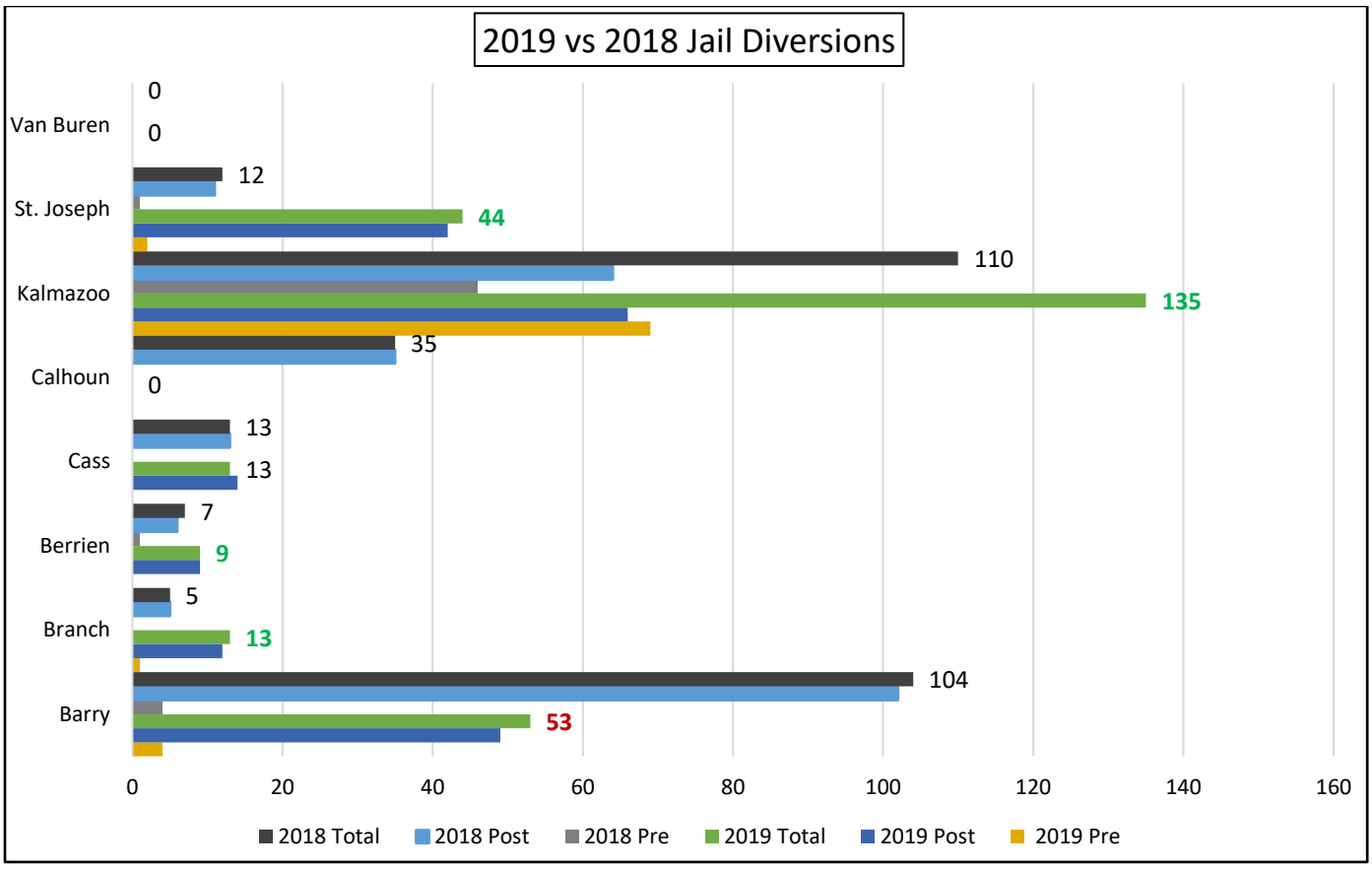
Recommendations:
The PIHP must ensure that CMHSPs are collecting and analyzing all data as required, including the length of time of interventions used per person. QMC will review data quarterly for potential identification of improvements, improved processes, and identification/analysis of any trends.

2019 Jail Diversion Data

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Jail Diversion Data Collection	✓ SWMBH collects and reports the number of jail diversions (pre-booking, and post-booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities and co-occurring mental health and substance abuse disorders (DD & COD).	✓ The QMC will evaluate data trends and specific CMHSP results. ✓ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ✓ Identified trends and suggestions for policy change are shared with Regional Entities through the Operations Committee and Utilization Management Committee as needed.	October 2018 – September 2019	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed



	Barry	Branch	Berrien	Cass	Calhoun	Kalmazoo	St. Joseph	Van Buren
2019 Total	53	13	9	13	0	135	44	0
2019 Post	49	12	9	14	0	66	42	0
2019 Pre	4	1	0	0	0	69	2	0



***Red signifies a decrease from last year**
***Green signifies an increase from the previous year**

Objective:
Collect, monitor, and report services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.

Results:
The collection of diversion data from participant CMHSPs is due to SWMBH annually. As you can see, the majority of CMHSPs have had an increase in diversions over the past year. Affiliate input suggests administration at jails may be a factor in the utilization of jail diversion programs.

Identified Barriers:
Identified barriers include data being reported in an accurate, complete, and timely manner as required by MDHHS. Appropriate training and reporting from the administrative staff in the jails seems to be an ongoing issue and is reflective of the data collected and reported.

Recommendations:
Scheduling recurring discussion of jail diversion more frequently at QMC/RUM/RPC. Analysis of outcomes can be used to develop and target best practice interventions and strategies for improvement. We will also update our Jail Diversion Educational Power Point and send to new providers, as reference on reporting expectations.

2019 Member Experience

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Member Experience	➢ Develop and evaluate the effectiveness of programs and initiatives, the QM Department and QMC and MHL Committee analyzes data and customer input from various sources, including customer surveys, audits, reported incidents, and member or provider complaints. ➢ Data is used to identify trends and make improvements for customer experience and improved outcomes.	✓ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey period. ✓ Distribution, collection, and analysis of annual Person in Recovery Survey (RSA-r). ✓ Medicaid Member Service Satisfaction Surveys. ✓ Medicare Member Service Satisfaction Surveys. ✓ MI Health Link – Dual Eligible Member Satisfaction Surveys. ✓ Complex Case Management Member Experience Survey. ✓ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys. ✓ Causal analysis of grievance and appeal data broken into categories including Quality of care, access, attitude and service, billing and financial issues, and quality of practitioner office site. ✓ Member Grievance and Appeals data Complex Case Management. ✓ Grievance and Appeals data o Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RCP, RUM, SWMBH Board, and other stakeholders annually.	January 2019 - December 2019	QAPI Specialist QAPI Director Chief Administrative Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

Mental Health Statistics Improvement Program Survey Analysis

(MHSIP-Adult) and Youth Statistics Survey (YSS-Youth)

How Did We Do?

MHSIP Results

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

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

YSS Results

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

+0.30% Percent Improvement over 2018 Scores (All Categories)

Overall Response Rates

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

Overall Result

+2.76% **Percent Overall Improvement (MHSIP + YSS)**

Survey Process and Preparation

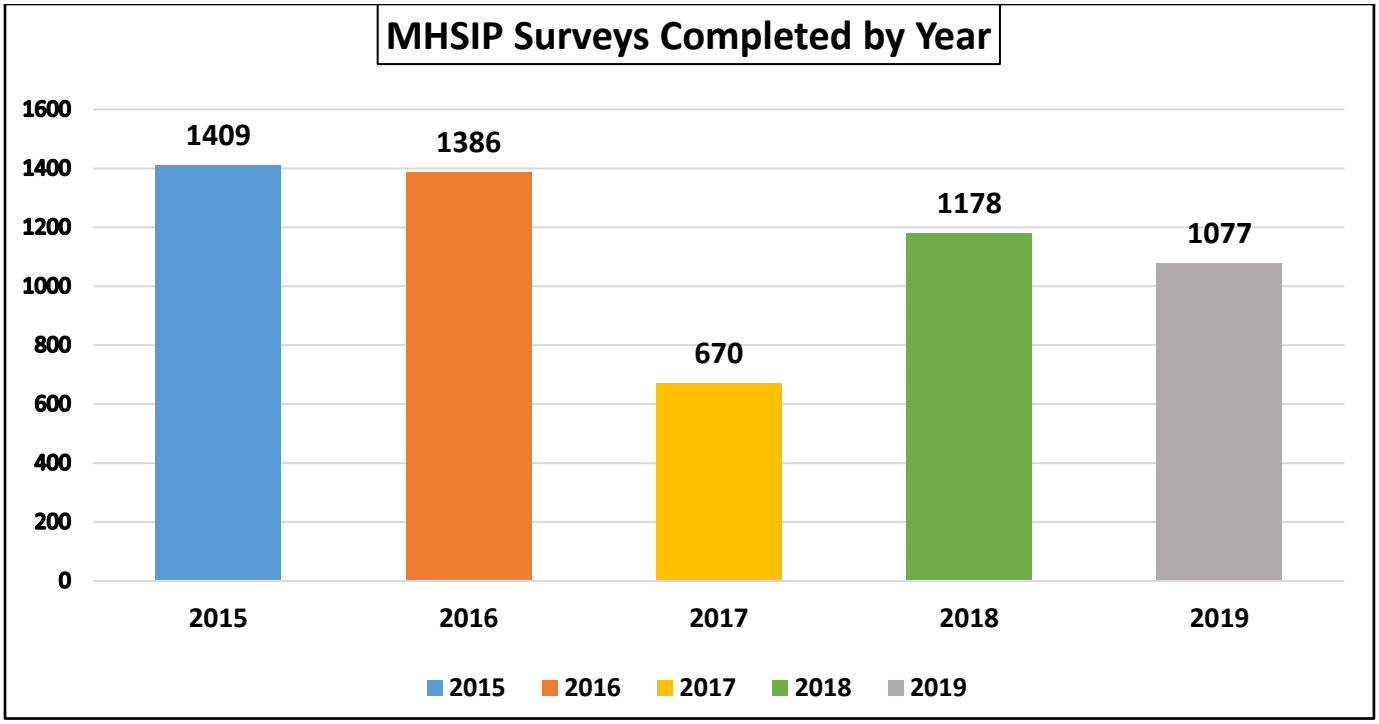
How the survey is conducted:

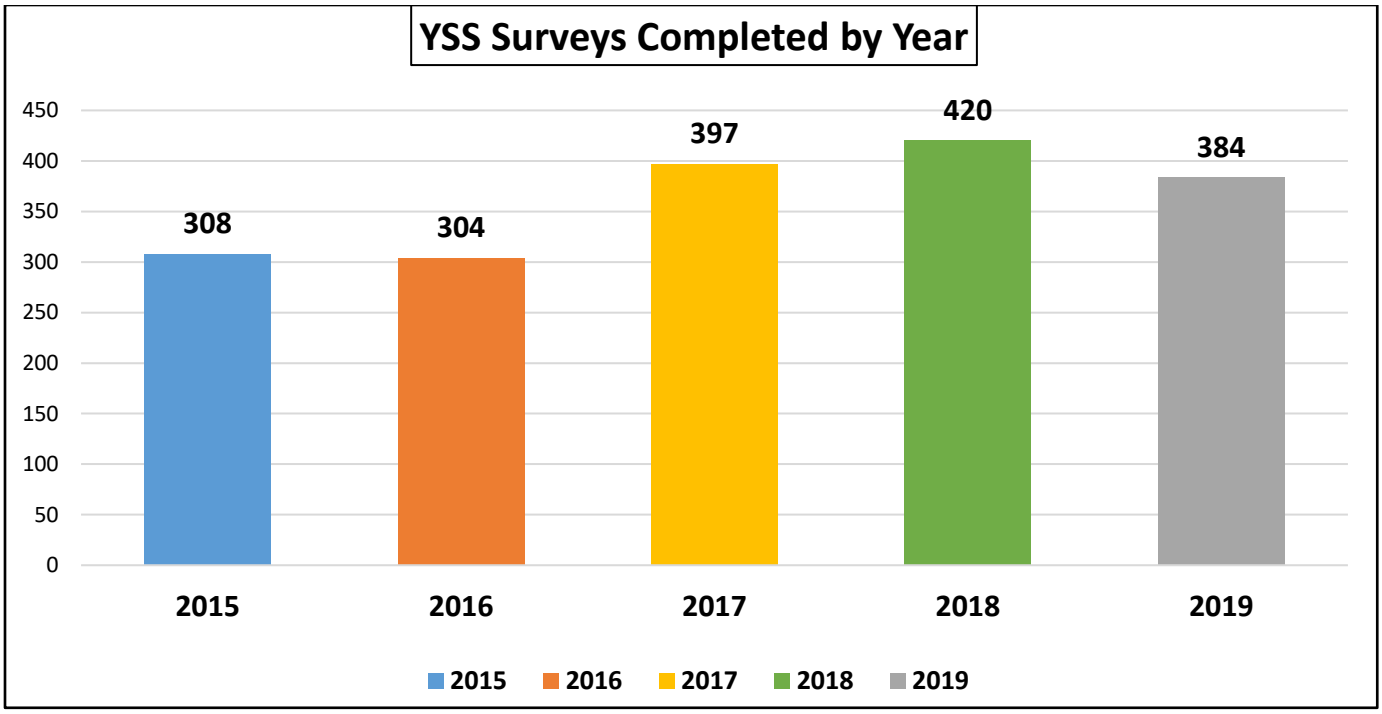
- Telephonically
- Using the following survey tools:
- Mental Health Statistics Improvement Program (MHSIP) – consumers 18 years + .
- Youth Services Survey (YSS) – under 18 years of age.

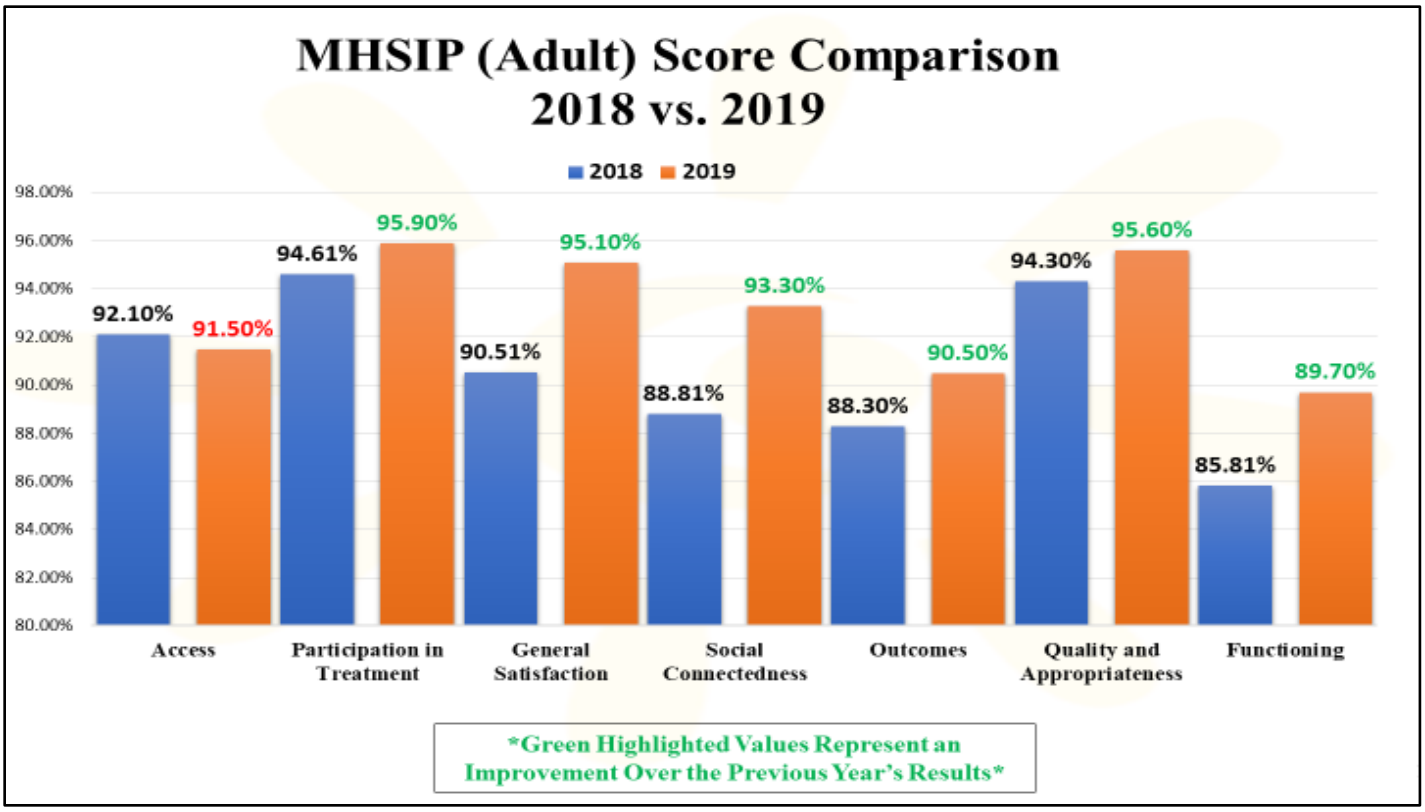
About the survey tools:

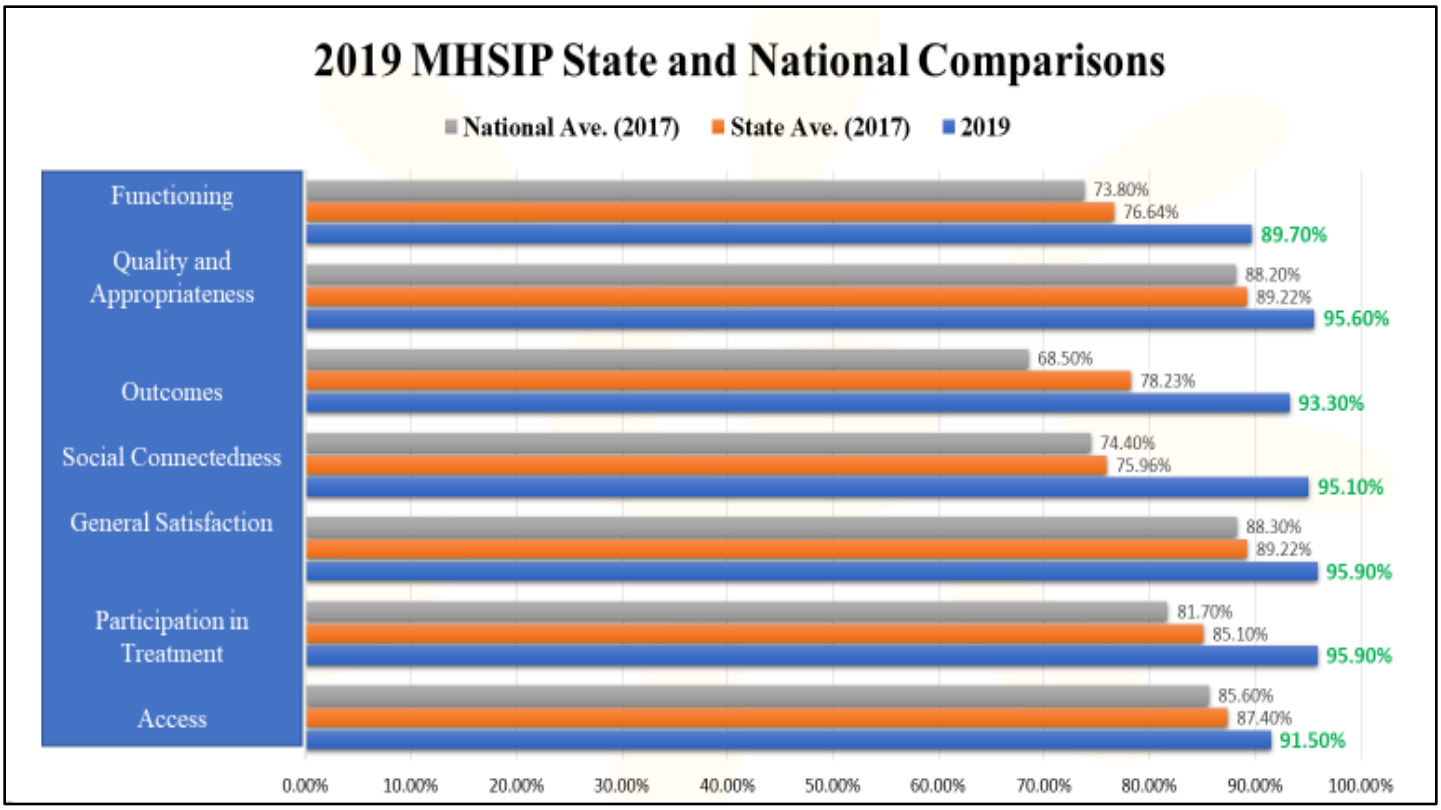
- Contractually obligated by MDHHS for SMWBH to utilize.
- Both offer a wide range of flexibility in the capturing of feedback.
- Offer comparison against other national and state results (currently implemented in 55 states).

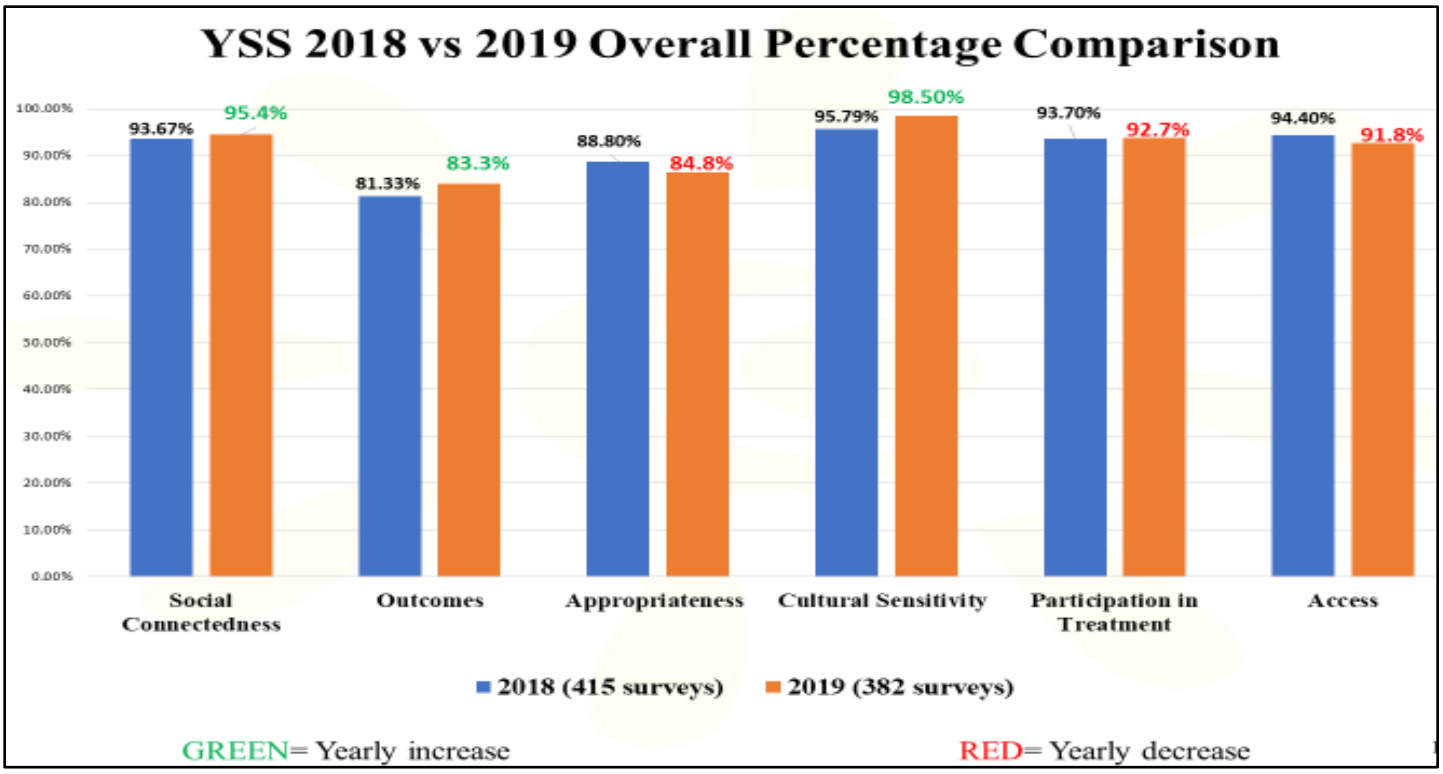
Complete survey results and consumer feedback can be found in the following slides

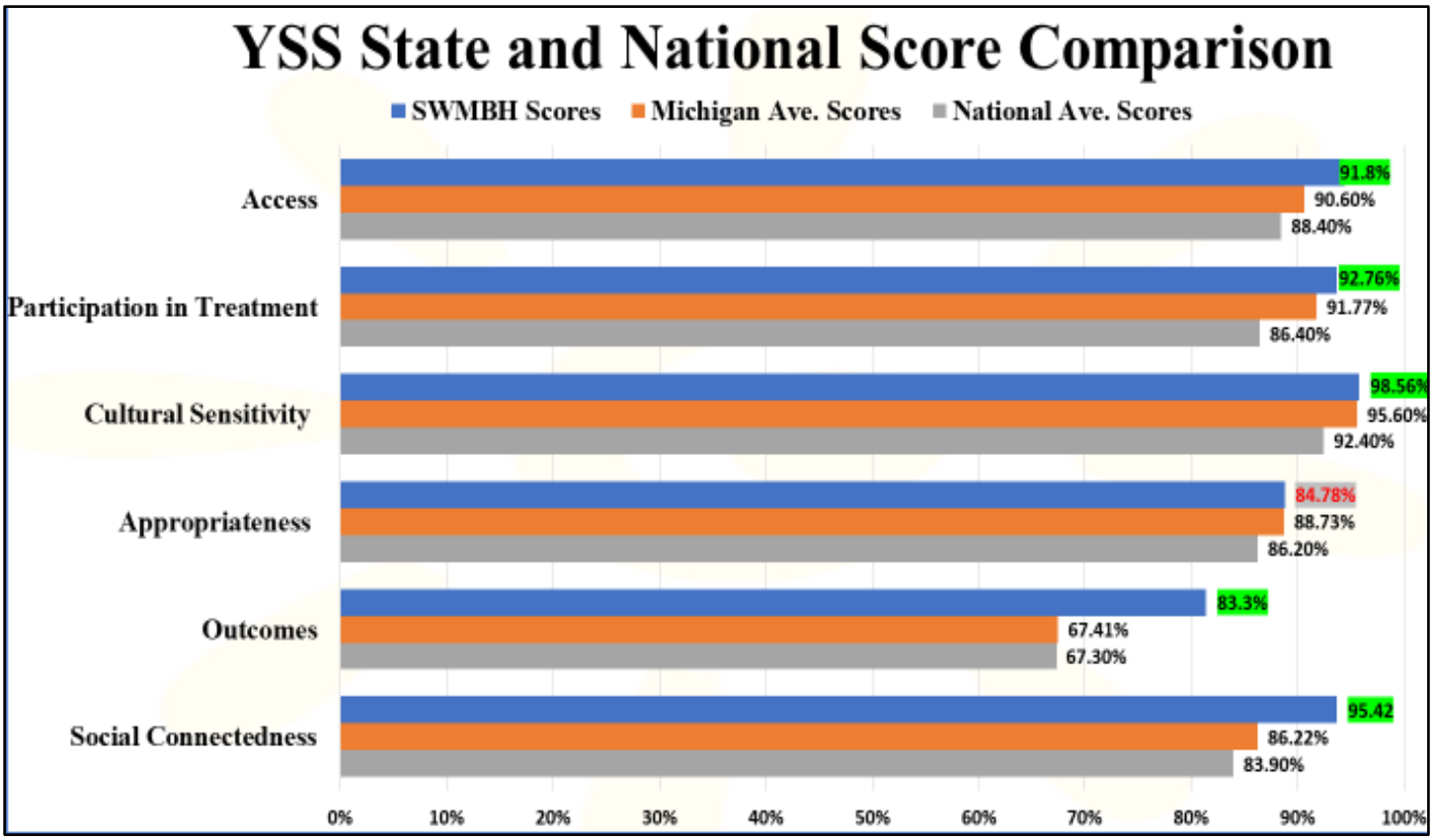

MHSIP Surveys Completed by Year
1600
1400
1200
1000
800
600
400
200
0
1409
1386
670
1178
1077
2015
2016
2017
2018
2019
2015 2016 2017 2018 2019


YSS Surveys Completed by Year
450
400
350
300
250
200
150
100
50
0
308
304
397
420
384
2015
2016
2017
2018
2019
2015 2016 2017 2018 2019

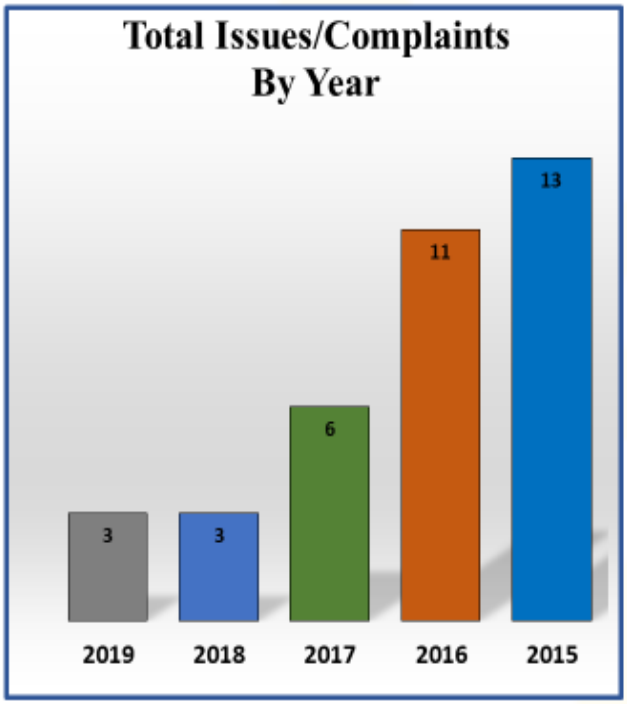

MHSIP (Adult) Score Comparison
2018 vs. 2019
2018
2019
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
92.10%
91.50%
94.61%
95.90%
90.51%
95.10%
88.81%
93.30%
88.30%
90.50%
94.30%
95.60%
85.81%
89.70%
Access
Participation in Treatment
General Satisfaction
Social Connectedness
Outcomes
Quality and Appropriateness
Functioning
Green Highlighted Values Represent an Improvement Over the Previous Year's Results


2019 MHSIP State and National Comparisons
National Ave. (2017)
State Ave. (2017)
2019
Functioning
73.80%
76.64%
89.70%
Quality and Appropriateness
88.20%
89.22%
95.60%
Outcomes
68.50%
78.23%
93.30%
Social Connectedness
74.40%
75.96%
95.10%
General Satisfaction
88.30%
89.22%
95.90%
Participation in Treatment
81.70%
85.10%
95.90%
Access
85.60%
87.40%
91.50%
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
90.00%
100.00%

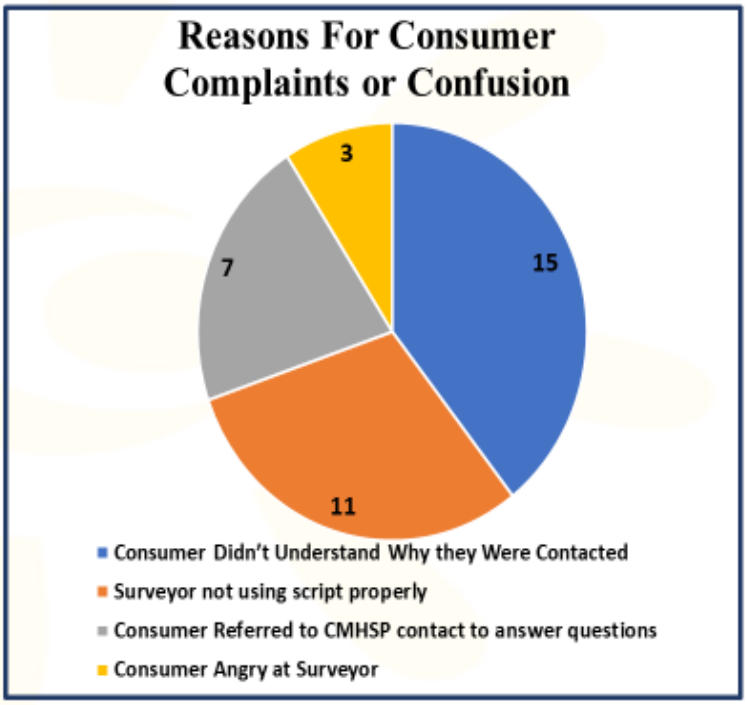

YSS 2018 vs 2019 Overall Percentage Comparison
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
93.67%
95.4%
81.33%
83.3%
88.80%
84.8%
95.79%
98.50%
93.70%
92.7%
94.40%
91.8%
Social Connectedness
Outcomes
Appropriateness
Cultural Sensitivity
Participation in Treatment
Access
2018 (415 surveys)
2019 (382 surveys)
GREEN= Yearly increase
RED= Yearly decrease


YSS State and National Score Comparison
SWMBH Scores
Michigan Ave. Scores
National Ave. Scores
Access
91.8%
90.60%
88.40%
Participation in Treatment
92.76%
91.77%
86.40%
Cultural Sensitivity
98.56%
95.60%
92.40%
Appropriateness
84.78%
88.73%
86.20%
Outcomes
83.3%
67.41%
67.30%
Social Connectedness
95.42
86.22%
83.90%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Consumer Issues and Complaints

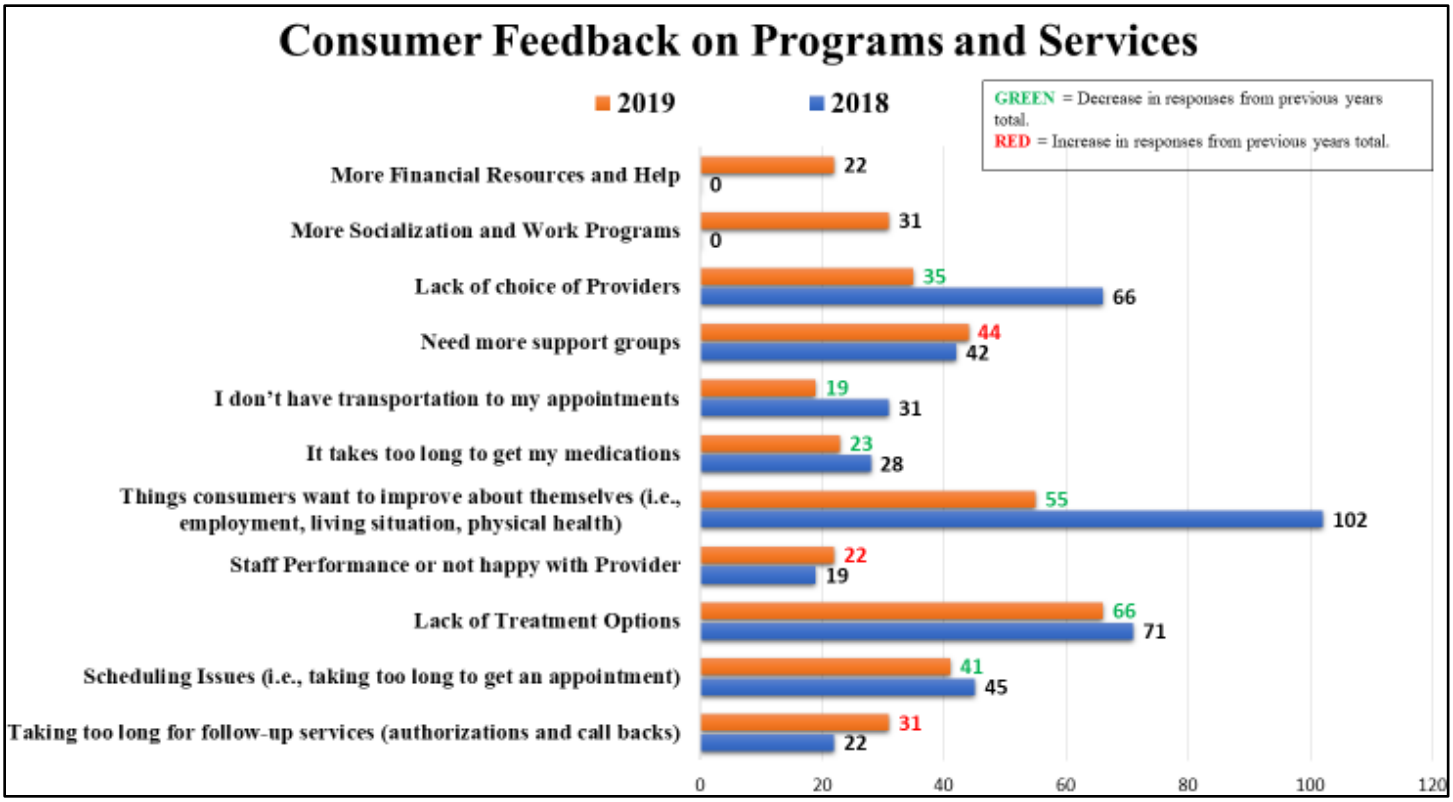


(3) Complaints during 2019



(36) Total Across All 5 Year's

Consumer Feedback on Programs and Services




Positive Feedback From Consumers Regarding Improved Outcomes
MY THERAPIST HELPED ME GET A REALATIONSHIP WITH MY FAMILY BACK
1
I CAN NOW LIVE INDEPENDTLY AND NOT HAVE TO RELY ON OTHERS
3
I FEEL COMFORTABLE IS SOCIAL SITUATIONS NOW
6
MY SOCIAL WORKER HELPED ME GO BACK TO WORK
6
THANKS TO MY THERAPIST, I HAVE NEVER FELT BETTER
2
I FEEL EMPOWERED TO MAKE MY OWN DECISIONS
3
GETTING MY MEDS RIGHT MADE A HUGE DIFFERENCE
5
MY THERAPIST TAUGHT ME HOW TO BE MY OWN ADVOCATE
2
I HAVE MY LIFE BACK
2
MY DOCTOR IS ALWAYS WILLING TO SEE ME AND IS UNDERSTANDING
5
WORK PROGRAMS ARE VERY HELPFUL
11
ACCESS TO MY DOCTOR AND THERAPIST IS VERY GOOD
13
GROUP THERAPY AND PEER SUPPORT GROUPS REALLY HELP
20
I LOVE MY THERAPIST AND INDIVIDUAL SESSIONS
21
MY SOCIAL WORKER IS EXCEPTIONAL
30
0
5
10
15
20
25
30
35


Direct Service Consumer Feedback and Opportunities for Improvement
MY THERAPIST NEEDS TO LISTEN BEFORE MAKING JUDGEMENTS
3
FRONT DESK AT CMHSPS SHOW NO EMOTION OR COMPASSION
4
MY CMHSP WONT GIVE ME A RIDE TO MY APPOINTMENTS
7
I WAITED LONGER THAN 2 WEEKS FOR A MED REFILL
7
THE LENGTH OF MY APPOINTMENTS ARE TO SHORT AND RUSHED
8
EASIER ACCESS TO TALK TO INDIVIDUALS INSTEAD OF A SWITCHBOARD WHEN YOU CALL
9
IT TAKES A LONG TIME FOR MY CMHSP TO ANSWER THE PHONE
11
0
2
4
6
8
10
12

2019 Consumer Satisfaction Survey Analysis and Opportunities for Improvement

Objective:

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 access, participation in treatment, general satisfaction, social connectedness, quality, and appropriateness, and outcomes. THE MHSIP consists of 44 questions. 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 has (6) different measurements; social connectedness, outcomes, appropriateness, cultural sensitivity, participation in treatment, and access. THE YSS consists of 46 questions.

Results:

*SWMBH achieved an overall **+2.76% Percent Improvement** over the 2018 Results*. This met the Board Ends Metric target, which is indicated: Consumer Satisfaction Surveys collected by SWMBH during 2019 are at or above the SWMBH 2018 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey). These categories were selected, as they have been the lowest-scoring categories measured over the past 4 years.

The 2019 survey project also resulted in a tie with the 2018 survey year, for the fewest consumer complaints (3). Total Number of Consumer Complaints by year: 2015 – (13); 2016 – (11) and 2017 – (6); 2018 – (3); 2019 – (3). The decrease in consumer complaints over the past 2 years is primarily attributed to better advertisement and communications regarding the survey before it begins. Letters are sent to all consumers who may be selected to take the survey, explaining why participation is important, and their feedback will be used to improve programs and services. Additionally, the QAPI team implemented (2) audits on the survey vendor; to ensure scripts were being followed correctly by the surveyors. This helped delivery and explanation to the consumers remain consistent and accurate. Furthermore, this year the QAPI team selected a new survey vendor that may have positively affected the results.

Identified Barriers:

The 2019 survey process got off to a late start but picked up momentum quickly. Due to the late start, this didn't give us as much time to train the surveyors as we would have liked. This is our second year working with the selected vendor, so we are still working through how to train surveyors while ensuring maximum efficiency. The QAPI Department has adjusted processes/schedules to begin the surveys earlier in 2020. We believe an earlier start will allow us to achieve a higher rate of samples and target a more validated sample size for each CMHSP. The QAPI department has also adjusted processes, to only request the minimum information necessary from CMHSPs when identifying eligible survey participants. This will help eliminate exposure to Protected Health Information from SWMBH to the selected survey vendor.

Recommendations:

SWMBH is aware that significant improvement in each category measured in the survey is not sustainable every year. SWMBH has adjusted its Board Ends Metric to target identified categories that need the most improvement and have been our Regions' lowest scores in the past (3) years.
In 2020, through consumer feedback analysis, some access issues were identified as a trend. Specific issues included; waiting too long to see a provider, waiting too long for Rx refills, timeliness of answering phones at particular locations, and lack of transportation options to attend appointments. SWMBH will work through Regional Committees to develop a performance improvement plan and causal analysis, which targets improvement in timeliness of access to care for the consumers we serve. CMHSP's were also requested to complete performance improvement projects, based on their specific results from the development of CMHSP tailored reports for all (8) Counties. The CMHSP specific reports were delivered on 2/24/2020.

MI Health Link Satisfaction

MIHL Medicare Business Line
Consumer Satisfaction Survey Analysis

Core contractual deliverable to our Integrated Healthcare Partners
(Meridian & Aetna Health Plans)

- Measures concerns that are important to consumers, who are enrolled under Meridian or Aetna Health Plans, who received Mental Health or Substance Abuse Service Authorizations by Southwest Michigan Behavioral Health (SWMBH)

This includes:

- **Improved functioning**
- **Quality and Appropriateness**
- **Outcomes**
- **Social Connectedness**
- **General Satisfaction**
- **Participation in treatment**
- **Access**

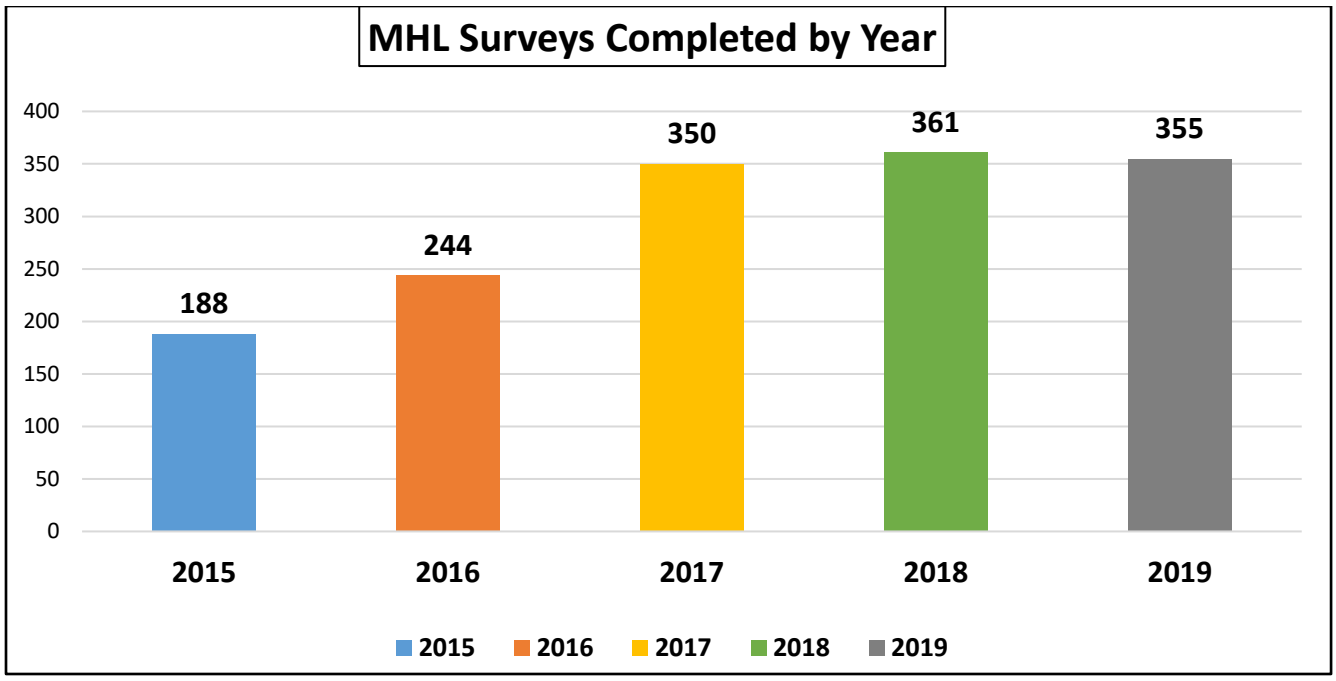
How Did We Do?

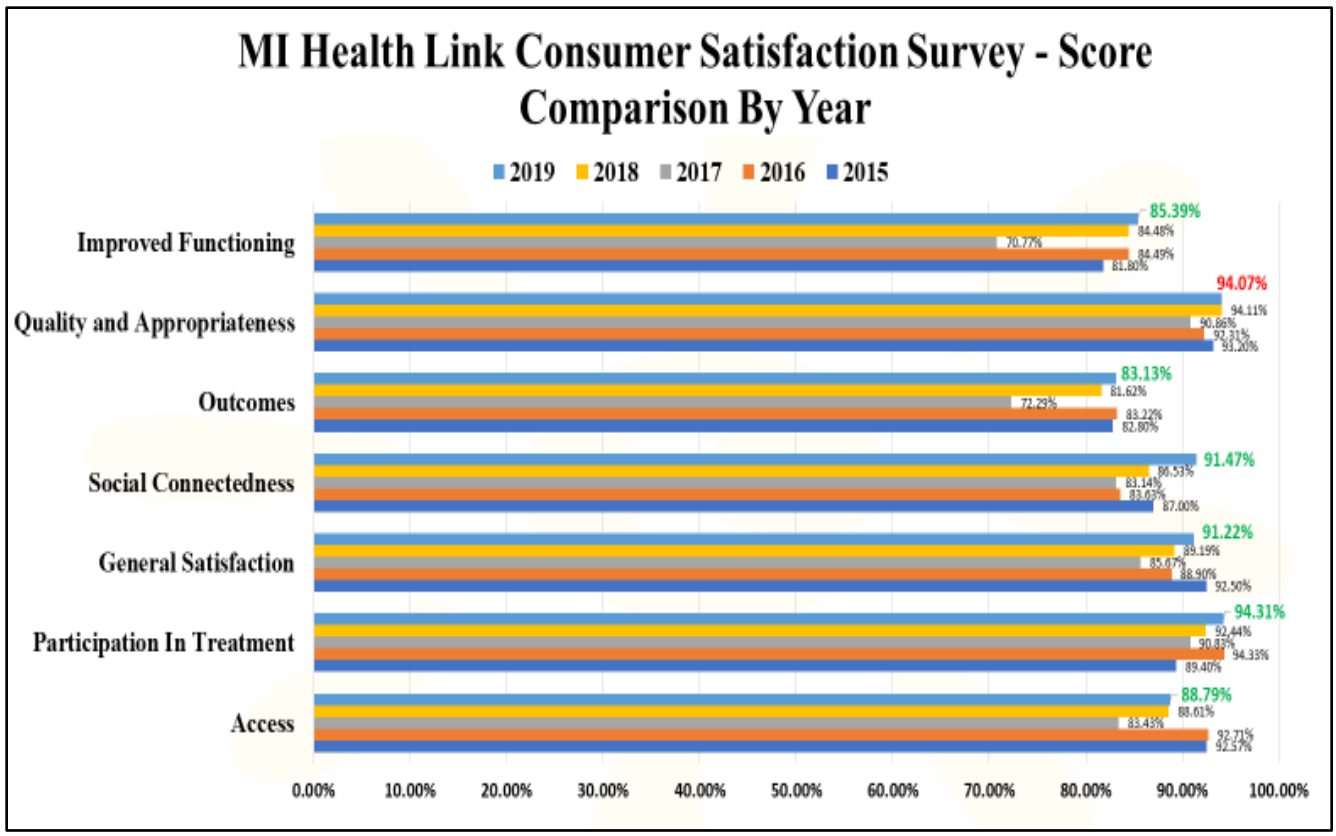
MIHL Results

- ❑2019 Aggregate Score: 89.8%
- ❑2018 Aggregate Score: 88.1%

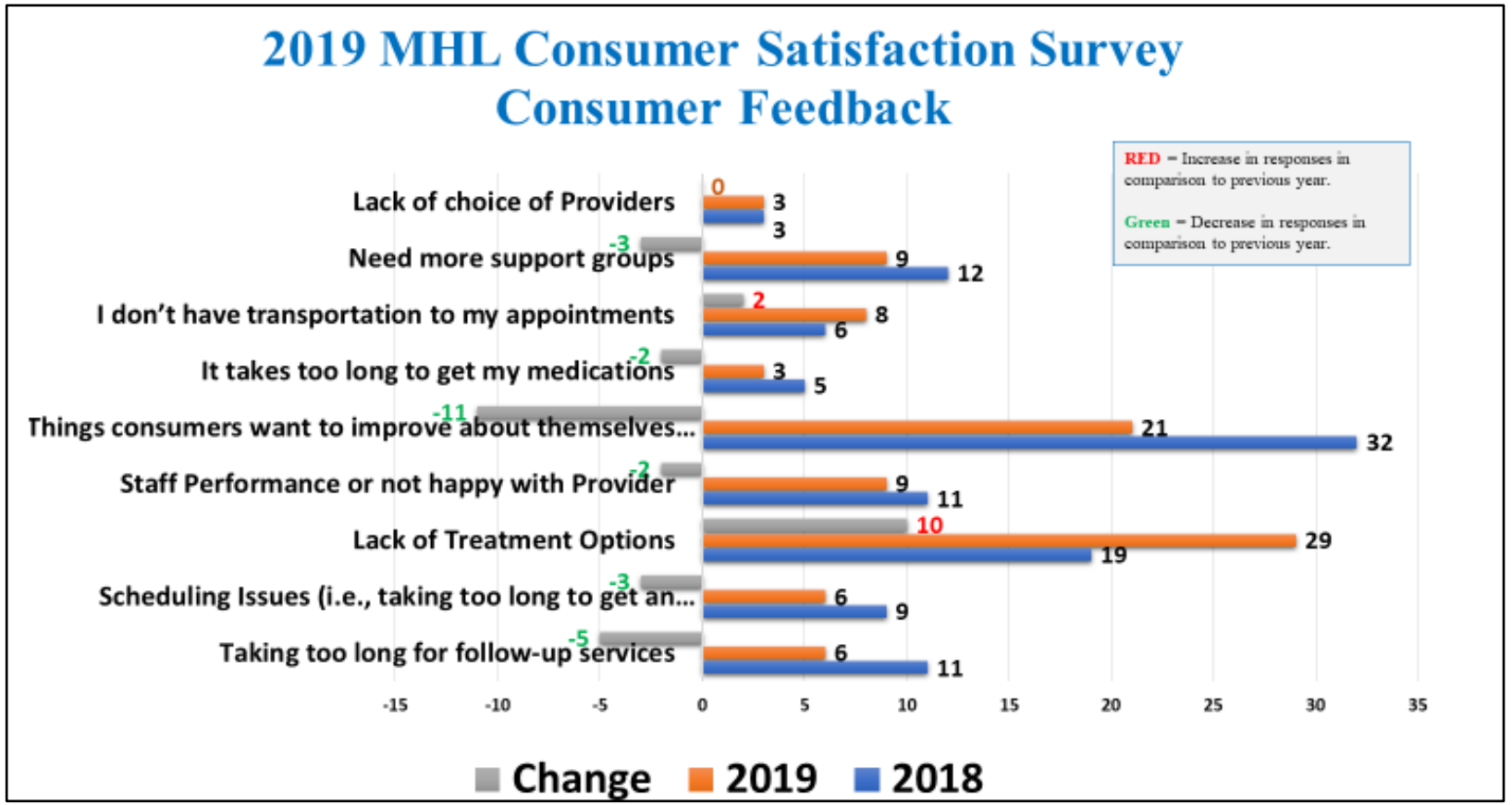
- ❑2019 Response Rate: 37.4%
- ❑2018 Response Rate: 39.7%

+1.7% Percent Improvement over 2018 Scores





*Improvement in (6 of 7) total categories was achieved during the 2019 survey period.



Summary of Finding:

In summary, (355) valid surveys were completed, resulting in a 37.4% response rate. The response rate was down a touch in comparison to 2018 results 42.9%, but was not considered significant, and still well ahead of the national average. This response rate is very good and attributed to the letters and advertisement efforts taken before the survey implementation. The current 2019 results are a significant improvement over the 2018 results. The percentages of 'In Agreement' ratings across domain areas are also higher this year, netting an average 'In Agreement' score of 3.98 on a 5.0 scale, in comparison to the 2018 average 'In Agreement' score of 3.44. The Quality Department will continue to evaluate consumer survey participant feedback to identify common denominators and trends associated with the 2019 survey process. The current results tend to reflect national trends for the respective MHSIP survey tool domains. They tend to reflect results reported by [some] states that employ credible survey methods for MHSIP URS (SAMSHA) reporting (i.e., Oregon / Utah / Ohio / California…). These states have similar evaluation and validation processes as Southwest Michigan Behavioral Health.

Improvement Measures:

During the 2019 survey process and evaluation, it was identified that increased vendor oversight and monitoring needed to occur. In 2018 it was found that some surveyors were inconsistent using scripts and identified themselves incorrectly to consumers. This caused some confusion for the consumers in understanding the significance of their participation in the survey. Due to this finding, SWMBH sent out letters to all potential members who may be selected to receive a survey call. The letter informed the consumer of the purpose of the survey and how their responses will be used to improve programs and services.

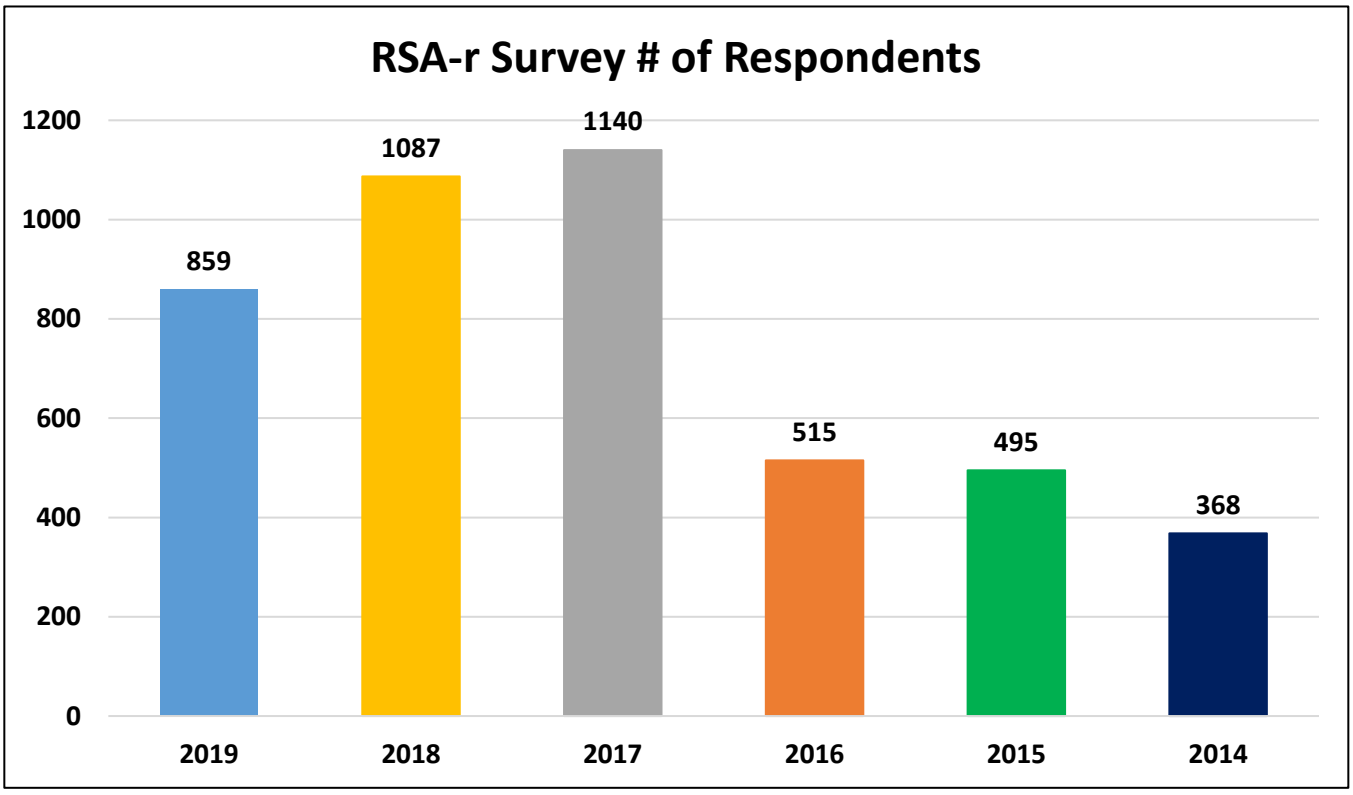
Additionally, SWMBH Management made (2) random visits to the vendor/survey location to observe the consistency in scripts and survey protocol was being followed correctly. It was found that the 4 surveyors evaluated were using the appropriate scripts and techniques they had been educated on. Consumer feedback and comments will be assessed to identify potential trends. Workgroups and Regional Committees will review the detailed data and formulate a performance improvement plan for categories with identified outliers.

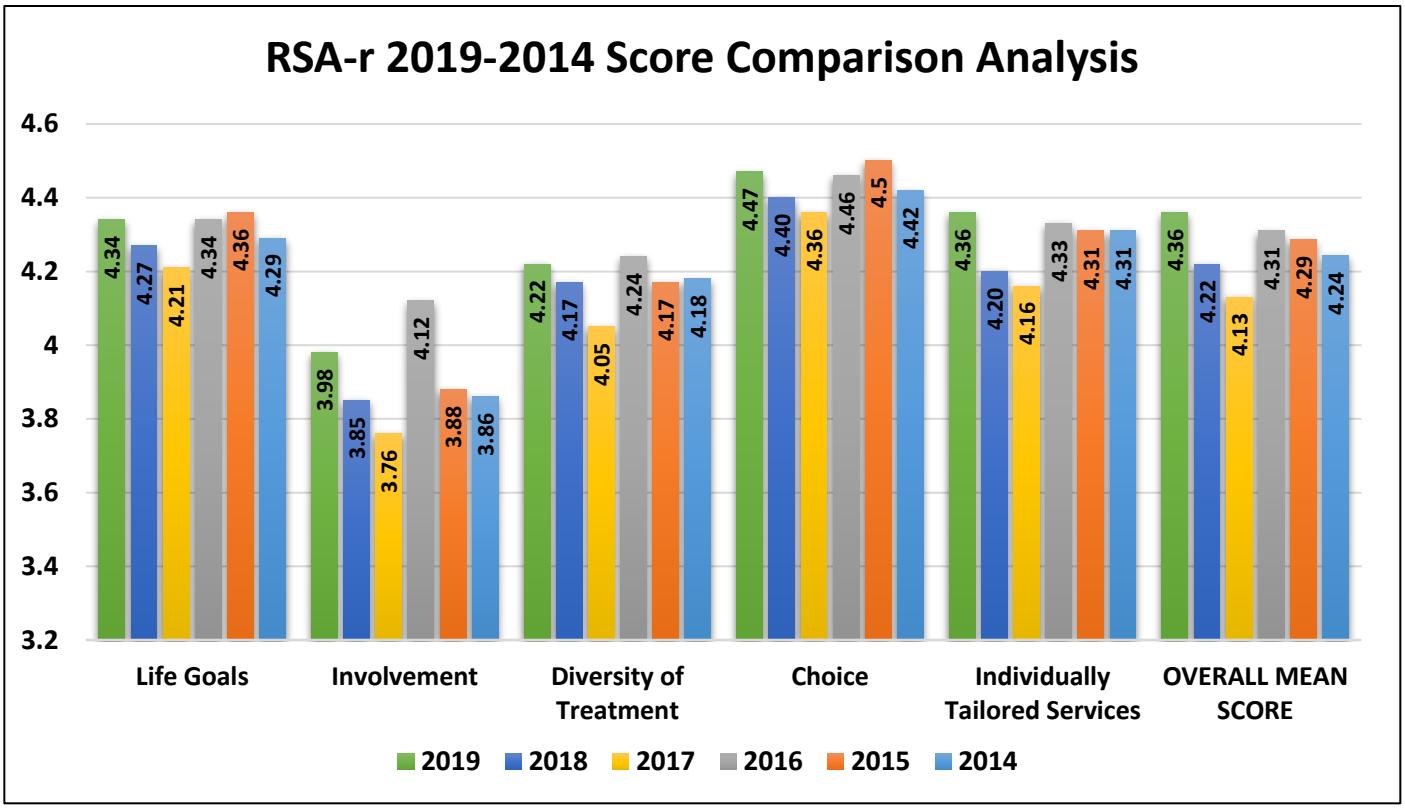
Recovery Self-Assessment – Person in Recovery (RSA-r) Survey

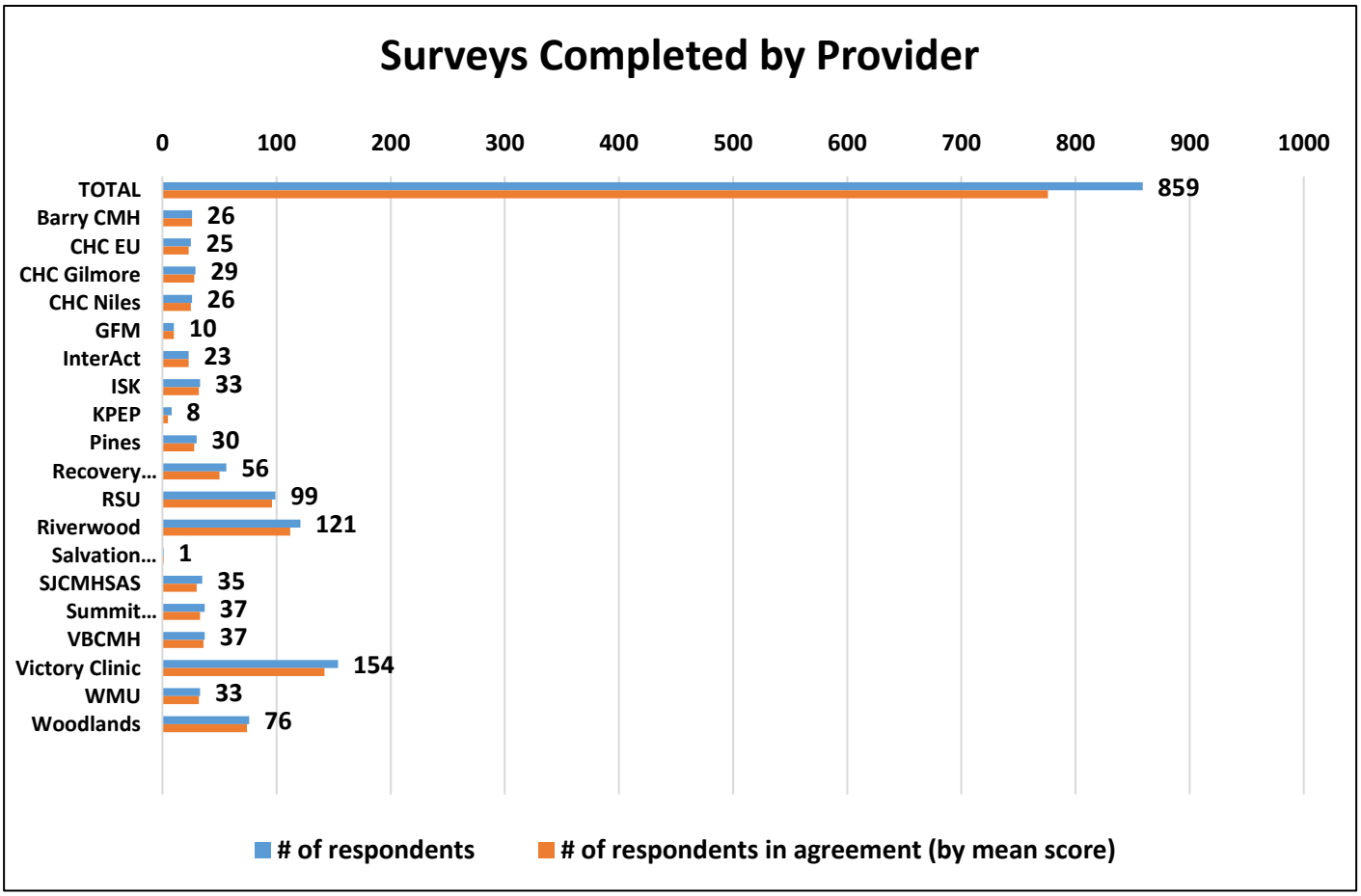
RSA-r Results Year Comparison

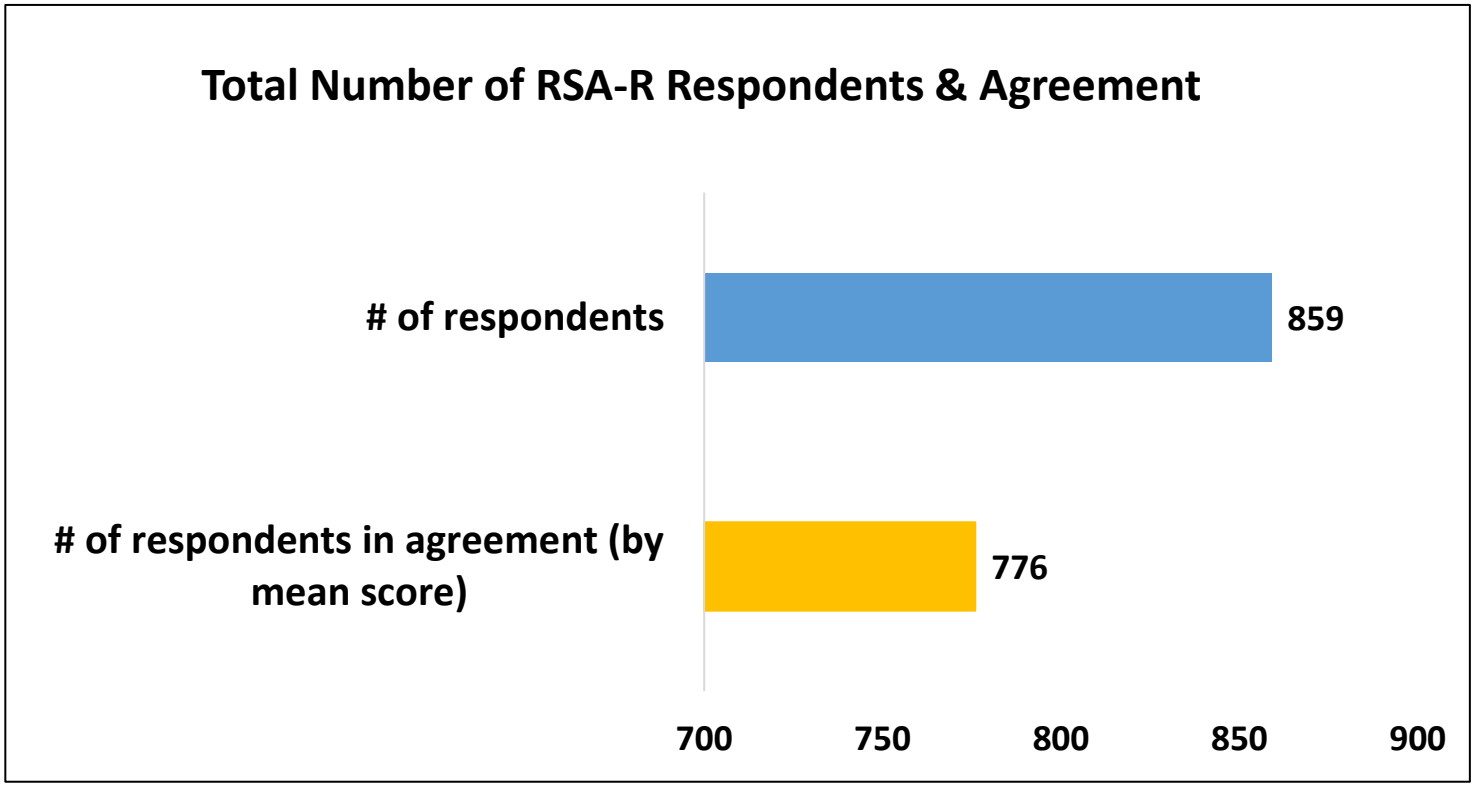
- ❑ 2019 Overall Mean Score: 4.36
  (+0.14 Percent increase from 2018)
- ❑ 2018 Overall Mean Score: 4.22
- ❑ 2017 Overall Mean Score: 4.13
- ❑ 2016 Overall Mean Score: 4.31
- ❑ 2015 Overall Mean Score: 4.29
- ❑ 2014 Overall Mean Score: 4.24

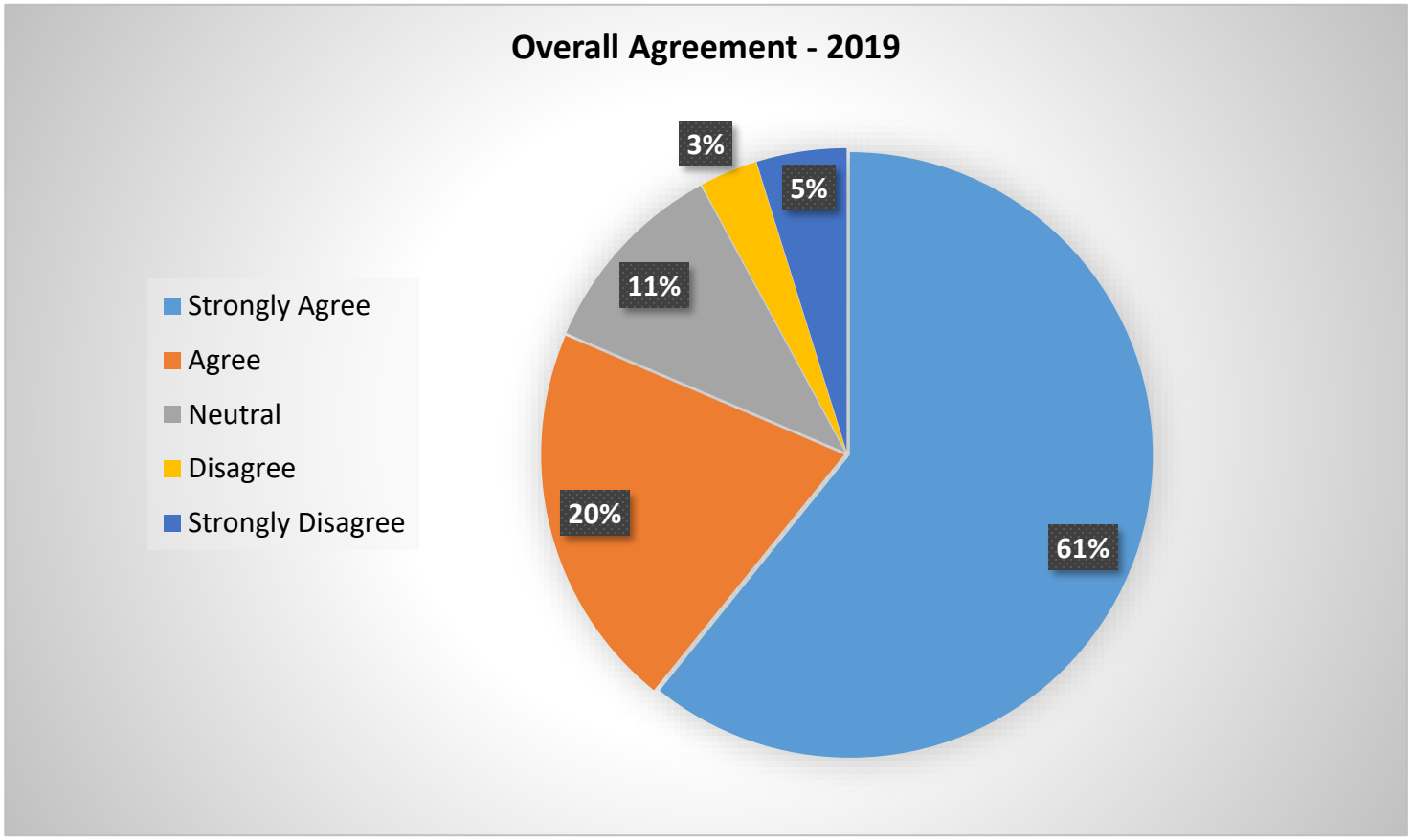
6 Year Average	Mean Score
Life Goals (Q3,Q7,Q8,Q9,Q12,Q16,Q17,Q18,Q28,Q31,Q32)	**4.30**
Involvement (Q22,Q23,Q24,Q25,Q29	**3.91**
Diversity of Treatment (Q14,Q15,Q20,Q21,Q26)	**4.17**
Choice (Q10, Q27, Q4, Q5, Q6)	**4.44**
Individually Tailored Services (Q11, Q13, Q19, Q30)	**4.28**

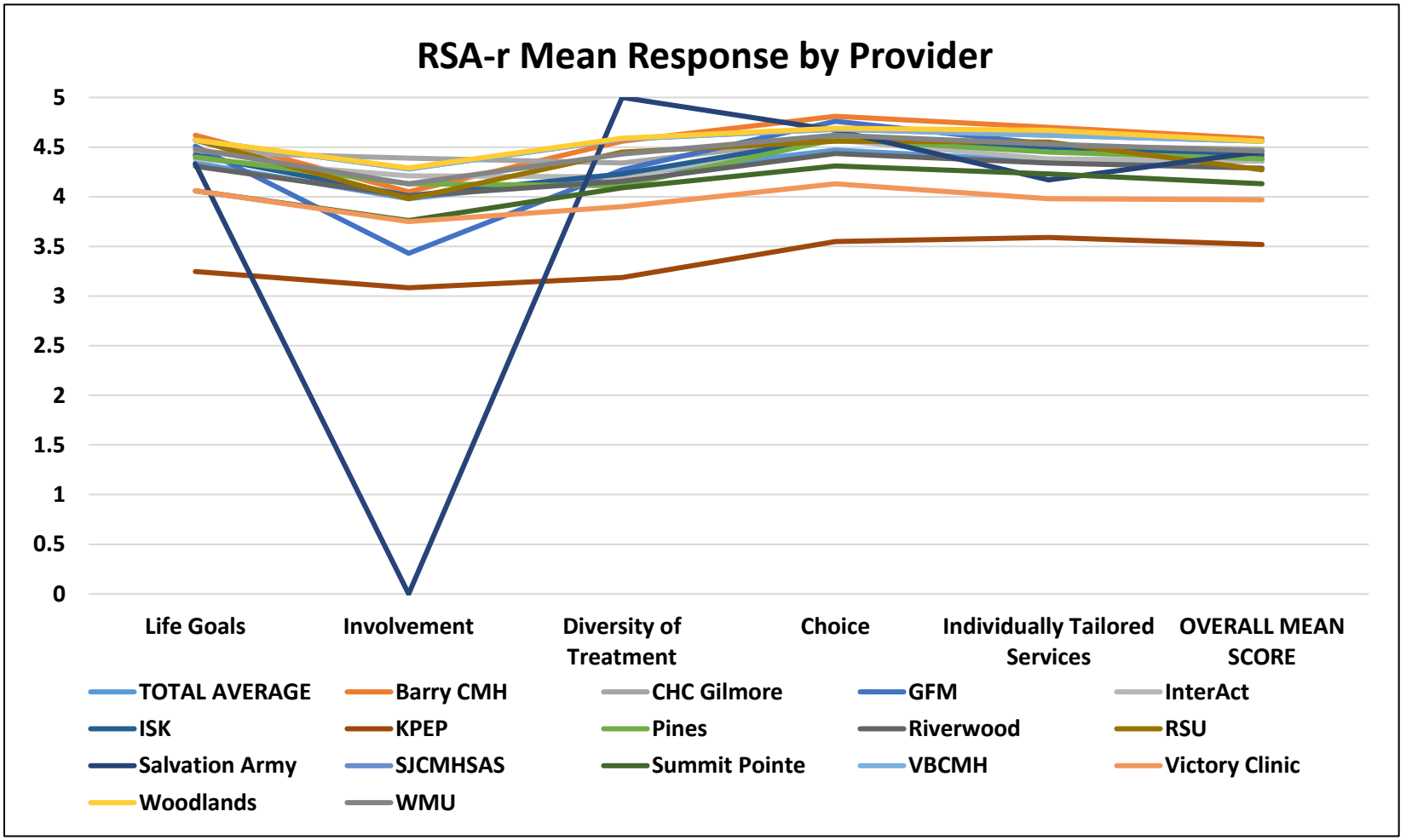


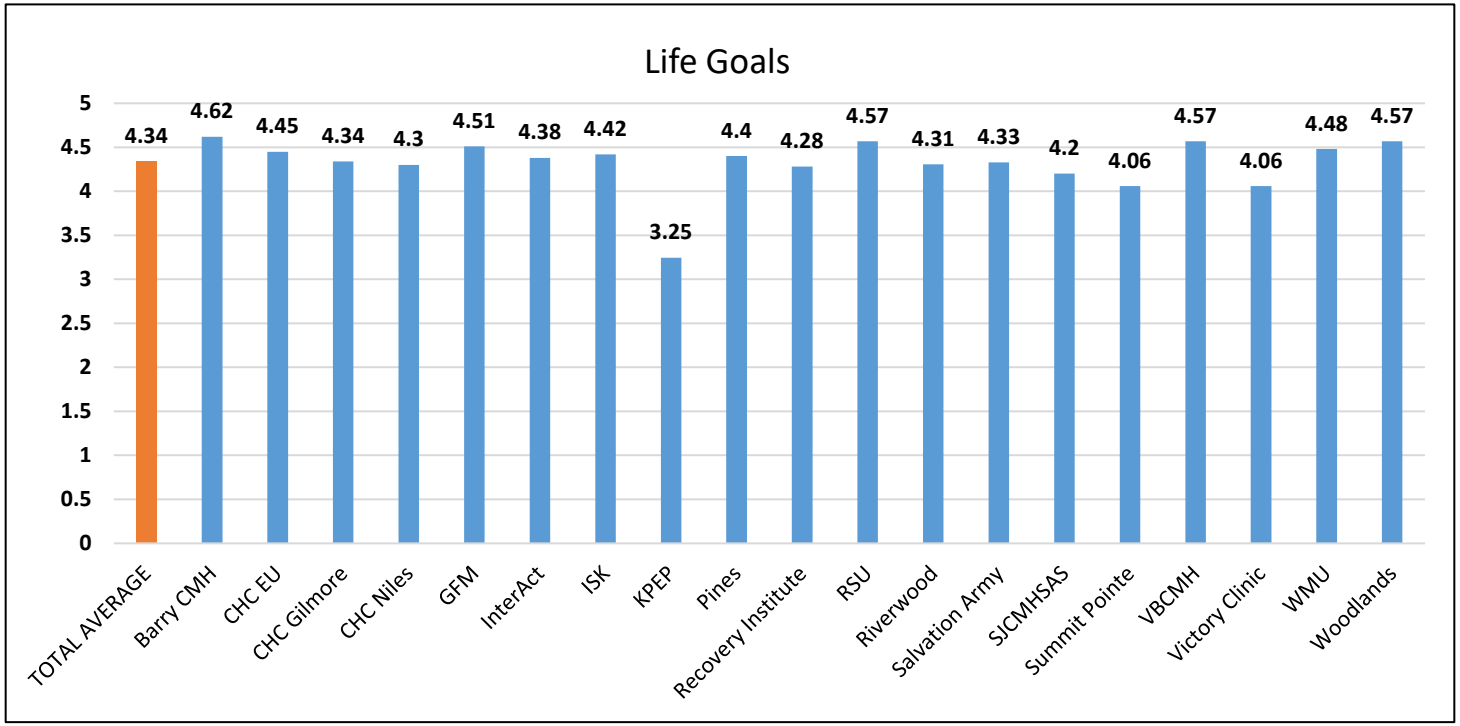

RSA-r 2019-2014 Score Comparison Analysis
4.6
4.4
4.2
4
3.8
3.6
3.4
3.2
4.34 4.27 4.21 4.34 4.36 4.29
3.98 3.85 3.76 4.12 3.88 3.86
4.22 4.17 4.05 4.24 4.17 4.18
4.47 4.40 4.36 4.46 4.5 4.42
4.36 4.20 4.16 4.33 4.31 4.31
4.36 4.22 4.13 4.31 4.29 4.24
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE
2019 2018 2017 2016 2015 2014


Surveys Completed by Provider
0 100 200 300 400 500 600 700 800 900 1000
TOTAL 859
Barry CMH 26
CHC EU 25
CHC Gilmore 29
CHC Niles 26
GFM 10
InterAct 23
ISK 33
KPEP 8
Pines 30
Recovery... 56
RSU 99
Riverwood 121
Salvation... 1
SJCMHSAS 35
Summit... 37
VBCMH 37
Victory Clinic 154
WMU 33
Woodlands 76
# of respondents
# of respondents in agreement (by mean score)

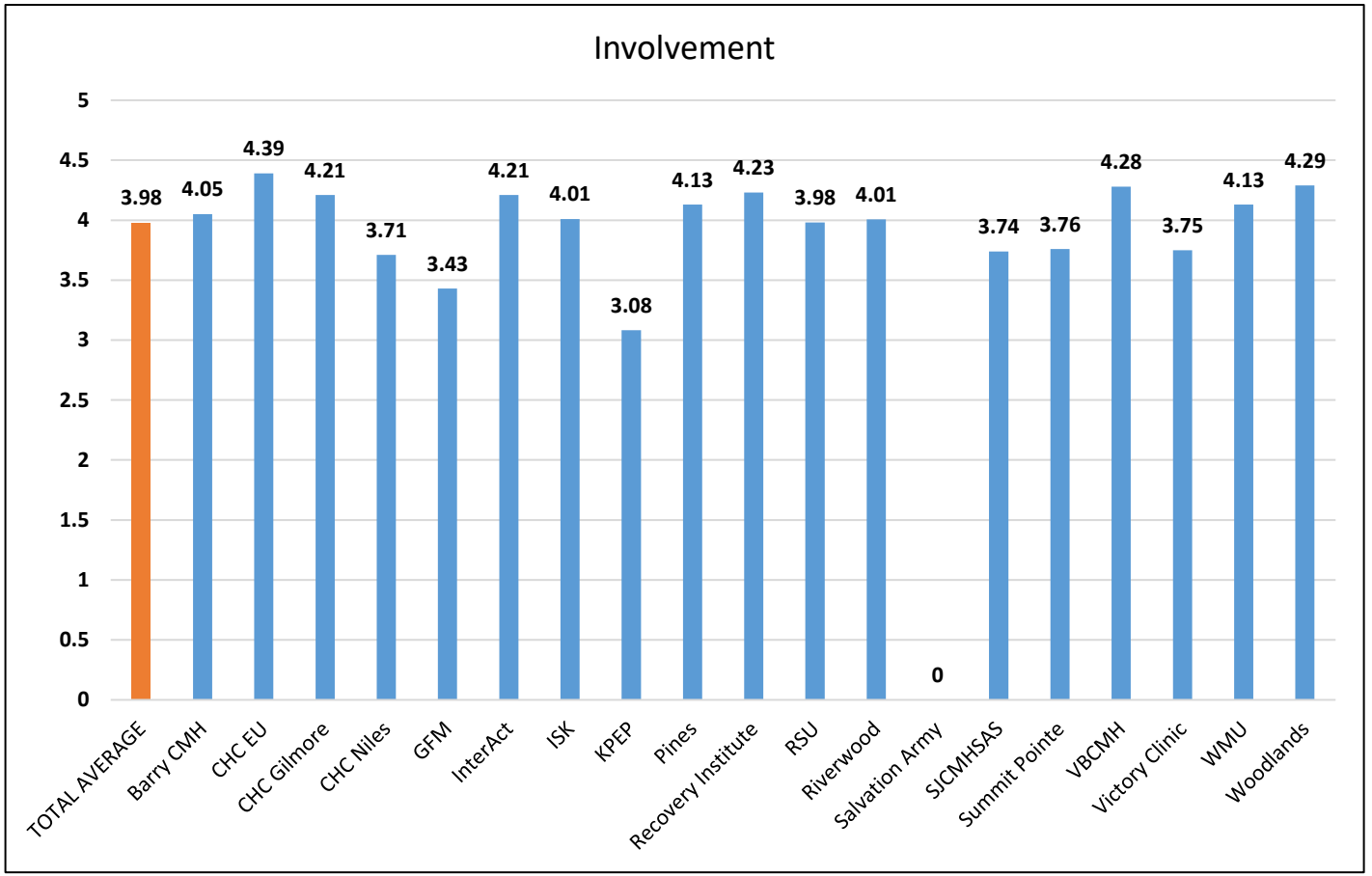

Total Number of RSA-R Respondents & Agreement
# of respondents
859
# of respondents in agreement (by mean score)
776
700
750
800
850
900


Overall Agreement - 2019
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
3%
5%
11%
20%
61%

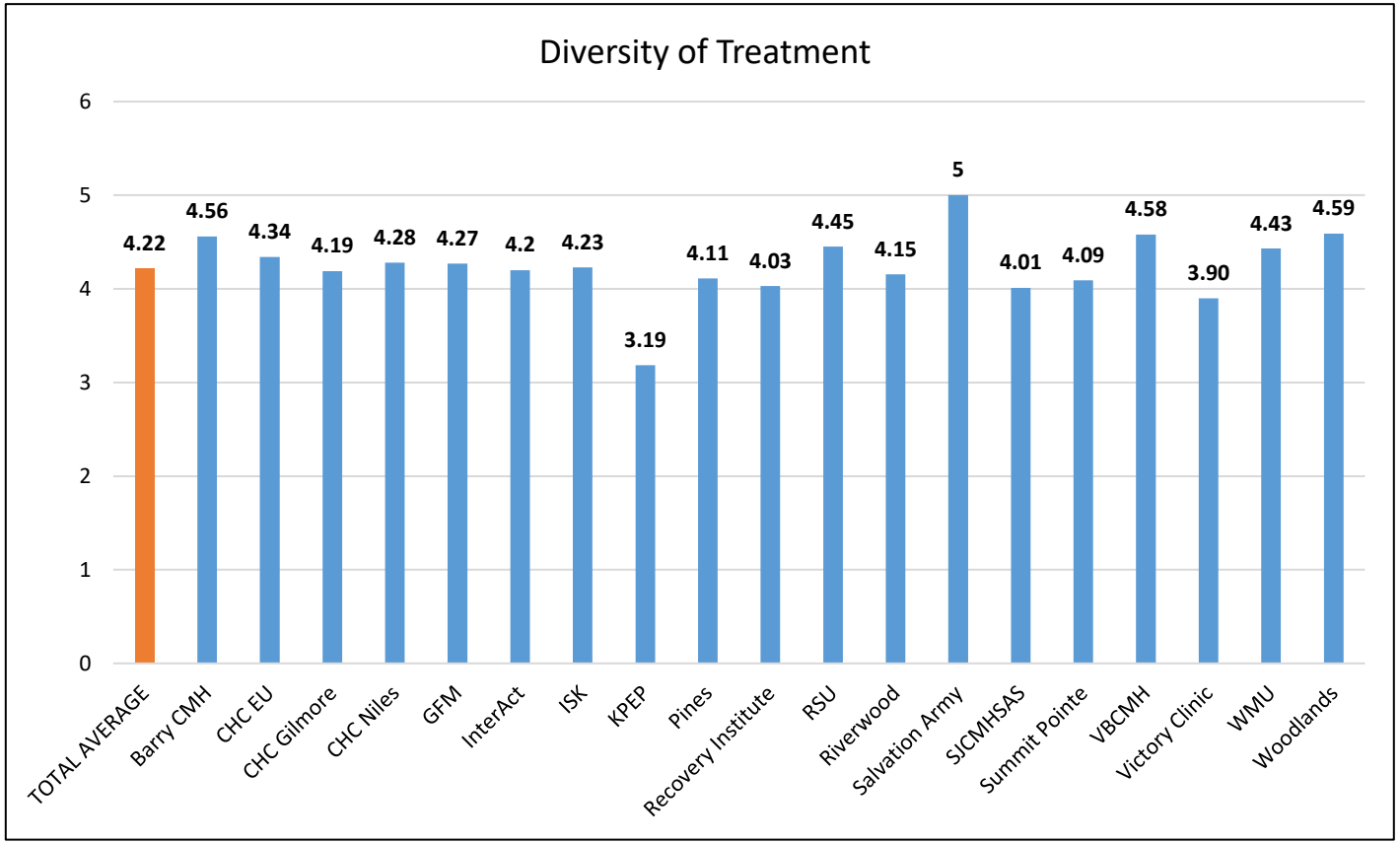

RSA-r Mean Response by Provider
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE
TOTAL AVERAGE
Barry CMH
CHC Gilmore
GFM
InterAct
ISK
KPEP
Pines
Riverwood
RSU
Salvation Army
SJCMHSAS
Summit Pointe
VBCMH
Victory Clinic
Woodlands
WMU



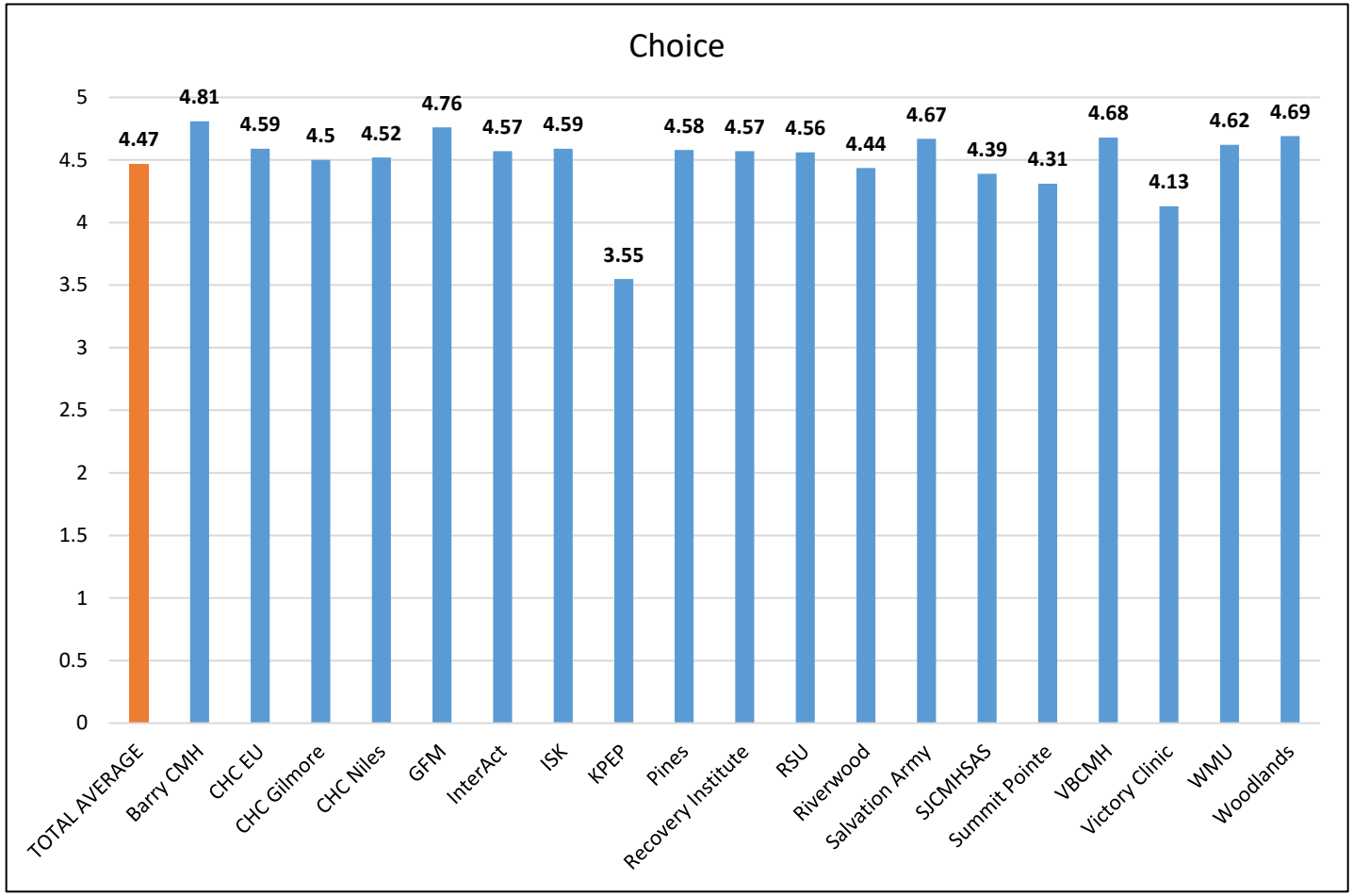
- 3. Staff encourage program participants to have hope and high expectations for their recovery.
- 7. Staff believe in the ability of program participants to recover.
- 8. Staff believe that program participants have the ability to manage their own symptoms.
- 9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
- 12. Staff encourage program participants to take risks and try new things.
- 16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g. employment, education physical fitness, connecting with family and friends, hobbies).
- 17. Staff routinely assist program participants with getting jobs.
- 18. Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.
- 28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
- 31. Staff are knowledgeable about special interest groups and activities in the community.
- 32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.



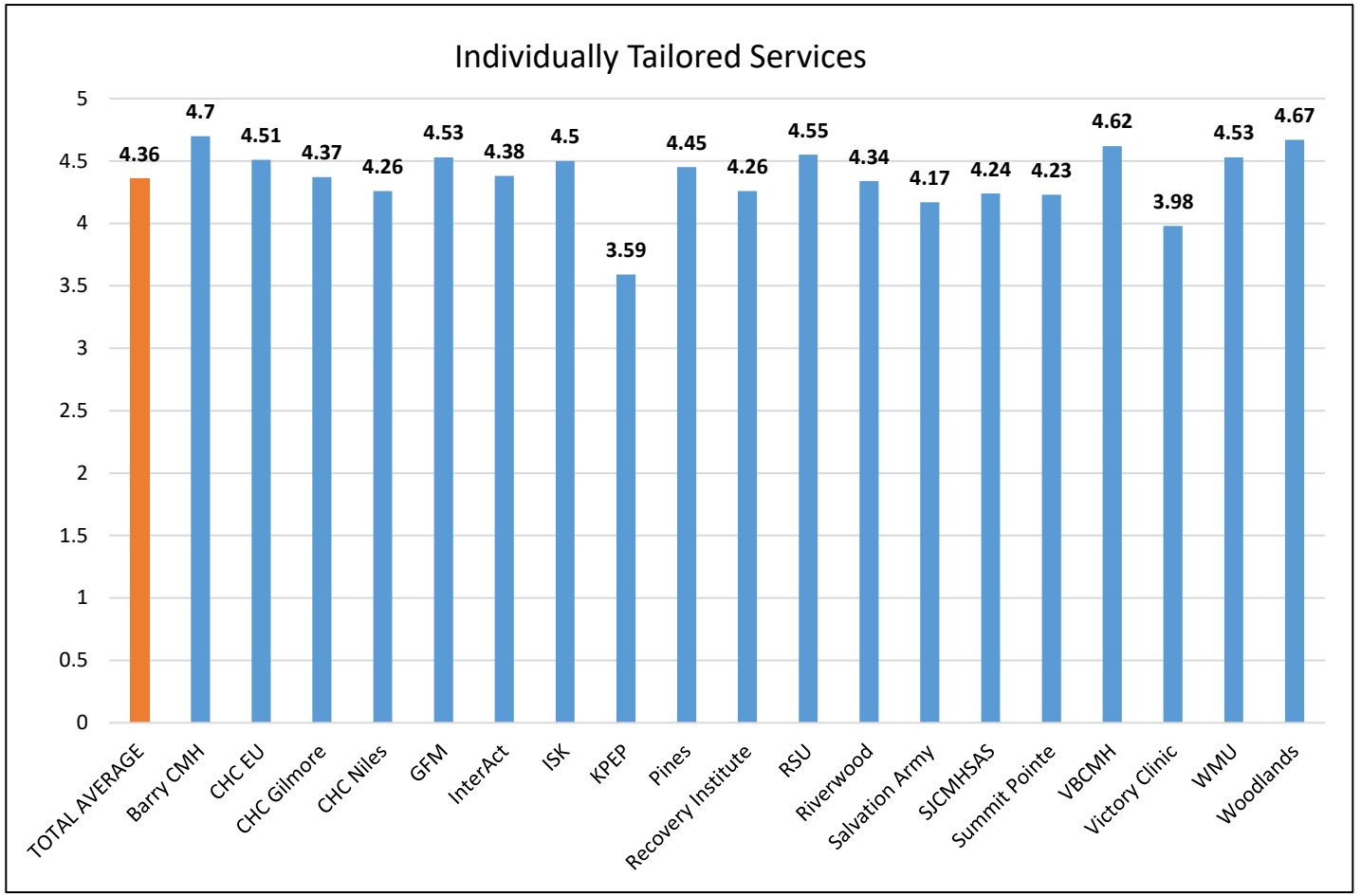
- 22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
- 23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
- 24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
- 25. People in recovery are encouraged to attend agency advisory boards and management meetings.
- 29. Persons in recovery are involved with facilitating staff trainings and education at this program.



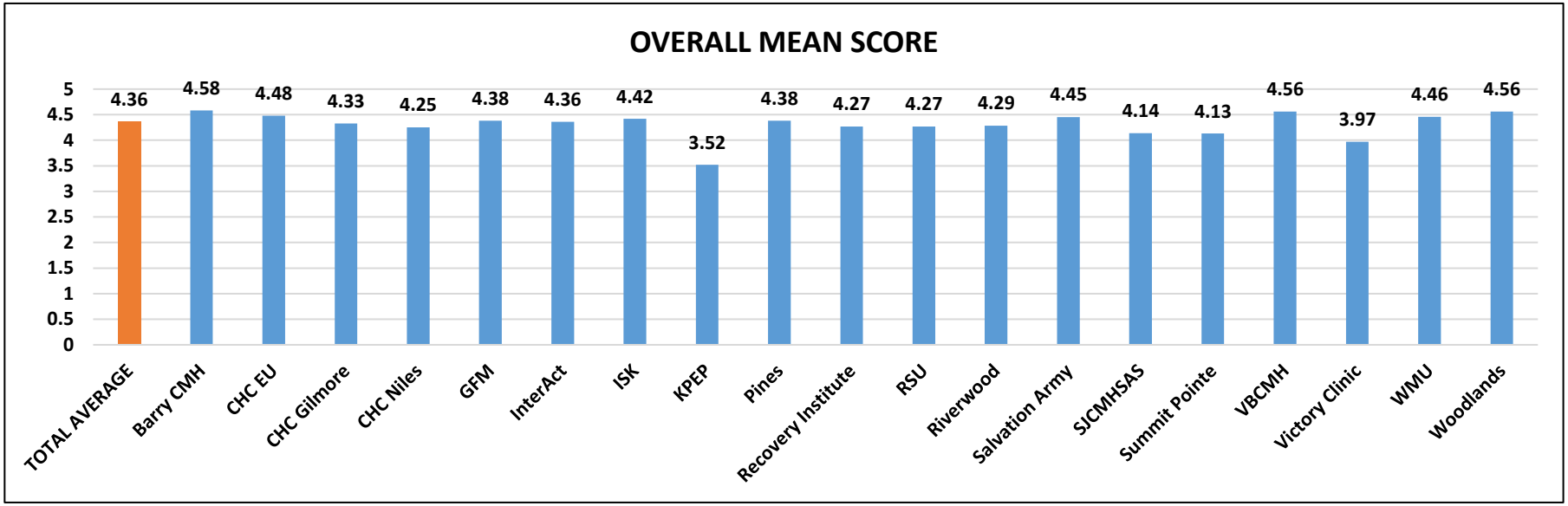
- 14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
- 15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
- 20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
- 21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
- 26. Staff talk with program participants about what it takes to complete or exit the program.



- 4. Program participants can change their clinician or case manager if they wish.
- 5. Program participants can easily access their treatment records if they wish.
- 6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
- 10. Staff listen to and respect the decisions that program participants make about their treatment and care.
- 27. Progress made towards an individual's own personal goals is tracked regularly.



- 11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
- 13. This program offers specific services that fit each participant's unique culture and life experiences.
- 19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).
- 30. Staff at this program regularly attend trainings on cultural competency.



Objective:

The Recovery Self-Assessment – Person in Recovery Survey is a 32-question tool; designed to gauge the degree to which programs implement recovery-oriented practices. It is a reflective tool intended to identify strengths and target areas of improvement, geared toward improving consumer outcomes and treatment modalities.

Results:

The 2019 RSA-r survey administration period was from 9/23/2019 to 11/15/2019.

For the 2019 process, SWMBH received total (859) surveys back, which was a decrease from the 2018 response of (1087) total surveys returned. (19) Different provider organizations participated in the 2019 survey process, which was 3 less than the 2018 participation; (22) provider organizations participated. SWMBH's analysis of the overall mean score *represented a +0.14 increase in comparison to 2018 scores*.

Consumers of substance abuse services complete the surveys, which were administered through their provider.

Identified Barriers:

The data entry process is manual and takes significant time to enter all provider organization results. Furthermore, this was the second year in a row where the number of surveys received was less than the year before (not including a submission received with no paper surveys inside of the envelope). These are all areas of improvement for the survey next year.

Recommendations:

The QAPI Department explored utilizing Survey Monkey to automate the data entry system, which would save employee time and speed up the results/analysis process. The decision was made to make the electronic survey optional, and one provider chose to submit their results electronically. The results were that the electronic survey analysis was within +/- 1% of SWMBH's internal analysis, so this information will be used to plan for 2020's survey administration. QMC will also explore ways to improve scores in the Involvement category, which once again was the lowest score and has been the Regions' lowest score since 2015.

Sharing and Communication of Information

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Sharing and Communication of Information	➢ The Quality Department will demonstrate sharing of information and communication through various internal and external resources to its membership and providers.	✓ Ensure availability of information about the QI program and results through newsletter, mailings, website, and member handbook and practitioner agreements. ✓ Provide member newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ✓ Provide access to QMC and MHL meeting minutes and materials to internal customers. ✓ Access to the SWMBH website for various publications and Provider Directory. ✓ Access to the SWMBH SharePoint Portal for internal and external stakeholders, as a collaborative information sharing resource and report delivery system.	January 2019 - December 2019	QAPI Specialist QAPI Director Chief Administrative Officer Manager of UM and Call Center Newsletter Editor Chief Information Officer	Quarterly

The SWMBH Website

http://www.swmbh.org

Process for Updating Website Content

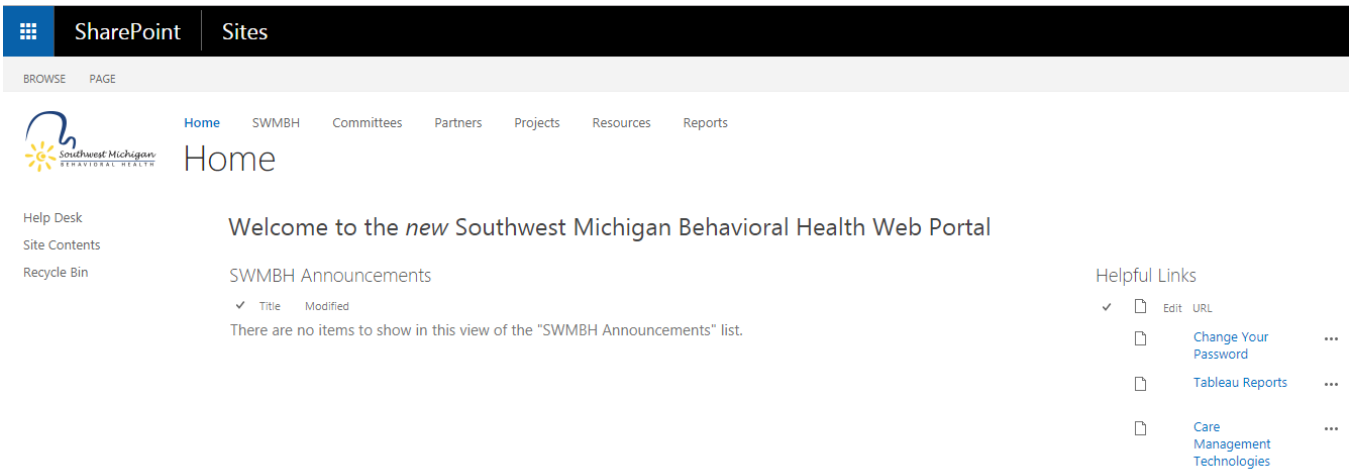
SWMBH formulated a website committee that meets monthly to discuss updates and proposed edits. Currently, each functional area has a designated team member who is responsible for implementing recommended updates. This process helps to keep information from getting outdated and ensures that members and community partners can access the most updated information possible.

Sharing of Information

SWMBH produces and distributes quarterly Member and Provider Newsletters. The Newsletter's primary focus is to keep members updated with the latest information regarding programs and services, and providers updated with the latest information on regulations, reports, and contractual requirements that affect our Region. Types of information the quality department shares on a routine basis include:

- Accreditation Standard Requirements
- Recent Consumer Satisfaction Survey Results
- Person in Recovery Survey Results (SUD)
- Mental Health and Physical Health Provider Communication Survey Results
- Critical Incident Analysis
- Jail Diversion Program Updates
- Performance Indicator Results and Updates
- Audit or Review Results
- Successes and Achievements
- Relevant State and National Data for Member/Provider Education

The SWMBH Portal



SWMBH Portal – SharePoint Site

In 2018 a new SWMBH SharePoint Portal was created due to the switching of IT vendors. Many enhancements were added to the new SWMBH Portal to improve access to data and improve communications with internal and external stakeholders. Some of the primary features added to the Portal include access for Integrated Care Organizations (ICOs) to view reports for dually enrolled consumers, the Tableau data analytics report inventory, access to Regional Committee documents, and meeting information. Additionally, a Reports tab of where all of the reports will be housed in a central location, and a new resources tab with all the Services Policy Manuals, Policies, and Attachments. Consumers can also access the website to view customer handbooks, policies, and procedures.

For more information on the SWMBH Portal, please visit the portal by clicking the link below:

https://portal.swmbh.org

Objective:

The Quality and Utilization Management Departments at SWMBH will use various methods to ensure the availability of accurate information to members, practitioners, CMHSPs, and internal customers via newsletters, mailings, SWMBH websites, member handbook, and practitioner agreements.

Results:

- A description of the QAPI Program is located on the SWMBH website and the SWMBH Portal.
- Communication was made with the following groups:
  - Stakeholders
  - SWMBH Board
  - CMH staff and SWMBH staff
  - Others, including State Representatives.
- Methods of sharing:
  - Provider Network and Member Services Newsletters
  - SWMBH Website
  - SWMBH SharePoint Site

- Tableau Analytics and Visual Dashboards
- SWMBH QM Reports
- Regional and Internal Meetings
- External Reports

Identified Barriers:
Training Internal and External Stakeholders on how to access data sources, such as the SWMBH SharePoint Site and Tableau Visual Dashboard site. Establishing permission levels for each access point was challenging and took longer than anticipated.

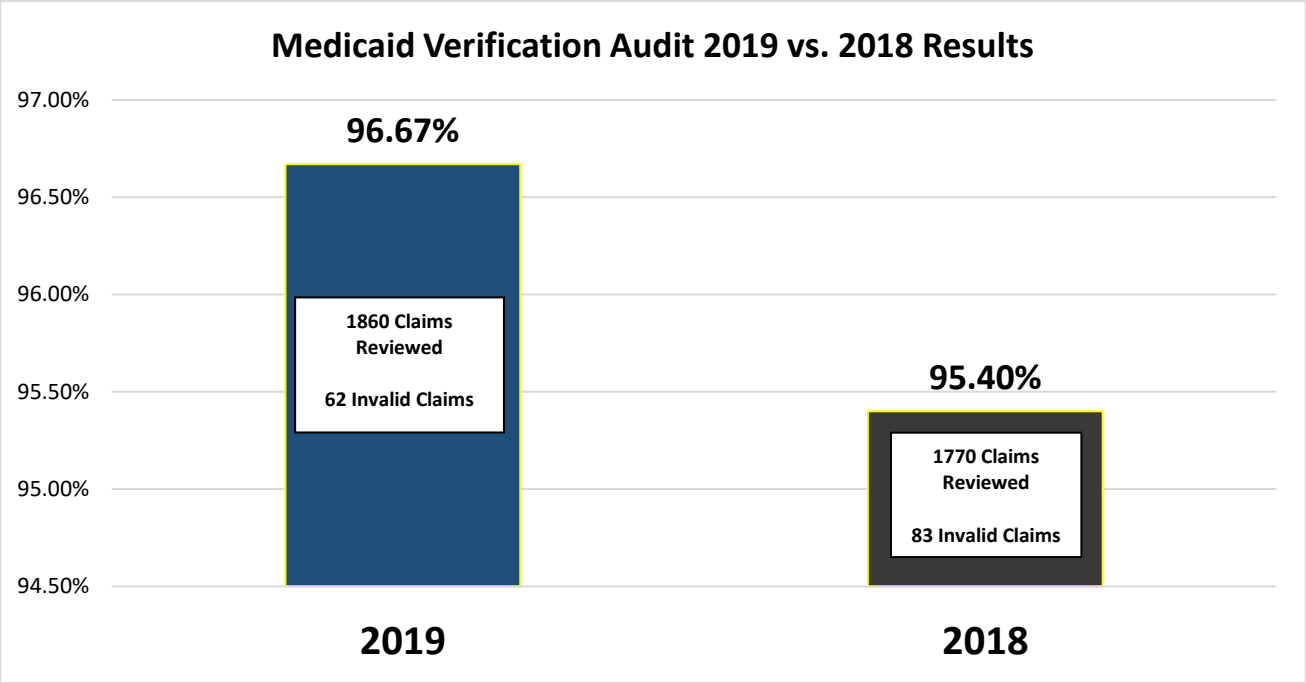
Actions were taken to Improve Processes:
In early 2019 a portal navigation user guide was developed to help users navigate and access resources more effectively. The users' guide helps break down the different sections of the portal and also provides education on how to access reports and other data readily available to them. This has alleviated a significant amount of help desk time and has been an excellent resource for new and existing team members.

Recommendations:
Hold a Regional Managed Information Business Intelligence Training for Internal and External Stakeholders twice annually. This will allow SWMBH to show/demonstrate new tools and answer any questions Stakeholders have regarding data resources.

Medicaid Verification, Provider Network Audits, and Clinical Guidelines

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Review of Provider Network Audits, Guidelines, and Medicaid Verification	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities.	✓ Annual report to the QMC Committee on any findings or opportunities for improvement. ✓ Corrective Action Plans (CAP) developed, issued, and tracked as needed. ✓ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the yearly QAPI Evaluation report. ✓ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer	Annually

2019 Medicaid Verification Audit



Objective:
Managed by the compliance department, this is a review of the Medicaid encounters submitted by the region to confirm that Medicaid funds were used appropriately. The 2019 and 2018 Board Ends Metric target for Medicaid claims verification is over 90%.

Process:

- Reviews are conducted on an annual basis.
- The reviews are comprised of a combination of desk and on-site methods.
- Reviews include an evaluation of all delegated functions.
- Any functions that are not in full compliance with MDHHS, 42 CFR & 438 (Managed Care Regulations), and SWMBH requirements require a written corrective action plan to be submitted by the participant CMHSP and approved by SWMBH.
- SWMBH monitors select programs each year for program and staffing fidelity and adherence to MDHHS contractual requirements for specialty service programs.
- Requirements and sections reviewed not meeting 90% compliance require corrective action plans
- SWMBH staff work with CMHSP staff throughout the year to implement and ensure areas needing attention have been addressed.

Results:
SWMBH Compliance Department completed the annual Medicaid Verification review using the sampling methodology per the Office of Inspector General standards. Overall the result in 2019 was a 96.67% Medicaid claims compliance rate with 1860 total claims reviewed with 62 invalid claims identified. In 2018 the Medicaid claims verification compliance rate was 96.25% with 1,770 and 83 invalid claims identified. Overall, the result was a 1.27% improvement in the claims verification rate over the previous year's result.

The following are a detailed breakout of claim deficiencies identified:

- Was the person eligible for Medicaid coverage on the date of the service reviewed?
  - **1 deficiency**
- Is the provided service eligible for payment under Medicaid?
  - **0 deficiencies**
- Is there a current treatment plan on file which covers the date of service?
  - **23 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed?
  - **27 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer?
  - **27 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid?
  - **9 deficiencies**
- Was the appropriate amount paid (contract rate or less)?
  - **15 deficiencies**

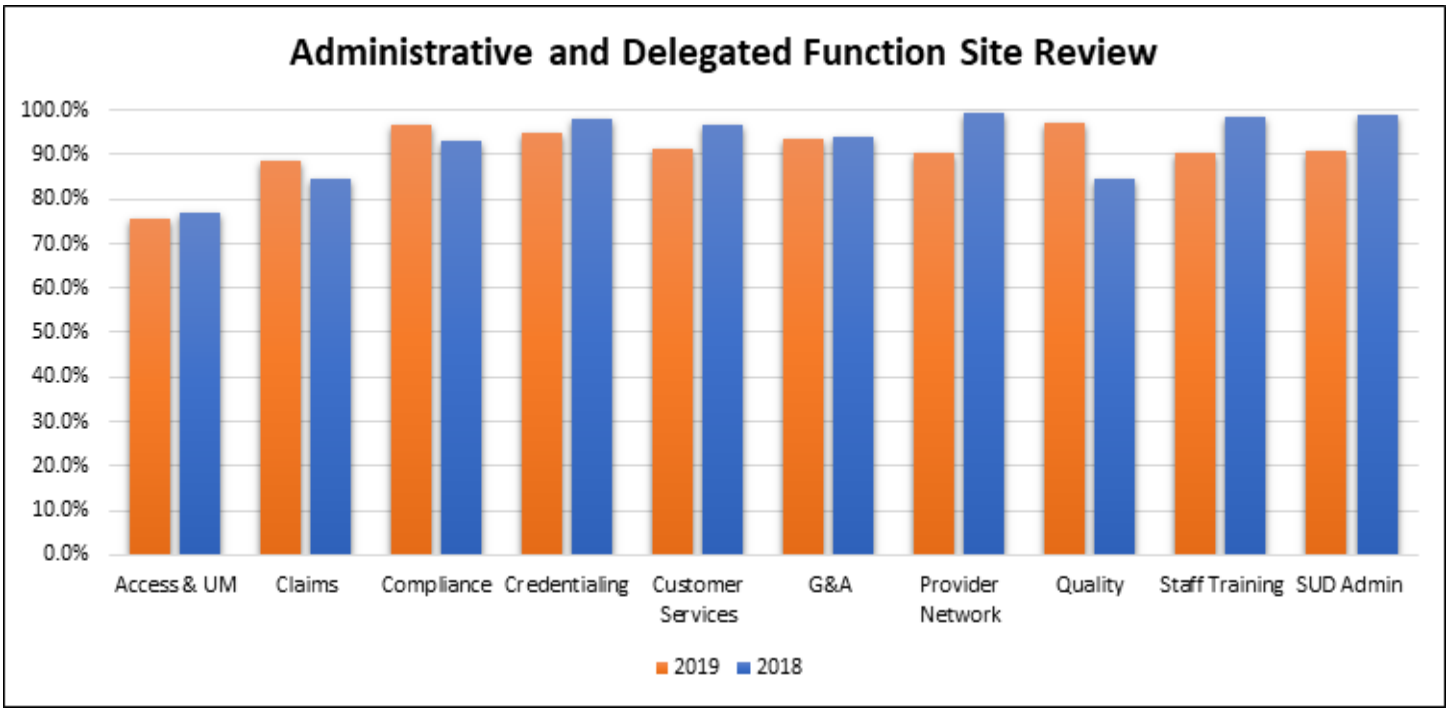
Identified Barriers:
None identified.

Recommendations:
No corrective action plans were required based on the standards set in the Medicaid Services Verification-Technical Requirements set by MDHHS.
The deficiencies noted were regarding a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the service billed. The majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with a clinician signature before the provision of service and within 15 business days of the effective date of the plan (per MDHHS Treatment Planning/Person-Centered Planning Policy). SWMBH will continue to work with our CMHSPs and sub-contracted providers to address the timeliness of treatment planning and the signatures of the clinician validating the treatment plan. Additionally, SWMBH will continue to educate providers on the importance of specific and individualized goals/objectives/interventions for services contained within the treatment plan.
The deficiencies noted that despite documentation being supplied to support the service provided, many providers struggled with the MDHHS requirement of a provider signature and signature date on documentation. SWMBH has been working and will continue to work with CMHSPs and sub-contracted providers to ensure adherence to all MDHHS clinical records policies and requirements.

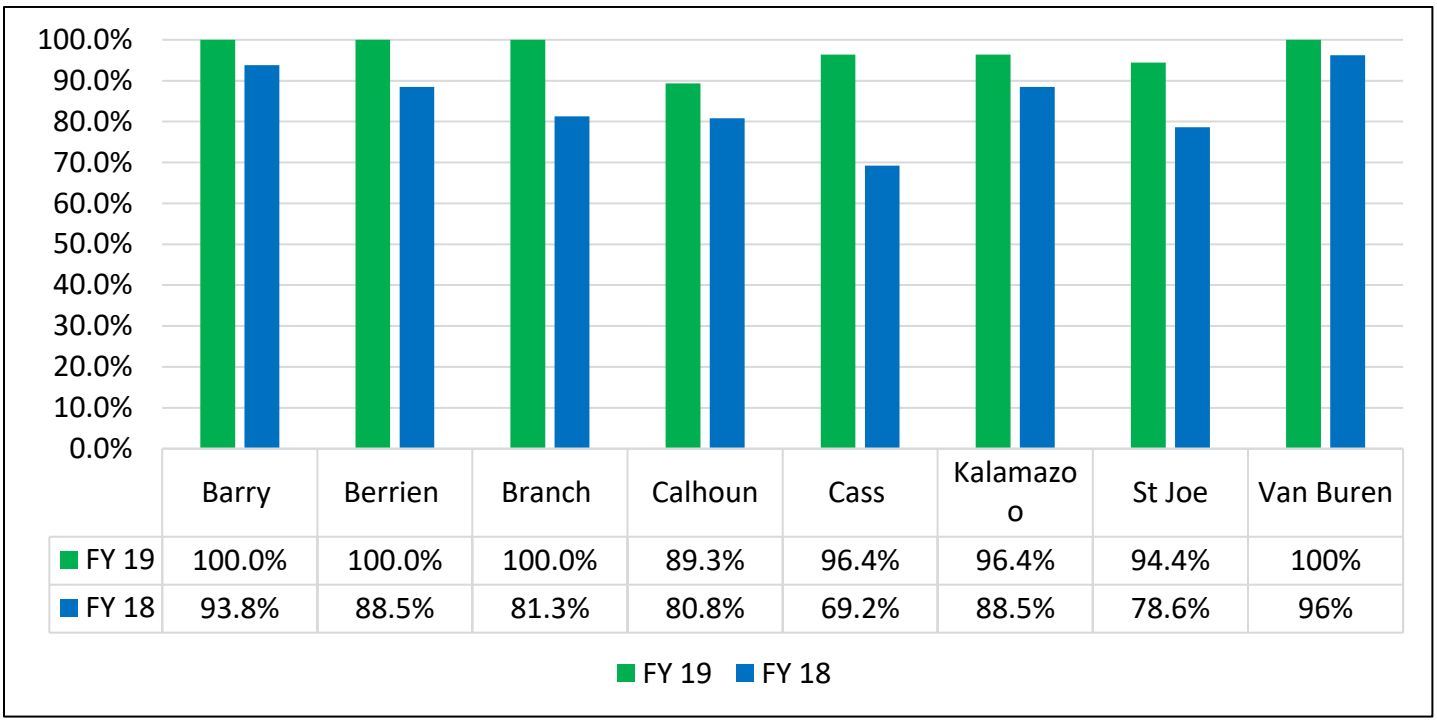
Administrative and Delegated Function Site Review

Summary Score		
Standard	**2019 Section Score**	**2018 Section Score**
Access and Utilization Management	75.4%	76.9%
Claims Management	88.7%	70.8%
Compliance	96.9%	80.5%
Credentialing	94.9%	98.2%
Customer Services	91.3%	96.8%
Grievances and Appeals	93.5%	94.2%
Provider Network	90.5%	86.9%
Quality	97.1%	84.6%
Staff Training	90.4%	98.5%
SUD EBP Fidelity and Administration	91.1%	99.0%

- Red indicates Section Score decreased from 2018.
- Green Indicates Section Score increased from 2018.



2019 CMHSP Quality Program Review Results



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100%
FY 18	93.8%	88.5%	81.3%	80.8%	69.2%	88.5%	78.6%	96%

Results:
Overall results show an improvement for all counties (8) counties during the 2019 review process. However, 6/10 categories reviewed showed a decrease in the score, in comparison to 2018 site review scores. For purposes of this review, the overall quality review resulted in a +12.5% increase across all categories measured. This was directly attributed to an overall improvement in performance indicator compliance and timeliness reporting. The utilization management review observed an overall -1.5% decrease across all categories measured. This was attributed to lower scores in the timeliness of service approvals and quality of notification letters distributed to consumers.

Barriers:
No significant barriers to performance were observed for quality or utilization management during this review period.

Recommendations:
Per our on-site review and feedback SWMBH received during our last HSAG review, it is fully acknowledged that SWMBH needs to make remediations with our Adverse Benefit Decision documents (ABD).
HSAG recommends that the PIHP implement a quality auditing process to ensure that each notice of ABD is easily understood and written at the appropriate reading grade level for the PIHP's membership.
HSAG strongly recommends that the PIHP confirm all CMHSPs have implemented the State-mandated ABD template.
HSAG further suggests that the PIHP implement a quality auditing process to ensure that the language documented within the template is accurate and includes all required information per the requirements under this element.

External Audit and Reviews Compliance

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ICO's, NCQA, and other organizations, as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics or meets the reviewing organization's expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations, and other contractual standards and provide education and resources to SWMBH and CMHSPs.	✓ The Quality Department will ensure all documentation is returned to the external monitoring agency promptly. ✓ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ✓ The SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase the level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2019 – December 2019	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Administrative Officer Provider Network Director	Annually or audits as scheduled

2019 Health Services Advisory Group (HSAG) Performance Measure Validation Audit Results

The following report represents a summary of preliminary findings during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 23, 2019, at Southwest Michigan Behavioral Health.

Results:
37/37 or 100% Of Total Elements Evaluated received a designation score of "Met," "Reportable," or "Accepted."

This meets the *successful completion of our 2019 Board Ends Metric*, which indicates: 95% of Elements Evaluated/Measured shall receive a score of "Met."

The detailed results for each category and element evaluated can be found below:

Scoring Category	Performance Results
Accepted	3/3 – 100% Data Integration Elements Evaluated was ***"Accepted"*** and met full compliance standards.
Reportable	12/12 – 100% Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications, and the percentage reported.
Met	13/13 – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	9/9 – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance Standard.

Data Integration, Control, and Performance Indicator Elements Evaluated:

Standard	Scoring Criteria "Acceptable or "Not Acceptable"	Recommendation
1). Data Integration	Acceptable – 100%	Full Compliance
2). Data Control	Acceptable – 100%	Full Compliance
3). Performance Indicator Documentation	Acceptable – 100%	Full Compliance

PIHP Strengths
Southwest Michigan Behavioral Health experienced some staffing changes in the past year. However, newly hired staff members and Chief Information Officer had extensive backgrounds in behavioral health and all processes related to performance indicator (PI) and data reporting requirements. A Managed Information Business Intelligence Steering Committee was formed and is focusing on data integrity, data completeness, data structures/reporting, and reporting of key performance indicators.

Recommendations:
HSAG recommends that **Southwest Michigan Behavioral Health** and the CMHSPs employ an over-read or validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered, to account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system or if any data were keyed incorrectly. HSAG also recommends that the PIHP and the CMHSPs clearly define the processes for entering the data into PIHP's EMR with additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State.

2019 Health Services Advisory Group (HSAG) External Quality Review Results

Audit Objectives

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

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

Table 1-1 – Standard Schedule of Review

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

Table 1-2 – Audit Scores by Standard

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

Table 1-2 represents the scores for the (9) standards evaluated during the 2019 review period

Table 1-3 Scoring Methodology

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

Audit Summary of Results

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

Southwest Michigan Behavioral Health demonstrated compliance in 74 of 82 elements, with an overall compliance score of 90 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out most required functions of the contract. In contrast, other areas demonstrated opportunities for improvement to operationalize the elements required by federal and state regulations. Detailed Standard scores are represented in table 1-2, and scoring methodology is detailed in table 1-3.

Next Steps and Follow-up:

Southwest Michigan Behavioral Health is required to submit to MDHHS a CAP for all elements scored *Not Met*. The CAP must be provided within 30 days of receipt of the final report. For each component that requires correction, the PIHP must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible for each intervention, and the timeline, including scheduled dates of completion for each intervention.

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

2019 MDHHS Substance Use Disorder Administrative Monitoring Protocol Audit

Results:

- **26/26 Standards Evaluated Received a Score of Full Compliance.**

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Substance Use Disorder Administrative Monitoring Protocol
Page 2 of 12

PIHP Name: SWMBH	Date: June 4, 2019

	Requirement (citation)	Evidence To Support Compliance Requirement	Evidence Document Name and Location in Document (Page Number)	Compliance Rating 2= Full 1 = Partial 0= None	Comments/Findings
2) Annual Evaluation of SUD Services	The PIHP must annually evaluate and assess substance use disorder services in the department-designated community mental health entity in accordance with the guideline established by the Department. MDHHS/PIHP Contract Boilerplate, 1.0 Statement of Work, Item 7, Page 69	Copies of policies and procedures Monitoring tool Copies of reports findings Evidence of making reports available to public	Provider Network Policy, Member Newsletter, Memo on Making reports Available to Public, Review Tools, Prevention Site Reviews for Van Buren and Barry CMHs, Treatment Site Reviews for HTC, BCCCH, VBCMH, CHC, Site Review Schedule	26/26 Standard Evaluated Received a Score of Full Compliance (2 = Full).	Use of Site Metrics and Clinical Quality Review is exemplary. String Evidence of full Compliance. Metrics scorecard is also made available to public.

MI Health Link and Integrated Care Organization Audit Results

Aetna Claims Delegation Audit

Review Period: 7/1/2019 through 9/30/2019

Summary of Claims Audit Results: 100% Compliance

Medicare Advantage / Standard Delegation - Claim Audit Results										
OVERALL RESULTS				30	30	100%	30	100%	30	100%
Product Line	Product Description	Deal Type	Universe / Unit Description	Total Claims Audited	Turn-Around Time Compliance		Payment / Denial Accuracy		Coding Accuracy	
					#	%	#	%	#	%
Medicare	MMP	BH Clm	Member Denials	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Paid Claims - Contracted	30	30	100%	30	100%	30	100%
Medicare	MMP	BH Clm	Paid Claims - Non-Contracted	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Provider Denials	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Provider Disputes	NR	NR	NR	NR	NR	NR	NR

Auditor Comments and Summary of Results:

- ✓ The annual claims desk audit review was conducted and finalized on 11/18/2019
- ✓ All of the claim documents reviewed were summitted by SWMBH through the Aetna FTP website.
- ✓ There was always a SWMBH staff member available to answer questions, and they did a great job.
- ✓ There were no issues noted, or findings pointed out during the review.
- ✓ The next audit will be conducted during the 3rd quarter of 2020.

Aetna Delegated Utilization Management Oversight Audit

Review Period: 1/16/2019 through 7/1/2019

Summary of Utilization Management Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
1. UM 1 UTILIZATION MANAGEMENT STRUCTURE	Full
2. UM 2 CLINICAL CRITERIA FOR UM DECISIONS	Full
3. UM 3 COMMUNICATION SERVICES	Full
4. UM 4 APPROPRIATE PROFESSIONALS	Full
5. UM 5 TIMELINESS OF UM DECISIONS	Full
6. UM 6 CLINICAL INFORMATION	Full
7. UM 7 DENIAL NOTICES	Full
8. UM 11 SATISFACTION WITH UM PROCESS	Full
9. UM 12 EMERGENCY SERVICES	Full
10. UM15 SUBDELEGATION OVERSIGHT	NA
Total Percentage of Compliance = 100%	**Total Level of Compliance:** Full

Summary of Case Management Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
1. QI 7 Complex Case Management	NA
2. QI 12 Delegation of QI	NA
3. UM 8 Policies for Appeals	Met
4. UM 9 Appropriate Handling of Appeals	Met
5. RR 2 Policies and Procedures fo Complaints and Appeals	Met
Total Percentage of Compliance = 100%	**Total Level of Compliance:** Full

Summary of Credentialing Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
I. Policy and Procedure Review	Full
II. Credentialing Committee	Full
III. Credentialing Verification (File Audit)	Full
IV. Recredentialing Cycle Length	Full
V. Practitioner Office Site Quality	NA
VI. Ongoing Monitoring	Full
VII. Notification to Authorities and Practitioner Appeal Rights	Full
VIII. Organizational Providers Credentialing and Recredentialing (File Audit)	Full
IX. Evaluation of Sub-Delegated Credentialing	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Summary of Grievance and Appeals Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
UM 8: Policies for Appeals	Full
UM 9: Appropriate Handling of Appeals	Full
RR 2: Policies and Procedures for Complaints and Appeals	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full
CMS Criteria	
1. Meet timeframes for Appeals and Grievance as it applies to Members	NA – no member appeals
2. Meet timeframes for Appeals and Grievance as it applies to Providers	NA – no provider appeals
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Meridian Delegated Credentialing Audit

Review Period: 1/1/2019 through 9/30/2019

Thank you for allowing Meridian to review your organization's credentialing program in support of the Annual Delegation oversight audit. We had a few updates from the Center for Medicare & Medicaid Services (CMS) regarding provider updates and compliance. Please update your policies to reflect any of the new changes (if applicable). **You are approved for delegated credentialing**. You may anticipate your next audit in October 2020.

The audit results are as follows:

The assessment process consisted of a review of the following measures:

1. Credentialing and re-credentialing policies and procedures
2. Credentialing list
3. Recredentialing list
4. Evidence of ongoing monitoring of sanctions and limitations
5. Credentialing files: 5
6. Recredentialing files: 5

The results of the assessment yielded the following scores:

Measure	Score
Health care professional credentialing file audit	100%
Health care professional re-credentialing file audit	100%
Policies and procedures review	100%
Overall Score	100%

Utilization Management Program Evaluation

VI. Utilization Management Program Evaluation

Utilization Management Program Description

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the yearly QAPIP and will be completed at the end of the fiscal year, or shortly after that. The QAPI & UM Effectiveness Review/Evaluation assesses the overall effectiveness of the QAPI and UM Programs including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with particular focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals is also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the last year's QM activities. When a gap is identified and addressed during that year, it will be reported in the QAPI Effectiveness Review/Evaluation, and other deficiencies may be incorporated into the next year's QAPI plan. The findings within the QAPI Effectiveness Review/Evaluation will be reported to the QM Committee, Operations Committee, SWMBH EO, and SWMBH Board.

A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement plan could be requested of a SWMBH department, CMHSP, or Provider Organization. When a provider within the network is required to complete such a plan, the Provider Network department will be involved, and a notification of the needed action and expected response will be given to the provider. A sanction may be initiated based on the level of deficiency and/or failure to respond to a Performance Improvement/Corrective Action Plan request.

References:
BBA Regulations, 42 CFR 438.240
MDHHS –PIHP Contract Attachment P 6.7.1.1 et al
SWMBH Quality Management Policies 3.1 and 3.2
NCQA – 2020 MBHO Accreditation Standards: UM 1 A-D, 2 A-C, 3, 4 A-B, D-F, 6 B
UM and Quality Management Regional Committee Charter
MHL UM and QAPI Committee Charters

The Utilization Management (UM) Program purpose is to maximize the quality of care provided to customers while effectively managing the Medicaid, MI Health Link Duals Demonstration project, Healthy Michigan Plan, 1115 Medicaid Waiver Expansion, 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, 1115 Medicaid Waiver, Autism Benefit, Habilitation Supports Waiver and SUD Community Grant. SWMBH is responsible for ensuring adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Michigan Department of Health and Human Services (MDHHS) Medicaid Specialty Services and SUD contracts, MI Health Link demonstration project contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act, 42 CFR and the National Council on Quality Assurance (NCQA).

The UM program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated, and self-directed care. One of the most critical aspects of the utilization management plan is to monitor population health effectively 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 evidence-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 behavioral health and substance abuse services, which is responsive to the community, family, and individual needs. The entry process must be transparent, readily available, and well known to all constituents. To be effective, information, assessment, referral, and linkage capacity must be readily and seamlessly accessible. The level of care and care management decisions must be based on medical necessity and evidenced-based wellness, recovery, and best practice. SWMBH is committed to ensuring the use of evidence-based services with member matching that drives 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 lesser cost 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 services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing Access to service depends upon appropriate utilization throughout all aspects of the level of care and care management decision-making process.

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year goals have been achieved and what areas for improvement there are. The MHL UM and Quality Management committees are involved in this review and implementing any improvement activities throughout the provider network. The Quality Management unit, led by a senior-level administrative staff, conducts a variety of member and stakeholder surveys to evaluate the effectiveness of the UM Program. As part of the QAPI process and development of the UM Program plan, MHL cross-functional committees and the CAC review population health data, stakeholder survey data in relation to medical necessity criteria, policy, procedure, and clinical protocols/criteria. They provide input on trends and specific data to inform the decision making regarding approving the use of medical necessity criteria, system clinical changes and training, and best practice implementation. The purpose of the annual evaluation is to identify any Best Practices that could be incorporated into the UM program, as well as continue to improve on the care provided to SWMBH members. The specific evaluation is contained in and conducted as part of the Quality Assurance, and Performance Improvement plan as UM is designated in our MDHHS contract as a subset of QAPI.

Additionally, Inter-rater reliability will be evaluated annually. All clinical professionals making medical necessity determinations and utilization management decisions will be tested yearly to validate consistent application and understanding of uniform benefit, clinical protocols, and medical necessity criteria. All evaluation data is reviewed by members of the MHL UM committee consisting of the Medical Director, Senior-level masters licensed clinical staff, masters or higher practitioners as well as MHL Plan members.

Behavioral Healthcare Practitioner Involvement

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director and Manager of Utilization Management and Call Center. The Medical Director and the Manager of Utilization Management and Call Center will provide clinical and operational oversight and direction to the UM program and staff and ensure that SWMBH has qualified staff accountable to the organization affecting customers.

To determine if the UM program remains current and appropriate, QAPI evaluated:

UM Program Structure

- **2019 UM Program Description, Plan & Policies**
  - ✓ In compliance with contractual, state, and regulatory and accreditation requirements and with Established UM standards. SWMBH ensures compliance through Access and Eligibility, Clinical Protocols, Service Authorization, and Utilization Management.
  - ✓ Program Description of processes, procedures, and criteria necessary to ensure cost-effectiveness, achieving the best customer outcome for the resources spent.
  - ✓ Management information systems adequate to support the UM Program.
- **Committees**
  - Regional Utilization Management Committee (RUM)
    - ✓ RUM Committee held monthly meetings
  - Regional Clinical Practices Committee (RCP)
    - ✓ RCP Committee held monthly meetings
    - ✓ RUM and RCP Collaborative Meetings held Quarterly
  - MI Health Link Committee meetings
    - ✓ MI Health Link Committee meetings held Quarterly

UM program scope, processes, information sources used to determine benefit coverage and medical necessity.

- **SWMBH UM Decision-Making:**
  - Ensuring uniformity
  - Service determinations based on medical necessity criteria and benefits coverage information.
  - Application of functional assessment tools evidenced-based practices and medical necessity criteria.
    - ✓ UM screening and assessment process contains the mechanisms needed to identify the needs and integration of care.
    - ✓ Tools used: Level of Care Utilization System (LOCUS); CAFAS (Child and Adolescent Functional Assessment Scale); SIS (Supports Intensity Scale) and ASAM-PPC (American Society for Addition Medicine-Patient Placement Criteria).
  - UM decision-making, including the application of eligibility criteria and level of care guidelines.
  - ✓ Clinical Criteria
  - ✓ Availability of Criteria
  - ✓ Consistency of Applying Criteria
  - ✓ Inter-rater reliability (IRR audit)
    - ✓ Consistency in Applying Criteria-Interrater reliability testing: Evaluated the consistency with staff involved in UM apply criteria in decision making.
    - ✓ Those evaluators that score under 90% will be provided with additional education and be retested.

Uniformity of Benefits	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	✓ Perform analysis on tool scores relative to medically necessary level of care (LOC). ✓ Identify and schedule reports on functional assessment tool scores. ✓ Ensure functional assessment data related to the LOCUS, SIS, CAFAS, and ASAM are being received in the SWMBH data warehouse.	October 2018 – September 2019	Manager of UM and Call Center Director of Clinical Quality Clinical Data Analyst Director of QAPI QAPI Specialist	Quarterly

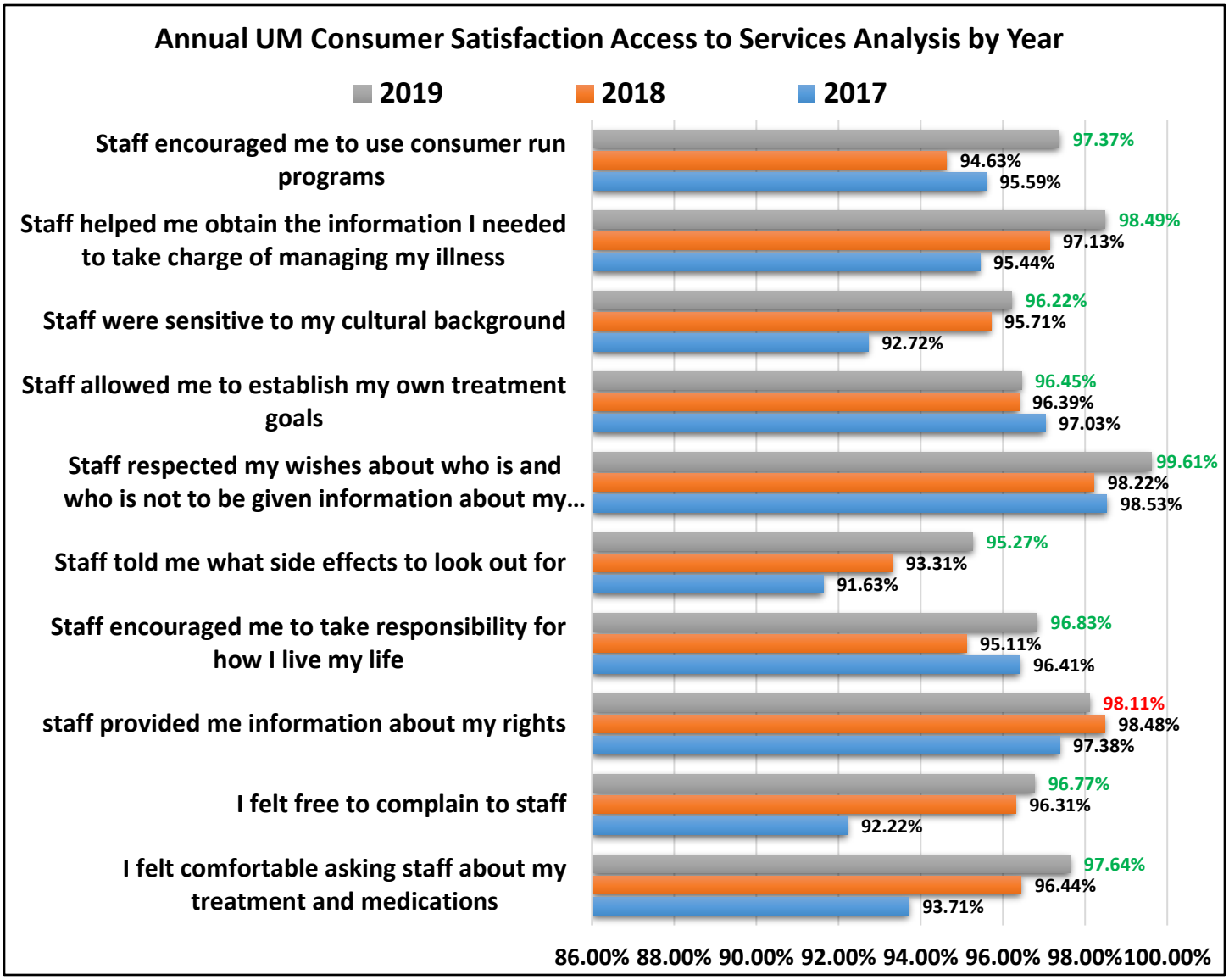
Inter-Rater Reliability Results for SWMBH 2019

Date & Case	# of Raters	% Matching Medical Necessity Criteria	Comments
11/1/18 Gregg Locus 20 LOC 4	10	50% - 5/10 Outpatient 40% - 4/10 Detox/Residential	Range 16-23 LOC 2-5
1/3/19 Arthur Locus 17 LOC 3	10	90% 9/10 – Outpatient Meds & CSM or therapy	Range 16-18 LOC 2 & 3
4/30/19 Esther Locus 15 LOC 5	11	82% - 9/11 Outpatient Psych Eval and Medication Management	
11/4/19 Jane Locus	10	100% - 10/10 Outpatient Psych Services and Medication Evaluation	
2/13/20 Taylor	11	91% - 10/11 Detox Residential or IOP	

- **Over and underutilization**
  - Outlier Management
    - ✓ Tools for monitoring analyzing and addressing outliers. SWMBH's performance indicators, service utilization data, and cost analysis reports.
  - Access Standards
- ❖ 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%)
- ❖ 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%)
- ❖ The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional (Standard=95%)
- ❖ The percent of discharges from a psychiatric inpatient unit who are seen for follow up care within seven days (Standard=95%)
- ❖ The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days (Standards=95%)
  - **59/68 Total Performance Indicators in 2019 met the State Standard of 95%**
  - **86.76% of indicators achieved the State indicated benchmark of 95%**
    - **1st Quarter = 14/17**
    - **2nd Quarter = 14/17**
    - **3rd Quarter = 16/17**
    - **4th Quarter = 15/17**

- **Adequate timely Access to Services:**
  - ✓ Telephone Access to Services & Staff during business and after hour's toll-free access/crisis line.
  - ✓ Face-to-Face evaluation by regional CMHSP
  - ✓ Crisis services through inpatient hospitals, mobile crisis teams, and urgent care center
  - ✓ Achieved a call abandonment rate of 5% or less.
  - ✓ Average answer time of 30 seconds or less.

UM Customer Survey Analysis



Survey Description: During the months of November and December 2019, the Mental Health Statistic Improvement Project (MHSIP) survey was administered (through telephone interviews and random probability sampling) to 1458 consumers who received Mental Health authorization and support through Southwest Michigan Behavioral Health and Services through our CMHSP partners from April through August 2019. In observation the current results – representing consumer feedback received from 355 consumers who are enrolled in the MI Health Link (Dual Eligible) program and engaged with Southwest Michigan Behavioral Health Utilization Management staff to receive services. **Green** values represent an improvement over the previous year's score, while **Red** values represent a decrease in comparison to the previous year's score.

Analysis and Observations: Overall results are much improved in comparison to the previous 2 years. Although there was a slight decrease of (-.37%) in the category of "*staff provided me information about my rights*", no significant variations were identified.

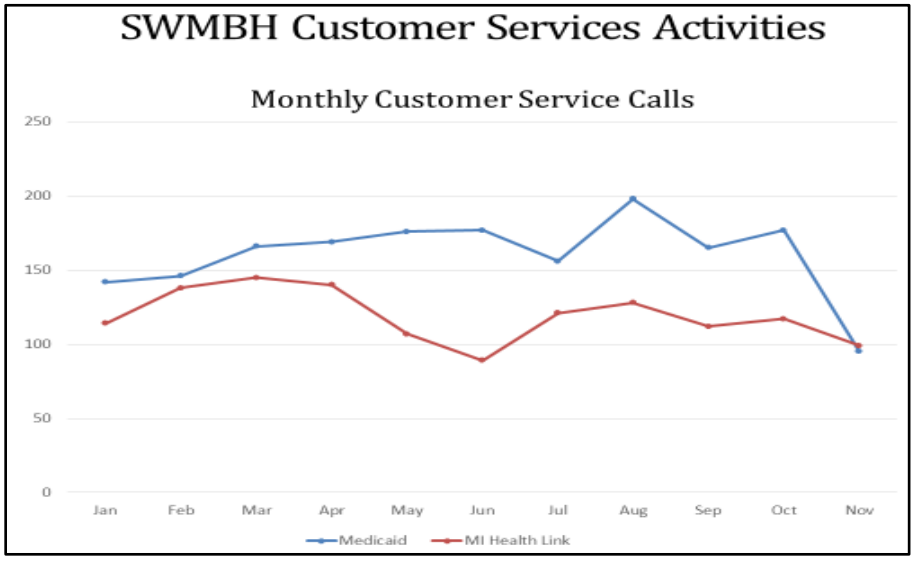
Opportunities for Improvement and Next Steps: The consumer responses received, will be evaluated by UM staff, QAPI staff and Regional Committees to identify any common denominators, or trends in responses. If significant trends are identified in a particular category, then an improvement plan will be formulated. However, the initial score analysis is consistently positive with no significant variance in scores indicated for this survey period.

Monitoring the Customer Service Complaint Tracking System 2019

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Monitor the Complaint Tracking System for Providers and Customers	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints For all business lines	✓ At a minimum quarterly report on customer complaints to the QMC Committee, MHL Committee, RUM Committee, and RCP Committee are reviewed. ✓ Ensure proper reporting, monitoring, and follow-up resolution of Grievance and Appeals data, including: ✓ Billing or Financial Issues ✓ Access to Care ✓ Quality of Practitioner Site ✓ Quality of Care ✓ Attitude & Service	October 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer and Director of Provider Network Management Customer Service Manager Chief Administrative Officer	Quarterly

2019 Calls and Access Analysis

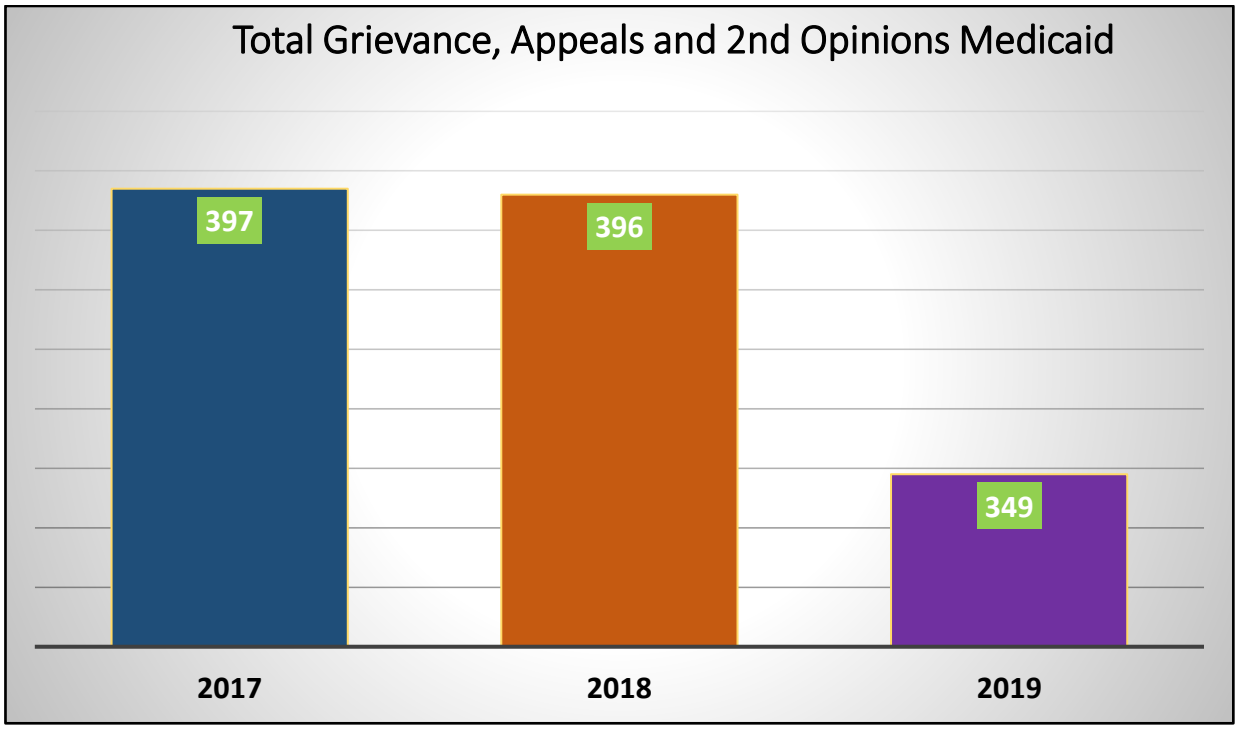
Customer Service Information: (Measurement Period: October 1, 2018 – September 30, 2019)



In FY 19 Customer Service fielded 3071 phone calls
Medicare Customer Service Line: 1761 calls
MHL Member Service Line: 1310
Completed 800 follow up calls
692 members were discharged from Substance Use Disorder Residential Settings
108 members were discharged from Inpatient Psychiatric setting

2019 Grievances and Appeals

In FY 19, Customer Service Managed/provided oversite of 360 grievances and appeals:
❖ MA/HMP/BG Appeals reported: **103**
❖ MA/HMP/BG Grievances reported: **217**
❖ MA/MHL Fair Hearings reported: **15**
❖ MA/HMP/BG Second Opinions reported: **16**
❖ MI Health Link Grievances reported**: 4**
❖ MI Health Link Appeals reported: **5**



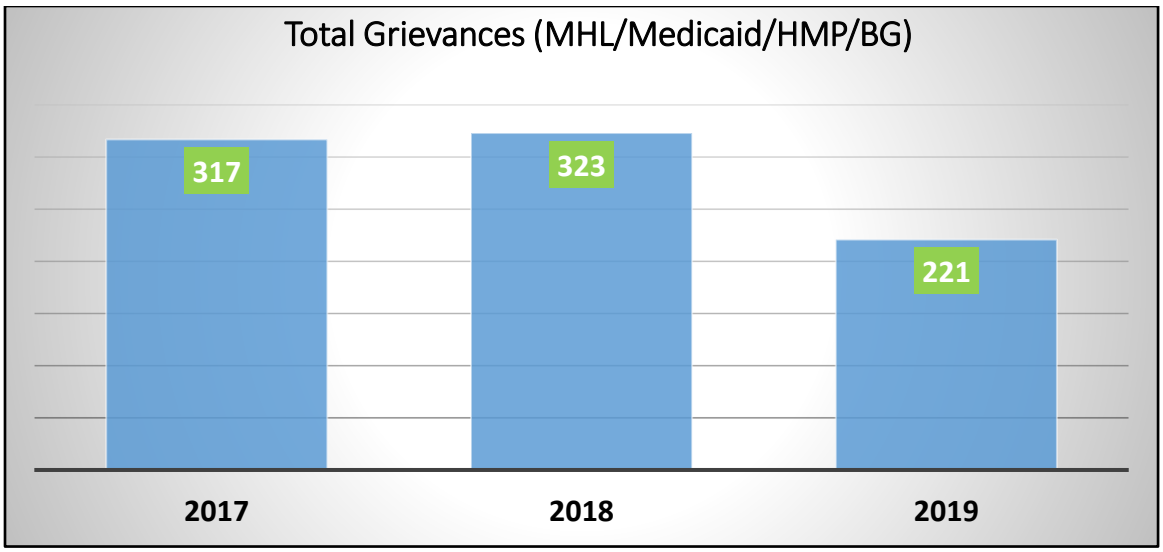
FY 2020 Goals:

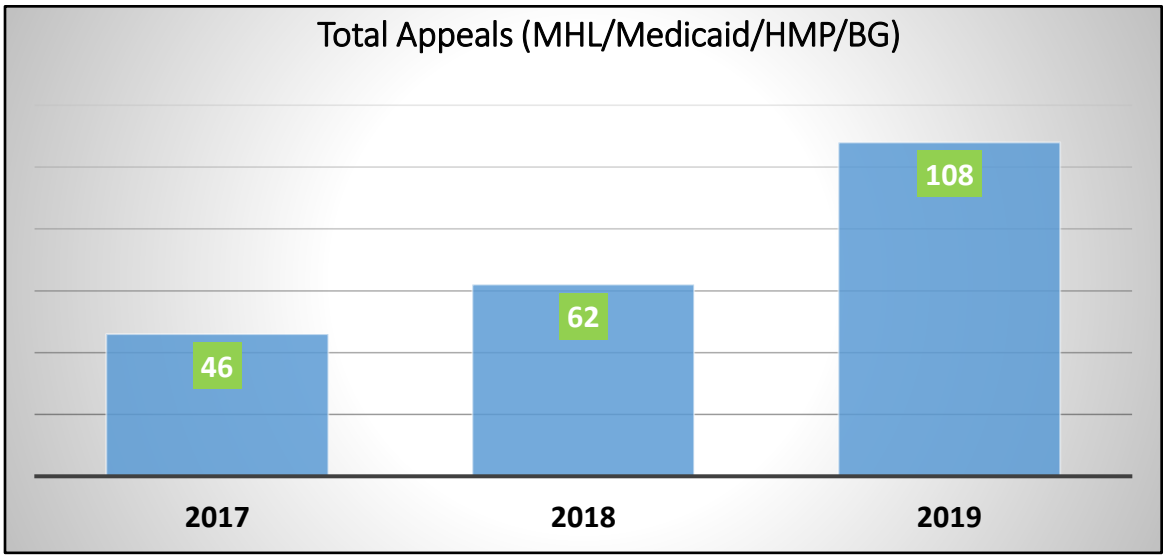
- Complete the Health Services Advisory Group 2020 audit with 90% or higher compliance for Customer Services, Grievances, and Appeals.
- Review and update regional processes for MHL and SUD Adverse Benefit Determinations
    - To ensure effective and efficient communication and notification of rights to members
    - Define what is being sent by whom, why and when
- Define and implement a regional process to notify members of denials of payment
    - This is in response to 2019 HSAG audit
    - Templates and method will be developed for both MI Health Link and Medicaid

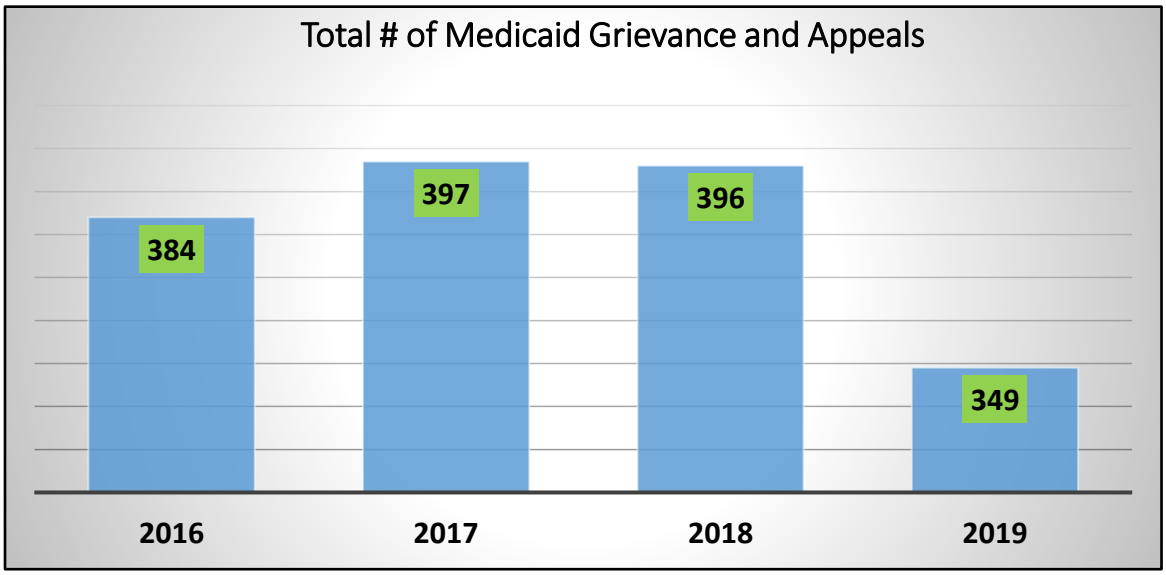
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data FY 2019						
SWMBH REGIONAL TOTAL (MA/HMP/BG)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn	1				**1**
	Decision Upheld/Affirmed	18	22	22	6	**68**
	Decision Overturned	5	7	9	7	**28**
	Settled/Resolved	2		2	2	**6**
Access 2nd Opinions	Withdrawn		4			**4**
	Decision Upheld/Affirmed	2	2	1	2	**7**
	Decision Overturned		1	1	1	**3**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed			1	1	**2**
	Decision Overturned					**0**
	Settled/Resolved					**0**
	Decision Affirmed	2			2	**4**
	Decision Overturned			1		**1**
	Settled/Resolved					**0**
Grievances	Withdrawn	3	1	3	1	**8**
	Settled/Resolved	57	61	55	44	**217**
TOTAL Events:		**90**	**98**	**95**	**66**	**349**

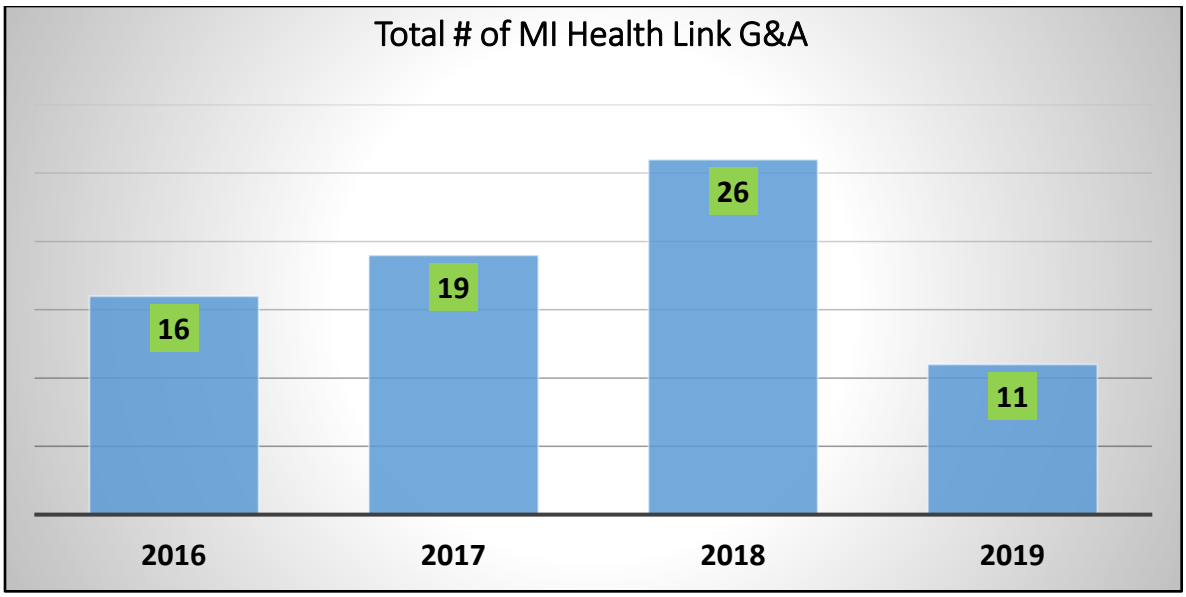
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data CY January 2019 – December 2019						
SWMBH REGIONAL TOTAL (MHL)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn					**0**
	Decision Upheld/Affirmed	2	1			**3**
	Decision Overturned	1	1			**2**
	Settled/Resolved					**0**
Access 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Administrative Medicaid (Fair) Hearing	Withdrawn					**0**
	Decision Affirmed		1			**1**
	Decision Overturned					**0**
	No Show					**0**
	Settled/Resolved					**0**
Grievances	Withdrawn			1		**1**
	Settled/Resolved		1	3	0	**4**
	Recipient Rights Referral					**0**
TOTAL Events:		**3**	**4**	**4**	**0**	**11**

✓ A decrease of 15 Grievance and Appeals has been observed in comparison to the previous year (2019 vs. 2018)


Total Grievances (MHL/Medicaid/HMP/BG)
317
323
221
2017
2018
2019


Total Appeals (MHL/Medicaid/HMP/BG)
46
62
108
2017
2018
2019


Total # of Medicaid Grievance and Appeals
384
397
396
349
2016
2017
2018
2019



Causal Analysis of 2019 Grievance and Appeals

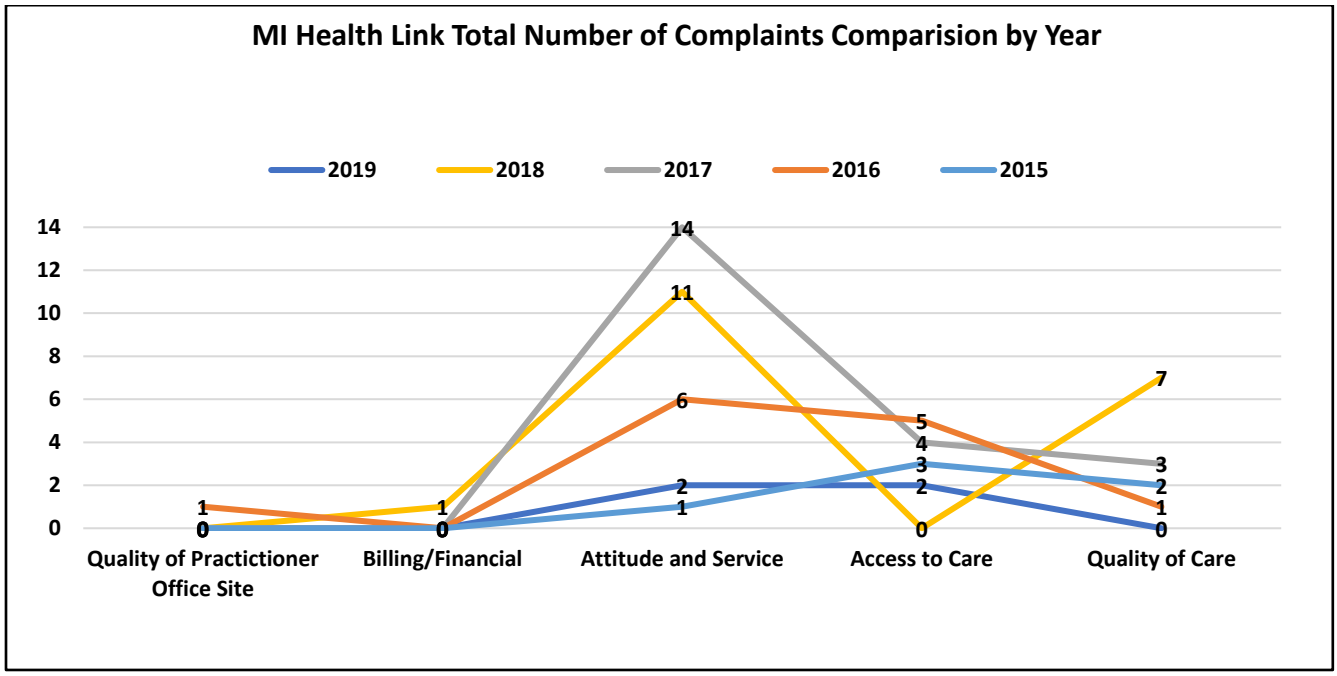
- The total number of Medicaid Grievance, and Appeals, and 2nd Opinions for FY 2019 was 349, (47) less than 2018 total of 396. This translates into an overall decrease of (-12.37%).
- There was also a decrease in the total number of Grievances (MHL/Medicaid/HMP/BG) from 323 in 2018 to 221 in 2019. This translates into a significant decrease of (31.57%) in total Grievances for FY 2019.
- The total number of MHL Grievance, Appeal, and 2nd Opinions was (11) for 2019, which is a (-57.69%) decrease from 2018 (26).

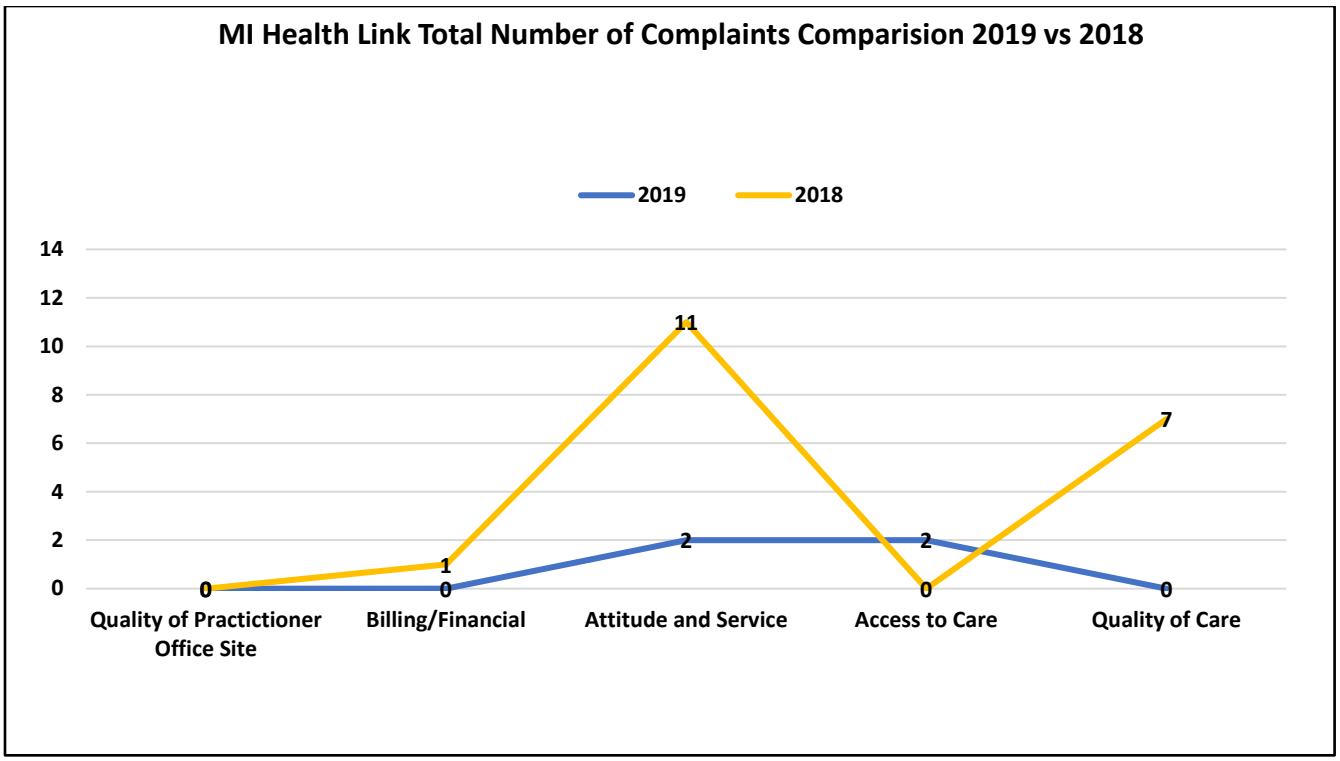
As shown in the above results, a significant improvement was observed with both total Medicaid and MI Health Link Grievance and Appeals totals. This data analysis has been reviewed by internal Quality and Customer Services Workgroups, as well as Regional Quality Assurance and Customer Service Committees. Many of the improvements have been attributed to improved processes at the local and administrative levels. Updated forms, policies, and guidance documents have significantly decreased overall customer inquiries into the Grievance or Appeals processes, as they are not more familiar with their options.

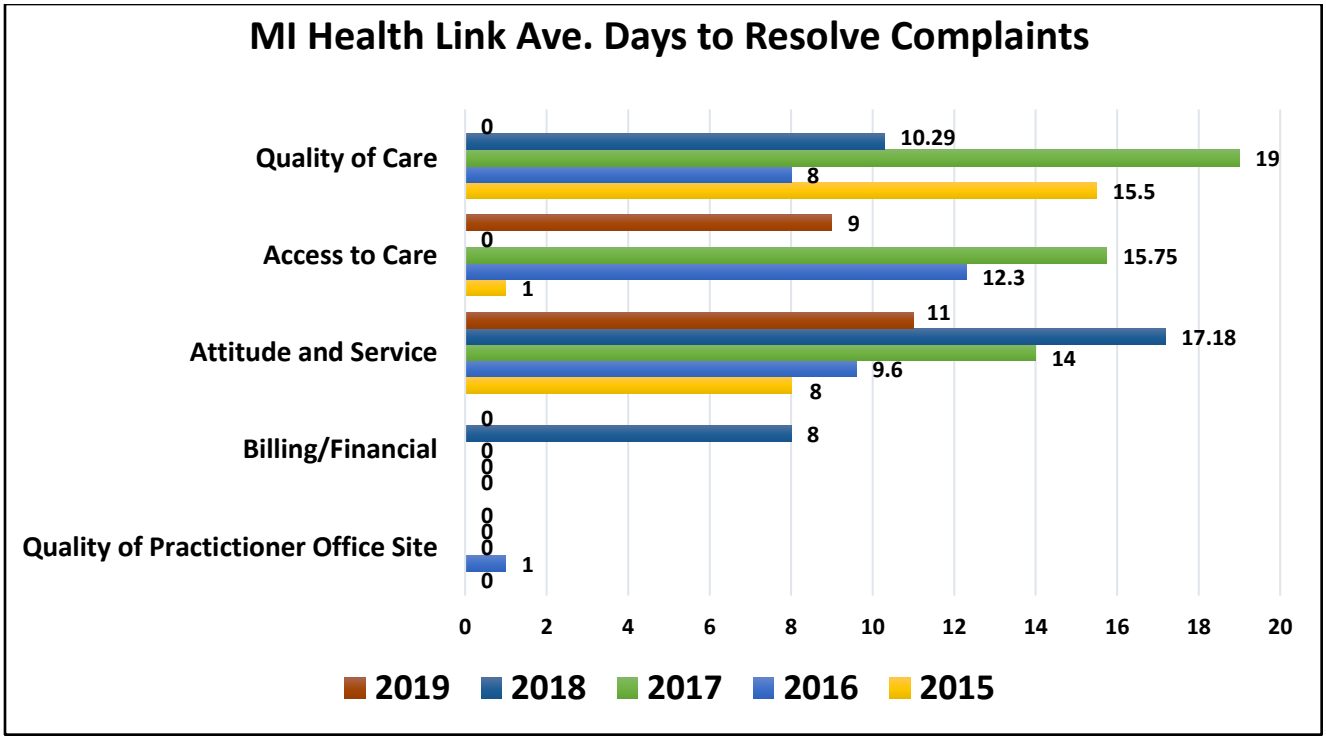
Additionally, It has been determined by the Regional Customer Services Committee that; if a consumer attempts to re-engage in services after being supplied an adequate action notice, within the given timeframe (12 days), services will continue without interruption and the incident is not tracked as an open appeal. If the consumer attempts to reengage after a given timeframe or if problematic issues are surrounding the consumer and their services, an investigation will be conducted. When the investigation is performed, the incident is treated as a Local Level Appeal. Before 2018, anytime a consumer attempted to reengage in services after being supplied an adequate action notice, any attempt to reengage the consumer was considered a Local Level Appeal regardless of the timeframe.
The Regional Customer Services Committee and the Regional Quality Assurance and Performance Improvement Committee will continue to review Grievance and Appeals data quarterly and follow-up on any trends that are identified.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Monitor the Complaint Tracking System for Providers and Customers	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints For all business lines	✓ At a minimum quarterly report on customer complaints to the QMC Committee, MHL Committee, RUM Committee, and RCP Committee are reviewed. ✓ Ensure proper reporting, monitoring, and follow-up resolution of Grievance and Appeals data, including: ➢ Billing or Financial Issues ➢ Access to Care ➢ Quality of Practitioner Site ➢ Quality of Care ➢ Attitude & Service	October 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Provider Network Director	Quarterly

2019 MI Health Link Complaints




MI Health Link Total Number of Complaints Comparision 2019 vs 2018
2019
2018
14
12
10
8
6
4
2
0
0
1
11
0
2
2
0
7
0
Quality of Practictioner Office Site
Billing/Financial
Attitude and Service
Access to Care
Quality of Care


MI Health Link Ave. Days to Resolve Complaints
Quality of Care
0
10.29
19
8
15.5
Access to Care
9
0
15.75
12.3
1
Attitude and Service
11
17.18
14
9.6
8
Billing/Financial
0
8
0
0
0
Quality of Practictioner Office Site
0
0
0
1
0
0
2
4
6
8
10
12
14
16
18
20
2019
2018
2017
2016
2015

MI Health Link Qualitative Analysis on Member Complaint Data

Complaints & Grievances- A casual and trend analysis has been completed and reviewed during the regional MHL Committee meeting to, identify opportunities for improvement, and implement interventions.

The following table shows the aggregate complaint total and rate per 1,000 MHL members for the past three years

CATEGORY	2019 (10,673) MEMBERS	2018 (9,586) MEMEBRS	2017 (11,179) MEMBERS	2016 (8,024) MEMBERS	2015 (5,186) MEMBERS
QUALITY OF CARE	0/0	3/0.313	3/0.268	1/0.125	2/0.386
ACCESS	2/0.187	0/0	4/0.358	5/0.623	3/0.578
ATTITUDE/SERVICE	2/0.187	11/1.148	14/1.252	6/0.784	1/0.193
BILLING/FINANCIAL	0/0	1/0.104	0/0	0/0	0/0
QUALITY OF PRACTITIONER OFFICE SITE	0/0	0/0	0/0	1/0.125	0/0
TOTAL	2/0.187	15/1.565	21/1.879	13/1.869	6/1.157

Causal Analysis of MI Health Link Complaints

Objective:
SWMBH functional area departments held a causal analysis meeting with representatives from Member Services, Provider Relations, Quality Improvement, and Utilization Management. The Medical Director also participated.

Results:
There were 2 complaints each for the Access and Attitude and Service Categories.

Identified Improvement Opportunities:

- Owners of the building were notified to create a handicap accessible ramp to the building.
- Improve telephone communication skills with education and with the creation of a Customer Service Phone Tip sheet for each Clinician. Suggestions included adopting a positive tone and answering the phone with a smile.
- MI Health Link complaints and trends will be presented and discussed during the MI Health Link Committee and Quality Committee monthly meetings.
- If trends are identified during reporting analysis, corrective action plans or other immediate actions may be taken to resolve the situation.

Consumer Involvement in Quality Assurance and Performance Improvement

The Annual Quality Plan and Evaluation is reviewed by the Regional Consumer Advisory Committee, which includes 6-7 consumers. Consumer and provider input at the committee level is received through consumers who sit on the Regional Customer Services Committee, MI Health Link Committee, Quality Management Committee, and SUD Committees. This structure provides an opportunity for consumers and providers to review current analysis, trends, and common denominators for programs and services and provide feedback on suggested opportunities for improvement.

Input/Satisfaction Surveys

Consumer satisfaction is represented within the Quality Assurance and Performance Improvement Plan (QAPIP), Annual Quality Assurance Evaluation, and through the annual Mental Health Statistics Improvement Program (MHSIP) and Youth Statistics Surveillance (YSS) surveys. The results and analysis reports are presented to the Quality Management Committee (QMC) and reflect overall SWMBH performance compared to state and national averages. Additionally, survey participant responses are reviewed and evaluated for trends. This consumer feedback is used by the QMC to improve processes and ultimately drive improvement in overall consumer outcomes.

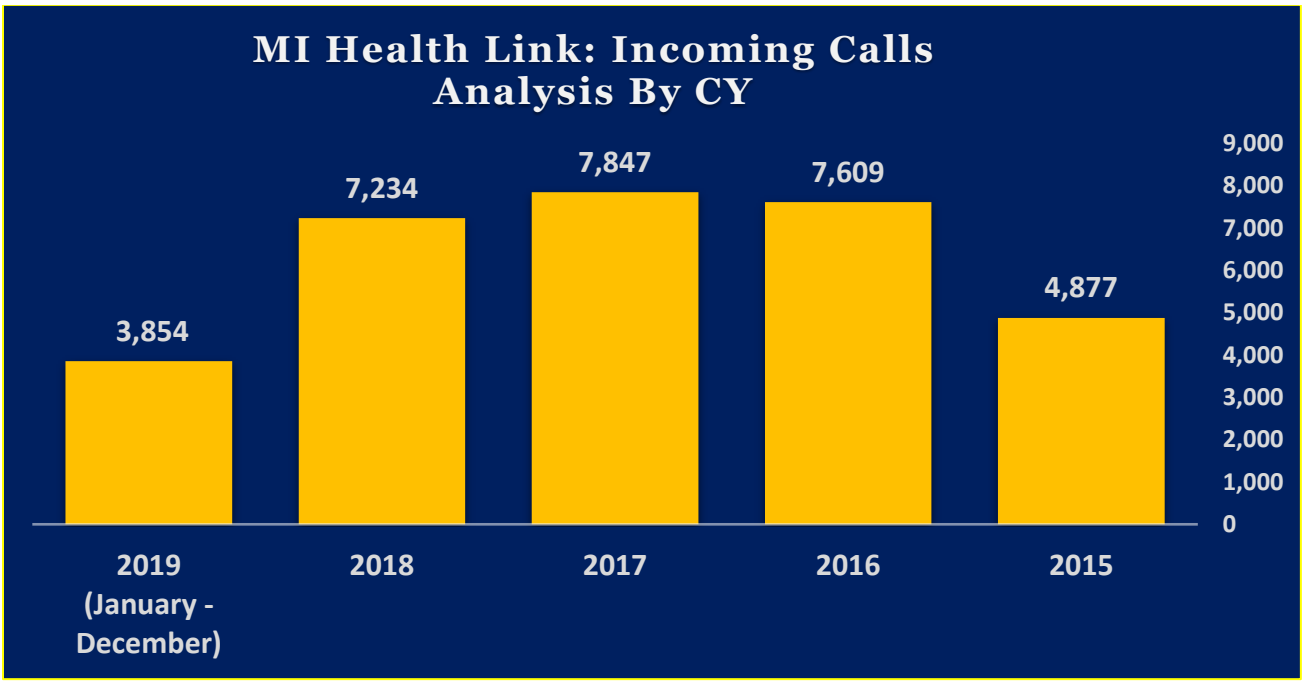
Providers administer the RSA-R survey. Several provider-based surveys required by NCQA exist between the mental health and primary care providers regarding how they receive collaborative information from each other. SWMBH also administers an online survey about access to care.

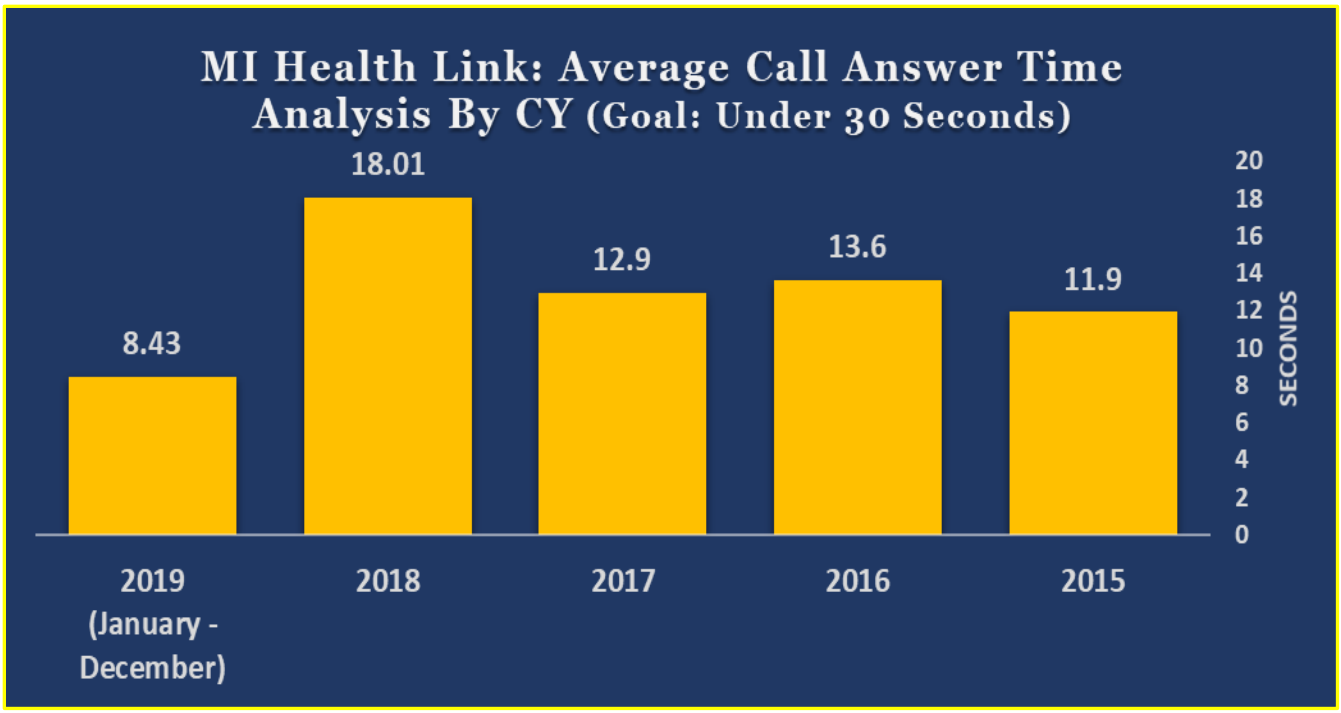
When surveys are completed, SWMBH follows a validation and review process with internal QAPI team members, Quality Management Committee, Regional Utilization Management and Clinical Practices Committee, and the Consumer Advisory Committee. Survey results, including narrative feedback, are given to each committee, and the committees plan program adjustments, additional interventions, and follow-up on significant concerns. If survey results were far below expectations, QAPI team members would conduct a follow-up survey following the prescribed program adjustments and interventions.

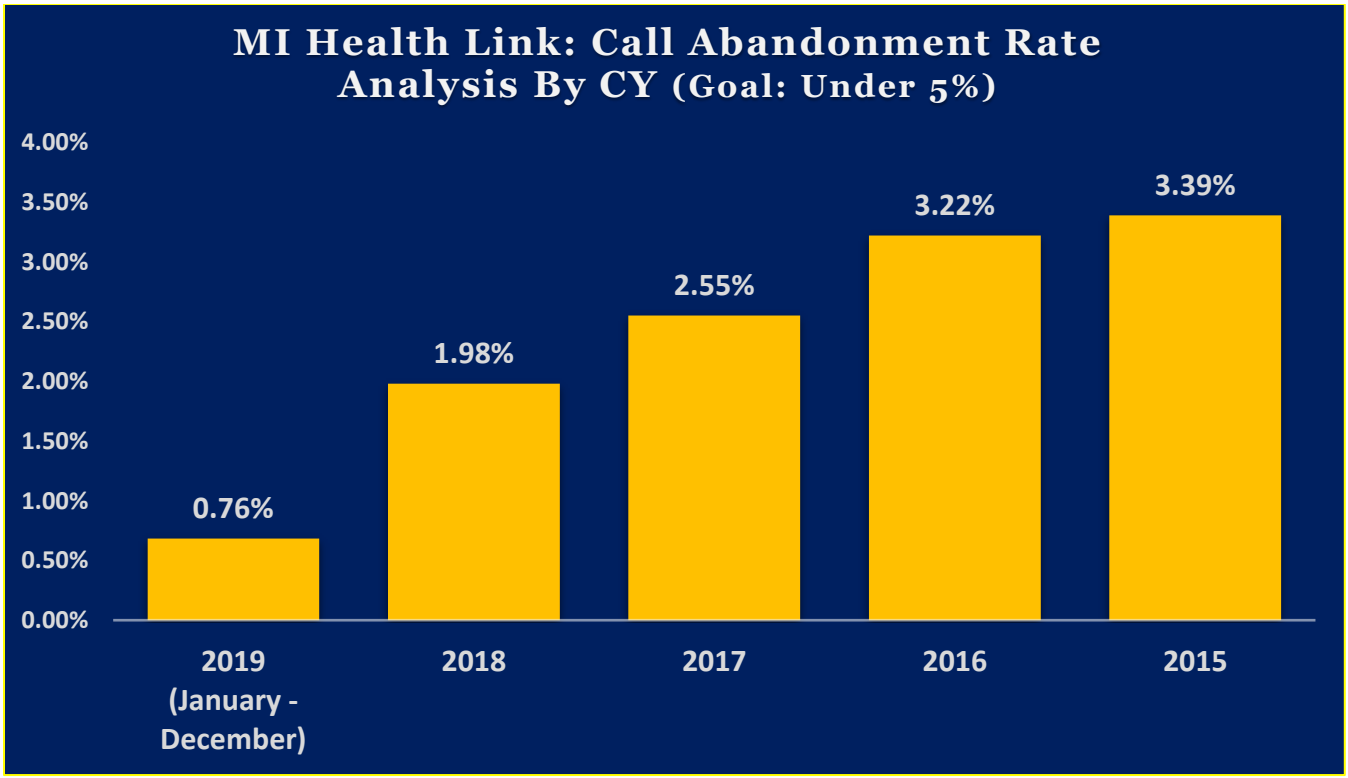
2019 Call Center Data Analysis

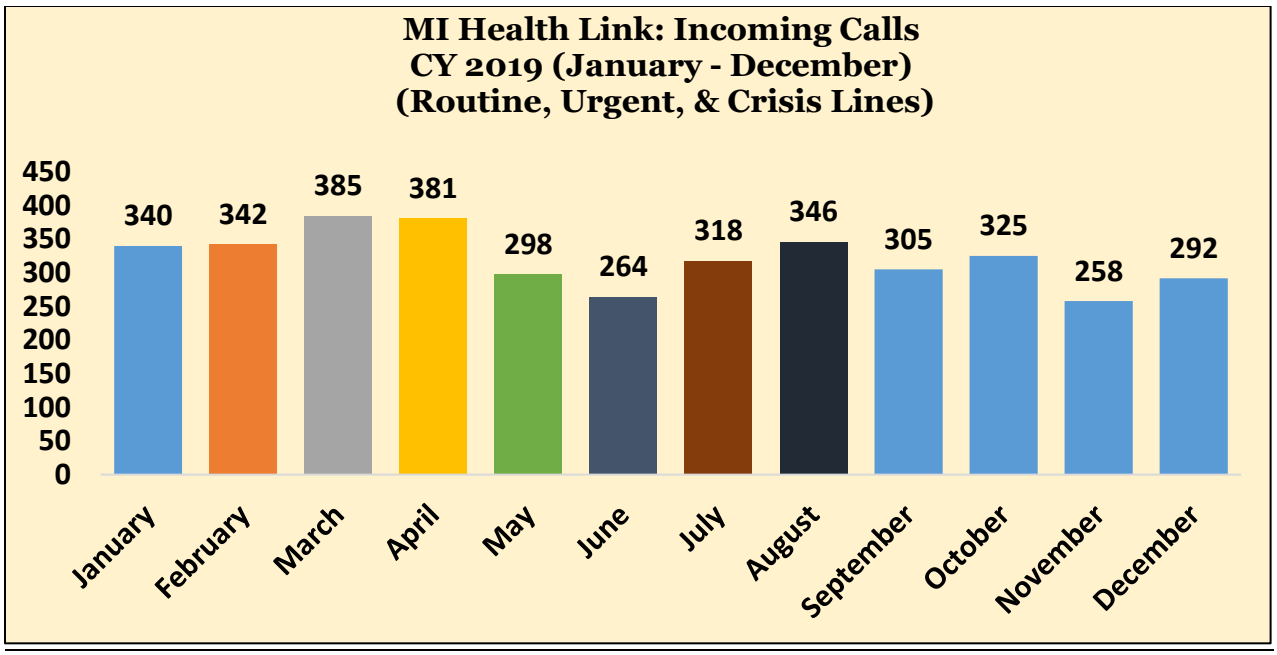
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ✓ Tracking and monitoring of all internal service lines (crisis, emergent, immediate and routine) ✓ Collect and analyze quarterly call reports submitted by CMHSPs	✓ A review of calls and agent performance to meet the scoring criteria of 96.25% performance rate is completed and evaluated. (*not required)* ✓ Achieve a call abandonment rate of 5% or less. ✓ Monitor the number of calls received for each service line. ✓ The average answer time is confirmed as; 30 seconds or less. ✓ Service level standard of 75% or above. ✓ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	January 2019 – December 2019	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

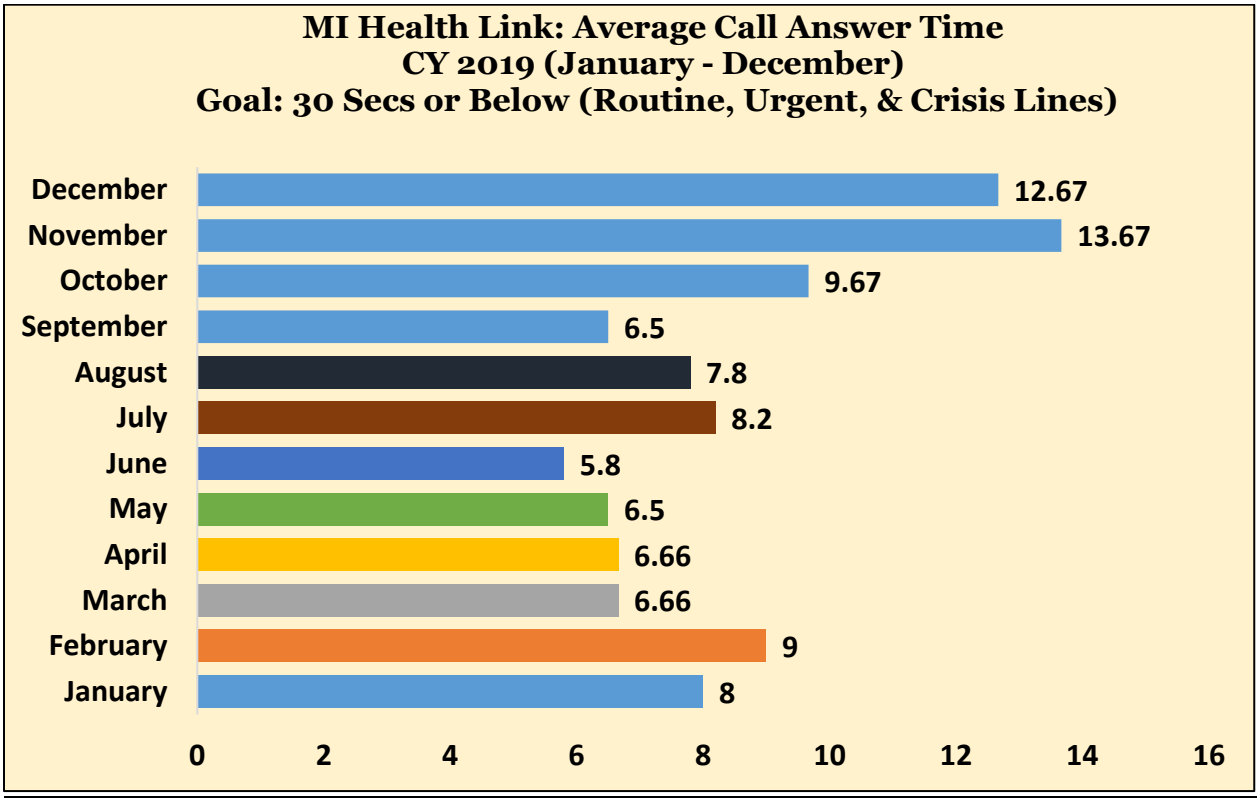
SWMBH 2019 MI Health Link Call Center Data Analysis

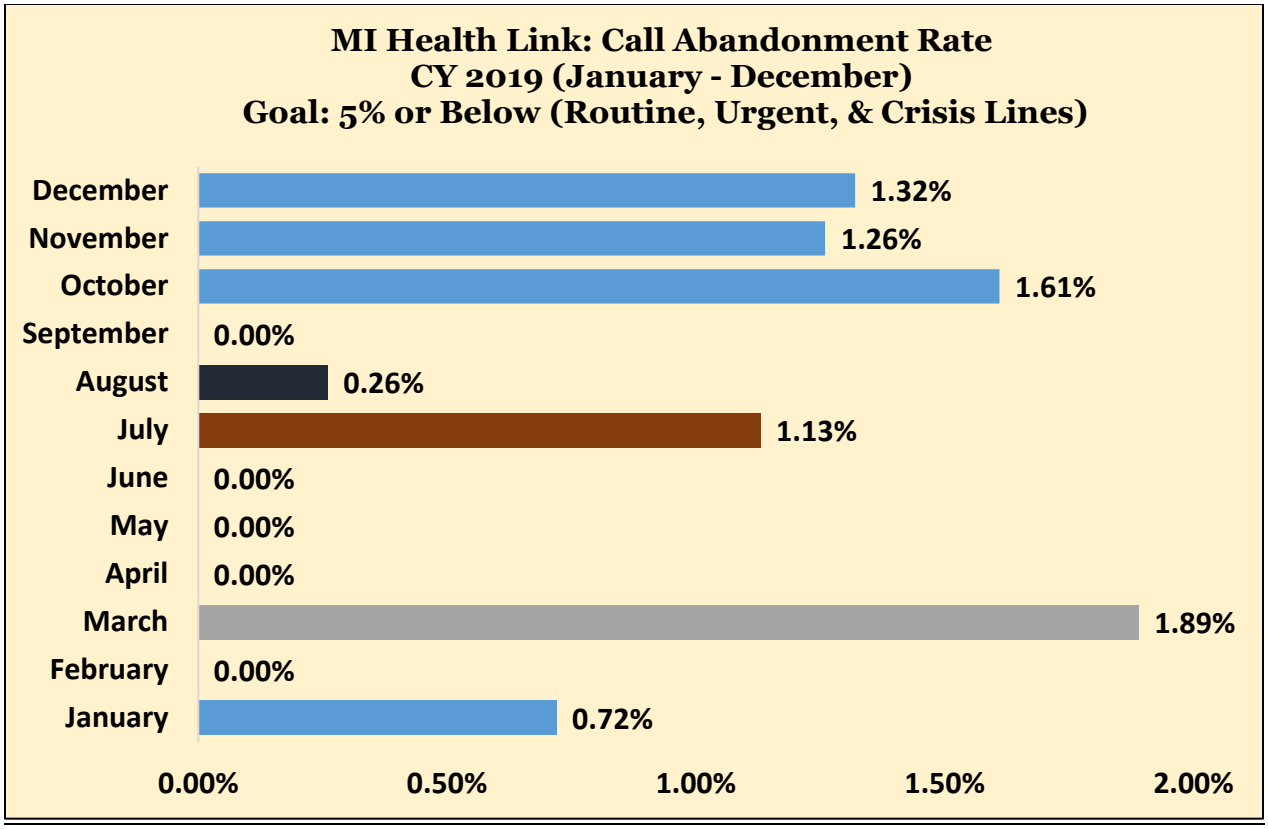



MI Health Link: Average Call Answer Time
Analysis By CY (Goal: Under 30 Seconds)
8.43
18.01
12.9
13.6
11.9
20
18
16
14
12
10
8
6
4
2
0
SECONDS
2019 (January - December)
2018
2017
2016
2015


MI Health Link: Call Abandonment Rate
Analysis By CY (Goal: Under 5%)
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
0.76%
1.98%
2.55%
3.22%
3.39%
2019 (January - December)
2018
2017
2016
2015


MI Health Link: Incoming Calls
CY 2019 (January - December)
(Routine, Urgent, & Crisis Lines)
450
400
350
300
250
200
150
100
50
0
340
342
385
381
298
264
318
346
305
325
258
292
January
February
March
April
May
June
July
August
September
October
November
December


MI Health Link: Average Call Answer Time
CY 2019 (January - December)
Goal: 30 Secs or Below (Routine, Urgent, & Crisis Lines)
December
November
October
September
August
July
June
May
April
March
February
January
12.67
13.67
9.67
6.5
7.8
8.2
5.8
6.5
6.66
6.66
9
8
0
2
4
6
8
10
12
14
16



Objective:

The Quality Improvement Department is primarily responsible for the oversight and management of all SWMBH quality programs and initiatives. The QI Department will appoint appropriate clinical SWMBH staff, deemed as appropriately trained in call auditing procedures and how to deliver constructive performance feedback to CM. The scores/evaluations are tracked over time so that call center staff can see progress, and senior leadership can identify trends and track ongoing improvements. Call center staff will receive evaluations upon completion of the monitoring form and be allowed to ask questions, identify additional training needs and/or formulate a corrective action plan. Department supervisor(s) will be directly involved in situations in which employees receive negative performance feedback that may result in the activation of SWMBH's progressive discipline process and/or situations where call center staff continue to fail to improve call servicing skills.

Results:

All required call performance metrics stayed within acceptable ranges during 2019. Please find the current breakdown of call metric averages for 2019:

- Call Abandonment Rate: **0.76%**
- Call Answer Time: **8.43 seconds**
- Average Incoming Calls per Month: **321 Calls**
- Total Number of Incoming Calls for 2018: **3,854**

Identified Barriers:

Evaluation of Call Monitoring and Calibration Process during vender transition.

Recommendations:

Calibration ensures that all SWMBH clinical staff, who have been deemed appropriate to engage in monitoring activities, can rate call center staff interactions consistently and fairly. Calibration will occur on an annual basis and/or when a

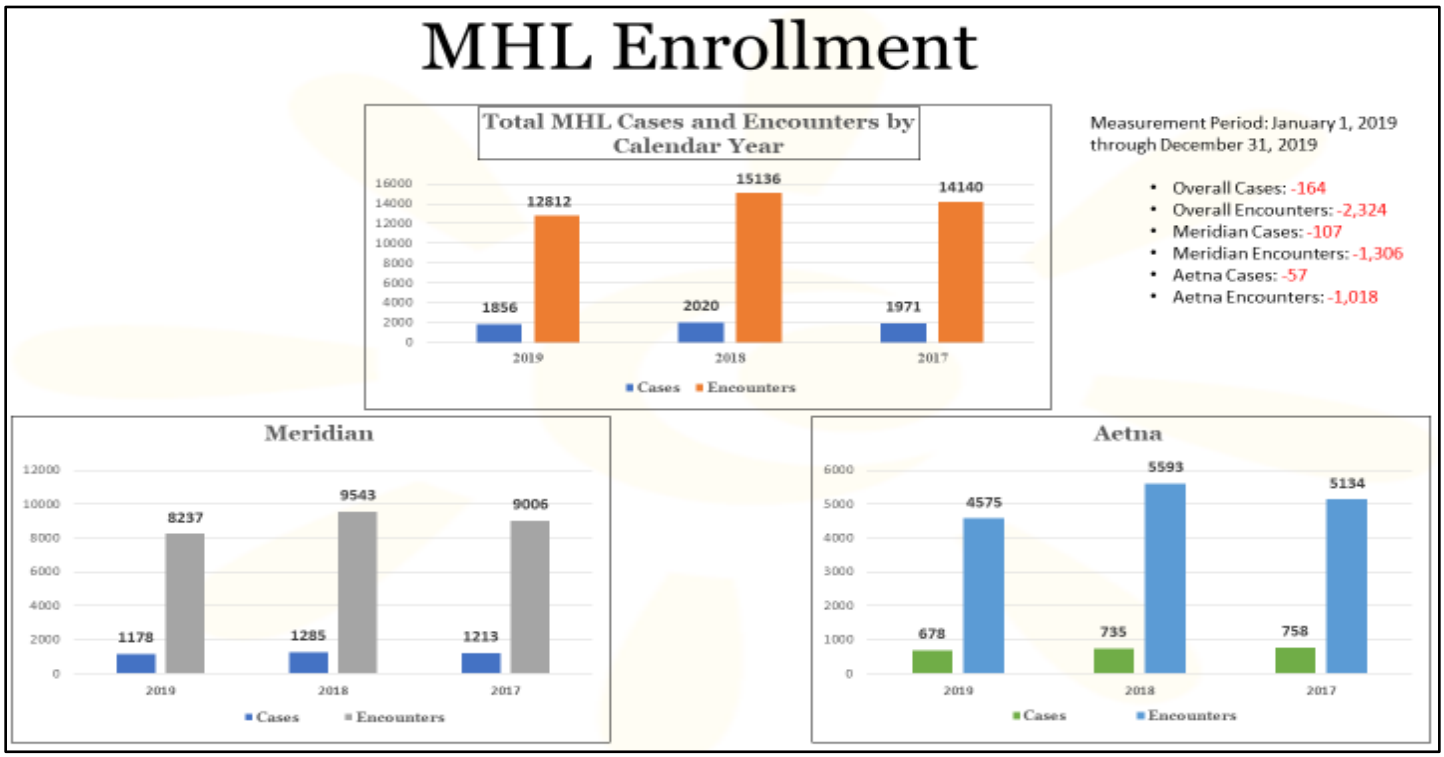
new clinical staff member is designated to perform monitoring activities. During each calibration session, multiple evaluators will independently score the same call center staff interaction.

Enrollment and Eligibility Breakdown in the MI Health Link Demonstration

MI Health Link Enrollment by County (CY 2019):

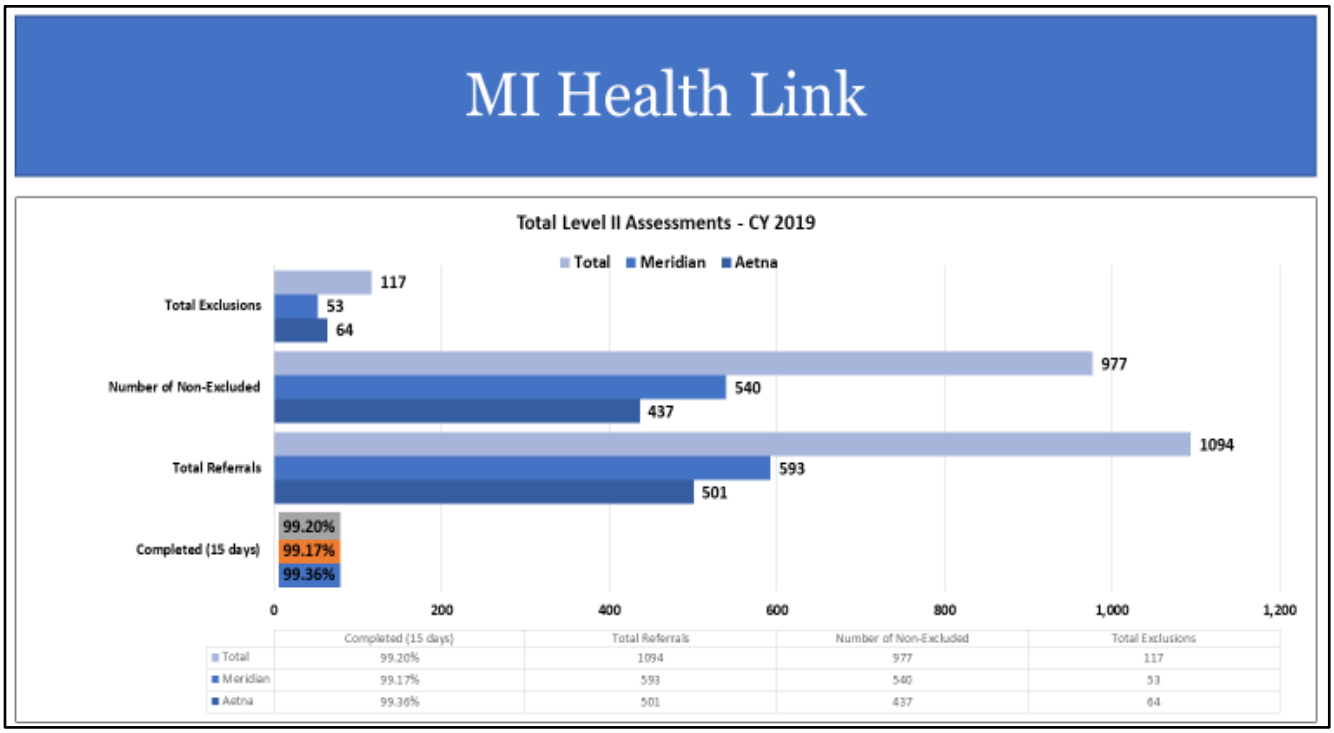
**Data includes MI Health Link Business Line for both Aetna and Meridian (ICO Partners) **
Data Snapshot taken 1/27/20

County Name	# Consumers Covered	# Consumers Served	# of Encounters
Kalamazoo	2,653	388	35,900
Calhoun	2,337	277	14,000
Berrien	2,237	166	9,031
Van Buren	1,133	135	7,700
St. Joseph	785	77	4,086
Cass	577	72	5,400
Branch	512	71	4,200
Barry	439	66	1,300
Total:	**10,673**	**1,252**	**81,617**

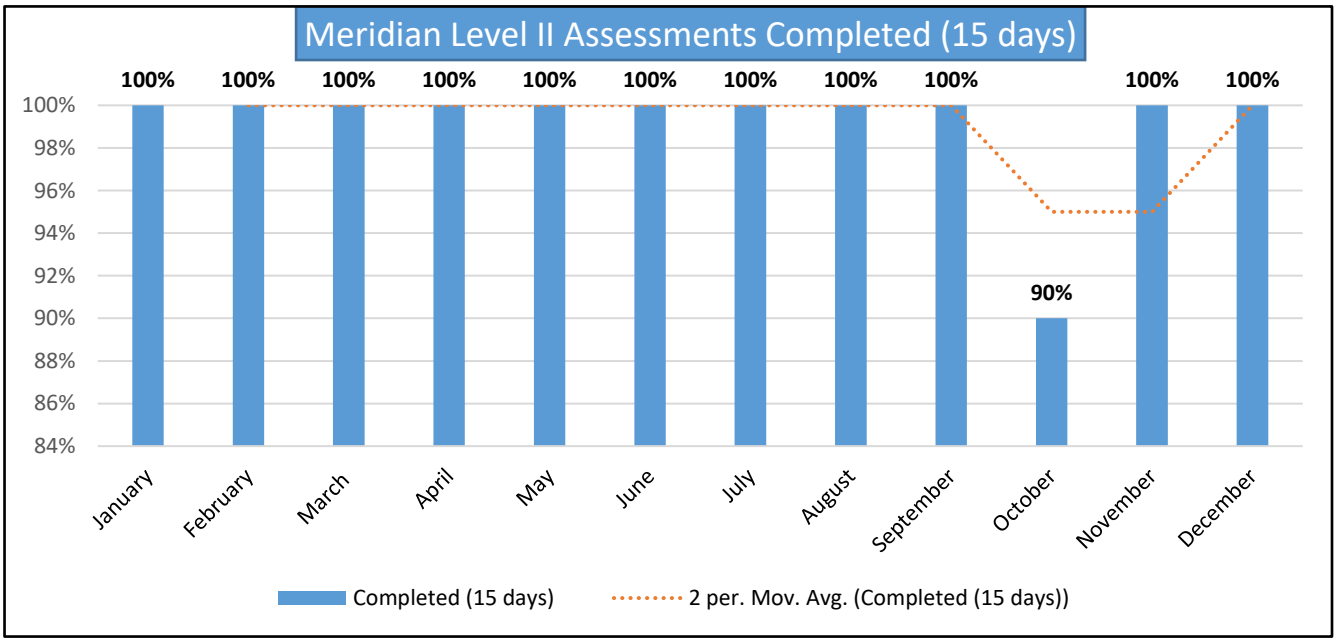


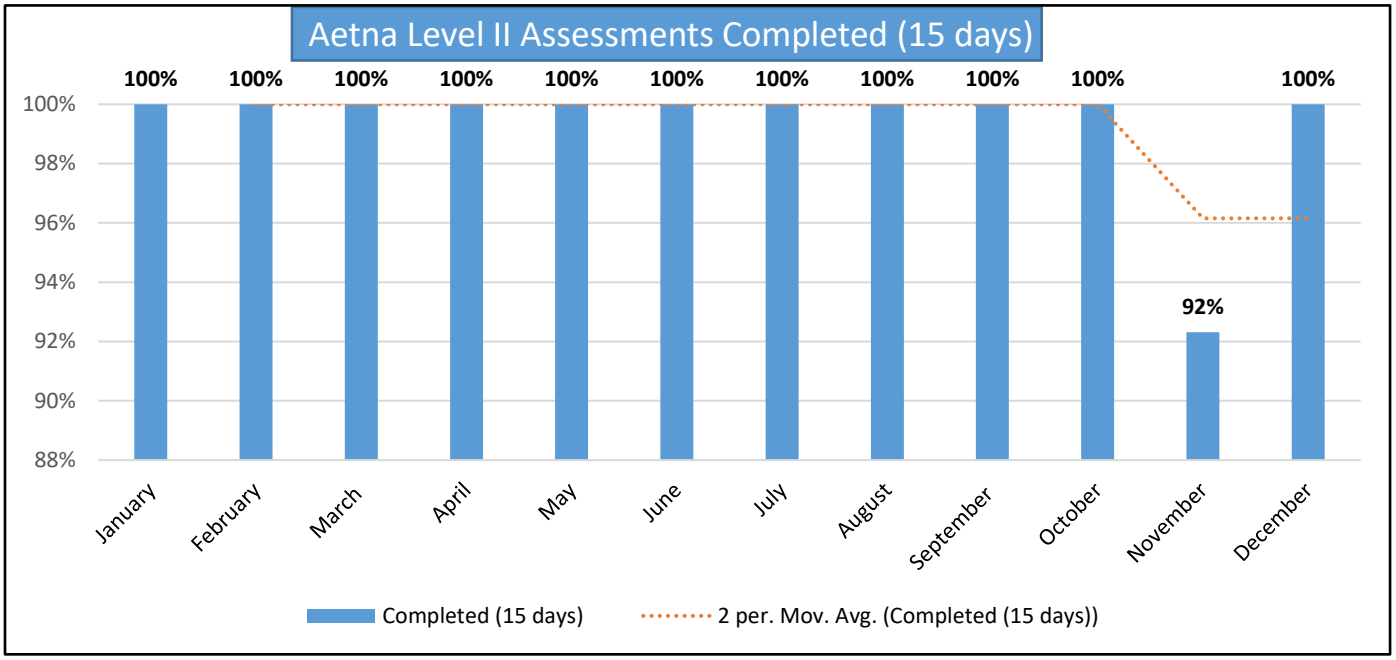
MI Health Link Level II Assessment Timeliness Report Analysis

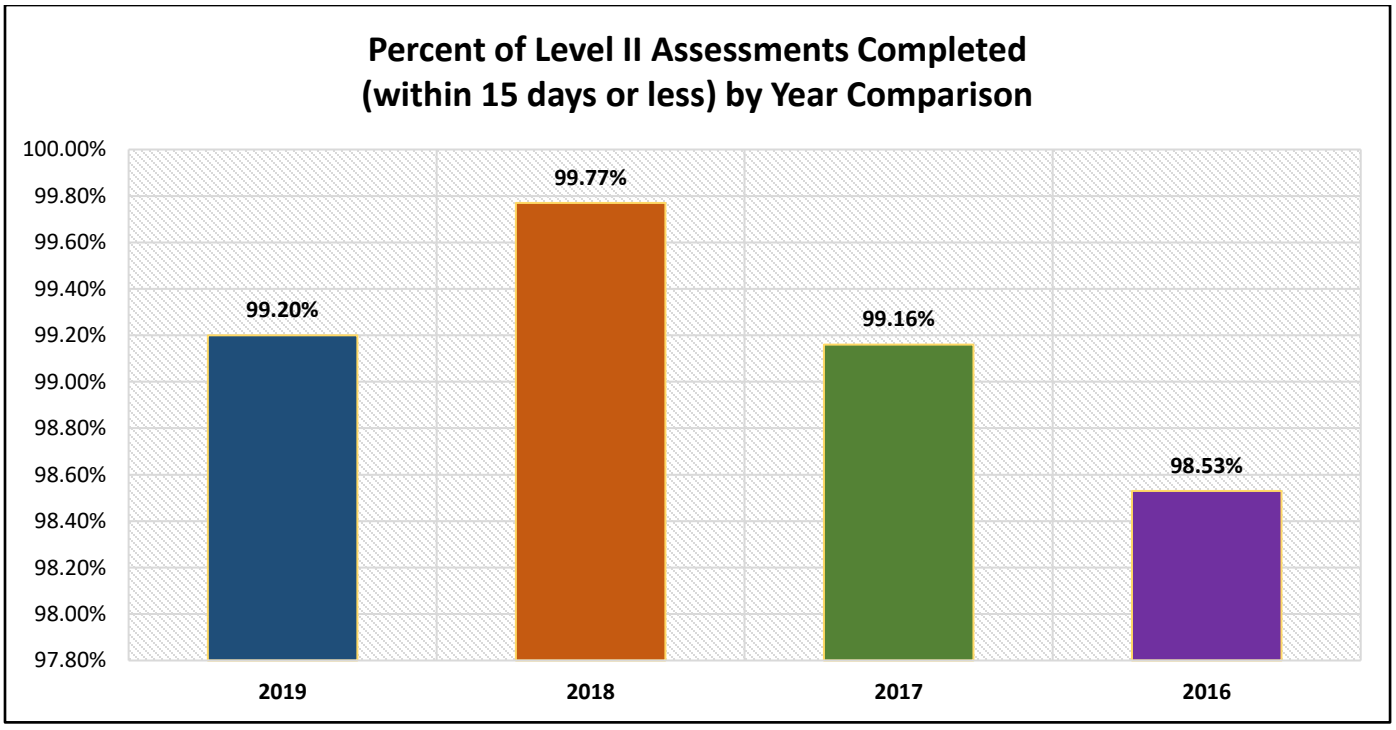
January 1, 2019 – December 31, 2019

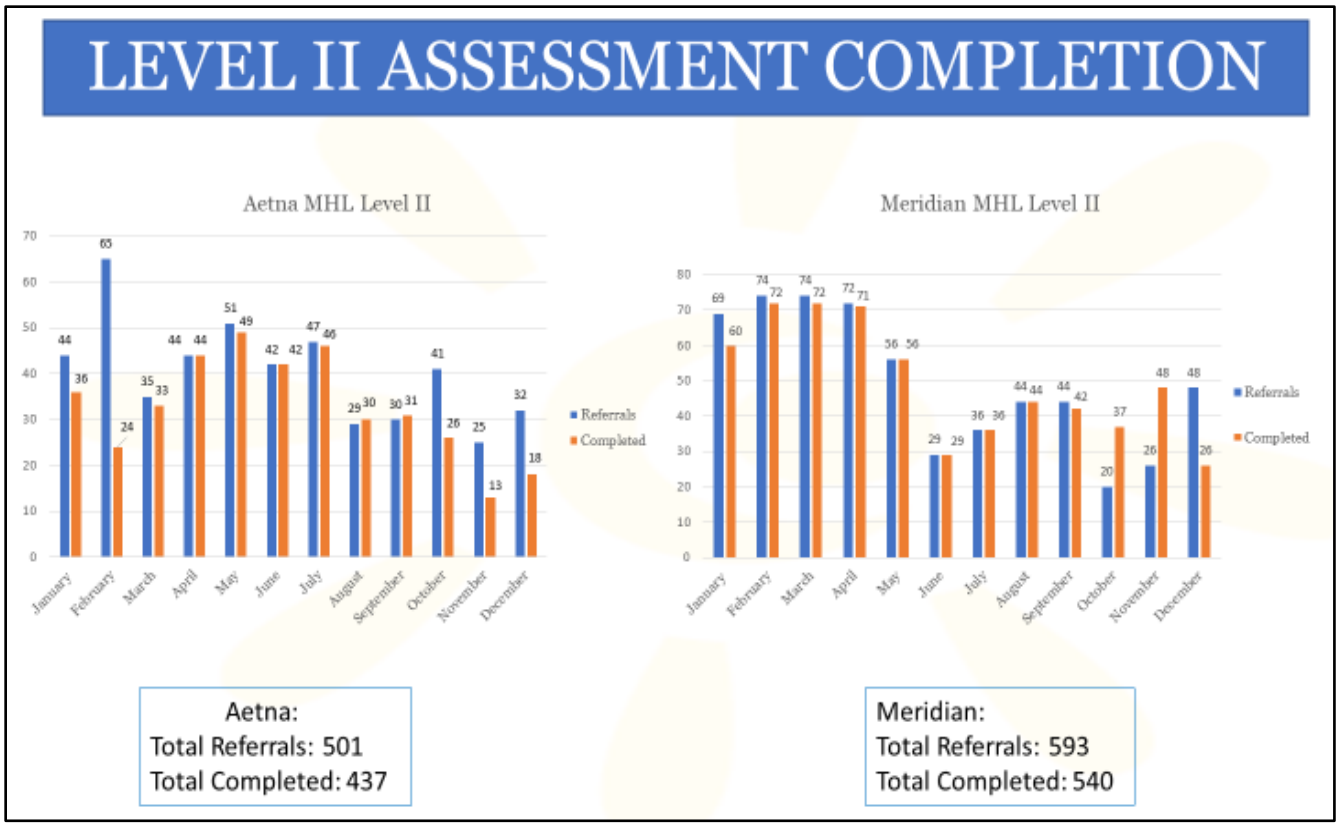


- **Target/Goals:** The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric within (15 days) is 95% or above.
- During CY 2019 99.20% of Level II Assessments achieved the Timeliness Standard of follow-up within (15 days or less).




Aetna Level II Assessments Completed (15 days)
100%
98%
96%
94%
92%
90%
88%
100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 92% 100%
January
February
March
April
May
June
July
August
September
October
November
December
Completed (15 days)
2 per. Mov. Avg. (Completed (15 days))


Percent of Level II Assessments Completed
(within 15 days or less) by Year Comparison
100.00%
99.80%
99.60%
99.40%
99.20%
99.00%
98.80%
98.60%
98.40%
98.20%
98.00%
97.80%
99.20%
99.77%
99.16%
98.53%
2019
2018
2017
2016



Objective:

The analysis measures are the percentage of enrollees who completed a Level II Assessment within 15 days. The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric is within (15 days) or 95% or above.

Results:

In 2019, 99.20% of consumers received an initial Level II Assessment within 15 days of a referral. This was a 0.61% decrease compared to 2018 and a 0.04% increase from 2017. Review Level II Assessment analysis and exclusion determinations are reviewed during MHL Committee Meetings, on a quarterly schedule. If outliers are identified, a corrective action plan may be implemented.

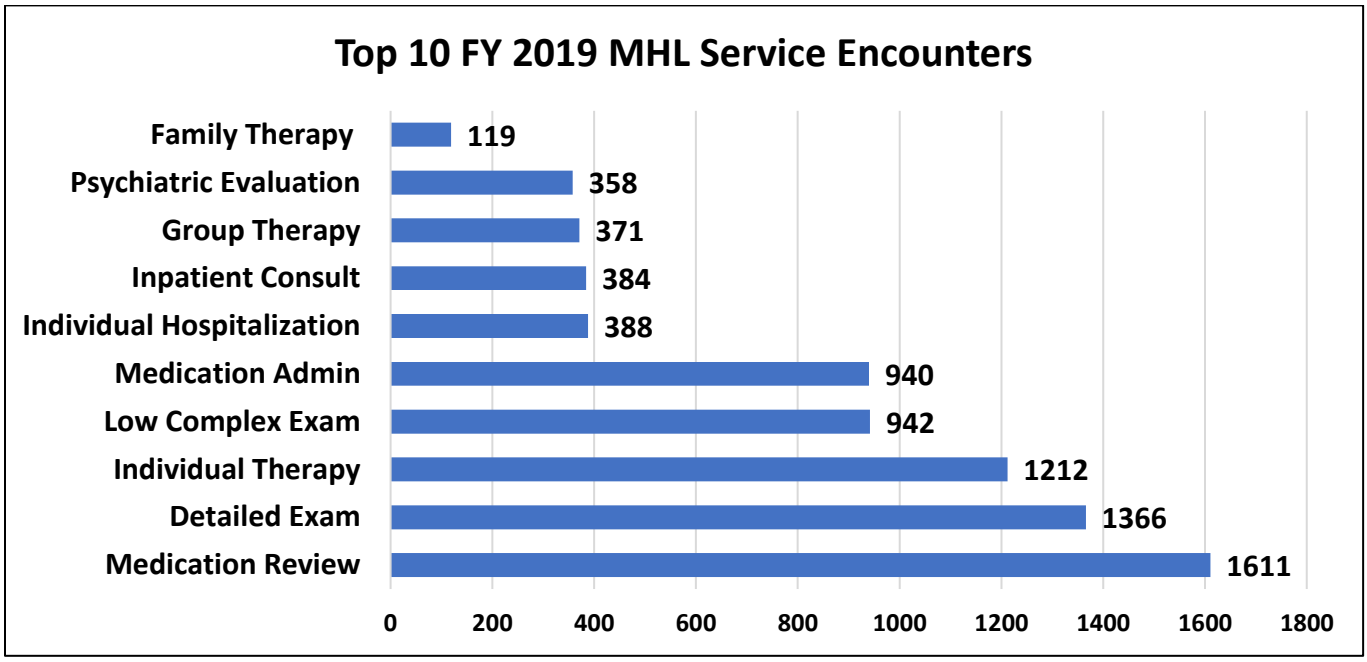
Identified Barriers:

In May of 2019, the Call Center/UM staff were very short-handed and going through a transitional phase of training those newly hired. There were also some system changes regarding how the event was captured in the EHR. This required additional training/education to staff and updates to report logic.

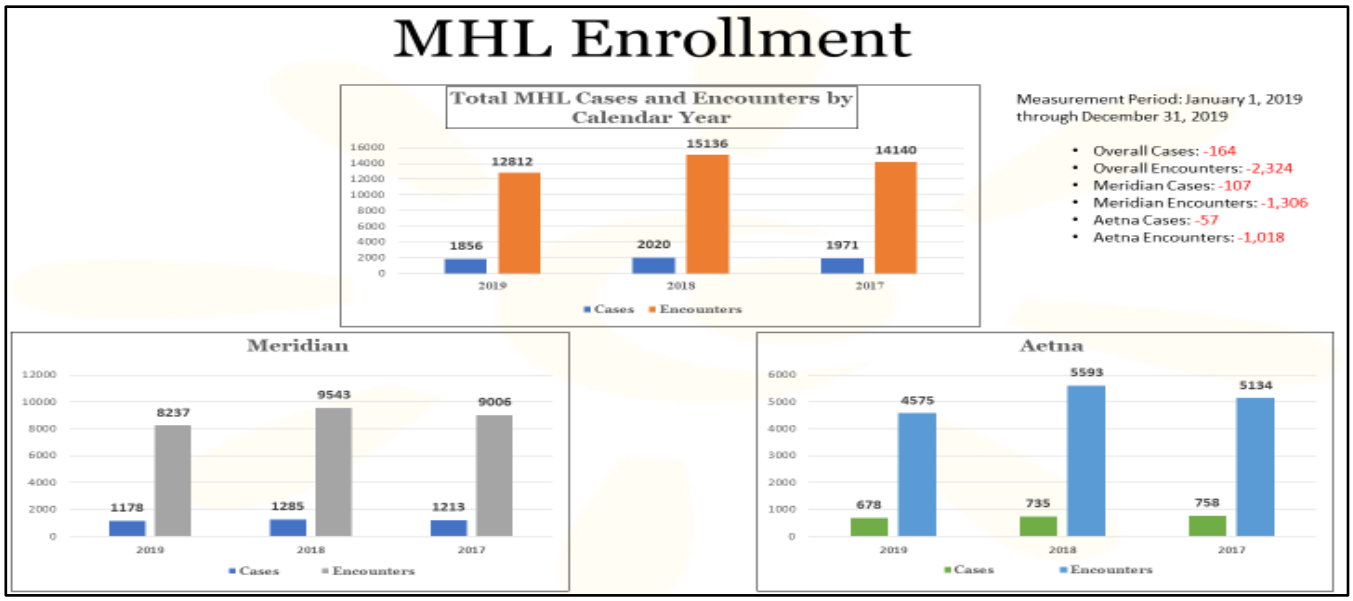
Recommendations:

SWMBH is currently working on the redevelopment of the Level II report in SmartCare. This will improve the validity and accuracy of the report. This will also help capture our agreed-upon methodology for Level II Assessment exclusion categories with Integrated Care Organizations (ICO's). This will be very helpful when we are negotiating our established quality withhold measures at the end of the contract year.

The graph below is the ICO Service Encounter Breakdown (FY 2019) of the top 10 MHL services out of the many services offered:



- ❖ The graph above is the ICO Service Encounter Breakdown (FY2019) of the top 10 MHL services out of the many services offered.
- ❖ Service Dates (October 1, 2018 through September 30, 2019).
- ❖ Dashboard Includes Services Provided to both Aetna and Meridian Plan Members.
- ❖ A total of 7691 provider services were administered during FY 2019.



Access to Care and Timeliness of Services

Access Standards *(SWMBH policy 3.6)*
Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for access to:

- Regular and routine care appointments.
- Urgent care appointments.
- After-hours care.
- Member Services, by telephone.
- UM by telephone SWMBH Reporting:
    - Care of non-life-threating emergency – defined as a pre-screen process at the hospital and crisis line calls. Standards: 3 hours to complete the pre-screening process, and the crisis line will be answered by a live person 24 hours a day.
    - Assessment – 14 calendar days
    - First Service- 14 calendar days

Level of Intensity Service and Decision Type

LEVEL OF INTENSITY/DECISION TYPE	DEFINITION	EXPECTED DECISION/ RESPONSE TIME
EMERGENT/PRESERVICE – 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 of request; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of the request.
URGENT CONCURRENT	A request for extension of a previously approved ongoing course of treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment; or in the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.	Within 24 hours of request; prior authorization required
URGENT PRESERVICE	At the 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 needed within 72 hours of denial
ROUTINE/PRESERVICE NONURGENT	At the risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 calendar days of request; Prior authorization required
RETROSPECTIVE/POSTSERVICE	Accessing appropriateness of medical necessity on a case-by-case or aggregate basis after services were provided	Within 30 calendar days of the request

The organization adheres to the following time frames for timeliness of UM decision making:

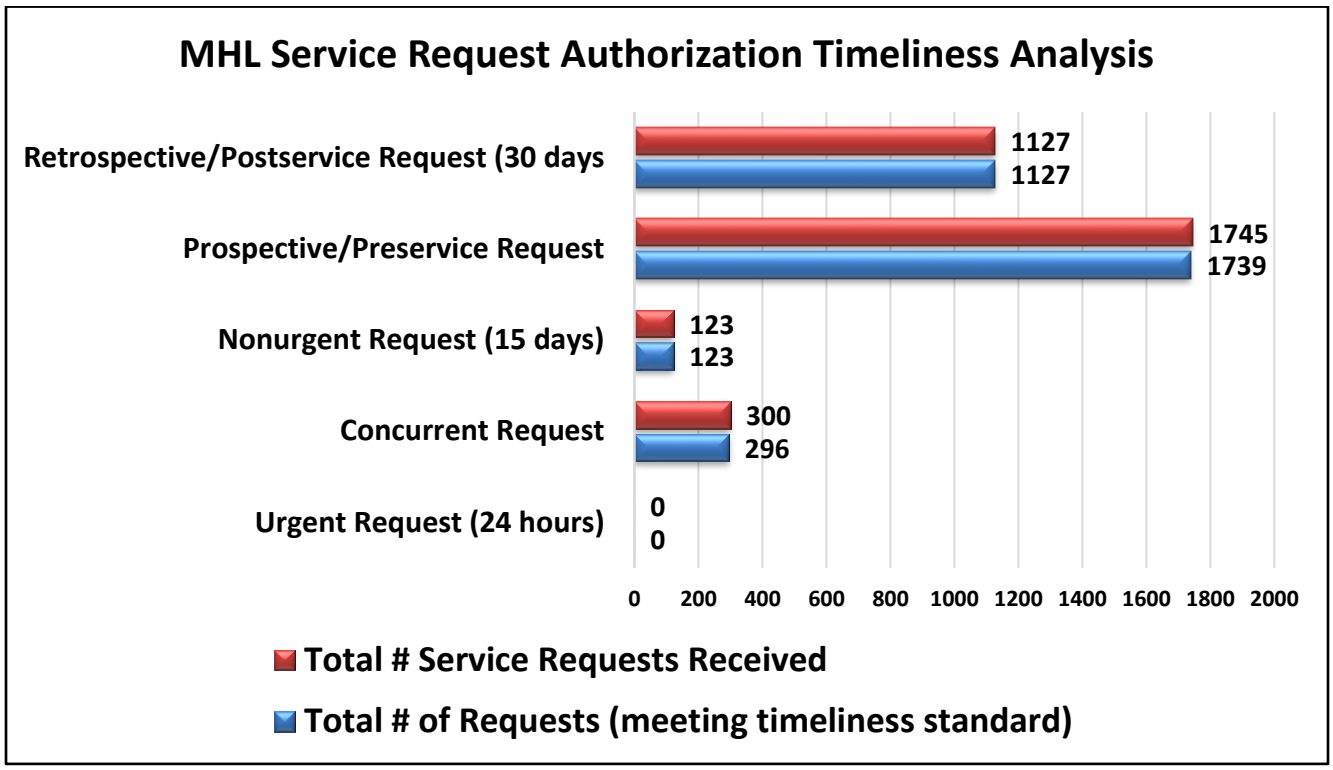
1. For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.
2. For urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request.
3. For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.
4. For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Timeliness Categories:

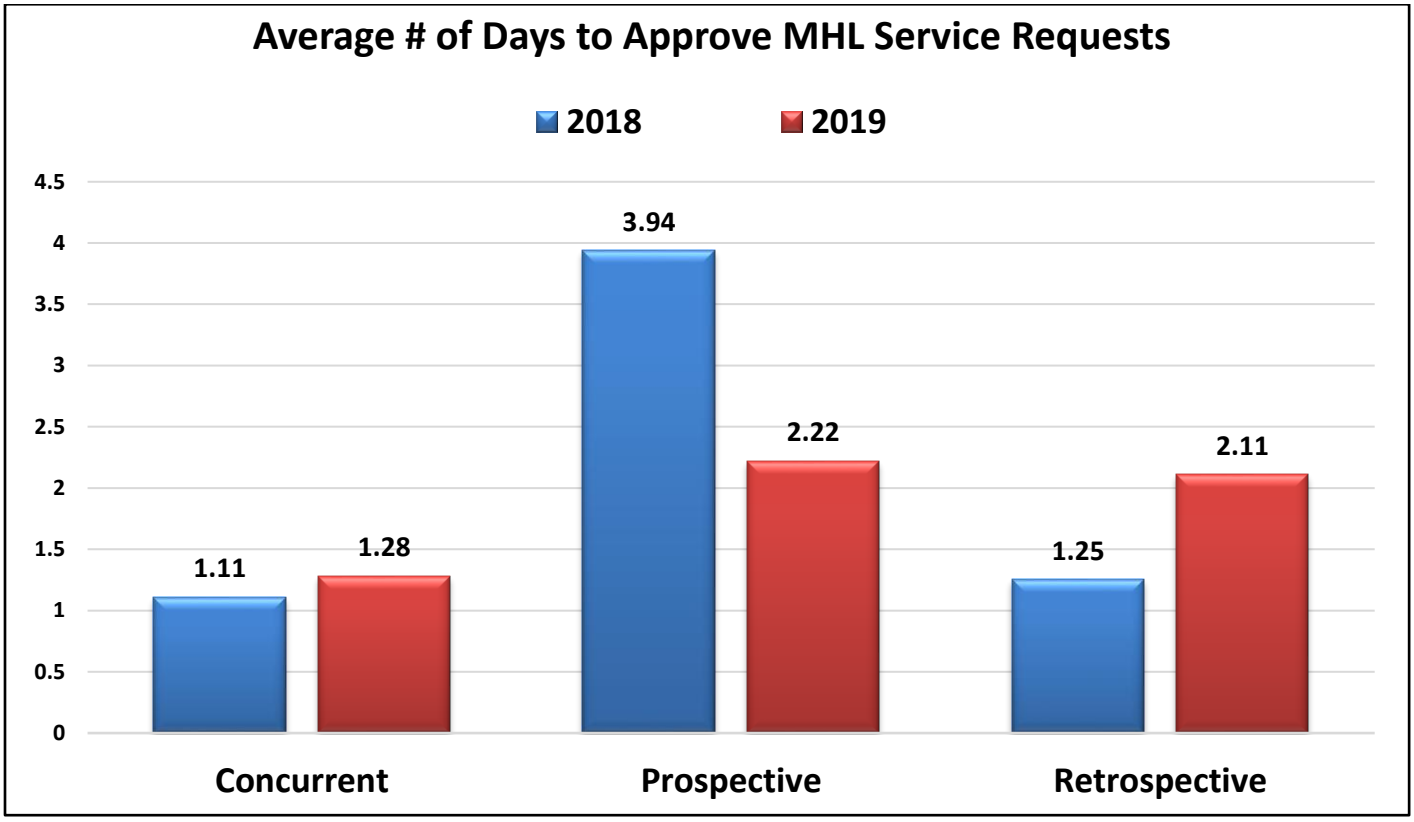
- **Urgent request:** A request for care or services where the application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- **Concurrent request:** A request for coverage of care or services made while a member is in the process of receiving the requested care or services, even if the organization did not previously approve the earlier care.
- **Nonurgent request:** A request for care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
- **Preservice request:** A request for coverage of care or services that the organization must approve in advance, in whole or in part.
- **Post-service request:** A request for coverage of care or services that have been received (e.g., retrospective review).

2019 MI Health Link Service Authorization Timeliness Analysis

Measurement Period: January 1, 2019 through December 31, 2019
NCQA Standard UM-5C



MHL Service Request Timeliness Report	Urgent Request (24 hours)	Concurrent Request	Nonurgent Request (15 days)	Prospective/Preservice Request	Retrospective/Post service Request (30 days
Total # of Requests (meeting timeliness standard)	0	296	123	1739	1127
Total # Service Requests Received	0	300	123	1745	1127
Timeliness Rate	N/A	98.60%	100%	100%	100%



Analysis and Observations:

Overall, the timeliness performance met or exceeded standard and department requirements.

At this time, no corrective action plans are warranted for this measurement period, as each category has maintained satisfactory compliance.

The MHL Committee will continue to review the timeliness measures quarterly to identify and remediate any potential trends, outliers, or delayed decisions. Timely service authorization and delivery are essential to the consumers we serve so that they can achieve improved outcomes.

Care Coordination

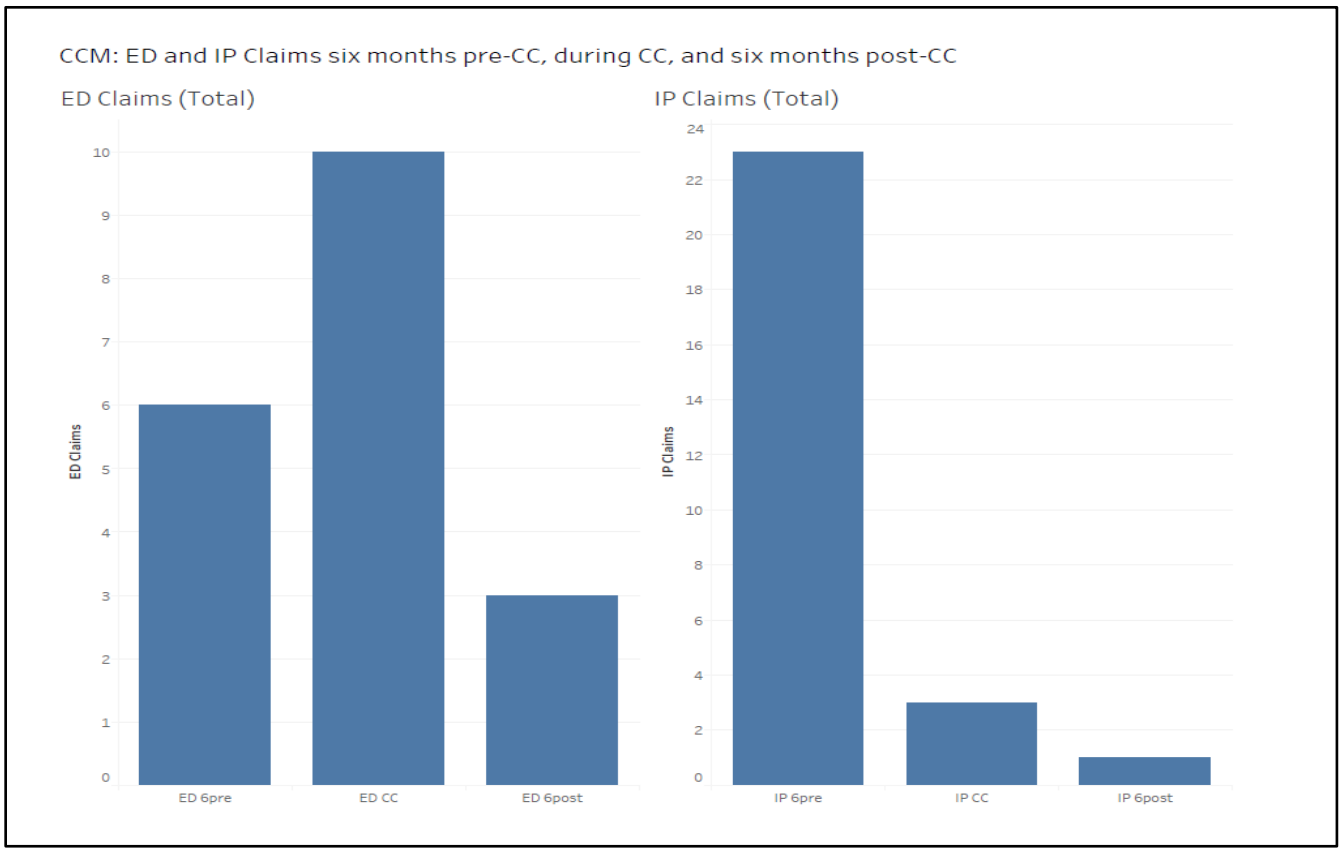
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Coordination of Care	➢ Monitors for continuity and coordination of care members receive across the network and actions improve. ➢ Demonstrate re-measurement for selected interventions. ➢ Quantitative and causal analysis of data to identify improvement opportunities. ➢ Collaboration with health plans to coordinate BH treatment for members.	✓ Use of Care Management Technology (CMT) and CC360 to measure: Exchange of information across the continuum of BH Services. ✓ Administration and analysis of Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ✓ Measure and analyze the appropriate use of psychotropic medications. ✓ Measure and analysis of services/programs for consumers with severe and persistent mental illness. ✓ Develop and implement a procedure for Complex Care Management community outreach to improve member engagement and coordination. ✓ Increase outreach and care coordination with regional ED to improve the BH prescreening process and reduce IP admissions. ✓ Increase outreach to veterans and Military Families that are not currently receiving services.	January 2019 – December 2019	Senior Integrated Healthcare Specialist QAPI Director Chief Operations Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant	Quarterly

Complex Case Management Coordination and Overview

In 2019, the Integrated Care Team revised and updated the Complex Case Management Process. A workflow was created, beginning at risk stratification and ending with the closure of the member from the program.
The workflow, having been streamlined, has created consistency and efficiency of care, communication, and collaboration that is being provided to members. Some important updates include:

- SWMBH sends an initial packet to the member's home upon identification to notify them of the program and that someone from SWMBH will be reaching out. The result of this has been that members are likely to answer the phone when we call if they are aware, we are going to be outreaching them to help support them.
- SWMBH meets members where they are in the community. The Integrated Healthcare Specialist has made visits to public locations (McDonald's), an inpatient hospital setting, and a homebound patient's home this year. With this flexibility and person-centered focus, the CCM program was able to establish and build relationships that resulted in member improvement and graduation from the program as well as member engagement in other services such as psychiatric care and outpatient therapy.
- SWMBH's Integrated Healthcare Specialist works with members to create person-centered plans and update plans according to their personal needs. Progress notes and closure letters are provided to each member throughout the process based on their needs.

All of these factors and the rest of the workflow process have created a consistent environment where member's needs are addressed timely, hospitalizations are decreased, and member engagement with ambulatory care is improved.



2019-member emergency department (ED) and inpatient (IP) claims pre-, during, and post- complex case management involvement. Note decreased ED and IP claims six months post-graduation from CCM.

Patient-Centered Care:

The overall goal of Complex Case Management (CCM) is to help members move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. The member selects the health goals that they wish to address, and a SWMBH RN will help facilitate the identification of steps needed and the community support available to meet the patient-centered goals.

Complex Case Management is available to members who have a variety of co-morbid behavioral health, physical conditions, and needs. Complex Case Management offers SWMBH members the opportunity to talk with a Registered Nurse to assess physical and behavioral health needs; establish member-centered goals to address needs; identify barriers and solutions to help achieve goals and identify additional available community resources.

The purpose of Complex Case Management is to help organize and coordinate services for members with complex physical and behavioral health conditions. A SWMBH RN will work through physical and behavioral health obstacles or barriers with members on a 1:1 basis. The RN will help the member to navigate confusing multiple service pathways and secure necessary physical health, behavioral health, and community services.

The criteria for enrollment include, but is not limited to one or more severe and persistent mental illness (SPMI) Behavioral Health diagnoses and at least one of the following criteria:

- Recent (2 in the past six months) inpatient admissions (IP) to the hospital
- High Emergency Department (ED) User
- Four or more chronic medical diagnoses
- A combination of IP admissions/high ED use along with a less severe mental illness

Furthermore, the criteria for SUD/Withdrawal Management/Residential Treatment includes two or three withdrawal management or residential SUD treatments in the past twelve months in conjunction with two or three chronic medical conditions.

Those members identified for enrollment in CCM are contacted via phone to schedule a time to talk with the RN. This is done via telephone or in-person to learn about the CCM program. Additionally, a SWMBH RN is available to meet members during a psychiatric inpatient stay to educate them about the CCM program and assess their eligibility and interest.

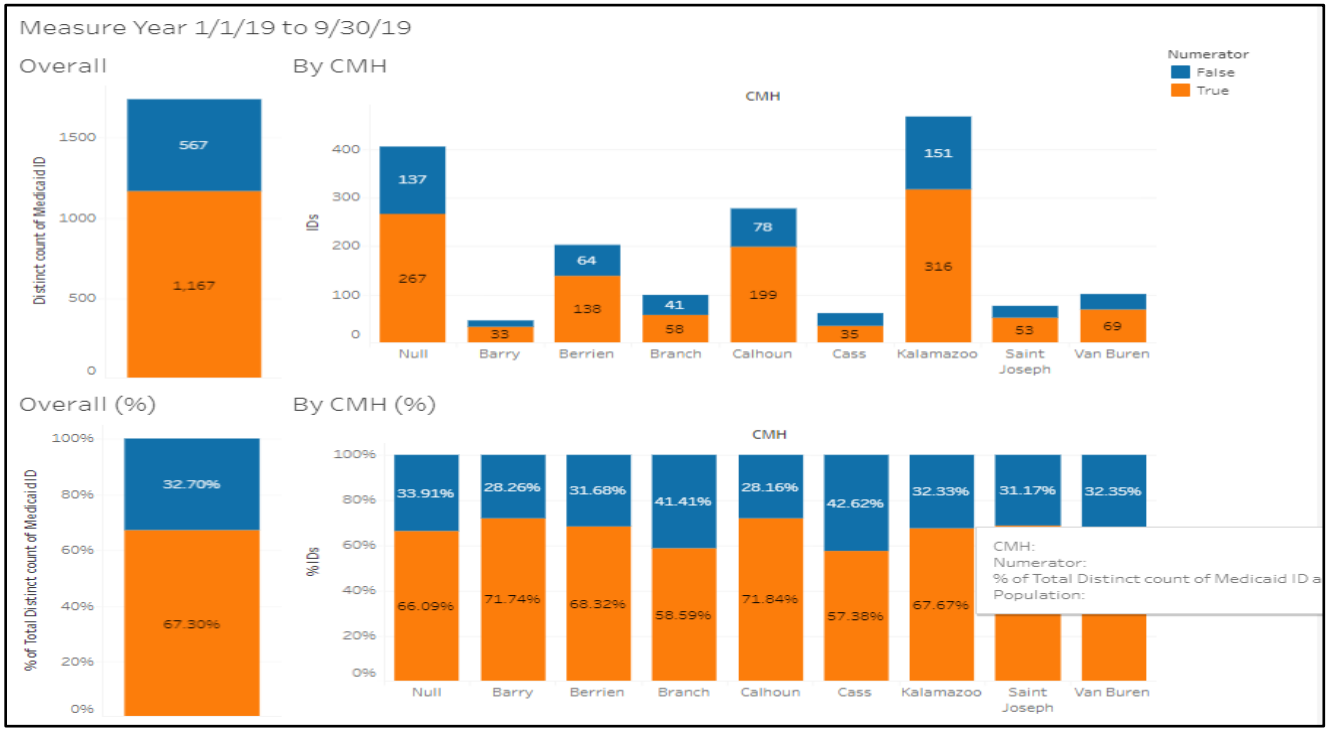
Care Management Technologies (CMT) ProAct Application:

SWMBH utilizes ProAct (an application produced by CMT using Care Connect 360 data) to monitor behavioral health and physical health aspects of members served. CMT contains hundreds of reports measuring HEDIS metrics, inpatient and ER utilization, medication adherence, opioid alerts, and prescriber trends. Each CMHSP has at least one identified clinical or quality professional trained in CMT to monitor these measures. CMT reports are utilized at the PIHP to provide a comprehensive health status of complex case management customers, to identify regional and local trends, and to drive decision-making for regional clinical initiatives.

Diabetes Screening for People with Schizophrenia and Bipolar Disorder who are Using Antipsychotic Medications (PIP):

Southwest Michigan Behavioral Health (SWMBH) has a Performance Improvement Project (PIP) in place to improve the proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for

diabetes. SWMBH's PIP on diabetes screening was validated by HSAG this year. We submitted our baseline measurement (the 2018 calendar year), which was a rate of 76.6%. Our remeasurement one goal is 80%. SWMBH worked with our regional CMH partners to ensure that each CMH has a process set up internally to ensure that members taking antipsychotics are screened annually for diabetes. Educational materials for CMHs and customers were developed and distributed. Reports have been made available for CMHs to monitor their performance. A screenshot of year-to-date progress for 2019 is below. CMHs can export their data so they can identify and follow up with individuals who need a screen completed.



MEASURE	
The percentage of beneficiaries ages 18 to 64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.	
MINIMUM STANDARD	
This measure will be informational only for FY2019.	
ELIGIBLE POPULATION	
Age	Ages 18 to 64 as of the last day of the measurement period (December 31).
Continuous Enrollment	During the measurement year.
Allowable gap	As of the last day of the measurement period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for two months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement period.

Event/Diagnosis	Identify beneficiaries with a diagnosis of schizophrenia or bipolar disorder from either: 1) at least one acute inpatient encounter, or 2) at least two visits on different dates of service in an outpatient, intensive outpatient, partial hospitalization, ED, or non-acute inpatient setting, during the measurement period.
Exclusions	Beneficiaries identified as having diabetes, beneficiaries who had no antipsychotic medications dispensed during the measurement period, and beneficiaries in hospice are excluded from the eligible population.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population.
Numerator	A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement period, as identified by claim/encounter.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting:*
https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf
NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications, Antipsychotic Combination Medications, and Diabetes Medications can be found at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018/hedis-2018-ndc-license/hedis-2018-final-ndc-lists.

PROCESS

The plan-specific percentages will be electronically transmitted to each PIHP.

MEASUREMENT FREQUENCY

Annually

Care Coordination Efforts

Integrated Care Team Meetings and Communications with Health Plans:

SWMBH began monthly Integrated Care Team (ICT) meetings in August 2016. SWMBH's Integrated Care Team continues to schedule and facilitate monthly meetings with each of the seven different MHPs in our region. We complete risk stratification, collaboration, update agendas, maintain, and share meeting minutes. As of 9/30/2019, there were a total of 128 SWMBH Coordinated Care Plan (CCP) Members. In CC360, 45 members had an open CCP; 69 had a CCP status of completed, and 14 had canceled CCPs. Of those 69 completed:

- 32 met all goals
- 13 had some goals met
- 23 lost coverage
- 1 refused participation

All-Cause Readmissions Joint MHP/PIHP Protocol Development:

The MHPs and PIHPs meet monthly in their Collaboration Workgroup to discuss the integration of behavioral health and physical health care. A protocol for prevention of All-Cause Readmissions is being developed (a sub-workgroup co-chaired by SWMBH and HAP Midwest has been assigned to this task; the group has met minimally monthly from May through November 2019 and has drafted risk stratification criteria to identify individuals at highest risk for readmission, based on published research and data analysis regarding potentially preventable readmissions). We will be developing guidance for PIHP / MHP support during care transitions with implementation anticipated in early 2020. Ultimately, this guidance/protocol will create a consistent and collaborative effort between all PIHPs and MHPs to decrease potentially avoidable readmissions.

We include individuals at high risk of readmission in PIHP/MHP ICT meetings to ensure that individuals are connected to community resources and outpatient care. These interventions have been highly effective. The positive results can be attributed to outreach and education regarding resources and disease processes, supporting participant engagement with providers, and communication/collaboration between the member, caregivers, behavioral health and medical health providers, and health plans to decrease gaps in care and bring awareness to member's needs.

Updates to CC360 to Support Implementation of SSD and COPD PIHP/MHP Joint Care Management Protocols:

SWMBH participates monthly in the MHP and PIHP Collaboration Workgroup to support the integration of behavioral health care and physical health care, and to ensure compliance with MDHHS contractual requirements related to Integrated Care. As part of the workgroup's activities, protocols have been developed to ensure that individuals taking antipsychotic medications (who have been diagnosed with Bipolar Disorder or Schizophrenia) have annual diabetes screening, and to ensure that spirometry testing is used in the initial diagnosis of COPD. SWMBH assisted in the development of upgrades to the Joint Care Management reports available in CC360 for identifying members who fall in the targeted populations for the protocols. The upgrades assist in identifying individuals who are the responsibility of the MHP or the PIHP.

Aetna Transition of Care Calls:

Aetna Population Health department offered SWMBH engagement in the transition of care meetings with four entities (Borgess, Intercare, Family Health Center, and Lakeland Network). These weekly or monthly coordination calls consist of a collaboration of high risk, high utilization members. SWMBH Integrated Care staff outreach community mental health sites and providers to provide an update on the utilization of PIHP services and provided information and member outreach as needed. We engaged in updates from October 1, 2019, to December 31, 2019. We began attending meetings in January 2019 and engaged weekly until June 2019 when Aetna discontinued meetings due to staffing changes.

- There was a total of thirty-seven (37) Transition of Care meetings attended by an Integrated Healthcare Specialist in 2019.

MI Health Link Process Improvements:

SWMBH Integrated Care staff identified inefficiency in the biweekly inpatient and cold call Integrated Care Team (ICT) process. SWMBH staff recreated the process to include increased collaboration, increased efficiency, and decreased risk of oversight of a member. The process was discussed with Aetna and Meridian personnel, and there was an agreement in the process.

The process includes

- SWMBH identification of behavioral health admissions and cold calls
- SWMBH notification to ICOs of admissions and cold calls
- ICO confirmation of agenda
- In-meeting collaboration and discussion of possible treatment plan needs
- Continued review through follow-up with a scheduled provider and/or greater than 30 days past discharge date
- Discussion of other members as needed
- SWMBH provides meeting minutes as requested by ICO

Within one month of implementation of the process, biweekly MI Health Link ICTs ran efficiently, ICOs expressed buy-in in the process, and member collaboration became more efficient. Overall, this is positively affecting the collaboration and care the member is receiving.

- Coordination of care between medical and behavioral healthcare providers
- The state mandate for Prepaid Inpatient Health Plans (PIHP)

Current Integrated Healthcare Goals:

1. Reduce the rate of ER use for chronic, non-emergent care
2. Reconnect patients to their PCP and CMH
3. Include patients in their coordination of care
4. Provide authorization for services as needed
5. Positively impact Population Health through coordination of care

Additional Mental Illness Statistics:

- Mood disorders (Major depression, dysthymic disorder, and bipolar disorder) are the third most common cause of hospitalization in the US from age 18 to 44.
- Only 41% of adults with a mental health condition received mental health services in the past year.
- Suicide is the 10th leading cause of death in the U.S., the 3rd leading cause of death for people aged 10–24 and the 2nd leading cause of death for people aged 15–24.

PHIP Region 4 – High ED Use:

- 96 patients had more than 6 ED visits during 3 months

- 36 of these patients have had PIHP contact – only about 1/3
- 6 to 17 visits per patient per 90 days
  - Up to once a week, per patient, for 90 days
- 701 total ED visits for these 96 patients = 87.6 visits over 90 days
  - Improved CMH/ED integration could potential reduce ED visits by 1 visit/county /day in Region 4

2019-2020 Customer Service Priorities and Goals

SWMBH Customer Service		
Priorities	**Goals**	**Service Activities**
• Welcome and orient individuals to services and benefits available, as well as the provider network. • Develop and provide information to members about how to access mental health, primary health, and other community services. • Provide information to members about how to access the various Rights processes. • Help individuals with problems and inquiries regarding benefits. • Assist people with and oversee local complaints and grievance processes. • Track and report patterns of problem areas for the organization. • Establish Policies and Procedures that meet and exceed all expectations set. • Manage the Customer Services Committee Charter and membership to represent all of SWMBH member counties. • Create/Manage and Distribute the SWMBH Medicaid and MI Health Link Customer Handbooks. • Develop documents/Action Notices to communicate with customers regarding SWMBH-level service decisions. • Communicate with SWMBH Provider Network regarding CS office functions. • Develop marketing and member-related communications	• Create and Maintain a *Welcoming* atmosphere for customers of SWMBH network. • Promote Customer Voice to be heard throughout SWMBH business activities. • Assist with all complaints, grievances, or appeals filed with the CS office. • Collect and review aggregate data regarding customer grievances and appeals.	• Developed common training materials for SWMBH/Providers/CMHSPs. • Developed, updated, and/or distributed SWMBH network customer/stakeholder educational materials, including: ▪ 3 Members Newsletters ▪ 2 Provider Newsletters ▪ 1 Handbook ▪ Informational materials-SWMBH, Substance Use Disorder, Recovery Oriented Systems of Care, MI Health Link, VA Navigator, Complex Case Management, and Autism Services Brochures ▪ SWMBH and Recovery Oriented Systems of Care Marketing Materials ▪ MI Health Link Welcome Packet and orientation materials

2019 Cultural Competence Plan

Cultural Competence Strategies

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Serving Culturally and Linguistically Diverse Members	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership.	✓ Ensure that Cultural Competency policies are being followed. ✓ Review the Cultural Competency Plan on an annual basis to address any identified barriers to care. ✓ Work with RCP and RUM Committee to reduce health care disparities in clinical areas. ✓ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ✓ Work with Provider Network to perform analysis on the network adequacy report and support the identification of culturally diverse provider resources. ✓ Improve Cultural Competency materials and communication. ✓ Review of Annual Cultural Competency Policies and Plan. ✓ Annually review and update Cultural Competency Goals and work plan. ✓ Annually review CMHSP partner Cultural Competency Plans.	October 2018 - September 2019	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Personnel

Business Practice – to promote Competency	Source	Outcome
A. SWMBH actively recruits a workforce of diverse backgrounds through the candidate selection process.	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To promote a workforce that is reflective of the community and individuals served.
B. The SWMBH hiring process includes the utilization of "Guidelines to Explore Diversity in Job Interview" to determine an interviewees experience/willingness to support diversity and cultural competence as a SWMBH employee	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	To promote the hiring of staff who embrace cultural competency as a work ethic.
C. SWMBH utilizes non-discrimination statements in all hiring and contracting searches.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	SWMBH seeks to develop a workforce reflective of our community/individuals served.
D. SWMBH Personnel/Providers are required to follow training guidelines related to Cultural Competence and all other required topics of the training. The monitored process is to occur annually.	• SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Cultural Competency and Diversity Training (PowerPoint Presentation) • SWMBH Cultural Competency and Diversity Attestation Form • Network Adequacy Analysis – Population Race/Ethnicity Analysis	SWMBH promotes workforce education in working with diverse populations. Spanish is the most common non-English language spoken in the SWMBH 8-county region. According to the American Community Survey Aggregate Data, 5-Year Summary File, 2006–2010, 3.5% of the population in the SWMBH region speak Spanish
E. SWMBH reviews the *Essential Functions* of each employee.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency	To ensure tasks and responsibilities remain accurate as well as provided in a Culturally Competent manner.
F. SWMBH promotes Cultural Competence practices in design, monitoring of contractual provider performance.	• SWMBH Member/Provider Handbook • SWMBH Site/Monitoring Reviews • SWMBH Cultural Competency Workgroup • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To ensure provider network performance meets SWMBH standards.
G. SWMBH maintains representation within the Recovery Oriented Systems of Care (ROSC) Community-Wide Collaboration, which explores Cultural Competency and barriers.	• ROSC Community Collaboration Meeting Minutes. • Network Adequacy Analysis – Population Race/Ethnicity Analysis	Based on needs, there is a community-wide partnership to address/discuss Cultural issues and barriers to care.

H. SWMBH annually evaluates demographic data of network and individuals served through its Network Adequacy review (Attached on pg. 7-8).	• SWMBH Employee Satisfaction Surveys • SWMBH Policy 3.7 – Cultural Competency • SWMBH Policy 2.12 – Network Adequacy • SWMBH Policy 2.7 – Communication to Providers	The evaluation is performed to identify if SWMBH workforce continues to be reflective of the demographics of the community/individuals served.

Individuals Served

Business Practice – to promote Competency	Source	Outcome
I. SWMBH encourages customers to identify their need for language support services via the use of "I Speak" tools at service sites or via telephone contacts.	• SWMBH Policy 6.5 Limited English Proficiency • SWMBH Network Adequacy Plan	When customers can't identify their primary language, SWMBH can direct the supports necessary to provide support and services.
J. SWMBH provides no-cost interpretation and translation as necessary for vital documents, during appointments, and telephone contacts.	• SWMBH Policy 4.3 – Authorization and Outlier Management	To engage in services, SWMBH offers free language assistance to customers and individuals seeking services.
K. Via the Person-Centered Planning process, SWMBH (and all contracted providers) encourages discussion of the importance of issues such as culturally sensitive needs, gender or age-specific needs, economic issues, spiritual needs/beliefs, and/or issues related to sexuality/orientation – in all treatment planning.	• SWMBH Policy 4.5 – Person and Family-Centered Planning	To ensure customers are receiving services suited to their individual needs.
L. SWMBH maintains a competent provider panel of interpreters and translators.	• SWMBH Policy 4.1 – Access Management	To ensure customers can receive educational materials and supportive services in their preferred language.
M. SWMBH will utilize the community needs assessment process and feedback generated from annual customer satisfaction surveys to evaluate any changing cultural/linguistic needs of the community.	• SWMBH 2019 Customer Satisfaction Survey Analysis and Results • SWMBH Grievance and Appeal Data Analysis • SWMBH 2019 QAPI – UM Evaluation of Services	SWMBH can modify printed materials as language thresholds change and can target workforce training needs to new community needs.
N. SWMBH educational materials are written in simple language and provided in preferred languages to customers.	• SWMBH Customer Handbook • SWMBH UM Policy	Community members and customers will have access to information in commonly used languages. Vital documents are translated into Spanish.
O. Customer access to Grievance and Appeal processes is aided by translated documents, assistance to all customers, and available interpretation at all steps. Customers can identify Authorized Representatives to represent them.	• SWMBH Policy 2.14 – Grievance and Appeals • Network Adequacy Assessment of cultural, ethnic, racial and linguistic needs	Customers will have processes explained to them in preferred language and have access to language support to represent themselves while SWMBH addresses their complaint(s).

2019 Cultural Competence Goals

Goal	Source	Steps to take/Completion Date	Outcome	Responsibility
1. Implement Staff/Provider survey to gauge the Organizational level of Cultural Competence.	Network Adequacy Analysis – Population Race/Ethnicity Analysis	A. ACTION for the Cultural Competency Workgroup to research and identify tools to utilize (By June 2020).	SWMBH to utilize data for future planning and movement of the organization along the path of Competence. Specifically, are their improvement opportunities for SWMBH policy/training	ACTION: SWMBH Cultural Competency Workgroup to work with internal/external stakeholders to complete a needs assessment, and use data to improve outcomes.
2. Utilize feedback from Customers related to Cultural Competency of the workforce.	Customer Satisfaction Surveys RSA-r Surveys Grievance and Appeals Data Network Adequacy Analysis – Population Race/Ethnicity Analysis Consumer Advisory Committee to review and provide feedback	A. ACTION to evaluate current customer survey tools to identify if existing tools provide questions regarding customer opinion of Competency and if not - Identify tool(s) to add to surveys to collect data (By October 2020) B. The Consumer Advisory Committee and possibly other Regional Committees with consumer representation, will review current tools and protocols and provide feedback to improve processes.	SWMBH to utilize data for future planning and movement of the organization along the path of Competence. Specifically, are customers identifying that SWMBH can meet their individual needs through services.	ACTION Workgroup to work with QMC and CAC to identify tool(s). ACTION the Consumer Advisory Committee will review and provide input on the 2020 Network Adequacy Plan/Report. ACTION an analysis and improved outcome measures will be documented in a 2020 Member Services Newsletter and the 2020 Quality Assurance and Performance Improvement Plan.

3. Utilize outcome data to guide service design toward cultural competency	Network Adequacy Analysis Customer Satisfaction Survey Data Analysis RSA-r Survey Evaluation	A. ACTION to research SWMBH customer service outcomes based on populations of MIA, I/DD, and SED to B. Identify if customer demographics are part of the data collection process (By October 2020) C. SWMBH to add CMHSP Cultural Competency plan/needs review to the 2020 CMHSP site review tool.	SWMBH to utilize data for future planning and movement of the organization along the path of Competence. Specifically, are outcomes impacted by cultural considerations?	ACTION Committee to work with QMC, RUM, and RCP to identify tool(s).
Goal	**Source**	**Steps to take/Completion Date**	**Outcome**	**Responsibility**
4. Promote continued education throughout the agency and community by participating in or contributing to an organization/event.	Cultural Diversity Training Curriculum	A. ACTION to present at the 2020 All-Staff meeting. B. ACTION to provide at least 1 Cultural educationally focused article to the SWMBH newsletter during 2020. C. ACTION to evaluate and promote new Culturally Competent educational opportunities for SWMBH staff/providers such as Lunch and Learns, and portal-based information.	A. To promote Workgroup activities and provide information to staff/providers regarding new ACTION plans. B. To enhance the Cultural Competency educational experiences for SWMBH staff.	A. ACTION B. ACTION C. ACTION Workgroup to work with HR and QMC to review and approve new training opportunities for staff/providers.

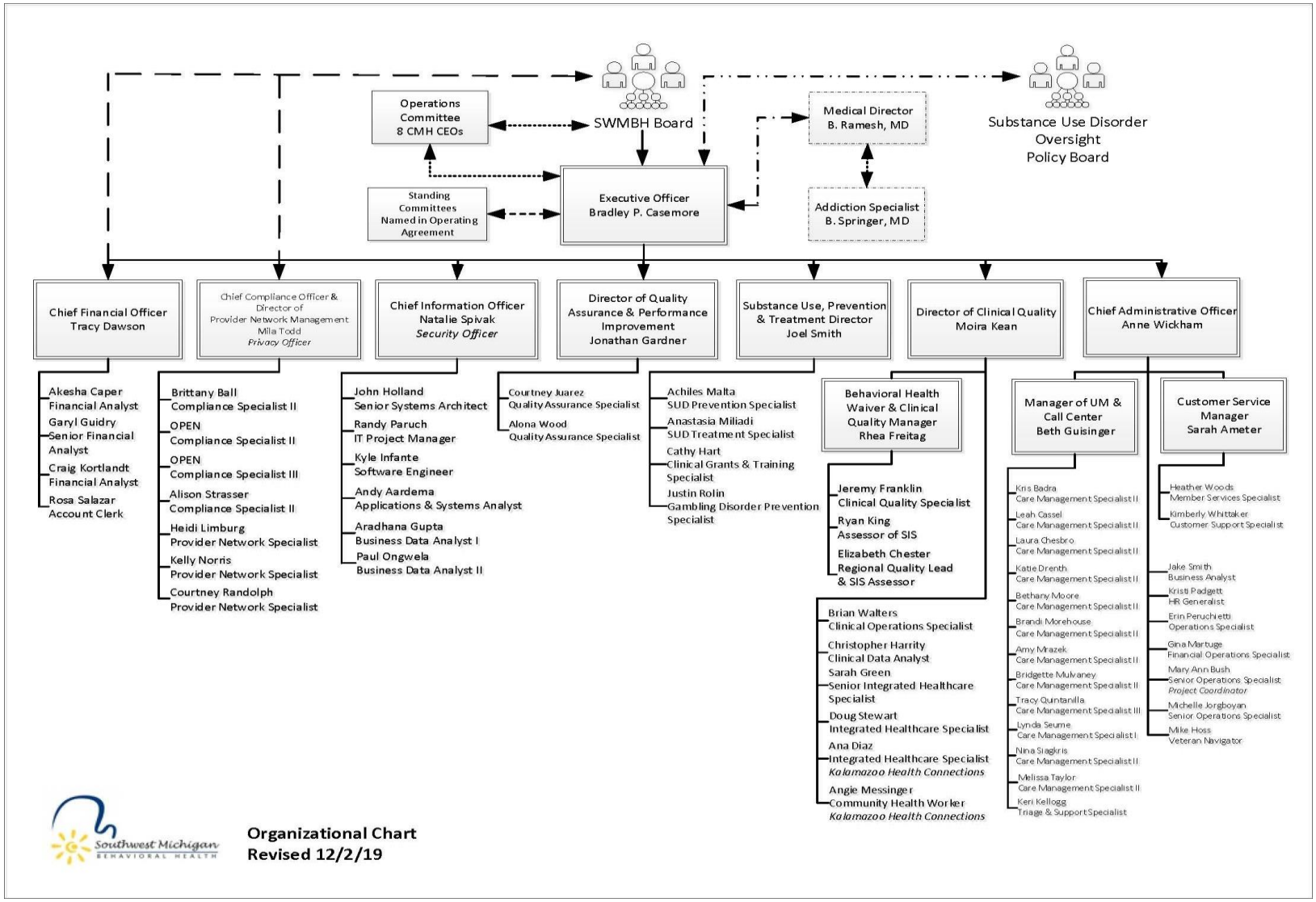
Interventions Attempted

SWMBH and its participant CMHs have attempted various methods to increase Hispanic/Latino clinician representation on our panel, including recruiting for positions in Hispanic/Latino cultural publications and at Hispanic/Latino community organizations. The overall available pool of clinicians with Hispanic/Latino backgrounds in our area is low, so these efforts have had minimal success. We have determined that we need a method to encourage behavioral health careers in the Hispanic/Latino population from very young ages. We are working with our local university to determine potential approaches to increasing Hispanic/Latino interest in the behavioral health field.

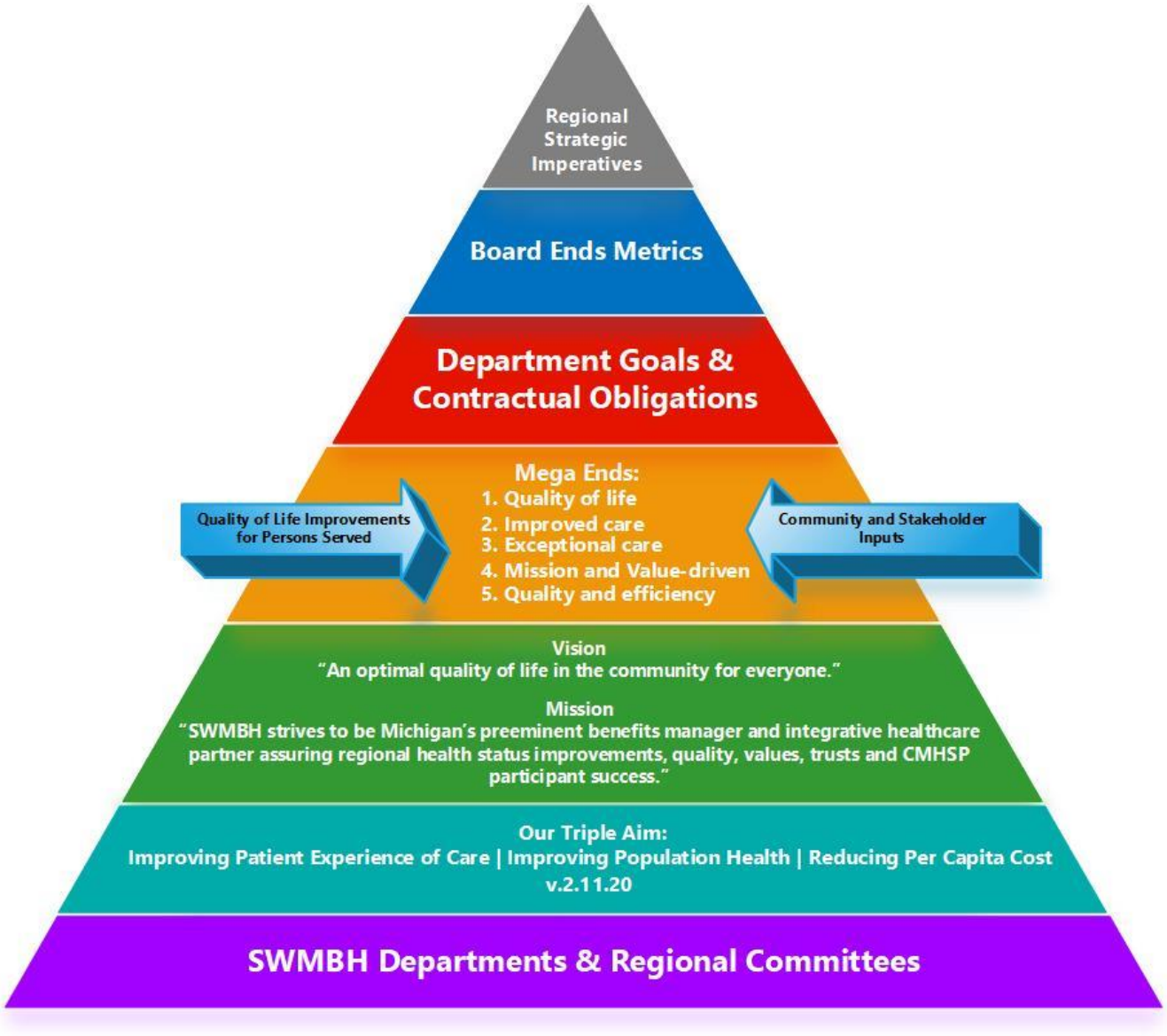
We did not set a specific goal regarding the short-term recruitment of Spanish-speaking clinicians, as our current availability of Spanish-speaking clinicians (1.6% of network clinicians) is only about 2 percentage points lower than the overall population of Spanish-speaking individuals in our region (3.5%).

VII. Attachments

Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Attachment B: SWMBH 2019 Strategic Alignment – Annual Goal Planning



Attachment C: 2020-2022 Strategic Imperatives

1) Public Policy Legislative Education

- Inform legislators of Michigan statutory changes necessary for publicly led Specialty Integrated Plan
- Inform executive branch of Michigan regulatory changes necessary for publicly led Specialty Integrated Plan
- Inform legislators of potential negative impacts of Reforms on CMHSPs.
- Inform Legislators of key Behavioral Health and SUD issues
- Hold public policy & legislative education events

2) Uniformity of Benefits

- Ensure that persons served receive objectively appropriate services across all specialty populations
- Automate Level of Care Guidelines and Utilization Management processes

➢ Use the Level of Care Guidelines (LOCG) for service authorization consistency

- Consistent use, attached to Assessment Tool scores
- Embedded in EMR and MCIS
- Update LOCG Tables and business processes as necessary and indicated

➢ Consistent Use of Assessment Tools

- CMHSPs and Providers submit scores in detail as discrete data fields
- Real-time, accessible analytics, and reporting
- Identification of outliers and trends for over- and under-utilization monitoring

3) Integrated Health Care

- Michigan Health Endowment Fund Grant success
- Extend MI Health Link with Integrated Care Organizations beyond 12/31/2020
- Multi-agency Performance Improvement Projects
- Improve CMHSP and PIHP communications with primary physical health providers
- Improve SWMBH communications with Medicaid Health Plans

4) Revenue Maximization/Diversification

- Assure the capture of Performance Bonus Incentive Pool funds
- Continue assertive efforts internally and externally to maximize regional capitation funds
- Assess SWMBH opportunities for Grants, alternative funding streams, and expanded or new business lines
- Assess CMHSP opportunities for Grants, alternative funding streams, and expanded or new business lines, upon request

➢ Cost reductions in Medical Loss Ratio and Administrative Loss Ratio

- Support CMHSP cost reduction strategies upon request

5) Improve Healthcare Information Exchange, Analytics and Business Intelligence

- Improve Health Information Exchange systems
- Improve healthcare data analytics capabilities
- Regional individual access to industry-standard management information tools

6) Managed Care Functional Review

- Build consistency, replicability, and scalability for all managed care functions

7) Proof of Value and Outcomes

- Create, monitor and publish proofs of clinical and administrative performance
- Maintain NCQA MBHO Accreditation
- Consider other NCQA Accreditations and/or Certifications
- Assure Program Integrity

Attachment D: SWMBH 2019 Board Ends Metrics

Summary of 2019 Board Ends Metrics

(Completion within the Review Period)

Results:

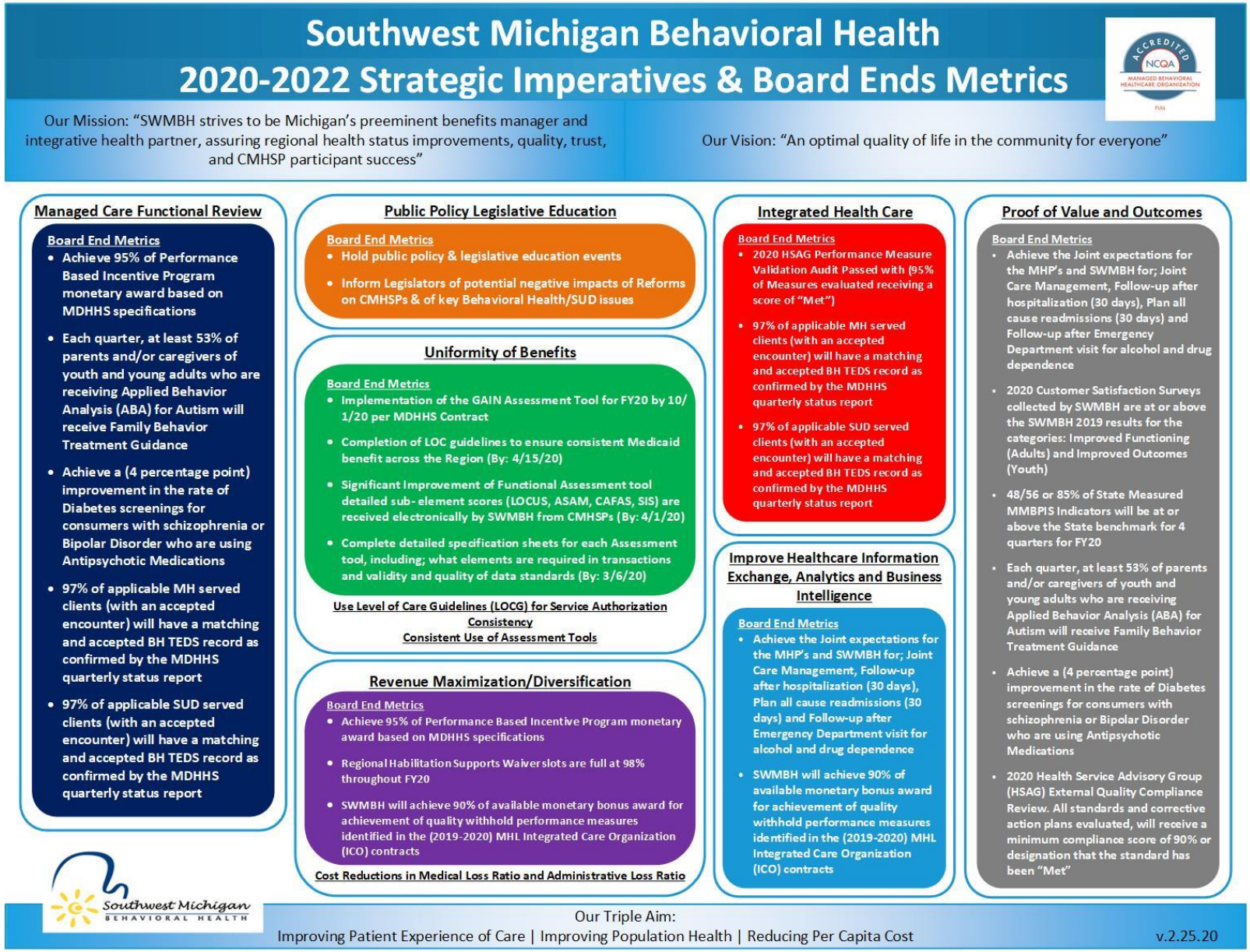
***14/15 Board Metrics Achieved within the Review Period**

Board Ends Metric	Metric Result	Board Approved Date
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." (January 2018 - March 2019)	**Metric Achieved** Formal Assessment Completed by TBD Consulting.	6/14/2019
SWMBH will achieve 95% of quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts. (January 2018 - December 2018)	**Metric Achieved** Demonstration Year 1-2 Quality Withholds were Completed with Aetna at 95%.	1/11/2019
Regional Habilitation Supports (HSW) Waiver slots are full at 99% throughout the year. (October 2018-September 2019)	**Metric Achieved** 99.9% of HSW slots have been filed in FY 19. SWMBH has been the best performing PIHP in the State for 3 consecutive years. ***+1 Bonus Point*** *for achieving (20) additional slots.*	10/11/2019
Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2018 results; for the Improved Functioning (MHSIP survey) and Improved Outcomes (YSS survey) measurement categories, utilizing the MHSIP and YSS Survey tools (January 19 - December 2019)	**Metric Achieved** **MHSIP Improved Function** 18=85.8% 19=89.7% **+3.9%** **YSS Improved Outcomes** 18=81.3% 19=83.3% **+2.0%** Overall (all categories measured) ***+2.76%*** *Improvement*	3/13/2020

Medicaid Administrative Loss Ratio for the region is (< 10.0%) (October 18 – September 19)	**Metric Achieved** Result: 9.1% and a (.07%) improvement over 2018 results.	3/8/2019
Fully implement contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Mental Illness (SMI) and Serious Emotional Disturbances (SED). Further analysis of data will be completed. (By: December 31, 2018)	**Metric Achieved** Percent of scores and files received for each Level of Care Tool: LOCUS: 98.6% ASAM: 85.1% CAFAS: 95.6% SIS: 88.8%	11/9/2018
SWMBH to "Establish and implement an inclusive formal Regional public policy, legislative education program." (By: October 2018)	**Metric Achieved** Legislative Event list available upon request.	11/9/2018
2019 HSAG Performance Measure Validation Passed (95% of Critical Measures receiving a score of "Met")	**Metric Achieved** 37/37 or 100% of Standards Evaluated received a designation of "Met", "Accepted" or "Reportable".	11/8/2019
SWMBH will ensure the following Customer Service and Grievance and Appeals contractual requirements and HSAG corrective actions are achieved at 100% compliance:	**Metric Achieved** All provider directories are using link to SWMBH directory on website. All CMHSPs are using Approved HSAG grievance resolution letters as of 7/1/19.	11/8/2019
• 95% of MH reportable encounters will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report. • 95% of SUD reportable encounters will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.	**Metric Achieved** As of 1/1/2020 MH = 96.79% SUD = 97.47%	3/13/2020
At least 18% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism	**Metric Achieved** 57% per Michigan Department of Health and Human Services (MDHHS) Metric	1/10/2020

will receive Family Behavior Treatment Guidance at least once per quarter. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors.		
PBIP Narrative Report Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications.	**Metric Achieved** SWMBH achieved **98.20%** of possible bonus award earnings $1,799,741	3/13/2020
PBIP Metrics Reports Achieve the following Joint expectations for the MHP's and SWMBH. There are 100 points possible for this bonus metric in FY2019:	**Metric Achieved** Joint PIHP/MHP Reports received 93 out of a possible 100 points. PCR and FUA metrics received 50 out of 50 possible score.	3/13/2020
2019 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met").	**Metric Achieved** SWMBH achieved 74/82 Standards evaluated achieving an overall score of 90.24%.	3/13/2020
92% of MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 19.	**Metric Missed** Indicators Met at the MDHHS benchmark: 59/68 = 86.76%	3/13/2020

Attachment E: 2020-2022 Alignment of Strategic Imperatives & Board End Metrics



Attachment F: 2020 MI Health Link Committee Charter

☒ **MI Health Link**

☒ **SWMBH Committees: Quality Management (QMC);** ☒ **Provider Network Credentialing (PNCC);** ☒ **Clinical and Utilization Management (CUMC);** ☒ **Cultural Competency Management**

Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Charter Effective Date: 6/1/15

Charter last Review Date: 12/17/19

Next Review Date: 12/17/2020

Approved By:

Signature: _____

Date: _____

Purpose:	SWMBH MI Health Link Committees are formed to assist SWMBH in executing the MI Health Link demonstration goals and requirements, NCQA requirements, and contractual obligations and tasks. MI Health Link Committees ensure a care management quality control program is maintained at all times and that the PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions in authorized timeframes. The committee ensures the PIHP and ICO conduct regular and ongoing collaborative initiatives that address methods of improved clinical management of chronic medical conditions and methods for achieving improved health outcomes. The organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, the ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH Executive Officer and is responsible for assisting SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committees Purposes:	**Quality Management Committee:**

	• The QI Committee must provide evidence of review and thoughtful consideration of changes in its QI policies and procedures and work plan and make changes to its policies where they are needed. *NCQA, MBHO, QI 1: Program Structure: Quality Improvement Program Structure, Element A; QI 2: Program Operations: QI Committee Responsibilities, Element A.* • Analyzes and evaluates the results of QI activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. Ensures follow-up as appropriate. *NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5)* • Ensures practitioner participation in the QI program through planning, design, implementation or review. *NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).* • Ensures discussion (and minutes) reflects appropriate reporting of activities, as described in the QI program description. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).* • Reports by the QI director and discussion of progress on the QI work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).* • Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).* • Ensures all MI Health Link required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 1: Program Structure; QI 2: Program Operations, QI Committee Responsibilities, Element A.* • Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 6: Member Experience; 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1); UM 10 Experience with the UM Process.* • Review of current status and upcoming MHL audits • Review of demonstration year quality withhold measures **Credentialing Committee:** • Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Aetna Contract-Attach C4; Meridian Contract.* • Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Aetna Contract; Meridian Contract.*

- Implements and conducts a process for the Medical Director review and approval of clean files.
  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Aetna Contract; Meridian Contract.
- Reviews and authorizes policies and procedures.
  NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4; Meridian Contract
- Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision.
  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Aetna Contract & Meridian Contract
- Ensures reporting of practitioner suspension or termination to the appropriate authorities.
  NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.
- Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service.
  NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 6: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.
- Ensures the organization's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following:
  - Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions.

  NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7) Aetna Contract & Meridian Contract
  - Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners.
    NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7). Aetna Contract& Meridian Contract
- Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination.
  NCQA, MBHO, CR 5: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract; Meridian Contract.

Utilization Management Committee:

- Reviews and authorizes policies and procedures.
  NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.
- Is involved in implementation, supervision, oversight and evaluation of the UM program.

NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.

- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.
  NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B. Aetna Contract; Meridian Contract.
- Ensures review of tools/instruments to monitor quality of care are in meeting minutes.
  NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.; Meridian Contract.
- Ensures annual written description of the preservice, concurrent urgent and non-urgent and postservice review processes and decision turnaround time for each.
  NCQA, MBHO, UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Aetna Contract; Meridian Contract-Attach C.
- Ensures at least annually the PIHP review and update BH clinical criteria and other clinical protocols that ICO may develop and use in its clinical case reviews and care management activities; and that any modifications to such BH clinical criteria and clinical protocols are submitted to MDCH annually for review and approval.
  NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27); Meridian Contract
- Ensures the organization:
  - Has written UM decision-making criteria that are objective and based on medical evidence.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Aetna Contract; Meridian Contract-Attachment C.
  - Has written policies for applying the criteria based on individual needs.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2). Aetna Contract; Meridian Contract.
  - Has written policies for applying the criteria based on an assessment of the local delivery system.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3). Aetna Contract; Meridian Contract.
  - Involves appropriate practitioners in developing, adopting and reviewing criteria.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Aetna Contract; Meridian Contract-Attachment C.
  - Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.
    NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B; Aetna Contract; Meridian Contract

Cultural Competency Management Committee:

- Has written policies, procedures and plan for promoting and ensuring a culturally competent, sensitive and inclusive environment.
- Conducts an annual review of the Network Adequacy Report to ensure that the data covers all members' language, race and ethic needs as well as ensure that there is data available for practitioner race, ethnic background and language skills. There will be a

	comparison of the two data sets to determine if the provider network is enough to meet its members' needs, identify areas of improvement and set interventions if needed. Will review internal and provider organizational systems to determine level of compliance with the Culturally & Linguistic Appropriate Services (CLAS) standards and other pertinent requirements for MI Health Link. *NCQA, MBHO, QI 4: Availability of Practitioners and Providers.* **Integrated Care/Clinical Quality Committee:** • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. *NCQA, MBHO, QI 10: Clinical Practice Guidelines-Element A; 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions. • The organization collaborates with relevant medical delivery systems to monitor, improve and measure the effectiveness of actions related to coordination between behavioral and medical care. *NCQA, MBHO, CC 1 & 2: Collaboration between Behavioral Healthcare and Medical Care Aetna Contract-Attachment C.2; Meridian Contract* • Ensures assessment of population health needs, including social determinants and other characteristics of member population, is completed annually, and the CCM program is adjusted accordingly. *NCQA, MBHA, QI 9A: Complex Case Management, Population Assessment* • Ensures member survey results feedback is reviewed and follow-up occurs as appropriate. *NCQA, MBHO, QI 9J: Complex Case Management, Experience with Case Management* • The organization demonstrates improvements in the clinical care and service it renders to members. *QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Monitors performance for all HEDIS/NQF measurements minimally annually. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Selects 3 or more clinical issues for clinical quality improvements annually. Ensures that appropriate follow up interventions are implemented to improve performance in selected areas. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Approves developed logic for calculating HEDIS measure and ensure it follows HEDIS specifications. o *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program*
Relationship to Other Committees:	These three committees will sometimes plan and likely often coordinate together. The committees may from time-to-time plan and coordinate with the other SWMBH Operating Committees.
Membership:	The SWMBH Executive Officers and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information

	decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. Members are representing the regional needs related to Provider Network Credentialing; Quality Management and Clinical/Utilization Management as it relates to MI Health Link. It is expected that members will share information and concerns with the committee. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges to the attention of the SWMBH committee for possible project creation and/or assistance.
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person they also lose the right to participate in the voting structure on that day.

Attachment 1: - Credentialing

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Kelly Norris *Provider Network Specialist II*	*SWMBH*	*Voting*
Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)	*Western Michigan University*	*Voting*
Beth Guisinger, LPC *Utilization Management and Call Center Manager*	*SWMBH*	*Voting*
Jonathan Gardner BS, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, MA *Director of Clinical Quality*	*SWMBH*	*Voting*
Stephanie Lagalo, LMSW, CAADC, CCS (Practitioner and Provider)	*Western Michigan University* *Interact of Michigan (Contract)*	*Voting*
Sarah Green RN, BSN, MBA	*SWMBH*	*Voting*

Senior Integrated Healthcare Specialist		
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Natalie Spivak *CIO*	*SWMBH*	*Voting*

Attachment 2: - Quality/UM/Clinical

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Kelly Norris LMSW, CAADC *Provider Network Specialist II*	*SWMBH*	*Voting*
Dr. Bangalore K. Ramesh D.O., *Psychiatrist (Medical Director/* *Practitioner/Provider)*	*Western Michigan University*	*Voting*
Beth Guisinger, LPC, CAADC *Utilization Management and Call Center Manager*	*SWMBH*	*Voting*
Jonathan Gardner BS, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, MA *Director of Clinical Quality*	*SWMBH*	*Voting*
Stephanie Lagalo, LMSW, CAADC, *CCS (Practitioner and Provider)*	*Western Michigan University* *Interact of Michigan (Contract)*	*Voting*
Sarah Green, R.N, B.S.N, M.B.A *Integrated Healthcare Specialist*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Courtney Juarez *Quality Assurance Specialist*	*SWMBH*	*Voting*
Chris Harrity, MHSA *Clinical Data Analyst*	*SWMBH*	*Voting*

Attachment 3: - Cultural Competency Management Committee

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Achiles Malta *Prevention Specialist*	*SWMBH*	*Voting* *Committee Chair*

Jonathan Gardner B.S, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, M.A. *Director of Clinical Quality*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Kimberly Whittaker *Consumer Advisory Committee Rep*	*SWMBH*	*Voting*
Open for Consumer Participation	*Open*	*Open*

Attachment G: 2020 Quality Management Committee Charter

Quality Management Committee Charter

☒ **SWMBH Committee** **Quality Management Committee (QMC)** ☐ **SWMBH Workgroup:** _____ **Duration:**
☒ **On-Going** ☐ **Deliverable Specific**

Date Approved: **5/1/14**

Last Date Reviewed: **12/19/19**

Next Scheduled Review Date: **12/17/20**

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.

Committee Purpose:	• *The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.* • *The QMC will implement the QAPI Program developed for the fiscal year.* • *The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.* • *The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.* • *The QMC will review and provide feedback related to policy and tool development.*

	• *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*

Relationship to Other Committees:	As needed, there will be planning and coordination with the other Operating Committees including: • Finance Committee • Utilization Management Committee • Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits, it is expected that committee members attend and are engaged in issues and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback

Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members and a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person, they will lose the right to participate in the voting structure for that meeting.
Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dash Board • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment H: Regional Utilization Management Committee Charter

☒ **SWMBH Committee: Regional *Utilization Management Committee* (RUM)**
Duration: ☒ **On-Going**

Charter Effective Date: 2/12/18 (reviewed at RUM)
Revision Dates: 2/11/19. 1/13/20

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Medicaid Managed Care Benefit requirements within the Balanced Budget Act, Parity, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committee Purpose:	*In the context of the overall functionality of the PIHP's Utilization Management Program, the Regional **Utilization Management (RUM) Committee** is the PIHP's designated committee that reviews and provides input to SWMBH for the Regional Utilization Management Program and assisting with the review and/or development of:* 1. *The Annual UM Program Plan* 2. *UM, service determination and utilization review policies, procedures and protocols* 3. *Service determination/authorization and level of care criteria* 4. *Service Use Encounter (SUE) report* 5. *Over/under utilization reports* 6. *Outlier Management reports* 7. *RUM work plan/committee goals* *The RUM Committee is charged with making efficient, effective, and innovative recommendations for:* 1. *monitoring and ensuring the uniformity and consistent application of standardized assessment tools and level of care, service determination and eligibility criteria at a local care management level*

	2. *using assessment tool, level of care and utilization data to track service provision to customers,* 3. *implementation of level of care and care management practices,* 4. *identification of services gaps and training needs* *The **Utilization Management Program** assures that statutory and contractual state and federal regulatory requirements are met in a cost effective and timely manner. To ensure this standard is achieved and/or surpassed, programs are consistently and systematically monitored and evaluated. There are four basic management techniques deployed within the utilization management program with reports and data reviewed by RUM Committee:* 1. *Access and Eligibility* 2. *Level of Care Assessment/Service Support* 3. *Service Determination/Outlier Management* 4. *Utilization Review/Care Management* *The RUM is responsible for holding themselves and each organization in the region accountable for:* 1. *Proper use of assessment tools, level of care guidelines and medical necessity criteria* 2. *Timely and accurate collection and reporting of assessment and utilization data to SWMBH* 3. *Uniformity of benefit* 4. *Installation, use and revision of level of care guidelines and medical necessity criteria* 5. *EMR/MCIS authorization (278) application, documentation, and submission to SWMBH*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees. • Regional Finance Committee • Regional Quality Management Committee • Regional Provider Network Management Committee • Information Technology • Regional Customer Services Committee • Regional Compliance Coordinating Committee • Regional Clinical Committee The RUM utilizes the Regional Clinical Committee to address population specific issues and issues such as high utilization or high risk. The SWMBH Medical Director will also be available for consultation to the committee.
Membership:	The Operating Committee appoints their CMH participant membership who should be the senior manager responsible for utilization and local care management. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information reviewed or decided on in the committee. This includes

	keeping relevant staff, providers and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Utilization Management. It is expected that members will share information and concerns with SWMBH staff. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. RUM is a PIHP Committee consisting of UM, Quality, Information Technology and clinical leadership representatives from each of the eight Community Mental Health Service Programs, customers/individuals with lived experience and SWMBH staff. RUM representatives are experienced administrative and clinical professionals with specialty representation for Child and Adolescent Serious Emotional Disturbance, Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Substance Abuse and Addiction. Ongoing consultation and ad hoc representation from the SWMBH Medical Director is available to the committee.
Decision Making Process:	The RUM committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members; a super majority of one vote per CMH will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person they also lose the right to participate in the voting structure on that day.
Deliverables:	• *Annual Utilization Management Program Plan* • RUM assigned priorities • Regional Level of Care Guidelines (review or update) • Regional UM Policies and Procedures Review

Attachment 1:

Membership Name	*Organization/County*	*Type of member (Ad hoc, standing, alternate)*
Emily Whisner	Barry	*Standing*
Jill Bishop	Barry	*Standing*
Tammy Winchell	Branch d/b/a Pines	*Standing*
Jennifer Poole	Berrien d/b/a Riverwood	*Standing*
Anne Cornell	Berrien d/b/a Riverwood	*Standing*
Natalie Tenney	Calhoun d/b/a Summit Pointe	*Standing*
Mary Munson	Cass d/b/a Woodlands	*Standing*
David Gamble	Cass d/b/a Woodlands	*Standing*
Jane Konyndyk	Kalamazoo	*Standing*
Beth Ann Meints	Kalamazoo	*Standing*
Sheila Hibbs	Kalamazoo	*Standing*
Jarrett Cupp	St. Joseph	*Standing*
Liz Courtney	Van Buren	*Standing*
Mary Green	Van Buren	*Standing*
Kyleen Gray	Van Buren	*Standing*
Mike Horein	Van Buren	*Standing*
Anne Wickham, Chair	SWMBH	*Standing,*
Leah Cassel, Recorder	SWMBH	*Standing*
Moira Kean	SWMBH	*Standing*
Natalie Spivak	SWMBH	*Ad Hoc*
Jonathan Gardner	SWMBH	*Ad hoc*
Bangalore Ramesh	SWMBH	*Ad hoc*

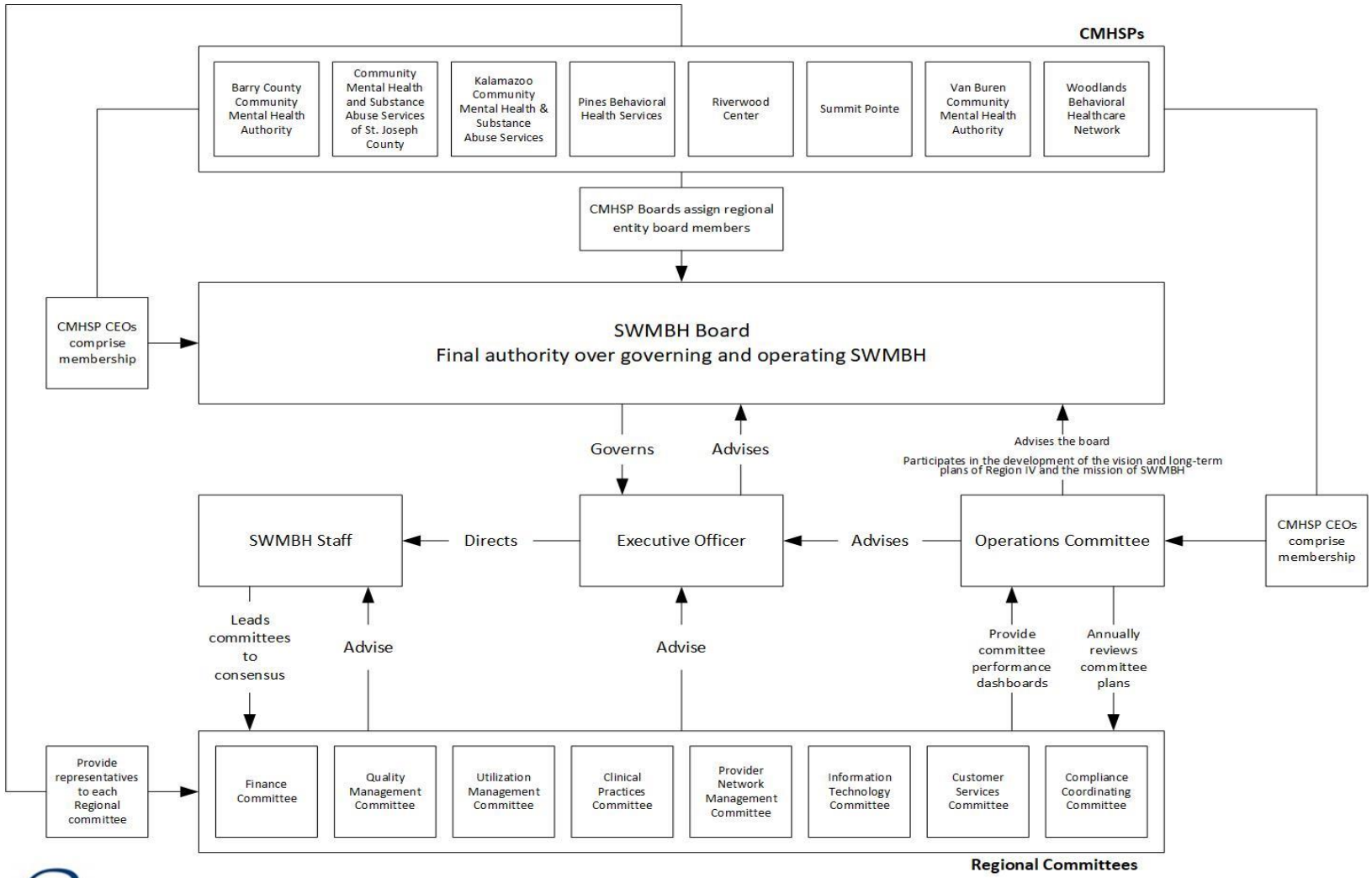
Attachment I: Regional Utilization Management Committee Goals

Regional Utilization Management Committee

FY 2019 Goals & Timelines

Strategic Imperative	*Goal* and Timeline for Completion (Sub Goals to be completed quarterly)	Brief Description	Responsible Leader
Parity & Utilization Management Normalization to Assure Uniform Benefit **Goal: Implement MCG software & updated level of care guidelines to ensure Consistent Medicaid Benefit across the Region with all services.**	2nd Quarter (Jan, Feb, March) • Establish MCG implementation teams (by: Nov 28)	• Phase 1- Use MCG Guidelines for LOC determination at each CMHSP and SWMBH (inpatient)	Gale
	• Implementation team completes a project plan (by: January 31)		Gale
	• Training all applicable UM-CMHSP and UM- SWMBH staff on new Medical Necessity Criteria (within: 30 days from time of URL/notification)		Beth (SWMBH) Gale (Regional)
	• RUM reviews LOCUS guidelines during Nov mtg. (by: November 30)		Moira
	• All CMHSPs install updated LOC guidelines (by: December 31)		Moira

Attachment J: SWMBH Organizational & Committee Structure Chart



Attachment K: 2020 Board Member Roster

Southwest Michigan BEHAVIORAL HEALTH

2020 Board Member Roster

Barry County

- Robert Nelson
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Vice-Chair
- Nancy Johnson (Alternate)

Branch County

- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County

- Patrick Garrett
- Kathy-Sue Vette (Alternate)

Cass County

- Michael McShane
- Vacant

Kalamazoo County

- Vacant
- Patricia Guenther (Alternate)

St. Joseph County

- Vacant
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

Southwest Michigan
BEHAVIORAL HEALTH

2019 Quality Assurance Performance Improvement and Utilization Management Program Evaluation

Evaluation Period: Medicaid (October 1, 2018- September 30, 2019)
Evaluation Period: MI Health Link (January 1, 2019 – December 31, 2019)

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) and Utilization Management Plan; that meets required federal regulations: the specified Balanced Budget Act of 1997 (BBA) as amended standards, 42 CFR § 438, requirements set forth in the PIHP contract(s), specifically Attachment P.6.7.1.1.

The Purpose of the QAPI/UM Evaluation

The Quality Management and Utilization Management Plans are approved annually by the SWMBH Board. The authority of the QAPI department, the UM department, the Quality Management Committee (QMC) and Regional Management Committee (RUM) is granted by SWMBH's Executive Officer (EO) and Board.

SWMBH's Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the Quality and Utilization Management Effectiveness Review/Evaluation.

Southwest Michigan BEHAVIORAL HEALTH

2019 Quality Performance Activities and Results Overview

Key Performance Indicator	Results
Michigan Mission Based Performance Indicators (MMBPIS)	59/68 (86.7%) of total Performance Indicators in 2019 met the State Standard of 95%: SWMBH Metric Goal was: 92%
(Medicaid) Consumer Satisfaction Survey	Overall improvement on 2019 Customer Satisfaction Survey Scores= +2.76% MHSIP (adult survey) = **+ 2.46%** improvement YSS (youth survey) = **+ 0.30%**
Recovery Self - Assessment (RSA-r)	2019 Overall Mean Score: 4.36 **(+0.14 Percent increase from 2018)** 2018 Overall Mean Score: 4.22
Critical Incidents – Event Reporting	Total Ave. Incidents by Year: **2014** = 25.33 **2015** = 22.25 **2016**= 19.83 **2017**=25.3 **2018**=26.0 **2019**= 26.58
Jail Diversion Data	Total Diversions: 2017 =330 2018 = 301 **2019= 267**
External Reviews and Audits	• *HSAG External Quality Review* – compliance in 74 of 82 elements, with an overall compliance score of **90 percent**. (*Metric Goal was 90%)* • *HSAG PMV Audit - 37/37 or* **100%** Of Total Elements Evaluated received a designation score of "Met," "Reportable," or "Accepted." (*Metric Goal was 95%)* • Aetna UM and Customer Service Audit: **100%** of Standards reviewed. achieved full compliance. (*Metric Goal was: 95%)* • Meridian Delegated Credentialing Audit: **100%** of elements reviewed achieved full compliance. *(Metric Goal was: 95%)*
(MI Health Link) Consumer Satisfaction Survey	**2019** Aggregate Score= 89.8% **2018** Aggregate Score= 88.1% **2019** Response Rate= 37.4% **2018** Response Rate= 39.7% **+1.7%** Improvement over 2018 *(Metric Goal was: Any Improvement)*

Utilization Management Performance Activities and Results

Key Performance Indicator	Results
Access Timeliness of Authorizations Analysis	Concurrent Request (72 hours) • 296/300 = 98.6% Routine Nonurgent Request (14 days) • 123/123=100% Prospective/Preservice • 1739/1745=99.7% Retrospective Post service (30 days) • 1127/1127= 100%
Adequate Timely Access to Services **Call Center (MHL Business Line)**	All required call performance metrics stayed within acceptable ranges during 2019. Please find the current breakdown of call metric averages for 2019: Call Abandonment Rate: **0.76%** Call Answer Time: **8.43 seconds** Average Incoming Calls per Month: **321 Calls** Total Number of Incoming Calls for 2018: **3,854**
Access and Authorizations for Services **Level II Assessments**	During 2019 Level II Assessments Timeliness Standard of follow-up within (15 days) **2018 = 99.81% 2019=99.2%** **= -0.61% decrease from 2018**
Grievance and Appeals	The total number of Medicaid Grievance, and Appeals, and 2nd Opinions for FY 2019= 349, (47) less than 2018 total of 396. This translates into an overall decrease of -12.37%. There was also a decrease in the total number of Grievances (MHL/Medicaid/HMP/BG) from 323 in 2018 to 221 in 2019. This translates into a significant decrease of 31.57% in total Grievances for FY 2019. The total number of MHL Grievance, Appeal, and 2nd Opinions was (11) for 2019, which is a -57.69% decrease from 2018 (26).

2019 Quality Management Committee (QMC) Goal Status

SWMBH took a different approach to the Department and Committee goal setting in 2019. Each Department and Regional Committee worked together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 11, 2019. These (7) Strategic Imperatives replaced the 2019 Regional Committee Goals. The following represent a list of those Strategic Imperatives:

1. Public Policy and Legislative Education
2. Uniformity of Benefit
3. Integrated Health Care
4. Revenue Maximization and Diversification
5. Managed Care Functional Review
6. Improved Healthcare Information Exchange, Analytics and Business Intelligence
7. Proof of Value and Outcomes

Quality Assurance Improvement Program Evaluation

Southwest Michigan Behavioral Health
2019 Customer Satisfaction Survey Analysis

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

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

To access the survey results listed above on the SWMBH Portal go to:
SWMBH→QAPI→2019-2020 Survey Analysis Report. Final
Or
Click Here.

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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 2019). Barnes Research was selected as the vender for the 2019 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 2019 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

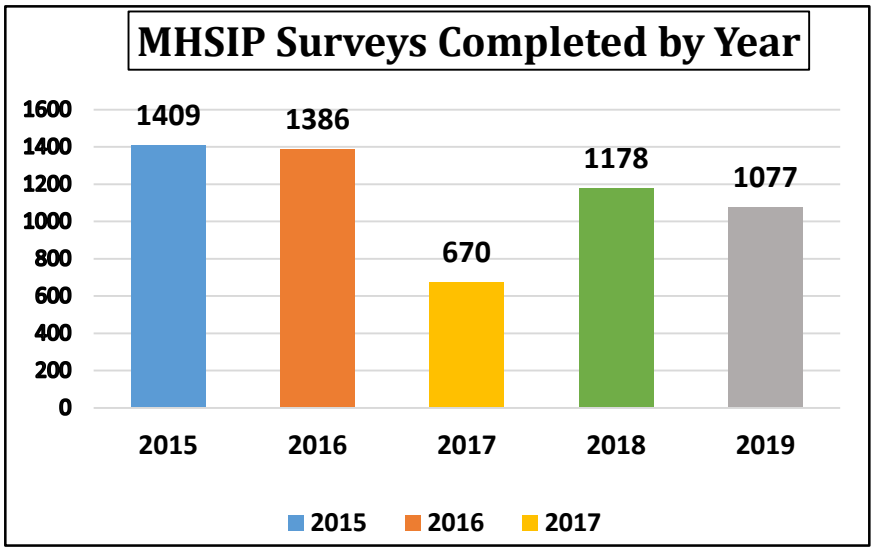
MHSIP Survey Information

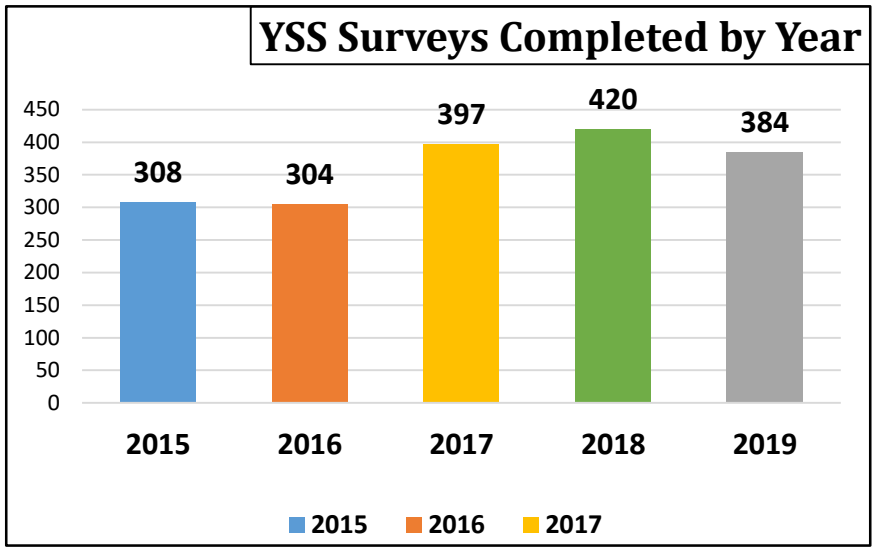
- The Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys measure concerns that are important to consumers of publicly funded mental health services in (7) different areas including:
  1. Access
  2. Quality/Appropriateness
  3. Outcomes
  4. General Satisfaction
  5. Social Connectedness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

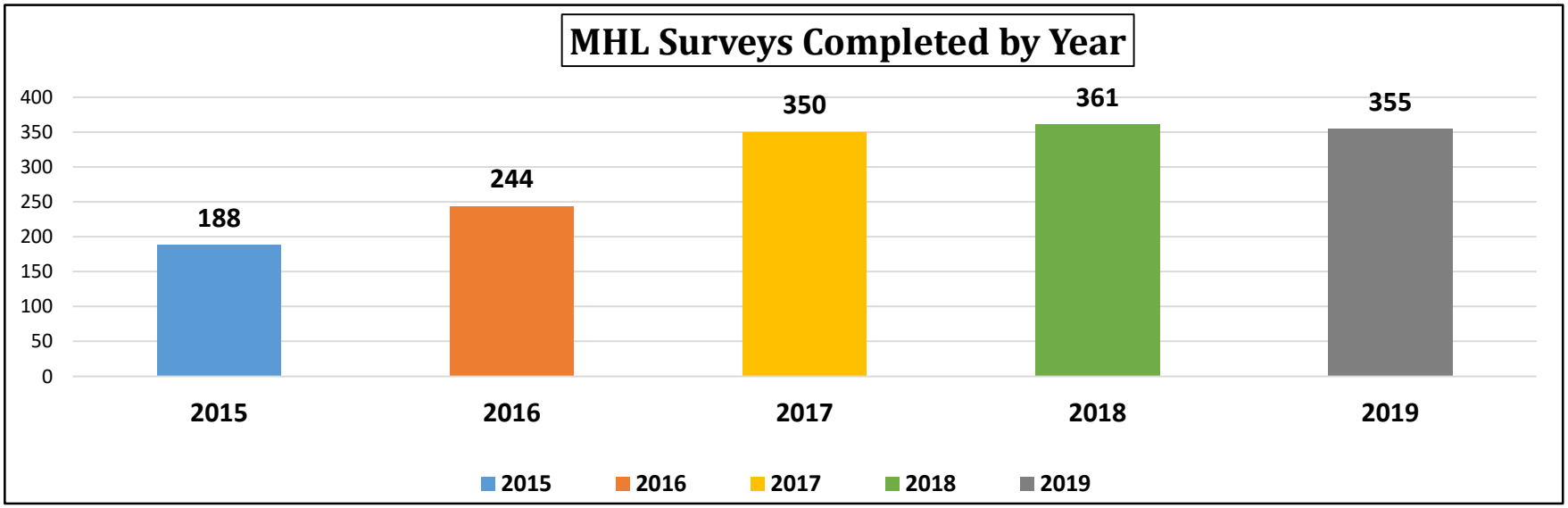
YSS-F Survey Information

- 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.

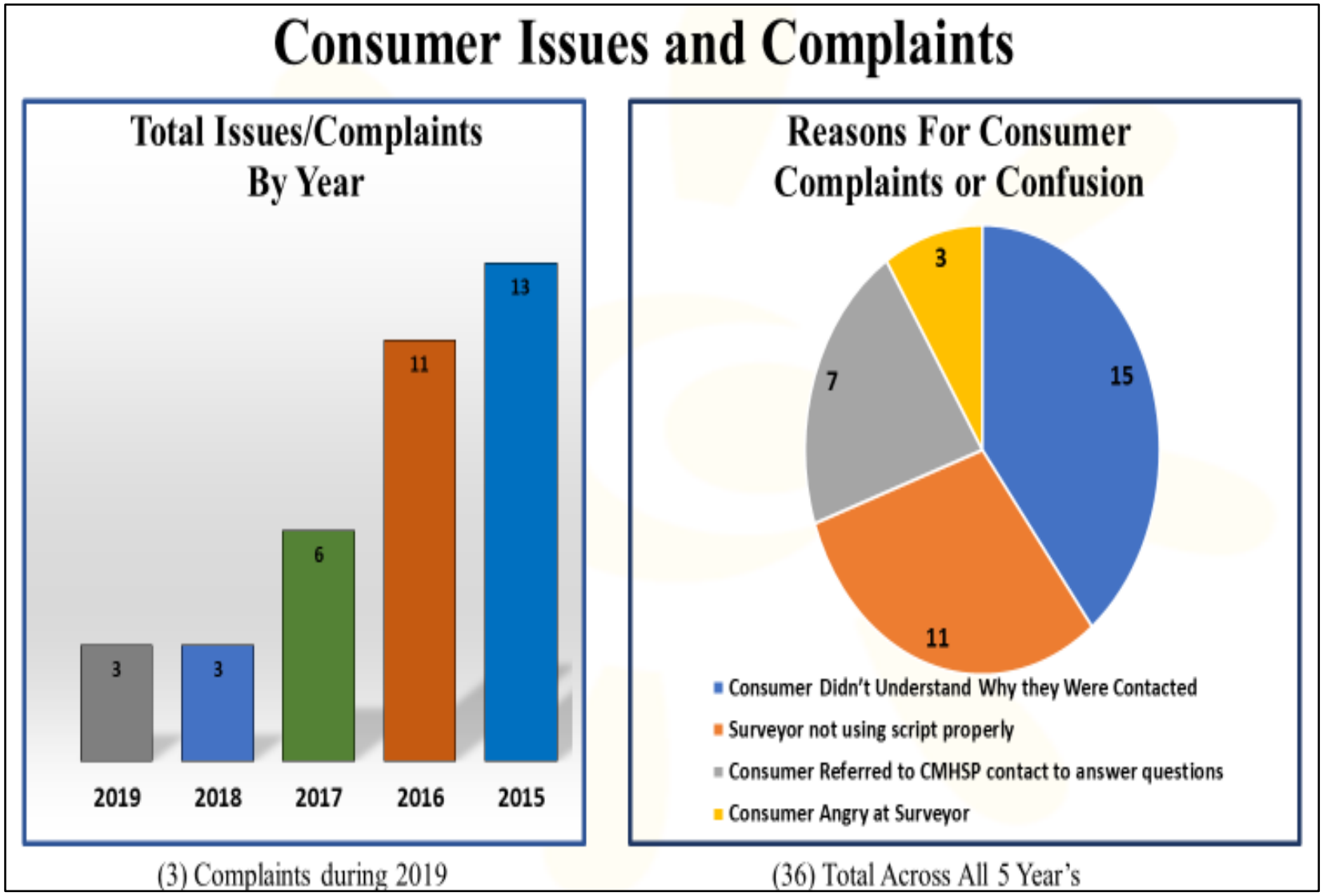
How Many Surveys Were Completed







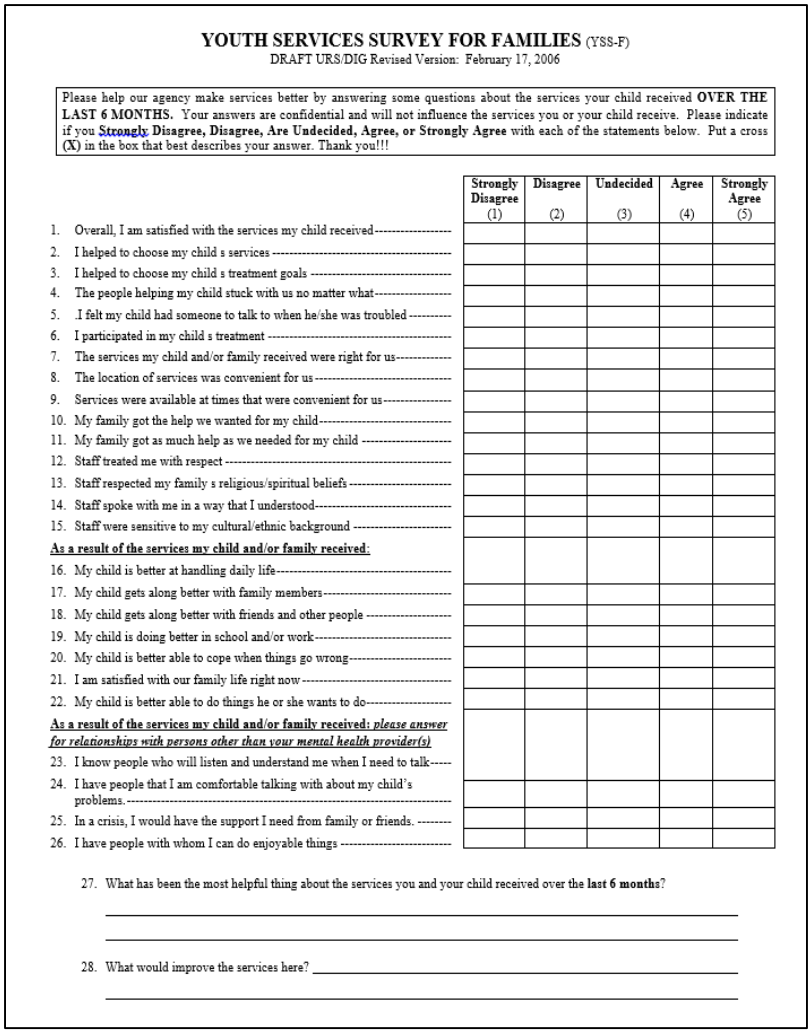
Consumer Issues and Complaints



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)



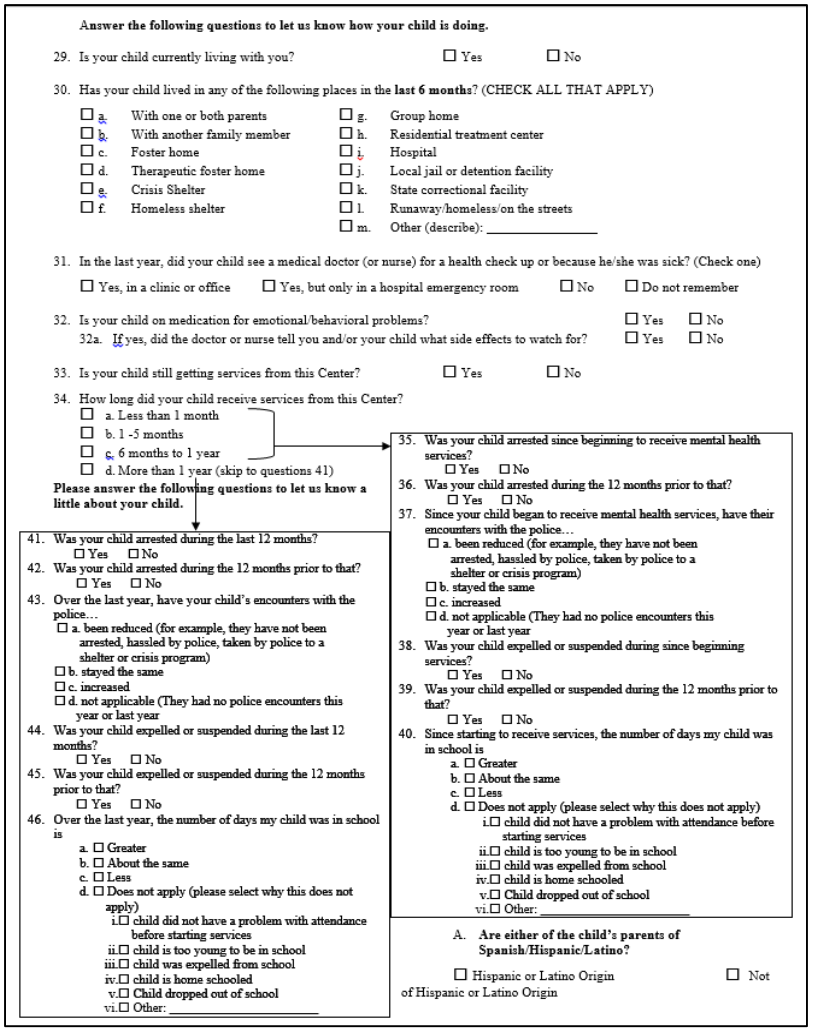
YOUTH SERVICES SURVEY FOR FAMILIES (YSS-F)
DRAFT URS/DIG Revised Version: February 17, 2006

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

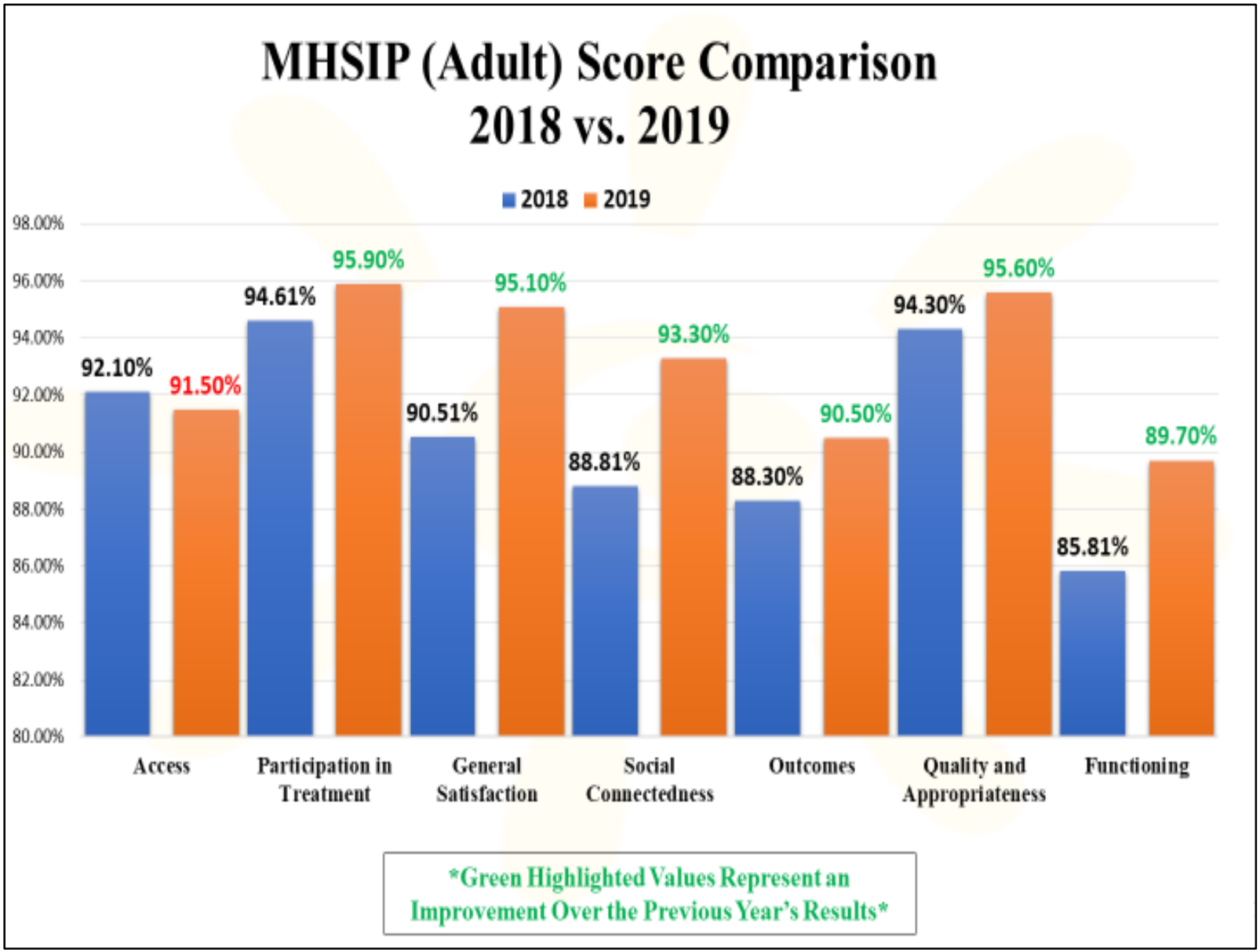
34. How long did your child receive services from this Center?
☐ a. Less than 1 month
☐ b. 1 -5 months
☐ c. 6 months to 1 year
☐ d. More than 1 year (skip to questions 41)

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

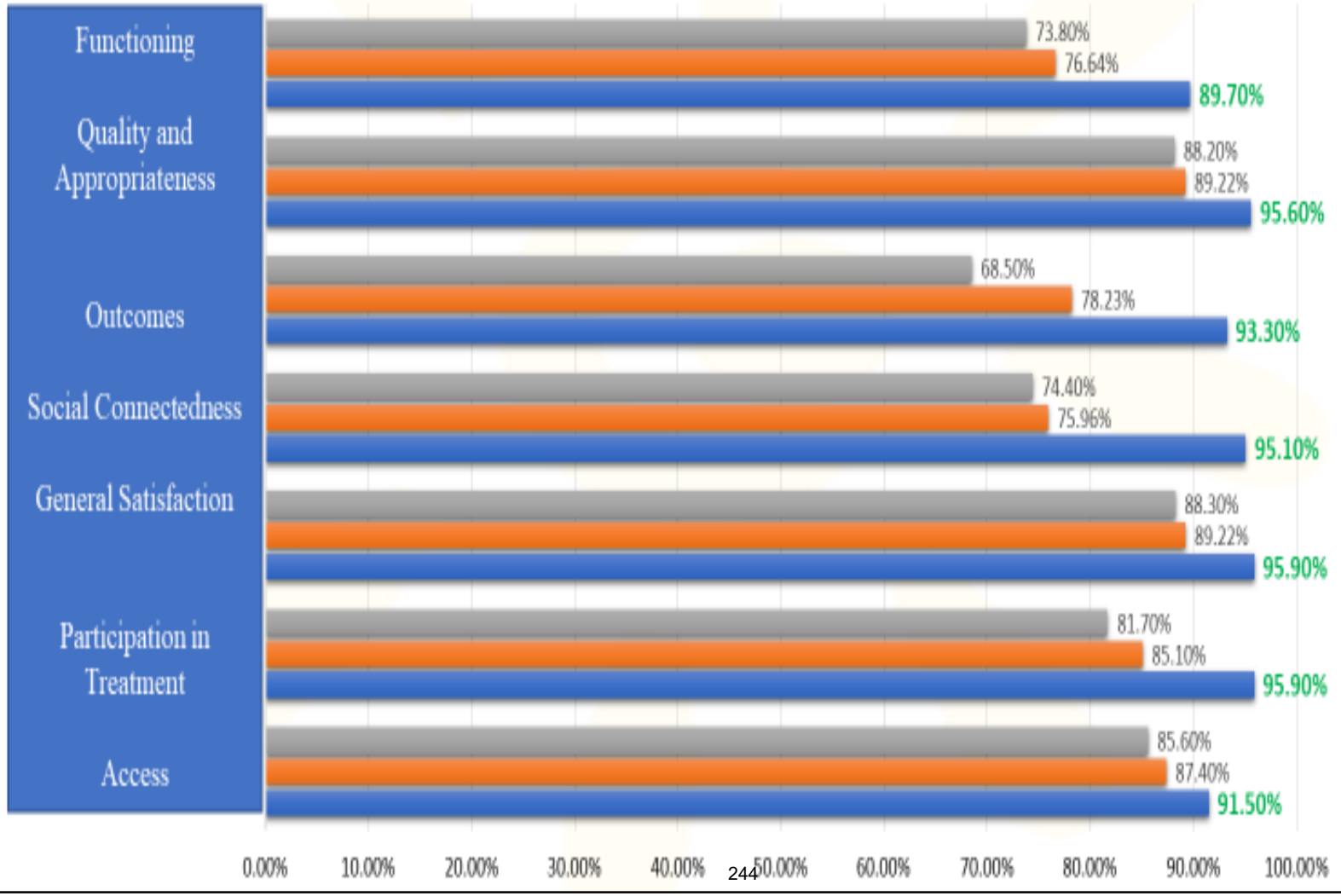
41. Was your child arrested during the last 12 months? ☐ Yes ☐ No
42. Was your child arrested during the 12 months prior to that? ☐ Yes ☐ No
43. Over the last year, have your child's encounters with the police…
☐ a. been reduced (for example, they have not been arrested, hassled by police, taken by police 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, hassled 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: _____

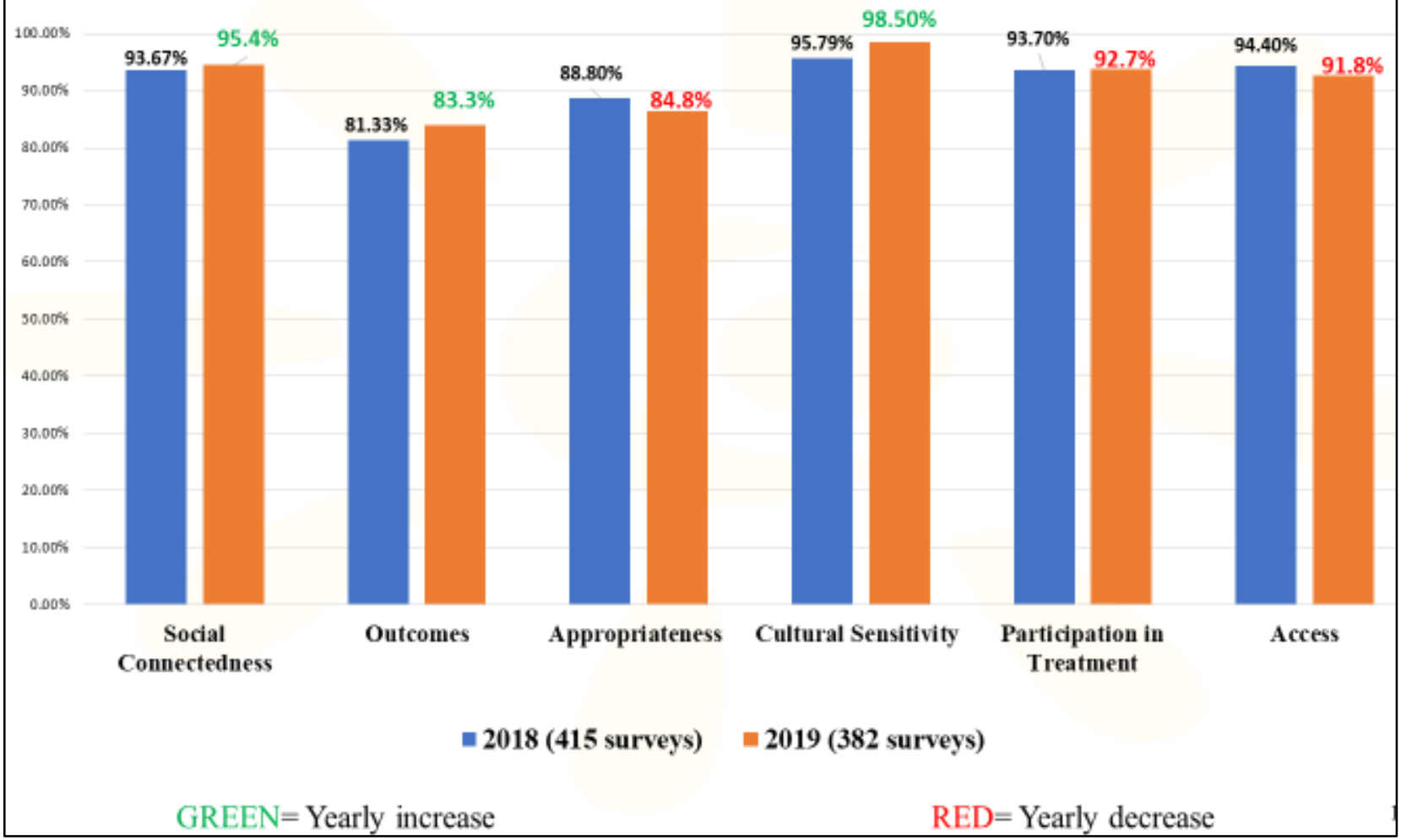
A. **Are either of the child's parents of Spanish/Hispanic/Latino?**
☐ Hispanic or Latino Origin ☐ Not of Hispanic or Latino Origin


MHSIP (Adult) Score Comparison
2018 vs. 2019
2018
2019
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
92.10%
91.50%
94.61%
95.90%
90.51%
95.10%
88.81%
93.30%
88.30%
90.50%
94.30%
95.60%
85.81%
89.70%
Access
Participation in Treatment
General Satisfaction
Social Connectedness
Outcomes
Quality and Appropriateness
Functioning
Green Highlighted Values Represent an Improvement Over the Previous Year's Results

2019 MHSIP State and National Comparisons

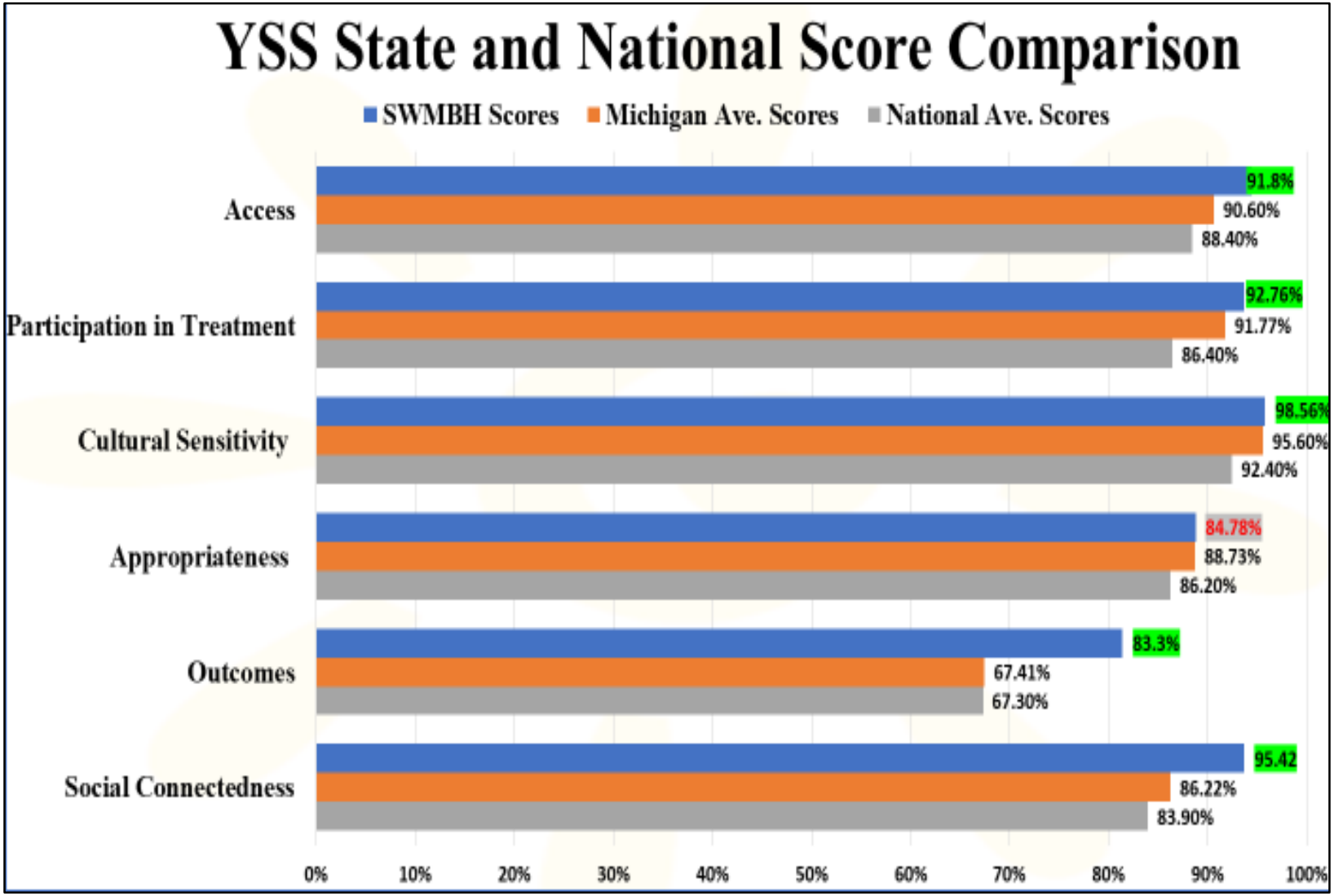


YSS 2018 vs 2019 Overall Percentage Comparison



GREEN= Yearly increase

RED= Yearly decrease


YSS State and National Score Comparison
SWMBH Scores
Michigan Ave. Scores
National Ave. Scores
Access
91.8%
90.60%
88.40%
Participation in Treatment
92.76%
91.77%
86.40%
Cultural Sensitivity
98.56%
95.60%
92.40%
Appropriateness
84.78%
88.73%
86.20%
Outcomes
83.3%
67.41%
67.30%
Social Connectedness
95.42
86.22%
83.90%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

How Did We Do?

MHSIP Results

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

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

YSS Results

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

+0.30% Percent Improvement over 2018 Scores (All Categories)

Overall Response Rates

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

Overall Result

+2.76% **Percent Overall Improvement (MHSIP + YSS)**

How Did Your County Do?
FY 19 MHSIP "In Agreement" Percentages by County

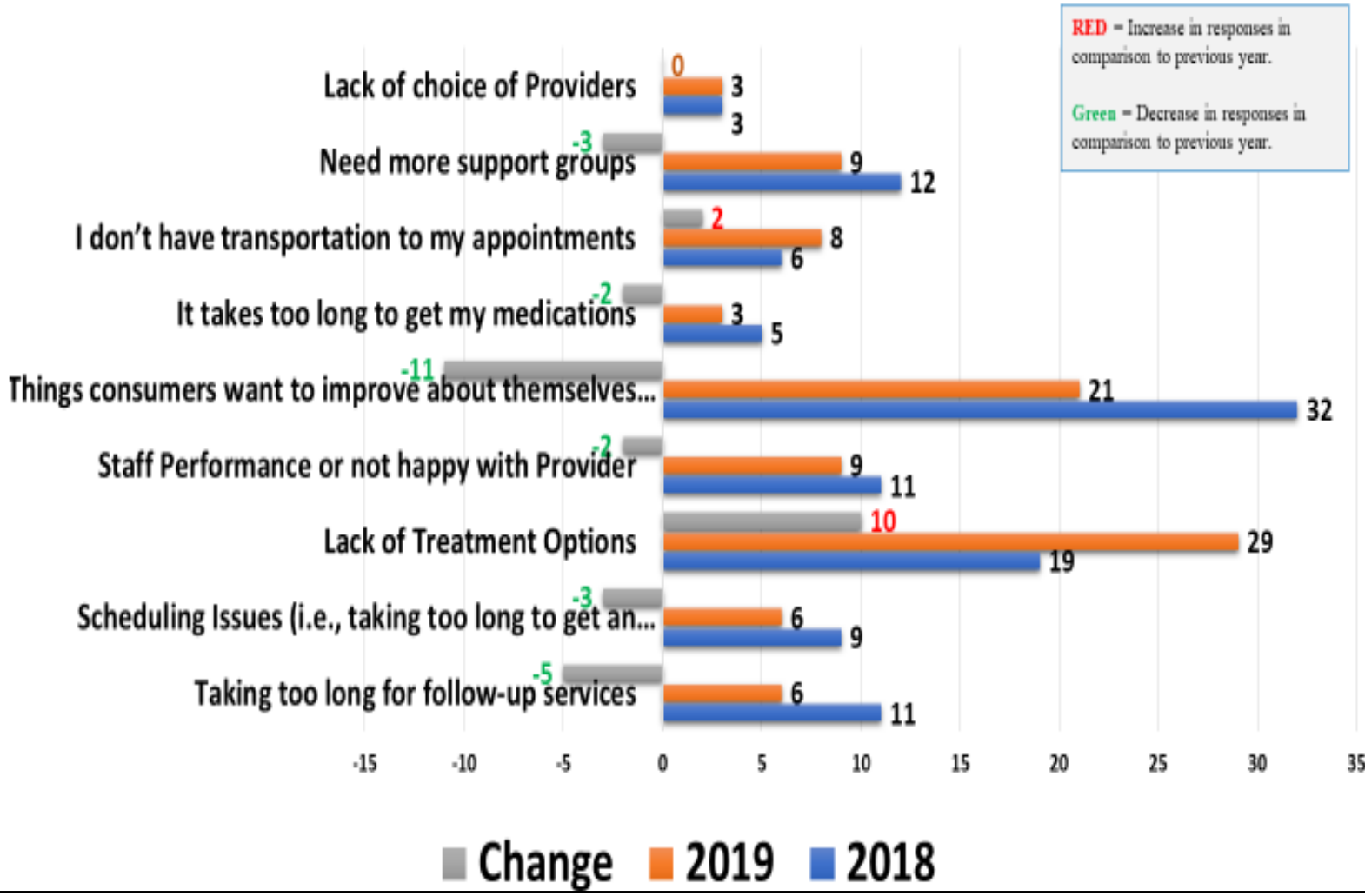
Year	CMHSP Participant	Statistic	General Satisfaction	Access	Quality and Appropriateness	Participation in Treatment	Outcomes	Improved Functioning	Social Connectedness	CMHSP Average (All	Difference 2018 vs 2019
2019	Barry	Percent in Agreement	97.01%	92.29%	95.93%	94.03%	93.28%	90.67%	93.66%	93.84%	3.80%
2018	Barry	Percent in Agreement	87.00%	91.40%	92.90%	94.90%	85.80%	88.50%	89.80%	90.04%	
2019	Berrien	Percent in Agreement	97.90%	92.05%	95.24%	95.20%	90.41%	89.28%	92.30%	93.20%	3.68%
2018	Berrien	Percent in Agreement	87.10%	92.80%	94.90%	93.50%	86.40%	84.30%	87.60%	89.51%	
2019	Branch	Percent in Agreement	91.10%	88.67%	94.18%	95.33%	88.33%	86.33%	92.00%	90.85%	1.16%
2018	Branch	Percent in Agreement	90.20%	91.70%	93.70%	90.80%	87.20%	83.90%	90.30%	89.69%	
2019	Calhoun	Percent in Agreement	96.18%	90.97%	96.69%	97.66%	89.58%	88.41%	91.80%	93.04%	6.07%
2018	Calhoun	Percent in Agreement	89.30%	88.80%	92.70%	89.30%	85.20%	82.80%	80.70%	86.97%	
2019	Cass	Percent in Agreement	90.56%	90.56%	94.39%	96.67%	90.83%	93.33%	98.75%	93.58%	1.97%
2018	Cass	Percent in Agreement	94.30%	93.60%	95.20%	96.20%	84.10%	85.50%	92.40%	91.61%	
2019	St. Joseph	Percent in Agreement	95.77%	88.62%	95.82%	95.24%	86.51%	87.70%	92.06%	91.67%	2.16%
2018	St. Joseph	Percent in Agreement	91.20%	89.80%	92.80%	93.80%	87.10%	83.70%	88.20%	89.51%	
2019	Kalamazoo	Percent in Agreement	95.05%	92.53%	95.28%	95.65%	90.77%	88.95%	89.19%	92.49%	1.06%
2018	Kalamazoo	Percent in Agreement	90.30%	94.80%	95.80%	95.90%	87.60%	85.10%	90.50%	91.43%	
2019	Van Buren	Percent in Agreement	97.16%	96.38%	97.18%	97.67%	94.67%	93.02%	96.32%	96.06%	5.09%
2018	Van Buren	Percent in Agreement	90.60%	93.70%	94.60%	93.30%	86.80%	87.40%	90.40%	90.97%	
2019 SWMBH Average for all each category.			95.1%	91.5%	95.6%	95.9%	90.5%	89.7%	93.3%		
2018 SWMBH Average for each category.			90.00%	92.08%	94.08%	93.46%	86.28%	85.15%	88.74%	RED signifies a decrease in score from 2018.	
2018 vs 2019 difference for each category.			5.09%	-0.57%	1.51%	2.47%	4.27%	4.56%	4.52%		

How Did Your County Do?
FY 19 YSS "In Agreement" Percentages by County

Year	CMHSP Participant	Statistic	Access	Participation in Treatment	Cultural Sensitivity	Appropriateness	Outcomes	Social Connectedness	CMHSP Average (All Categories)	Difference 2018 vs 2019
2019	Barry	Percent in Agreement	85.71%	90.48%	100%	81.0%	81.6%	100%	89.79%	
2018	Barry	Percent in Agreement	94.20%	92.70%	94.20%	92.90%	81.10%	95.10%	91.70%	-1.91%
2019	Berrien	Percent in Agreement	94.07%	94.35%	99.58%	91.81%	90.00%	95.76%	94.26%	
2018	Berrien	Percent in Agreement	92.70%	95.70%	96.00%	85.60%	79.60%	94.70%	90.72%	3.55%
2019	Branch	Percent in Agreement	91.25%	94.2%	97.5%	82.5%	76.8%	91.9%	89.02%	
2018	Branch	Percent in	96.20%	94.8%	98.1%	86.2%	81.3%	95.2%	91.97%	-2.95%
2019	Calhoun	Percent in Agreement	93.75%	96.2%	98.3%	87.9%	88.1%	93.8%	93.00%	
2018	Calhoun	Percent in Agreement	92.90%	94.4%	96.3%	87.7%	83.6%	94.9%	91.63%	1.37%
2019	Cass	Percent in Agreement	87.50%	86.90%	100.00%	78.57%	79.10%	97.32%	88.23%	
2018	Cass	Percent in Agreement	91.40%	93.20%	96.80%	84.40%	83.20%	93.90%	90.48%	-2.25%
2019	St. Joseph	Percent in Agreement	90.59%	92.16%	97.06%	88.43%	80.30%	92.35%	90.15%	
2018	St. Joseph	Percent in Agreement	94.50%	91.20%	95.50%	83.70%	77.40%	94.10%	89.40%	0.75%
2019	Kalamazoo	Percent in Agreement	96.55%	91.95%	99.14%	81.61%	80.80%	93.10%	90.53%	
2018	Kalamazoo	Percent in Agreement	96.70%	95.30%	97.10%	88.90%	84.10%	95.80%	92.98%	-2.46%
2019	Van Buren	Percent in Agreement	95.31%	95.83%	96.88%	86.46%	87.50%	99.22%	93.53%	
2018	Van Buren	Percent in Agreement	95.90%	94.10%	92.30%	86.50%	83.90%	95.30%	91.33%	2.20%
2019 SWMBH Average for each category.			91.8%	92.76%	98.56%	84.78%	83.03%	95.42%		
2018 SWMBH Average for each category.			94.31%	93.93%	95.79%	86.99%	81.78%	94.88%		
2018 VS 2019 difference for each category.			-2.47%	-1.17%	2.77%	-2.21%	1.25%	0.55%		

RED signifies a decrease in score from 2018.

2019 MHL Consumer Satisfaction Survey
Consumer Feedback



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

- Publish results widely (*i.e., newsletters, share with stakeholders and regional committees)*
- Develop CMHSP Specific Reports for all (8) Counties.
- 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, RUM, RCP, and other Regional Committees for the 2020 Customer Satisfaction Survey Process.

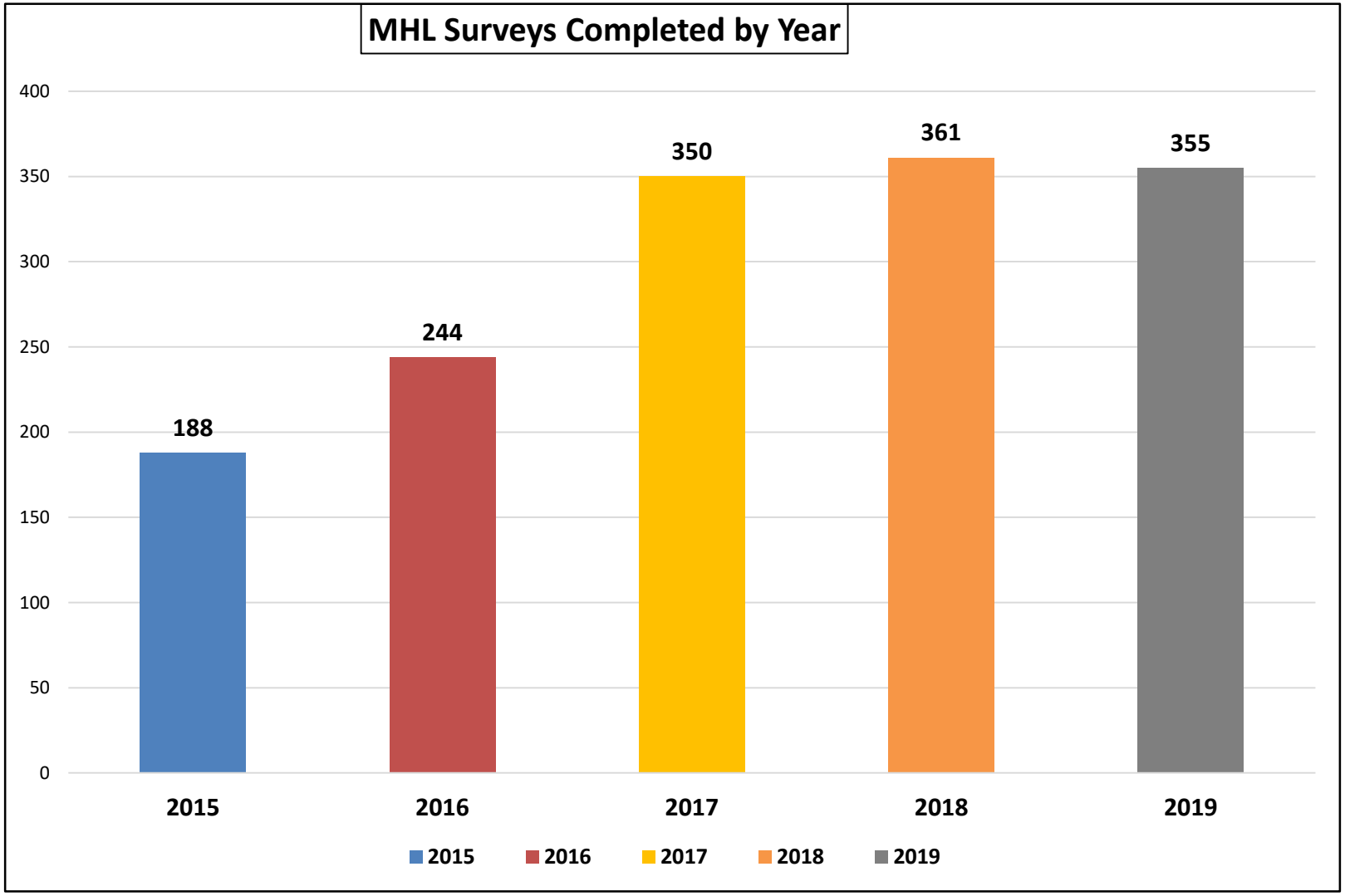
2019

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



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 3)*

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

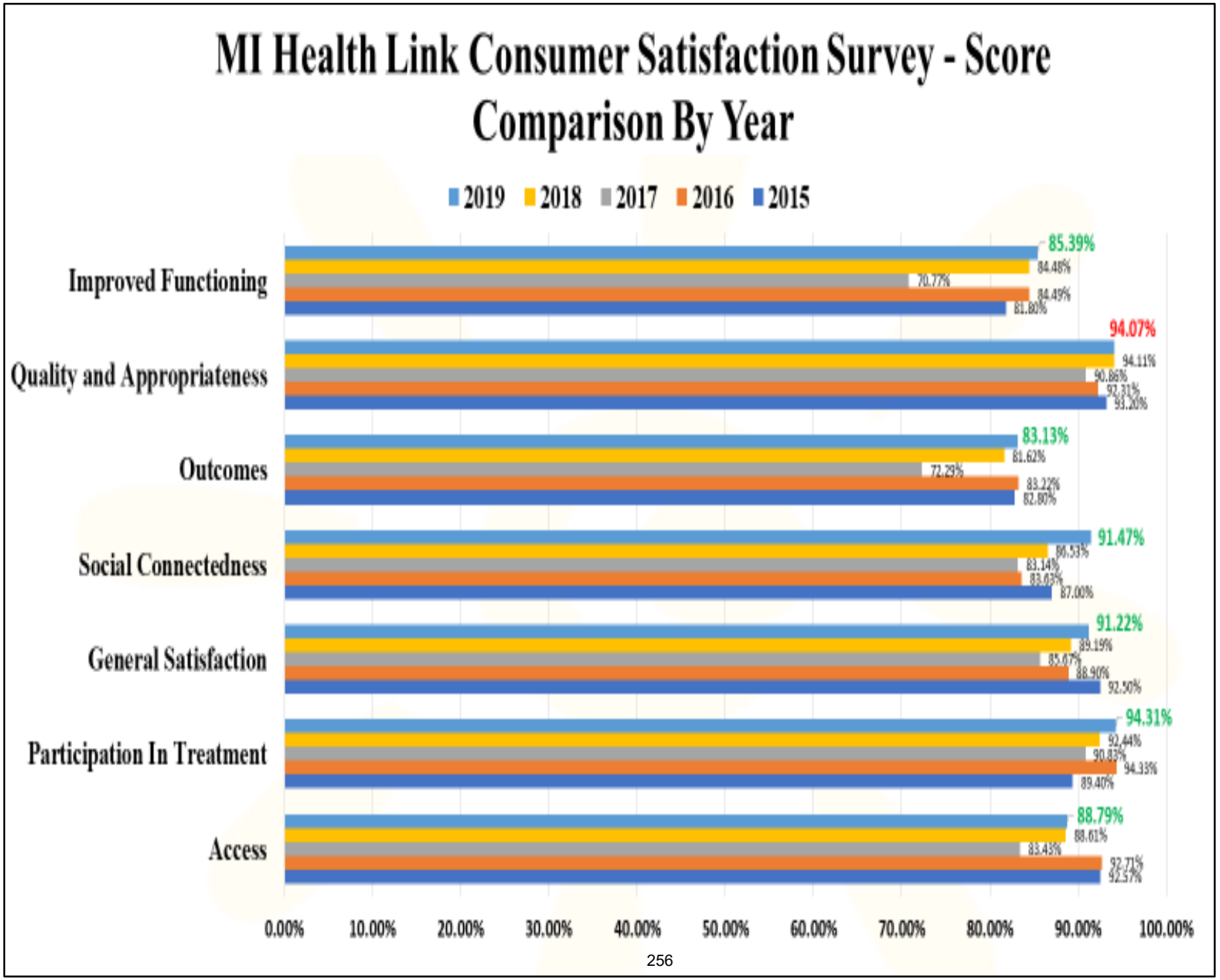
ADD COMMENT (VERBATIM):

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?

255


MI Health Link Consumer Satisfaction Survey - Score Comparison By Year
2019
2018
2017
2016
2015
Improved Functioning
85.39%
84.48%
70.77%
84.49%
81.80%
Quality and Appropriateness
94.07%
94.11%
90.86%
92.31%
93.20%
Outcomes
83.13%
81.62%
72.29%
83.22%
82.80%
Social Connectedness
91.47%
86.53%
83.14%
83.63%
87.00%
General Satisfaction
91.22%
89.19%
85.07%
88.90%
92.50%
Participation In Treatment
94.31%
92.44%
90.83%
94.33%
89.40%
Access
88.79%
88.61%
83.43%
92.71%
92.57%
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
90.00%
100.00%

How Did We Do?

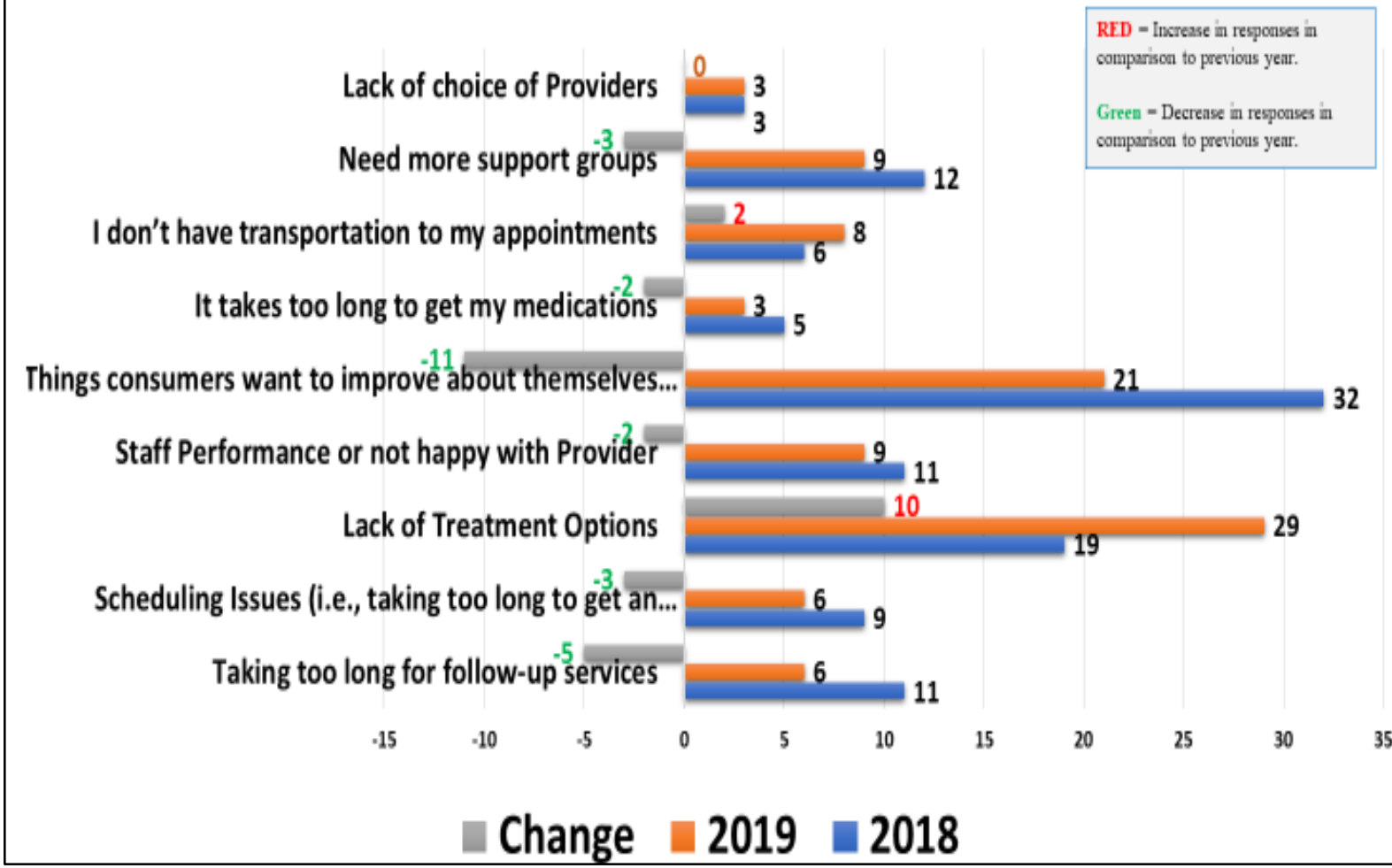
MIHL Results

- 2019 Aggregate Score: 89.8%
- 2018 Aggregate Score: 88.1%

- 2019 Response Rate: 37.4%
- 2018 Response Rate: 39.7%

+1.7% Percent Improvement over 2018 Scores

2019 MHL Consumer Satisfaction Survey
Consumer Feedback



2019 MIHL Satisfaction Survey Analysis

Summary of Finding:

In summary, (355) valid surveys were completed, resulting in a 37.4% response rate. The response rate was down a touch in comparison to 2018 results 42.9%, but was not considered significant, and still well ahead of the national average. This response rate is very good and attributed to the letters and advertisement efforts taken before the survey implementation. The current 2019 results are a significant improvement over the 2018 results. The percentages of 'In Agreement' ratings across domain areas are also higher this year, netting an average 'In Agreement' score of 3.98 on a 5.0 scale, in comparison to the 2018 average 'In Agreement' score of 3.44. The Quality Department will continue to evaluate consumer survey participant feedback to identify common denominators and trends associated with the 2019 survey process. The current results tend to reflect national trends for the respective MHSIP survey tool domains. They tend to reflect results reported by [some] states that employ credible survey methods for MHSIP URS (SAMSHA) reporting (i.e., Oregon / Utah / Ohio / California…). These states have similar evaluation and validation processes as Southwest Michigan Behavioral Health.

Improvement Measures:

During the 2019 survey process and evaluation, it was identified that increased vendor oversight and monitoring needed to occur. In 2018 it was found that some surveyors were inconsistent using scripts and identified themselves incorrectly to consumers. This caused some confusion for the consumers in understanding the significance of their participation in the survey. Due to this finding, SWMBH sent out letters to all potential members who may be selected to receive a survey call. The letter informed the consumer of the purpose of the survey and how their responses will be used to improve programs and services.

Additionally, SWMBH Management made (2) random visits to the vendor/survey location to observe the consistency in scripts and survey protocol was being followed correctly. It was found that the 4 surveyors evaluated were using the appropriate scripts and techniques they had been educated on. Consumer feedback and comments will be assessed to identify potential trends. Workgroups and Regional Committees will review the detailed data and formulate a performance improvement plan for categories with identified outliers.

2019

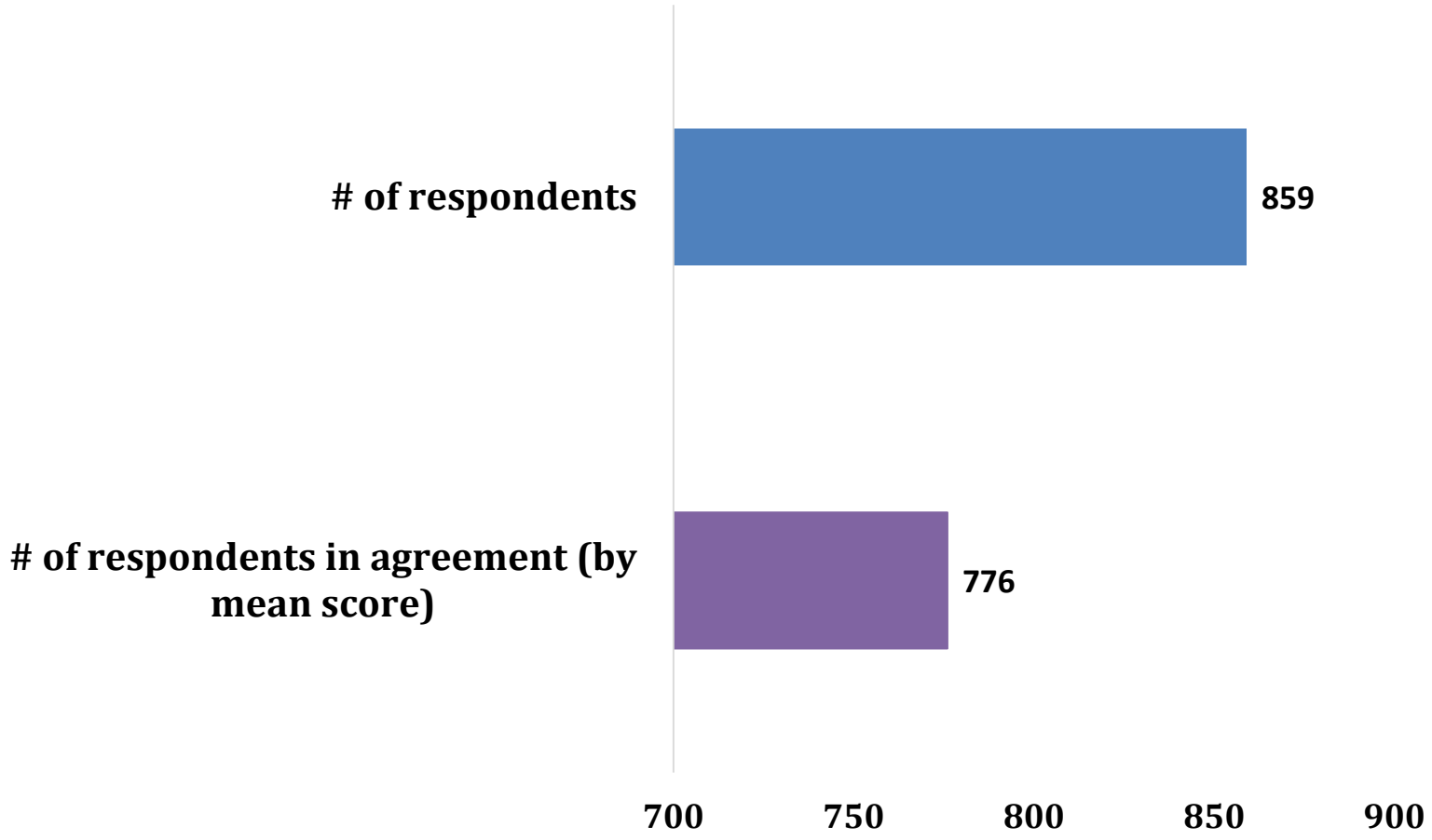
Recovery Self-Assessment-revised

Person in Recovery Survey (RSA-r)

Recovery Self Assessment (RSA-r) Survey Information

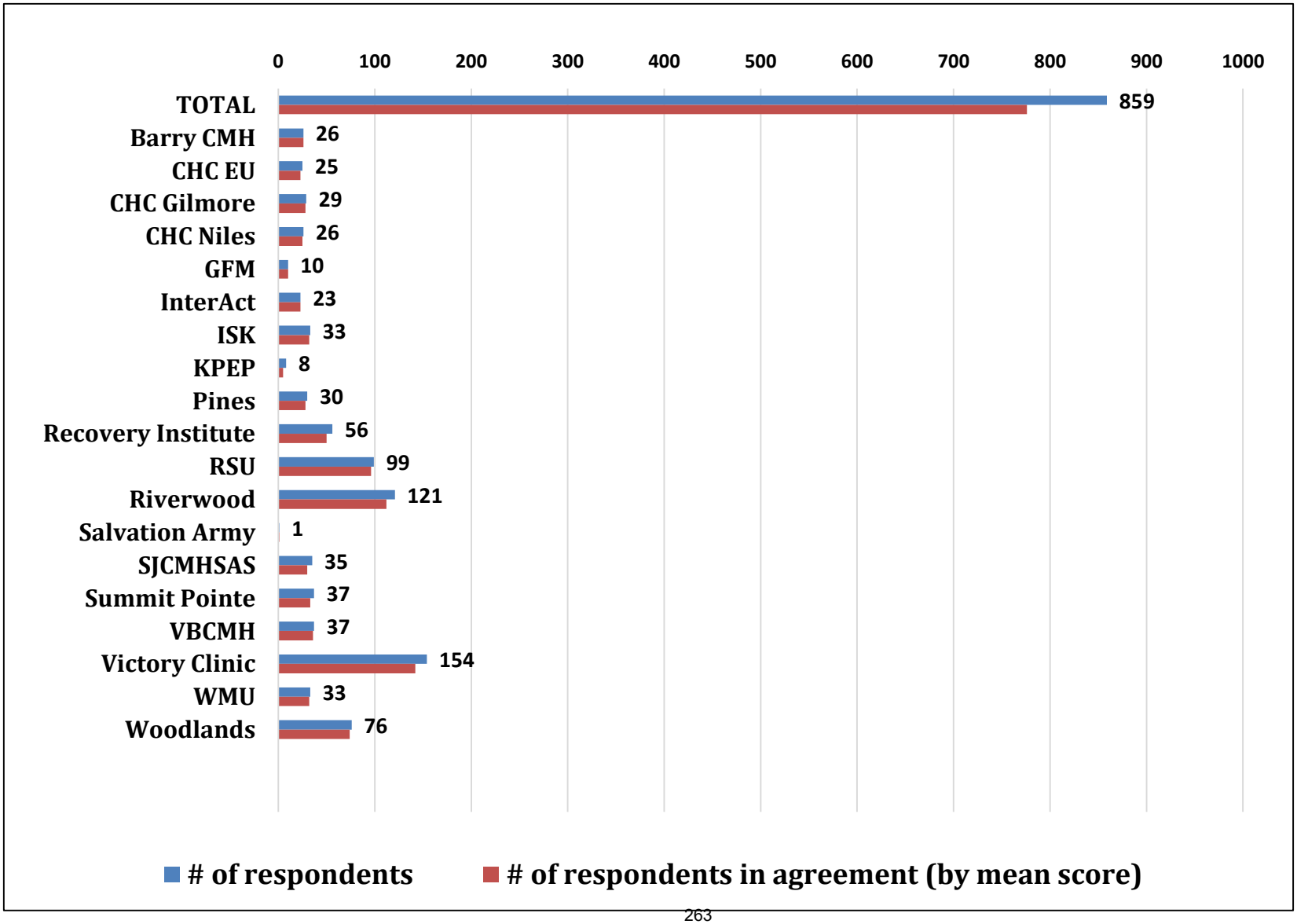
- The Recovery Self-Assessment – Person in Recovery Survey (RSA-r) is:
  - A 32-question tool
  - Designed to gauge the degree to which programs implement recovery-oriented practices
  - A reflective tool designed to identify strengths and target areas of improvement, geared toward improving consumer outcomes and treatment modalities
- Consumers of substance abuse services complete the surveys, which were administered through their provider.
- The survey's administration period was from: 9/23/2019 to 11/15/2019.

Total Number of RSA-R Respondents & Agreement

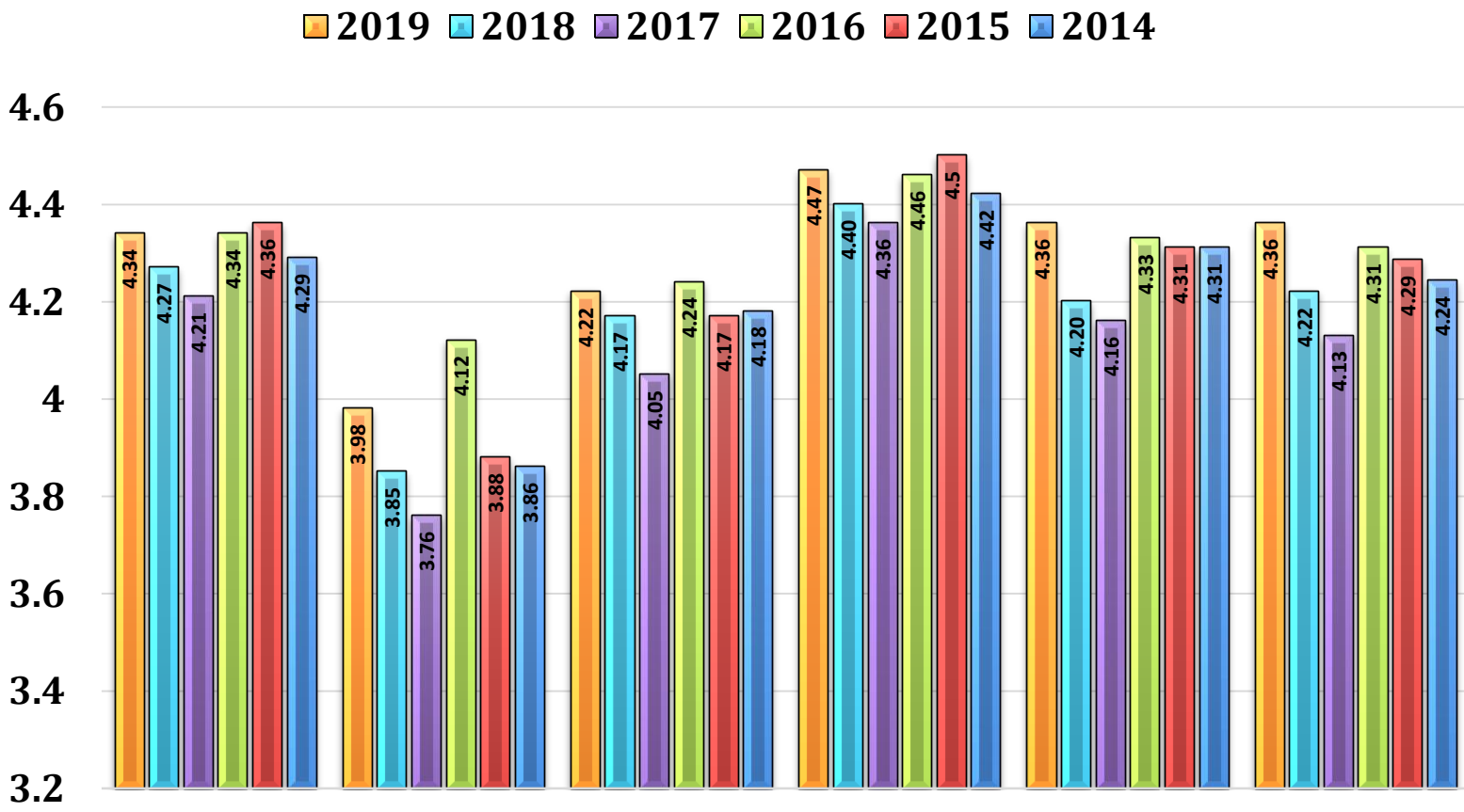


262

Number of Surveys Completed by Provider

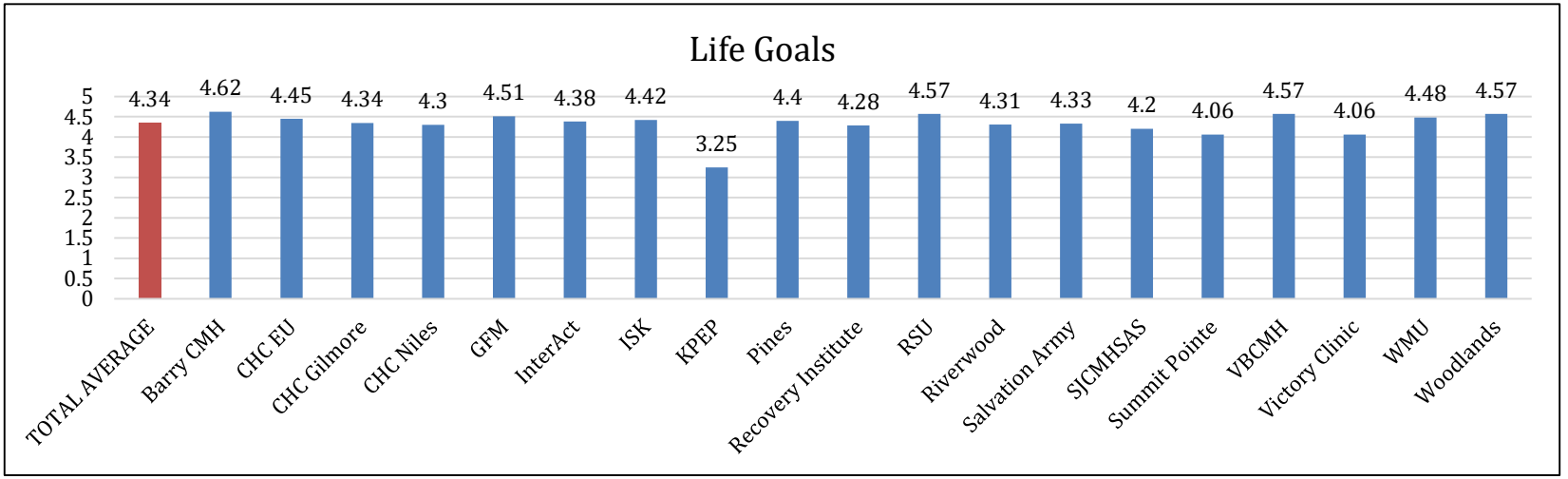


RSA-r 2019 - 2014
Score Comparison Analysis



264

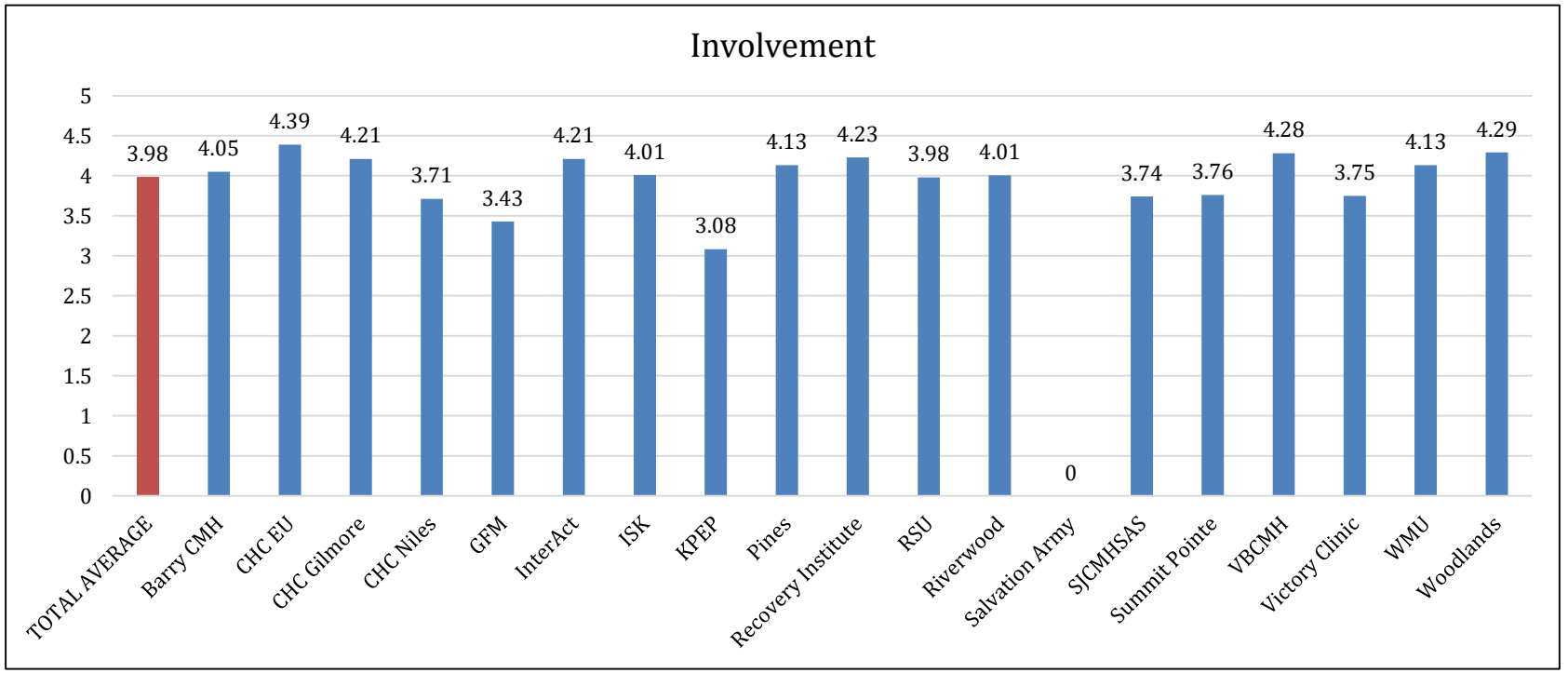
Recovery Self Assessment Survey (RSA-r) Scores by Provider and Category



3. Staff encourage program participants to have hope and high expectations for their recovery.
7. Staff believe in the ability of program participants to recover.
8. Staff believe that program participants have the ability to manage their own symptoms.
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
12. Staff encourage program participants to take risks and try new things.
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g. employment, education physical fitness, connecting with family and friends, hobbies).
17. Staff routinely assist program participants with getting jobs.
18. Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
31. Staff are knowledgeable about special interest groups and activities in the community.
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

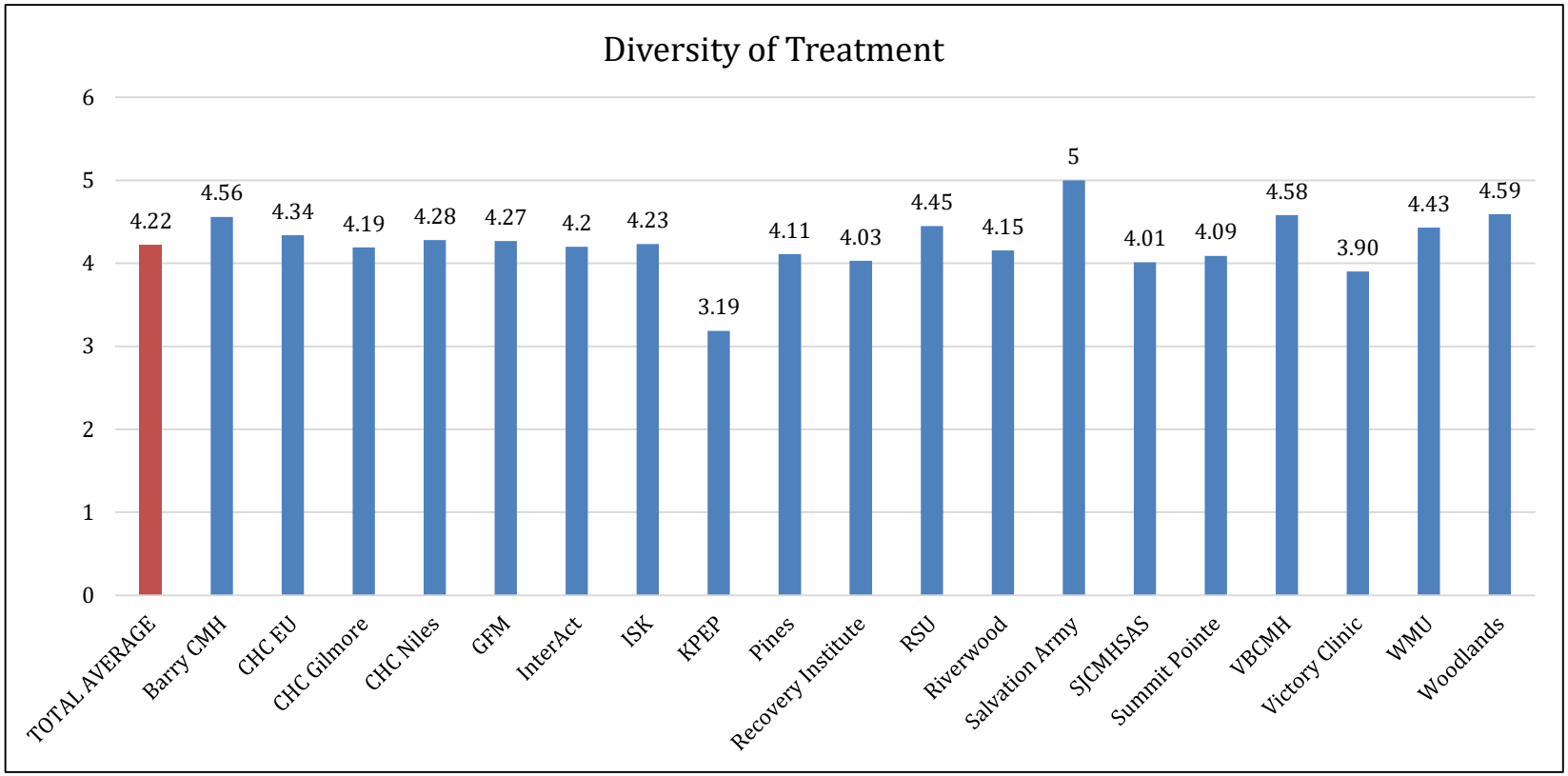
265

Recovery Self Assessment Survey (RSA-r) Scores by Provider and Category



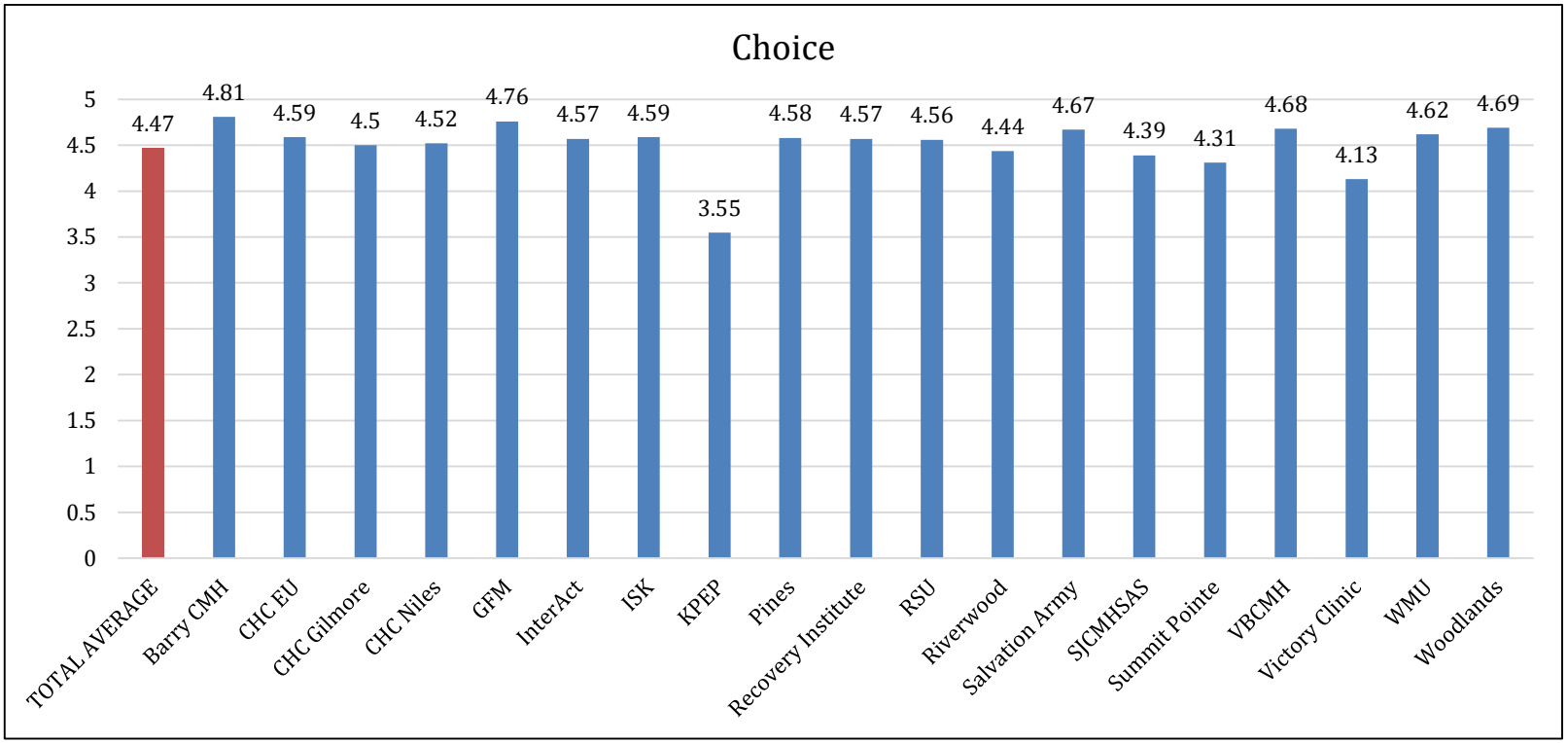
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
25. People in recovery are encouraged to attend agency advisory boards and management meetings.
29. Persons in recovery are involved with facilitating staff trainings and education at this program.

Recovery Self Assessment Survey (RSA-r) Scores by Provider and Category



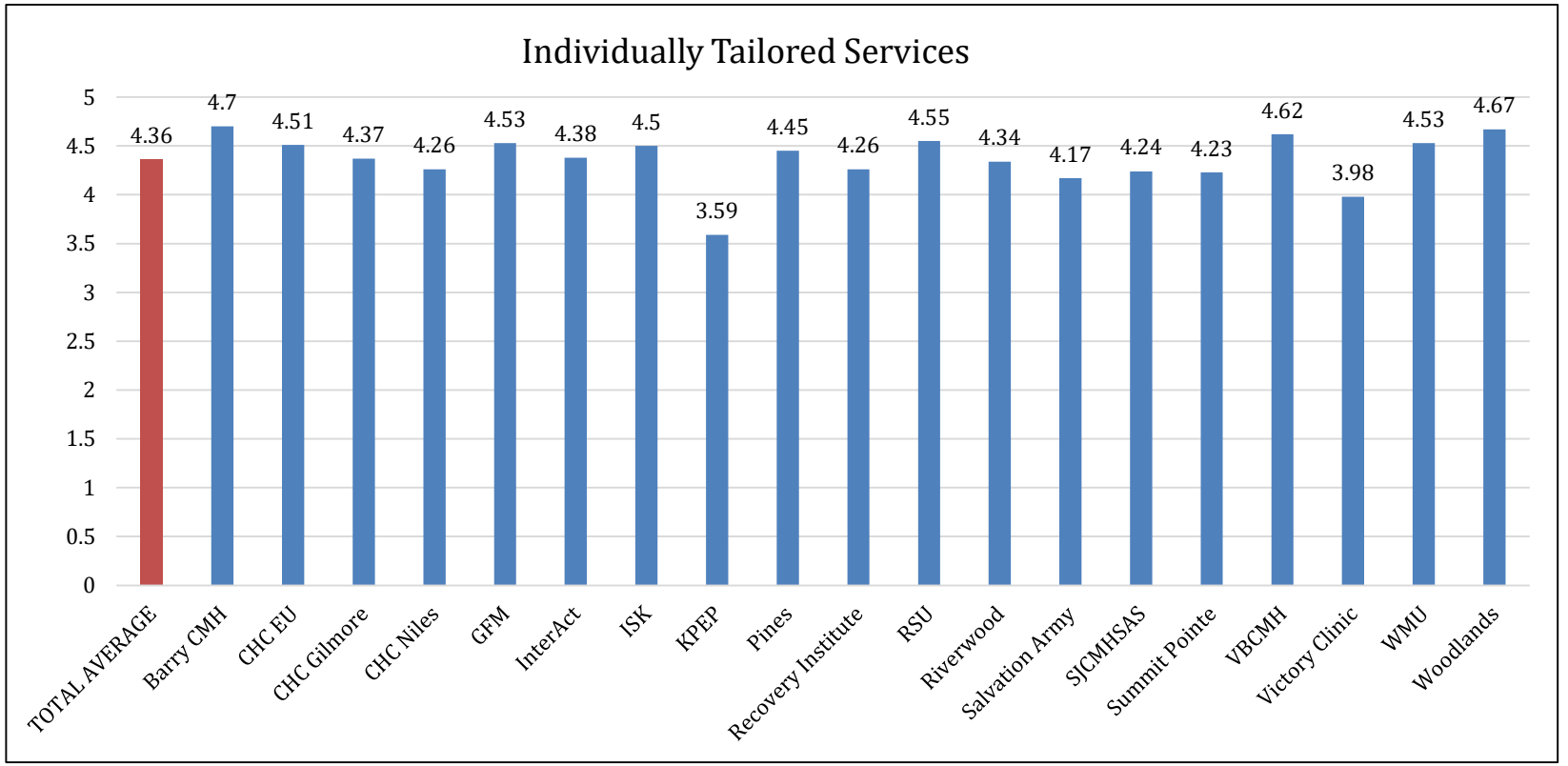
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
26. Staff talk with program participants about what it takes to complete or exit the program.

Recovery Self Assessment Survey (RSA-r) Scores by Provider and Category



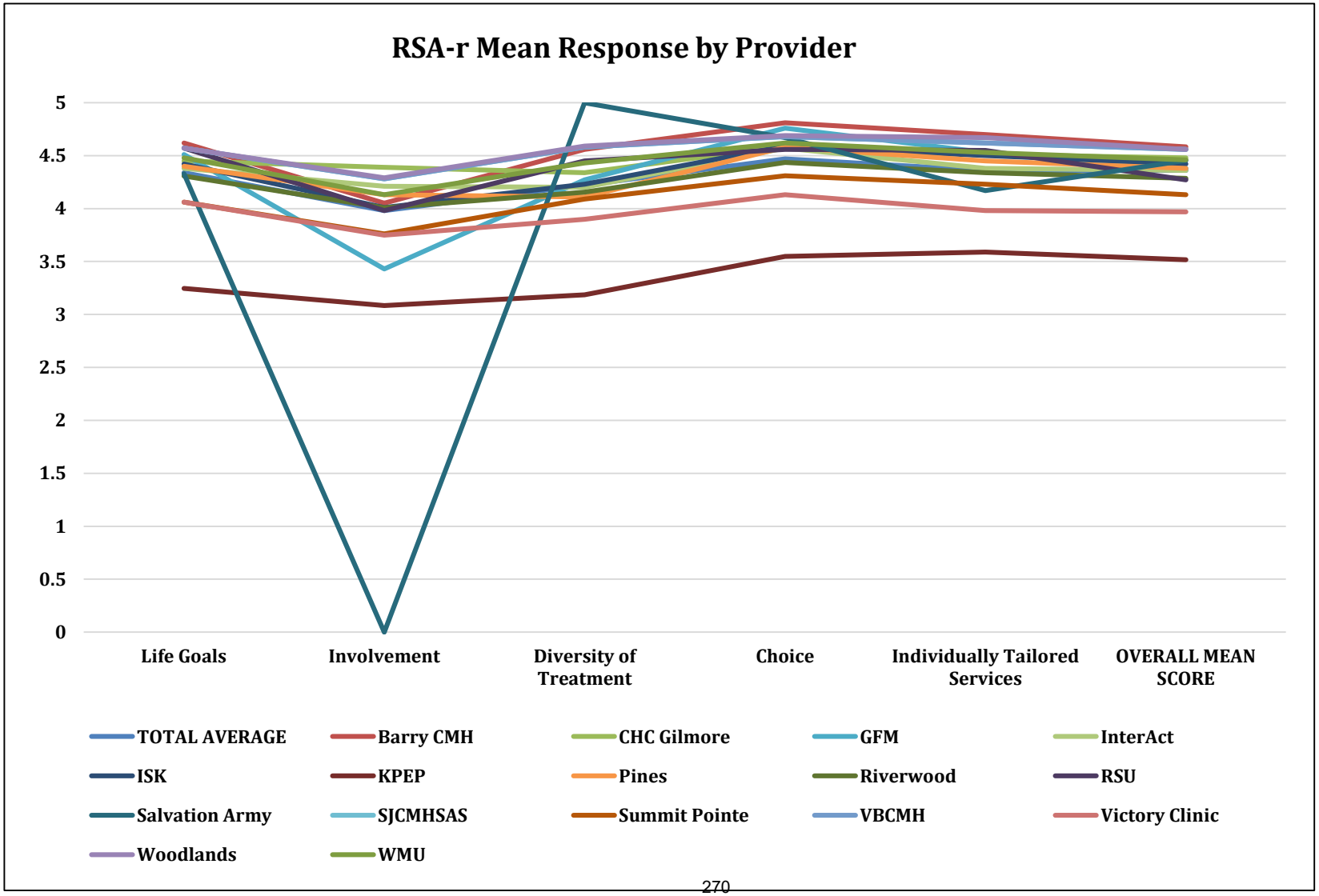
4. Program participants can change their clinician or case manager if they wish.
5. Program participants can easily access their treatment records if they wish.
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
10. Staff listen to and respect the decisions that program participants make about their treatment and care.
27. Progress made towards an individual's own personal goals is tracked regularly.

Recovery Self Assessment Survey (RSA-r) Scores by Provider and Category



11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
13. This program offers specific services that fit each participant's unique culture and life experiences.
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).
30. Staff at this program regularly attend trainings on cultural competency.

Recovery Self Assessment Survey (RSA-r)



How Did We Do?

RSA-r Results Year Comparison

- 2019 Overall Mean Score: 4.36
  (+0.14 Percent increase from 2018)
- 2018 Overall Mean Score: 4.22
- 2017 Overall Mean Score: 4.13
- 2016 Overall Mean Score: 4.31
- 2015 Overall Mean Score: 4.29
- 2014 Overall Mean Score: 4.24

6 Year Average	Mean Score
Life Goals (Q3,Q7,Q8,Q9,Q12,Q16,Q17,Q18,Q28,Q31,Q32)	**4.30**
Involvement (Q22,Q23,Q24,Q25,Q29	**3.91**
Diversity of Treatment (Q14,Q15,Q20,Q21,Q26)	**4.17**
Choice (Q10, Q27, Q4, Q5, Q6)	**4.44**
Individually Tailored Services (Q11, Q13, Q19, Q30)	**4.28**

2019 Recovery Self Assessment Survey (RSA-r) Analysis – Next Steps – Opportunities for Improvement

Summary of Findings:

The 2019 RSA-r survey administration period was from: 9/23/2019 to 11/15/2019.
For the 2019 process, SWMBH received total (859) surveys back, which was a decrease from the 2018 response of (1087) total surveys returned. (19) Different provider organizations participated in the 2019 survey process, which was 3 less than the 2018 participation; (22) provider organizations participated. SWMBH's analysis of the overall mean score *represented a +0.14 increase in comparison to 2018 scores*.

Improvement Measures:

The data entry process is manual and takes significant time to enter all provider organization results. Furthermore, this was the second year in a row where the number of surveys received was less than the year before (not including a submission received with no paper surveys inside of the envelope). These are all areas of improvement for the survey next year.

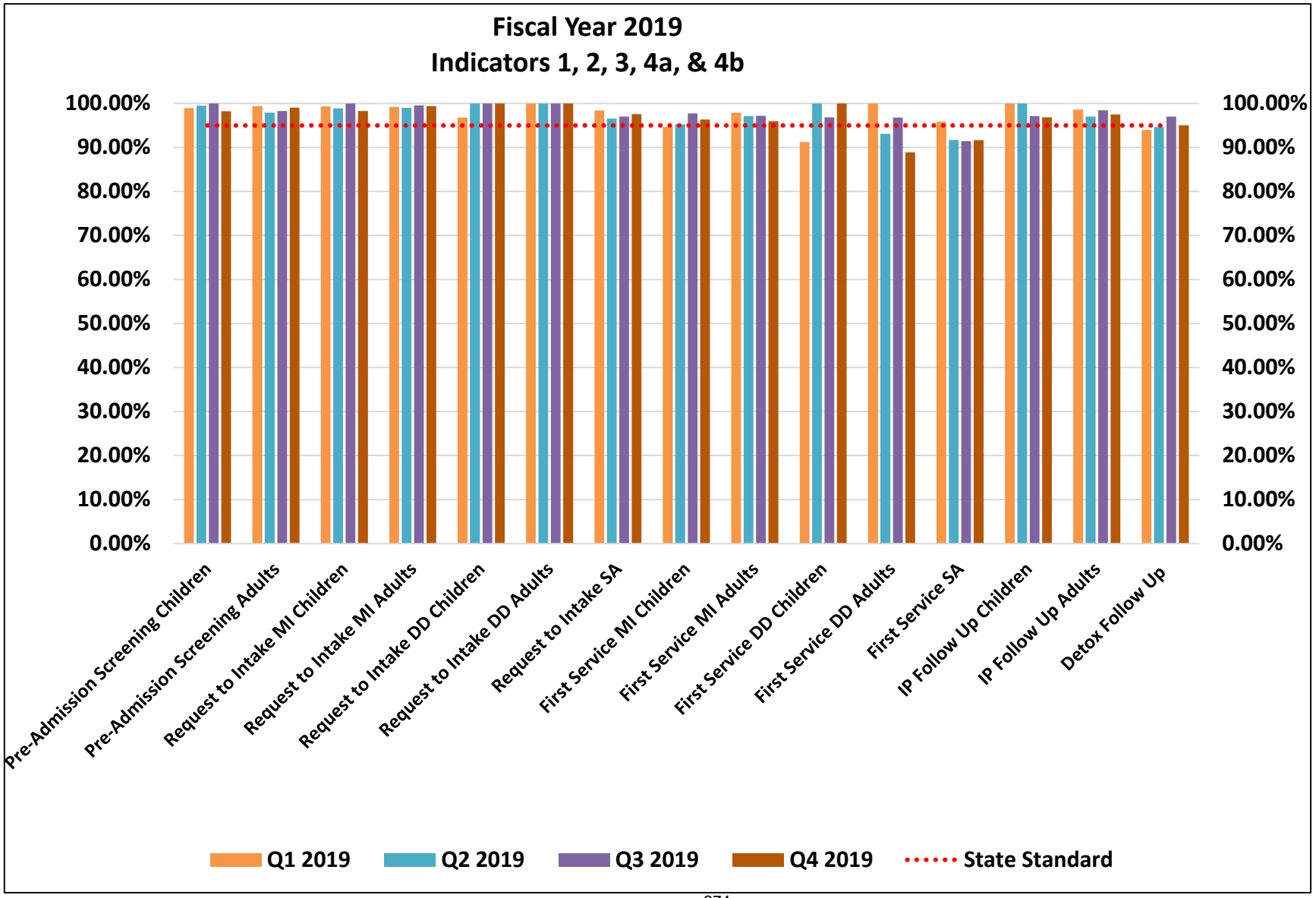
Next Steps:

The QAPI Department explored utilizing Survey Monkey to automate the data entry system, which would save employee time and speed up the results/analysis process. The decision was made to make the electronic survey optional, and one provider chose to submit their results electronically. The results were that the electronic survey analysis was within +/- 1% of SWMBH's internal analysis, so this information will be used to plan for 2020's survey administration. QMC will also explore ways to improve scores in the Involvement category, which once again was the lowest score and has been the Regions' lowest score since 2015.

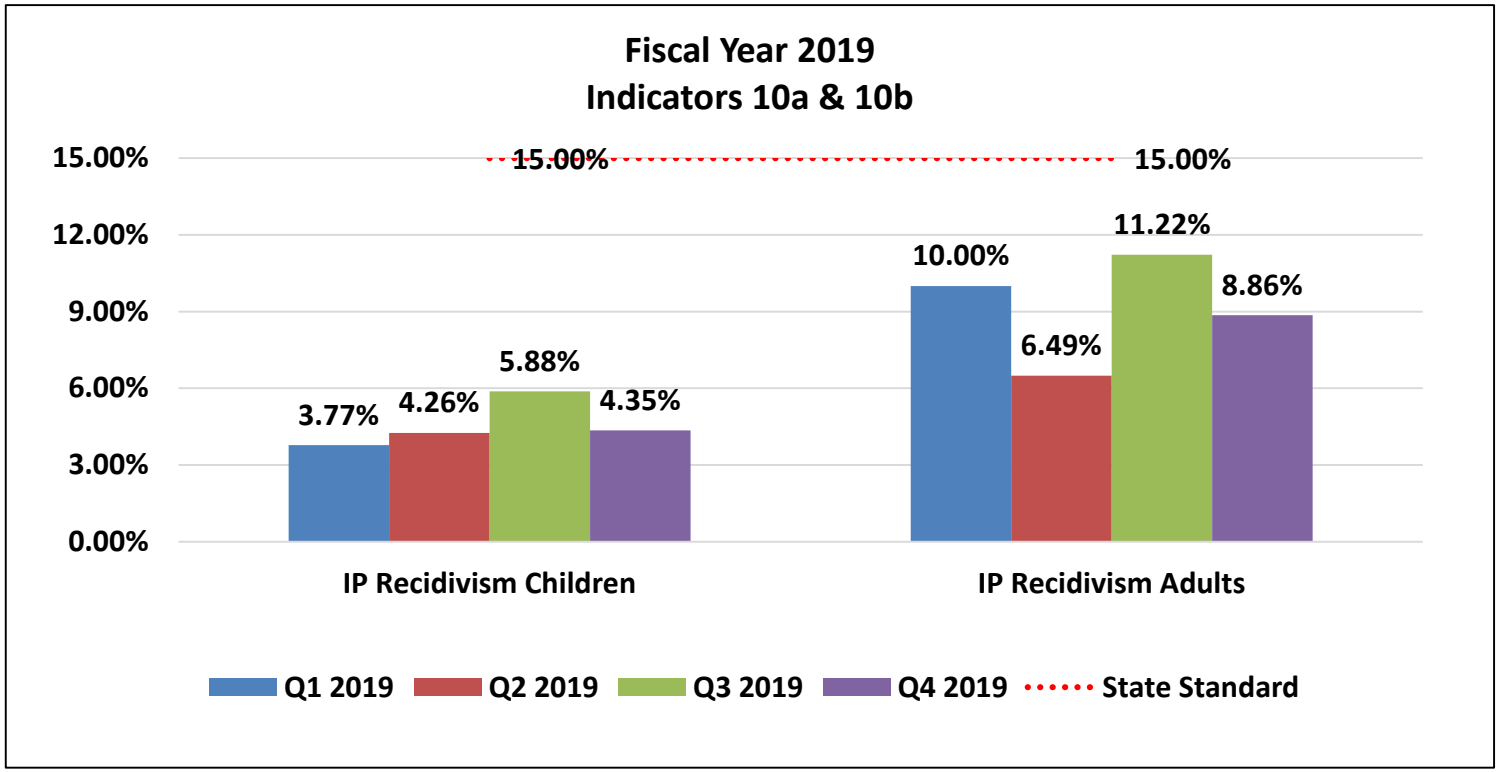
2019

Michigan Mission Based Performance Indicator System (MMBPIS)

MMBPIS - Fiscal Year 2019



MMBPIS - Fiscal Year 2019



Objective:
State defined indicators that are aimed at measuring access, quality of service and provide benchmarks for the state of Michigan and all (10) PIHPs.

Results:
59/68 or 86.7% of total Performance Indicators in 2019 met the State Standard of 95%:

- 1st Quarter = 14/17
- 2nd Quarter = 14/17
- 3rd Quarter = 16/17
- 4th Quarter = 15/17

MMBPIS - Fiscal Year 2019

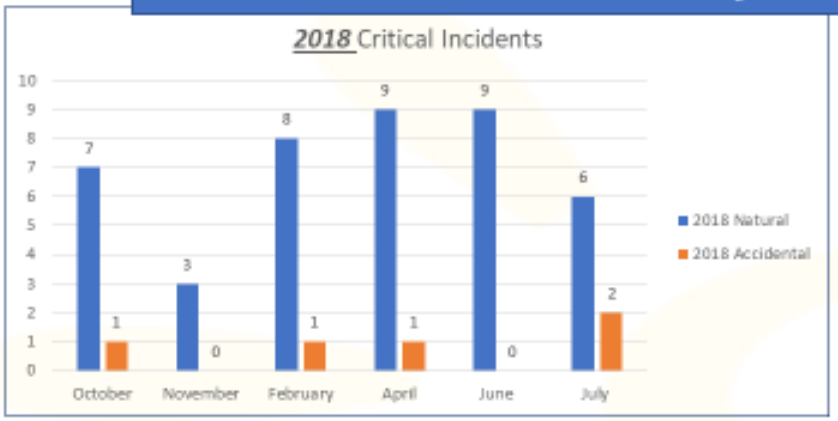
MMBPIS Performance Indicator	*State Standard*	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Pre-Admission Screening Children	95.00%	98.93%	99.49%	100.00%	98.25%
Pre-Admission Screening Adults	95.00%	99.36%	97.90%	98.28%	99.08%
Request to Intake MI Children	95.00%	99.35%	98.87%	100.00%	98.26%
Request to Intake MI Adults	95.00%	99.21%	98.97%	99.55%	99.37%
Request to Intake DD Children	95.00%	96.77%	100.00%	100.00%	100.00%
Request to Intake DD Adults	95.00%	100.00%	100.00%	100.00%	100.00%
Request to Intake SA	95.00%	98.39%	96.55%	97.02%	97.58%
First Service MI Children	95.00%	94.61%	95.26%	97.72%	96.36%
First Service MI Adults	95.00%	97.91%	97.11%	97.16%	95.96%
First Service DD Children	95.00%	91.23%	100.00%	96.83%	100.00%
First Service DD Adults	95.00%	100.00%	93.10%	96.77%	88.89%
First Service SA	95.00%	95.83%	91.70%	91.43%	91.67%
IP Follow Up Children	95.00%	100.00%	100.00%	97.14%	96.88%
IP Follow Up Adults	95.00%	98.62%	97.01%	98.44%	97.49%
Detox Follow Up	95.00%	93.98%	94.64%	97.04%	95.05%
IP Recidivism Children	15.00%	3.77%	4.26%	5.88%	4.35%
IP Recidivism Adults	15.00%	10.00%	6.49%	11.22%	8.86%
Overall Results		14/17	14/17	16/17	15/17

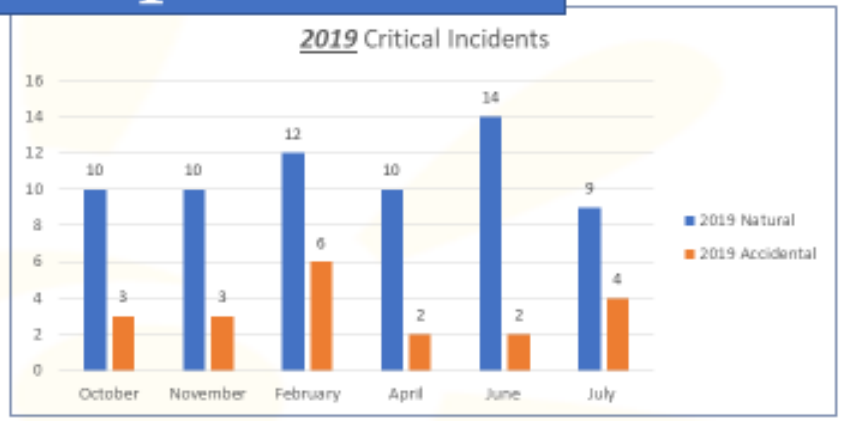
2019

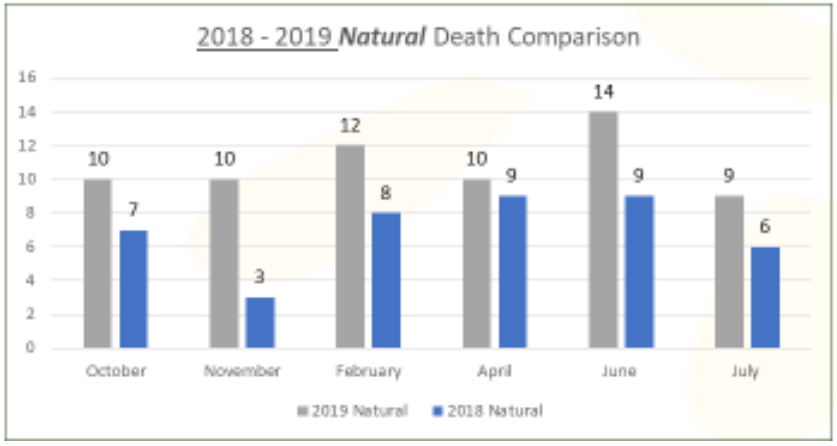
Critical Incident Analysis

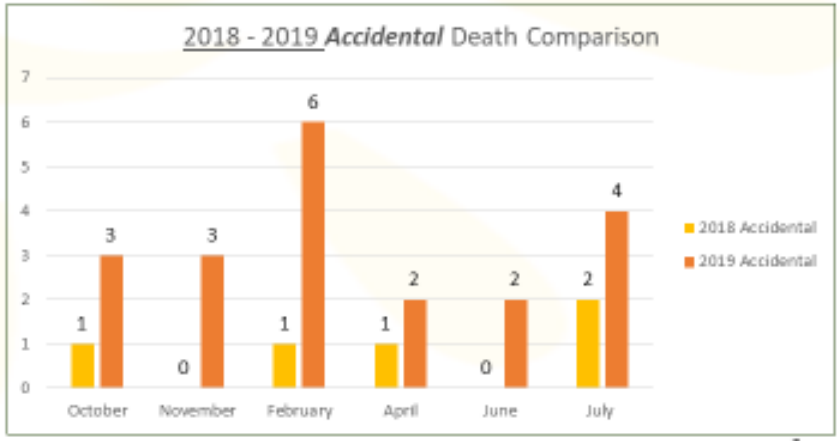
Critical Incident (CI) Analysis – Fiscal Year 2019

2018 vs 2019 Comparison

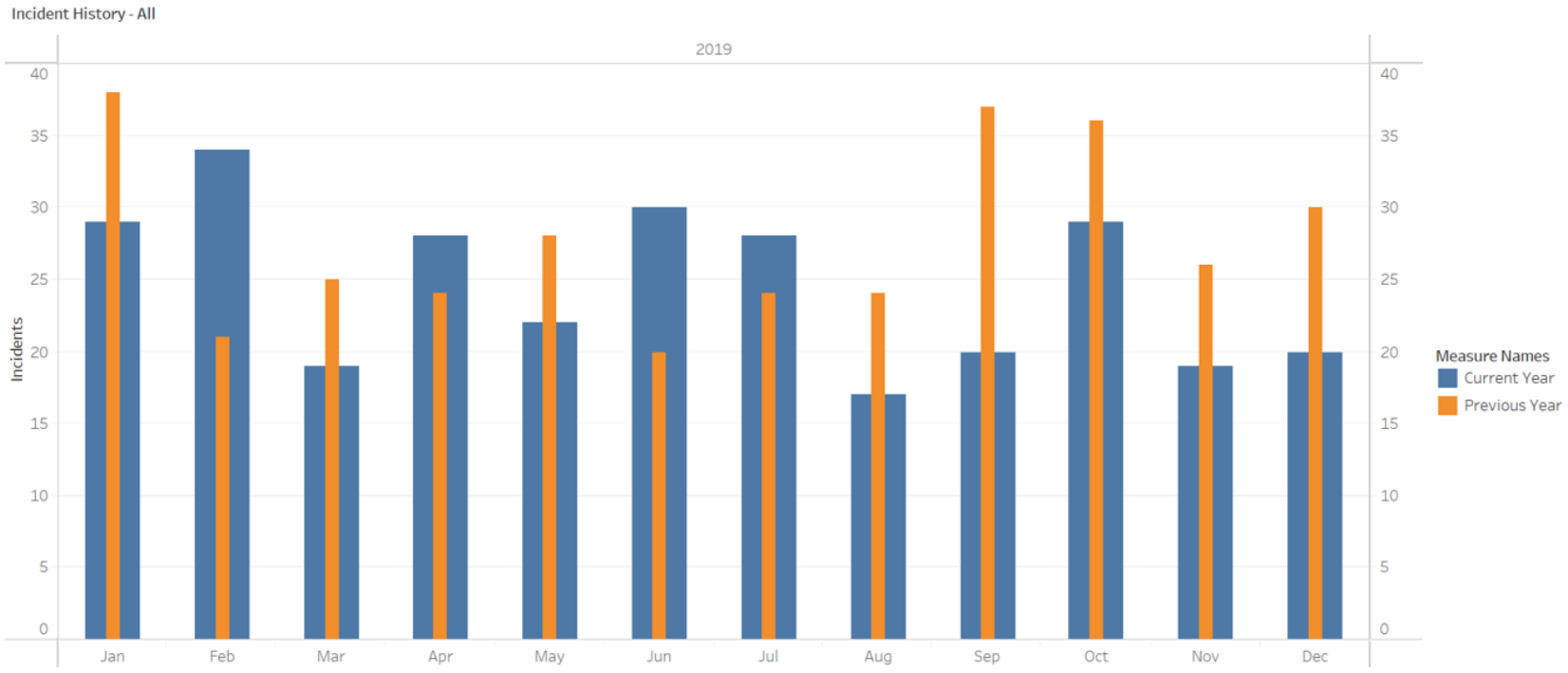






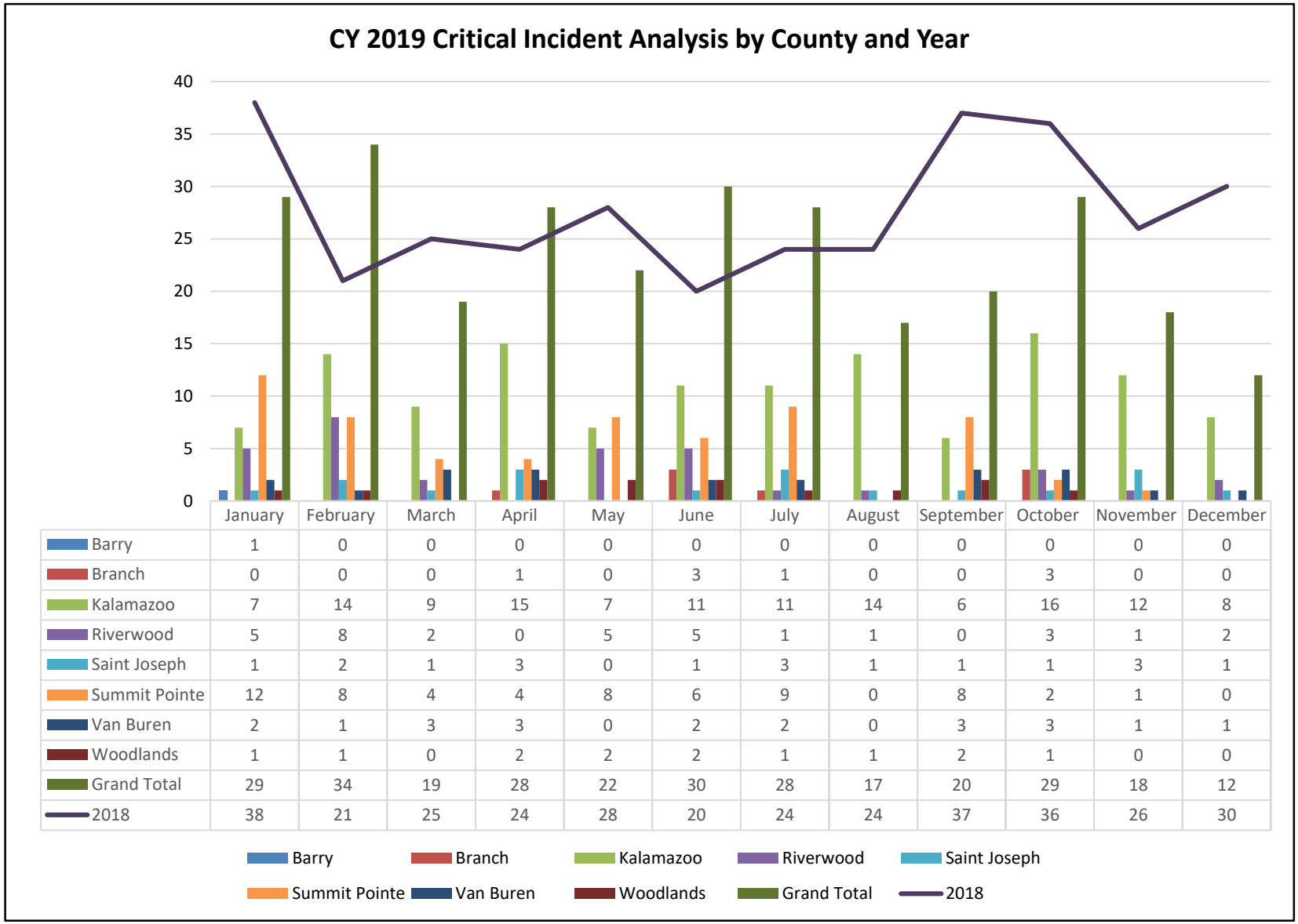


Critical Incident (CI) Analysis – Yearly Comparison



Blue= Current Year (2019) **Orange**= Previous Year (2018)

Critical Incident (CI) Analysis – Fiscal Year 2019

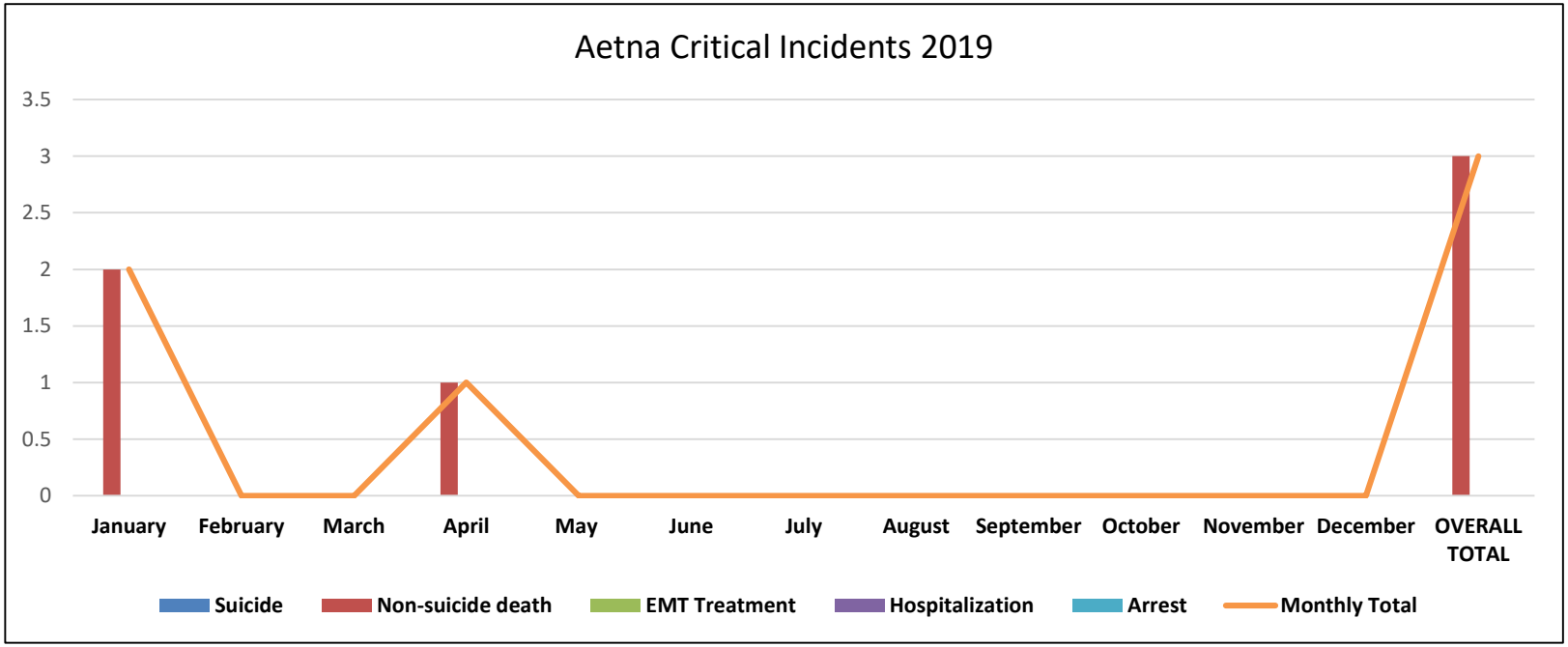


	January	February	March	April	May	June	July	August	September	October	November	December
Barry	1	0	0	0	0	0	0	0	0	0	0	0
Branch	0	0	0	1	0	3	1	0	0	3	0	0
Kalamazoo	7	14	9	15	7	11	11	14	6	16	12	8
Riverwood	5	8	2	0	5	5	1	1	0	3	1	2
Saint Joseph	1	2	1	3	0	1	3	1	1	1	3	1
Summit Pointe	12	8	4	4	8	6	9	0	8	2	1	0
Van Buren	2	1	3	3	0	2	2	0	3	3	1	1
Woodlands	1	1	0	2	2	2	1	1	2	1	0	0
Grand Total	29	34	19	28	22	30	28	17	20	29	18	12
2018	38	21	25	24	28	20	24	24	37	36	26	30

2019

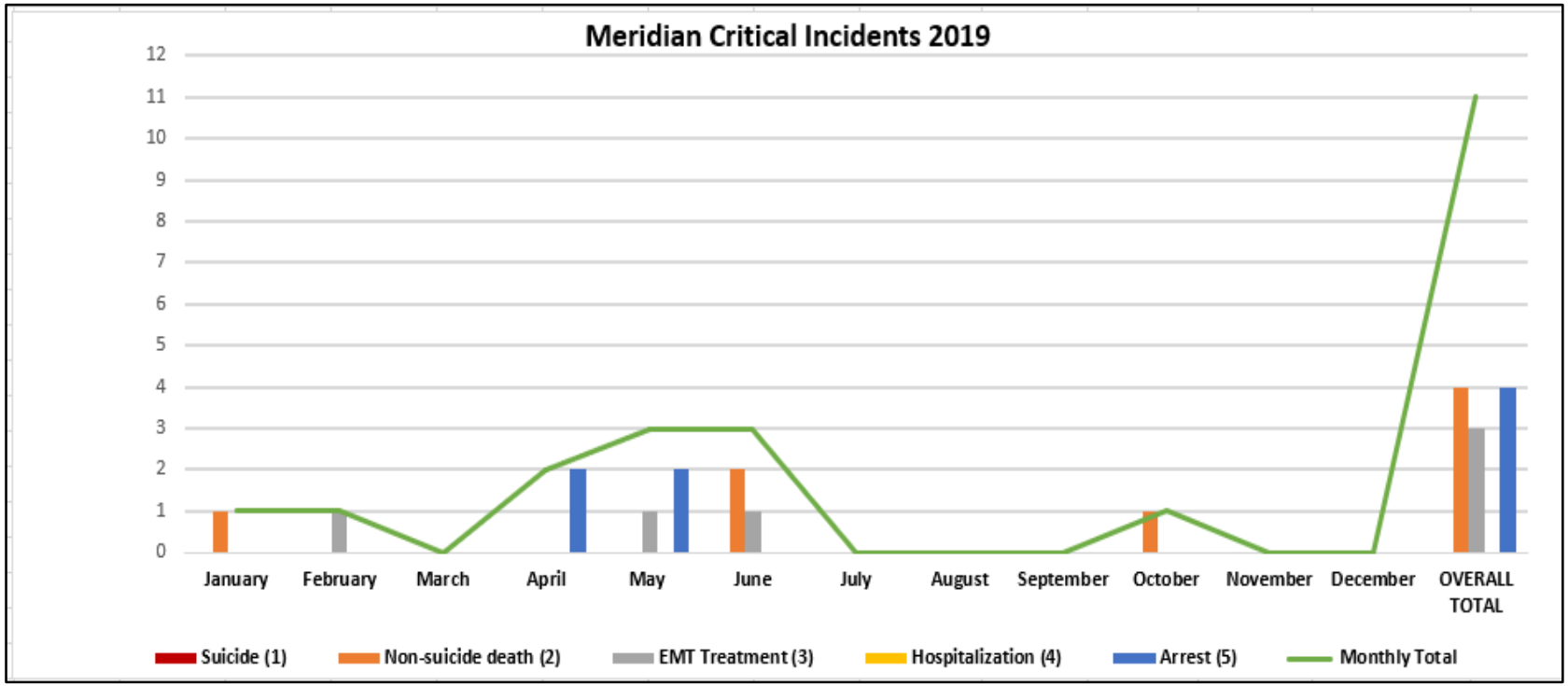
MI Health Link Critical Incident Analysis

Aetna Critical Incident (CI) Analysis Calendar Year 2019



	2019-Q1			2019-Q2			2019-Q3			2019-Q4			
	January	February	March	April	May	June	July	August	September	October	November	December	OVERALL TOTAL
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death	2	0	0	1	0	0	0	0	0	0	0	0	3
EMT Treatment	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly Total	2	0	0	1	0	0	0	0	0	0	0	0	3

Meridian Critical Incident (CI) Analysis Calendar Year 2019



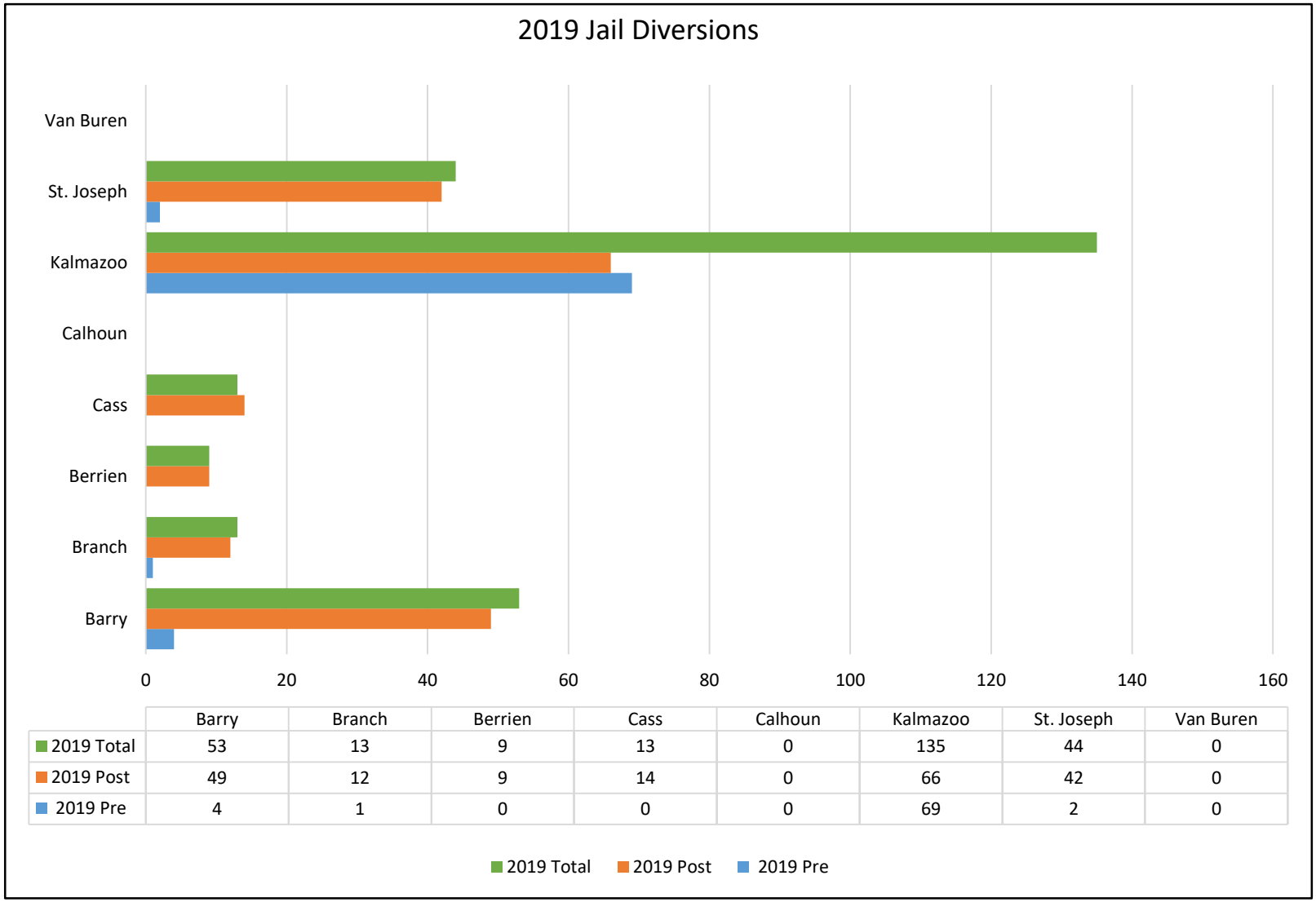
	2019-Q1			2019-Q2			2019-Q3			2019-Q4			OVERALL TOTAL
	January	February	March	April	May	June	July	August	September	October	November	December	
Suicide (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death (2)	1	0	0	0	0	2	0	0	0	1	0	0	4
EMT Treatment (3)	0	1	0	0	1	1	0	0	0	0	0	0	3
Hospitalization (4)	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest (5)	0	0	0	2	2	0	0	0	0	0	0	0	4
Monthly Total	1	1	0	2	3	3	0	0	0	1	0	0	11

Southwest Michigan
BEHAVIORAL HEALTH

2019

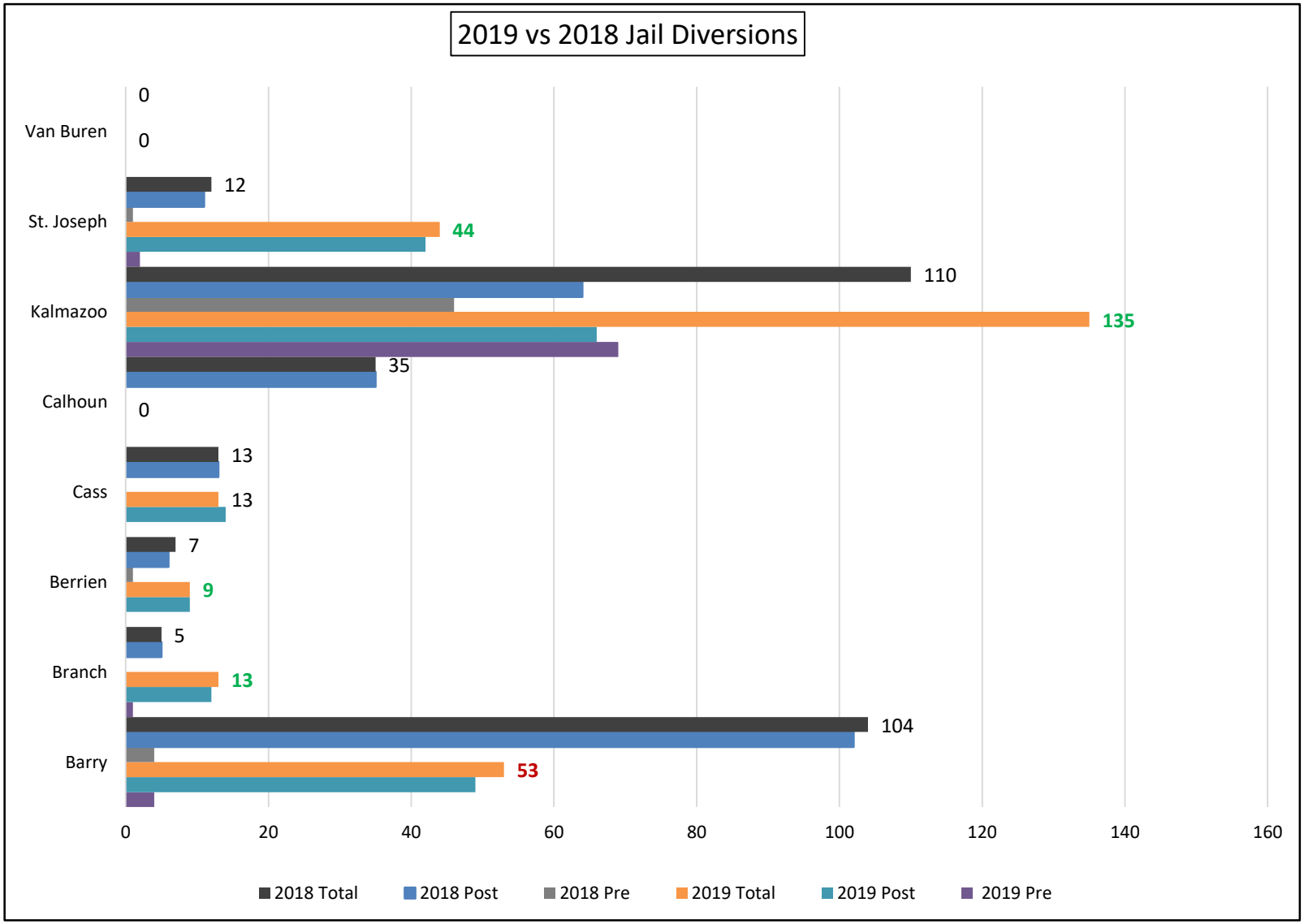
Jail Diversion Data

Jail Diversion Data – FY 2019



	Barry	Branch	Berrien	Cass	Calhoun	Kalmazoo	St. Joseph	Van Buren
2019 Total	53	13	9	13	0	135	44	0
2019 Post	49	12	9	14	0	66	42	0
2019 Pre	4	1	0	0	0	69	2	0

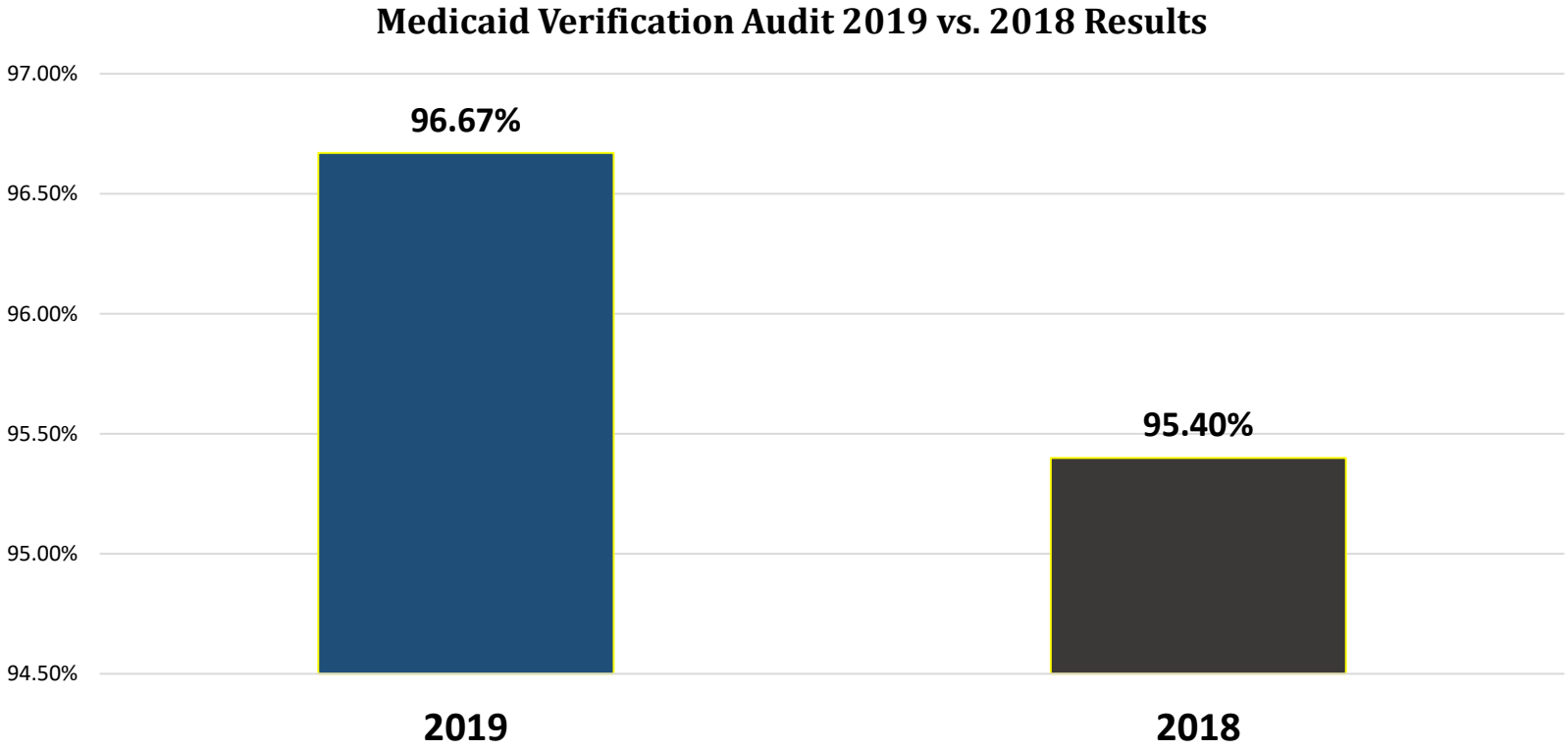
Jail Diversion Data – FY 2019



2019

Medicaid Verification

Medicaid Verification Data – FY 2019



- In 2019 the Medicaid claims verification compliance was 96.67% with 1860 total claims reviewed with 62 invalid claims identified.
- In 2018 the Medicaid claims verification compliance rate was 96.25% with 1,770 and 83 invalid claims identified.
- Overall, the result was a 1.27% improvement in the claims verification rate over the previous year's result.

2019

Site Reviews

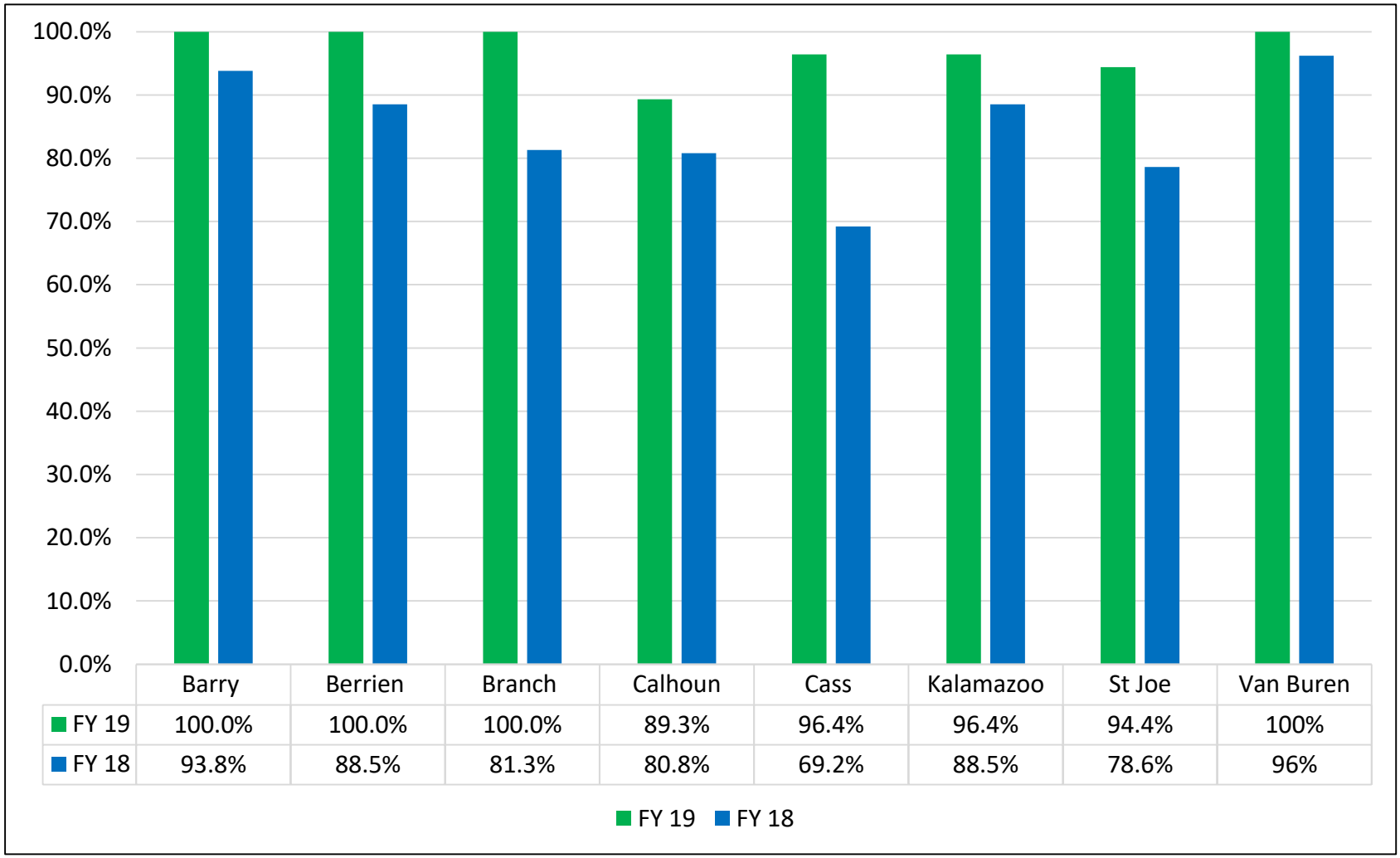
2019 Site Reviews

2019 Provider Network CMHSP Site Reviews

Summary Score		
Standard	2019 Section Score	2018 Section Score
Access and Utilization Management	75.4%	76.9%
Claims Management	88.7%	70.8%
Compliance	96.9%	80.5%
Credentialing	94.9%	98.2%
Customer Services	91.3%	96.8%
Grievances and Appeals	93.5%	94.2%
Provider Network	90.5%	86.9%
Quality	97.1%	84.6%
Staff Training	90.4%	98.5%
SUD EBP Fidelity and Administration	91.1%	99.0%

- Red indicates Section Score decreased from 2017.
- Green Indicates Section Score increased from 2017.

2019 Site Reviews



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100%
FY 18	93.8%	88.5%	81.3%	80.8%	69.2%	88.5%	78.6%	96%

Southwest Michigan
BEHAVIORAL HEALTH

2019
External Audit and Reviews Compliance

NCQA – National Committee for Quality Assurance

On March 2, 2018 Southwest Michigan Behavioral Health (SWMBH) earned full Managed Behavioral Health Organization (MBHO) Accreditation for their MI Health Link Business Line from the National Committee for Quality Assurance (NCQA). NCQA is an independent 501(c) (3) not-for-profit organization dedicated to improving health care quality and has been a central figure in helping to elevate the issue of healthcare quality in the national agenda by driving improvement throughout the health care system.

Accreditation is a nationally recognized evaluation that consumers, providers, and regulators may use to assess managed NCQA behavioral health organizations (MBHOs). NCQA evaluates the implementation of evidence-based standards, measures, programs, and continuous quality improvement practices by organizations striving for excellence in administration and delivery of services. The NCQA review process includes rigorous on-site and off-site evaluations conducted by a team of physicians and managed care experts. A national oversight committee of physicians and behavioral health providers analyzes the team's findings and assigns an accreditation level based on the MBHO's performance compared to NCQA standards. For more information: http://www.ncqa.org/programs/accreditation/managed-behavioral-healthcareorganization-mbho

2019 Health Services Advisory Group (HSAG) Performance Measure Validation Results

The following report represents a summary of preliminary findings during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 23, 2019, at Southwest Michigan Behavioral Health.

Results:

37/37 or 100% Of Total Elements Evaluated received a designation score of "Met," "Reportable," or "Accepted."

This meets the *successful completion of our 2019 Board Ends Metric*, which indicates: 95% of Elements Evaluated/Measured shall receive a score of "Met."

The detailed results for each category and element evaluated can be found below:

Scoring Category	Performance Results
Accepted	3/3 – 100% Data Integration Elements Evaluated was ***"Accepted"*** and met full compliance standards.
Reportable	12/12 – 100% Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications, and the percentage reported.
Met	13/13 – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	9/9 – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance Standard.

Data Integration, Control, and Performance Indicator Elements Evaluated:

Standard	Scoring Criteria "Acceptable or "Not Acceptable"	Recommendation
1). Data Integration	Acceptable – 100%	Full Compliance
2). Data Control	Acceptable – 100%	Full Compliance
3). Performance Indicator Documentation	Acceptable – 100%	Full Compliance

2019

Utilization Management Program Evaluation

FY 2020 Utilization Management Goals

- Complete the Health Services Advisory Group 2020 audit with 90% or higher compliance for Customer Services, Grievances, and Appeals.

- Review and update regional processes for MHL and SUD Adverse Benefit Determinations
  - To ensure effective and efficient communication and notification of rights to members
  - Define what is being sent by whom, why and when

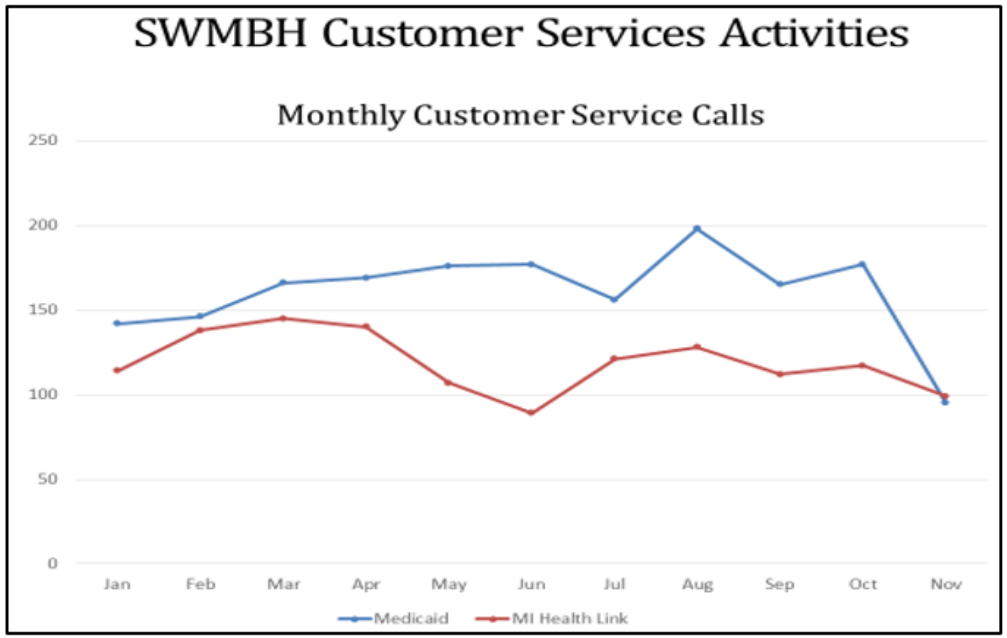
- Define and implement a regional process to notify members of denials of payment
  - This is in response to 2019 HSAG audit
  - Templates and method will be developed for both MI Health Link and Medicaid

2019

Grievance and Appeals

2019 Grievance and Appeals

Customer Service Information: (Measurement Period: October 1, 2018 – September 30, 2019)



In FY 19 Customer Service fielded
3071 phone calls
Medicare Customer Service Line:
1761 calls
MHL Member Service Line: 1310
Completed 800 follow up calls
692 members were discharged from Substance Use Disorder Residential Settings
108 members were discharged from Inpatient Psychiatric setting

In FY 19, Customer Service Managed/provided oversite of 360 grievances and appeals:
❖ MA/HMP/BG Appeals reported: **103**
❖ MA/HMP/BG Grievances reported: **217**
❖ MA/MHL Fair Hearings reported: **15**
❖ MA/HMP/BG Second Opinions reported: **16**
❖ MI Health Link Grievances reported**: 4**
❖ MI Health Link Appeals reported: **5**

298

2019 Grievance and Appeals

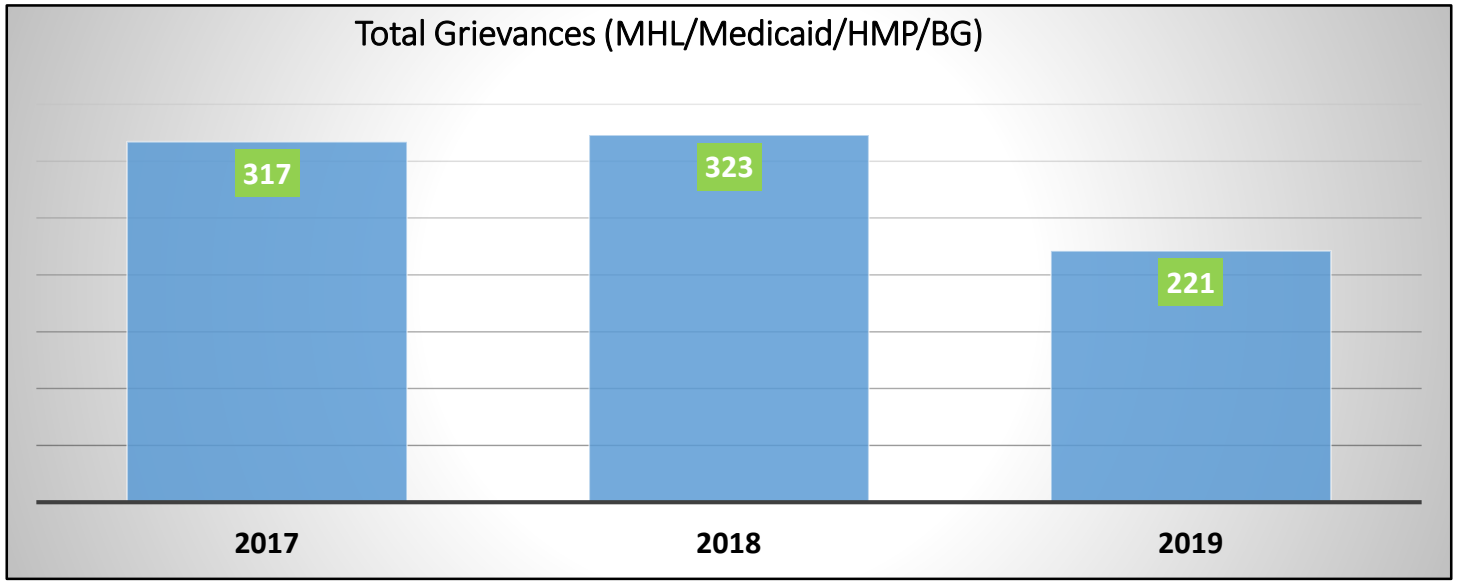
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data FY 2019						
SWMBH REGIONAL TOTAL (MA/HMP/BG)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn	1				**1**
	Decision Upheld/Affirmed	18	22	22	6	**68**
	Decision Overturned	5	7	9	7	**28**
	Settled/Resolved	2		2	2	**6**
Access 2nd Opinions	Withdrawn		4			**4**
	Decision Upheld/Affirmed	2	2	1	2	**7**
	Decision Overturned		1	1	1	**3**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed			1	1	**2**
	Decision Overturned					**0**
	Settled/Resolved					**0**
	Decision Affirmed	2			2	**4**
	Decision Overturned			1		**1**
	Settled/Resolved					**0**
Grievances	Withdrawn	3	1	3	1	**8**
	Settled/Resolved	57	61	55	44	**217**
TOTAL Events:		**90**	**98**	**95**	**66**	**349**

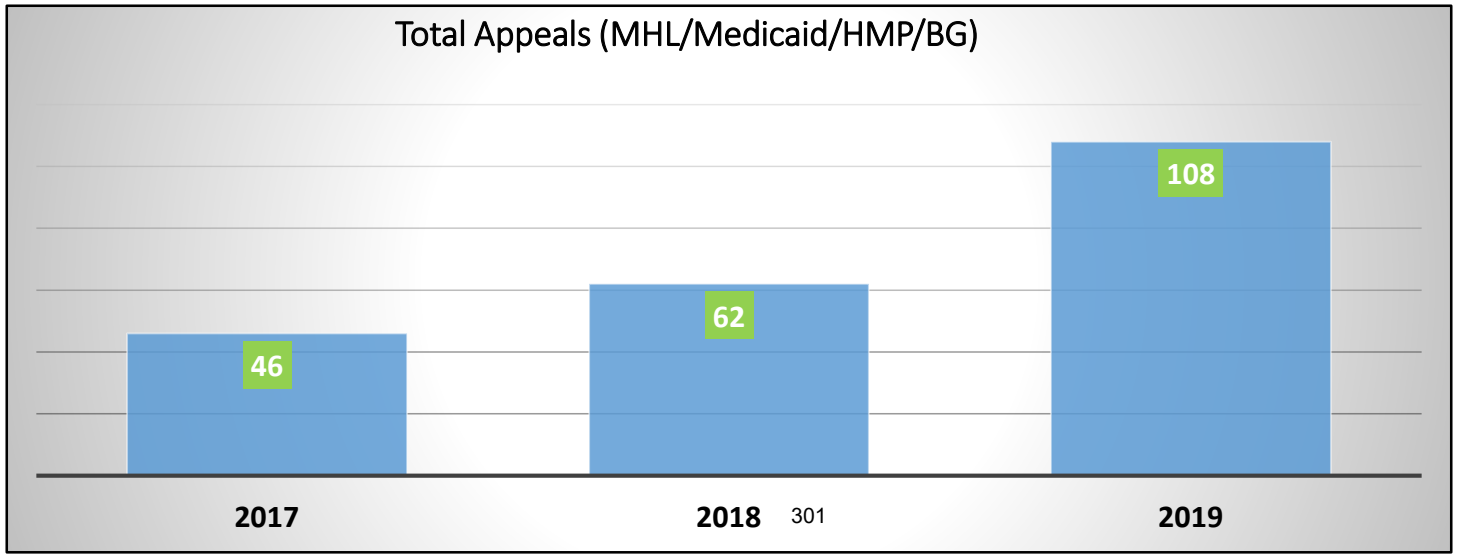
2019 Grievance and Appeals

Southwest Michigan Behavioral Health Customer Grievance and Appeal Data CY January 2019 – December 2019 SWMBH REGIONAL TOTAL (MHL)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn					**0**
	Decision Upheld/Affirmed	2	1			**3**
	Decision Overturned	1	1			**2**
	Settled/Resolved					**0**
Access 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Administrative Medicaid (Fair) Hearing	Withdrawn					**0**
	Decision Affirmed		1			**1**
	Decision Overturned					**0**
	No Show					**0**
	Settled/Resolved					**0**
Grievances	Withdrawn			1		**1**
	Settled/Resolved		1	3	0	**4**
	Recipient Rights Referral					**0**
TOTAL Events:		**3**	**4**	**4**	**0**	**11**

- A decrease of 15 Grievance and Appeals has been observed in comparison to the previous year (2019 vs. 2018)

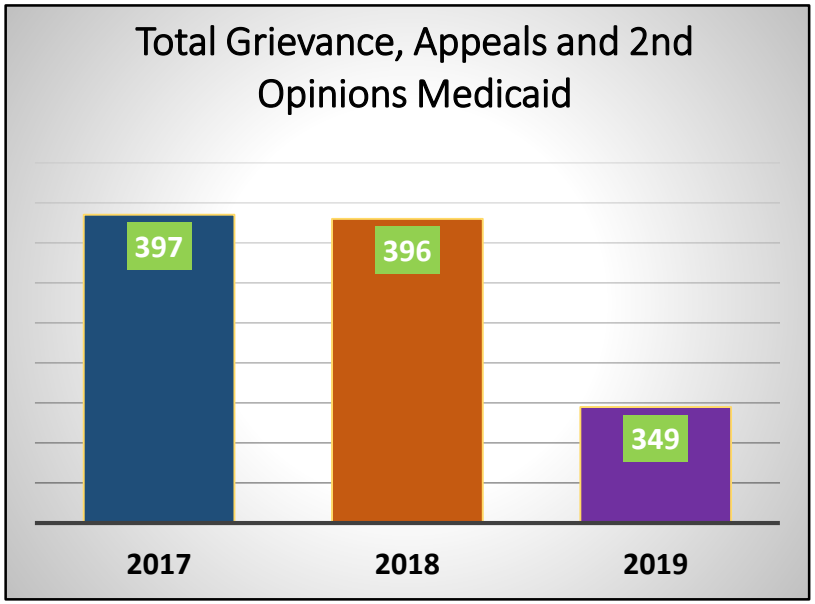
2019 Grievance and Appeals

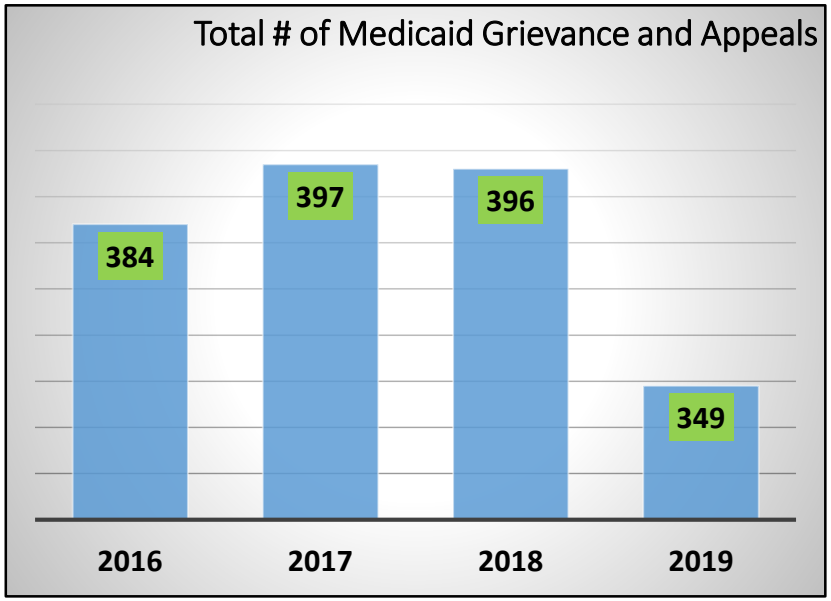


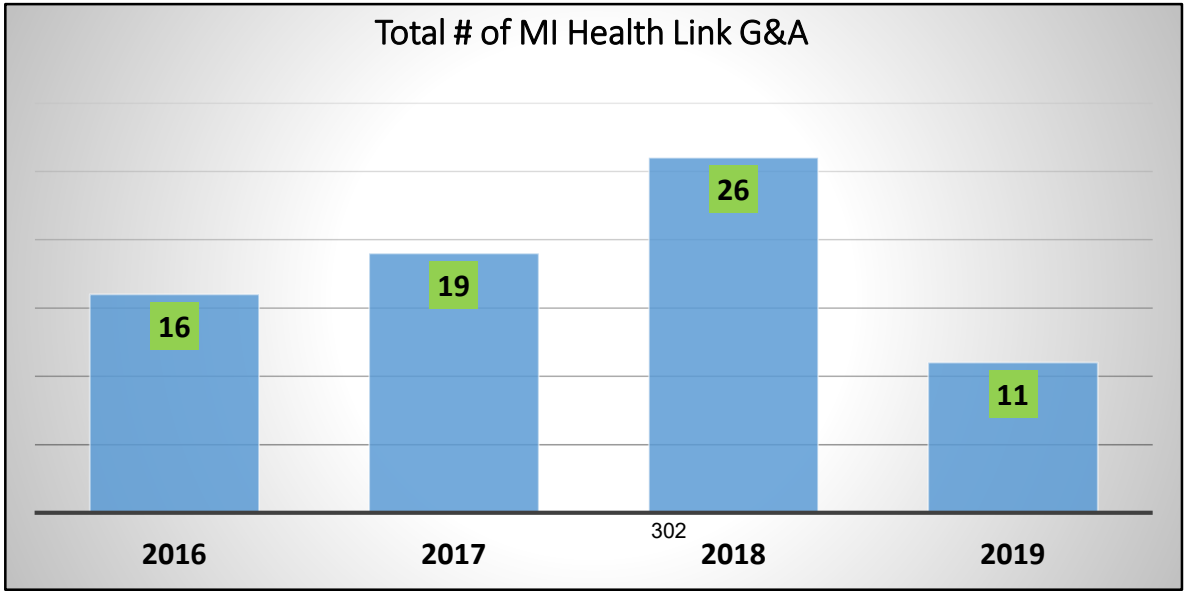


301

2019 Grievance and Appeals





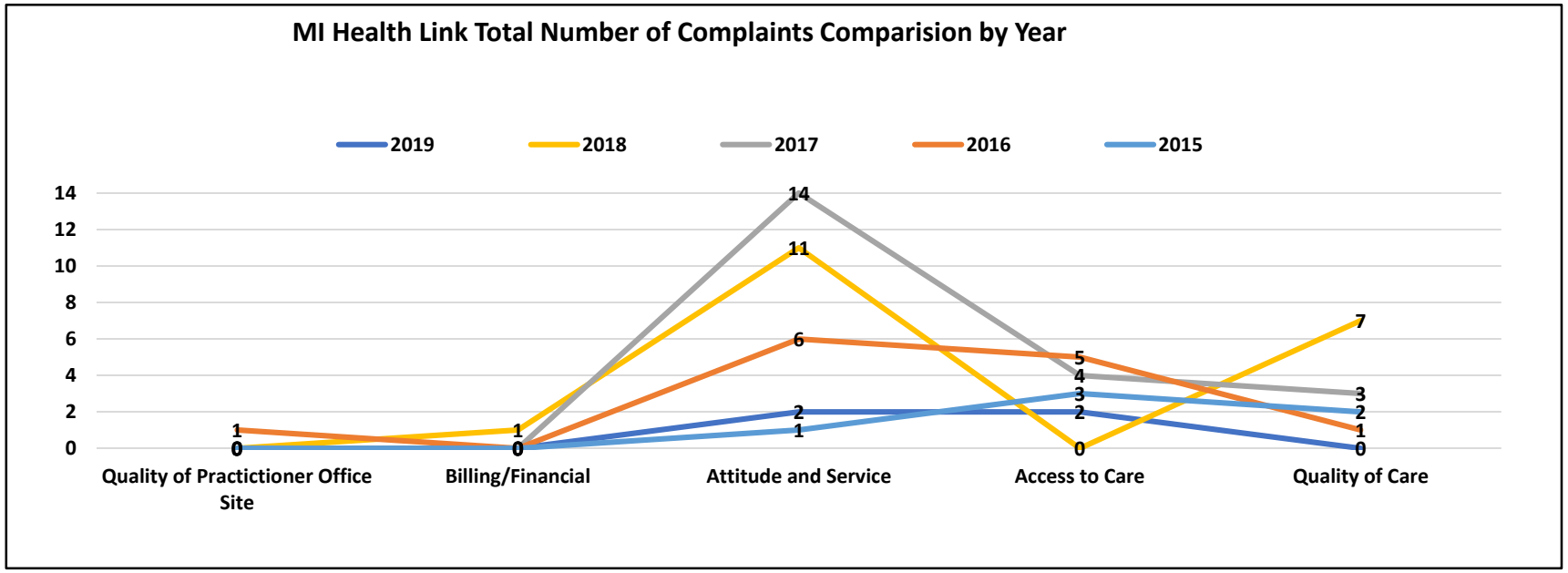


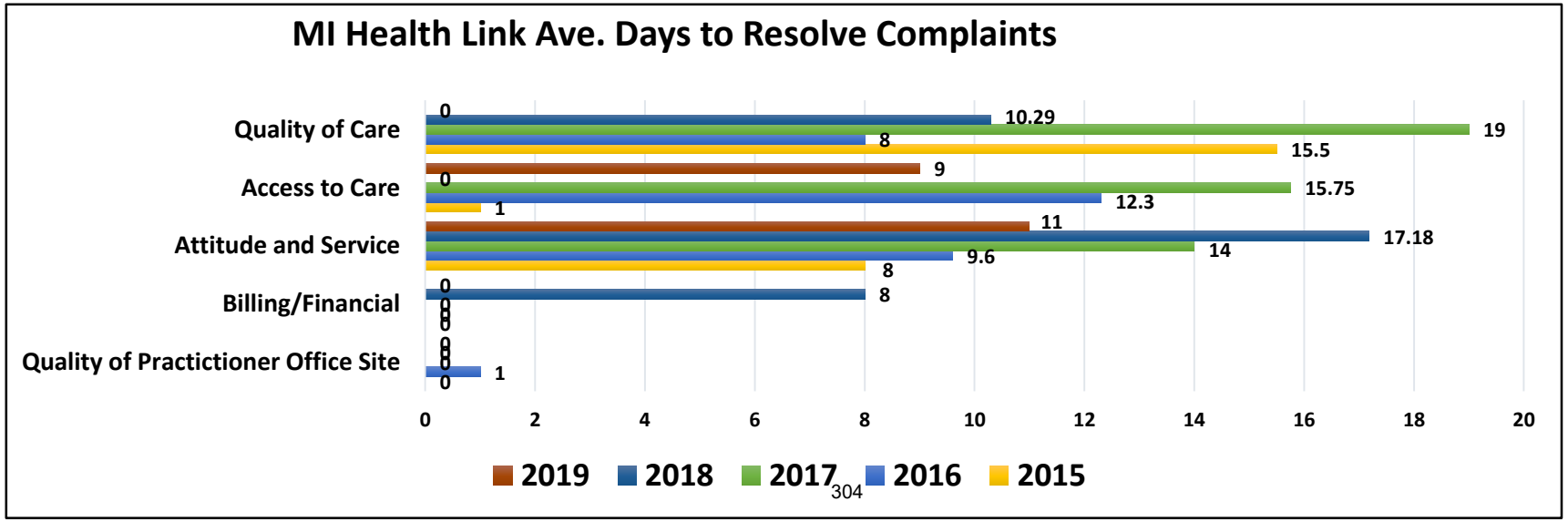
302

Southwest Michigan
BEHAVIORAL HEALTH

2019
MI Health Link Complaints

2019 MHL Complaints





2019 MHL Qualitative Analysis on Member Complaint Data

MI Health Link Qualitative Analysis on Member Complaint Data

Complaints & Grievances- A casual and trend analysis has been completed and reviewed during the regional MHL Committee meeting to, identify opportunities for improvement, and implement interventions.

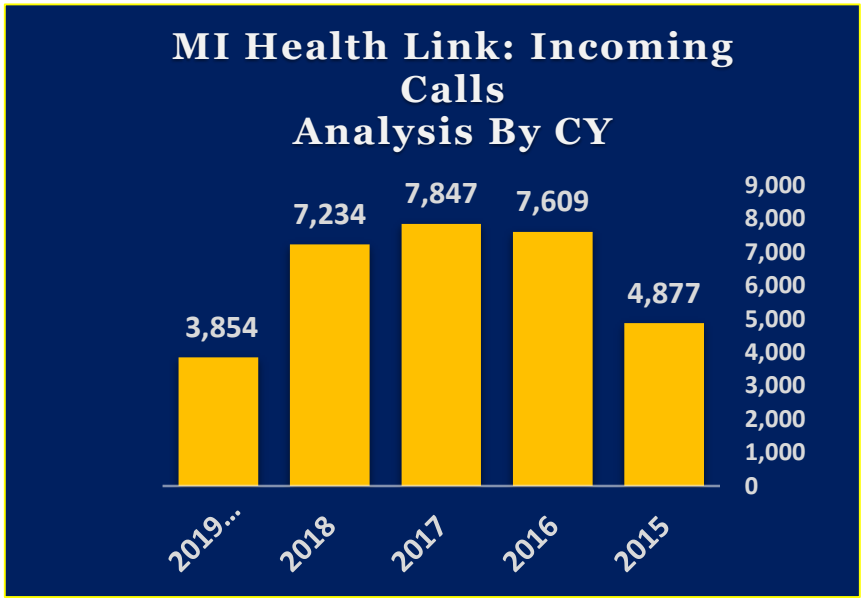
The following table shows the aggregate complaint total and rate per 1,000 MHL members for the past three years

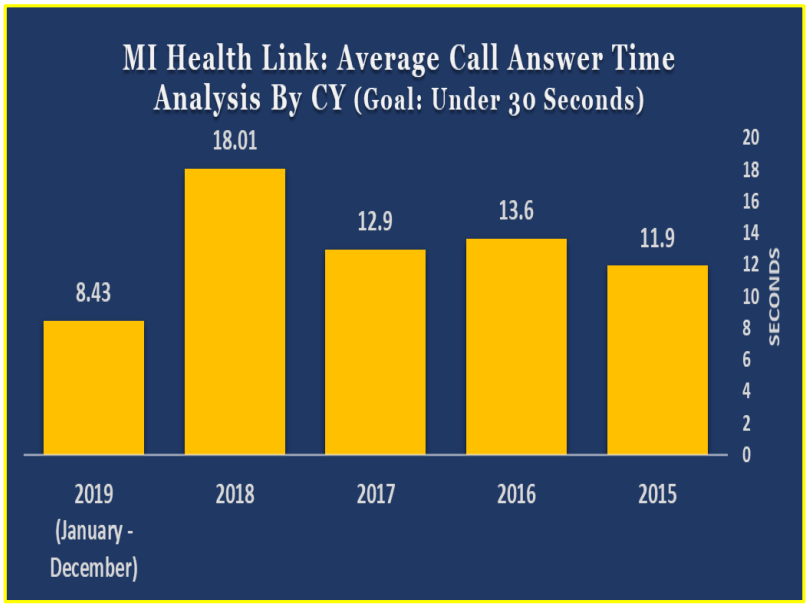
CATEGORY	2019 (10,673) MEMBERS	2018 (9,586) MEMEBRS	2017 (11,179) MEMBERS	2016 (8,024) MEMBERS	2015 (5,186) MEMBERS
QUALITY OF CARE	0/0	3/0.313	3/0.268	1/0.125	2/0.386
ACCESS	2/0.187	0/0	4/0.358	5/0.623	3/0.578
ATTITUDE/SERVICE	2/0.187	11/1.148	14/1.252	6/0.784	1/0.193
BILLING/FINANCIAL	0/0	1/0.104	0/0	0/0	0/0
QUALITY OF PRACTITIONER OFFICE SITE	0/0	0/0	0/0	1/0.125	0/0
TOTAL	2/0.187	15/1.565	21/1.879	13/1.869	6/1.157

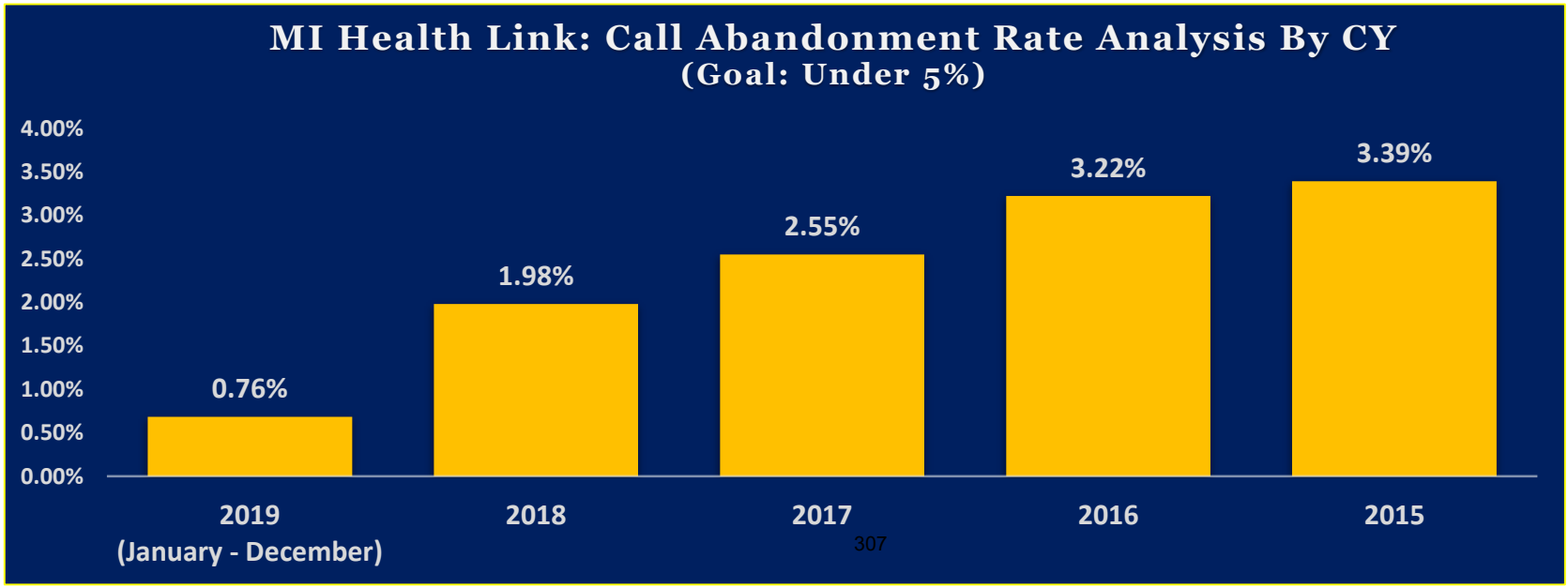
2019

Call Center Data

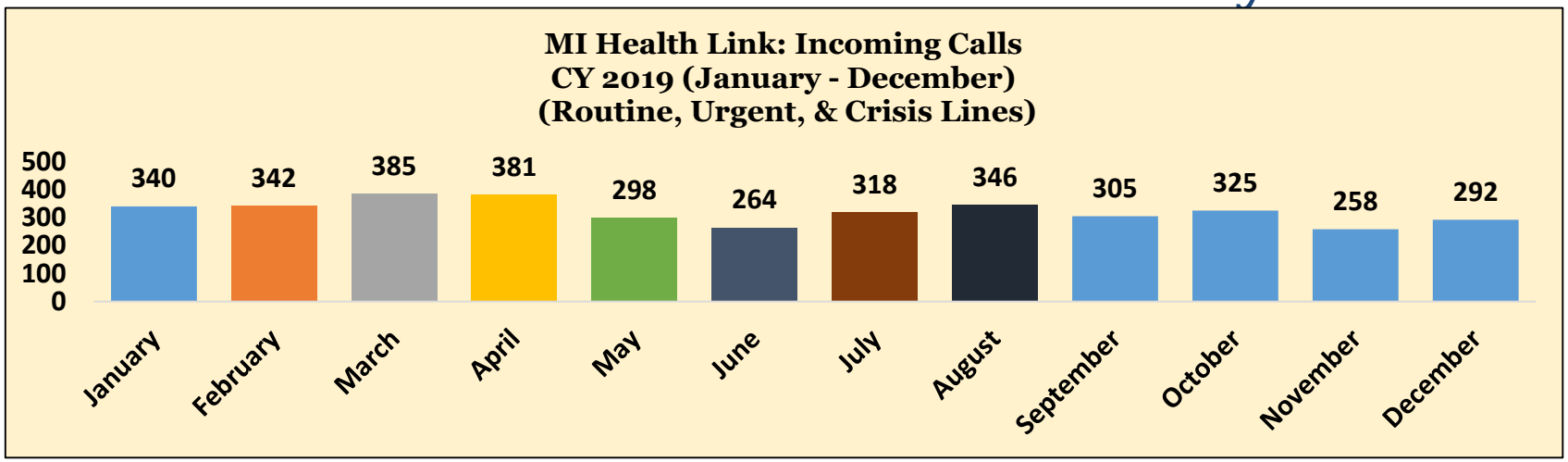
2019 MHL Call Center Data Analysis

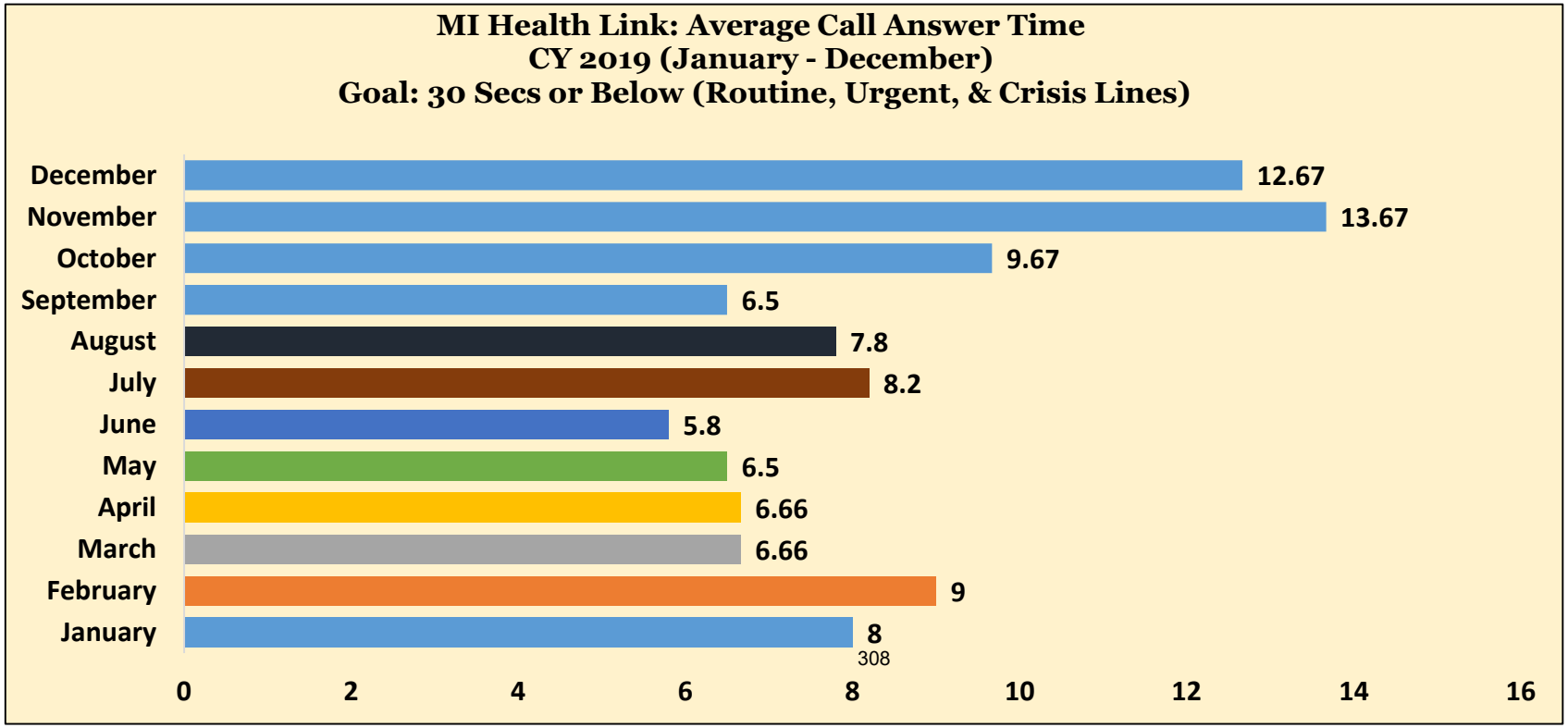


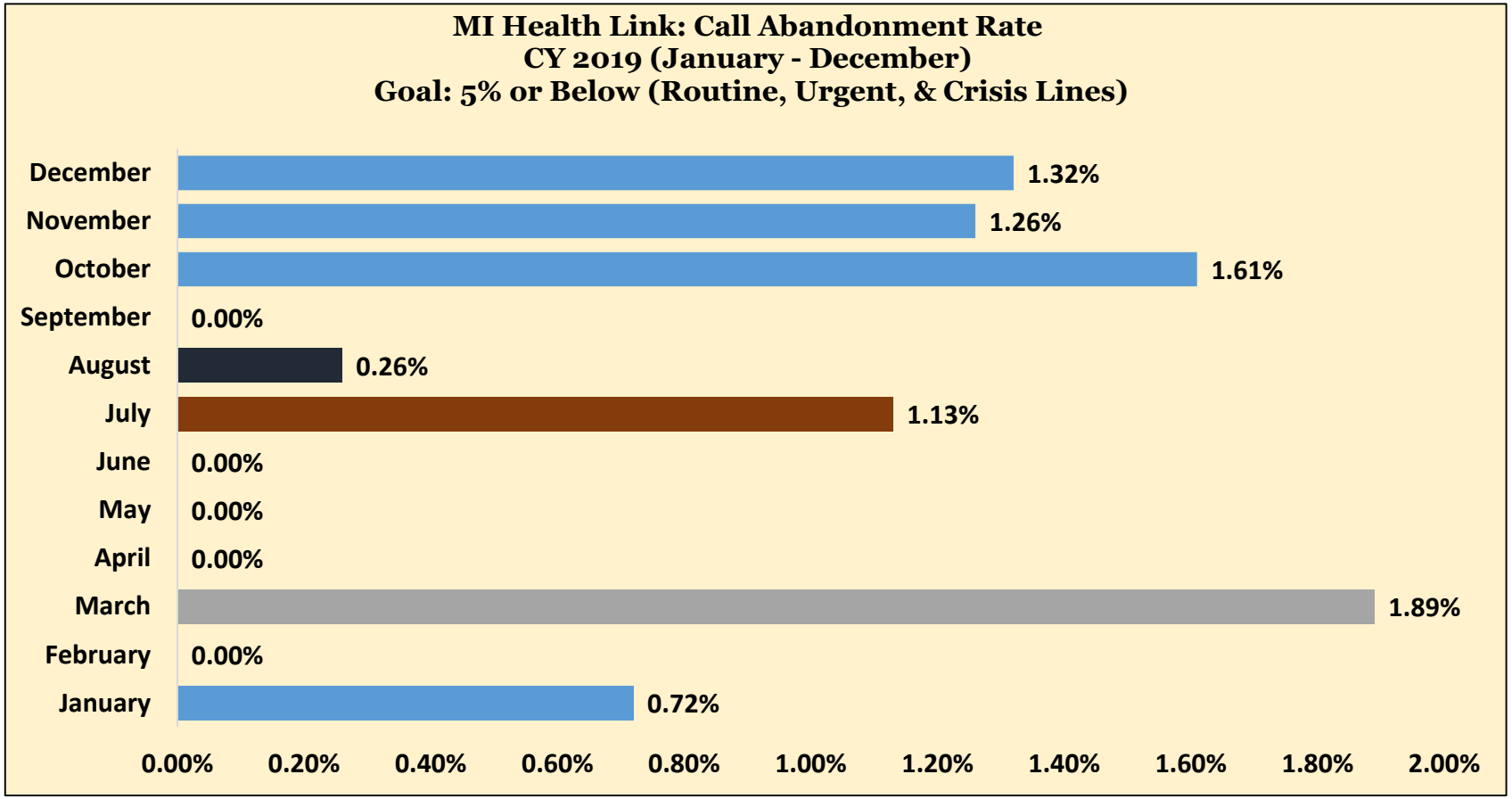




2019 MHL Call Center Data Analysis






MI Health Link: Call Abandonment Rate
CY 2019 (January - December)
Goal: 5% or Below (Routine, Urgent, & Crisis Lines)
December
November
October
September
August
July
June
May
April
March
February
January
1.32%
1.26%
1.61%
0.00%
0.26%
1.13%
0.00%
0.00%
0.00%
1.89%
0.00%
0.72%
0.00%
0.20%
0.40%
0.60%
0.80%
1.00%
1.20%
1.40%
1.60%
1.80%
2.00%

2019

Enrollment Eligibility Breakdown in MHL Demonstration

MHL Enrollment by County

**Data includes MI Health Link Business Line for both Aetna and Meridian (ICO Partners) **
Data Snapshot taken 1/27/20

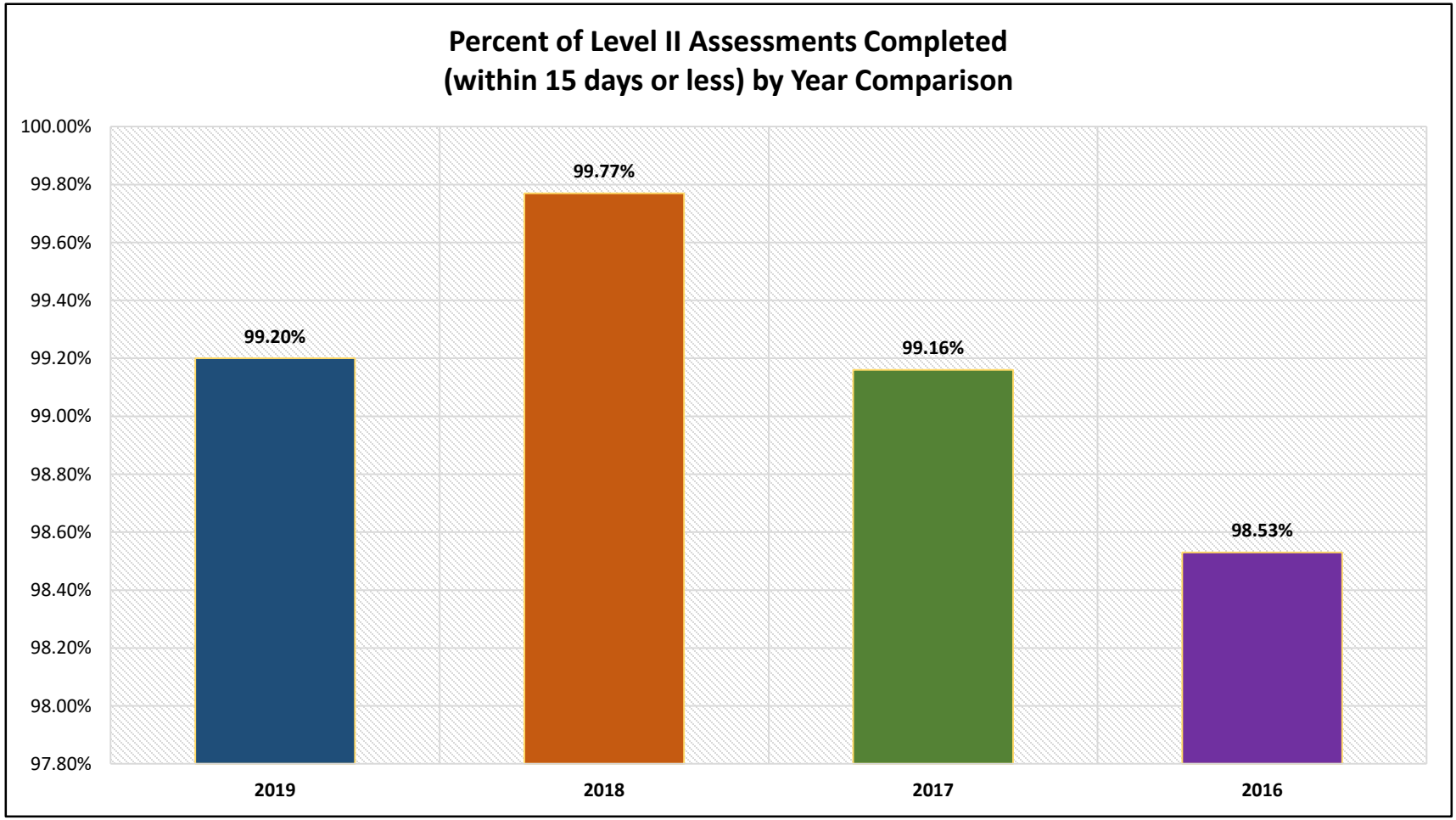
County Name	# Consumers Covered	# Consumers Served	# of Encounters
Kalamazoo	2,653	388	35,900
Calhoun	2,337	277	14,000
Berrien	2,237	166	9,031
Van Buren	1,133	135	7,700
St. Joseph	785	77	4,086
Cass	577	72	5,400
Branch	512	71	4,200
Barry	439	66	1,300
Total:	**10,673**	**1,252**	**81,617**

2019

MI Health Link

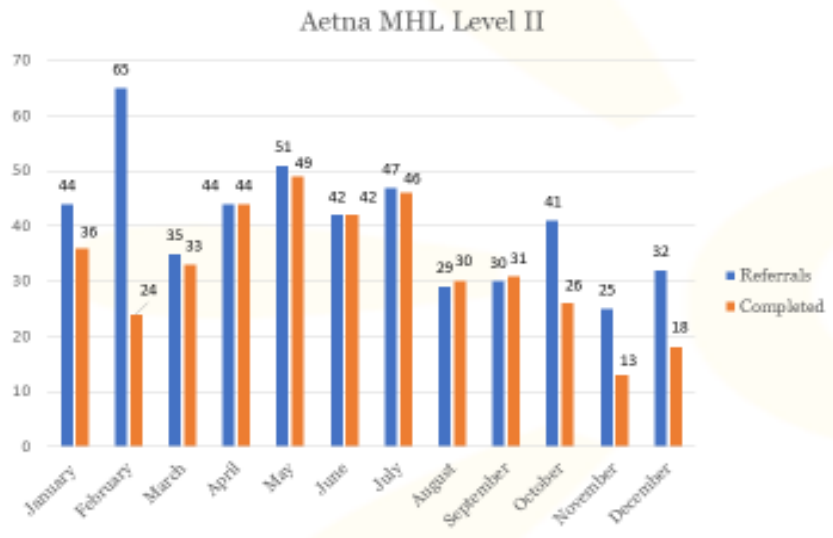
Level II Assessment Timeliness Report

MHL Level II Assessment Timeliness Report

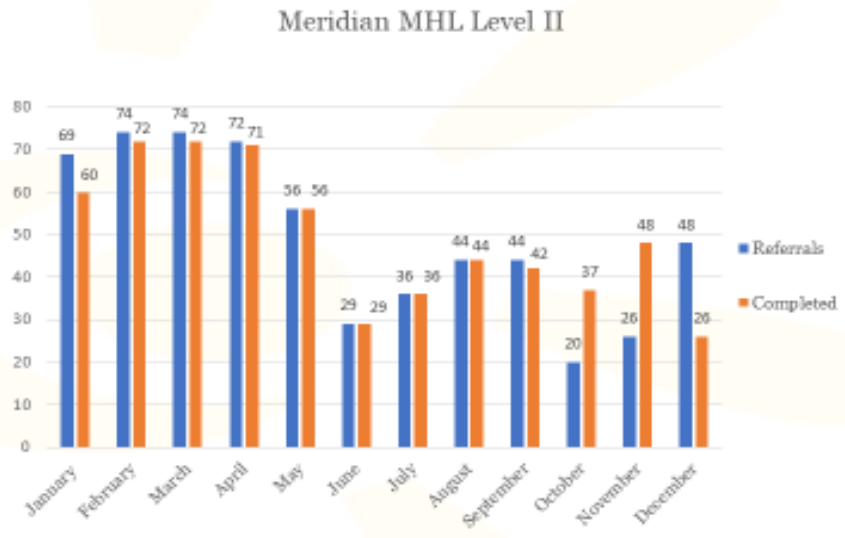


MHL Level II Assessment Timeliness Report

LEVEL II ASSESSMENT COMPLETION



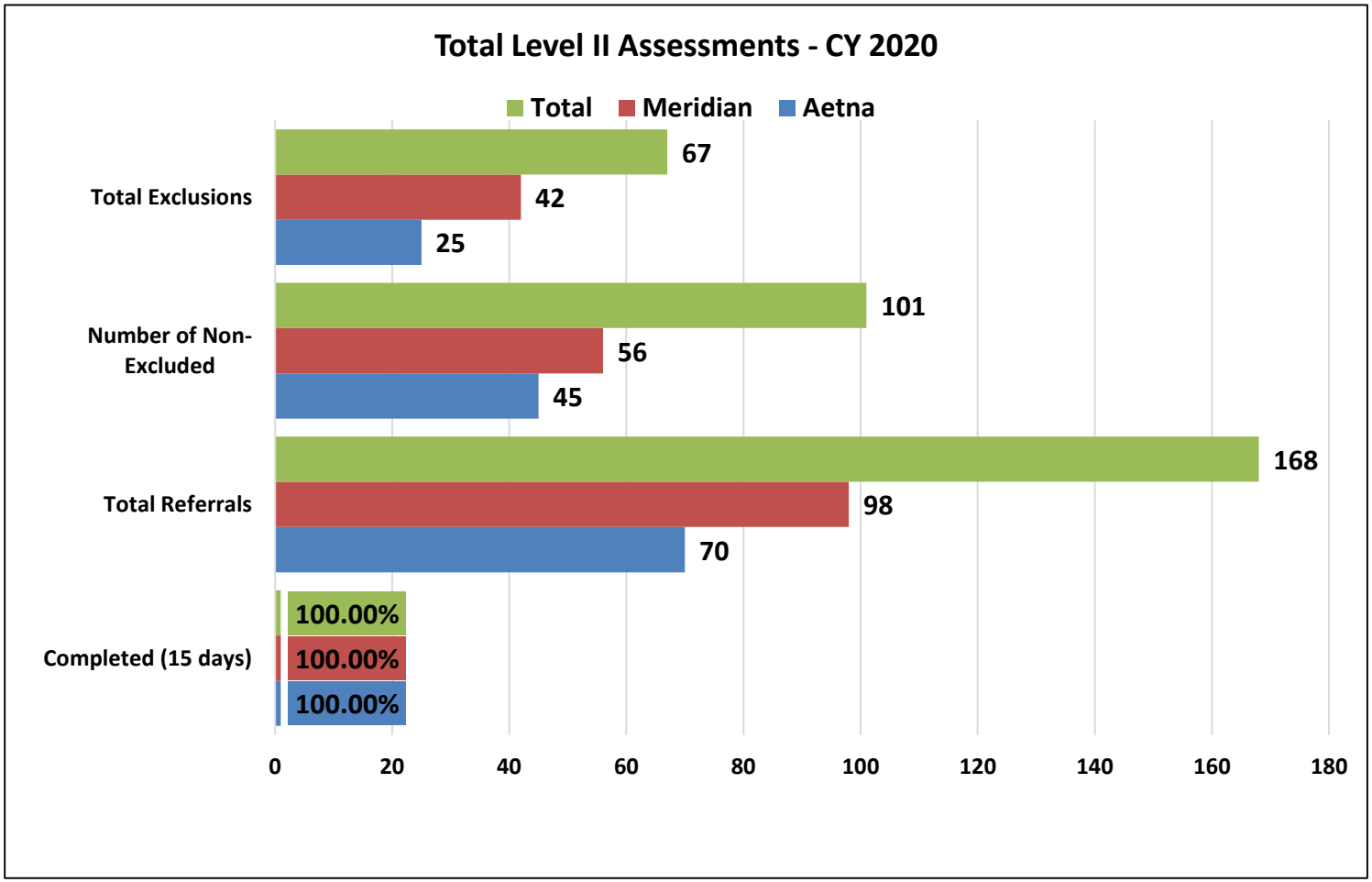
Aetna:
Total Referrals: 501
Total Completed: 437



Meridian:
Total Referrals: 593
Total Completed: 540

- In 2019, 99.20% of consumers received an initial Level II Assessment within 15 days of a referral. This was a 0.61% decrease compared to 2018 and a 0.04% increase from 2017

MHL Level II Assessment Timeliness Report



- **<u>Target/Goals:</u>** The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric within (15 days) is 95% or above.
- During CY 2019 99.20% of Level II Assessments achieved the Timeliness Standard of follow-up within (15 days or less).

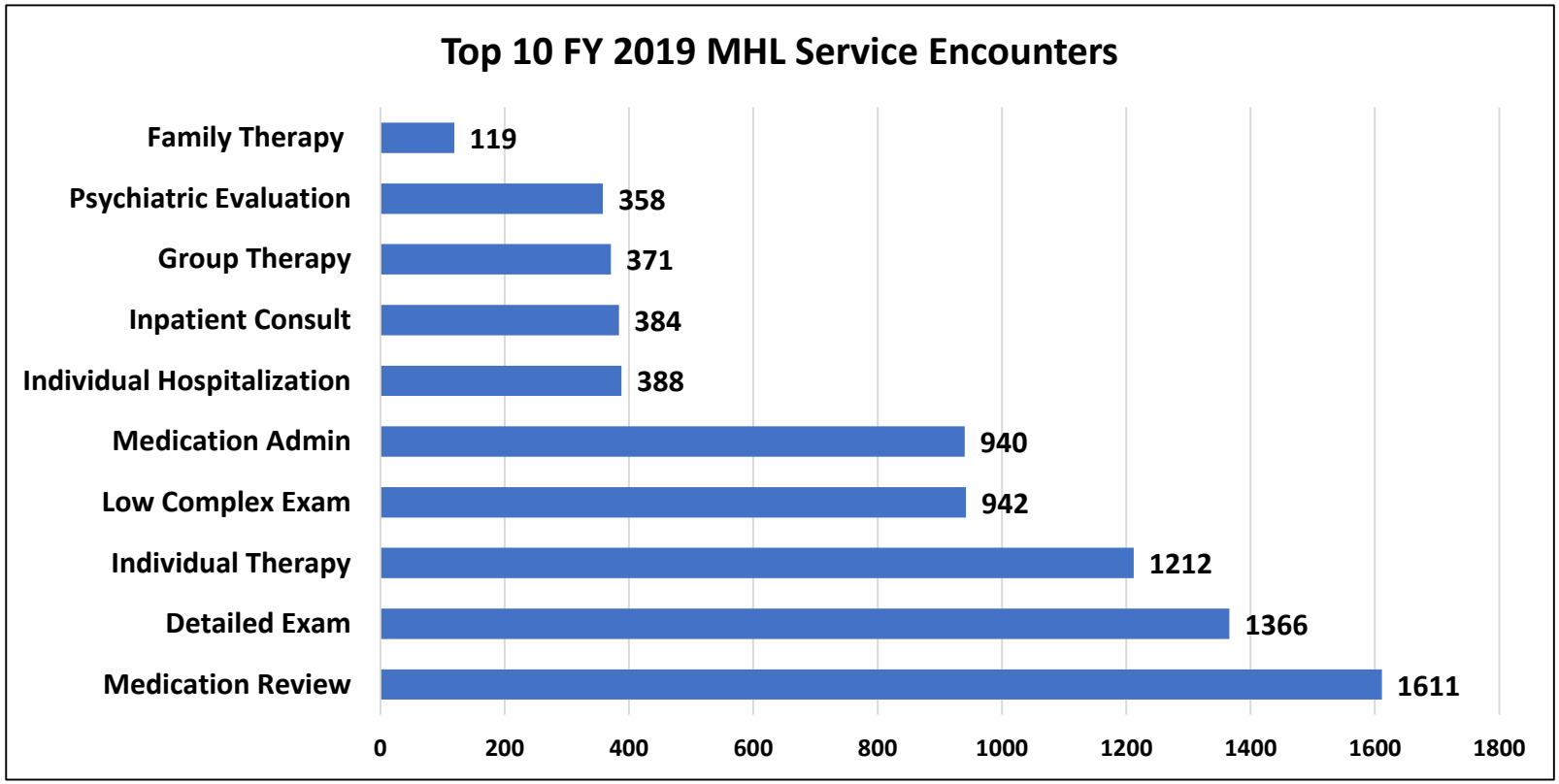
315

Southwest Michigan
BEHAVIORAL HEALTH

2019

MHL Cases & Encounters Analysis

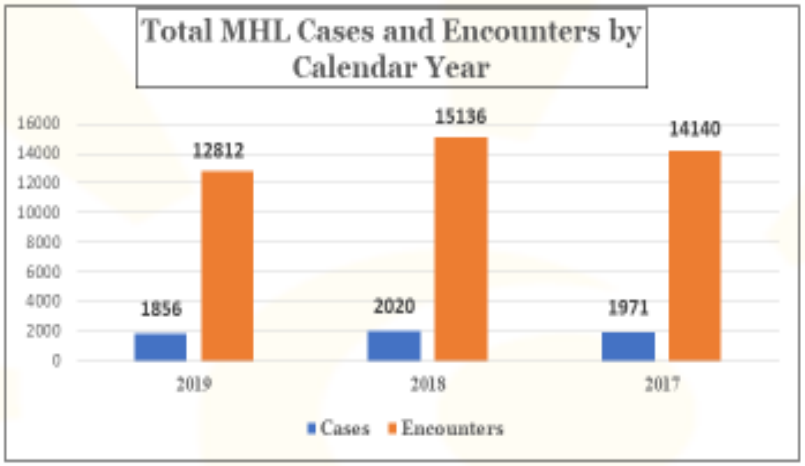
MHL Service Encounters



- The graph above is the ICO Service Encounter Breakdown (FY2019) of the top 10 MHL services out of the many services offered.
- Service Dates (October 1, 2018 through September 30, 2019).
- Dashboard Includes Services Provided to both Aetna and Meridian Plan Members.
- A total of 7691 provider services were administered during FY 2019.

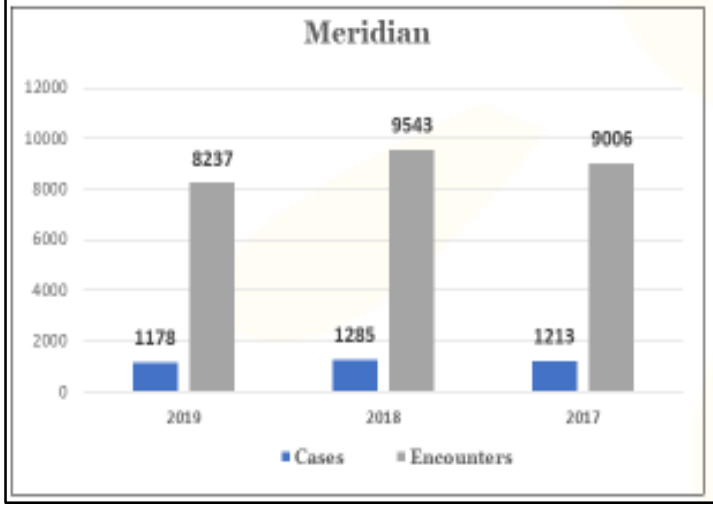
MHL Cases & Encounters

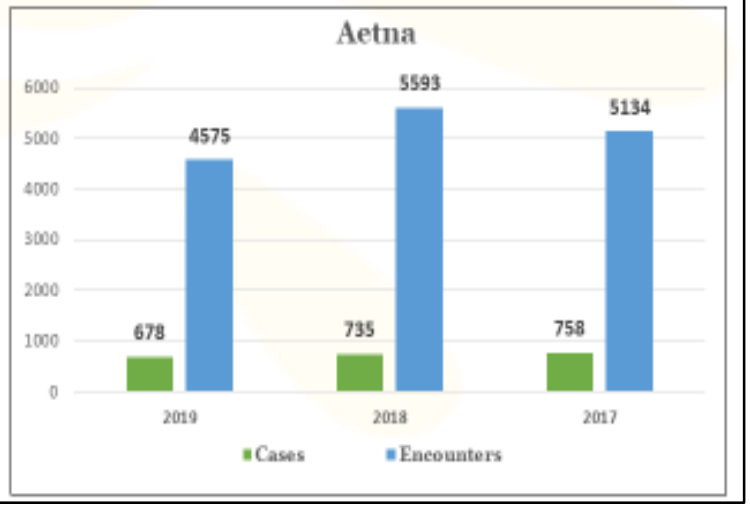
MHL Enrollment



Measurement Period: January 1, 2019 through December 31, 2019

- Overall Cases: -164
- Overall Encounters: -2,324
- Meridian Cases: -107
- Meridian Encounters: -1,306
- Aetna Cases: -57
- Aetna Encounters: -1,018





2019

Coordination of Care

Coordination of Care

Integrated Care Team Meetings and Communications with Health Plans:

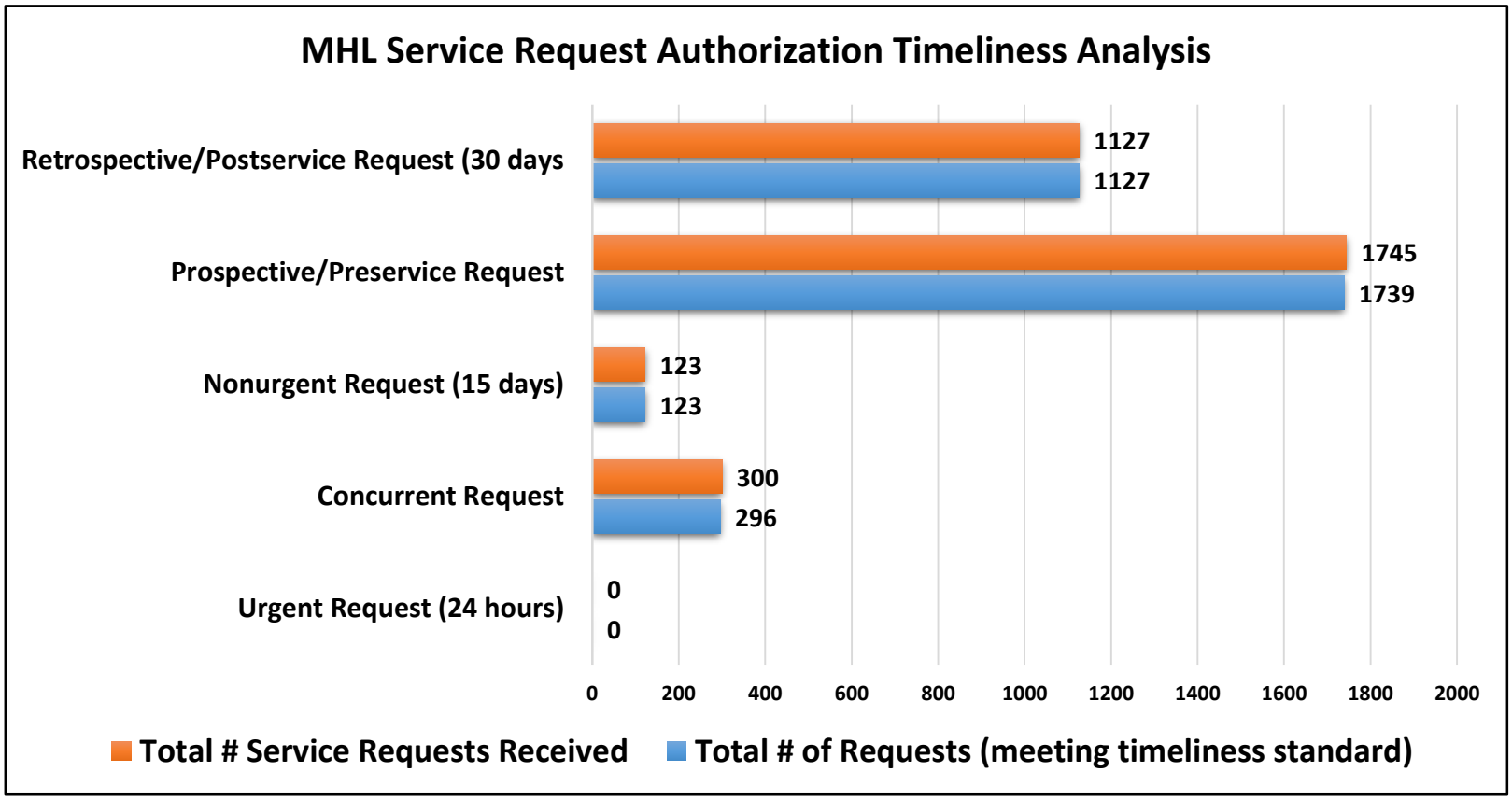
SWMBH began monthly Integrated Care Team (ICT) meetings in August 2016. SWMBH's Integrated Care Team continues to schedule and facilitate monthly meetings with each of the seven different MHPs in our region. We complete risk stratification, collaboration, update agendas, maintain, and share meeting minutes. As of 9/30/2019, there were a total of 128 SWMBH Coordinated Care Plan (CCP) Members. In CC360, 45 members had an open CCP; 69 had a CCP status of completed, and 14 had canceled CCPs. Of those 69 completed:

- 32 met all goals
- 13 had some goals met
- 23 lost coverage
- 1 refused participation

2019

Timeliness of UM Decision Making Analysis

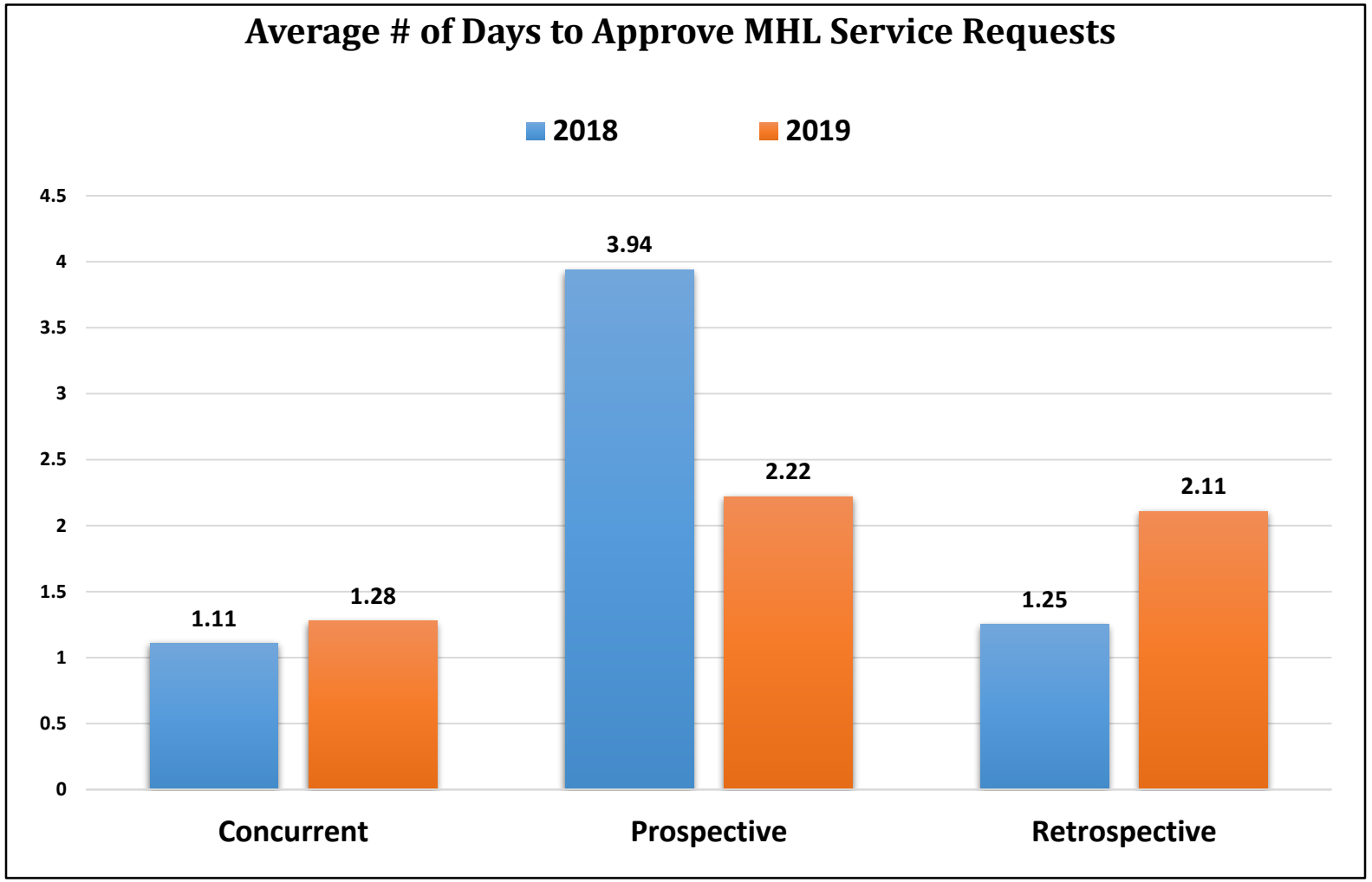
Timeliness of UM Decision Making



Timeliness of UM Decision Making

MHL Service Request Timeliness Report	Urgent Request (24 hours)	Concurrent Request	Nonurgent Request (15 days)	Prospective/Preservice Request	Retrospective/Post service Request (30 days
Total # of Requests (meeting timeliness standard)	0	296	123	1739	1127
Total # Service Requests Received	0	300	123	1745	1127
Timeliness Rate	N/A	**98.60%**	**100%**	**100%**	**100%**

Timeliness of UM Decision Making



Questions?

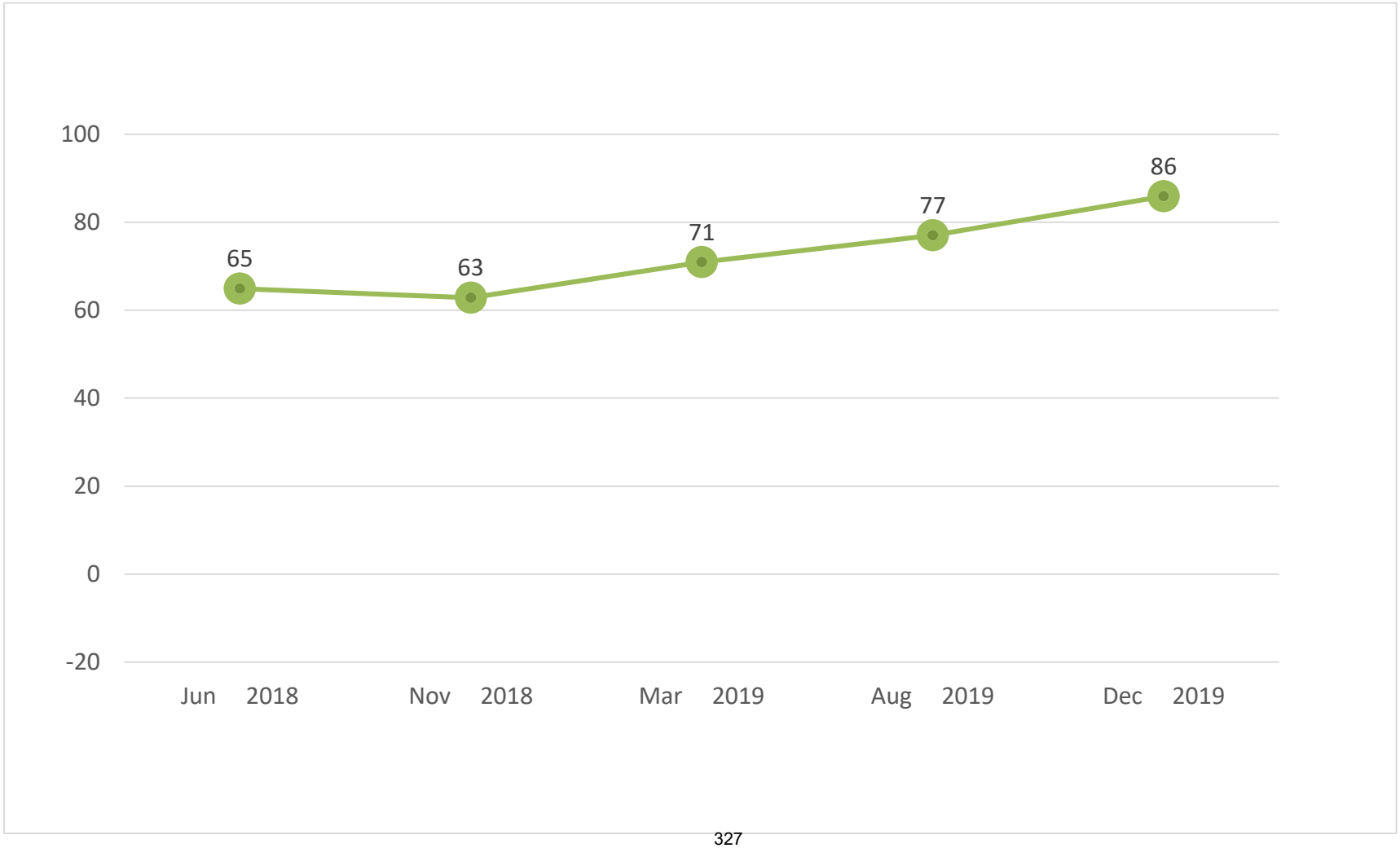
SWMBH

Cultural Accelerator Report

December 2019

Cultural Accelerator Report

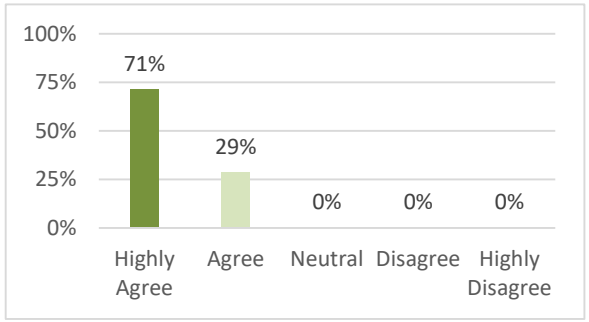
December 2019

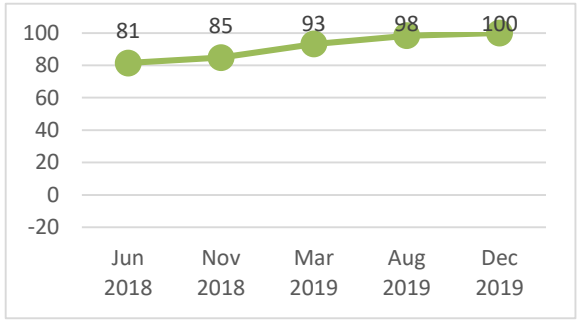


Work Environment

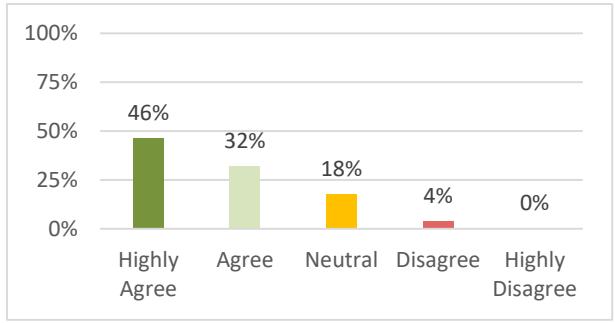
89 /100

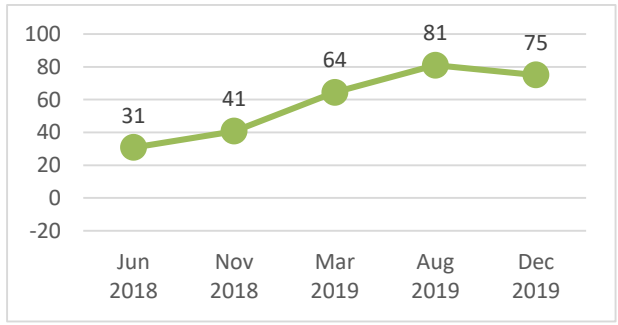
1 I feel safe at work.



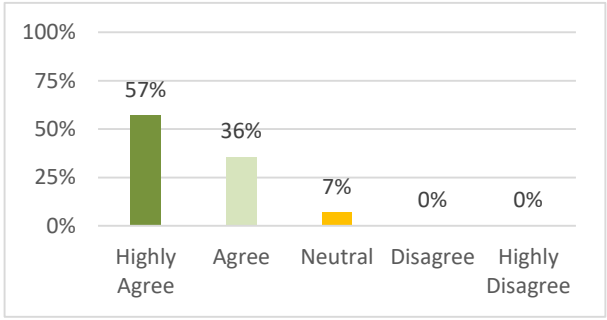


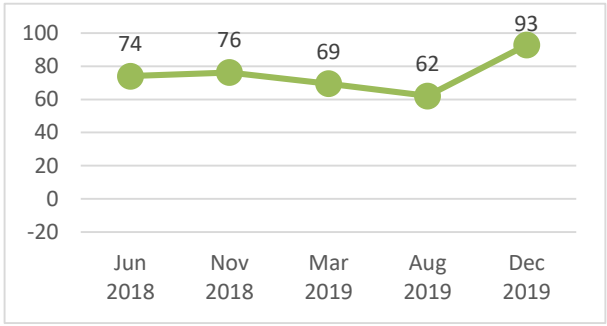
2 I would recommend working here to a friend.





3 My organization offers a competitive total compensation package.





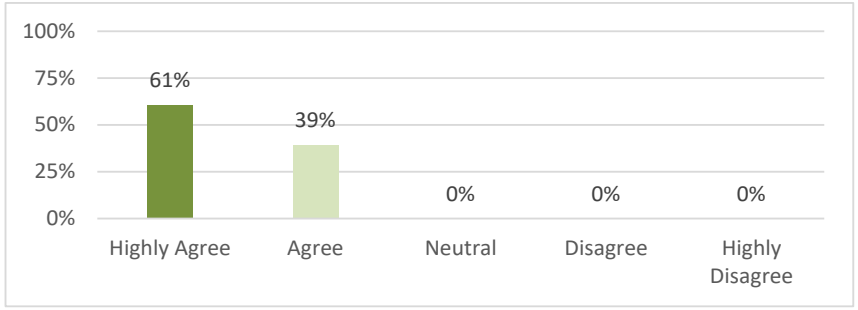
Themes

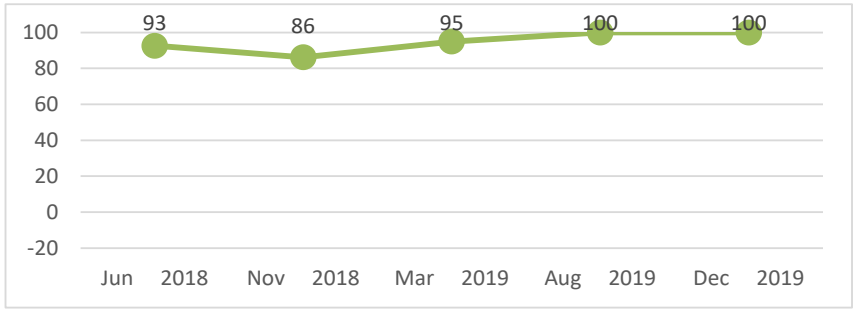
Employees shared that they feel safe at work and appreciate the "panic button" some were given when working offsite. Most employees would recommend SWMBH to a friend. Those who disagreed, or gave a neutral rating, were concerned about state funding. Employees were very happy with their total compensation package, noting appreciation for market adjustments to wages, as well as fully covered insurance premiums.

Vision/Mission/Values

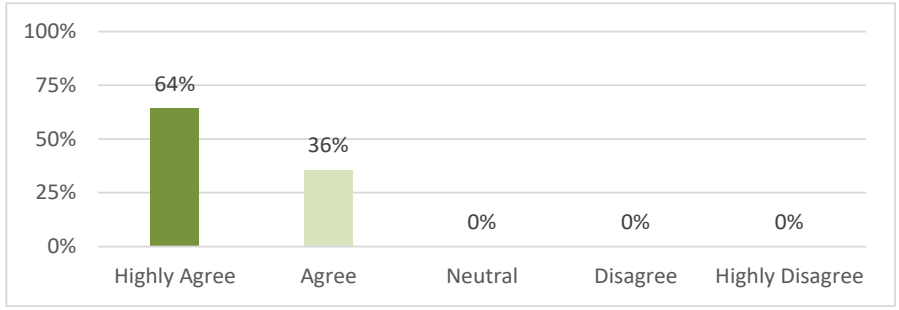
100 /100

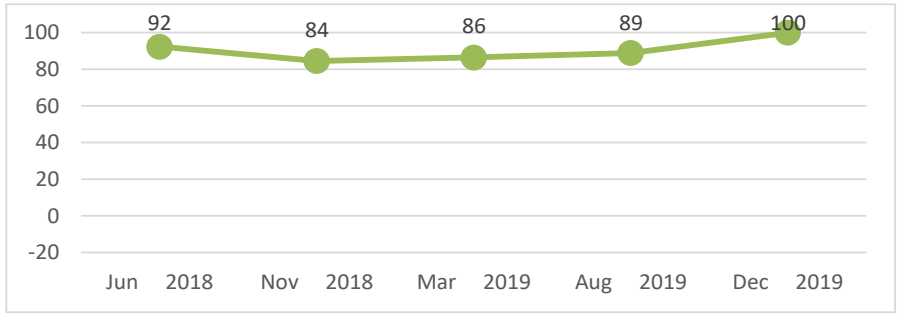
4 I understand how my job contributes to the mission/purpose of the organization.





5 My leader tries to do the right thing.





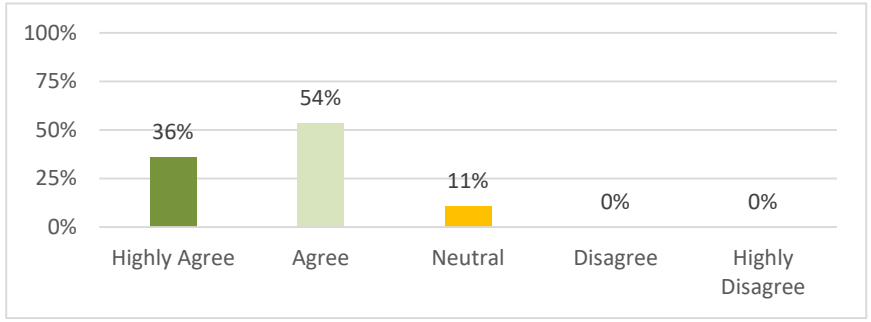
Themes

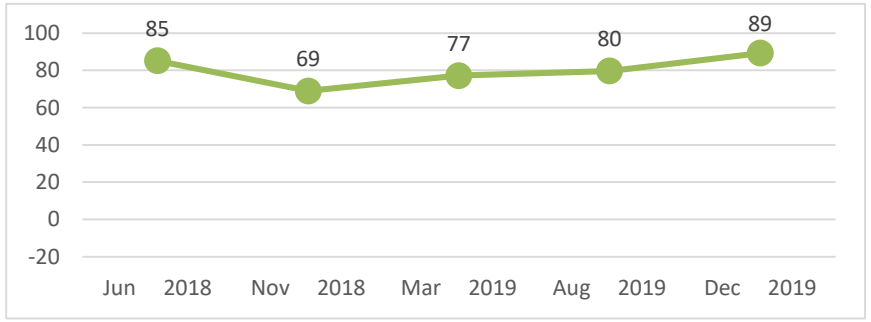
SWMBH employees definitely make the connection between the work they perform and the mission of the organization. The comments reflected a real passion for helping clients receive the treatment they need. These comments also included how they saw this same passion and commitment in their leaders and appreciated both transparency and flow of communications.

Resources

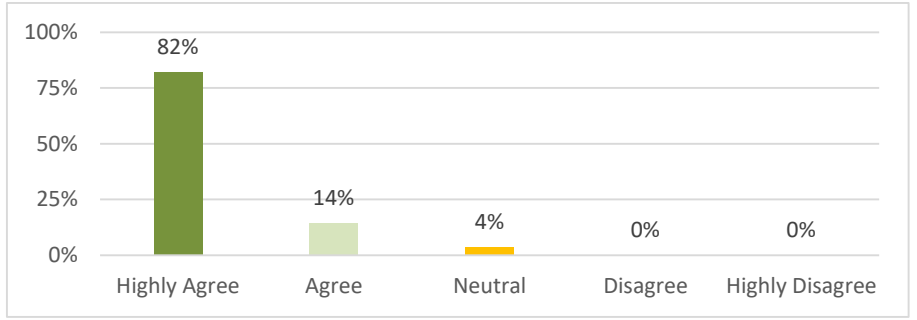
93 /100

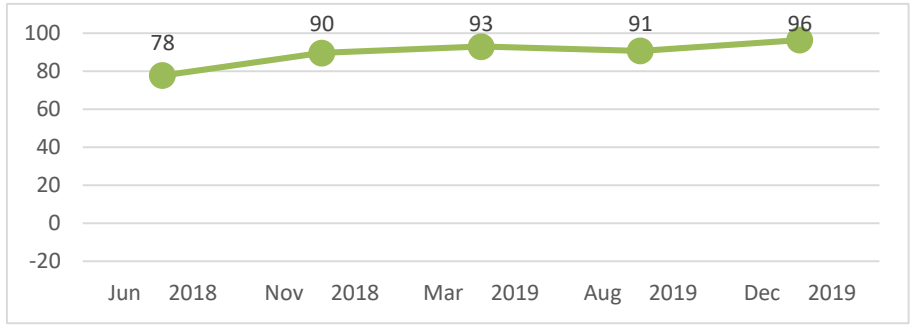
6 I have the information I need to do my work.





7 I have the resources to do my work. (materials, technology, and equipment)





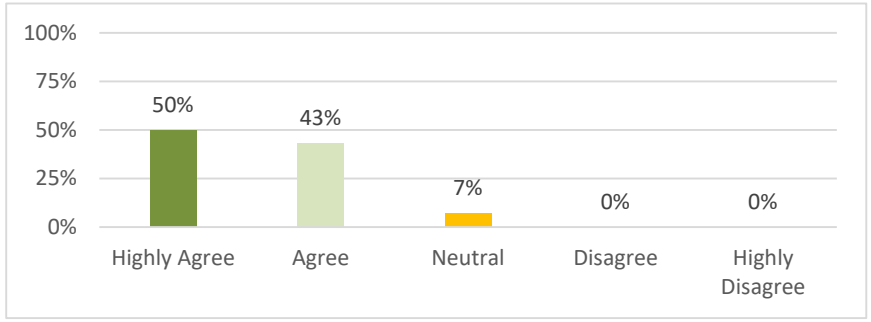
Themes

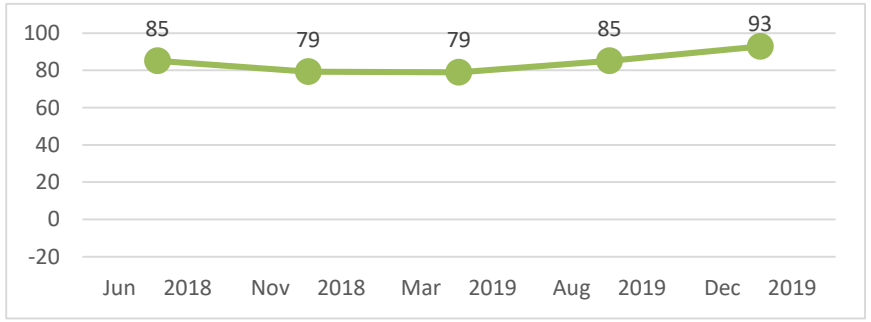
Overall, employees have the information they need to do their work. There were some comments about the challenges of getting information from other departments in a timely manner, along with frustrations with the state. Resources (materials, technology and equipment) received very high ratings. A few comments included the desire to bring IT in-house, projectors and TVs in each conference room, and to have a Fax to email option.

Team Camaraderie

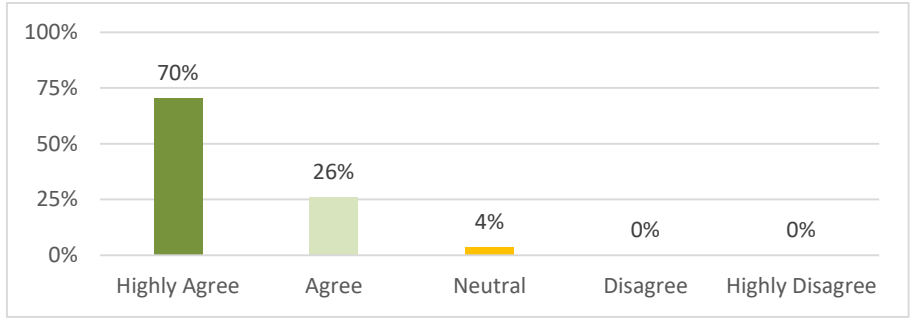
95 /100

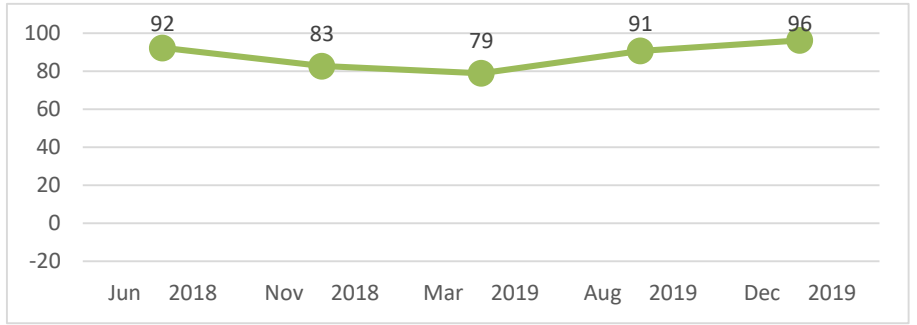
8 My co-workers care about me as a person.





9 My supervisor and I have a good working relationship.



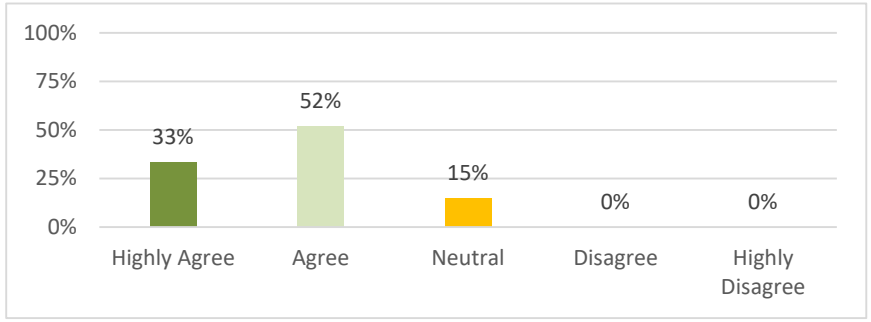


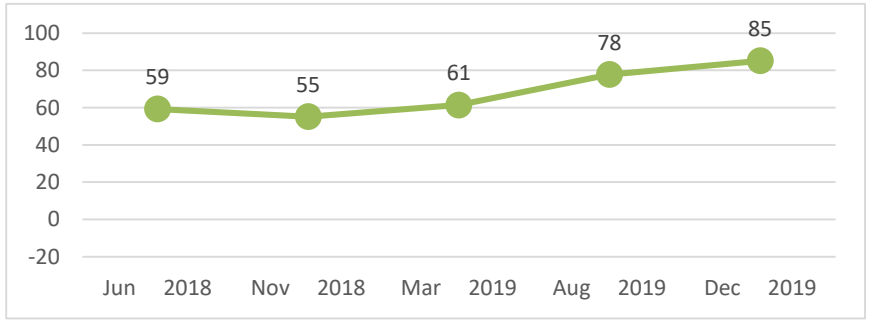
Themes

Team Camaraderie ratings took a nice jump! Employees describe SWMBH as having a very welcoming environment. Comments included an appreciation for SWMBH-sponsored activities, as well as afterhours gatherings. Likewise, employees gave their supervisor high marks. The majority of them feel cared for and enjoy an open door relationship with their supervisor.

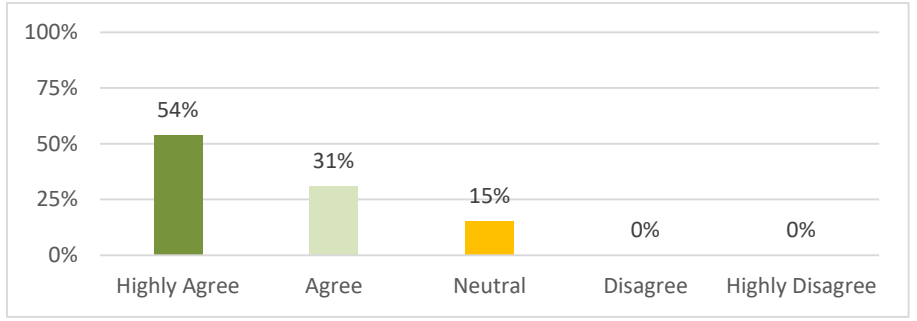
Personal Growth & Development 85 /100

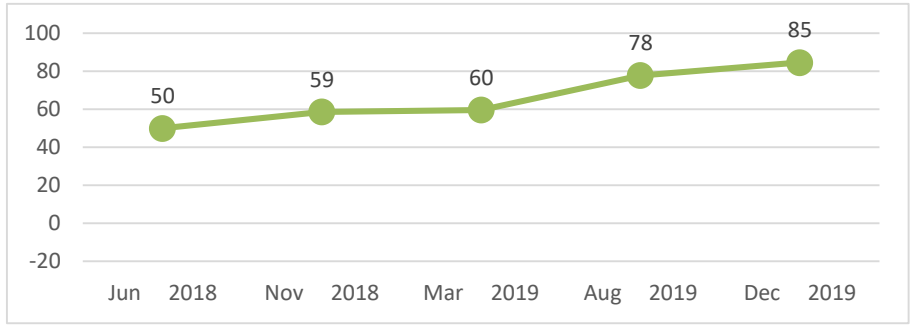
10 At work, I have the opportunity to use my strengths on a regular basis.





11 In the past year, I have had opportunities to develop new skills at work.



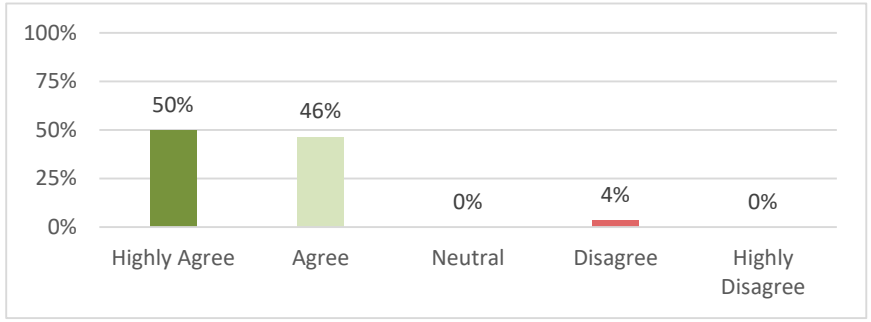


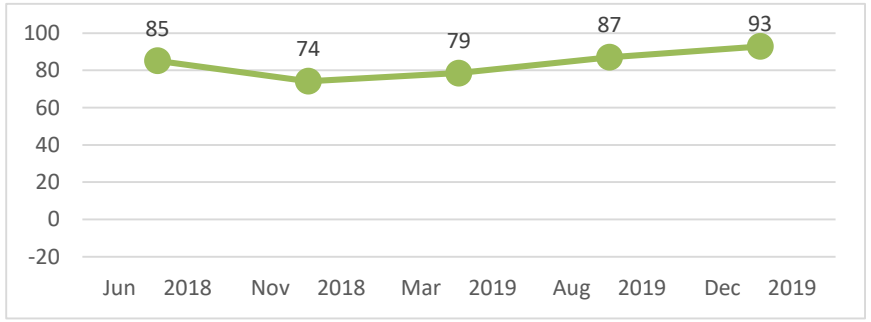
Themes

Personal Growth & Development also took a nice upturn. Comments included an appreciation for not being micro managed. There are opportunities for training and education. One suggestion was to do better job communicating opportunities within the organization.

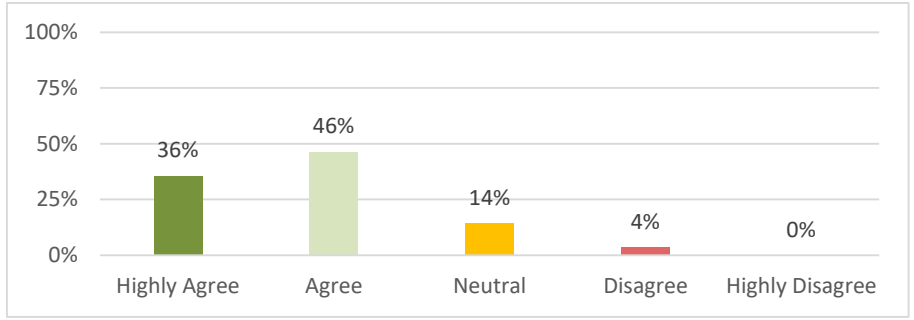
Clear Expectations/Accountability 86 /100

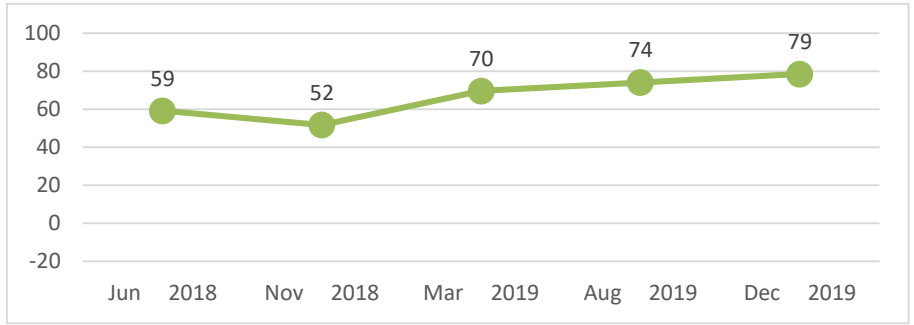
12 I receive the direction I need from my leader.





13 I receive constructive feedback on my performance from my supervisor on a timely basis.





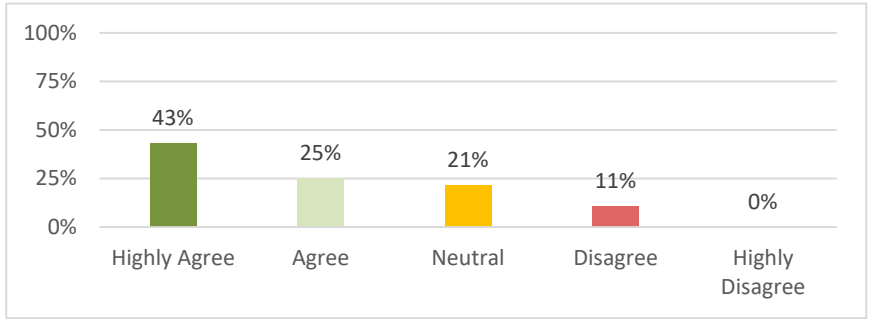
Themes

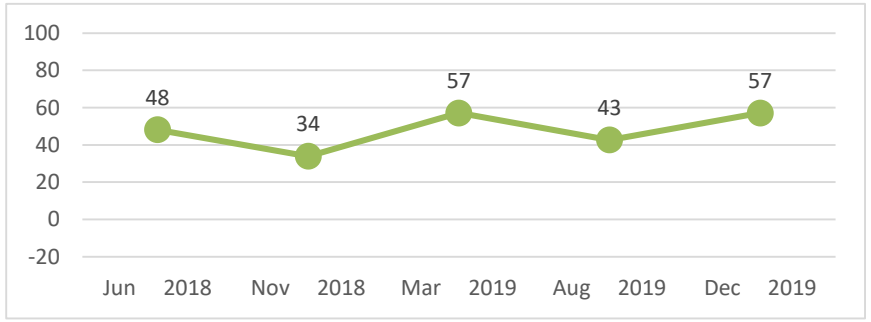
Leaders seem to do a good job answering employee questions. Some employees see their leaders less than others, which leads to infrequent interaction. There are mixed feelings on this - some like not being micro-managed, while others would prefer more guidance. There also seems to be variance in the frequency of performance evaluations. Standardizing the timing of evaluations may help improve scores on feedback.

Recognition

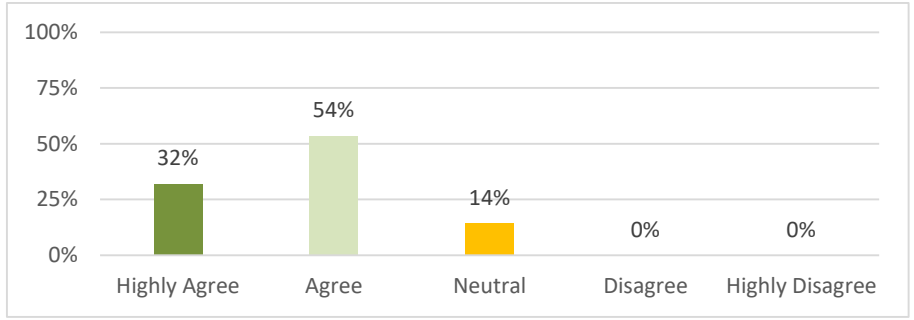
71 /100

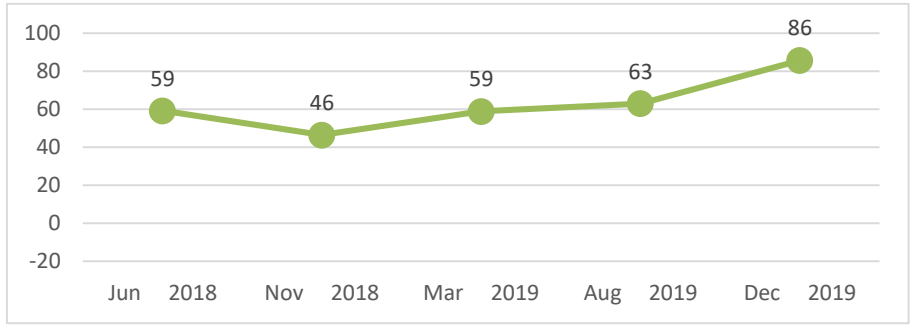
14 In the last week, I have received recognition for doing good work from my leader.





15 At work, my opinions are heard and considered.





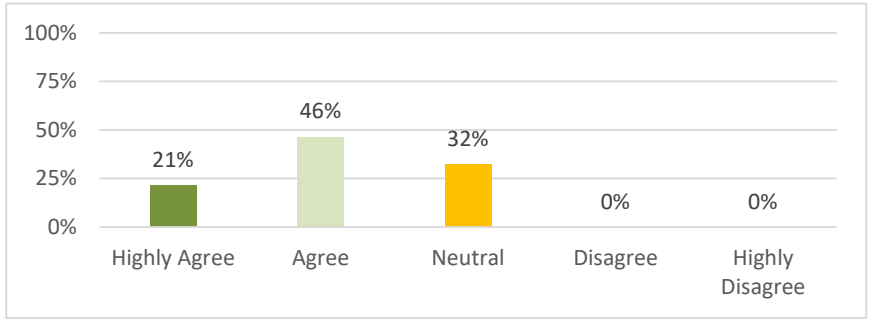
Themes

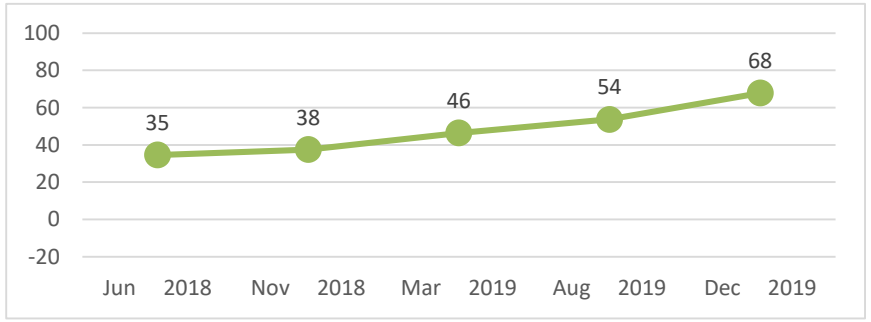
Receiving recognition still remains an opportunity for improvement. The comments really varied. Some said that they don't need, nor desire recognition. Some claim it happens, just not in the last week. Many commented that they don't receive "personal" recognition. It either comes in the form of an email, or the group is recognized, rather than individual contributions. That said, most employees reported that they do feel that their opinions matter and are heard. This category took a nice jump!

Best People

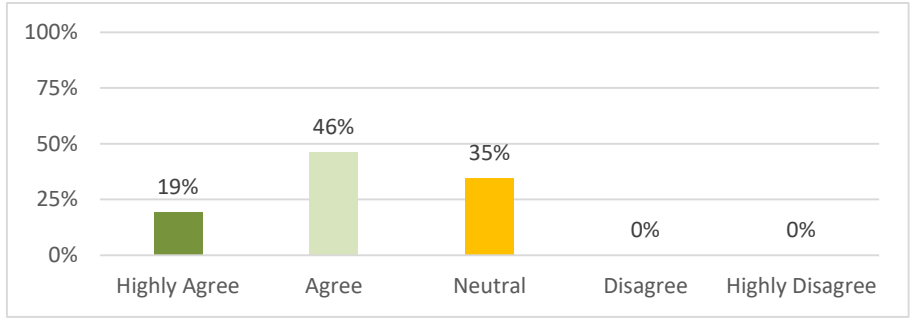
67 /100

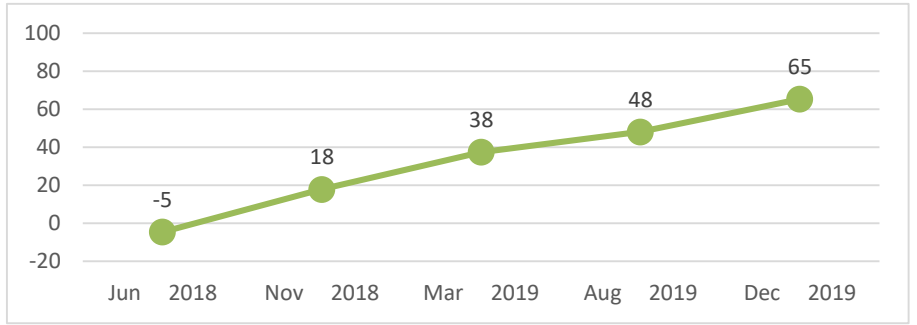
16 My organization selects the best candidates.





17 My organization promotes the right employees.





Themes

Best People scores increased nicely! Although employees realize it is a tough market and there are limited applicants, they believe the organization is doing what they can to bring on the right talent and combat turnover. Promotions seem to be infrequent due to limited career paths and a flat organization. Even with limited opportunities, overall, employees are pleased with the promotions over the last year.

CHCF

Making Integration Work:
Key Elements for Effective Partnerships Between Physical and Behavioral Health Organizations in Medicaid

FEBRUARY 2020

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Center for Health Care Strategies

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Contents

IN BRIEF

A growing number of states are implementing integrated models to address problems of fragmented care and poor health outcomes for individuals with serious behavioral health needs. Many states have transitioned to contracting with managed care or accountable care organizations that are responsible for managing all physical and behavioral health services for Medicaid enrollees. These organizations commonly involve new partnerships between physical and behavioral health plans and providers that can advance the goals of integrated care. This brief, produced with support from the California Health Care Foundation, identifies key elements that contribute to successful partnerships. It synthesizes insights from organizational leaders representing Medicaid-based partnerships in Arizona, Arkansas, Colorado, and Oregon. Key elements include (1) employing joint-ownership models representing both physical and behavioral health, (2) ensuring stable system transitions for consumers and providers, (3) marrying the expertise of physical and behavioral health partners to create new and enhanced capacities, and (4) allowing adequate time for planning and implementation. These lessons are broadly applicable for health care organizations and policymakers considering how to support successful partnerships to advance physical and behavioral health integration.

Background

Many states and regions are seeking to improve access, quality, and costs of care for Medicaid enrollees with behavioral health needs, defined as people with mental health conditions and/or substance use disorders (SUD). The relatively poor outcomes for these populations are well documented: People with behavioral health conditions have higher rates of chronic physical conditions, poor social outcomes such as homelessness and unemployment, and early mortality.[1] People with behavioral health needs experience fragmented care and receive less preventive care, while using more acute care.[2] Medicaid spending for this population is more than four times higher than for those without behavioral health conditions, largely the result of increased physical health care spending.[3] Informed by the growing evidence that clinical integration of physical and behavioral health can improve health outcomes and quality of life as well as reduce health care costs, many states have sought to advance integrated care for Medicaid beneficiaries with behavioral health needs.[4]

Separate financing and administrative structures for physical and behavioral health care in Medicaid can contribute to fragmented care. While the majority of states organize and finance physical health benefits through managed care organizations (MCOs), historically many states "carved out" the administration of specialty mental health and SUD services to separate managed behavioral health organizations (often public entities) or on a fee-for-service basis. Under such systems, with different care components managed by disparate entities, consumer access to care and care coordination can be diminished, often resulting in worse health outcomes.[5]

States seeking more integrated physical and behavioral health care in their Medicaid programs are pursuing a variety of approaches including integrated managed care, health homes, and accountable care organizations (ACOs).[6] A growing number of states have newly contracted with either integrated managed care plans or ACOs to manage all physical and behavioral health services for Medicaid enrollees. The structure of these

models — including the populations covered, phasing of implementation, and structure and responsibility of contracted entities — varies widely, as states often tailor policy approaches to address unique state and regional environments as well as existing managed care and provider capacity. As of 2019, only nine states carve out behavioral health benefits — a significant decrease over the last decade.[7] While there are limited data on the impact of these state integrated managed care initiatives, evaluations from Arizona and Washington have shown promising results.[8]

In this evolving landscape, there is much to learn from states, plans, and providers that have advanced integration efforts, both in terms of strategies to support effective implementation and impacts on care delivery and outcomes. Their experiences thus far have shown that financial integration alone is not sufficient for clinical integration — data-sharing and payment policies are critical.[9] But to understand the key elements for successful integration, it is also necessary to examine the partnerships between physical and behavioral health entities that undergird integration.

When states consider changing how behavioral health benefits are managed, often the debate centers around which entities are best positioned to manage an integrated benefit, with options commonly including physical health MCOs and public or private behavioral health organizations. However, regardless of which option is selected, partnerships between physical and behavioral health stakeholders — including both administrators and providers — often emerge. These partnerships can take many forms, ranging from formal to more informal relationships, and may have responsibility for an entire state or a specific region. How well such partnerships function can have a significant impact on efforts to advance integrated care.[10]

To examine how partnerships have advanced physical and behavioral health integration — and to identify lessons for states and other stakeholders — the Center for Health Care Strategies (CHCS), with support from the California Health Care Foundation, conducted interviews with leaders of organizations that are partnering to integrate care for Medicaid enrollees. Interviewees represented both physical and behavioral health care in four states: **Colorado** and **Oregon**, which have regional Medicaid ACOs, and **Arizona** and **Arkansas**, which have integrated specialty health plans for those with serious behavioral health needs.

Through their integration efforts, the profiled states and regions experienced significant transformation in how behavioral and physical health services were managed. Details on the interviewees and their integration models are summarized in Table 1 and described in the next section.

Table 1. Overview of Profiled Partnerships and Characteristics, by State

	INTEGRATION MODEL	PARTNERSHIP SCOPE	ENTITY	INTERVIEWED PARTNER(S)
Arizona	**Integrated Regional Behavioral Health Authorities (RBHAs).** Specialty managed care plans for adults with serious mental health needs	Joint ownership between 2015 and 2018 (duration limited by design)	Health Choice Integrated Care	Steward Health Choice Arizona* (now Health Choice Arizona)
Arkansas	**Provider-Led Arkansas Shared Savings Entities (PASSEs).** Specialty managed care plans for adults and children with serious behavioral health needs or intellectual or developmental disabilities	Joint ownership since 2018	▶ Empower Healthcare Solutions ▶ Arkansas Total Care	▶ Beacon Health Options, Arkansas Healthcare Alliance ▶ Arkansas Health & Wellness (a Centene subsidiary)
Colorado	**Regional Accountable Entities (RAEs).** Medicaid ACOs cover all adults and children	Joint ownership since 2019	Health Colorado	Beacon Health Options, Solvista Health
Oregon	**Coordinated Care Organizations (CCOs).** Medicaid ACOs cover all adults and children	Informal partnership	Jackson Care Connect	Jackson Care Connect, CareOregon, Jackson County Mental Health

*After the interview was conducted, Blue Cross Blue Shield of Arizona acquired Steward Health Choice Arizona, and "Steward" was dropped from the name.

Profiled Partnerships

Arizona

Arizona's Medicaid agency began integrating the financing of physical and behavioral health in 2013, after having carved out specialty behavioral health benefits to Regional Behavioral Health Authorities (RBHAs) for many years. To promote integration, beginning in 2014 the state carved physical health benefits into RBHA contracts for adults with serious mental illness (SMI) and required that integrated RBHAs include a physical health plan. A single integrated RBHA in each of three regions managed care for this population.

The integrated RBHA profiled in this brief, Health Choice Integrated Care (Health Choice), was a joint venture between Steward Health Choice Arizona (Steward) and the Northern Arizona Regional Behavioral Health Authority (NARBHA). While NARBHA was a behavioral health plan, it was owned by behavioral health providers in the region and thus was closely connected to providers. Health Choice covered six counties in northern Arizona, including the cities of Flagstaff and Prescott. In 2018, as the state expanded its integration strategy to include most Medicaid enrollees, Steward assumed further responsibility as an integrated plan for the general population. At this time, it bought out NARBHA's portion of the integrated RBHA contract for the SMI population and developed a new contractual relationship allowing NARBHA to have an ongoing role advising on services for members with SMI.

Arkansas

Arkansas developed a unique partnership model of risk-based provider organizations that integrate specialized services for adults and children with either severe or persistent behavioral health needs, or intellectual and developmental disabilities (IDD). The state chose to focus on these high-need populations due to their rising costs of care, limited access to care, and fragmented delivery of service in the state's fee-for-service system, with the goal of developing a model to achieve savings within five years.[11] Arkansas pursued a hybrid approach that merged provider leadership with the expertise of managed care organizations.[12]

These new entities, known as Provider-Led Arkansas Shared Savings Entities (PASSEs), cover approximately 44,000 adults and children enrolled in Medicaid with high levels of behavioral health or IDD service needs, and are now fully at risk for all enrollees after a multiphase launch.[13] PASSEs manage all physical and behavioral health services as well as home- and community-based long-term services and supports. Each PASSE must organize and coordinate across the full continuum of care, including development of a statewide provider network and provision of care coordination services. The program has been quickly implemented — after passage of enabling legislation in 2017, PASSEs began providing care coordination services to attributed beneficiaries in February 2018, and in March 2019 became fully at risk for all services and began receiving a global capitated payment. The state structured this phased launch to enable PASSEs to test their approaches and to use full claims data for approximately one year before becoming fully at risk.

In the PASSE model, the state requires that different providers — including a behavioral health services provider, developmental disability service provider, physician, hospital, and pharmacist — enter into a partnership with an organization that manages administrative functions, with the providers retaining majority ownership. Of three statewide PASSEs, two are profiled in this brief: Arkansas Total Care, owned by two provider groups and by Arkansas Health & Wellness (a subsidiary of Centene, a national managed care plan), and Empower Healthcare Solutions (Empower), owned by five provider groups as well as by Beacon Health Options, a national behavioral health managed care plan.

Colorado

Colorado sought to promote integration of physical health, mental health, and SUD services while maintaining separate financing streams for physical and behavioral health. In 2011, under the first phase of Colorado's delivery system transformation, the state

focused on strengthening primary care, creating Regional Care Collaborative Organizations (RCCOs) to coordinate care across primary and specialty care on a fee-for-service basis. Meanwhile, Behavioral Health Organizations (BHOs) continued to manage a carved-out benefit as they had done previously.

In 2018, the second phase of transformation began, with a focus on advancing integration of physical and behavioral health services and making one entity accountable at the administrative level for these services to increase providers' ability to deliver whole-person care.[14] Regional Accountable Entities (RAEs) replaced both the RCCOs and BHOs, and became responsible for administering the capitated behavioral health benefit as well as overseeing an expanded scope of care coordination activities and increased accountability among primary care providers still operating under a fee-for-service reimbursement model. The RAEs were responsible for contracting with primary care providers to serve as medical homes, building a statewide network of behavioral health providers, coordinating care across all providers, and monitoring data and improving population health across the region. Since this phase began, RAEs are increasingly incentivized to achieve improved member outcomes across physical and behavioral health indicators, and may use value-based payments in their contracts with behavioral health and primary care providers.[15] Health Colorado, profiled in this brief, covers over 130,000 members across 19 counties in primarily rural and frontier south-central and southeastern regions of the state, and is jointly owned by four community mental health centers (CMHCs), a Federally Qualified Health Center (FQHC), and Beacon Health Options. One other RAE is partially owned by CMHCs and FQHCs, and the remaining RAEs have varied ownership structures, including plans as sole operators.[16]

Oregon

In January 2020, Oregon implemented a significant initiative to address the fragmentation of physical and behavioral health services, with all of the state's Coordinated Care Organizations (CCOs) becoming fully accountable for behavioral health services. Some CCOs initiated this move earlier, and the experience of the Jackson Care Connect CCO, outlined in this brief, illustrates how organizations can evolve their partnerships to navigate significant transitions in organizational responsibilities. Oregon first introduced CCOs in 2012, as locally governed regional collaboratives that included health plans, providers, county public health, and community-based organizations that administer a single global budget to serve Medicaid enrollees regionally.[17] While CCOs are a type of ACO — referred to by some as "ACOs on steroids" — their financing structure more closely resembles Medicaid managed care organizations.[18] Initially, most CCOs carved out the behavioral health benefit by passing through a portion of the global budget to local mental health agencies, with reported negative outcomes including limited access to care, delayed authorizations, and barriers to advancing clinical integration.[19]

Jackson Care Connect CCO had originally partnered with Jackson County Mental Health (Jackson County), the local mental health agency, which served as both the subdelegated behavioral health managed care entity for all members and as the primary provider of services for a high-need subpopulation. Both entities are located in Jackson County in southern Oregon, one of the more populous counties in the state and home to the cities of Medford and Ashland. In 2016, Jackson Care Connect opted to carve in the behavioral health benefit to address the fragmented care experienced by members with behavioral health needs, and to pare back on the services for which it contracted with the county to deliver. This partnership underwent a significant transition, with Jackson County limiting its scope to a more targeted set of services, primarily for high-need adult and youth members, including crisis and safety-net services, outpatient treatment, assertive community treatment, wraparound services, specialized services for forensics populations, and mental health court. While the scope of services that Jackson County provides is significantly narrower, the county continues to participate in the board of directors and clinical advisory panel for Jackson Care Connect, and both organizations collaborate in the development and management of a county-level behavioral health strategic plan.

Insights: Key Elements for Successful Partnerships

Through interviews with leaders of physical and behavioral health organizations, CHCS identified a set of elements underpinning successful partnerships:

1. **Employ joint-ownership models** that include both physical and behavioral health entities.
2. **Ensure stable system transitions** for consumers and providers.
3. **Marry the expertise of physical and behavioral health partners** to create new and enhanced capacities.
4. **Allow adequate time** for planning and implementation.

These key ingredients may be broadly applicable for health care organizations and policymakers considering how to support successful partnerships as part of broader strategy to advance physical and behavioral health integration. Following is a discussion of each of these elements based on insights gleaned from the four featured states and their efforts to collectively advance integrated care across changing policy environments.

ELEMENT 1 Employ joint-ownership models that include both physical and behavioral health entities.

Joint ownership of integrated entities, as exists with the Arkansas PASSEs, some Colorado RAEs, and integrated RBHAs in Arizona before 2018, can create new incentives and help align different organizations around shared goals. Many of these joint-ownership models knit together different systems — such as behavioral health, physical health, and in the case of Arkansas PASSEs, home- and community-based services — through shared governance and shared ownership of the partnership entity. Notably, these arrangements arose both in states that *required* joint ownership between physical health plans and behavioral health plans or providers, and in states that did not. For example, all Arkansas PASSEs are statutorily required to be majority-owned by providers representing a range of practice types, while Colorado has no such requirement, and only some of the Colorado RAEs, including Health Colorado, are jointly owned by plans and providers focused on physical and behavioral health. Interviewees underscored the importance of joint ownership in transforming their operations and in navigating challenges that can arise when bringing together leaders with different perspectives and business interests.

These joint-ownership models bring together plans and providers to collaborate in the design of managed care functions and require accountability for integrated care outcomes that extend beyond the measures that physical or behavioral health entities may be accustomed to assessing. While organizations may come into the partnership with divergent interests, joint ownership creates new financial stakes, and shared governance creates new pathways for making key decisions. Owners in the Empower PASSE in Arkansas shared how they codesigned strategies for medical necessity criteria, care management, and provider reimbursements with the goal of creating shared benefits among behavioral health providers, hospitals, primary care providers, IDD providers, and the health plan, even when some of the proposed changes would potentially hurt one partner. Various Empower partners characterized this process as transformative — a health plan leader called it "a natural and healthy tension in how managed care is brought to bear," while a provider leader said, "It's eye-opening to wear a provider hat and an insurer hat, because sometimes these things do not agree." The provider leader shared that the experience of governing Empower fundamentally changed the perspective of all governing partners to be mindful of how reshaping the delivery of care may improve member outcomes, and to simultaneously prepare themselves to be nimble in response to potential changes in revenue. While profiled entities within and across states had different governance structures, a health plan leader said that for Empower

PASSE, equity in governance participation is "the most meaningful requirement to bring the cross-functional parts of the health care system together to manage the membership on a holistic basis."

For the owners of Health Colorado RAE, which include community-based physical and behavioral health providers as well as Beacon Health Options, the diversity of perspectives among partners is both the biggest challenge and the greatest catalyst for change. Partners are forced to think beyond their individual organizational interests, sharing the responsibility and risk of managing care for Medicaid enrollees across the region. "The entire design of this new system is based on improving coordination around the health care supply chain," a behavioral health provider leader in Health Colorado said. "Partnering without being contentious takes communication, patience, compromise, and culture change, which is a big shift in health care." This leader described how the partnership creates a reason for physical and behavioral health providers to work together even when their financial interests may seem to differ. For example, to promote greater clinical integration, Colorado recently added a Medicaid benefit for a limited number of behavioral health visits within primary care settings to be billed under the physical health fee-for-service system. In regions of the state served by other RAEs, this new benefit may have had the unintended consequence of incentivizing physical health providers to limit their collaborations with external behavioral health providers, instead limiting integration efforts to those services that they can provide and bill for in-house. By contrast, Health Colorado focused on leveraging this new benefit to create a more integrated model between physical and behavioral health services, through better referral pathways and opportunities for co-location and integration. The structure of the Health Colorado RAE, with shared ownership between physical and behavioral health providers, creates a clear business rationale for these providers to work together and avoid turf battles for resources.

When behavioral health entities have a seat at the table to shape how integrated services are managed and delivered, they can also help prioritize a system design that is financially sustainable for providers delivering behavioral health services to high-need members. For providers facing dramatic changes related to physical-behavioral health integration, participating in a joint-ownership partnership can support providers to, as a plan leader said, "define their own destiny rather than have someone else define it for you." Many behavioral health providers lack the financial capital to manage financial risk across physical and behavioral health care, and are reliant on volume-based services based on specific behavioral health funding streams. Joint-ownership models may enable providers to move toward value-based, coordinated care that advances integration. As a health plan leader in the Arkansas Total Care PASSE said, "Providers want and deserve to play a more active role in population health management and value-based purchasing." Being a part of an organization like this PASSE gives providers, from the perspective of this plan leader, "more stake in the game and more control in the delivery system and model of care." A provider leader in a PASSE observed that participating in a joint-ownership model allows behavioral health providers to shape system changes to strengthen their work and potentially avoid provider closures that could reduce access to care.

Ultimately, as a Beacon Health Options interviewee working with both the Arkansas PASSE and Colorado RAE models said, integrating care for those with the most severe needs remains a persistent challenge across the country, with no easy solutions. However, this plan interviewee suggested that "there is no way to advance the ball without engaging providers directly to realign the organizational and financing structures to the clinical redesign needed to drive improved outcomes at the local, community level." As a plan interviewee in Arkansas Total Care explained, the shared ownership model of the PASSE will help "force innovation and bring creativity to the front" to structure provider reimbursements based on agreed-upon quality measures and incentives that foster the most desirable outcomes. With the evolution of PASSE and other joint-ownership models, their experiences in designing new value-based payment approaches are likely to provide additional valuable insights.

ELEMENT 2 Ensure stable system transitions for consumers and providers.

Transitioning to new models for financing, delivering, and reimbursing behavioral health services can be disruptive for consumers as well as providers. Successful partnerships, however, can optimize the unique strengths of individual organizations to focus on consumer and community needs and to mitigate transition challenges. Partnerships are well positioned to lead robust stakeholder engagement inclusive of providers, advocates, and consumers. A partnership structure can also create new models for sustainability for behavioral health organizations transitioning to redefined responsibilities.

Partnerships that use consumer and provider input to tailor the transition approach to integrated care can engender greater buy-in among stakeholders. Community-based behavioral health organizations are particularly well positioned to engage consumers and providers to facilitate smoother transitions to integrated care. A behavioral health provider partner in the Health Colorado RAE noted that local behavioral health providers represent the needs of and are accountable to their communities, which fundamentally strengthens their ability to design systems that improve community outcomes. Through its community-based focus, Health Colorado could also more successfully engage cross-sector entities, including schools and criminal justice agencies, to partner with RAE and collaborate on community-wide approaches. While Arkansas Total Care does not include a locally based behavioral health provider among its joint owners, the PASSE did engage advocacy groups, provider associations, and consumers early in its development. A plan partner in the Arkansas Total Care PASSE described the importance of early and frequent conversations with stakeholders to understand their experiences and challenges under the previous system. When the PASSEs transitioned to a full-risk model in 2018 and became responsible for many new services, from this interviewee's perspective "you don't just turn that on, you have to understand the way to turn it on" — with sustained stakeholder engagement essential to achieving that understanding.

Successful partnerships can support behavioral health providers navigating potentially disruptive transitions and collaboratively solve problems. For behavioral health providers transitioning from billing the state fee-for-service or on a contract basis to billing multiple managed care entities, as in Arkansas's PASSE transition, submitting claims and receiving payment could create major problems for providers operating with narrow margins. Partnerships that actively engage providers may be better positioned to identify these problems early and develop solutions quickly, especially during a transition to new billing systems. A plan interviewee of the Arkansas Total Care PASSE said that "being provider-sponsored caused us to have a higher sensitivity to provider challenges," especially during the transition to becoming fully at risk for all services. In the experience of this plan partner, the dynamic of this partnership model changes how both the plan and providers (including equity partners and other providers) participate. Providers in the Arkansas Total Care PASSE model have been much more engaged in policies and procedures, addressing questions such as how to best ensure that claims are filed and paid. Often these conversations were driven by an immediate operational issue but evolved into a broader conversation about the best strategy to improve providers' ability to deliver care that can improve consumer outcomes.

Additionally, behavioral health provider partners are well positioned to identify and share transition-related problems that consumers experience, which can help partnerships mitigate these issues. When Arkansas providers reported to the Empower PASSE that some members were being placed in the wrong level of services due to statewide challenges in completion of an independent assessment, Empower sought to identify members at risk of incomplete assessments and develop a strategy to complete them. An interviewee at one of Empower's provider partners said that having providers in this leadership role enabled Empower to quickly pivot to develop solutions that better serve consumers and providers. In Oregon, when Jackson

Care Connect CCO shifted the management of the behavioral health benefit and the provision of many specialty mental health services away from Jackson County in 2016, the two organizations collaborated to transition consumers with behavioral health needs to new providers. Jackson County said that partnering with Jackson Care Connect led to a well-designed process that put the needs of vulnerable consumers first, which "helped to minimize the impact" with the goal of "making it as seamless as possible for clientele."

Finally, as systems continue to evolve, partnerships may create new pathways for sustainability for individual organizations. After transitioning the behavioral health benefit and many services away from Jackson County, Jackson Care Connect CCO in Oregon focused on working with the county to stabilize and explore different ways of maintaining the county's role as a service provider. Jackson Care Connect began contracting with Jackson County to provide additional services for specific populations, finding that the county brought unique strengths in working with high-need groups, such as young people experiencing early symptoms of psychosis and justice-involved populations. In interviews, both partners described now having shared ownership of the behavioral health system in the county, with greater transparency about their responsibilities and roles. Notably, Jackson County wrote a letter of support for Jackson Care Connect's 2019 CCO application, which noted "since [Jackson Care Connect] began managing the behavioral health system directly, [their] partnership has grown to even deeper levels."[20] This testimonial to the strength of their partnership is especially noteworthy given these organizations' history, with Jackson County experiencing significant organizational disruption and layoffs three years earlier. As another example of new partnership opportunities, when the shared contract to manage the integrated plan for SMI ended in Arizona in 2018, Steward (the health plan that began managing an integrated benefit) developed a new contractual arrangement with NARBHA, the prior regional behavioral health plan, to continue their partnership toward improving care for this population.

ELEMENT 3 Marry the expertise of physical and behavioral health partners to create new and enhanced capacities.

Physical and behavioral health organizations — including both plans and providers — have distinct areas of expertise shaped by the history, culture, and practice of their traditionally independent systems. Successful partnerships to advance integrated care create shared new capacities, expertise, and culture forged by collaboration between partners, providing value greater than the sum of their parts. As a result, these partnerships can leverage their combined expertise to design and implement administrative and clinical processes, and innovations in service delivery, to effectively meet community needs and to improve member health outcomes. In particular, where physical health plans have a leadership role in managing integrated care, such as in Arizona and in Oregon's Jackson Care Connect CCO, partnerships with behavioral health stakeholders can help the plans to change the culture and underlying capacities of their plans.

Interviewed health plan leaders in both Arizona and Oregon agreed that culture shifts were among the biggest challenges for their organizations in implementing financial integration. In the words of a Jackson Care Connect interviewee from Oregon, it is important "not to underestimate what it takes to change a physical health plan to a global health plan." Partnerships with behavioral health entities enabled these plans to develop new capacities to manage integrated care, with improved member outcomes. Plan interviewees said that prior to 2016, when Jackson Care Connect delegated the behavioral health benefit to Jackson County, its staff held the entrenched belief that behavioral health would be too different and complex to manage within a traditional physical health plan. When the benefit was carved in, Jackson Care Connect turned to Jackson County for its expertise and adopted county processes to inform Jackson Care Connect's approach to managing an integrated benefit. Jackson Care Connect's efforts included (1) conducting comprehensive staff education, (2) incorporating behavioral health processes and providers

into the existing system, and (3) pursuing internal integration of staff and programmatic approaches, including hiring many more social workers to lead teams and drive care coordination, a substantially different model than it previously employed. As a result, Jackson Care Connect reported improved access to mental health services and reduced costs among its members, with the penetration rate for mental health services increasing from approximately 12% to 19%, and an over 9% reduction in the cost per member served.[21]

In Arizona, Steward and NARBHA partnered to codevelop a new integrated care management strategy while preparing their bid for the integrated contract. Based on a member survey that identified flaws in the existing care management strategy for adults with SMI, the partners decided to pursue an integrated approach, leveraging health homes based in community mental health settings. To implement this model and to support physical and behavioral health providers in working together, Health Choice hired new care management staff to be the "glue" between these different provider systems, as many providers did not have staff trained to coordinate across these different services. Among the highest-need tier of members with SMI served in this program, Steward reported overall cost savings of 7% to 8% as a result of major decreases in inpatient spending along with moderate increases in physical and behavioral health outpatient spending.[22] Interviewed plans also reported steady or slightly improved outcomes related to member and provider satisfaction and quality of care.

Partner collaboration may also lead to the design of improved clinical services, such as better referral and coordination pathways between primary care and behavioral health providers. In Arkansas, Empower partners (who manage physical and behavioral health as well as home- and community-based services) are working together to develop a mobile crisis system for individuals with developmental disabilities and behavioral health needs to ensure access to highly responsive services in times of greatest need.[23] By leveraging partners with expertise in acute care as well as community-based behavioral health and IDD services, Empower is working to develop solutions to complex issues such as addressing ambulance funding for transportation to non-emergency room settings. Empower is also looking to expand telehealth utilization and to implement other innovations to better coordinate care for those with serious physical and/or behavioral health needs.

Similarly, Jackson Care Connect and Jackson County in Oregon are continuously codeveloping new initiatives to serve members with complex health and social needs. For example, the two organizations have collaborated to increase access to medication-assisted treatment, link individuals with co-occurring SUD and physical or mental health needs with other providers, and expand mobile crisis response. Additionally, the partners have collaborated on jail-diversion activities and on developing an outpatient behavioral health forensics team. Jackson Care Connect and Jackson County have worked with other agencies, including the Jackson County Sheriff's Office, to open a Community Justice Resource Center to help members leaving jail or prison to access needed resources. These initiatives demonstrate how a partnership approach may, in the words of a Jackson Care Connect interviewee, "allow for optimizing the strengths of each organization," and lead to new opportunities for public behavioral health plans to take on a new role, such as focusing on cross-sector collaboration to address key unmet community and member needs.

ELEMENT 4 Allow adequate time for planning and implementation.

Partnerships benefit from strong alignment between partners related to long-term goals and strategy, but rapidly paced timelines for standing up new integrated care models, as well as unexpected policy shifts, can be particularly destabilizing for these arrangements. Many states have implemented financial integration as part of a multiphase process, but with considerable variation in both in implementation timelines and in transparency about the overall direction of policy change. While interviewed partners described their efforts to adapt to these issues, including through leveraging preexisting relationships, they

also identified adequate time and planning as critically important for stakeholders and policymakers interested in setting up partnerships to succeed.

When a physical and behavioral health partnership model must be achieved on a short timeline, organizations struggle to develop new processes. Partners from different worlds have a lot to learn, and rushed decisions can lead to long-term tensions that hamper collaboration. As a plan interviewee observed, in these models it can be "difficult to reconcile the pace with which government wants to move with the reality of how long it takes to operationalize those challenges.... We need to both have aspirational state regulations and the necessary time to implement them on the ground." A plan interviewee at one PASSE, Arkansas Total Care, identified one of the most important considerations for state policymakers interested in ensuring access to integrated care as taking the necessary time to "let the model work" and being mindful that "transformational work takes time." In another Arkansas PASSE, Empower, plan and provider partners both identified the difficulties of adapting to ongoing regulatory changes and described how frequent changes can leave partners as well as the broader provider community struggling to remain focused on big-picture goals.

These challenges can be particularly pronounced for local behavioral health plans and providers that are often smaller than larger physical health partners. Behavioral health providers said that it is hard to commit limited resources to developing new models when policy, regulatory, and contractual requirements can quickly change. As a Health Colorado provider interviewee said, provider partners of the RAE must "shift how they allocate resources to ensure that they are on top of not only what is currently required, but in anticipation of what the state may want them to do in the future." The uncertainty can lead to inefficiencies and ineffectiveness. This interviewee offered that partners can better work together in models that are "iterative without being unpredictable." Thus, models should enable innovation while also supporting longer-term investments in system transformation.

Arizona emphasized a transparent integration-rollout process with a multiyear plan for how populations would be phased into an integrated benefit, which may have better positioned partners to navigate challenges. Arizona's purpose in designing the integrated specialty plan model for physical and behavioral health plans as it did was to *begin* learning how to manage integrated benefits, with the understanding that the initial plans were a transitional product that would be incorporated for the general population at a later date. As an interviewee at Steward described, this approach helped to "ease organizations into the transition toward integration" by phasing in different populations. While the model created some challenges, including for providers navigating new claims and payment policies as well as for partners who had to negotiate new contracts twice in a three-year period, from the perspective of the plan the partnership succeeded in its goal to be "a vehicle to help guide the transition to integration."

Across different state processes — and especially in those with fast timelines to implement new models — organizations benefit from partnering with established organizational relationships. Multiple interviewees characterized their relationships with partners as going back decades, and said that these preexisting relationships facilitated the development of a new organization. Because partners need to quickly develop bids, governing agreements, and plans, these preexisting relationships can help to accelerate their work. A plan interviewee shared that working with longstanding partners "fundamentally changes the learning curve and relative capabilities of the [participating] organizations." Whether or not partners have longstanding relationships, strong working relationships are essential. In the words of a behavioral health provider partner, integrated care in Medicaid requires "finding a group of people that can collaborate to create a better system." As states prepare for major system transitions, they should consider opportunities to seed or otherwise support the development of partnerships that can provide important foundations for long-range strategic goals.

Looking Ahead

Successful physical-behavioral integration approaches often bring together physical and behavioral health organizations as partners in designing and implementing new models of care. States interested in advancing physical-behavioral health integration in Medicaid, including through developing or refining integrated managed care or ACO models, may benefit from applying the lessons of partnerships that have emerged and matured in other states. Leaders in partnering organizations interviewed for this brief identified key ingredients that can best position these partnerships to succeed in designing, implementing, and improving system changes to meet the comprehensive health needs of members and communities. These lessons reflect the importance of designing an overall policy approach, timeline, and requirements that best position key stakeholders to innovate and achieve more integrated care.

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Michigan Consortium for Healthcare Excellence
SWMBH Executive Officer Board Report

For period July 2019 thru March 2020

April 10, 2020

MCHE Activity July 2019 – March 2020

Board Meetings

- July 11, 2019
- September 5 2019
- November 7, 2019
- January 9, 2020
- March 5, 2020

Annual MCHE Members Meeting

- November 7, 2019

External Contacts Under Development or Complete

- Statewide Portal-Support with Oakland County Community Mental Health Authority
- Statewide Utilization Management Parity Software system selected and under installation state-wide
- Michigan Department of Corrections (MDOC) Substance Use Disorder (SUD) - each PIHP will have a contract with MDOC for community-based MDOC sponsored and paid SUD services for supervisees (parolees and probationers) effective April 1 2020

Future Plans

- Conversations underway to positively influence MDHHS Public System Reform efforts

MCHE Activity July 2019 – March 2020

Initiatives

Ongoing Work Groups

- Managed Care Regulations (all Prepaid Inpatient Health Plans (PIHPs). Work completed, group suspended.
- Reciprocity: Direct Care Worker Training (all PIHPs)
- Reciprocity: Provider Reviews and Audits (all PIHPs)
- Behavioral Health Advocate Community Representatives (all PIHPs)
- SAPT (Substance Abuse Prevention and Treatment) Advocacy including regarding revise LARA Regulations
- Standardization of Provider Network Applications, Credentialing, and Site Reviews

New

- Statewide Portal
- Inpatient Psychiatric Bed Inventory Management
- Utilization Management Parity

Why Collaborate?

- Enhance public policy influence via collective consensus views and advocacy with executive branch
- Enhance collective and individual relations with Advocacy groups and individuals
- Share scarce resources
- Share operational and performance information for quality improvement and benchmarking
- Reduce provider burdens and provider administrative costs
- Reduce PIHP administrative costs
- Identify and pursue system opportunities

Questions?

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

as of 3/13/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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

REGIONAL ENTITY/PRE-PAID INPATIENT HEALTH PLAN CHIEF EXECUTIVE OFFICERS GROUP

Willie Brooks	Joseph Sedlock	Bradley P. Casemore
Vice Chair	*Chair*	*Spokesperson*

Proposal for PIHP Provision of Complex Care Management with Michigan Medicaid Unenrolled Beneficiaries

March 23, 2020

Mr. Robert Gordon, Director
Michigan Department of Health and Human Services
333 S. Grand PO Box 30195 Lansing MI 48909 and via e-mail

Director Gordon,

We hope that you and yours are healthy and safe during these unusual times and we appreciate the Administration's efforts in public health and safety. Our specialty services populations and providers are especially vulnerable. Please know that our efforts also have been focused on supporting our regions.

As proposed in our February 28 memo to you on behalf of the Regional Entity (RE)/Prepaid Inpatient Health Plan (PIHP) CEO's, this Proposal frames the exploration of and discussions with the Michigan Department of Health and Human Services (MDHHS) *regarding contracting with the current REs/PIHPs as the provider of Complex Care Management to manage physical and behavioral health care for unenrolled/fee for service (FFS) Medicaid beneficiaries with severe mental illness, intellectual & developmental disabilities and/or substance use disorders with one or more chronic comorbid physical ailments.* We believe this is an approach that can begin relatively soon. We look forward to discussing this with you and your MSA and BHDDA Teams on April 1 during the Regional Entity/ PIHP CEO Call Meeting beginning at 2:00 p.m. For ease of reference, the telephone number to call for participation is **#** 800.250.3900 / Passcode: 16927953#.

Michigan Medicaid offers benefits under a state managed FFS program or through Medicaid Health Plans (MHPs) for physical healthcare services with specialty behavioral health services[1] managed through 10 RE/PIHPs *for both enrolled and unenrolled*

[1] Specialty behavioral health services include services to persons with severe mental illness, intellectual/developmental disabilities, children with serious emotional disturbance and/or substance use disorders.

beneficiaries. As is the case in most Medicaid state programs, traditional MHP enrolled beneficiaries are primarily non-disabled children and adults under the age of 65 while the FFS program provides physical healthcare services to beneficiaries who are predominately disabled, higher cost, and exempt from mandatory MHP enrollment. Per Dave Schneider at our meeting on March 5 Michigan spends approximately $4 billion on physical and behavioral health combined for the specialty services population. Of that amount roughly $2.7 billion goes towards behavioral health and $1.3 billion for physical health. Of the $4 billion about $1.4 billion is expended for the unenrolled population for behavioral health and physical health combined.

Although Michigan's behavioral health carve out is sometimes claimed to be a barrier to integrated care, the behavioral health carve out via PIHPs are the primary and best vehicle to fund and manage specialty behavioral health services to the FFS population given their lack of managed care support. Because the FFS population inherently has more physical health comorbid conditions, services and costs, PIHPs and their CMHSPs and substance use disorder service systems have been providing varying levels of care coordination/management for both physical and behavioral health care for decades. This is accomplished in two ways. PIHPs are responsible for the *entire Medicaid population* for specialty behavioral health services within their geographic regions and freedom of choice is waived through Michigan's Section 1115 Managed Care Waiver.

While PIHPs have contractually required Coordination of Care Agreements with MHPs with shared at-risk performance metrics, no such requirement or effort is required of PIHPs for persons in FFS status. Notably, PIHPs already have access to behavioral health (including substance use disorder) and physical health data via CC360 and its downloads to identify and stratify target subsets of individuals for Complex Care Management. This combined with the decades of experience of the public behavioral health system in outreach, engagement, support and whole health management for specialty populations makes our proposed approach an obvious solution.

Our Proposal is to contract with MDHHS to provide Complex Care Management for the Medicaid unenrolled fee for service specialty service populations with prospectively identified health services utilization reduction and health status positive outcomes measures.

REs/PIHPs with MDHHS would:

a. Identify and stratify subset(s) of Medicaid beneficiaries in FFS status with specialty services behavioral health disorder and at least one chronic physical health co-morbidity;
b. Detail in writing the additional roles and functions of the REs/PIHPs in providing Complex Care Management (CCM);
c. Quantify in writing the resources required such that adequate additional prospective non-risk payments are made to REs/PIHPs for CCM services;
d. Monitor the health status and utilization of physical health services for assigned individuals and quantify the favorable impacts; and
e. Provide in writing for sharing of the physical health expense savings and physical health improvement performance bonus awards with proceeds earned by REs/PIHPs as local funds.

In summary, to accomplish this Complex Care Management, the RE/PIHP CEOs invite MDHHS to rapidly engage with us to co-develop such an approach and PIHP contract Amendment. Since the state and the REs/PIHPs are both governmental entities, we propose that MDHHS and the REs/PIHPs would jointly retain and share their respective savings and earnings for reinvestment into the public behavioral system healthcare savings recognized from these Complex Care Management efforts.

The RE/PIHP CEO's look forward to further dialog regarding some or all these options during our call meeting April 1. Again, thank you for your time and considerations.

Respectfully on behalf of all RE/PIHP CEOs,

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CEO SWMBH

cc: M. Groen, L. Hertel, S. Esty, Regional Entity/PIHP CEOs