Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For audio you must dial in on your phone:
1-844-655-0022
access code: 738 811 844
To request accommodation under ADA please call Anne Wickham at 269-488-6982
May 8, 2020
9:30 am - 11:00 am
Draft: 4/29/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d) p. 1**
3. **Board Action: Financial Interest Disclosure Handling (M. Todd)**
   - None scheduled
4. **Consent Agenda**
   - April 10, 2020 SWMBH Board Meeting Minutes (d) p. 3
5. **Operations Committee**
   a. March 25, 2020 Operations Committee meeting minutes (d) p. 10
   b. April 8, 2020 Operations Committee meeting minutes (d) p. 13
6. **Environmental Scan – Alan Bolter (9:45-10:15am) (content to be displayed during the meeting)**
7. **Ends Metrics Updates *needs motion**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   - *Michigan Mission Based Performance Indicator System Update (d) (J. Gardner) p. 15
8. **Board Actions to be Considered**
   a. Strategic Imperatives (d) (B. Casemore) p. 22
   b. Substance Use Disorder Oversight Policy Board Inter-Governmental Contract Renewal (d) (B. Casemore) p. 24
   c. Credentialing of Behavioral Health Organizational Providers Policy (d) (M. Todd) p. 31
   d. Board Retreat Planning
9. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - BG-011 Governing Style (d) p. 37

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

- BEL-004 Treatment of Staff (d) (E. Meny) p. 39

11. Board Education

- MI Health Link Update (d) (M. Kean) p. 40

12. Communication and Counsel to the Board

a. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson) p. 53
b. Fiscal Year 2020 Mid-Year Contract Vendor Summary (d) (T. Dawson) p. 61
c. Community Mental Health Association of Michigan System Transformation (d) (B. Casemore) p. 65
d. SWMBH Board Retreat Notebook Material for May (d) (Mary Ann Bush) p. 68
e. Board Member Attendance Roster (d) p. 83
f. June: BEL-002 Financial Conditions (T. Schmelzer)
g. June: BEL-006 Investments (P. Garrett)

13. Public Comment

14. Adjournment

SWMBH adheres to all applicable laws, rules, and regulations in the operation of its public meetings, including the Michigan Open Meetings Act, MCL 15.261 – 15.275.

SWMBH does not limit or restrict the rights of the press or other news media.

Discussions and deliberations at an open meeting must be able to be heard by the general public participating in the meeting. Board members must avoid using email, texting, instant messaging, and other forms of electronic communication to make a decision or deliberate toward a decision and must avoid "round-the-horn" decision-making in a manner not accessible to the public at an open meeting.

Next SWMBH Board Meeting
June 12, 2020
9:30 am - 11:00 am
Planning Session 11:15 am to 1:30 pm
Lunch Served – please RSVP
5250 Lovers Lane, Portage, MI 49002

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
April 10, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 4/13/20

Members Present via phone: Tom Schmelzer**,** Edward Meny, Susan Barnes, Robert Nelson, Michael McShane, Patrick Garrett, Erik Krogh, and Janet Bermingham

Guests Present via phone: 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; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Deb Hess, Van Buren Community Mental Health; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Richard Thiemkey, Barry County Community Mental Health; Jon Houtz, Pines BH Alternate; Pat Guenther, Kalamazoo Alternate; Robert Becker, Barry Alternate; Randy Hyrns, Berrien Alternate; Jeff Patton, ISK; Randy Paruch, IT Program Manager, SWMBH; Derek Miller, Roslund, Prestage & Company; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Mary Ann Bush, Senior Operations Specialist and Project Coordinator, SWMBH

Welcome Guests

Tom Schmelzer called the meeting to order at 9:48 am, introductions were made, and Tom welcomed the group. Tom Schmelzer gave the following announcement: We have established Public Comment times whose availability, duration and number of speakers is at the Chair's discretion. Please hold public comment until those times are announced. Please do not place your phones on hold – mute is ok. Brad Casemore gave the following announcement: SWMBH cannot and will not limit or restrict Press or Media Participation. Board Members must refrain from communicating with and amongst each other during the meeting by any means, including but not limited to texting, e-mail, Instant Messaging etc.

Public Comment

None

Agenda Review and Adoption

Motion	Edward Meny moved to accept the agenda as presented with the deletion of Alan Bolter's presentation as Mr. Bolter was unavailable.
Second	Erik Krogh
Motion Carried	

Financial Interest Disclosure Handling

Mila Todd reviewed the Financial Interest and Conflict of Interest statements from Janet Bermingham.

Motion	Erik Krogh moved that a conflict of interest exists, the Board is not able to obtain a more advantageous transaction or arrangement from someone other than Janet Bermingham, the Financial Interest disclosed by Janet Bermingham 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 Janet Bermingham, and the conflict should be waived.

Second Patrick Garrett

Motion Carried

Fiscal Year 2019 Audit Report

Derek Miller of Roslund, Prestage & Company reported as documented and thanked the Audit Committee for their in-depth review of the report presented to them on April 3, 2020.

Motion Edward Meny moved that the Audit Committee reviewed and approved the report as presented by Derek Miller.

Second Erik Krogh

Motion Carried

Consent Agenda

Motion Susan Barnes moved to approve the March 13, 2020 Board meeting minutes as presented.

Second Edward Meny

Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Operations Committee

Operations Committee Minutes February 26, 2020

Debra Hess reported as documented. Minutes accepted.

Operations Committee Quarterly Report

Debra Hess reported as documented. Report accepted.

Environmental Scan

Brad Casemore stated that the Governor announced supplemental funds are coming for COVID-19 response and the dramatic influence it is and will have in our State and system. Brad Casemore thanked SWMBH senior leadership, SWMBH staff and the CMH providers for all their work on COVID-19. The Board also expressed their gratitude to SWMBH staff.

Ends Metrics

Assessment Tools: American Society of Addiction Medicine (ASAM)

Moira Kean reported as documented. Discussion followed.

Motion	Pat Garrett moved that the data is relevant and compelling, the Executive Officer is not in compliance as SWMBH achieved a 94.1% and the Metric threshold is 95%. The Ends do not need revision at this time.	
Second	Erik Krogh	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Board Actions to be Considered

SWMBH Board Elections

Tom Schmelzer noted the SWMBH Board discussion and decision of the last year that every two years the SWMBH Board Vice Chair will become the SWMBH Board Chair and as such Edward Meny would become the SWMBH Board Chair. Edward Meny stated that he is willing to take on the responsibilities of Chair.

Motion	Sue Barnes moved to acknowledge the policy and nominate Edward Meny as the SWMBH Board Chair.	
Second	Erick Krogh	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Tom Schmelzer opened the floor for nominations for SWMBH Board Vice-Chair. Susan Barnes nominated Patrick Garrett. Patrick Garrett thanked Susan Barnes for the nomination, but due to personal reasons was not able to accept the nomination. Tom Schmelzer stated if there were no nominations he would serve as the Vice-Chair.

Motion	Susan Barnes moved to nominate Tom Schmelzer as SWMBH Board Vice-Chair.	
Second	Erik Krogh	
Roll call vote	Bob Nelson	yes

	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Tom Schmelzer opened the floor for nominations for SWMBH Board Secretary. Robert Nelson nominated Susan Barnes for SWMBH Board Secretary. No other nominations were brought forward.

Motion	Robert Nelson moved to nominate Susan Barnes as SWMBH Board Secretary.	
Second	Erick Krogh	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Elections occur each April per Board Policy.

2020-2024 Strategic Imperatives

Brad Casemore reported as documented. Discussion followed. Board agreed to table the strategic imperatives until May Board meeting, and more is known regarding COVID-19 considerations and ramifications. Brad and Board members encouraged circulation to CMH Boards, with comments to Brad.

May 8 Board Planning Session

Tom Schmelzer discussed the May 8th Board Retreat scheduled for Sherman Lake.

Motion	Susan Barnes moved to postpone the Board Retreat and reschedule the meeting at a later date.	
Second	Michael McShane	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

This topic will be placed on the May Board Agenda.

Board Policy Review

BG-006 Annual Board Planning

Tom Schmelzer reported as documented.

Motion	Edward Meny moved that the Board is in compliance and Policy BG-006 Annual Board Planning does not revision.	
Second	Patrick Garrett	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

BG-010 Board Committee Principles

Tom Schmelzer reported as documented.

Motion	Patrick Garrett moved that the Board is in compliance and Policy BG-010 Board Committee Principles does not need revision.	
Second	Susan Barnes	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Executive Limitations Review

None scheduled

Board Education

COVID-19 Business Continuity

Anne Wickham reported the responses and steps that SWMBH has taken regarding COVID-19.

- On March 16th SWMBH observed and issued social distancing based on the Governor's order.
- High risk SWMBH staff left the building first followed by all SWMBH staff on March 18th.
- All SWMBH staff are working remotely and IT technology has gone fairly well.

- A few SWMBH staff enter the SWMBH offices weekly for essential functions such as paying vendors, providers, and mailing materials to customers. Social distancing and other COVID-19 guidelines are followed.
- SWMBH Senior Leadership continues to assess the COVID-19 pandemic and has begun the next planning phase of returning to work in the office when the Governor lifts the Stay at Home order.

Edward Meny stated that he was grateful to SWMBH staff for their calm, collective ability to adjust and remain focused on their jobs. He said, "It's remarkable and please share this with your staff."

Final Fiscal Year 2019 Financial Statements

Tracy Dawson reported as documented. Additional funding from the State is expected to begin in April. Discussion followed.

Auditor Procurement

Tracy Dawson stated that SWMBH will be issuing an RFP at the end of April. Four to five auditing firms have been identified for solicitation.

Fiscal Year 2019 Quality Assurance and Performance Improvement and Utilization Management Annual Evaluation Report

Jonathan Gardner reported as documented. Discussion followed.

Workplace Culture Program

Anne Wickham reported as documented. Tom Schmelzer commented that he is glad to see SWMBH having a program for their employees.

System Reform Part 2

Brad Casemore reported as documented.

Communication and Counsel to the Board

Michigan Consortium for Healthcare Excellence (MCHE) Update

Brad Casemore reported as documented.

April 17, 2020 Public Policy Legislative Event Canceled

Brad Casemore noted that the April 17th Legislative Event has been cancelled. SWMBH is looking to reschedule in late summer or early fall.

Board Member Attendance Roster

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

Regional Entities/PIHPs Unenrolled Complex Care Management Proposal to MDHHS

Brad Casemore stated that a three-page proposal was send to DHHS and that DHHS stated that that are interested, and they would respond when they were able.

Public Comment

Randy Hyrns refined his prior statement in interpreting the Governor's Executive Order to be clear that the Executive Order says roll call votes were "urged" but not required as previously stated. Tom Schmelzer thanked everyone for their participation and asked that everyone stay safe.

Adjournment

Motion	Erik Krogh moved to adjourn at 11:26am	
Second	Susan Barnes	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes
Motion Carried		

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: March 25, 2020
9:00am-2:00pm

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

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Jane Konyndyk, Integrated Services of Kalamazoo; Pat Davis, Integrated Services of Kalamazoo; Mary Ann Bush, Senior Operations Specialist and Project Coordinator

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

Review and approve agenda – Agenda approved.

COVID-19 Responses:
SWMBH – Anne Wickham shared SWMBH's first response steps:

- 3/16 Staff moved to remote work
- 3/18 All Utilization Management staff moved to remote work and skeleton crew established
- 3/23 Governor Whitmer announced shelter in place. SWMBH offices closed except for Thursdays with three staff on site to issue checks and mail customer service documents.
- Utilization Management functioning normally. No reductions in hospitalizations.
- Struggles: SUD Detox and Residential COVID-19 response creating less space.

Barry County – Richard Thiemkey shared Barry CMH's first response steps:

- Reduced on site staff to one clinician, one clinical supervisor, two front desk and Admin as needed to issue checks and other.
- Services moved to telehealth with choice for client
- Struggles: discharges and intakes that request face to face, equipment and technology to work from home.

Berrien County – Ric Compton shared Riverwood's first response steps:

- Reduced staff onsite
- Main office closed, safety officer screening people
- Doctor screens telephonically
- Website includes telehealth instructions
- Purchased 50 GoTo licenses

- Daily leadership meetings
- Struggles: personal and pre-paid cell phones, circuits overloaded, mail, FedEx and UPS

Branch County – Sue Germann shared Pines BH's first response steps:

- All staff telehealth or phone
- Face to face very limited
- Staff onsite for injections
- Lobby has two rooms available for telehealth of calls
- Struggles: phones for crisis workers, need iPad, reception not 6ft distance from visitor, CLS, ABA, HAB waiver, recerts and ADOS

Calhoun County – Jeannie Goodrich shared Summit Pointe's first response steps:

- Essential staff moved to one building downtown for injections, crisis, issuing checks
- Phone pre-screens
- Services moved to telehealth
- Summit Pointe working with Battle Creek City emergency plan
- Leadership meetings twice per day
- Struggles: high call volume so switchboard moved back onsite
-

Cass County – Tim Smith shared Woodland BH's first response steps:

- Skeleton crew, one phone support, med clinic doctor, access and crisis
- Website announcement
- Telehealth
- Face to face for emergencies

Kalamazoo County – Jane Konyndyk shared ISK's first response steps:

- Staff reduced to 615 Building, mobile crisis, injections, Oakland Shelter and one staff doing jail services
- Switchboard moving to home
- Implementing telehealth for most services
- Provider telephone meetings
- ISK working with Kalamazoo County emergency plan
- Struggles: mail, UPS, FedEx, Office of Recipient Rights working from home

St. Joe County – Kris Kirsch shared St. Joe CMH's first response steps:

- Centreville office locked down
- Injections on the road
- Staff working from home
- Services moved to telehealth
- Two in front office with crisis
- Screening at front door

Van Buren County – Deb Hess shared Van Buren CMH's first response steps:

- Staff reduced in buildings and most working from home
- Switchboard and injections remain on site
- Leadership calls twice per day

- Q&A email for staff and posted on shared drive
- Struggles: Laptops, PPE, phone minute limits for customers

Upstream Guidance Handling – Brad Casemore stated that Upstream Guidance Handling (UGH) documents are being organized at SWMBH. What, if anything, do the CMHSP's want? Discussion followed. A couple of CMHSPs would like UGH information that SWMBH receives. Brad Casemore emphasized that the PIHPS asked the State to be clear on what is mandatory .vs permissible and the need for our CHMSPs to reach a uniform single interpretation to apply region wide.

Provider Special Operational Support (SOS) Team – Brad Casemore reviewed proposed draft of a SWMBH Provider SOS Team. Discussion followed. Operations Committee would like to discuss in the future but does not feel it's needed at this time during the crisis.

Review and approve minutes from 2/26/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 YTD Financials – Tracy Dawson reported as documented, noting changes will come next month due to COVID-19 changes. Discussion followed.

Rate Setting Update – Tracy Dawson reported as documented, noting Milliman and the State stated there was a 70-90-million-dollar problem. Milliman is correcting rates with an announcement that the April payment will be adjusted with addition dollars. How much money to each PIHP was not known. CHAMPS also stated that there were errors in the HSW payments. Brad Casemore added that the PIHPs advocated that the State should pay a lump sum for October through March errors and then additional money April through September.

Cost Allocation Workgroup – Pat Davis stated that the group has not met since early January. The sub workgroup that she is on continues coding review.

Death Audit Recoupments – Tracy Dawson reported that the State is still working on recoupment data and no date for recoupments has been announced.

Strategic Imperative Descriptions – Brad Casemore reported as documented noting that the review process started in February. Discussion followed and group agreed the document was reviewed and could be presented to the Board at their April 10, 2020 meeting.
April SWMBH Board Agenda – Brad Casemore noted the draft Board agenda. Decision to be made by the Board regarding the May Board Retreat meeting.

MDHHS Announcement – Mila Todd shared that MDHHS just announced a reconsidered position regarding certification on Indiana hospitals and would release information soon.

Adjourned – Meeting adjourned at 11:00 am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: April 8, 2020
9:00am-10:00am

Members Present via phone – Debbie Hess**,** Jeannie Goodrich, Jeff Patton, Richard Thiemkey, Ric Compton, Bradley Casemore, Sue Germann

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Jane Konyndyk, Integrated Services of Kalamazoo; Pat Davis, Integrated Services of Kalamazoo

Call to Order – Brad Casemore began the meeting at 9:03 am.

Review and approve agenda – Agenda approved with an addition of SWMBH CMH audit schedule discussion

Upstream Guidance Handling – Brad Casemore stated that Upstream Guidance Handling (UGH) documents are on the SWMBH portal for CMH use. Michelle Jacobs reviewed portal access and document organization during webinar. Discussion followed. Group would like to receive documents via email as well as portal uploads and commented that the organization of the documents on the portal are good and useful.

COVID-19 Updates/Concerns:

Barry County – Richard Thiemkey shared that Specialized Residential is at a critical point and guidance, processes and funding is needed.

Berrien County – Ric Compton asked for more information regarding the State hotel/motel offers. Brad said he was aware that MDHHS BHDDA will have information soon.

Calhoun County – Jeannie Goodrich shared Summit Pointe continues to work with Calhoun County Health Department and City's emergency management plan and is identifying hotels in the area for possible use.

Kalamazoo County – Jeff Patton shared ISK priority is to support providers to stay open. How to fund them and keep them open. Currently one ABA provider has closed and WMU is closed which is creating some difficulties. ROI, CLO and Beacon are not currently taking new clients. Workforce for Specialized Residential and SUD is critical. Concerns with discharges from community hospitals and making sure that

the hospitals are not making determinations on who receives or does not receive treatment based on disability, socio-economic status or other inappropriate reasons. ISK is working with Kalamazoo County emergency management plan in identifying hotels in the area for possible use.

PIHP/CMH/DHHS COVID Planning Calls – Brad Casemore updated group on recent calls including meeting notes that are drafted, emailed out and loaded to the portal. Group appreciated the meeting notes. Brad encouraged CMHs to speak out on the calls.

Senator Bizon – Brad Casemore stated that he received a call from Senator Bizon alleging that inpatient psychiatric hospitals are turfing clients to emergency departments and then will not take the client back due to COVID positive or COVID suspected. Brad Casemore asked that CMH CEOs contact him if this is happening in our region. Brad has been in active communications with Senator Bizon on this.

Review and approve minutes from 3/25/20 Operations Committee Meeting – Minutes were approved by the Committee.

Provider Payment Methodologies – Brad Casemore stated that DHHS is aware of the PIHPs funding, CMH funding and provider cash flow and solvency issues and is working to resolve as soon as possible. Brad Casemore stated that PIHPs continue to request rate letters with payments from the State. Tracy Dawson reported that finance is working with providers around funding issues. Jeff Patton expressed concerns about providers remaining open in our region. Sue Germann inquired about Freedom Recovery opening in Coldwater. Mila Todd addressed and stated that SWMBH would reach out to Freedom Recovery to assist with needed documentation. Discussion followed.

Audits – Mila Todd stated CMH Site Review on-site dates will be postponed and rescheduled with dates TBD. Formal notice is forthcoming, once SWMBH determines how Grievance & Appeals and clinical remote access will be done. Brad reinforced that SWMBH current approach is to postpone or move to desk review at SWMBH to cease or greatly minimize burdens on CMHs. He pointed out that some upstream Audits of SWMBH and our region are unavoidable with one example being the HSAG Performance Measure Validation audit.

April SWMBH Board Agenda – Brad Casemore reviewed the draft Board agenda.

Adjourned – Meeting adjourned at 10:00 am

Performance Measurement Period (MMBPIS)

Date Range: FY 2019 (Oct 18 – Sept 19)

Updated April 15th, 2020

Objective/Results

Board Ends Metric Language:

92% of MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 19

Objective:

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

Overall Results:

59/68 Total Performance Indicators in 2019 met the State Indicated Benchmark of 95% (86.76%)

Reporting Schedule

- Q1: 10/1 to 12/31 (report due to MDHHS on: 3/31)
- Q2: 1/1 to 3/31 (report due to MDHHS on: 6/30)
- Q3: 4/1 to 6/30 (report due to MDHHS on: 9/30)
- Q4: 7/1 to 9/30 (report due to MDHHS on: 12/31)

*MDHHS sends SWMBH a consultative draft report approximately 1 month after results have been submitted, verifying the accuracy and quality of the data submitted.

FY2019 MMBPIS Results

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

Individual Results by CMHSP Overall

Quarter	CMHSP							
	Barry	Pines	ISK	Riverwood	St. Joe	Summit Pointe	Van Buren	Woodlands
Q1	15/17	16/17	14/17	15/17	16/17	13/17	17/17	17/17
Q2	17/17	15/17	17/17	14/17	14/17	16/17	16/17	17/17
Q3	15/17	15/17	15/17	16/17	15/17	16/17	17/17	17/17
Q4	14/17	16/17	16/17	16/17	17/17	11/17	17/17	16/17
Percent:	89.70%	91.17%	91.17%	89.70%	91.17%	82.35%	98.53%	98.53%

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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.

Improvement Efforts

- SWMBH sends CMHSP's appreciation letters upon meeting 100% of the State's performance indicators, which are directed to 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.

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

INTERGOVERNMENTAL CONTRACT

This Contract (this "Contract") is made as of this ___day of _____, ~~2017~~2020, by and among Southwest Michigan Behavioral Health Regional Entity ("SWMBH"), Barry County, Berrien County, Branch County, Cass County, Calhoun County, Kalamazoo County, St. Joseph County and Van Buren County (individually referred to as the "County," and collectively referred to as the "Counties").

RECITALS

SWMBH is a community mental health regional entity formed under the Mental Health Code, MCL 330.1204b.

The Counties are located in a region designated by the Michigan Department of Health and Human Services ("MDHHS") as Region 4 under MDHHS's restructuring of PIHPs in Michigan.

Under 2012 PA 500 and 2012 PA 501, the coordination of the provision of substance use disorder services were transferred from prior existing coordinating agencies to community mental health entities designated by MDHHS to represent a region of community mental health authorities, community mental health organizations, community mental health services programs or county community mental health agencies, as defined under MCL 300.1100a(22).

SWMBH represents eight (8) community mental health authorities in Region 4, and is a MDHHS-designated community mental health entity to coordinate the provision of substance use disorder services in Region 4.

SWMBH, as a MDHHS-designated community mental health entity, is required, under MCL 330.1287(5) to establish a substance use disorder oversight policy board (SUD Oversight Policy Board) through a contractual agreement, under appropriate law, between SWMBH and each of the Counties in Region 4.

SWMBH and the Counties are authorized to enter into contracts under 1951 PA 35, Intergovernmental Contracts Between Municipal Corporations, MCL 124.1 et. seq.

SWMBH and the Counties desire to enter into this Contract, under 1951 PA 35, to establish a SUD Oversight Policy Board.

NOW, THEREFORE, in furtherance of the foregoing and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE I

PURPOSE

Section 1.1 PURPOSE. The purpose of this Contract is to set forth the terms and conditions for the establishment of a SUD Oversight Policy Board pursuant to MCL 330.1287(5).

ARTICLE II

SUD POLICY BOARD

Section 2.1 FUNCTIONS AND RESPONSIBILITIES. The SUD Oversight Policy Board shall have the following functions and responsibilities:

2.1.1 Approval of any portion of SWMBH's budget that contains 1986 PA 2 (MCL 211.24e(11)), funds ("PA 2 Funds") for the treatment or prevention of substance use disorders which shall be used only for substance use disorder treatment and prevention in the Counties from which the PA 2 Funds originated;

2.1.2 Advise and make recommendations regarding SWMBH's budgets for substance use disorder treatment or prevention using non PA 2 Funds; and

2.1.4 Advise and make recommendations regarding contracts with substance use disorder treatment or prevention providers.

Any other function or responsibilities consistent with P.A. 500 330.1287 (5) (d) and as requested by the Community Mental Health Entities (CMHE)

Section 2.2 APPOINTMENT/COMPOSITION. The Board of Commissioners of each of the Counties shall appoint up to two (2) members of the SUD Oversight Policy Board. The Board of Commissioners may appoint any combination of County Commissioners or others, as allowed by Michigan law, that it deems best represents the interests of its County.

Section 2.3 VACANCIES. A vacancy on the SUD Oversight Policy Board shall be filled by the County that originally filled the vacated position.

Section 2.4 REMOVAL. The County that appointed a SUD Oversight Policy Board member may remove its appointee at any time. The SUD Oversight Policy Board is responsible for informing the relevant County of any lack of participation or attendance by the County's appointed SUD Oversight Policy Board member. Attendance records shall be provided to County Commissions at least twice annually.

Section 2.5 ETHICS AND CONFLICTS OF INTEREST. The SUD Oversight Policy Board shall adhere to all conflict of interest and ethics laws applicable to public officers and public servants, serving as members of the SUD Oversight Policy Board.

Section 2.6 **COMPLIANCE WITH LAWS.** The SUD Oversight Policy Board shall fully comply with all applicable laws, regulations and rules, including without limitation 1976 PA 267 (the "Open Meetings Act"), 1976 PA 422 (the "Freedom of Information Act"), 2012 PA 500, 2012 PA 501 and 1986 PA 2.

Section 2.7 **BYLAWS.** The SUD Oversight Policy Board shall maintain and periodically review its Bylaws.

Section 2.8 Bylaws may be amended by the SUD Oversight Policy Board as provided in those Bylaws. The parties hereto agree that said Bylaws are not subject to SWMBH's approval.

ARTICLE III

SWMBH

Section 3.1 **FUNDING.** SWMBH shall ensure that PA2 funding dedicated to substance use disorder services shall be retained for substance use disorder services and not diverted to fund services that are not for substance use disorders. MCL 330.1287(2).

ARTICLE IV

TERM AND TERMINATION

Section 4.1 **TERM.** The Term of this Contract shall commence on January 1, ~~2018~~2021, and continue for a term of three (3) years ending December 31, ~~2020~~2024, unless terminated at an earlier date as provided in Section 4.2.

Section 4.2.1 TERMINATION. Any party may terminate their participation in this Contract at any time for any or no reason by giving all other parties thirty (30) days written notice of the termination. Any notice of termination of this Contract shall not relieve either party of its obligations incurred prior to the effective date of such termination.

Section 4.2.2 TERMINATION of CMHE status. This contract shall automatically and simultaneously terminate in the event MDHHS withdraws its authorization of SWMBH as CMHE for PA2.

ARTICLE V

LIABILITY

Section 5.1 **LIABILITY/RESPONSIBILITY.** No party shall be responsible for the acts or omissions of the other party or the employees, agents or servants of any other party, whether acting separately or jointly with the implementation of this Contract. Each party shall have the sole nontransferable responsibility for its own acts or omissions under this Contract.

The parties shall only be bound and obligated under this Contract as expressly agreed to by each party and no party may otherwise obligate any other party.

ARTICLE VI

MISCELLANEOUS

Section 6.1 AMENDMENTS. This Contract shall not be modified or amended except by a written document signed by all parties hereto.

Section 6.2 ASSIGNMENT. No party may assign its respective rights, duties or obligations under this Contract.

Section 6.3 NOTICES. All notices or other communications authorized or required under this Contract shall be given in writing, either by personal delivery or certified mail (return receipt requested) and shall be deemed to have been given on the date of personal delivery or the date of the return receipt of certified mail. Notices shall be delivered to the Executive Officer of SWMBH and the County Administrator of each County in the (8) eight county region.

Section 6.4 ENTIRE AGREEMENT. This Contract shall embody the entire agreement and understanding between the parties hereto with respect to the subject matter hereof. There are no other agreements or understandings, oral or written, between the parties with respect to the subject matter hereof and this Contract supersedes all previous negotiations, commitments and writings with respect to the subject matter hereof.

Section 6.5 GOVERNING LAW. This Contract is made pursuant to, and shall be governed by, construed, enforced and interpreted in accordance with, the laws and decisions of the State of Michigan.

Section 6.6 BENEFIT OF THE AGREEMENT. The provisions of this Contract shall not inure to the benefit of, or be enforceable by, any person or entity other than the parties and any permitted successor or assign. No other person shall have the right to enforce any of the provisions contained in this Contract including, without limitation, any employees, contractors or their representatives.

Section 6.7 ENFORCEABILITY AND SEVERABILITY. In the event any provision of this Contract or portion thereof is found to be wholly or partially invalid, illegal or unenforceable in any judicial proceeding, such provision shall be deemed to be modified or restricted to the extent and in the manner necessary to render the same valid and enforceable, or shall be deemed excised from this Contract, as the case may require. This Contract shall be construed and enforced to the maximum extent permitted by law, as if such provision had been originally incorporated herein as so modified or restricted, or as if such provision had not been originally incorporated herein, as the case may be.

Section 6.8 CONSTRUCTION. The headings of the sections and paragraphs contained in this Contract are for convenience and reference purposes only and shall not be used in the construction or interpretation of this Contract.

Section 6.9 **COUNTERPARTS.** This Contract may be executed in one or more counterparts, each of which shall be considered an original, but together shall constitute one and the same agreement.

Section 6.10 **EXPENSES.** Except as is set forth herein or otherwise agreed in writing by the parties, each party shall pay its own costs, fees and expenses of negotiating and consummating this Contract, the actions and agreements contemplated herein and all prior negotiations, including legal and other professional fees.

Section 6.11 **REMEDIES CUMULATIVE.** All rights, remedies and benefits provided to the parties hereunder shall be cumulative, and shall not be exclusive of any such rights, remedies and benefits or of any other rights, remedies and benefits provided by law. All such rights and remedies may be exercised singly or concurrently on one or more occasions.

Section 6.12 **BINDING EFFECT.** This Contract shall be binding upon the successors and permitted assigns of the parties.

Section 6.13 **NO WAIVER OF GOVERNMENTAL IMMUNITY.** The parties agree that no provision of this Contract is intended, nor shall it be construed, as a waiver by any party of any governmental immunity or exemption provided under the Mental Health Code or other applicable law.

ARTICLE VII

CERTIFICATION OF AUTHORITY TO SIGN THIS CONTRACT

The persons signing this Contract on behalf of the parties hereto certify by said signatures that they are duly authorized to sign this Contract on behalf of said parties, and that this Contract has been authorized by said parties pursuant to formal resolution(s) of the appropriate governing body(ies), copies of which shall be provided to SWMBH.

IN WITNESS WHEREOF, the parties hereto have entered into, executed and delivered this Contract as of the dates noted below.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH REGIONAL ENTITY

By: _____ Date: _____
Its: _____

BARRY COUNTY

By: _____ Date: _____
Its: _____

BERRIEN COUNTY

By: _____ Date: _____
Its: _____

BRANCH COUNTY

By: _____ Date: _____
Its: _____

CASS COUNTY

By: _____ Date: _____
Its: _____

CALHOUN COUNTY

By: _____ Date: _____
Its: _____

KALAMAZOO COUNTY

By: _____ Date: _____
Its: _____

ST. JOSEPH COUNTY

By: _____ Date: _____
Its: _____

VAN BUREN COUNTY

By: _____ Date: _____
Its: _____

IA 7-19-17
MJ

Section: **Provider Network Management**	Policy Name: **Credentialing and Re-Credentialing: Organizational Providers**	Policy Number: **2.3**
Owner: **Director of Provider Network**	Reviewed By: **Mila C. Todd**	Total Pages: **6**
Required By: ☒ **BBA** ☒ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: **<Signature of SL approving policy>**	Date Approved: **<M-D-YYYY>**
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **01-01-2014**

Policy: Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (CMHSP) will credential and re-credential behavioral health organizational providers with whom they contract and that fall within their scope of authority and action. In addition to organizations it directly contracts with, SWMBH shall credential the following organizations on behalf of the Region:

1. Inpatient Psychiatric providers;
2. Crisis Residential providers;
3. Autism Service providers.

Neither SWMBH nor its participant CMHSPs will discriminate against any provider solely on the basis of licensure, registration or certification. Neither SWMBH nor its participant CMHSPs will discriminate against health care professionals or organizations who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

Purpose: To ensure that all customers served receive care from licensed organizational providers who are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network Management; CMHSPs' Provider Network Management departments

Responsibilities:

SWMBH Provider Network Management department is responsible for credentialing and re-credentialing behavioral health organizational providers with which SWMBH directly contracts, as well credentialing and re-credentialing various provider organizations on behalf of the Region.

Participant CMHSPs are responsible for credentialing and re-credentialing behavioral health organizations with which they directly contract and that fall within their scope of authority and action.

Organizational behavioral health providers may be required to credential and re-credential employed/contracted individual practitioners, pursuant to the organization's contract with SWMBH and/or participant CMHSP(s).

Definitions: None

Standards and Guidelines:

A. Credentialing of Licensed Behavioral Health Facilities

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require licensed behavioral health facilities (i.e., acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities) and organizations providing Home and Community Based Services (HCBS) wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application. The application will contain:
    a. A signed and dated statement from an authorized representative.
    b. Documentation collected and verified for health care facilities will include (as applicable), but are not limited to, the following information:

Documentation Requirement	**Clean File Criteria**
Complete application with a signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization SWMBH or CMHSP to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure information. License status and any license violations or special investigations incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license violations and no special state investigations in time frame (in past five years for initial credentialing and past two years for re-credentialing).

Accreditation by a national accrediting body (if such accreditation has been obtained). Substance abuse treatment providers are required to be accredited. If an organization is not accredited, an on-site quality review will occur by SWMBH or CMHSP provider network staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction for an on-site pre-credentialing site review. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, NCQA, CHAPS, COA, and AOA.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgments from within the last ten (10) years.
Verification that the providers has not been excluded from Medicare/Medicaid participation.	Is not on the OIG Sanctions list /SAM List
A copy of the facility's liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.
Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of facility.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals and recipient rights complaints are within the expected threshold given the provider size, MMBPIS and other performance indicators if applicable meet standard.

2. During initial credentialing and at re-credentialing, SWMBH or participant CMHSPs will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding the inclusion on the SWMBH Provider Network. Packets will be reviewed for completeness prior to committee meeting. If files meet clean file criteria in every category listed, the medical director or designee may sign off to approve the provider, in lieu of taking to Credentialing Committee.
3. During initial credentialing and at re-credentialing, SWMBH and its participant CMHSPs will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision the organizational provider will be notified of the reason in writing and of their right to and process for appealing /disputing the decision in accordance with SWMBH policy 2.14. Reapplication for terminated or denied providers will be considered after six months from the date of the last decision.

B. Temporary/Provisional Credentialing Process

1. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed.

2. Providers seeking temporary or provisional status must complete a signed application with attestation.
3. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of application.
4. In order to render a temporary/provisional credentialing decision, verification will be conducted of:
    a. Primary-source verification of a current, valid license.
    b. Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.
    c. Medicare/Medicaid sanctions
5. Each factor must be verified within 180 calendar days of the provisional credentialing decision. The organization shall follow the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
6. Temporary / Provisional credentialing status shall not exceed 60 days, after which time the credentialing process shall move forward according to this credentialing policy.

C. Assessment of Other Behavioral Health Organizations (other than acute care psychiatric facilities, specialized residential homes, crisis residential providers, substance abuse residential and detoxification facilities, and substance abuse outpatient facilities)
    1. Before executing an initial contract, SWMBH and participant CMHSP will require other behavioral health organizations not listed in section A to provide:
        a. State and federal license, if applicable
        b. Current W-9
        c. Verification of liability insurance coverage
        d. Accreditation status, if applicable
    2. If the provider is not accredited and will be providing services at their place of business (ambulatory clinics), an on-site quality review must occur prior to contracting. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, CHAPS, NCQA, COA, and AOA.
    3. SWMBH or the participant CMHSP will verify that the provider has not been excluded from Medicare participation (is not on the OIG Sanctions list/SAM List).
    4. SWMBH or the participant CMH will verification that the provider has met all state and federal licensing and regulatory requirements, if applicable.

D. Organizational providers may be held responsible for credentialing and re-credentialing their direct employed and subcontracted professional service providers per SWMBH or SWMBH CMHSP contractual requirements. They shall maintain written policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements. SWMBH or a participant CMHSP shall verify through on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

E. SWMBH will have processes in place for implementing procurement standards in compliance with Federal Managed Care Requirements (42 CFR Part 438 and Federal Procurement Requirements 45 CFR Parts 74, 92 and 95), including but not limited to the below (see SWMBH Operational Policy 1.3 for more information):

1. Will not discriminate against the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. (42 CFR §438.12)
2. Will give those providers not selected for inclusion in the network written notice of the reason for its decision. (42 CFR §438.12)
3. Shall not discriminate against providers, in the selection and practices, which serve high risk populations or specialize in conditions that require costly treatment. (42 CFR §438.214)
4. Shall not select providers for contracting who are sanctioned or disbarred from a Federal Health Care program. (Social Security Act 1128, 1128A; 42 CFR §438.214; 45 CFR Part 74)
5. Shall prohibit any employee, officer or agent from participating in the selection, award or administration of a contract if a conflict of interest exists, unless the SWMBH Board or its designee determines that the interest is not substantial and has granted a Conflict Waiver. (45 CFR §74.42; 45 CFR §92.36(b)(3)(iv))

References:

A. NCQA Credentialing and Credentialing CR8
B. MDHHS-PIHP Contract Attachment P.7.1.1
C. Medicaid Managed Care Regulations 42 CFR § 438.214

Attachments:

<Name of attachments>

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
01	04/29/20	N/A	Updated to new template.	Mila C. Todd
02	04/29/20	"Policy" Section	Clarified which organizational providers SWMBH credentials and re-credentials on behalf of the Region (inpatient psych, crisis res, and autism service providers).	Mila C. Todd

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-011	Pages: 2
Subject: Governing Style and Commitment	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
04.11.2014	5.10.19	04.11.15, 05.08.15, 5.13.16, 12.9.16, 5.12.17, 5.11.18

I. **PURPOSE:**

The SWMBH Board will engage in continual refinement of its values and vision, guaranteeing the accountability of SWMBH through monitoring of performance.

,

II. **POLICY:**

The Board will govern lawfully, observing the principles of the Policy Governance model, with an emphasis on (a) outward vision rather than an internal preoccupation, (b) encouragement of diversity in viewpoints, (c) strategic leadership more than administrative detail, (d) clear distinction of Board and Chief Executive roles, (e) collective rather than individual decisions, (f) future rather than past or present focus, and (g) proactivity rather than reactivity.

III. **STANDARDS:**

Accordingly, the SWMBH Board shall:

1. Cultivate a sense of group responsibility. The Board, not the staff, will be responsible for excellence in governing. The Board will be the initiator of policy, not merely a reactor to staff initiatives. The Board will not use the expertise of individual member to substitute for the judgment of the Board, although the expertise of individual members may be used to enhance the understanding of the Board as a body.

2. Direct, control, and inspire the organization through the careful establishment of broad written policies reflecting the Board's values and perspectives. The Board's major policy focus will be on the intended long-term impacts, not on administrative or programmatic means of attaining those effects.

3. Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policy-making principles, respect of roles, and ensuring the continuance of governance capability. Although the Board can change its governance process policies at any time, it will observe those currently in force.

4. Continual Board development will include orientation of new Board members in the Board's governance process and periodic Board discussion of process improvement.

5. Allow no officer, individual, or committee of the Board to hinder or be an excuse for not fulfilling group obligations.

6. The Board will monitor and discuss the Board's process and performance periodically. Self-monitoring will include comparison of Board activity and discipline to policies in the Governance Process and Board-Management Delegation categories.

7. Follow the SWMBH Conflict of Interest Policy.

8. When a Member either must recuse themselves or chooses to recuse themselves from voting on a Board decision their prior potential vote count will be removed from the vote tally denominator.

   When a Member abstains from voting on a Board decision their potential vote count will not be removed from the vote tally denominator.

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board Policy	BEL-004	1
Subject:	**Required By**:	**Accountability:**
Treatment of Staff	Policy Governance	SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
03.14.2014	5.10.19	12.12.14, 3/11/16, 4/14/17, 4.13.18

I. **PURPOSE:**

To clearly define the Treatment of SWMBH staff by SWMBH.

II. **POLICY:**

With respect to the treatment of paid and volunteer staff, the EO shall not cause or allow conditions that are unfair, undignified, disorganized, or unclear.

III. **STANDARDS:**

Accordingly the EO may not:

1. Operate without written personnel rules that:
   a. Clarify rules for staff
   b. Provide effective handling of grievances and
   c. Protect against wrongful conditions such as nepotism and grossly preferential treatment for personal reasons.

2. Retaliate against any staff member for expression of dissent.

3. Fail to acquaint staff with the EO interpretation of their protections under this policy.

4. Allow staff to be unprepared to deal with emergency situations.

MI Health Link

Presented by Moira Kean

SWMBH Board Meeting May 8, 2020

MI Health Link

- CMS Capitated Financial Alignment Model Demonstration
- Blends Medicaid and Medicare funding into one health plan
- Began March 1, 2015 in four Michigan regions (Region 4/SWMBH, Upper Peninsula, Macomb, Detroit Wayne)
- Concurrent MI Health Link 1915 (b)(c) Waivers extended from prior end date of 12/31/20, to 12/31/2024.

MI HEALTH LINK
Linking Medicare and Medicaid for you

Structure

- Integrated Care Organizations (ICOs) manage Medicare and Medicaid services for enrolled beneficiaries
- Prepaid Inpatient Health Plans (PIHPs) administer behavioral health services, including for mild to moderate population
  - Medicaid capitation through MDHHS
  - Medicare capitation through ICOs
- Each beneficiary has an ICO Care Coordinator who develops and oversees an integrated care coordination plan
- CareBridge concept for information exchange between plans, providers, and individuals

Eligibility

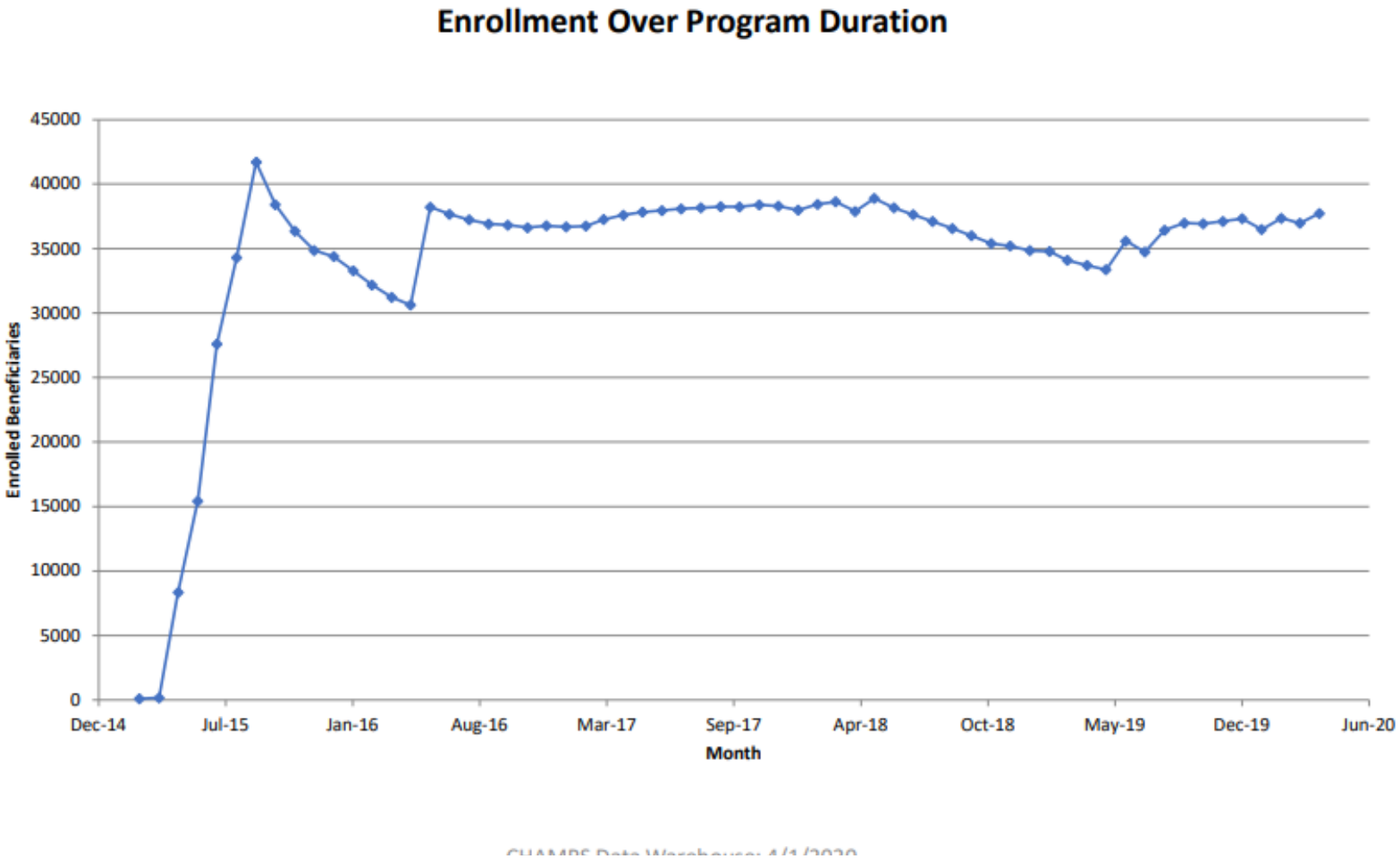
- People may be eligible for MI Health Link if they:
  - Live in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, or any county in the Upper Peninsula
  - Are age 21 or older
  - Have full Medicare and full Medicaid
  - Are not enrolled in hospice
- Eligible individuals may opt in at their request at the beginning of any month, or may be passively enrolled by MDHHS

Beneficiaries Enrolled as of April 2020

	Total Enrollment
Region 1 (Upper Peninsula)	4061
Region 4 (Southwest)	7945
Region 7 (Wayne)	20568
Region 9 (Macomb)	5157
All Regions	37728

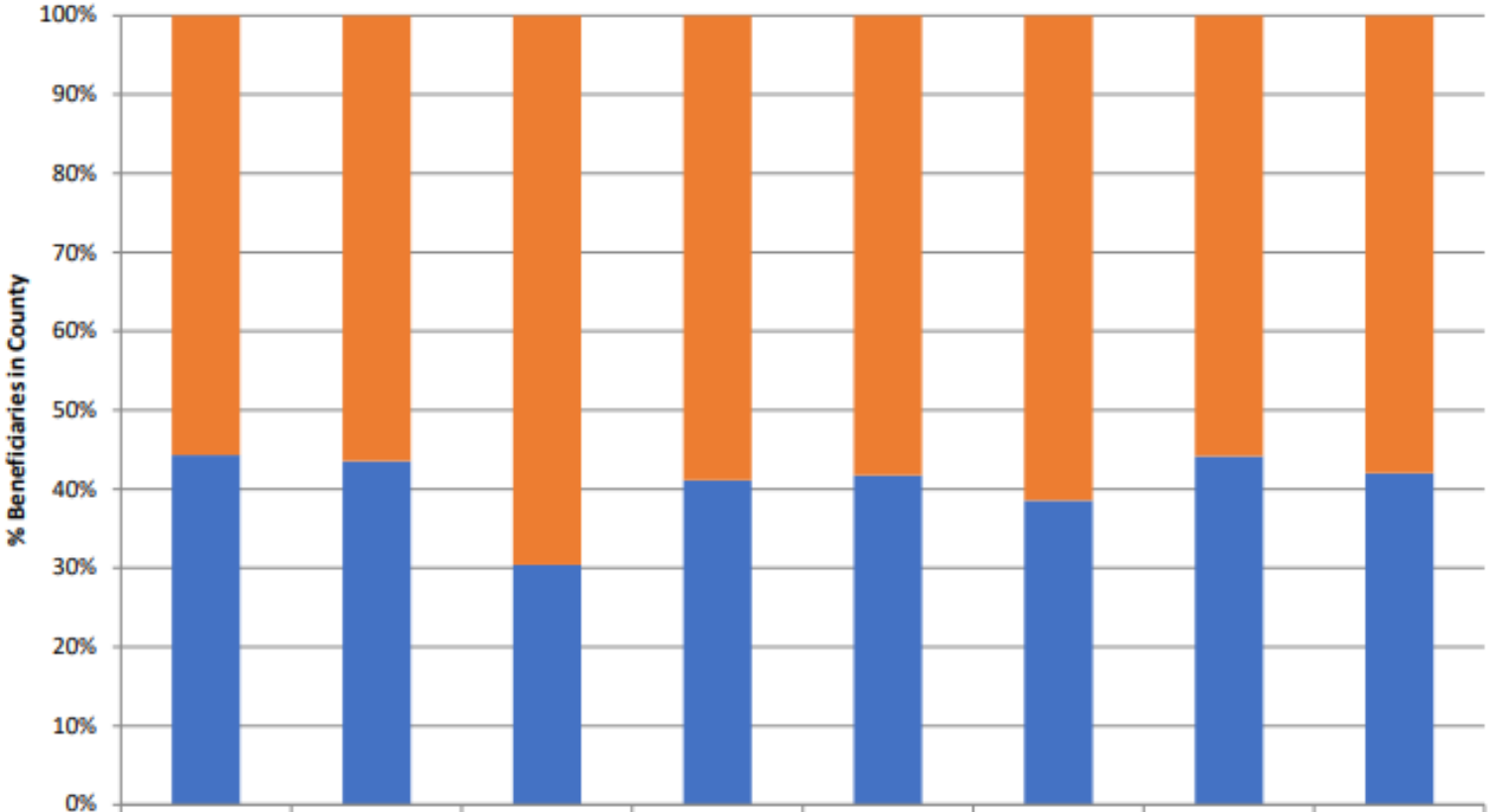
Source: April 2020 Enrollment Dashboard by Michigan Department of Health and Human Services Integrated Care Division

Historical Enrollment – all regions



Source: [April 2020 Enrollment Dashboard](#) by Michigan Department of Health and Human Services Integrated Care Division [45]

Region 4 (SW) Enrollment

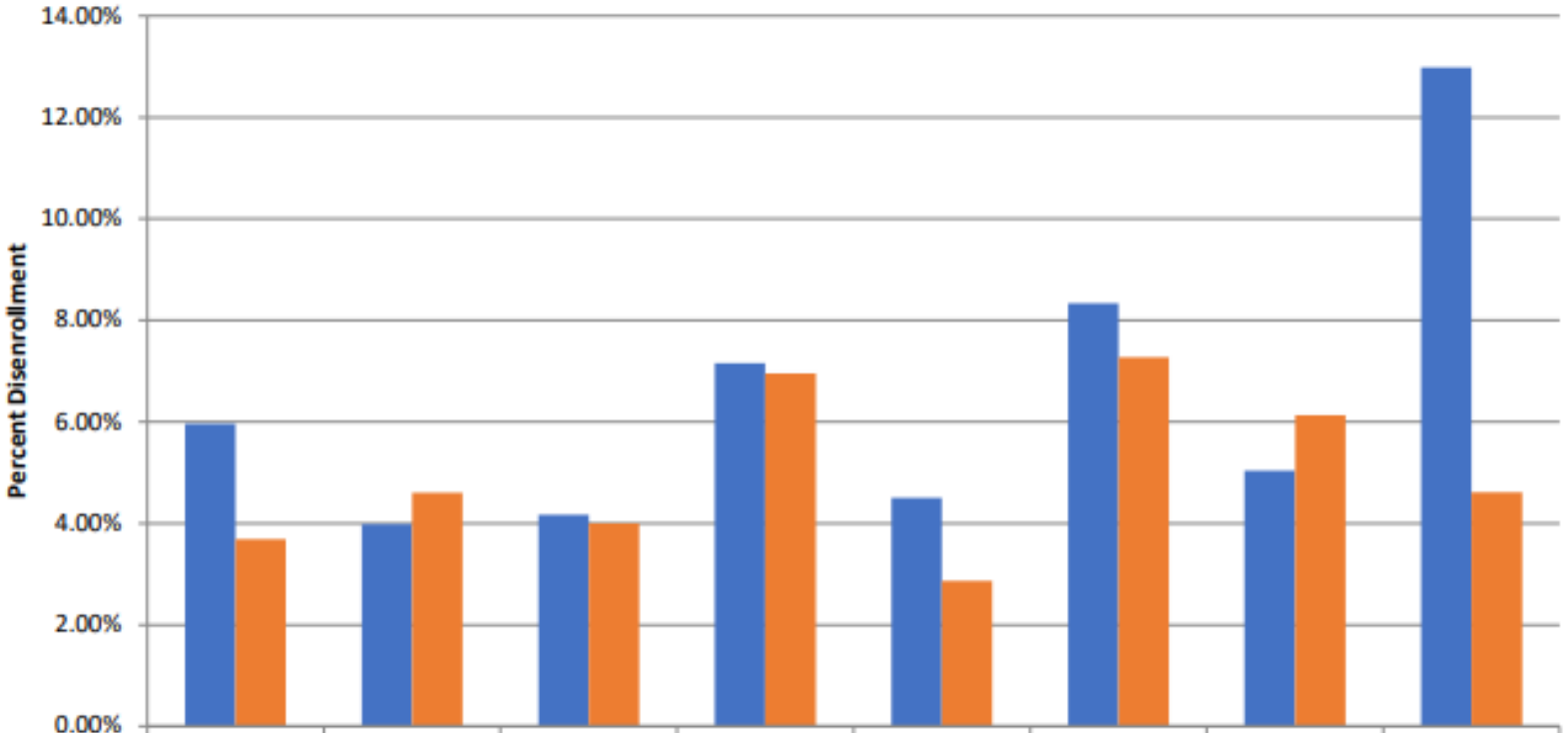


	BARRY	BERRIEN	BRANCH	CALHOUN	CASS	KALAMAZOO	SAINT JOSEPH	VAN BUREN
MER	190	977	275	920	279	1,224	326	499
AET	151	753	120	643	200	768	258	362

Source: [April 2020 Enrollment Dashboard](#) by Michigan Department of Health and Human Services Integrated Care Division [46]

Disenrollment Past Month

As Percent of County Enrollment in ICO



	BARRY	BERRIEN	BRANCH	CALHOUN	CASS	KALAMAZOO	SAINT JOSEPH	VAN BUREN
AET	5.96%	3.98%	4.17%	7.15%	4.50%	8.33%	5.04%	12.98%
MER	3.68%	4.61%	4.00%	6.96%	2.87%	7.27%	6.13%	4.61%

Source: [April 2020 Enrollment Dashboard](#) by Michigan Department of Health and Human Services Integrated Care Division [47]

Table 4
Demonstration enrollment at the end of each calendar year

Enrollment indicator	Number of beneficiaries		
	December 2015	December 2016	December 2017
Eligibility			
Beneficiaries eligible to participate in the demonstration as of the end of the month	104,690	107,423	109, 417
Enrollment			
Beneficiaries currently enrolled in the demonstration at the end of the month	34,858	36,761	38,259
Percentage enrolled			
Percentage of eligible beneficiaries enrolled in the demonstration at the end of the month	33.3%	34.2%	35.0%

SOURCE: RTI International, SDRS, 2016, 2017, and 2018, as revised March 2019.

Source: [Financial Alignment Initiative Michigan MI Health Link First Evaluation Report August 2019](#)

First-Year Evaluation Cost and Utilization Findings

- Cost analyses ***did not indicate statistically significant savings or losses during the first 22 months*** of the demonstration
- Impact analyses found changes in service utilization including decreases in:
  - inpatient admissions,
  - ambulatory care sensitive condition admissions (both overall and those specific to chronic care),
  - emergency room (ER) visits,
  - preventable ER visits,
  - and physician evaluation and management (E&M) visits.
- No change in 30-day all-cause readmission rate or probability of 30-day follow-up visits after mental health inpatient discharge.
- One measure—the rate of long-stay nursing facility (NF) admissions—increased

Source: Financial Alignment Initiative Michigan MI Health Link First Evaluation Report August 2019

Beneficiary Experience Focus Groups

Participants Liked	Participants Did not like
Available benefits and providers	Delays due to prior authorization requirements
Lack of co-pays	Transportation barriers
Free OTC medical supplies	Limited dental benefits
Care coordinators	Turn over among care coordinators
Peace of mind, reduction of health and financial anxiety	Certain non-coverage of prescription medications

Source: MICHIGAN MI HEALTH LINK BENEFICIARY EXPERIENCE CONSUMER FOCUS GROUPS AND INTERVIEWS EXECUTIVE SUMMARY OF KEY FINDINGS

SWMBH's Experience

Benefits of the Program

- Available services and supports for beneficiaries
- Lack of cost sharing
- Care coordination support
- All BH services through the PIHP, including mild to moderate

Challenges

- Many challenges related to contracting and payment, especially in first 2-3 years – confusion on all levels: providers, plans, CMS
- CareBridge and other data exchange challenges
- Eligibility determination challenges
- Medicare scope of practice limitations for behavioral health

Thank you

- Questions or comments?

	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 3/31/2020			**6**									
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%*	78.5%	77.0%	77.7%	78.8%	73.7%	80.3%	81.2%	85.1%	76.0%
7	Subcontract Revenue		103,797,681	7,326,671	96,471,010	4,056,390	18,824,855	5,241,689	17,552,296	5,294,553	29,693,212	6,545,317	9,262,697
8	Incentive Payment Revenue		301,809	180,616	121,193	13,767	-	7,942	38,123	(60)	58,773	-	2,647
9	**Contract Revenue**		**104,099,491**	**7,507,287**	**96,592,204**	**4,070,157**	**18,824,855**	**5,249,631**	**17,590,420**	**5,294,493**	**29,751,985**	**6,545,317**	**9,265,345**
10													
11	External Provider Cost		67,814,704	2,016,885	65,797,819	2,287,685	13,456,463	3,220,597	11,239,637	3,118,853	23,144,279	4,651,117	4,679,188
12	Internal Program Cost		24,999,852	-	24,999,852	1,424,393	5,004,661	1,339,271	5,210,279	1,547,871	4,388,777	2,327,933	3,756,669
13	SSI Reimb, 1st/3rd Party Cost Offset		(409,405)	-	(409,405)	(8,790)	(47,921)	(22,846)	(85,905)	(32,262)	(159,999)	(13,537)	(38,145)
14	Insurance Provider Assessment Withhold (IPA)		2,841,892	2,841,892	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		569,230	569,230	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**95,816,273**	**5,428,007**	**90,388,266**	**3,703,288**	**18,413,203**	**4,537,022**	**16,364,011**	**4,634,462**	**27,373,057**	**6,965,512**	**8,397,712**
17	**Medical Loss Ratio (HCC % of Revenue)**		**92.0%**	**72.3%**	**93.6%**	**91.0%**	**97.8%**	**86.4%**	**93.0%**	**87.5%**	**92.0%**	**106.4%**	**90.6%**
18													
19	**Managed Care Administration**		**9,605,202**	**2,741,685**	**6,863,518**	**273,651**	**1,313,088**	**402,595**	**1,087,451**	**407,003**	**2,360,417**	**462,356**	**556,956**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.1%**	**2.6%**	**6.5%**	**6.9%**	**6.7%**	**8.2%**	**6.2%**	**8.1%**	**7.9%**	**6.2%**	**6.2%**
21													
22	**Contract Cost**		**105,421,476**	**8,169,692**	**97,251,784**	**3,976,939**	**19,726,290**	**4,939,617**	**17,451,462**	**5,041,464**	**29,733,474**	**7,427,869**	**8,954,668**
23	**Net before Settlement**		**(1,321,985)**	**(662,405)**	**(659,580)**	**93,218**	**(901,435)**	**310,014**	**138,958**	**253,029**	**18,511**	**(882,552)**	**310,676**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		1,326,311	666,731	659,580	(93,218)	901,435	(310,014)	(138,958)	(253,029)	(18,511)	882,552	(310,676)
28	**Net after Settlement**		**4,326**	**4,326**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		148,156	148,156	148,156	7,572	28,615	8,233	28,094	8,768	38,966	12,264	15,644
32	Revenue PMPM		$ 117.11	$ 8.45	$ 108.66	$ 89.59	$ 109.64	$ 106.27	$ 104.35	$ 100.64	$ 127.26	$ 88.95	$ 98.71
33	Expense PMPM		$ 118.59	$ 9.19	$ 109.40	$ 87.54	$ 114.89	$ 100.00	$ 103.53	$ 95.83	$ 127.18	$ 100.94	$ 95.40
34	Margin PMPM		$ (1.49)	$ (0.75)	$ (0.74)	$ 2.05	$ (5.25)	$ 6.28	$ 0.82	$ 4.81	$ 0.08	$ (11.99)	$ 3.31
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		148,156	148,156	148,156	7,572	28,615	8,233	28,094	8,768	38,966	12,264	15,644
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)		(251)	(251)	(251)	51	(357)	(204)	181	218	(157)	42	(25)
43	% Variance - Fav / (Unfav)		-0.2%	-0.2%	-0.2%	0.7%	-1.2%	-2.4%	0.6%	2.5%	-0.4%	0.3%	-0.2%
44													
45	**Contract Revenue before settlement**												
46	Actual		104,099,491	7,507,287	96,592,204	4,070,157	18,824,855	5,249,631	17,590,420	5,294,493	29,751,985	6,545,317	9,265,345
47	Budget		102,034,425	8,621,019	93,413,405	3,698,189	18,598,069	4,994,615	17,141,552	4,876,181	28,882,605	6,270,485	8,951,711
48	Variance - Favorable / (Unfavorable)		2,065,066	(1,113,732)	3,178,798	371,968	226,786	255,017	448,868	418,313	869,380	274,832	313,633
49	% Variance - Fav / (Unfav)		2.0%	-12.9%	3.4%	10.1%	1.2%	5.1%	2.6%	8.6%	3.0%	4.4%	3.5%
50													
51	**Healthcare Cost**												
52	Actual		95,816,273	5,428,007	90,388,266	3,703,288	18,413,203	4,537,022	16,364,011	4,634,462	27,373,057	6,965,512	8,397,712
53	Budget		95,324,617	5,165,021	90,159,596	3,888,088	18,226,531	4,779,606	16,072,378	4,628,388	27,327,754	6,485,880	8,750,971
54	Variance - Favorable / (Unfavorable)		(491,656)	(262,986)	(228,670)	184,800	(186,671)	242,584	(291,633)	(6,074)	(45,303)	(479,633)	353,259
55	% Variance - Fav / (Unfav)		-0.5%	-5.1%	-0.3%	4.8%	-1.0%	5.1%	-1.8%	-0.1%	-0.2%	-7.4%	4.0%
56													
57	**Managed Care Administration**												
58	Actual		9,605,202	2,741,685	6,863,518	273,651	1,313,088	402,595	1,087,451	407,003	2,360,417	462,356	556,956
59	Budget		10,292,882	3,483,965	6,808,917	289,526	1,358,643	399,156	1,159,968	354,643	2,297,264	404,962	544,755
60	Variance - Favorable / (Unfavorable)		687,680	742,280	(54,600)	15,875	45,556	(3,439)	72,517	(52,359)	(63,153)	(57,395)	(12,201)

	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 3/31/2020			**6**									
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)		6.7%	21.3%	-0.8%	5.5%	3.4%	-0.9%	6.3%	-14.8%	-2.7%	-14.2%	-2.2%
62													
63	**Total Contract Cost**												
64	Actual		105,421,476	8,169,692	97,251,784	3,976,939	19,726,290	4,939,617	17,451,462	5,041,464	29,733,474	7,427,869	8,954,668
65	Budget		105,617,499	8,648,986	96,968,513	4,177,615	19,585,175	5,178,762	17,232,346	4,983,031	29,625,018	6,890,842	9,295,726
66	Variance - Favorable / (Unfavorable)		196,024	479,294	(283,271)	200,676	(141,116)	239,145	(219,116)	(58,433)	(108,456)	(537,027)	341,057
67	% Variance - Fav / (Unfav)		0.2%	5.5%	-0.3%	4.8%	-0.7%	4.6%	-1.3%	-1.2%	-0.4%	-7.8%	3.7%
68													
69	**Net before Settlement**												
70	Actual		(1,321,985)	(662,405)	(659,580)	93,218	(901,435)	310,014	138,958	253,029	18,511	(882,552)	310,676
71	Budget		(3,583,074)	(27,967)	(3,555,108)	(479,426)	(987,105)	(184,147)	(90,794)	(106,850)	(742,413)	(620,356)	(344,014)
72	Variance - Favorable / (Unfavorable)		2,261,089	(634,438)	2,895,527	572,644	85,670	494,162	229,753	359,879	760,924	(262,195)	654,691
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 3/31/2020			**6**									
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%*	9.0%	10.2%	9.4%	7.2%	11.8%	6.2%	7.3%	8.7%	9.5%
76	**Contract Revenue**		**17,031,664**	**3,589,063**	**13,442,601**	**641,860**	**2,785,048**	**623,457**	**2,428,197**	**795,634**	**3,802,565**	**1,062,633**	**1,303,207**
77													
78	External Provider Cost		9,074,564	3,166,531	5,908,033	202,783	1,429,397	143,603	1,338,695	73,498	1,879,727	275,527	564,803
79	Internal Program Cost		4,448,352	-	4,448,352	286,699	799,309	270,284	1,288,783	284,180	597,005	432,635	489,457
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**13,522,916**	**3,166,531**	**10,356,385**	**489,482**	**2,228,707**	**413,887**	**2,627,478**	**357,678**	**2,476,731**	**708,162**	**1,054,260**
82	**Medical Loss Ratio (HCC % of Revenue)**		**79.4%**	**88.2%**	**77.0%**	**76.3%**	**80.0%**	**66.4%**	**108.2%**	**45.0%**	**65.1%**	**66.6%**	**80.9%**
83													
84	**Managed Care Administration**		**1,172,874**	**404,526**	**768,347**	**36,170**	**158,934**	**36,726**	**174,606**	**31,412**	**213,572**	**47,006**	**69,921**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.0%**	**2.8%**	**5.2%**	**6.9%**	**6.7%**	**8.2%**	**6.2%**	**8.1%**	**7.9%**	**6.2%**	**6.2%**
86													
87	**Contract Cost**		**14,695,790**	**3,571,058**	**11,124,732**	**525,652**	**2,387,641**	**450,613**	**2,802,084**	**389,090**	**2,690,304**	**755,168**	**1,124,181**
88	**Net before Settlement**		**2,335,874**	**18,006**	**2,317,868**	**116,208**	**397,407**	**172,844**	**(373,888)**	**406,544**	**1,112,261**	**307,465**	**179,026**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,269,289)	48,579	(2,317,868)	(116,208)	(397,407)	(172,844)	373,888	(406,544)	(1,112,261)	(307,465)	(179,026)
93	**Net after Settlement**		**66,585**	**66,585**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		50,911	50,911	50,911	2,465	10,522	2,386	9,123	3,118	14,270	4,021	5,005
97	Revenue PMPM		$ 55.76	$ 11.75	$ 44.01	$ 43.40	$ 44.12	$ 43.54	$ 44.36	$ 42.53	$ 44.41	$ 44.05	$ 43.39
98	Expense PMPM		48.11	11.69	36.42	35.54	37.82	31.47	51.19	20.80	31.42	31.30	37.43
99	Margin PMPM		$ 7.65	$ 0.06	$ 7.59	$ 7.86	$ 6.29	$ 12.07	$ (6.83)	$ 21.73	$ 12.99	$ 12.74	$ 5.96
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		50,911	50,911	50,911	2,465	10,522	2,386	9,123	3,118	14,270	4,021	5,005
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)		(659)	(659)	(659)	(47)	112	(45)	(45)	143	(783)	104	(98)
108	% Variance - Fav / (Unfav)		-1.3%	-1.3%	-1.3%	-1.9%	1.1%	-1.8%	-0.5%	4.8%	-5.2%	2.7%	-1.9%
109													
110	**Contract Revenue before settlement**												
111	Actual		17,031,664	3,589,063	13,442,601	641,860	2,785,048	623,457	2,428,197	795,634	3,802,565	1,062,633	1,303,207
112	Budget		14,513,508	2,508,100	12,005,408	579,627	2,422,277	562,614	2,148,282	684,155	3,524,806	908,431	1,175,216
113	Variance - Favorable / (Unfavorable)		2,518,157	1,080,964	1,437,193	62,233	362,771	60,843	279,915	111,479	277,759	154,203	127,991
114	% Variance - Fav / (Unfav)		17.4%	43.1%	12.0%	10.7%	15.0%	10.8%	13.0%	16.3%	7.9%	17.0%	10.9%
115													
116	**Healthcare Cost**												
117	Actual		13,522,916	3,166,531	10,356,385	489,482	2,228,707	413,887	2,627,478	357,678	2,476,731	708,162	1,054,260
118	Budget		12,563,862	2,906,513	9,657,349	690,377	1,444,227	632,915	2,381,900	491,217	2,564,139	582,656	869,917
119	Variance - Favorable / (Unfavorable)		(959,054)	(260,018)	(699,036)	200,895	(784,480)	219,028	(245,578)	133,539	87,408	(125,505)	(184,343)
120	% Variance - Fav / (Unfav)		-7.6%	-8.9%	-7.2%	29.1%	-54.3%	34.6%	-10.3%	27.2%	3.4%	-21.5%	-21.2%
121													
122	**Managed Care Administration**												
123	Actual		1,172,874	404,526	768,347	36,170	158,934	36,726	174,606	31,412	213,572	47,006	69,921
124	Budget		1,202,828	475,281	727,548	51,409	107,656	52,856	171,905	37,639	215,550	36,380	54,153
125	Variance - Favorable / (Unfavorable)		29,955	70,754	(40,800)	15,239	(51,279)	16,130	(2,701)	6,227	1,978	(10,627)	(15,768)
126	% Variance - Fav / (Unfav)		2.5%	14.9%	-5.6%	29.6%	-47.6%	30.5%	-1.6%	16.5%	0.9%	-29.2%	-29.1%
127													
128	**Total Contract Cost**												
129	Actual		14,695,790	3,571,058	11,124,732	525,652	2,387,641	450,613	2,802,084	389,090	2,690,304	755,168	1,124,181

	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 3/31/2020			**6**									
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		13,766,691	3,381,794	10,384,896	741,786	1,551,882	685,771	2,553,806	528,856	2,779,690	619,036	924,070
131	Variance - Favorable / (Unfavorable)		(929,100)	(189,264)	(739,836)	216,134	(835,758)	235,158	(248,279)	139,766	89,386	(136,132)	(200,111)
132	% Variance - Fav / (Unfav)		-6.7%	-5.6%	-7.1%	29.1%	-53.9%	34.3%	-9.7%	26.4%	3.2%	-22.0%	-21.7%
133													
134	**Net before Settlement**												
135	Actual		2,335,874	18,006	2,317,868	116,208	397,407	172,844	(373,888)	406,544	1,112,261	307,465	179,026
136	Budget		746,817	(873,695)	1,620,512	(162,158)	870,395	(123,157)	(405,523)	155,299	745,116	289,394	251,146
137	Variance - Favorable / (Unfavorable)		1,589,057	891,700	697,357	278,367	(472,987)	296,001	31,636	251,245	367,145	18,071	(72,120)
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 3/31/2020			**6**									
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%*	7.3%	5.1%	8.9%	9.4%	7.7%	5.9%	6.7%	3.2%	9.1%
141	**Contract Revenue**		**8,391,620**	**19,874**	**8,371,746**	**409,555**	**1,593,016**	**460,559**	**1,525,485**	**414,994**	**2,471,168**	**675,045**	**821,923**
142													
143	External Provider Cost		7,413,040	-	7,413,040	-	2,099,588	536,433	984,827	341,256	2,255,407	254,877	940,652
144	Internal Program Cost		1,031,927	-	1,031,927	243,246	2,496	2,487	715,890	1,365	-	4,910	61,533
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**8,444,967**	**-**	**8,444,967**	**243,246**	**2,102,083**	**538,920**	**1,700,717**	**342,621**	**2,255,407**	**259,788**	**1,002,185**
147	**Medical Loss Ratio (HCC % of Revenue)**		**100.6%**	**0.0%**	**100.9%**	**59.4%**	**132.0%**	**117.0%**	**111.5%**	**82.6%**	**91.3%**	**38.5%**	**121.9%**
148													
149	**Managed Care Administration**		**889,631**	**252,624**	**637,007**	**17,974**	**149,904**	**47,821**	**113,019**	**30,089**	**194,487**	**17,244**	**66,467**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.5%**	**2.7%**	**6.8%**	**6.9%**	**6.7%**	**8.2%**	**6.2%**	**8.1%**	**7.9%**	**6.2%**	**6.2%**
151													
152	**Contract Cost**		**9,334,598**	**252,624**	**9,081,974**	**261,221**	**2,251,988**	**586,741**	**1,813,736**	**372,711**	**2,449,894**	**277,032**	**1,068,652**
153	**Net before Settlement**		**(942,978)**	**(232,750)**	**(710,228)**	**148,334**	**(658,972)**	**(126,182)**	**(288,251)**	**42,283**	**21,274**	**398,013**	**(246,729)**
154	Contract Settlement / Redistribution		942,978	232,750	710,228	(148,334)	658,972	126,182	288,251	(42,283)	(21,274)	(398,013)	246,729
155	**Net after Settlement**		**-**	**-**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.5%	3.2%	1.1%	0.7%	0.0%	0.7%	0.0%	1.1%	0.5%
159	**Contract Revenue**		**4,298,928**	**3,634,358**	**664,570**	**45,722**	**236,503**	**17,480**	**-**	**73,817**	**135,581**	**95,631**	**59,837**
160													
161	External Provider Cost		4,162,647	4,162,647	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		648,523	-	648,523	152,690	264,702	40,346	-	41,296	1,977	86,768	60,745
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**4,811,171**	**4,162,647**	**648,523**	**152,690**	**264,702**	**40,346**	**-**	**41,296**	**1,977**	**86,768**	**60,745**
165	**Medical Loss Ratio (HCC % of Revenue)**		**111.9%**	**114.5%**	**97.6%**	**334.0%**	**111.9%**	**230.8%**	**0.0%**	**55.9%**	**1.5%**	**90.7%**	**101.5%**
166													
167	**Managed Care Administration**		**(512,242)**	**(512,242)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-11.9%**	**-11.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**4,298,928**	**3,650,405**	**648,523**	**152,690**	**264,702**	**40,346**	**-**	**41,296**	**1,977**	**86,768**	**60,745**
171	**Net before Settlement**		**(0)**	**(16,047)**	**16,047**	**(106,969)**	**(28,199)**	**(22,866)**	**-**	**32,522**	**133,604**	**8,864**	**(908)**
172	Contract Settlement		0	16,047	(16,047)	106,969	28,199	22,866	-	(32,522)	(133,604)	(8,864)	908
173	**Net after Settlement**		**0**	**0**	**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 3/31/2020			**6**									
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		133,519,893	14,569,966	118,949,927	5,153,527	23,439,423	6,343,185	21,505,979	6,578,998	36,102,525	8,378,626	11,447,665
178	Incentive Payment Revenue		301,809	180,616	121,193	13,767	-	7,942	38,123	(60)	58,773	-	2,647
179	**Contract Revenue**		**133,821,703**	**14,750,582**	**119,071,120**	**5,167,294**	**23,439,423**	**6,351,127**	**21,544,102**	**6,578,938**	**36,161,299**	**8,378,626**	**11,450,312**
180													
181	External Provider Cost		88,464,955	9,346,064	79,118,891	2,490,468	16,985,448	3,900,633	13,563,159	3,533,607	27,279,413	5,181,521	6,184,643
182	Internal Program Cost		31,128,655	-	31,128,655	2,107,029	6,071,168	1,652,387	7,214,952	1,874,712	4,987,758	2,852,245	4,368,404
183	SSI Reimb, 1st/3rd Party Cost Offset		(409,405)	-	(409,405)	(8,790)	(47,921)	(22,846)	(85,905)	(32,262)	(159,999)	(13,537)	(38,145)
184	Insurance Provider Assessment Withhold (IPA)		2,841,892	2,841,892	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		569,230	569,230	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**122,595,327**	**12,757,186**	**109,838,142**	**4,588,706**	**23,008,695**	**5,530,174**	**20,692,206**	**5,376,057**	**32,107,173**	**8,020,229**	**10,514,902**
187	**Medical Loss Ratio (HCC % of Revenue)**		**91.6%**	**86.5%**	**92.2%**	**88.8%**	**98.2%**	**87.1%**	**96.0%**	**81.7%**	**88.8%**	**95.7%**	**91.8%**
188													
189	**Managed Care Administration**		**11,155,465**	**2,886,593**	**8,268,872**	**327,796**	**1,621,926**	**487,143**	**1,375,076**	**468,504**	**2,768,476**	**526,607**	**693,345**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.2%**	**6.2%**	**6.7%**	**6.6%**	**8.1%**	**6.2%**	**8.0%**	**7.9%**	**6.2%**	**6.2%**
191													
192	**Contract Cost**		**133,750,792**	**15,643,778**	**118,107,014**	**4,916,502**	**24,630,621**	**6,017,317**	**22,067,282**	**5,844,560**	**34,875,649**	**8,546,836**	**11,208,246**
193	**Net before Settlement**		**70,911**	**(893,196)**	**964,107**	**250,792**	**(1,191,198)**	**333,810**	**(523,180)**	**734,378**	**1,285,650**	**(168,210)**	**242,065**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		0	964,107	(964,107)	(250,792)	1,191,198	(333,810)	523,180	(734,378)	(1,285,650)	168,210	(242,065)
198	**Net after Settlement**		**70,911**	**70,911**	**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 3/31/2020			**6**									
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%*	4.7%	4.6%	3.0%	4.0%	6.8%	6.8%	4.8%	2.0%	4.9%
202	**Contract Revenue**				**5,563,865**	**361,106**	**962,364**	**343,500**	**1,003,107**	**286,774**	**1,839,310**	**297,286**	**470,418**
203													
204	External Provider Cost				1,929,852	84,487	30,639	19,984	357,511	268,252	998,657	80,417	89,905
205	Internal Program Cost				3,518,657	135,402	669,444	207,786	1,149,467	126,607	697,180	81,509	451,262
206	SSI Reimb, 1st/3rd Party Cost Offset				(87,489)	-	-	-	-	-	(87,489)	-	-
207	**Total Healthcare Cost**				**5,361,020**	**219,889**	**700,083**	**227,769**	**1,506,978**	**394,859**	**1,608,349**	**161,926**	**541,167**
208	**Medical Loss Ratio (HCC % of Revenue)**				**96.4%**	**60.9%**	**72.7%**	**66.3%**	**150.2%**	**137.7%**	**87.4%**	**54.5%**	**115.0%**
209													
210	**Managed Care Administration**				**450,178**	**17,895**	**56,425**	**22,681**	**110,751**	**37,835**	**152,716**	**12,031**	**39,845**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.7%**	**7.5%**	**7.5%**	**9.1%**	**6.8%**	**8.7%**	**8.7%**	**6.9%**	**6.9%**
212													
213	**Contract Cost**				**5,811,198**	**237,783**	**756,509**	**250,450**	**1,617,729**	**432,694**	**1,761,065**	**173,957**	**581,011**
214	**Net before Settlement**				**(247,333)**	**123,323**	**205,855**	**93,050**	**(614,622)**	**(145,920)**	**78,245**	**123,329**	**(110,593)**
215													
216	Other Redistributions of State GF				(45,028)	-	-	-	(0)	-	-	-	(45,028)
217	Contract Settlement				(487,346)	(118,672)	(157,737)	(91,437)	-	-	-	(119,500)	-
218	**Net after Settlement**				**(779,707)**	**4,651**	**48,118**	**1,613**	**(614,622)**	**(145,920)**	**78,245**	**3,829**	**(155,621)**
219													

	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 3/31/2020			**P06FYTD20**	**6**									
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			136,492,785	103,797,681	17,031,664	8,391,620	1,774,243	4,298,928	1,198,648	-	-	-	
17	DHHS Incentive Payments			301,809	301,809	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			794,043	-	-	-	-	794,043	-	-	-	-	
19	Interest Income - Working Capital			72,509	-	-	-	-	-	-	72,509	-	-	
20	Interest Income - ISF Risk Reserve			3,506	-	-	-	-	-	-	3,506	-	-	
21	Local Funds Contributions			863,096	-	-	-	-	-	-	863,096	-	-	
22	Other Local Income			126,330	-	-	-	-	-	-	126,330	-	-	
24	**TOTAL REVENUE**			**138,654,079**	**104,099,491**	**17,031,664**	**8,391,620**	**1,774,243**	**5,092,971**	**1,198,648**	**1,065,441**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			12,362,799	2,016,885	3,166,531	-	2,253,399	4,162,647	763,336	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			109,842,468	89,634,902	10,356,385	8,444,967	757,691	648,523	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			1,418,008	1,418,008	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			1,423,884	1,423,884	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,382,968	-	-	(1,382,968)	-	-	-			
34	**Total Healthcare Cost**			**125,047,159**	**95,876,647**	**13,522,916**	**8,444,967**	**1,628,122**	**4,811,171**	**763,336**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**91.4%**	**92.1%**	**79.4%**	**100.6%**	**91.8%**	**111.9%**	**63.7%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			241,932	-	-	-	-	-	-	241,932	-	-	
39	Administrative and Other Cost			3,506,204	-	-	-	-	-	-	3,506,142	-	62	
41	Depreciation			44,691	-	-	-	-	-	-	44,691	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	133,874	-	(133,874)	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	62	-	(62)	
44	Delegated Managed Care Admin			8,268,872	6,807,470	768,347	637,007	56,047	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			(0)	2,741,685	404,526	252,624	90,074	147,927	-	(3,636,836)	-	-	
46														
47	**Total Administrative Cost**			**12,061,699**	**9,549,155**	**1,172,874**	**889,631**	**146,121**	**281,801**	**-**	**22,117**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**8.8%**	**9.1%**	**8.0%**	**9.5%**	**8.2%**	**5.5%**	**0.0%**	**2.7%**			
49														
50	Local Funds Contribution			863,096	-	-	-	-	-	-	863,096	-	-	
51														
52	**TOTAL COST after apportionment**			**137,971,954**	**105,425,802**	**14,695,790**	**9,334,598**	**1,774,243**	**5,092,972**	**763,336**	**885,213**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**682,125**	**(1,326,311)**	**2,335,874**	**(942,978)**	**-**	**(0)**	**435,313**	**180,228**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**0.5%**	**-1.3%**	**13.7%**	**-11.2%**	**0.0%**	**0.0%**	**36.3%**	**16.9%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(435,312)	-	-	-	-	-	(435,312)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,506)	-	-	-	-	-	-	(3,506)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	1,326,311	(2,269,289)	942,978	-	0	(0)	-			
62	**NET SURPLUS (DEFICIT)**			**243,307**	**-**	**66,585**	**-**	**-**	**-**	**-**	**176,722**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
64														
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			66,585	-	66,585	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			176,722	-	-	-	-	-	-	176,722	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			**243,307**	**-**	**66,585**	**-**	**-**	**-**	**-**	**176,722**	**-**	**-**	
72														

SWMBH SERVICES ADMINISTRATIVE CONTRACT Mid-Year Comparison FY20 vs FY19*	
BLUE FIRE MEDIA, INC	
Deliverables/Services	• Supports the SWMBH public website
	FY20 Expenditure: $750 (FY19 Expenditure: $890)
CAPITOLINE CONSULTING	
Deliverables/Services	• Consultation service on federal regulations & funding opportunities • Secure materials and prepare briefs summarizing attended event
	FY20 Expenditure: $8,292 (FY19 Expenditure: $5,750)
CARE MANAGEMENT TECHNOLOGIES, INC	
Deliverables/Services	• Licensed proprietary healthcare data analytics solution • Analyze data in order to determine opportunities for improving care and decreasing costs for SWMBH and CMHSPs • Install and manage population health and case level user application
	FY20 Expenditure: $84,892 (FY19 Expenditure: $80,850)
CONTRACT PHYSICIANS	
Deliverables/Services	• Program policy issue consultation • Service guideline consultation and review • Medical policy review and approval • SWMBH credentialing panel participant • Consultation provided to Member Services and Contractor Network Management as necessary • On-call Medical decisions with Utilization Management during non-business hours • BH Human Resource Management Committee consultant
	FY20 Expenditure: $23,155 (FY19 Expenditure: $61,733)
DALE K. HOWE CONSULTING, LLC	
Deliverables/Services	• Medicaid Capitation Databases • Medicaid Eligibility • Revenue Forecast
	FY20 Expenditure: $525 (FY19 Expenditure: $1,050)
DEERFIELD BEHAVIORAL HEALTH	
Deliverables/Services	• LOCUS training for regional partners MI staff and monthly licensing fee for the software
	FY20 Expenditure: $420 (FY19 Expenditure: $420)

FINCH CONSULTING	
Deliverables/Services	Assisting with activities and documents related to: • State reporting development • Risk reserve requirements review • Refinement of cost management systems region wide • CMH financial statement support
	FY20 Expenditure: $57,998 (FY19 Expenditure: $69,936)
HEALTH MANAGEMENT ASSOCIATES	
Deliverables/Services	• Technical assistance on emerging regulatory initiatives regarding population health management, duals, health homes and data analytics
	FY20 Expenditure: $425 (FY19 Expenditure: $4,891)
INFORMATION TECHNOLOGY PARTNERS (Contract was not renewed)	
Deliverables/Services	• Provides Service Encounter Data Management & Storage Services • Web Hosting • Cloud Computing Services • Network Infrastructure • VOIP • Wireless Communications • Hardware and Software Needs (with Helpdesk Support) • Related Project Management
	FY20 Expenditure: N/A (FY19 Expenditure: $75,257)
INSTITUTE FOR HEALTH & RECOVERY	
Deliverables/Services	• Onsite training; Trauma & Seeking Safety
	FY20 Expenditure: N/A (FY19 Expenditure: $7,374)
INTEGRATED SERVICES OF KALAMAZOO	
Deliverables/Services	• Access to EDI system
	FY20 Expenditure: $6,000 (FY19 Expenditure: $6,000)
MORC, INC	
Deliverables/Services	• Support intensity scale assessment training
	FY20 Expenditure: $5,794 (FY19 Expenditure: $15,666)
ON-CALL LEGAL RESOURCES	
Deliverables/Services	• Medicaid fair hearing counsel: Act as legal representation on behalf of SWMBH and participant CMHSP's for the Fair Hearing process • Perform tasks related to Fair Hearing preparation process: Record review, witness preparation and interviews • Hearing Summary preparation • Legal consultation related to Fair Hearing process
	FY20 Expenditure: $525 (FY19 Expenditure: $825)
PARENT MANAGEMENT TRAINING - OREGON model (PMTO)	
Deliverables/Services	• Provide training to clinicians using PMTO coaching model
	FY20 Expenditure: $10,320 (FY19 Expenditure: $9,342)

PARMENTER & ASSOCIATES	
Deliverables/Services	• General legal counsel
	FY20 Expenditure: $10,432 (FY19 Expenditure: $18,888)
PHD CONSULTANTS/LIGHTHOUSE BEHAVIORAL HEALTH	
Deliverables/Services	• Mental Health Parity project • Clinical consultation and project management
	FY20 Expenditure: $39,913 (FY19 Expenditure: $69,318)
PREST AND ASSOCIATES	
Deliverables/Services	• Health Plan professional independent review and consulting service • Utilization reviews concerning medical necessity and/or medical appropriateness of treatment
	FY20 Expenditure: $488 (FY19 Expenditure: $1,591)
PROTOCALL	
Deliverables/Services	• On-call crisis intervention counseling and related reporting
	FY20 Expenditure: $20,310 (FY19 Expenditure: $15,754)
QUEST ANALYTICS, LLC	
Deliverables/Services	• Annual Software licensing cost • To Provide Network Adequacy analysis
	FY20 Expenditure: $8,138 (FY19 Expenditure: $7,751)
ROSE ST ADVISORS/HRM INNOVATIONS, INC	
Deliverables/Services	Provides support, direction and consultation in the area of Human Resources ensuring federal and state regulations and standards are met. Tasks include, but not limited to: • Cultural Insights Surveys • Strategic leadership planning • Human Resource Consulting • Recruiting
	FY20 Expenditure: $12,800 (FY19 Expenditure: $19,600)
ROSLUND PRESTAGE & COMPANY, P.C	
Deliverables/Services	• Financial, Compliance & Single audit
	FY20 Expenditure: $25,650 (FY19 Expenditure: $54,525)
AUNALYTICS/SECANT	
Deliverables/Services	• Provides Data Center & Storage Services • Web Hosting • Cloud Computing Services • Network Infrastructure • VOIP • Wireless Communications • Hardware and Software Needs (with Helpdesk Support) • Related Project Management
	FY20 Expenditure: $173,549 (FY19 Expenditure: $194,735)

SF	
Deliverables/Services	• Consultation on authorization for ABA services
	FY20 Expenditure: $900 (FY19 Expenditure: N/A)
STREAMLINE HEALTHCARE SOLUTIONS	
Deliverables/Services	• Streamline Care Management System is a desktop application used to manage and pay external providers
	FY20 Expenditure: $94,020 (FY19 Expenditure: $96,134)
TBD SOLUTIONS LLC	
	• Level of Care Data Analytics and Guidelines project • Internal Functional assessment of UM Call Center and Provider Network
	FY20 Expenditure: $46,396 (FY19 Expenditure: $101,501)
VARNUM LLP	
Deliverables/Services	• Retirement plans legal consultation
	FY20 Expenditure: $1,037 (FY19 Expenditure: $7,692)
VOICES FOR HEALTH	
Deliverables/Services	• Translation and Interpretation services
	FY20 Expenditure: $12,063 (FY19 Expenditure: $2,741)

Total FY20 Contract Services Provided: $644,792 (Total FY19 Expenditures: $930,214)

Community Mental Health Association

Directors Forum discussion of next steps on system design

April 2020

With the halting of the MDHHS efforts to redesign Michigan's public mental health system, as a result of the COVID-19 pandemic, CMHA, its members and stakeholders are taking this time to assess the situation and think through next steps.

Below are some thoughts, relative to those next steps, to fuel discussion by the CMHA Directors Forum members around the strategy to be pursued by CMHA relative to system design. As this strategy takes shape it will be brought to the CMHA Executive Board for review and approval before it is used to guide CMHA system design work.

Environment related to system design

MDHHS halted its system design effort and it is clear that the Whitmer administration is unlikely to spend energy and resources on moving system design forward this year.

In CMHA discussions with MDHHS leadership around the system design effort, they shared that the fact that the work related to COVID19 has taken all of the attention and time of MDHHS senior leadership, delaying the timetable for the redesign of the public mental health system.

Going farther than that, they indicated that the impact of the pandemic, on the state's economy and, as a result, the tax revenues for the state are projected to be so dramatic that MDHHS and all of state government are reassessing many things, including the redesign effort.

The state's FY 2020 budget is expected to have a $1 to $3 billion budget gap with a $4 billion gap in FY 2021.

This halt/hibernation and the state budget pressures **opens the door for other options**, now or in future, some offering opportunity, some offering threat

Potential scenarios

Scenario 1. System redesign is taken permanently off the table

> **Analysis**: Seen as highly unlikely, given the momentum of system design across the country and within Michigan, on both sides of the aisle and in both the Executive and Legislative branches, over the last few years.

Scenario 2. Some legislative leaders, with the prompting of the health plans will, once again, **propose a carve-in**; the idea of redesign will continue to float within Michigan's policy circles (MDHHS, Governor's Office, State Legislature) and emerge in some form in the mid-term future – potentially fueled by the false claims that such a carve-in would address state budget concerns.

> **Analysis**: MDHHS has less confidence in the private health plans and may not support a carve-in if proposed by Legislature. Such lack of support would come in the form of the Whitmer

administration's negotiations on this point or a veto of statutory or appropriations language that called for a carve-in.

However, if Governor Whitmer goes to Washington as part of a new administration in DC (dependent, of course, on the outcome of the presidential election), many of the MDHHS leadership who built and championed the SIP model will also exit, leaving the Legislature as a stronger party on this front – and without a counterweight to a carve-in proposal by the Legislature.

Finally, the complexity of a carve-in works against it being easily done, given: the use of high levels of fiscal and staff resources required to make such a change as well as the complexity of the management of the non-Medicaid SUD funds and the management of the benefit for the unenrolled Medicaid beneficiaries by private physical healthcare managed Medicaid care plans.

Scenario 3. The system design effort is put on hold until the pandemic abates and the debris is cleared and budget gaps are patched, then it picks up again, with the **SIP foundation, under MDHHS leadership**

Analysis: MDHHS is unlikely to walk away from the SIP model, given the time, energy, and political capital used to move this model forward and the momentum of SIP-like system design across the country and within Michigan, on both sides of the aisle and in both the Executive and Legislative branches, over the last few years.

However, the distraction of the COVID pandemic and the state's budget pressures draws away any of the energy and focus needed to move a SIP-based effort forward.

Additionally, as noted above, if the Governor goes to DC, so will many of the MDHHS leadership who built and championed the SIP model will also exit, leaving the Legislature as a stronger party on this front.

Scenario 4. The system design effort is put on hold until the pandemic abates and, regardless of the budget condition (albeit it is projected to be bad), MDHHS, fatigued and battered, does not pick up redesign. Instead the responsibility for proposing a system design efforts **falls to the public system**.

Analysis: The performance of the public system, during the COVID pandemic, and the work of the system, CMHA, its members and allies, to develop and articulate a picture of a publicly-run system (tied to county governments) provide a strong foundation upon which a set of system design models that are public and tied to county government can be built.
Additionally, the impending designation of Michigan as a CCBHC state may provide an opportunity to use CCBHC funds and concepts to redesign the system – built around the public system. The prospective payment system of CCBHC will have to be integrated with Michigan's managed care system and its inclusion of services to persons with IDD as part of any system redesign. MDHHS is unlikely to want to revert to a fee-for-service payment.

Other factors that impact the emergence of these scenarios

1. The fiscal instability of some of the state's PIHPs will play into the system design models that may come forward.
2. The public system's response, during the pandemic, has been very strong and should serve as a model for system design going forward.
3. The work, of some of the private providers within the CMH/PIHP provider network, to go around and/or undermine the public CMH and PIHP system.

Public system's potential leadership in developing and making system design proposals

Basis for public system leadership of system design:

> It is key that the **public system have a strong hand** in the redesign and the related statutory, regulatory, and waiver changes, **preventing the system design process from being led by others who are not friendly to the public system.** Leaving the political arena open for others to propose designs leaves the public system with only a defensive or weakened bargaining position in the design of the new system and its related statutory, regulatory, and waiver changes
>
> Even if redesign pressures come later than expected, **the public system cannot wait until the emergence of those pressures to take the steps – complex steps – required to mount a sound alternate vision**

Foundational constructs that could be used in the public system's work in developing and promoting system design proposals:

- Adhere to the principles of CMHA as adopted by the CMHA Executive Board in February 2020, December 2019, and August 2016
- Build on the strength of the system:
    - demonstrated over the last six decades
    - the system's proven performance during the COVID pandemic, including the comprehensive community-based CMH and provider system and the strengths of the public CMH/County-based Regional Entity managed care system
- Pursue a both/and approach to model development with a package of models tied to the CMHA principles (see above) yet flexible enough to be applicable to a range of system design opportunities and threats

INSTITUTE FOR MEDICAID INNOVATION

April 2019

Behavioral Health Coverage in Medicaid Managed Care

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Approximately one in six adults in the United States lives with a behavioral health condition, with rates rising among children and adolescents. More than two-thirds (68.1%) of all Medicaid enrollees were enrolled in Medicaid health plans in 2016, an increase from 65.5 percent in 2015. Behavioral health continues to be a major focus for the Medicaid program, with many Medicaid health plans providing behavioral health coverage as part of their comprehensive benefits package. However, many individuals still do not seek or complete treatment. In this issue brief, we report findings from the Institute for Medicaid Innovation's annual Medicaid managed care survey that are specific to behavioral health, including trends in prevalence and disparities. We also outline opportunities to address research, clinical, and policy priorities for behavioral health.

Approximately 44.7 million adults in the United States live with a behavioral health condition.[1] Although Medicaid covers only approximately 14 percent of the general adult population, the program covers 21 percent of all adults with behavioral health conditions, 26 percent of all adults with serious mental illness (SMI), and 17 percent of all adults with substance use disorder (SUD). SUD is another primary behavioral health concern for Medicaid, providing coverage for approximately three million individuals with SUD, of which nearly 1.8 million have a comorbid behavioral health condition.[2]

Individuals living with SMI are at an increased risk for chronic physical health conditions and on average live 25 years less than individuals without SMI. A substantial portion (40%) of the increase in mortality can be linked to either suicide or injury, while the remaining 60 percent of deaths are largely the result of co-occurring physical health conditions, including cardiovascular disease, diabetes (including related conditions of kidney failure), respiratory issues including pneumonia and the flu, and infectious diseases such as HIV/AIDS.[3]

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

Support for this project is provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Behavioral Health Disparities

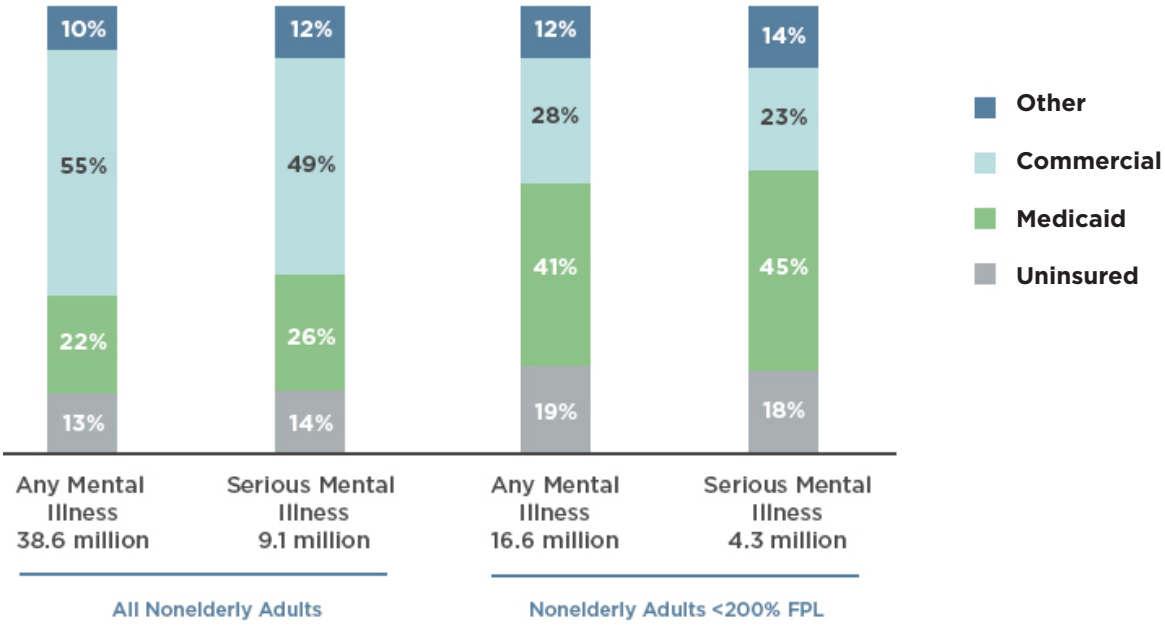
Disparities by Race/Ethnicity & Sex

Women and racial/ethnic minorities are disproportionately affected by behavioral health conditions. For example, adult women who are white and under age 50 are more likely to have a behavioral health condition than men, racial/ethnic minorities, or those age 50 or older.[4] It has been found that those who identify as Hispanic have a lower lifetime risk of SUD, whereas black and African American individuals have a lower lifetime risk of mood, anxiety, and substance use disorders than non-Hispanic and non-African American whites. However, if a mood or anxiety condition is present, lower-income Hispanics, blacks, and African Americans have a higher incidence of being persistently ill than non-Hispanic individuals or non-African American whites.[5]

Disparities by Insurance/Income

Medicaid is often the sole source of funding for some specialized behavioral health services such as SMI and SUD.[2] Low-income individuals (32%) are more likely to have a behavioral health condition than are moderate-income individuals (24%) and higher-income individuals (21%).[6] As illustrated in Figure 1 below, the majority of non-elderly adults with behavioral health conditions are covered by Medicaid or commercial insurance. Most nonelderly adults with behavioral health conditions are employed (63%), but more than 4 in 10 are low income, including 22 percent who are below the federal poverty level.[4]

Figure 1. Insurance Status of Nonelderly Adults with Behavioral Health Conditions and Serious Mental Illness, 2015



Source: Kaiser Family Foundation. (2017). "Facilitating access to mental health services: A look at Medicaid, private insurance, and the uninsured."

Child & Adolescent Disparities

Children from families living in poverty are three times more likely to have a behavioral health condition than those not living in poverty.[7] Children and youth in single-parent families and families receiving social assistance, headed by teen mothers, transitioning from foster care, or with disabilities are at higher risk of having behavioral health conditions than are those who do not live in poverty.[8]

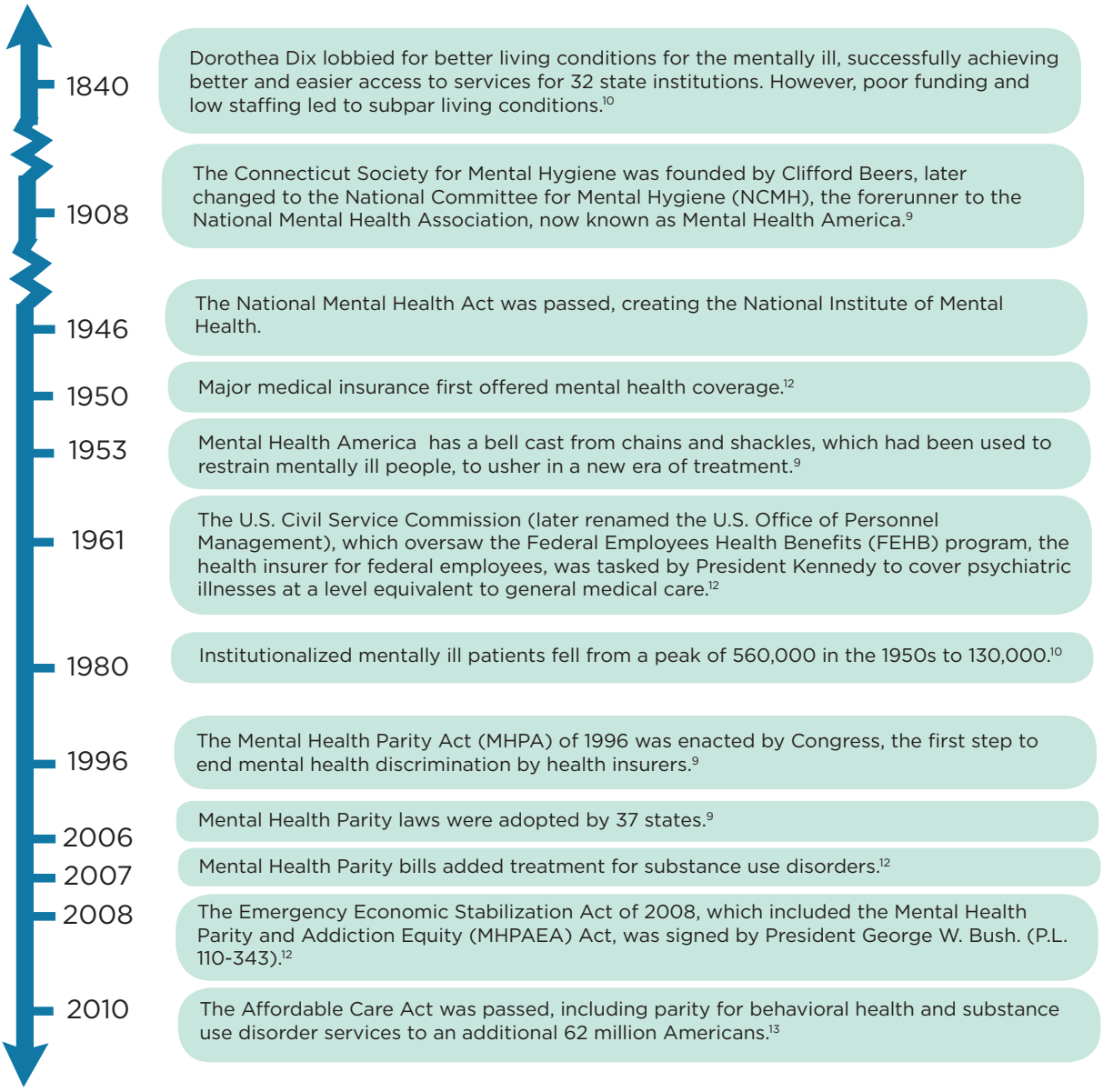
Historical Overview of Behavioral Health Care in the U.S.

Prior to World War II, behavioral health care was not covered by insurance.[9, 10] By the mid-1950s, there was mounting pressure toward deinstitutionalization and a move toward outpatient care models. The development of antipsychotic drugs was also critical in deinstitutionalization.[9] By 1980, the numbers of institutionalized individuals had dropped substantially.[10] In 1996, The Mental Health Parity Act was enacted, signaling the end of behavioral health discrimination. By 2006, 37 states had adopted policies supporting parity. Substance use treatment was added to the Mental Health Parity Act the following year.[11] By 2008, as part of the Emergency Economic Stabilization Act, the Mental Health Parity and Addiction Equity Act (MHPAEA) was included, removing loopholes used by insurance companies and ending limitations on all aspects of behavioral health coverage.[12] Protections included the following:

- Removing a limit on the number of hospital days covered for behavioral health conditions.
- Removing a cap on the number of outpatient treatment sessions.
- Prohibiting higher co-payments and deductibles for behavioral health services.

With the passage of the Affordable Care Act in 2010, parity for behavioral health and substance use disorder services were extended, and in 2016, coverage was extended to individuals eligible for Medicaid or Children's Health Coverage.[13] An extended timeline of behavioral health coverage can be found in Figure 2.

Figure 2. Expanded Timeline of Behavioral Health Coverage



Trends and Costs

In 2014, Medicaid covered 25 percent of all behavioral health and 21 percent of all SUD spending nationally. Findings from a 2015 report to Congress by the Medicaid and CHIP Payment and Access Commission (MACPAC)[14] showed that in 2011, Medicaid spent nearly four times as much on individuals with behavioral health conditions than on those without ($13,303 vs. $3,564), accounting for 48 percent of all Medicaid spending.[15]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), mental health and SUD treatment spending from all public and private sources is expected to total $280.5 billion in 2020, an increase from $171.7 billion in 2009. The estimates account for the potential impact of increased access and coverage as part of the Affordable Care Act.[18]

Utilization of behavioral health services among Medicaid enrollees is comparable to utilization among those with commercial insurance. Utilization for behavioral health and SUD emergency department (ED) services increased at a greater rate than the increased rate of ED utilization overall.[2] In addition, several service categories increased at greater levels than the overall increase (for example, 55.5 percent for depression, anxiety or stress reactions; 52 percent for psychoses or bipolar disorders; and 37 percent for SUD.[2] During the same time period, increases were the greatest in low-income communities (defined as ZIP codes with a median household income between $1 and $38,999), with SUD rising to 40.8 percent and depression, stress reactions, and anxiety rising to 79.4 percent. When comparing by payer type, utilization rates among those covered by commercial insurance decreased, while the percentage of Medicaid-insured increased from 2006 to 2013.[16]

Coverage Gap

More Americans now have access to insurance and treatment. States that expanded Medicaid as part of the Affordable Care Act have experienced the highest rates of reduction in uninsured adults with a behavioral health condition.[17] However, 6.3 million adults (14.7%) with a behavioral health condition still lack insurance coverage. This suggests that key differences may exist in behavioral health coverage between expansion and non-expansion states. The largest increases in uninsured adults were in Kansas (2.4%), Missouri (7.7%), and South Carolina (2.7%), all of them states that did not expand Medicaid coverage. Prevalence data of adults with behavioral health conditions who lack insurance coverage ranges from a low of 3.3 percent in Massachusetts (an ACA Medicaid expansion state) to a high of 23.8 percent in South Carolina (an ACA Medicaid non-expansion state).

Barriers in Access and Coverage

Insurance coverage for behavioral health services does not equate to receiving treatment. In 2015 it was found that approximately 56 percent of adults with a behavioral health condition did not receive treatment, a slight decrease from 2011 (59%).[17] The number of untreated adults ranged from 41.4 percent in Massachusetts to 66 percent in Nevada. The lack of an adequate behavioral health clinician workforce is a contributing factor in many states.[18] States with the greatest shortage require clinicians to provide services to six times as many individuals as those in states with more qualified clinicians. For example, in states with high levels of access and clinician coverage, there is one clinician for every 250 individuals who require their care. In states with less access and coverage, there are about 1,100 individuals for every clinician. In Alabama, the state with the lowest level of access, there is one clinician for every 2,600 individuals who require care.[18] As individuals covered by Medicaid are often from diverse backgrounds, it is critical that these providers are culturally competent in providing services to this population.

The Institute for Medicaid Innovation's (IMI's) 2018 Annual Medicaid Managed Care Survey[19] included questions specific to behavioral health, including barriers that Medicaid health plans experience when attempting to provide behavioral health coverage, subcontracting, and physical and behavioral health integration. Results from the survey indicate that Medicaid managed care organizations (MCOs) experience a number of challenges.

The list below highlights the barriers and challenges Medicaid MCOs experienced in 2017, stratified by health plan size Table 1.[19] Among Medicaid MCOs with fewer than one million individuals enrolled, the most significant barriers to addressing behavioral health was access to behavioral health clinicians in select regions (e.g., rural, underserved, etc.) and CFR 42 limitations on substance use disorder treatment information being shared.

Interestingly, the most significant barriers for MCOs were different when compared by size. For example, CFR 42 limitations on SUD treatment information sharing and access to behavioral health clinicians were the most significant barriers among larger plans, while access to data, clinician capacity to provide integrated care, and behavioral health clinician readiness for integrated care were the primary barriers in smaller plans.

Table 1. Barriers to Addressing Behavioral Health among Medicaid MCOs, by Rank with Enrollment by MCO Size, 2018

Medicaid MCOs with Less than One Million Members Enrolled
Top Policy Barriers:
• Fragmentation in program funding and contracting for physical and behavioral health services • CFR 42 limitations on SUD treatment information being shared • Institutions for Mental Disease (IMD) exclusion
Top Network Barriers:
• Provider capacity to provide integrated physical and behavioral health at point of care • Behavioral health provider readiness for managed care • Access to behavioral health providers in select regions (e.g., rural, underserved) • Behavioral health provider adoption of electronic health records
Top Operational Barriers:
• Access to data between care management and behavioral health teams • Staffing in care management to align skill sets with integrated care needs • System differences with subcontractor • Communication between care management and behavioral health
Medicaid MCOs with More than One Million Members Enrolled
Top Policy Barriers:
• CFR 42 limitations on SUD treatment information being shared • Fragmentation in program funding and contracting for physical and behavioral health services • Institutions for Mental Disease (IMD) exclusion
Top Network Barriers:
• Access to behavioral health providers in select regions (e.g., rural, underserved) • Provider capacity to provide integrated physical and behavioral health at point of care
Top Operational Barriers:
• Communication between care management and behavioral health • Staffing in care management to align skill sets with integrated care needs

Source: Institute for Medicaid Innovation. (2018). 2017 Annual Medicaid MCO Survey – Behavioral health. Washington, D.C.

State Variation

Although the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008,[20] requiring parity in aggregate lifetime and annual dollar limits for mental health benefits and medical surgical benefits,[21] the practical application of the parity rules remains a work in progress.[22] At the beginning of 2017, 11 states continued to carve out behavioral health coverage from Medicaid health plans.[15] Carve-outs can lead to less-coordinated care for the individual enrolled in Medicaid, as they

often do not receive all of their physical and behavioral care from the same entity, leading to fragmentation, lack of coordination, and missed symptomology.[15] In addition, carve-outs of pharmacy benefits that exist in some states increase the likelihood of unnecessary hospitalizations, lack of care coordination, timely clinician interventions, and lower quality of care. A recent report indicated that the cost of carving out pharmaceutical coverage, in whole or in part, led to increased costs for the state Medicaid programs and the federal government, undermining the objective of achieving optimal cost-effectiveness in the program.[23] Table 2 highlights the variation in state financing models for behavioral health coverage.

Table 2. Behavioral Health Financing Models by State, 2019

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Alabama				X	
Alaska				X	
Arizona- Acute Care			X		
Arizona- SMI Population					X
Arkansas- FFS/PCCM				X	
Arkansas- PASSE					X
Arkansas- AR WORKS			X		
California	X				
Colorado- RAEs			X		
Connecticut				X	
Delaware		X			
District of Columbia		X			
Florida			X		
Florida- SMI Population					X
Georgia			X		
Hawaii			X		
Hawaii- SMI Population	X				
Idaho	X				
Idaho- Duals Population			X		
Illinois			X		

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Indiana		X			
Iowa			X		
Kansas			X		
Kentucky			X		
Louisiana			X		
Maine				X	
Maryland		X			
Massachusetts-MCO Delivery System			X		
Massachusetts-PCCM/ACO Delivery System	X				
Michigan	X				
Minnesota			X		
Mississippi			X		
Missouri		X			
Montana				X	
Nebraska			X		
Nevada			X		
New Hampshire			X		
New Jersey		X			
New Mexico			X		
New York			X		
New York- SMI Population					X
New York-Long-Term Care		X			
North Carolina	X				
North Dakota				X	
North Dakota-Medicaid Ex-pansion			X		
Ohio			X		
Oklahoma				X	
Oregon			X		
Pennsylvania	X				
Rhode Island			X		
South Carolina			X		
South Dakota				X	

States	Primary Carve-Out To CMO	Primary Carve-Out to Medicaid FFS Plan	Integrated Financing In Medicaid Health Plan	Integrated Financing in Medicaid FFS Plan	Primary Vertical Carve-Out
Tennessee			X		
Texas			X		
Utah	X				
Vermont				X	
Virginia			X		
Washington-Integrated Managed Care Counties			X		
Washington-Transitional Counties[7]	X				
West Virginia			X		
Wisconsin		X			
Wisconsin-Family Care Program			X		
Wyoming				X	

Notes: The financing model presented in this table derived based on *OPEN MINDS*'s assessment of each state's Medicaid behavioral health financing system. Each state was assessed using the information contained in the OPEN MINDS Behavioral Health System State Profile Series.

Source: Open Minds. (2019). State Medicaid behavioral health carve-outs: The Open Minds 2019 annual update. https://www.open-minds.com/intelligence-report/state-medicaid-behavioral-health-carve-outs-the-open-minds-2019-annual-update/

The IMI found that in 2017, the majority of reporting health plans did not subcontract for behavioral health services, but instead coordinated and managed both physical and behavioral health.[19] However, there were slight differences that emerged when the analysis was stratified by size of the Medicaid MCO. Medicaid MCOs serving more than one million individuals were split evenly between using a subcontractor with merged operations within the Medicaid MCO and not using a subcontractor and coordinating and managing physical and behavioral health themselves. Among Medicaid MCOs with fewer than one million individuals, the majority of health plans did not have a subcontract in 2017 and managed physical and behavioral health (66.6%). The remaining plans either managed behavioral health services separately (33.3%) or reported not using a subcontractor and not managing behavioral health benefits (33.3%).

Overall, the majority of Medicaid MCOs (90%) reported that care coordinators and medical directors had access to review medical records in at least some individual markets, inclusive of physical and behavioral health information, with some variation by the size of the Medicaid MCO.[19] For example, a third of Medicaid MCOs with fewer than one million enrollees reported that care coordinators had this access in at least some markets, while only 16.7 percent did not have access. Finally, of the Medicaid MCOs that serve over a million individuals, 75 percent reported that care coordinators and medical directors had access to review medical records.

Behavioral and Physical Health Integration

There are a number of different approaches to physical and behavioral health integration, such as the following:[24]

- Aggregation of care from separate settings and systems that often involve minimal communication.
- Co-located care with some coordination with screening and treatment plan development.
- Full care integration where providers operate as a team in a shared practice model with a whole-person focus.

In 2012, individuals with co-occurring behavioral and medical conditions generated an additional almost $300 billion in health care costs.[25] According to the report, an estimate of between 9-16 percent of costs could have been avoided with effective integration of medical and behavioral services, an estimated savings of $26-48 billion.[25]

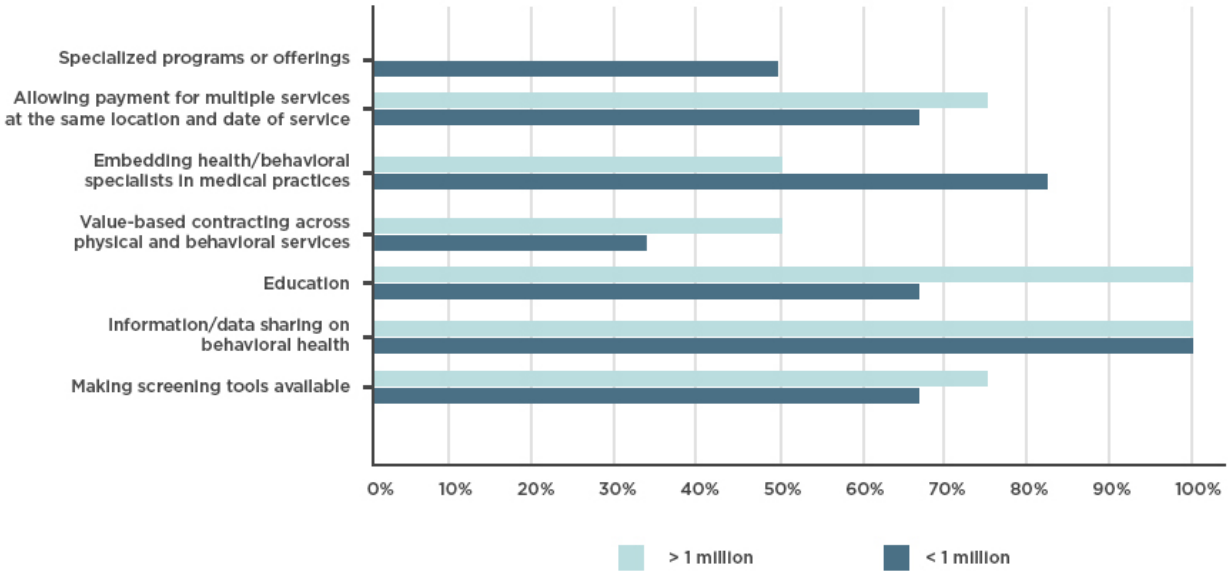
Coordination of physical and behavioral health has been a topic of research, policy, and clinical practice for more than 30 years. Over this time period, the approach that has been found to be the most efficient and effective, while consistently improving outcomes, is the Collaborative Care Model.[26] This model is team driven, measurement guided, evidence based, and population focused. In this model all team members are empowered to work at the top of their professional training and licensure in a coordinated manner. Measurement is based on patient reported outcomes.[26] In this model, a savings example for co-occurring depression and diabetes over a 24-month period when treated resulted in a savings of $896, compared to those not treated at all or not treated in a coordinated model. In a 48-month period, depression treated in a primary care setting cost $3,300 less.[27] Depression is the primary driver of overall health care costs when medical and medication costs and lost work productivity are all considered.[28] Fifty percent of all disability days are tied to a behavioral health disorder.[29]

Total medical expenses overall--medical and behavioral combined--carry an annual cost of 46 percent more than chronic medical conditions alone.[29] These outcomes suggest that integrating behavioral health and primary care is beneficial to patients and health systems.[30] However, disparities remain between access and reimbursement between physical and behavioral health care.[25]

In New Hampshire, Vermont, Maine, Massachusetts, and Minnesota, behavioral health clinicians were paid less than 50 percent of the medical clinician rate for the same services. In New Jersey, 45 percent of behavioral health office visits were conducted by out-of-network clinicians, while in Washington D.C., the number was found to be a staggering 63 percent.[25] Behavioral health services typically have higher out-of-pocket copays and percentage of coinsurance obligations for out-of-network clinicians than in-network clinicians, which increases the financial burden for an individual accessing an out-of-network clinician.[31]

IMI's annual Medicaid managed care survey collected data from health plans to determine approaches that they were working on with physical health clinicians to address behavioral health needs.[19] Regardless of health plan size, all Medicaid MCOs were engaged in information and data sharing on behavioral health services and education (Figure 3). Other common approaches included making screening tools available, embedding health and behavioral specialists in medical practices, and allowing payment for multiple services at the same location and date of service.

Figure 3. Approaches Medicaid MCOs Worked with Physical Health Providers to Address Behavioral Health Needs, Stratified by Medicaid MCO Size, 2017

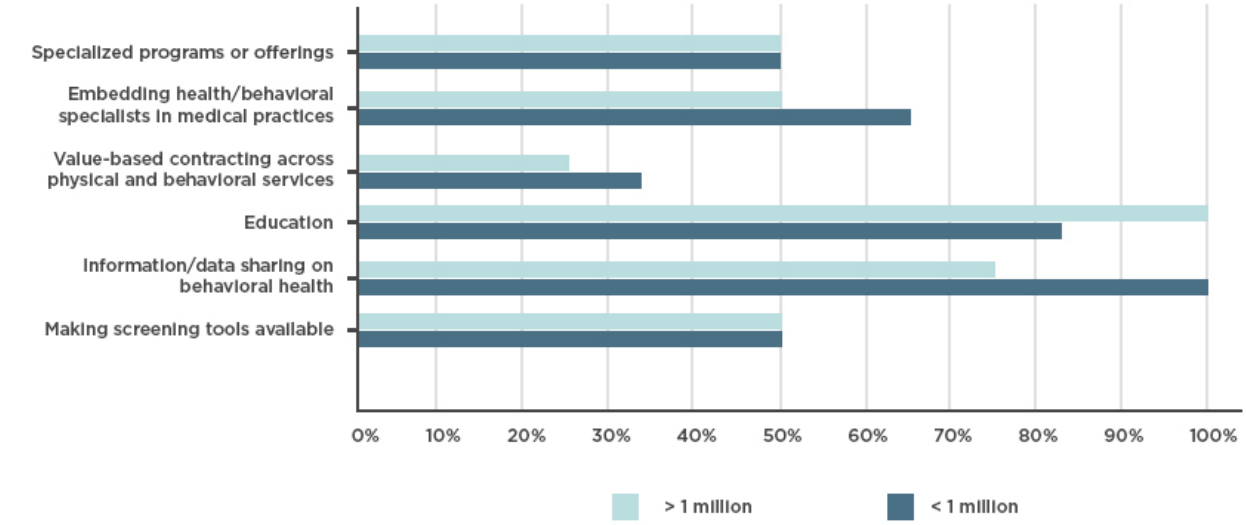


Note: For > 1 million and < 1 million refers to the total number of Medicaid covered lives for the managed care organization and not the number of covered lives for behavioral health.

Source: Institute for Medicaid Innovation. (2018). *2017 annual Medicaid MCO survey – Behavioral health.* Washington, D.C.

Conversely, the survey also assessed how Medicaid MCOs were working with behavioral health clinicians to address physical health needs. Again, nearly all Medicaid MCOs reported engaging in information and data sharing on behavioral health and education (Figure 4). Making screening tools available was reported by half of Medicaid MCOs, regardless of size.

Figure 4. Approaches Medicaid MCOs Used to Work with Behavioral Health Providers to Address Physical Health Needs, Stratified by Medicaid MCO Size, 2017



Note: For > 1 million and < 1 million refers to the total number of Medicaid covered lives for the managed care organization and not the number of covered lives for behavioral health.

Source: Institute for Medicaid Innovation. (2018). *2017 annual Medicaid MCO survey – Behavioral health.* Washington, D.C.

In addition, Medicaid MCOs also reported qualitative information on barriers that they experienced in 2017 specific to coverage for physical and behavioral health integration. For instance, they indicated the following challenges:[19]

- Cultural differences and fragmentation between physical and behavioral health and delivery systems.
- Funding fragmentation from the federal, state, and county levels affect how programs are delivered.
- Obtaining appropriate consents and ensuring that clinicians will accept these consents are barriers to care coordination.
- States have exclusions and benefit exhaustion parameters that negatively impact the MCO's ability to serve the behavioral health and related care coordination needs for these members.

Looking Ahead: Implications for the Future of Behavioral Health in Medicaid

Behavioral health continues to be a critical focus for the Medicaid program, as it serves a number of populations who are at-risk for behavioral health conditions. Prior research has demonstrated that behavioral health and physical health are closely linked, which suggests that improvements in behavioral health may be associated with improvements in physical health and vice versa. Despite a number of advances in access to behavioral health services, many individuals still do not initiate or complete treatment.

Additionally, policies and health systems have not been able to sufficiently address the barriers and needs of the population. Future potential efforts in behavioral health should consider opportunities to promote health equity among all populations (e.g., people of color, women, low-income individuals), improve access to evidence-based treatment models (e.g., integrated care), as well as remove policy barriers that prevent individuals from accessing or completing treatment. Based on the findings of this report, the following clinical, research, and policy priorities are provided.

Clinical Priorities

Promote the use of care models that integrate physical and behavioral health, such as the collaborative care model.

Research has demonstrated that collaborative care models lead to improved outcomes for individuals as well as reduce costs. Educating and training clinicians in these models may further encourage their adoption.

Address the shortage of behavioral health workers, particularly in underserved areas.

There are an insufficient number of behavioral health clinicians to address the growing needs of individuals seeking treatment. Encouraging clinicians to receive specialty training in behavioral health may serve to alleviate access problems surrounding small-workforce issues.

Integrate cultural competency in education and training.

Individuals in the Medicaid program may come from diverse cultural backgrounds, and significant disparities among a number of groups have been documented. Further, these diverse backgrounds may influence their willingness to disclose and discuss their behavioral health needs. Training behavioral health clinicians and other clinicians in cultural competency may serve to promote discussion in a culturally relevant, sensitive manner.

Improve screening efforts for behavioral health conditions.

Screening for behavioral health conditions in settings such as primary care may serve to identify individuals who would benefit from treatment, including psychotherapy or pharmacological treatment. The stigmatization of behavioral health may prevent individuals from initiating conversations with clinicians. The utilization of screening tools might better identify individuals in need of treatment as well as promote conversations.

Research Priorities

Conduct further research on collaborative care models in order to determine the efficacy and effectiveness of these models.

Research on these models should also focus on outcomes as well as quality improvement, particularly for low-income and racial/ethnic minorities who are oftentimes underrepresented in this type of research.

Provide financial support to encourage behavioral health research.

Researchers rely on funding from major, national funders (e.g., National Institutes of Health, National Science Foundation, Institute of Education Sciences) in order to support studies that advance our understanding and treatment of behavioral health conditions.

Policy & Advocacy Priorities

Improve efforts to support reimbursement for collaborative care models.

For Medicaid MCOs to adopt new collaborative care models, reimbursement needs to be provided to sustain these models.

Address Medicaid MCO concerns surrounding CFR 42 limitations on SUD treatment information sharing.

Restrictions on information sharing on SUD precludes sharing between behavioral health and physical health clinicians. This may lead to poor care coordination and unmet meets for the individual living with SUD.

Address Medicaid MCO concerns surrounding fragmentation in program funding and contracting for physical and behavioral health services.

Fragmentation in program funding creates a number of barriers for Medicaid MCOs. For example, it leads to a decreased focus on population health and has been shown to be costlier than providing integrated care. As such, funding for innovative integrated models should be pursued.

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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 4/10/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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