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:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
June 12, 2020
9:30 am to 11:30 am
Draft: 6/4/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Consent Agenda**
   - May 8, 2020 SWMBH Board Meeting Minutes (d) p. 3
5. **Operations Committee**
   - Operations Committee Minutes April 22, 2020 (d) p. 8
6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   a. Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder who are taking Antipsychotic Medications (J. Gardner and M. Kean) (d) p. 11
   b. Fiscal Year 2020 Performance Bonus Incentive Program Update (J. Gardner) (d) p. 12
7. **Board Actions to be Considered**
   - None
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - BG-012 Open Meetings Act and Freedom of Information Act (d) p. 21
9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   a. BEL-002 Financial Conditions (T. Schmelzer) (d) p. 22
   b. BEL-006 Investments (P. Garrett) (d) p. 27
   c. BEL-007 Compensation and Benefits (R. Nelson) (d) p. 29

10. Board Education

a. Fiscal Year 2021 Budget Development Calendar (T. Dawson) (d) p. 30
b. Fiscal Year 2021 Budget Assumptions (T. Dawson) (to be displayed)
c. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 31
d. Fiscal year 2019 Performance Bonus Incentive Program disbursements to CMHs (T. Dawson) (d) p. 39
e. Auditor Procurement (T. Dawson)
f. Health Services Advisory Group External Quality Review Results (J. Gardner) (d) p. 40
g. Regional Gambling Assessment and Plans (J. Rollin) (d) p. 43
h. Center for Healthcare Integration and Innovation (CHI2) "Tradition of Excellence and Innovation" (B. Casemore) (d) p. 64

11. Communication and Counsel to the Board

a. Provider Payments & Risk Corridor (B. Casemore) (d) p. 66
b. MDHHS 90 Day Follow-Up to the 1915(c) Home and Community Based Services (HCBS) Corrective Action Plan (B. Casemore) (d) p. 73
c. Advocates Letter (B. Casemore) (d) p. 74
d. July 10, 2020 Board Agenda (d) p. 79
e. Board Member Attendance Roster (d) p. 81
f. July Board Policies: BG-008 Board Member Job Description

12. Public Comment

13. Adjournment

14. Planning Meeting 11:45am-1:00pm

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
July 10, 2020
9:30 am - 11:00 am

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
May 8, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 5/8/20

Members Present via phone: Edward Meny, Tom Schmelzer, 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; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Alternate; Pat Guenther, Kalamazoo Alternate; Jeff Patton, ISK; Kris Kirsch, St. Joseph CMH; Randy Paruch, IT Program Manager, SWMBH; Alan Bolter, Community Mental Health Association of Michigan; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Mary Ann Bush, Senior Operations Specialist and Project Coordinator, SWMBH

Welcome Guests
Edward Meny called the meeting to order at 9:30 am, introductions were made, and Edward welcomed the group.

Public Comment
None

Agenda Review and Adoption

Motion	Tom Schmelzer moved to accept the agenda as presented.	
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

Motion Carried

Board Comment and Updates
Brad Casemore welcomed the Board members and thanked them for working through technology issues and participating remotely again this month. Brad Casemore acknowledged Tom Schmelzer for his years of service as the SWMBH Board Chair. Tom Schmelzer remarked his pleasure in serving and offered the new chair any assistance needed. Edward Meny thanked Tom Schmelzer for his service. Brad Casemore welcomed Edward

Meny as the new SWMBH Board Chair. Brad Casemore announced, in honor of the late Moses Walker, the SWMBH Board room would be renamed the Moses L. Walker Community Room and a plaque noting this would be placed as soon as possible, and that Mr. Walker's family would be officially notified.

Financial Interest Disclosure Handling

None

Consent Agenda

Motion	Erik Krogh moved to approve the April 10, 2020 Board meeting minutes as presented.	
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
Motion Carried		

Operations Committee

Operations Committee Minutes March 25, 2020

Debra Hess reported as documented. Minutes accepted.

Operations Committee Minutes April 8, 2020

Debra Hess reported as documented. Minutes accepted.

Environmental Scan

Alan Bolter, Associate Director, Community Mental Health Association of Michigan reported as documented noting power struggles between the Governor and the Legislators, the toxic environment in Lansing, State reopening plans, and projected budget shortfalls.

Ends Metrics

Michigan Mission Based Performance Indicator System (MMBPIS)

Jonathan Gardner reported as documented.

Motion	Tom Schmelzer moved that the data is relevant and compelling, the executive officer is not in compliance and the ends metric has been revised to reflect the FY 2020 reporting specifications required by the Michigan Department of Health and Human Services.	
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 Strategic Imperatives

Brad Casemore reported as documented, noting that the Strategic Imperatives approval was tabled until the June Board meeting to give each Board member time to review with local stakeholders.

Motion	Erik Krogh moved to approve the SWMBH Strategic Imperatives knowing that COVID-19 implications will cause possible future revisions to the imperatives.	
Second	Robert Nelson	
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

Substance Use Disorder Oversight Policy Board Intergovernmental Contract Renewal

Brad Casemore reviewed the history of the Intergovernmental Contract.

Motion	Tom Schmelzer moved to approve the revisions and renewal of the contract for the term of January 1, 2021 through December 31, 2024.	
Second	Sue 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

Credentialing of Behavioral Health Organizational Providers Policy

Mila Todd reported as documented, noting the policy revisions were a result of the Managed Care Functional Review. The revisions are not a change in practice, but a policy update.

Motion	Erik Krogh moved to approve the Credentialing of Behavioral Health Organizational Providers Policy revisions as presented.	
Second	Tom Schmelzer	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes

Motion Carried

Board Retreat Planning

Brad Casemore noted that the scheduled May Board Planning Retreat was cancelled and asked the Board for their preference in rescheduling. Discussion followed.

Motion	Robert Nelson moved to approve a Board planning session in June and a Board Retreat in August.	
Second	Tom Schmelzer	
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 Policy Review

BG-011 Governing Style

Edward Meny reported as documented.

Motion	Tom Schmelzer moved that the Board is in compliance and Policy BG-011 Governing Style 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

Executive Limitations Review

BEL-004 Treatment of Staff

Edward Meny reviewed the policy as documented.

Motion	Edward Meny moved that the Executive Officer is in compliance and Policy BEL-004 Treatment of Staff does not need revision.	
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 Education

MI Health Link Update

Moira Kean reported as documented. Brad Casemore noted that more information will be presented at the June Board meeting due to the extension of MI Health Link. Discussion followed.

Communication and Counsel to the Board

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented.

Fiscal Year 2020 Mid-Year Contractor Vendor Summary

Tracy Dawson reported as documented.

Community Mental Health Association of Michigan System Transformation

Brad Casemore noted the document in the packet and that Alan Bolter had touched on this during his presentation.

June Policy Reviews

Edward Meny noted policies that are scheduled for review at the June Board meeting.

Public Comment

None

Adjournment

Motion	Erik Krogh moved to adjourn at 11:20am
Second	Patrick Garrett

Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: April 22, 2020
9:00am-11:00am

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

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; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, 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.

Review and approve minutes from 4/8/20 Operations Committee Meeting – Minutes were approved by the Committee.

Personal Protective Equipment (PPE) – Anne Wickham stated that she spoke with Jeffrey Wienferich, DHHS Director, in coordinating a delivery of PPE for SWMBH. When the PPE arrives Anne Wickham will coordinate with each CMHSP for pick up. The distribution of the PPE is based on the reported number of direct care workers submitted by each CMHSP.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported as documented noting that April's payment appears to be higher than expected. Discussion followed.

Fiscal Year 2020 Encounters – Tracy Dawson reported as documented and reminded group that these reports are available to each CMSHP on Tableau.

Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI) – Tracy Dawson has scheduled a meeting on April 29th to include Information Technology and Finance staff to review new EQI template from the State and determine how the information in the SWMBH data warehouse will be compiled to complete the template. Submission to the State is 6/30/20. Tracy Dawson also noted that she reminded the State that EQI requests are not in the PIHP contract and should go through contract negotiations before EQI reports are mandated.

Cost Allocation Workgroup – Pat Davis commented this workgroup is not moving along well, but the rate development work group is working well. A letter was sent to the department requesting all projects be tabled until further notice due to COVID-19.

Death Audit Recoupment – Tracy Dawson shared the State notified SWMBH that the April death audit recoupment has been canceled as they continue to analyze the report and its impact.

DHHS Milliman Rate Setting Meeting – Tracy Dawson reported that Milliman, the State's actuary, admitted to making mistakes with rate setting methodologies. March data was received, and a $50 million shortage is being adjusted to $25 million this month statewide. Some questions addressed to Milliman were not answered. Discussion followed.

Strategic Imperatives 2020-2023 – Brad Casemore noted the endorsed Strategic Imperatives and commented that the SWMBH Board members are reviewing the document and are free to discuss with local CMHSP Boards and stakeholders knowing that there will be revisions to the Strategic Imperatives due to COVID-19 impacts and implications.

Levels of Care Utilization System (LOCUS) – Natalie Spivak reviewed the email from the State as documented. Natalie Spivak to ask State for details on 67% valid submitted LOCUS scores.

Fiscal Year 2020 Behavioral Health Treatment Episode Data Set (BH TEDS) – Natalie Spivak reviewed DHHS's Fiscal Year 2020 BH TEDS completion rates reports. Discussion followed.

Premium Pay – Brad Casemore reviewed email from Richard Thiemkey regarding premium pay for direct care workers. Brad Casemore noted the importance of stability in the Provider Network and said that each CMHSP has latitude in provider rates at the CMH level. Any monetary adjustments made should have a contract amendment submitted. Each CMHSP discussed processes, and guidance desires around premium pay. Discussion followed.

Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) – Jonathan Gardner updated group on upcoming audit dates, noting that the audits will be remote.

Michigan Mission Based Performance Indicator System (MMBPIS) – Jonathan Gardner reported as documented.

Substance Use Disorder Oversight Policy Board (SUDOPB) Intergovernmental Contract – Brad Casemore noted the Intergovernmental Contract, set to expire 12/31/20 was included the packet of materials and said the process for renewing the contract is beginning next month.

Hotels Offer – Ric Compton inquired about hotels in our Region that offered rooms for COVID-19 related issues. Brad Casemore said he would again send a request to Allen Jansen at the State to provide processes for utilization of hotels.

Adjourned – Meeting adjourned at 11:00 am

SWMBH Board Discussion & Planning Meeting

Date: Friday, June 12, 2020

11:45 am – 1:00 pm

GoToMeeting -- Continued from Board Meeting 9:30 – 11:30 am

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You can also dial in using your phone.
United States: +1 (571) 317-3122

Access Code: 515-345-453

To request accommodation under ADA please call Anne Wickham at 269-488-6982

11:45 am	**Welcome and Introductions**
11:50 am	**How the World has Changed Open Discussion – Brad Casemore & All**
1:00 pm	**Closing Comments**

* * * * * * *

Participants:

*** SWMBH Board and Board Alternates**

*** CMHSP CEOs**

*** SWMBH Senior Leaders**

*** SUD Board Chair/Vice-Chair**

*** Customer Advisory Committee Chair/Vice-Chair**

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2020 Diabetes Performance Improvement Plan Update:

Achieve a (4 percentage point) improvement in the rate of Diabetes screenings for consumers with schizophrenia or Bipolar Disorder who are using Antipsychotic Medications. Metric Measurement Period: 1/1/20 - 12/31/20 Board Report Date: June 12, 2021 Metric Measurement Period Reported on 6/12/20: 1/1/19 – 12/31/19 **Measurement:** Percent of members 18-64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.	**2018 Baseline: 76.88%** **Goal for 2019: 80%** **Goal for 2020: 80%** **Rate Achieved for 2019: 76.44%** (Note, the board metric is for the 1/1/20 - 12/31/20 time period, due in June 2021)

Background: SWMBH has a Performance Improvement Project (PIP) to improve the rates of annual preventative diabetes screening through an A1c or HbA1c test, for individuals who are prescribed anti-psychotic medications. The PIP is required through our Medicaid contract with MDHHS and is reviewed and validated annually by Health Services Advisory Group (HSAG). The PIP topic on diabetes screening was selected from a list of potential HEDIS metrics required by MDHHS and HSAG for the project, with input from the Regional Clinical Practices and Regional Quality Improvement Committees, in 2018.

A Note on the Metric Timeframe: The board metric is for the 2020 calendar year, with a goal rate of 80%, and a final report to the board in June 2021. The 2019 results are due to HSAG June 30, 2020. This metric does not work well for mid-year reports; individuals have a full calendar year to have the diabetes screening completed, so rates are lower in the earlier part of the year. So, the full calendar year 2019 rate is being used as an update on progress made so far.

Current Performance: In 2019, the regional rate of diabetes screening for the target population was 76.44%, compared to the 2018 baseline of 76.88%. The goal of 80% for 2019 was not met.

Steps Taken: Through a regional workgroup, each CMH developed a plan for implementing diabetes screening with their target populations, in late 2018 and early 2019. In February-March 2020, CMHs whose performance didn't improve from 2018 to 2019 were asked to look for ways to address the performance issue, and SWMBH met with the Medicaid Health Plans in the region to partner on the metric, for individuals not involved in Medicaid Specialty Supports and Services.

Next Steps: We will continue to work through the Regional Clinical Practices and Regional Quality Improvement Committees to maintain visibility on the metric and ensure that committee representatives are aware of the details and purpose. We will offer consultative assistance to CMHs for developing internal business processes, clinical workflows, trainings, or other ways to improve screening rates. Finally, we'll develop a specific plan with each Medicaid Health Plan to address screening for individuals who aren't connect to CMH services.

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FY 20 & 21 Performance Bonus Incentive Program (PBIP) Metric Updates

FY 2020 PBIP Narrative Reports and Updates

1. Identification of Veteran's eligible for services:

Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. Improve and maintain data quality on BH-TEDS military and veteran fields.

- Measurement period: 10/1/19 – 3/31/20
- Report submitted to MDHHS for review on 6/1/20

2. Increased Data sharing:

Send ADT messages for purposes of care coordination through health information exchange. Submit report addressing IT systems barriers and remediation efforts by: 7/31/20

3. Initiation and Engagement:

The percentage of adolescent and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- Initiation of AOD Treatment: The percentage of enrollees who initiate treatment within 14 calendar days of the diagnosis. SWMBH will submit a qualitative narrative

4. Summary report to MDHHS, related to efforts, activities and achievements with the following metrics:

- Comprehensive Care
- Patient – Centered Medical Homes
- Coordination of Care
- Accessibility to Services
- Quality and Safety

FY 2020 PBIP
Benchmark Reports and Updates

1. Joint Care Management:

- 90% of care plans evaluated must achieve full compliance.

2. Follow-up after Hospitalization for Mental Illness (30 days):

- The adult minimum standard is 58% and the child minimum standard is 70%.
- **Current SWMBH Results:**
  - Adult: 67.13%
  - Child: 77.51%

3. Plan All-Cause Readmission (30 days):

- Review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues. Submit report *Informational only in 2020* (By: June 30, 2020)

4. Follow-up after Emergency Department Visit for Alcohol and Drug Dependence: Members 13 years and older with an (ED) visit for alcohol and other drug dependence, that had a 30-day follow-up visit. Submit a narrative report (4 pages) on findings of efforts to review data. Analysis should include disparities among racial and ethnic minorities. Submit report. *Informational only in 2020*.(By: June 30, 2020).

FY 20 & 21 PBIP
Key Imperative Updates

- It is critical that our BH TEDS and LOCUS data is accurate and performance benchmarks are achieved, as these values will potentially affect our total PBIP Bonus Award. 2020 Board Ends Metrics Benchmarks; (TEDS = 97% - LOCUS = 95%).

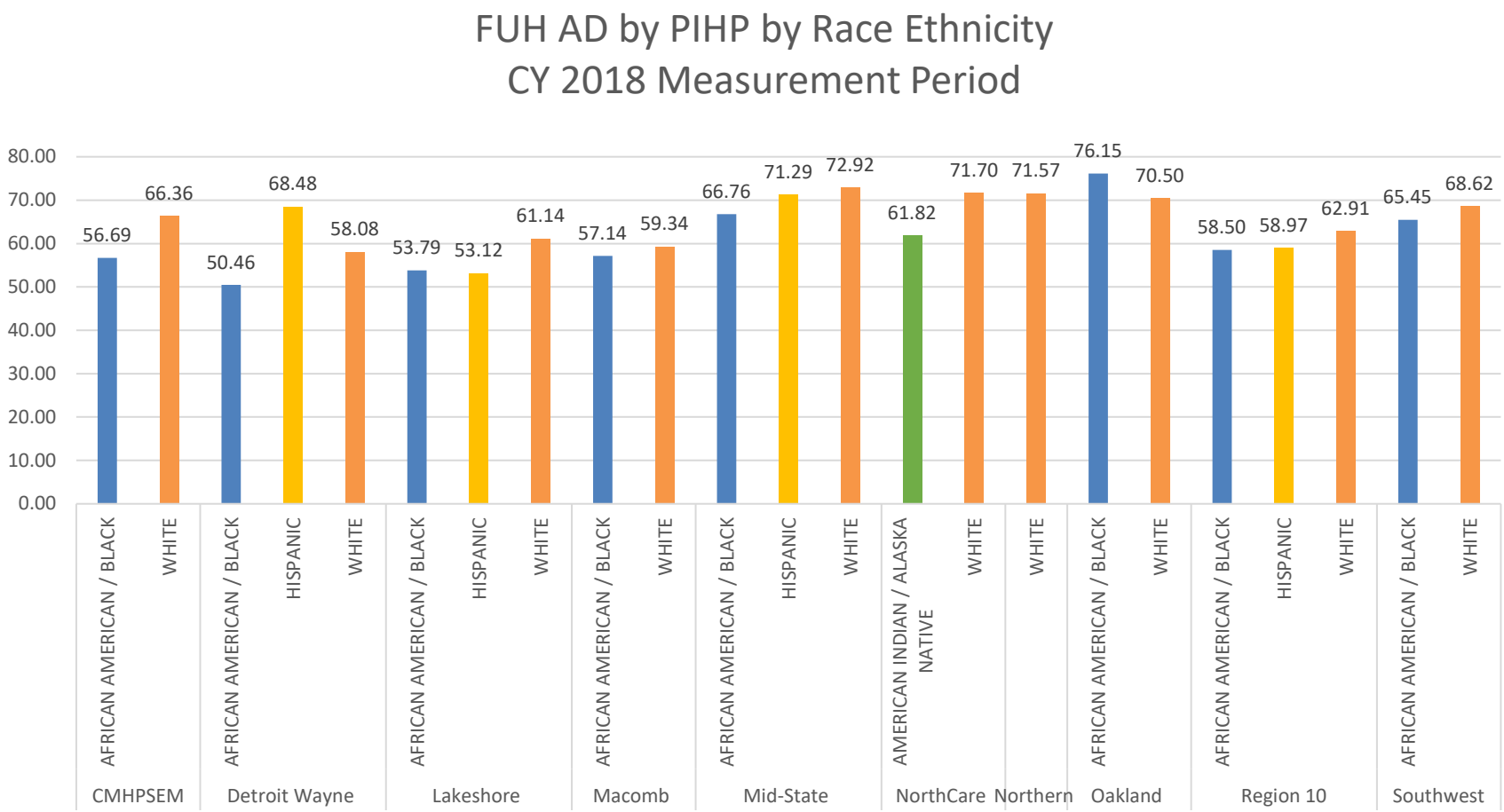
- Milliman is adjusting calculations to include BH TEDS and LOCUS data into capitation rates as early as FY 2021.

Proposed FY2021 Hospital Follow-up Benchmarks Changes

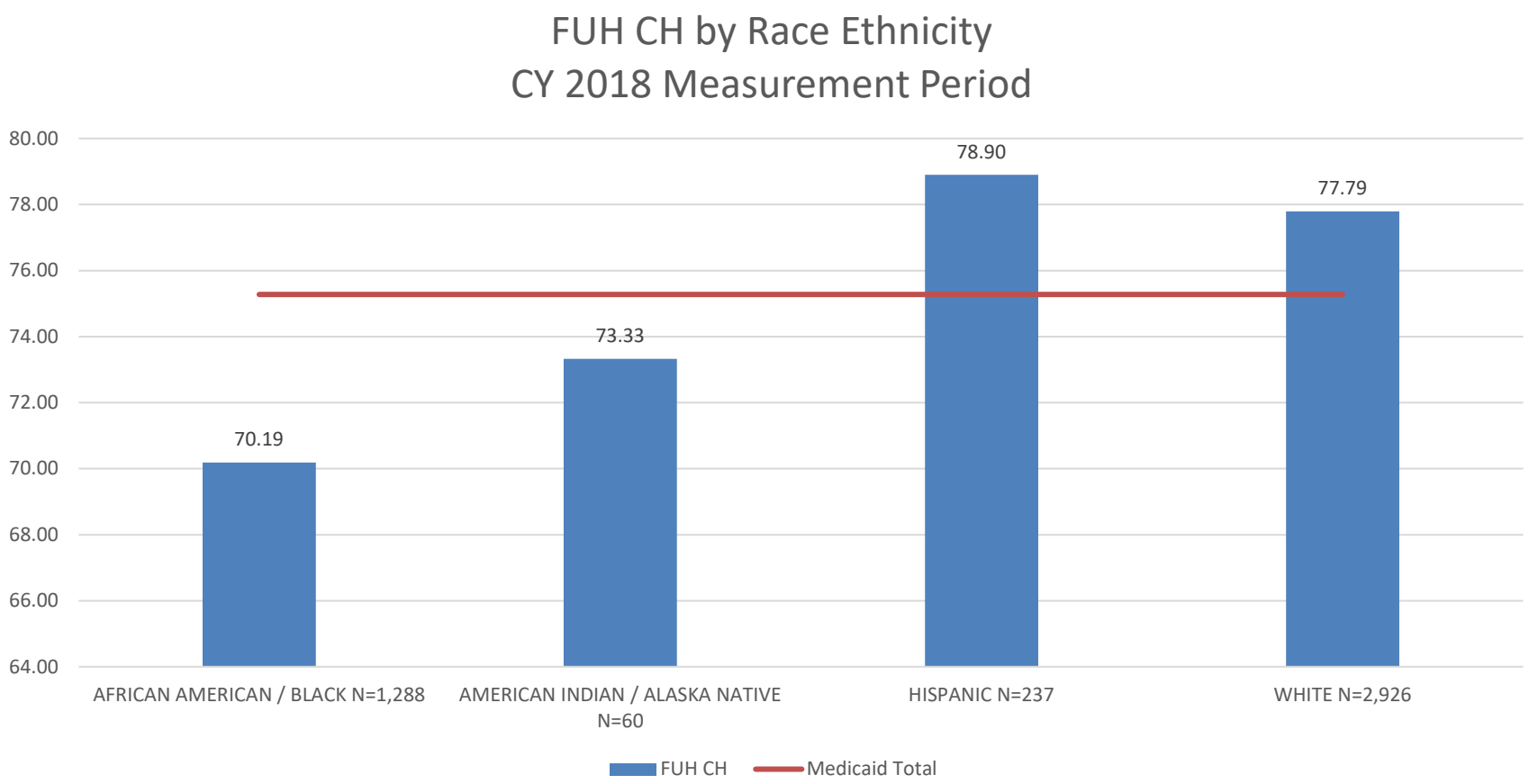
1. **Continue 50th percentile for FY2021:**
   - Child minimum standard (6-17): **70%**
   - Adult minimum standard (18+): **58%**

2. **Add incentive based on reducing racial/ethnic disparities.**

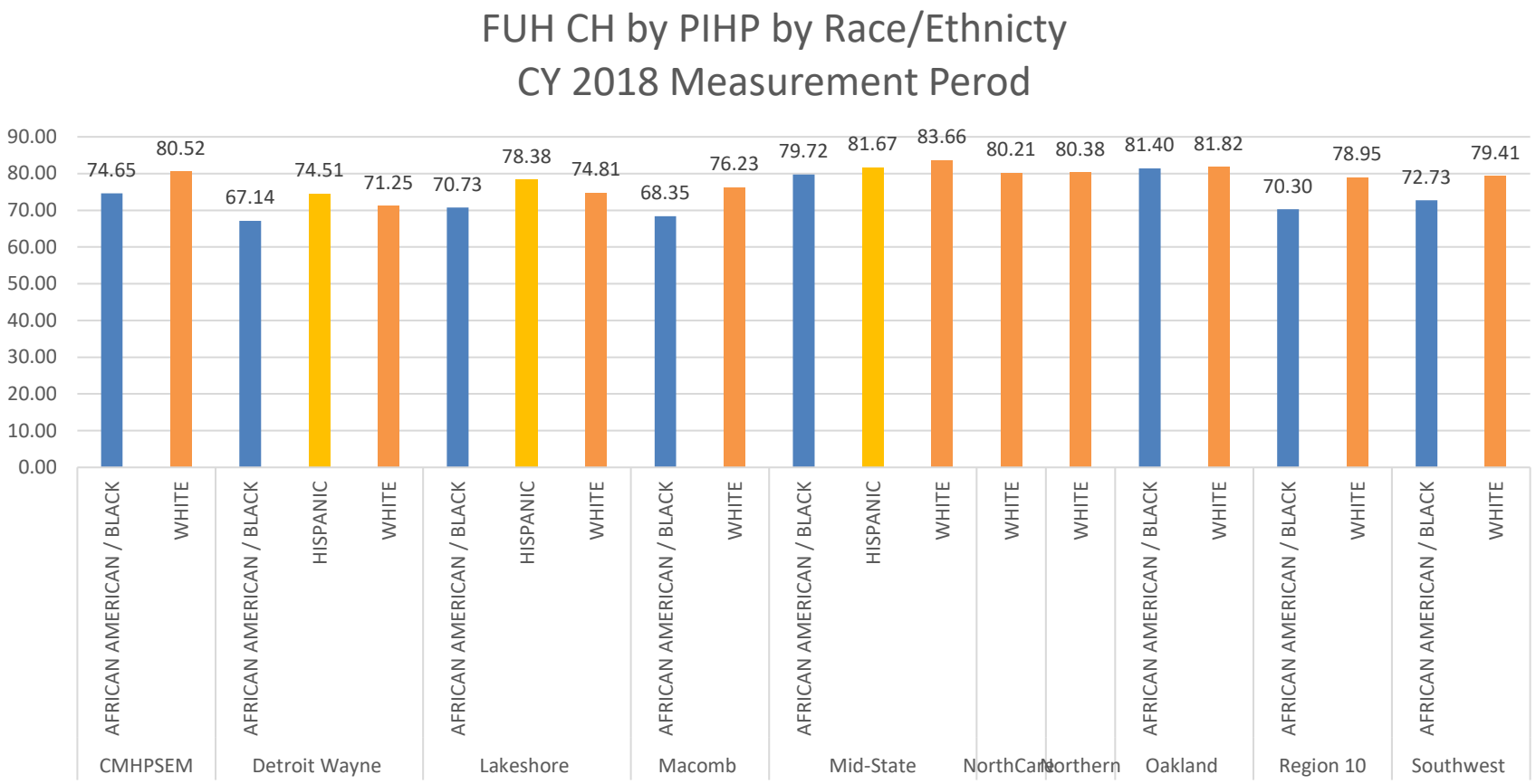
FUH Health Equity Analysis



FUH Health Equity Analysis



FUH Health Equity Analysis



FUH FY2021 Draft Contract Language

Category	Description	Criteria/Deliverables
J.2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) using HEDIS descriptions (~~65~~25 points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	Plans will meet set standards for follow-up within 30 Days for each rate (ages 6-20 and ages 21 and older). 1) Plans will be measured against an adult minimum standard of 58% and a child minimum standard of 70%, and 2) Data will be stratified by race/ethnicity. Plans will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period will be January 1-December 31. The points will be awarded based on MHP/PIHP combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	**Policy Number:** BG-012	**Pages:** 1
Subject: Open Meetings Act and Freedom Of Information Act	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 6.12.15	**Last Review Date**: 6/14/19	**Past Review Dates**: 6/9/17; 6/10/16; 6/8/18

I. **PURPOSE:**

To provide the SWMBH Board the specific requirements for operating in compliance with Michigan's Open Meetings Act, 1976 PA 267, and the Freedom of Information Act, 1976 PA 422.

II. **POLICY:**

The Regional Entity and its Participant CMHSP Boards, members of the Regional Entity Board, officers, staff and other employees shall fully comply with all applicable laws, regulations and rules, including without limitation 1976 PA 267 (the "Open Meetings Act") and 1976 PA 422 (the "Freedom of Information Act"). The Regional Entity shall develop such compliance policies and procedures. In the event that any such noncompliance is found, immediate corrective action as defined in the Operating Agreement shall be taken by the appropriate source to ensure compliance. Compliance policies and procedures will be defined in the Operating Agreement.
SWMBH Bylaws 04.13 Compliance with Laws

III. **STANDARDS:**

SWMBH shall operate in compliance with the procedures prescribed in Michigan's Open Meetings Act, 1976 PA 247 and the procedures prescribed in Michigan's Freedom of Information Act, 1976 PA 442.

References

- SWMBH Operating Policy 10.12: Freedom of Information Request Policy

Attachments:

- Michigan's Open Meetings Act, 1976 PA 267.
  - http://www.michigan.gov/ag/OMA_handbook_287134_7.pdf
- Michigan's Freedom of Information Act, 1976 PA 442
  - http://www.michigan.gov/documents/ag/FOIA_pamphlet_380084_7.pdf

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Meeting: June 12, 2020

Policy Number: BEL-002
Policy Name: Financial Conditions
Assigned Reviewer: Tom Schmelzer

Purpose: The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the Board's Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

Policy: With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from Board priorities established in policies.
This report addresses fiscal year 2019, October 1, 2018 to September 30, 2019. As expected, any material exceptions noted after September 30, 2019 to close of current year would be provided to the Board regardless of the reporting period.

Standards: Accordingly, the EO may not;

1. Expend more funds than have been received in the fiscal year to date, (including carry forward funds from prior year), unless the Board's debt guideline is met.

   EO Response: *SWMBH has expended more funds than have been received for the reviewed fiscal year. Based on the approved budget the Board was made aware of the expected excess expenditures.* (See attached Board Approved FY 2019 budget).

   In fiscal year 2019, October 1, 2018 to September 30, 2019, SWMBH received gross revenues, (all types), of $267,656,180 million. Expenses during the period, (all types), were $271,624,934 million and an unfavorable difference of $3,968,754 million. This negative margin was covered in full by the Internal Service Fund (ISF).

Please see 2019 Financial Audit as presented to the Board in April for a detailed breakdown by contract/business line/funding streams. Recall that Medicaid and Medicaid-Healthy Michigan are entitlements with cost settled risk contracts with MDHHS. Substance Abuse Prevention and Treatment

Block Grant and PA2 are not entitlements and are funded with a do-not-exceed grant contract from MDHHS.

2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.

   EO Response: *SWMBH has incurred no debt obligations.*

3. Use any designated reserves other than for established purposes.

   EO Response: *No designated reserve funds, (Internal Service Fund), have been used for any purpose other than that mentioned above. SWMBH has no other contractual or Board-designated reserves.*

4. Conduct interfund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.

   EO Response: *No interfund shifting has occurred outside these parameters.*

5. Fail to settle payroll and debts in a timely manner.

   EO Response: *Payroll has been paid in a timely manner as evidenced by payroll run reports and absence of staff complaints related thereto. Accounts Payable payment policy is 30 days. All invoices received and deemed accurate for payment were paid within this timeframe, on average 1200 invoices a year.*

6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.

   EO Response: *Tax payments and other government-ordered payments tax returns have been timely and accurately filed. Tax filings are available upon request.*

7. Fail to adhere to applicable Generally Acceptable Accounting standards.

   EO Response: *Per CFO all monthly financial statements were prepared and presented in accordance with generally accepted accounting principles. This was verified by external auditors via their clean opinion.*

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

EO Response: *No single purchase or commitment of greater than $100,000 has occurred between October 1, 2018 and September 30, 2019. The EO interprets "purchase or commitment" as acquisition of a product or service which excludes a termination clause.*

9. Purchase or sell real estate in any amount absent Board authorization.

   EO Response: *No real estate has been purchased. No real estate is owned.*

10. Fail to aggressively pursue receivables after a reasonable grace period.

    EO Response: *Receivables largely include payments from MDHHS which are routine transmissions to us on a regular MDHHS-defined schedule. Immaterial receivables stem from contracts with other agencies who are invoiced promptly and pay promptly.*

Materials available for Review: Fiscal Year 2019 External Audit and Financial Statements (provided at April 10, 2020 Board meeting).

Mr. Schmelzer was invited to contact the CEO and/or CFO, to request additional materials, or set a phone or live meeting to discuss.

Enclosures:

- 2019 Audited Financial Statements
- Board approved fiscal year 2019 budget

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitation	Policy Number: BEL-002	Pages: 2
Subject: Financial Conditions	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.14	**Last Review Date**: 06.14.19	**Past Review Dates**: 10.12.14, 02.13.15, 5.13.16,5.12.17, 6.8.18

I. **PURPOSE:**

The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the board's Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

II. **POLICY:**

With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from board priorities established in policies.

III. **STANDARDS:**

Accordingly, the Executive Officer may not:

1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year) unless the Board's debt guideline is met.

2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.

3. Use any designated reserves other than for established purposes.

4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.

5. Fail to settle payroll and debts in a timely manner.

6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.

7. Fail to adhere to applicable generally acceptable accounting standards.

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

9. Purchase or sell real estate in any amount absent Board authorization.

10. Fail to aggressively pursue receivables after a reasonable grace period.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-006	Pages: 2
Subject: Investments	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 02.14.2014	Last Review Date: 6.14.19	Past Review Dates: 2.13.15, 2.12.16, 2.10.17, 2.9.18

I. **PURPOSE:**
To establish a policy guiding investments.

II. **POLICY:**
It is the policy of SWMBH to invest public funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds.

III. **STANDARDS:**
Accordingly the Executive Officer may not:

1. Fail to comply with the requirements of Public Act 20 of 1943, as amended. The following types of securities are authorized by Public Act 20 of 1943, as amended:

    - Bonds, securities, and other obligations of the United Sates or an agency or instrumentality of the United States.
    - Certificates of deposit, savings accounts, deposit accounts or depository receipts of a financial institution as defined in Public Act 20 of 1943 as amended, no more than 60% of the total investment portfolio will be invested in a single security type or with a single financial institution with the exception of funds held in a CDARS account.
    - Commercial paper rated at the time of purchase at the highest classification established by not less than 2 standard rating services and that matures not more than 270 days after the date of purchase.
    - Repurchase agreements consisting of instruments in subdivision V., (A).
    - Banker's acceptances of United States banks.
    - Obligations of this state or any of its political subdivisions that at the time of purchase are rated as investment grade by not less than 1 standard rating service.
    - Obligations described in subdivision 6.1 through 6.6 if purchased through an interlocal agreement under the Urban Cooperation Act of 1967. 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512.
    - Investment pools organized under the Surplus Funds Investment Pool Act, 1982 PA 367, MCL 129.111 to 129.118.
    - Investment pools organized under the Local Government Investment Pool Act, 1985 PA

121, MCL 129.141 to 129.150.

2. Neglect to diversify investment portfolio. With the exception of U.S. Treasury securities and authorized investment pools as defined in Public Act 20 of 1943 as amended, no more than 60% of the total investment portfolio will be invested in a single security type or with a single financial institution with the exception of funds held in a Certificate of Deposit Account Registry Service (CDARS) account.

3. Fail to meet the standard of prudence. Investments shall be made with judgment and care, under circumstances then prevailing, which persons of prudence, discretion and intelligence exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of their capital as well as the probable income to be derived.

4. Endanger safekeeping of securities.

5. Avoid providing timely and accurate investment reports.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy Executive Limitations	**Policy Number:** BEL-007	**Pages:** 1
Subject: Compensation and Benefits	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 05.09.2014	**Last Review Date**: 4/12/19	**Past Review Dates**: 11/13/15, 1/13/17, 2/9/18

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

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

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

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

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

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

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

SWMBH
OPERATING BUDGET CALENDAR
FYE SEPTEMBER 30, 2021

	ACTION	RESPONSIBILITY	START DATE	END DATE
1	**BEGIN OPERATING BUDGET PROCESS**	SWMBH	MAY 18	SEPT 11
2	**FIRST DRAFT BUDGET TEMPLATE & ASSUMPTIONS**	SWMBH/CMHs	JUNE 2/3	
3	**MEDICAID ELIGIBILITY FORECAST**	SWMBH/CMHs	JUNE 2/3	Amounts Updated from the State
	(Dependent on the State for Actual, will estimate)			
4	**Budget Update with Operations Committee (Ops Com)**		JUNE 24	
5	**CMH BUDGETS DRAFT to SWMBH and Consultant**	CMHs	JULY 31	
	(Solid Draft needing only Minor Changes)			
6	**FIRST ITERATION OF CONSOL. FY 21 BUDGET**	SWMBH	AUG 19	
	(To Ops Committee)		AUG 26	
7	**SECOND ITERATION**	CMH/SWMBH	AUG 28	
	(To Ops Committee)			
8	**FINAL DRAFT OPERATING BUDGET-Electronic**	SWMBH/CMHs	AUG 31	
	(To Ops Committee)			
9	**PRESENT TO BOARD AT PUBLIC HEARING**	SWMBH		SEPT 11
10	**PRESENT TO SWMBH BOARD OF DIRECTORS**	SWMBH/CMHs		SEPT 11
11	**BOARD ACTION**	SWMBH		OCT 9

	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 4/30/2020			**P07FYTD20**	**7**									
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			161,810,320	123,177,775	20,419,561	9,833,645	2,051,662	4,929,255	1,398,423	-	-	-	
17	DHHS Incentive Payments			472,306	472,306	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			1,018,616	-	-	-	-	1,018,616	-	-	-	-	
19	Interest Income - Working Capital			74,027	-	-	-	-	-	-	74,027	-	-	
20	Interest Income - ISF Risk Reserve			3,635	-	-	-	-	-	-	3,635	-	-	
21	Local Funds Contributions			1,006,945	-	-	-	-	-	-	1,006,945	-	-	
22	Other Local Income			147,372	-	-	-	-	-	-	147,372	-	-	
24	**TOTAL REVENUE**			**164,533,221**	**123,650,081**	**20,419,561**	**9,833,645**	**2,051,662**	**5,947,871**	**1,398,423**	**1,231,980**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			14,454,371	2,271,093	3,701,448	-	2,721,451	4,866,370	894,008	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			127,119,867	104,213,710	11,766,450	9,499,492	890,232	749,984	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			1,665,559	1,665,559	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			1,423,884	1,423,884	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,735,684	-	-	(1,735,684)	-	-	-			
34	**Total Healthcare Cost**			**144,663,681**	**111,309,930**	**15,467,898**	**9,499,492**	**1,875,999**	**5,616,355**	**894,008**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**89.1%**	**90.0%**	**75.8%**	**96.6%**	**91.4%**	**113.9%**	**63.9%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			265,381	-	-	-	-	-	-	265,381	-	-	
39	Administrative and Other Cost			4,133,935	-	-	-	-	-	-	4,133,872	-	62	
41	Depreciation			52,087	-	-	-	-	-	-	52,087	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	156,419	-	(156,419)	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	62	-	(62)	
44	Delegated Managed Care Admin			9,579,799	7,923,713	875,916	714,055	66,115	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	3,229,854	469,166	288,135	109,548	175,097	-	(4,271,800)	-	-	
46														
47	**Total Administrative Cost**			**14,031,202**	**11,153,567**	**1,345,082**	**1,002,190**	**175,663**	**331,516**	**-**	**23,183**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**8.8%**	**9.1%**	**8.0%**	**9.5%**	**8.6%**	**5.6%**	**0.0%**	**2.7%**			
49														
50	Local Funds Contribution			1,006,945	-	-	-	-	-	-	1,006,945	-	-	
51														
52	**TOTAL COST after apportionment**			**159,701,828**	**122,463,497**	**16,812,980**	**10,501,682**	**2,051,662**	**5,947,871**	**894,008**	**1,030,129**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**4,831,393**	**1,186,583**	**3,606,581**	**(668,037)**	**-**	**(0)**	**504,415**	**201,851**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**2.9%**	**1.0%**	**17.7%**	**-6.8%**	**0.0%**	**0.0%**	**36.1%**	**16.4%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(504,415)	-	-	-	-	-	(504,415)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,635)	-	-	-	-	-	-	(3,635)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	313,172	(981,209)	668,037	-	0	(0)	-			
62	**NET SURPLUS (DEFICIT)**			**4,323,343**	**1,499,755**	**2,625,372**	**-**	**-**	**-**	**-**	**198,216**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
64														
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			4,125,127	1,499,755	2,625,372	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			198,216	-	-	-	-	-	-	198,216	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			**4,323,343**	**1,499,755**	**2,625,372**	**-**	**-**	**-**	**-**	**198,216**	**-**	**-**	
72														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 4/30/2020			**7**									
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%*	78.7%	75.7%	77.5%	79.1%	74.3%	80.5%	81.5%	85.6%	77.0%
7	Subcontract Revenue		123,177,775	8,444,662	114,733,113	4,823,101	22,364,043	6,238,541	20,926,735	6,281,760	35,267,935	7,787,673	11,043,325
8	Incentive Payment Revenue		472,306	172,674	299,632	27,004	16,944	21,180	78,365	3,646	129,196	19,062	4,236
9	**Contract Revenue**		**123,650,081**	**8,617,335**	**115,032,745**	**4,850,105**	**22,380,987**	**6,259,720**	**21,005,100**	**6,285,406**	**35,397,131**	**7,806,735**	**11,047,561**
10													
11	External Provider Cost		78,801,051	2,271,093	76,529,958	2,537,436	15,639,543	3,697,738	13,504,673	3,572,616	26,665,192	5,400,224	5,512,536
12	Internal Program Cost		29,053,253	-	29,053,253	1,684,148	5,789,959	1,579,029	6,057,142	1,853,524	5,097,757	2,687,261	4,304,432
13	SSI Reimb, 1st/3rd Party Cost Offset		(483,542)	-	(483,542)	(9,570)	(90,968)	(25,458)	(104,152)	(32,262)	(163,366)	(16,183)	(41,583)
14	Insurance Provider Assessment Withhold (IPA)		3,089,443	3,089,443	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		779,337	779,337	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**111,239,542**	**6,139,874**	**105,099,668**	**4,212,014**	**21,338,534**	**5,251,309**	**19,457,663**	**5,393,878**	**31,599,584**	**8,071,302**	**9,775,385**
17	**Medical Loss Ratio (HCC % of Revenue)**		**90.0%**	**71.3%**	**91.4%**	**86.8%**	**95.3%**	**83.9%**	**92.6%**	**85.8%**	**89.3%**	**103.4%**	**88.5%**
18													
19	**Managed Care Administration**		**11,219,682**	**3,229,854**	**7,989,828**	**314,671**	**1,518,651**	**467,442**	**1,319,298**	**481,972**	**2,723,664**	**536,904**	**627,227**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.2%**	**2.6%**	**6.5%**	**7.0%**	**6.6%**	**8.2%**	**6.3%**	**8.2%**	**7.9%**	**6.2%**	**6.0%**
21													
22	**Contract Cost**		**122,459,224**	**9,369,728**	**113,089,497**	**4,526,684**	**22,857,185**	**5,718,751**	**20,776,961**	**5,875,850**	**34,323,247**	**8,608,206**	**10,402,612**
23	**Net before Settlement**		**1,190,856**	**(752,392)**	**1,943,249**	**323,421**	**(476,198)**	**540,969**	**228,139**	**409,556**	**1,073,884**	**(801,471)**	**644,949**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		313,172	2,256,420	(1,943,249)	(323,421)	476,198	(540,969)	(228,139)	(409,556)	(1,073,884)	801,471	(644,949)
28	**Net after Settlement**		**1,504,028**	**1,504,028**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		148,999	148,999	148,999	7,617	28,775	8,288	28,257	8,813	39,209	12,326	15,714
32	Revenue PMPM		$ 118.55	$ 8.26	$ 110.29	$ 90.96	$ 111.11	$ 107.90	$ 106.19	$ 101.89	$ 128.97	$ 90.48	$ 100.43
33	Expense PMPM		$ 117.41	$ 8.98	$ 108.43	$ 84.90	$ 113.48	$ 98.57	$ 105.04	$ 95.25	$ 125.06	$ 99.77	$ 94.57
34	Margin PMPM		$ 1.14	$ (0.72)	$ 1.86	$ 6.07	$ (2.36)	$ 9.32	$ 1.15	$ 6.64	$ 3.91	$ (9.29)	$ 5.86
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		148,999	148,999	148,999	7,617	28,775	8,288	28,257	8,813	39,209	12,326	15,714
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)		592	592	592	96	(197)	(149)	344	263	86	104	45
43	% Variance - Fav / (Unfav)		0.4%	0.4%	0.4%	1.3%	-0.7%	-1.8%	1.2%	3.1%	0.2%	0.9%	0.3%
44													
45	**Contract Revenue before settlement**												
46	Actual		123,650,081	8,617,335	115,032,745	4,850,105	22,380,987	6,259,720	21,005,100	6,285,406	35,397,131	7,806,735	11,047,561
47	Budget		119,040,162	10,057,856	108,982,306	4,314,553	21,697,747	5,827,050	19,998,477	5,688,877	33,696,372	7,315,566	10,443,663
48	Variance - Favorable / (Unfavorable)		4,609,918	(1,440,520)	6,050,439	535,552	683,239	432,670	1,006,623	596,529	1,700,759	491,169	603,898
49	% Variance - Fav / (Unfav)		3.9%	-14.3%	5.6%	12.4%	3.1%	7.4%	5.0%	10.5%	5.0%	6.7%	5.8%
50													
51	**Healthcare Cost**												
52	Actual		111,239,542	6,139,874	105,099,668	4,212,014	21,338,534	5,251,309	19,457,663	5,393,878	31,599,584	8,071,302	9,775,385
53	Budget		111,212,053	6,025,858	105,186,195	4,536,103	21,264,287	5,576,207	18,751,108	5,399,785	31,882,380	7,566,860	10,209,466
54	Variance - Favorable / (Unfavorable)		(27,489)	(114,016)	86,527	324,089	(74,248)	324,898	(706,555)	5,907	282,796	(504,442)	434,081
55	% Variance - Fav / (Unfav)		0.0%	-1.9%	0.1%	7.1%	-0.3%	5.8%	-3.8%	0.1%	0.9%	-6.7%	4.3%
56													
57	**Managed Care Administration**												
58	Actual		11,219,682	3,229,854	7,989,828	314,671	1,518,651	467,442	1,319,298	481,972	2,723,664	536,904	627,227
59	Budget		12,008,362	4,064,625	7,943,737	337,781	1,585,084	465,682	1,353,296	413,751	2,680,141	472,455	635,547
60	Variance - Favorable / (Unfavorable)		788,680	834,771	(46,091)	23,110	66,433	(1,761)	33,998	(68,222)	(43,522)	(64,449)	8,321

	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 4/30/2020			**7**									
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)		6.6%	20.5%	-0.6%	6.8%	4.2%	-0.4%	2.5%	-16.5%	-1.6%	-13.6%	1.3%
62													
63	**Total Contract Cost**												
64	Actual		122,459,224	9,369,728	113,089,497	4,526,684	22,857,185	5,718,751	20,776,961	5,875,850	34,323,247	8,608,206	10,402,612
65	Budget		123,220,416	10,090,484	113,129,932	4,873,884	22,849,370	6,041,889	20,104,404	5,813,536	34,562,521	8,039,315	10,845,013
66	Variance - Favorable / (Unfavorable)		761,191	720,756	40,435	347,200	(7,815)	323,138	(672,557)	(62,314)	239,274	(568,891)	442,402
67	% Variance - Fav / (Unfav)		0.6%	7.1%	0.0%	7.1%	0.0%	5.3%	-3.3%	-1.1%	0.7%	-7.1%	4.1%
68													
69	**Net before Settlement**												
70	Actual		1,190,856	(752,392)	1,943,249	323,421	(476,198)	540,969	228,139	409,556	1,073,884	(801,471)	644,949
71	Budget		(4,180,253)	(32,628)	(4,147,626)	(559,330)	(1,151,623)	(214,839)	(105,927)	(124,659)	(866,149)	(723,749)	(401,350)
72	Variance - Favorable / (Unfavorable)		5,371,110	(719,765)	6,090,874	882,752	675,425	755,807	334,066	534,215	1,940,032	(77,722)	1,046,299
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 4/30/2020			**7**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
75	***Healthy Michigan Plan***			*HCC%*	8.8%	10.7%	9.1%	7.3%	11.7%	6.4%	7.2%	8.4%	8.9%
76	**Contract Revenue**		**20,419,561**	**4,230,180**	**16,189,381**	**775,492**	**3,351,355**	**752,342**	**2,914,093**	**960,110**	**4,585,187**	**1,271,736**	**1,579,067**
77													
78	External Provider Cost		10,376,501	3,701,448	6,675,053	250,357	1,574,384	175,874	1,534,036	87,598	2,144,894	303,038	604,871
79	Internal Program Cost		5,091,397	-	5,091,397	347,335	926,248	310,975	1,516,225	343,615	632,584	488,690	525,724
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**15,467,898**	**3,701,448**	**11,766,450**	**597,692**	**2,500,633**	**486,849**	**3,050,260**	**431,214**	**2,777,479**	**791,728**	**1,130,596**
82	**Medical Loss Ratio (HCC % of Revenue)**		**75.8%**	**87.5%**	**72.7%**	**77.1%**	**74.6%**	**64.7%**	**104.7%**	**44.9%**	**60.6%**	**62.3%**	**71.6%**
83													
84	**Managed Care Administration**		**1,345,082**	**469,166**	**875,916**	**44,652**	**177,969**	**43,337**	**206,818**	**38,531**	**239,399**	**52,666**	**72,543**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.0%**	**2.8%**	**5.2%**	**7.0%**	**6.6%**	**8.2%**	**6.3%**	**8.2%**	**7.9%**	**6.2%**	**6.0%**
86													
87	**Contract Cost**		**16,812,980**	**4,170,614**	**12,642,366**	**642,344**	**2,678,601**	**530,186**	**3,257,079**	**469,745**	**3,016,878**	**844,394**	**1,203,139**
88	**Net before Settlement**		**3,606,581**	**59,566**	**3,547,015**	**133,148**	**672,754**	**222,156**	**(342,986)**	**490,365**	**1,568,309**	**427,342**	**375,928**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(981,209)	2,565,807	(3,547,015)	(133,148)	(672,754)	(222,156)	342,986	(490,365)	(1,568,309)	(427,342)	(375,928)
93	**Net after Settlement**		**2,625,372**	**2,625,372**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		51,101	51,101	51,101	2,477	10,581	2,393	9,144	3,127	14,318	4,013	5,048
97	Revenue PMPM		$ 57.09	$ 11.83	$ 45.26	$ 44.73	$ 45.25	$ 44.91	$ 45.53	$ 43.87	$ 45.75	$ 45.28	$ 44.69
98	Expense PMPM		47.00	11.66	35.34	37.05	36.16	31.65	50.88	21.46	30.10	30.06	34.05
99	Margin PMPM		$ 10.08	$ 0.17	$ 9.92	$ 7.68	$ 9.08	$ 13.26	$ (5.36)	$ 22.40	$ 15.65	$ 15.21	$ 10.64
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		51,101	51,101	51,101	2,477	10,581	2,393	9,144	3,127	14,318	4,013	5,048
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)		(469)	(469)	(469)	(36)	171	(38)	(24)	152	(734)	96	(56)
108	% Variance - Fav / (Unfav)		-0.9%	-0.9%	-0.9%	-1.4%	1.6%	-1.5%	-0.3%	5.1%	-4.9%	2.4%	-1.1%
109													
110	**Contract Revenue before settlement**												
111	Actual		20,419,561	4,230,180	16,189,381	775,492	3,351,355	752,342	2,914,093	960,110	4,585,187	1,271,736	1,579,067
112	Budget		16,932,425	2,926,116	14,006,309	676,232	2,825,990	656,383	2,506,329	798,181	4,112,273	1,059,836	1,371,086
113	Variance - Favorable / (Unfavorable)		3,487,135	1,304,063	2,183,072	99,260	525,365	95,959	407,764	161,929	472,913	211,900	207,981
114	% Variance - Fav / (Unfav)		20.6%	44.6%	15.6%	14.7%	18.6%	14.6%	16.3%	20.3%	11.5%	20.0%	15.2%
115													
116	**Healthcare Cost**												
117	Actual		15,467,898	3,701,448	11,766,450	597,692	2,500,633	486,849	3,050,260	431,214	2,777,479	791,728	1,130,596
118	Budget		14,657,839	3,390,932	11,266,907	805,440	1,684,931	738,400	2,778,884	573,087	2,991,496	679,766	1,014,903
119	Variance - Favorable / (Unfavorable)		(810,059)	(310,516)	(499,543)	207,748	(815,701)	251,551	(271,377)	141,873	214,017	(111,962)	(115,692)
120	% Variance - Fav / (Unfav)		-5.5%	-9.2%	-4.4%	25.8%	-48.4%	34.1%	-9.8%	24.8%	7.2%	-16.5%	-11.4%
121													
122	**Managed Care Administration**												
123	Actual		1,345,082	469,166	875,916	44,652	177,969	43,337	206,818	38,531	239,399	52,666	72,543
124	Budget		1,403,300	554,494	848,806	59,977	125,598	61,666	200,556	43,912	251,475	42,443	63,179
125	Variance - Favorable / (Unfavorable)		58,218	85,328	(27,110)	15,325	(52,370)	18,329	(6,262)	5,381	12,076	(10,223)	(9,365)
126	% Variance - Fav / (Unfav)		4.1%	15.4%	-3.2%	25.6%	-41.7%	29.7%	-3.1%	12.3%	4.8%	-24.1%	-14.8%
127													
128	**Total Contract Cost**												
129	Actual		16,812,980	4,170,614	12,642,366	642,344	2,678,601	530,186	3,257,079	469,745	3,016,878	844,394	1,203,139

	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 4/30/2020			**7**									
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		16,061,139	3,945,426	12,115,712	865,417	1,810,529	800,066	2,979,440	616,999	3,242,971	722,209	1,078,082
131	Variance - Favorable / (Unfavorable)		(751,841)	(225,188)	(526,653)	223,073	(868,072)	269,880	(277,639)	147,254	226,093	(122,185)	(125,057)
132	% Variance - Fav / (Unfav)		-4.7%	-5.7%	-4.3%	25.8%	-47.9%	33.7%	-9.3%	23.9%	7.0%	-16.9%	-11.6%
133													
134	**Net before Settlement**												
135	Actual		3,606,581	59,566	3,547,015	133,148	672,754	222,156	(342,986)	490,365	1,568,309	427,342	375,928
136	Budget		871,287	(1,019,310)	1,890,597	(189,185)	1,015,461	(143,683)	(473,111)	181,182	869,302	337,627	293,004
137	Variance - Favorable / (Unfavorable)		2,735,294	1,078,876	1,656,419	322,333	(342,707)	365,839	130,125	309,183	699,006	89,715	82,924
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 4/30/2020			**7**									
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%*	7.1%	5.3%	9.2%	8.7%	7.4%	5.6%	6.1%	2.7%	9.1%
141	**Contract Revenue**		**9,833,645**	**19,839**	**9,813,806**	**481,419**	**1,861,685**	**544,139**	**1,787,092**	**488,007**	**2,896,002**	**792,630**	**962,832**
142													
143	External Provider Cost		8,287,222	-	8,287,222	-	2,532,602	575,077	1,100,142	375,113	2,369,087	247,913	1,087,287
144	Internal Program Cost		1,212,270	-	1,212,270	293,223	2,603	2,496	837,594	1,557	-	4,728	70,068
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**9,499,492**	**-**	**9,499,492**	**293,223**	**2,535,205**	**577,573**	**1,937,736**	**376,670**	**2,369,087**	**252,641**	**1,157,354**
147	**Medical Loss Ratio (HCC % of Revenue)**		**96.6%**	**0.0%**	**96.8%**	**60.9%**	**136.2%**	**106.1%**	**108.4%**	**77.2%**	**81.8%**	**31.9%**	**120.2%**
148													
149	**Managed Care Administration**		**1,002,190**	**288,135**	**714,055**	**21,906**	**180,429**	**51,412**	**131,385**	**33,658**	**204,199**	**16,806**	**74,260**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.5%**	**2.7%**	**6.8%**	**7.0%**	**6.6%**	**8.2%**	**6.3%**	**8.2%**	**7.9%**	**6.2%**	**6.0%**
151													
152	**Contract Cost**		**10,501,682**	**288,135**	**10,213,547**	**315,129**	**2,715,634**	**628,986**	**2,069,122**	**410,328**	**2,573,286**	**269,447**	**1,231,615**
153	**Net before Settlement**		**(668,037)**	**(268,296)**	**(399,741)**	**166,289**	**(853,949)**	**(84,846)**	**(282,029)**	**77,679**	**322,716**	**523,183**	**(268,783)**
154	Contract Settlement / Redistribution		668,037	268,296	399,741	(166,289)	853,949	84,846	282,029	(77,679)	(322,716)	(523,183)	268,783
155	**Net after Settlement**		**(0)**	**(0)**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.5%	3.5%	1.1%	0.8%	0.0%	0.8%	0.0%	1.1%	0.3%
159	**Contract Revenue**		**4,929,255**	**4,153,923**	**775,332**	**53,342**	**275,920**	**20,393**	**-**	**86,120**	**158,177**	**111,570**	**69,810**
160													
161	External Provider Cost		4,866,370	4,866,370	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		749,984	-	749,984	192,982	309,605	53,894	-	50,780	2,507	105,553	34,664
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**5,616,355**	**4,866,370**	**749,984**	**192,982**	**309,605**	**53,894**	**-**	**50,780**	**2,507**	**105,553**	**34,664**
165	**Medical Loss Ratio (HCC % of Revenue)**		**113.9%**	**117.2%**	**96.7%**	**361.8%**	**112.2%**	**264.3%**	**0.0%**	**59.0%**	**1.6%**	**94.6%**	**49.7%**
166													
167	**Managed Care Administration**		**(687,099)**	**(687,099)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-13.9%**	**-13.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**4,929,255**	**4,179,271**	**749,984**	**192,982**	**309,605**	**53,894**	**-**	**50,780**	**2,507**	**105,553**	**34,664**
171	**Net before Settlement**		**(0)**	**(25,348)**	**25,347**	**(139,640)**	**(33,684)**	**(33,501)**	**-**	**35,340**	**155,670**	**6,017**	**35,146**
172	Contract Settlement		0	25,348	(25,347)	139,640	33,684	33,501	-	(35,340)	(155,670)	(6,017)	(35,146)
173	**Net after Settlement**		**-**	**0**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175		x	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 4/30/2020			**7**									
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		158,360,235	16,848,603	141,511,632	6,133,354	27,853,003	7,555,415	25,627,920	7,815,996	42,907,301	9,963,608	13,655,034
178	Incentive Payment Revenue		472,306	172,674	299,632	27,004	16,944	21,180	78,365	3,646	129,196	19,062	4,236
179	**Contract Revenue**		**158,832,541**	**17,021,277**	**141,811,264**	**6,160,358**	**27,869,947**	**7,576,595**	**25,706,285**	**7,819,643**	**43,036,497**	**9,982,670**	**13,659,270**
180													
181	External Provider Cost		102,331,145	10,838,912	91,492,233	2,787,793	19,746,530	4,448,689	16,138,851	4,035,328	31,179,174	5,951,175	7,204,694
182	Internal Program Cost		36,106,904	-	36,106,904	2,517,688	7,028,415	1,946,395	8,410,961	2,249,477	5,732,849	3,286,232	4,934,888
183	SSI Reimb, 1st/3rd Party Cost Offset		(483,542)	-	(483,542)	(9,570)	(90,968)	(25,458)	(104,152)	(32,262)	(163,366)	(16,183)	(41,583)
184	Insurance Provider Assessment Withhold (IPA)		3,089,443	3,089,443	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		779,337	779,337	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**141,823,287**	**14,707,692**	**127,115,594**	**5,295,910**	**26,683,976**	**6,369,626**	**24,445,660**	**6,252,542**	**36,748,657**	**9,221,224**	**12,097,999**
187	**Medical Loss Ratio (HCC % of Revenue)**		**89.3%**	**86.4%**	**89.6%**	**86.0%**	**95.7%**	**84.1%**	**95.1%**	**80.0%**	**85.4%**	**92.4%**	**88.6%**
188													
189	**Managed Care Administration**		**12,879,854**	**3,300,055**	**9,579,799**	**381,229**	**1,877,049**	**562,191**	**1,657,501**	**554,161**	**3,167,262**	**606,376**	**774,030**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.1%**	**6.2%**	**6.7%**	**6.6%**	**8.1%**	**6.3%**	**8.1%**	**7.9%**	**6.2%**	**6.0%**
191													
192	**Contract Cost**		**154,703,141**	**18,007,748**	**136,695,393**	**5,677,139**	**28,561,025**	**6,931,817**	**26,103,161**	**6,806,703**	**39,915,919**	**9,827,600**	**12,872,029**
193	**Net before Settlement**		**4,129,400**	**(986,471)**	**5,115,870**	**483,219**	**(691,078)**	**644,777**	**(396,876)**	**1,012,939**	**3,120,578**	**155,070**	**787,241**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		0	5,115,871	(5,115,870)	(483,219)	691,078	(644,777)	396,876	(1,012,939)	(3,120,578)	(155,070)	(787,241)
198	**Net after Settlement**		**4,129,400**	**4,129,400**	**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 4/30/2020			**7**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	4.8%	4.8%	3.1%	4.1%	6.6%	6.7%	5.2%	2.2%	4.7%
202	**Contract Revenue**				**6,503,794**	**421,291**	**1,122,758**	**400,751**	**1,173,348**	**344,129**	**2,145,862**	**346,834**	**548,821**
203													
204	External Provider Cost				2,357,686	119,492	76,845	43,985	402,172	299,111	1,227,305	105,816	82,961
205	Internal Program Cost				4,134,334	147,569	767,050	226,095	1,332,914	152,193	886,579	101,961	519,974
206	SSI Reimb, 1st/3rd Party Cost Offset				(95,442)	-	-	-	-	-	(95,442)	-	-
207	**Total Healthcare Cost**				**6,396,579**	**267,061**	**843,895**	**270,080**	**1,735,085**	**451,304**	**2,018,443**	**207,777**	**602,935**
208	**Medical Loss Ratio (HCC % of Revenue)**				**98.4%**	**63.4%**	**75.2%**	**67.4%**	**147.9%**	**131.1%**	**94.1%**	**59.9%**	**109.9%**
209													
210	**Managed Care Administration**				**540,524**	**21,952**	**67,649**	**26,979**	**130,320**	**43,943**	**191,251**	**15,471**	**42,958**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**7.6%**	**7.4%**	**9.1%**	**7.0%**	**8.9%**	**8.7%**	**6.9%**	**6.7%**
212													
213	**Contract Cost**				**6,937,103**	**289,013**	**911,544**	**297,059**	**1,865,405**	**495,247**	**2,209,694**	**223,248**	**645,893**
214	**Net before Settlement**				**(433,309)**	**132,278**	**211,214**	**103,692**	**(692,057)**	**(151,118)**	**(63,832)**	**123,586**	**(97,072)**
215													
216	Other Redistributions of State GF				(51,766)	-	-	-	(0)	-	-	-	(51,766)
217	Contract Settlement				(502,855)	(126,852)	(155,076)	(101,809)	-	-	-	(119,118)	-
218	**Net after Settlement**				**(987,930)**	**5,426**	**56,138**	**1,883**	**(692,057)**	**(151,118)**	**(63,832)**	**4,468**	**(148,839)**
219													

SWMBH FY19 PBIP Distribution

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

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

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

2019 Health Service Advisory (HSAG)
External Quality Review Audit Results and Comparison Update

On September 17th, 2020 The Health Service Advisory Group (HSAG) conducted its annual on-site External Quality Review (EQR) on Southwest Michigan Behavioral Health's Medicaid Managed Care Delivery System standard requirements. This review focuses on the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

Southwest Michigan Behavioral Health was evaluated in nine Medicaid Managed Care Program areas referred to as "standards." The below Table presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). The Table also presents Southwest Michigan Behavioral Health's overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review.

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

The official 2018-2019 External Quality Review Technical Report for Prepaid Inpatient Health Plans was published to the MDHHS website on April 29th, 2020 and distributed to all Michigan PIHP's. The report highlights the breakdown of combined "standard" scores by each participant PIHP. Please see the below table for a comparison breakout for each PIHP:

Region – PIHP Name:	Audit Score (Combined all Standards)
1. North care	*82%*
2. Northern Michigan Regional Entity	*70%*
3. Lakeshore	*65%*
4. Southwest Michigan Behavioral Health	*90%*
5. Mid-State Network	*86%*
6. Community Mental Health Partnership	*77%*
7. Detroit Wayne	*79%*
8. Oakland	*82%*
9. Macomb	*78%*
10. Region 10	*82%*

As you can see by the above table, SWMBH continues to be the highest performing PIHP, in comparison to the other Michigan PIHP's.

Brad Casemore would like to extend his sincere gratitude to all Regional Committees and Workgroups, who contributed to the overall success of this audit. As you probably already know, the PIHP's have very few comparison reports, that show performance against other PIHP's. This report is a great representation of your continued hard work and dedications towards providing our consumers with the highest quality, programs and access to care possible!

Respectfully,

Jonathan Gardner
Director of Quality Assurance and Performance Improvement
Southwest Michigan Behavioral Health

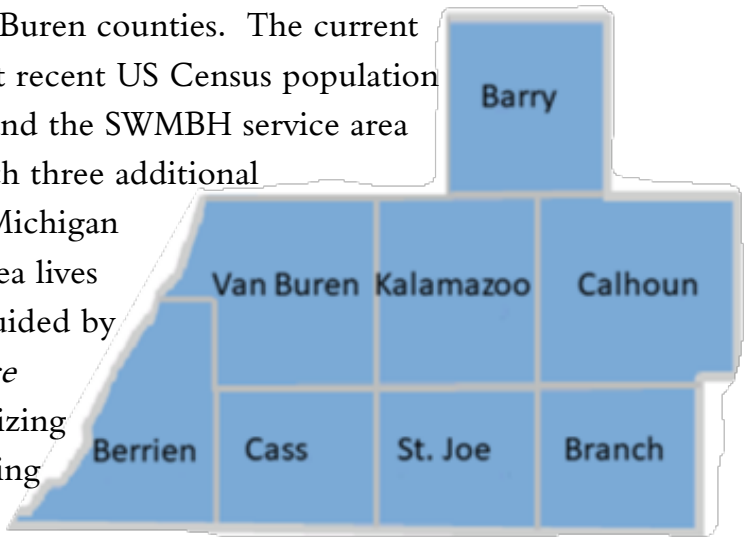
Region 4

Community Readiness Assessment

February 2020

Overview

Southwest Michigan Behavioral Health (SWMBH) serves eight counties in the southwest Michigan region; including, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties. The current population of the region, per the most recent US Census population estimate (7/1/17) is 843,049 persons, and the SWMBH service area is home of four full service casinos with three additional casinos within close proximity. Any Michigan resident living in SWMBH's service area lives within a 25-mile radius of a casino. Guided by the philosophy, *Quality and Excellence Through Partnerships*, SWMBH is utilizing a multi-phase approach and coordinating efforts with local leaders, task forces, and coalitions to reduce the negative impacts on our communities associated with problem gambling. This community-based effort will be necessary to identify, organize, and mobilize needed community resources to impact risk factors associated with gambling disorders and their consequences at the community level.



Project Narrative and Procedures

Initial efforts to address the issue of problem gambling in the SWMBH region began in May 2019 by conducting a community readiness assessment. The Community Readiness Model (CRM) was developed by researchers at the Tri-Ethnic Center for Prevention Research to help communities be more successful with their efforts to address a variety of issues, including problem gambling. The Tri-Ethnic CRM creates community change while integrating community culture, existing resources, and level of readiness in order to effectively address problem gambling. Additionally, this model allows a community to define issues and strategies in their own context, builds cooperation between systems and individuals, increases community capacity for prevention and intervention, and promotes and enhances community investment in awareness of the issue (Plested, 2009).

Dimensions of Community Readiness

The CRM measures specific factors that affect the issue of problem gambling in the community. The six key dimensions measured are: existing problem gambling prevention efforts, community knowledge of the efforts, community knowledge of problem gambling, community climate about the issue, leadership, and resources.

Existing Efforts	What programs and activities currently exist?
Community Knowledge of Efforts	How much does the community know about existing problem gambling efforts?
Leadership	What is leadership's attitude toward addressing the issue of problem gambling?
Community Climate	What is the community's attitude toward addressing the issue of problem gambling?
Community Knowledge of the Issue	How much does the community know about the issue of problem gambling?
Resources	What resources are being used or could be used to address problem gambling?

Each dimension receives a community readiness score and corresponds with one of the nine CRM readiness stages. Those scores are combined and averaged to produce the overall readiness score for each county. Measuring the SWMBH counties readiness levels in these areas assists with identifying where foundational efforts should be focused. Identifying the levels of readiness for each dimension guides strategy selection to move readiness levels forward. Other benefits of the CRM include identifying the strengths and weaknesses of the respective communities, obstacles that will likely be encountered, and establishing community partnerships.

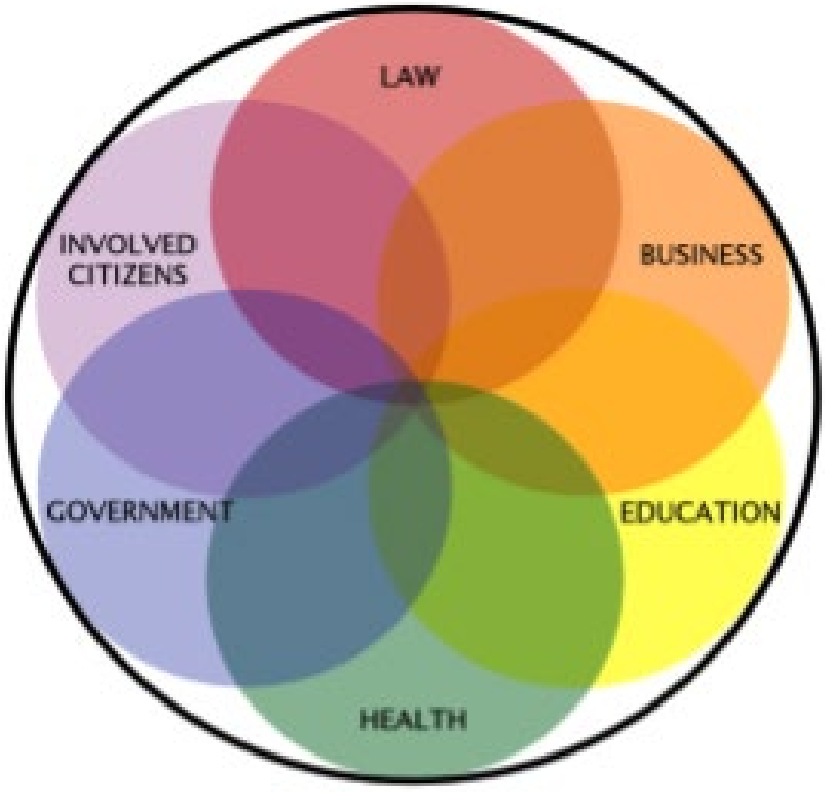
Process

Using the steps outlined below, we measured the community's readiness to address the issue of problem gambling. A readiness stage is calculated for each of the 5 dimensions. The seven steps taken to assess community readiness are:

1. Identify and clearly define the issue.
2. Identify and clearly define and delineate the community.
3. Prepare the interview questions.
4. Choose the key respondents.
5. Conduct and transcribe the interviews.
6. Score the interviews.
7. Calculate the average dimension scores.

Interviews

Key respondents from each county were chosen to participate in a qualitative interview process. Local law enforcement, social service providers, educators, health and medical officials, spiritual leaders, and elected officials from each county took part in the interview process to determine the community's knowledge and attitudes about problem gambling.



Participants were asked questions outlined in the CRM specific to the issue of problem gambling.

Interview Questions

DIMENSION A. PREVENTION PROGRAMMING AND DIMENSION B. COMMUNITY KNOWLEDGE ABOUT PREVENTION

1. In your opinion, using a scale from 1 to 10, how much of a priority is problem gambling to the community, with one being not at all and ten being a high priority? Please explain your rating. (A)

2. Please describe the efforts, programs or activities that are available in your community to address the issue of problem gambling. (A)

3. How long have these efforts been in place? (A)

4. Who can receive services from these programs/efforts? (A)

5. What are the strengths of these efforts? (A and possibly other Dimensions)

6. What are the weaknesses of these efforts? (A and possibly other Dimensions)

7. What type of plans are in place to continue these services? (A)

8. How is evaluation data being used to develop any new efforts? (A)

9. Please describe any policies that are in place in your community that address or support the prevention of problem gambling. (A)

10. How long have these policies been in place? (A)

11. In your opinion, using a scale from 1 to 10, how aware is the community of these efforts, programs activities or policies, with one being not at all and ten being a great deal. Please explain your rating. (B)

12. Please explain what you believe that the community knows about any problem gambling prevention efforts, such as, purpose, what services are offered, and how to access those services. (B)

13. Are there community members who are involved in sharing information about problem gambling activities or efforts? Please explain. (B)

DIMENSION C. LEADERSHIP

14. In your opinion, using a scale from 1 to 10, how much of a priority is the issue of problem gambling to the leadership in your community with one being not at all and ten being a high priority? Please explain.

15. How do the "leaders" in your community support and promote problem gambling prevention efforts, activities or events? (prompt: on committees, attend events, speak on issue in public) Please explain.

16. Would the leadership support additional efforts? Please explain.

DIMENSION D. COMMUNITY CLIMATE

17. Describe your county.

18. What is the community's attitude about problem gambling?

19. How supportive or involved is the community in the prevention of problem gambling? Please explain.

DIMENSION E. KNOWLEDGE ABOUT THE PROBLEM

20. In your community, what type of information is available regarding problem gambling issues?

21. How knowledgeable are community members about problem gambling issues; such as, signs, symptoms and local data, etc.? Please explain.

22. What local data on problem gambling is available in your community?

23. How do people obtain this information in your community?

DIMENSION F. RESOURCES FOR PREVENTION EFFORTS

24. What is the community's attitude about supporting efforts, such as people volunteering time, making financial donations, and providing meeting space?

25. Are you aware of any proposals or action plans that have been written to support problem gambling prevention initiatives in your community? If yes, please explain.

26. What type(s) of evaluation is being conducted on efforts?

27. Do you have any additional comments?

Scoring

Scoring is an easy step-by-step process that provides the stage of readiness for each of the six dimensions.

- The interviews were recorded and then transcribed to provide an accurate record of the respondent's comments for scoring.
- Working independently of each other, both scorers read through each interview in its entirety before scoring any of the dimensions so that they had a general feeling and impression of the community that is derived from the interview data.
- Again, working independently, both scorers read the anchored rating scale for the dimension being scored and produced INDIVIDUAL SCORES for each of the six dimensions. The scores range from one to nine and correspond to the levels of readiness.
- After independent scoring was completed, the two scorers met to discuss the scores. The goal was to reach CONSENSUS SCORES by discussing items or statements that might have been missed by one scorer and which may affect the combined or final score assigned.
- Consensus scores were assigned to each dimension and recorded on the scoring sheet. The scores were then added together across each row to determine a total for each dimension.
- To find the CALCULATED SCORES for each dimension, take the total for that dimension and divide it by the number of interviews. For example: If two scorers have the following combined scores for their interviews:

EXAMPLE

Interviews	#1	#2	#3	#4	#5	#6	#7	TOTAL
Dimension A	3.5	5.0	4.25	4.75	5.5	3.75	2.5	29.25

TOTAL Dimension A: 29.25 divided by # of interviews 7 = 4.17

- This process was repeated for all dimensions and the scores were totaled.

- To find the OVERALL STAGE OF READINESS, the totals of all calculated scores were divided by the number of dimensions (6). For example:

Dimension A	4.17	
Dimension B	3.26	
Dimension C	2.54	
Dimension D	3.51	
Dimension E	2.33	
Dimension F	2.42	
TOTAL	18.23	18.23 divided by 6 dimensions = 3.03

- The results provide the overall stage of readiness of the community. The scores correspond with the numbered stages and are "rounded down" rather than up. Therefore, a score between a 1.0 and a 1.99 would still fall into the first stage, a score of 2.0 to 2.99 would fall into the second and so forth. In the above example, the average 3.03 represents the third stage of readiness, or Vague Awareness.

Score	Stage of Readiness
1	No Awareness
2	Denial/Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilization
8	Confirmation/Expansion
9	High Level of Community Ownership

Stages of Community Readiness

Stage	Description
1. No Awareness	The issue is not generally recognized by the community or the leaders as a problem (if it truly is an issue as indicated by statistics).
2. Denial / Resistance	At least some community members recognize that the issue is a concern, but there is little recognition that it might be occurring locally.
3. Vague Awareness	Most feel that there may be a local concern, but there is no immediate motivation or willingness to do anything about it.
4. Preplanning	There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not yet focused or detailed.
5. Preparation	Active leaders begin planning in earnest. The community offers modest interest in efforts.
6. Initiation	Enough information has been gathered to justify initiation of efforts. Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced. The efforts are stable.
8. Confirmation/ Expansion	Efforts are established. Community members feel comfortable using services and are supportive. Efforts may expand to related issues. Local data are regularly obtained.
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about the issue, such as prevalence, causes, and consequences. In-depth evaluation guides new directions. Model is applied to other issues.

Barry County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	#9	Averages
Community Efforts	**2.5**	**2.5**	**1**	**2.5**	**2**	**2.5**	**1.5**	**2.25**	**1**	**1.97**
Knowledge of Efforts	**3**	**2**	**1**	**1**	**1**	**3**	**3**	**1**	**1**	**1.77**
Leadership	**1**	**2.75**	**1**	**2**	**1**	**1.5**	**1**	**1**	**1**	**2.22**
Community Climate	**3**	**3.5**	**1**	**1**	**2**	**2.5**	**1**	**1**	**1**	**1.77**
Knowledge of Issue	**3**	**4**	**1**	**1.5**	**1**	**3**	**2**	**2**	**1**	**2.05**
Resources	**4**	**3.5**	**1**	**1.5**	**3**	**4**	**1**	**2**	**1**	**2.33**
	Overall Community Readiness Score									**2.01**

Berrien County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	Averages
Community Efforts	**2**	**1**	**1**	**1**	**3**	**3**	**3.5**	**2**	**2.06**
Knowledge of Efforts	**2**	**1**	**1**	**1**	**3**	**3**	**4**	**1**	**2.00**
Leadership	**1**	**1**	**1**	**1**	**3**	**3**	**3**	**1**	**1.75**
Community Climate	**1**	**1**	**1.5**	**1**	**2**	**3**	**2**	**1**	**1.56**
Knowledge of Issue	**2.5**	**1.5**	**2**	**1**	**3**	**3**	**4.5**	**1.5**	**2.37**
Resources	**1**	**1**	**1**	**1**	**3**	**4**	**4**	**1**	**2.00**
	Overall Community Readiness Score								**1.95**

Branch County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	Averages
Community Efforts	**3**	**2.5**	**1**	**2**	**1**	**3**	**1**	**1.92**
Knowledge of Efforts	**3**	**2**	**1**	**1**	**1**	**2**	**1**	**1.57**
Leadership	**1.5**	**2**	**1**	**1**	**1**	**3**	**1**	**1.50**
Community Climate	**2**	**3**	**1**	**1**	**1**	**1**	**1**	**1.42**
Knowledge of Issue	**3**	**3**	**1**	**1**	**1**	**3**	**1**	**1.85**
Resources	**2.5**	**1**	**1**	**1**	**1**	**1**	**1**	**1.21**
	Overall Community Readiness Score							**1.57**

Cass County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	Averages
Community Efforts	**2.5**	**1**	**7**	**1**	**1**	**4**	**3**	**2.78**
Knowledge of Efforts	**2**	**1**	**4.5**	**1**	**2**	**3**	**3**	**2.35**
Leadership	**1.5**	**1**	**3**	**1**	**3**	**3**	**3**	**2.21**
Community Climate	**2**	**1**	**3.5**	**1.5**	**1.5**	**1**	**3**	**1.92**
Knowledge of Issue	**3**	**1**	**4**	**1**	**1**	**4**	**3**	**2.42**
Resources	**1**	**1**	**4**	**1**	**1.5**	**2**	**1**	**1.65**
	Overall Community Readiness Score							**2.22**

Calhoun County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	Averages
Community Efforts	**1**	**3**	**2.5**	**3**	**2**	**3**	**1**	**1**	**2.06**
Knowledge of Efforts	**2**	**3**	**3**	**3**	**1**	**1.5**	**1**	**2**	**2.06**
Leadership	**1**	**1**	**2**	**1**	**3**	**1**	**1**	**1**	**1.37**
Community Climate	**1**	**1.5**	**1**	**2.5**	**1.5**	**1.5**	**1**	**1**	**1.37**
Knowledge of Issue	**1**	**3**	**1**	**3**	**1.5**	**3**	**1**	**1**	**1.81**
Resources	**1**	**1**	**1**	**1**	**1**	**2.5**	**1**	**1**	**1.18**
	Overall Community Readiness Score								**1.64**

Kalamazoo County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	Averages
Community Efforts	**1**	**1**	**1**	**1**	**6**	**3**	**1.5**	**1**	**1.93**
Knowledge of Efforts	**1**	**1**	**1**	**1**	**3**	**3**	**2**	**2**	**1.75**
Leadership	**1**	**1**	**1**	**1**	**1**	**3**	**3**	**1**	**1.50**
Community Climate	**1**	**1**	**1**	**1**	**1**	**4**	**2**	**1**	**1.50**
Knowledge of Issue	**1**	**1**	**1**	**1**	**1**	**3**	**4**	**1**	**1.62**
Resources	**1**	**1**	**1**	**1**	**2.5**	**3.5**	**2.5**	**1**	**1.68**
	Overall Community Readiness Score								**1.24**

St. Joseph County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	#9	Averages
Community Efforts	**1**	**2.5**	**2.5**	**1**	**3**	**1**	**2.5**	**2.5**	**2.5**	**2.05**
Knowledge of Efforts	**3**	**2.5**	**2.5**	**1**	**2.5**	**1**	**2.5**	**2.5**	**2.5**	**2.22**
Leadership	**1**	**1**	**3**	**1**	**1**	**1**	**2**	**1**	**1**	**1.33**
Community Climate	**2**	**1**	**1**	**1**	**2**	**2**	**1**	**1**	**3**	**1.55**
Knowledge of Issue	**2**	**2.5**	**3**	**1**	**2.5**	**1**	**2.5**	**1**	**2.5**	**2.00**
Resources	**1**	**4**	**2.5**	**1**	**3**	**1**	**1**	**1**	**1**	**1.72**
	Overall Community Readiness Score									**1.81**

Van Buren County Readiness Assessment Scores

Interviews	#1	#2	#3	#4	#5	#6	#7	#8	Averages
Community Efforts	**3**	**2.5**	**2.5**	**2.5**	**2.5**	**3**	**1**	**3**	**2.50**
Knowledge of Efforts	**2**	**1**	**1**	**1**	**2.5**	**3**	**1**	**3**	**1.81**
Leadership	**3**	**1**	**1**	**1**	**2.5**	**3**	**1**	**1**	**1.68**
Community Climate	**3**	**1**	**2**	**1**	**1**	**2**	**2**	**1**	**1.62**
Knowledge of Issue	**3**	**1**	**1**	**1**	**1**	**3**	**1**	**1**	**1.50**
Resources	**4**	**1**	**1**	**1**	**4**	**4**	**1**	**2.5**	**2.31**
	Overall Community Readiness Score								**1.90**

Findings

A combination of the overall readiness assessment scores for all counties provides a regional readiness score of 1.84. This finding indicates the SWMBH region is at Stage 1 level of readiness, and problem gambling is not generally recognized by the community or the leaders as an issue, despite some contrary anecdotal information provided by respondents' post-interview commentary.

Although the respondent interviews produced some individual outlier scores, believed to be a result of personal experience with knowledge of community members affected by problem gambling, all calculated dimension scores fell within the range between 1.18 and 2.78.

As expected, the regional readiness assessment scores were on the low end of the readiness scale. However, it was originally posited the communities in the SWMBH region were in Stage 3, or the Vague Awareness stage. Strategies to advance the communities to a higher level of readiness are guided by the suggestions outlined in the CRM. Interventions are matched according to the lowest levels of readiness identified through the assessment process.

Regional Readiness Assessment Scores

Counties	#1	#2	#3	#4	#5	#6	#7	#8	Averages
Community Efforts	**1.97**	**2.06**	**1.92**	**2.78**	**2.06**	**1.93**	**2.05**	**2.50**	**2.15**
Knowledge of Efforts	**1.77**	**2.00**	**1.57**	**2.35**	**2.06**	**1.75**	**2.22**	**1.81**	**1.94**
Leadership	**2.22**	**1.75**	**1.50**	**2.21**	**1.37**	**1.50**	**1.33**	**1.68**	**1.69**
Community Climate	**1.77**	**1.56**	**1.42**	**1.92**	**1.37**	**1.50**	**1.55**	**1.62**	**1.58**
Knowledge of Issue	**2.05**	**2.37**	**1.85**	**2.42**	**1.81**	**1.62**	**2.00**	**1.50**	**1.95**
Resources	**2.33**	**2.00**	**1.21**	**1.65**	**1.18**	**1.68**	**1.72**	**2.31**	**1.76**
	Overall Regional Readiness Score								**1.84**

Community Interventions

Matching an intervention to a community's level of readiness is essential for success. Interventions must be challenging enough to move a community forward in its level of readiness. However, efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. The CRM provides stage-appropriate strategy suggestions for advancing the community to the next level of readiness.

Appropriate Strategies for Each Stage

STAGE 1: No Awareness	GOAL: Raise Awareness of Problem Gambling
• Make one-on-one visits with community leaders/members. • Visit existing and established small groups to share information with them about local problem gambling statistics and general information. • Make one-on-one phone calls to friends and potential supporters. • Conduct an environmental scan to identify the community's strengths, weaknesses, opportunities, and threats.	

STAGE 2: Denial/Resistance	GOAL: Raise Awareness that Problem Gambling Exists in the Community
• Continue one-on-one visits and encourage interview respondents to assist. • Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures. • Begin to point out media articles that describe local statistics and available problem gambling or intervention services • Prepare and submit articles on problem gambling for newsletters, church bulletins, local newsletters, club newsletters, etc. • Present information to local related community groups.	

STAGE 3: Vague Awareness	GOAL: Raise Awareness that the Community can do Something
• Get on the agendas and present information on problem gambling at local community events and to unrelated community groups. • Post flyers, posters, and billboards. • Begin to initiate community health events (pot lucks, potlatches, etc.) and use those opportunities to also present information on problem gambling. • Conduct informal local surveys and interviews with citizens by phone or door-to-door about attitudes and perceptions related to problem gambling. • Publish newspaper editorials and human-interest articles with general information and local implications.	

STAGE 4: Preplanning	GOAL: Raise Awareness with Concrete Ideas
• Introduce information about (PROBLEM GAMBLING) through presentations and media. Focus on reducing stigma and raising general awareness. • Visit and invest community leaders in the cause. • Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts. • Conduct local focus groups to discuss problem gambling and related issues and develop some basic strategies. • Increase media exposure through radio and television public service announcements.	

STAGE 5: Preparation	GOAL: Gather existing information with which to plan more specific strategies.
• Seek out local data sources about problem gambling. • Conduct more formal community surveys.	

- Sponsor a community health event to kick off the effort.
- Conduct public forums to develop strategies from the grassroots level.
- Utilize key leaders and influential people to speak to groups and participate in local radio and television shows to gain support.
- Plan how to evaluate the success of your efforts

STAGE 6: Preplanning	GOAL: Provide Community Specific Information

- Conduct in-service training on Community Readiness and other related topics for professionals and paraprofessionals (suicide, alcohol and drug use, etc.)
- Plan publicity efforts associated with start-up of activity or efforts.
- Attend meetings to provide updates on progress of the effort.
- Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.
- Begin library or Internet search for additional resources and potential funding.
- Begin some basic evaluation efforts.

STAGE 7: Stabilization	GOAL: Stabilize Efforts and Programs

- Plan community events to maintain support for problem gambling efforts.
- Conduct training for community professionals.
- Conduct training for community members, parents, elders and youth.
- Introduce your program evaluation results through training and newspaper articles.
- Conduct quarterly meetings to review progress, modify strategies.
- Hold recognition events for local supporters or volunteers.
- Prepare and submit newspaper articles detailing progress and future plans.
- Begin even wider networking among service providers and community systems, perhaps not specific to problem gambling, but related to health and wellness.

STAGE 8: Confirmation/Expansion	GOAL: Enhance and Expand Services
• Formalize the networking with qualified service agreements. • Prepare a community risk assessment profile. • Publish a localized program services directory. • Maintain a comprehensive database available to the public. • Develop a local speaker's bureau. • Initiate policy change through support of local city officials. • Conduct media outreach on specific data trends related to problem gambling. • Utilize evaluation data to modify efforts.	

STAGE 9: High Level of Community Ownership	GOAL: Maintain momentum and continue growth
• Maintain local business community support and solicit financial support from them. • Diversify funding resources. • Continue more advanced training of professionals and paraprofessionals. • Continue re-assessment of issue and progress made. • Utilize external evaluation and use feedback for program modification. • Track outcome data for use with future grant requests. • Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.	

Summary

Southwest Michigan Behavioral Health began efforts to address the issue of problem gambling in May of 2019. Recognizing the importance of community involvement and collaboration, SWMBH initiated the assessment process through application of the Tri-Ethnic Community Readiness Model. This model measured the communities' readiness levels on several dimensions and identified where initial efforts should be focused in a culturally appropriate way.

Key community respondents from multiple service sectors were identified and interviewed. The interviews were transcribed and then scored to determine community readiness levels for six key dimensions. The final dimension scores were calculated to identify an overall readiness score for each community. Overall readiness scores were utilized to determine strategic interventions appropriate for the communities' level of readiness with attention paid to the lowest dimensional scores.

Strategic interventions for Berrien, Branch, Calhoun, Kalamazoo, St. Joseph, and Van Buren Counties include: meeting with community leaders for one-on-one sessions, provide problem gambling information and statistics to established small groups within the community, and perform a strengths, weaknesses, opportunities, and threats assessment with community members.

Strategic interventions for Barry and Cass Counties include: engage local educational/health outreach programs to assist in problem gambling efforts with flyers, posters, or brochures, begin to point out media articles/information that describe local statistics and available problem gambling or intervention services, prepare and submit articles on problem gambling for newsletters and church bulletins, and present information to local related community groups.

References

Plested, B.A., Jumper-Thurman, P., & Edwards, R.W (2016, March). Community Readiness Manual, The National Center for Community Readiness, Colorado State University, Fort Collins, Colorado

For Immediate Release

Contact: Brenda Duong, Lambert
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Michigan's Public Health System - New Report Finds High Performance and Ability to Bend Healthcare Cost Curve

LANSING, Mich. (May 28, 2020) –Through the use of person-centered community-based rather than institution-based care, Michigan's public mental health system returns a 37-fold investment on the state dollars that fund that system, according to a new report released today by the Center for Healthcare Integration and Innovation (CHI2), the policy arm of The Community Mental Health Association of Michigan. (CMHA). The report, entitled "A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System," examines the performance of Michigan's public mental health system against several state-established and national standards. The report comes at a critical time as communities across Michigan and the U.S. face a growing need for mental health support, resulting from the devastating impact of coronavirus.

The study demonstrates performance from Michigan's public mental health system surpassed other states and systems, measured by dimensions of health care quality and innovation. CHI2 drew from national and Michigan-based sources to demonstrate services available to support residents seeking mental health services. Key data points include:

- **Strong, longstanding performance against state established and nationally recognized performance standards:** Michigan's public mental health system has exceeded the state established standards for 37 of the 38 standards measured. For the one standard not exceeded, the system was below the state standard by only 1.63% from the 95% standard.
- **A national leader in de-institutionalization and community-based care:** Michigan's use of state psychiatric hospitals compared to the rest of the country is significantly less, with other states using state psychiatric hospitals 17 times more, per-capita, than Michigan—a testament to the state's strong movement to a de-institutionalized and community-based system of care. In fact, if the $3.469 billion that are currently used to serve over 350,000 Michiganders per year were spent solely on the provision of long-term care at state psychiatric hospitals and developmental disability centers, then those dollars would only serve 9,500 people per year. This conversion of care from state mental hospitals to community-based care means Michigan's public mental health system serves 37 times more people through the community-based system, for the same dollars, than if these persons were served in state psychiatric hospitals.
- **High rankings against national standards of behavioral health prevalence and services accessibility:** Michigan ranks sixth nationally in serving adults, compared to 50 states and the District of Columbia, as cited by Mental Health in America in 2020.
- **Proven ability to control costs over decades, resulting in major costs savings:** When compared to Medicaid cost increases seen across the country, from 1998 to 2015, Michigan's public mental health system has saved the state of Michigan $5.27 billion. If extrapolated through 2024, Michigan could save over $12 billion. The report found the approaches that the public system uses to control costs—including active management of comprehensive services, a person-centered planning approach, a whole-person orientation that involves hands-on work in addressing the social determinants of health (housing, employment, income, safety, family functioning, transportation) and very low overhead—contrast sharply with the approach of private systems.
- **Pursuit of healthcare integration and evidence-based practices**: More than 620 integration efforts led by the public mental health system—weaving mental health care with primary care—take place throughout the state to lower costs of services, increase access to care, improve preventative intervention and serve the whole person.

“Michigan’s public mental health system has proven reliable and longstanding through financial challenges and pandemics alike, and continues to outperform systems across the country,” said CMHA CEO Bob Sheehan. “We must keep that system a public system and prioritize funding for our public mental health system to continue providing the high-quality mental health supports and services that hundreds of thousands of Michiganders have come to rely on now, and well into the future.”

The data also found factors that make a public system more cost effective than a private system, including active management of comprehensive services, a person-centered planning approach and high medical loss ratios (low spending on administrative costs to allocate those dollars towards Medicaid beneficiaries).

For more information and to access the full study, please visit https://cmham.org/wp-content/uploads/2020/05/CHI2-tradition-of-excellence-and-innovation-May-2020-1.pdf

###

From: Bradley P. Casemore, *MHSA, LMSW, FACHE*
Executive Officer, SWMBH

To: Jeff Wieferich and Al Jansen

Subject: SWMBH Response to MDHHS BHDDA COVID-19 Risk Corridor and COVID-19 Provider Funding Proposals from Memo dated April 30, 2020

This memorandum provides the SWMBH response to the provider retention funding and risk corridor change proposals for fiscal year 2020 communicated in the BHDDA memo dated April 30, 2020. We have carefully considered each from our perspective as well as from a state-wide perspective. We recognize and appreciate the good intentions of the Department as well as the action-oriented approach.

We note variations in views on these topics amongst the PIHPs regarding these proposals which is not unexpected since each PIHP was in differing financial and operational positions before the pandemic, has been and will be further affected differentially by the pandemic, and has differing contractual relations with its CMHs and its providers.

Thus, a one size fits all approach in any proposal category even if well-intended, is unwise.

We assume that any additional provider and/or administrative roles/functions and related costs imposed on the PIHPs and CMHs by DHHS including but not limited to the $2 per hour direct care wage increase will be duly compensated to the PIHPs and further that these COVID-19 system revenue increases will not be used to cease analysis of or diminish other future necessary system revenue upward adjustments.

We appreciate the opportunity to consider your proposals and offer feedback. Please recall that SWMBH is always ready, willing and able to offer constructive and productive review and feedback to the Department on any issue, upon request.

Key Points

- Overall, we are opposed to or have significant concerns about the risk corridor and provider retention proposals.
- Any and all revisions to provider payments ought to apply to the period March 1, 2020 to September 30, 2020, if truly intended to solely or primarily remedy COVID-19 issues.
- We do not support the proposed changes to the PIHP Risk Corridor for fiscal year 2020; retain the current PIHP Risk Corridors. Consider and remain open to other approaches supporting MDHHS goals.
- While we recognize and support the objective of stabilizing behavioral health network providers, we do not support the blanket 95% historical payment method to residential providers as described by BHDDA.
- While we recognize and support the objective stabilizing behavioral health network providers, we do not support the blanket 25% *per diem* increase for inpatient psychiatric hospitals as described by BHDDA. DHHS could achieve this objective via the Hospital Rate Adjustment (HRA) program, bypassing the PIHPs and not further complicating rate-setting, cost settlement, contractual boundaries and future ISFs.
- We do not support an asymmetrical Risk Corridor for PIHPs for fiscal year 2020, or any future fiscal year.
- Most providers serve multiple CMHs and/or PIHPs. This makes state-wide "solutions" less viable; any and all provider financial support approaches ought to be strictly local or regional to recognize this and other purely local circumstances.
- Implications and ramifications of any approach must be considered including but not limited to contracts, authorizations, data and encounters, administrative burdens, waste/abuse/fraud risk elevation, etc.
- Past and current impacts of the COVID-19 pandemic and federal Policy & relief on PIHPs, CMHs and providers vary widely and are in truth unknown in full.
- Future impacts of the COVID-19 pandemic and federal Policy & financial relief on PIHPs, CMHs and providers vary widely and are wholly unknown.

MDHHS Proposal 1:

Any change would be retroactive to October 1, 2019 and would be for this fiscal year only.

Region 4 Response:

We agree that any and all changes should be applicable only through September 30, 2020 at the latest. We agree that any Risk Corridor revision would have to apply to the entire fiscal year; varying Risk Corridors inside a single fiscal year is nonsensical. Other proposed changes timeframes should be considered independently as we do below.

We do not support any COVID-19 related provider retention or stabilization approach which extends prior to March 1, 2020 the date at which the pandemic emerged.

MDHHS Proposal 2-4:

The risk corridor will be changed to allow the PIHP to retain unexpended funds between 98% and 100% - all funds up to 98% must be returned if not expended.

The PIHP will be financially responsible for liabilities incurred between 100% and 102%.

MDHHS will be responsible for liabilities above 102%.

Region 4 Response:

We understand the *prima facie* logic of limiting the financial risk of the public behavioral health system during these uncertain times. This approach seems a large reduction in PIHP state-wide exposure by approximately $75,000,000 gross and $22,500,00 GF. Some believe that overall PIHP spend will go down 10% +/- or as much as $250,000,000 in fiscal year 2020 due to reduced demand and provider availability (not reduced need) directly due to COVID-19. Others have hypothesized that a significant need/demand/provision of services will emerge upon resumption of “reopening” which will result in supports and services overtaking pre-pandemic projections and rate-setting assumptions. Truth is no one knows for sure.

Past, current and future COVID-19 impact will vary by PIHP, CMH and provider given varying infection rates, varying provider responses, and the planned regional phase out of the stay home/stay safe order. A significant diminishment of service provision and thus costs will result in an artificially favorable financial year for PIHPs which is almost certain to punish the system’s capitation rates in fiscal year 2021 and beyond unless adequately considered. Conversely, a significant expansion of service provision and thus costs will result in an unanticipated reduction in public behavioral health system savings and reserves. The latter circumstances will cripple many PIHP’s risk tolerance ability in future years and be financially catastrophic for some.

Note that this risk corridor revision proposal materially **raises** state risk in the same amounts as above. We think this unwise as credible projections predict a $2.3 billion + General Fund and school aid budget deficit in fiscal years 2020 and 2021 and likely beyond.

If this current proposal moves forward – and we strongly recommend against it – the revised 2% maximum financial risk (or whatever is settled upon) for PIHPs should be calculated solely on fiscal year 2020 capitation payments and should not consider Medicaid Savings earned in fiscal year 2019.

MDHHS Proposals 5-6:

ISF amounts would remain at currently approved levels.

Medicaid savings (Section 8.6.2.1 of the contract) criteria will reflect the change for the PIHP to only be able to retain up to 2% of capitation funds.

Region 4 Response:

Regarding ISF amounts we assume this means that ISFs would remain at a maximum of 7.5% as is currently, and that the ISF figure for fiscal year 2020 would be calculated from actual Medicaid revenues in fiscal year 2020.

As we said above, we strongly object to the capping of Medicaid savings at 2% for fiscal year 2020.

MDHHS Proposal 7:

Mandated sub-capitation contracting based on 95% of historical costs over the last 2 years (primary focus to support residential service providers -MI/IDD/SUD).

Region 4 Response:

COVID-19 impacts on residential providers have been variable across the state for reasons stated above. Many residential providers have not had a significant reduction in the number of persons served, while others have closed temporarily and/or ceased admissions for a time. And future COVID-19 impacts are of course unknown. Residential providers that remained open or largely open have legitimate new operational costs and financial pressures. Many residential providers have wisely reduced census maximums to support social distancing needs. One might also predict an increase in residential service demand and provider availability throughout fiscal year 2020 upon lifting of the stay home/stay safe order, reducing full fiscal year negative impacts on residential providers.

It is also true that many non-residential community-based providers have suffered as much or worse financially than residential providers. As but one example facility based ASD services have dropped to zero since March 20 and at least through May 28. Focusing on residential providers only leaves out other provider types where there has been more of a revenue reduction problem due to fewer services being provided.

Operationalizing this proposal is easier said than calculated and done. We have serious concerns about how this boundary confusion (or intrusion to some) would work given that contractual relationships with most residential providers are with the CMHSP's not the PIHPs. DHHS can perhaps permit or compel PIHPs to take these actions with a MDHHS-PIHP Agreement Amendment, but PIHPs cannot compel CMHs to do the same absent a mutually agreeable PIHP-CMH Agreement Amendment.

In addition, many residential providers had/have access to federal paycheck protection forgivable loans. Logic and fairness - and most likely federal policy - would dictate a necessity to net the providers' receipt of paycheck forgivable loans and other federal supports related to COVID-19 against a guaranteed issue of 95% historical funding to avoid unintended financial windfalls to providers and wasteful, abusive or fraudulent CMH or PIHP Medicaid payments to providers.

If this proposal becomes reality, and we recommend strongly against it, a two year look back for calculation is too long as residential providers and their service volumes change materially over the course of this time. If implemented DHHS might consider using the time frame of the 2019 fiscal year quarter immediately preceding the onset of COVID-19, October to December 2019.

State-mandated cost increases unrelated to actual service utilization expense which were not calculated into fiscal year 2020 rates are wholly inappropriate unless truly considered and compensated to PIHPs in mid-year increases in capitation payments and/or the year-end cost settlement process.

If made reality, this will absolutely raise PIHP fiscal year 2020 inpatient psychiatric unit rates well above historical norms. We wonder how MDHHS and Milliman will comment on this and consider it in the rebasing process.

If mandated retroactive to any prior period this will have profound negative implications for revisions of contracts, utilization management authorizations, competitive procurement requirements, claims, encounters, and the like unless DHHS/CMS simply requires/permits supplemental payment(s) to providers, also an administrative burden and an elevation of Medicaid waste/abuse/fraud risk for CMHs and PIHPs.

We do not understand the DHHS statement "*(**primary focus** to support residential service providers -MI/IDD/SUD)."* Is this intended to signal that DHHS may or PIHPs may apply this tactic to other providers? For now, we interpret it a statement of the objective of the approach, not an expansion to other providers.

DHHS could consider allowing CMHs/PIHPs to make direct payment for certified and documented residential provider COVID-19 expense **not covered thorough other means**. We believe PIHPs can do this unilaterally now without DHHS review or approval.

MDHHS Proposal 8:

Mandated inpatient psych per diem increase of 25% - effective April 1- September 30 (for those taking COVID-19 patients, still considering this for all facilities due to social distancing requirements impact on hospital census).

Region 4 Response:

We object to this proposal.

COVID-19 impacts on acute care hospital and free standing inpatient psychiatric hospitals have varied across the state again making a one size fits all approach inappropriate. State-mandated unit cost increases which were not calculated into fiscal year 2020 rates are wholly inappropriate unless truly considered and compensated in mid-year PIHP capitation payments and/or the year-end cost settlement process. Many inpatient psychiatric hospitals have wisely reduced census maximums to support social distancing needs. Where inpatient psychiatric hospitals have reduced admissions and/or lengths of stay and/or census maximums, community-based services have increased in many instances.

Some have suggested that such a mandate from DHHS is tantamount to tortious interference as inpatient psychiatric hospital contracts are held by CMHs and PIHPs, not by the state.

Operationalizing this proposal is easier said than calculated and done. We have serious concerns about how this would work given the contractual relationships with most providers are with the CMHSP's not the PIHP's. Most providers had/have access to federal paycheck protection forgivable loans and/or other financial benefits. Logic and fairness and most likely federal policy and regulation would dictate a necessity to net the providers' receipt of paycheck forgivable loans and other federal COVID-19 related benefits against a state-mandated 25% *per diem* increase to avoid unintended financial windfalls to providers and wasteful or fraudulent CMH or PIHP Medicaid payments.

It is wholly unrealistic to expect that we will know "…*for those taking COVID-19 patients*" which hospitals were/were not in the retrospective period and are/are not taking COVID-19 patients in current and future periods. CMHs/PIHPs would have to rely on hospital self-report certified in writing by a senior hospital executive. Recognize that such a binary status has varied/will vary by each hospital monthly, weekly and even daily. Absent a written waiver of liability from CMS and MDHHS to the CMHs and PIHPs on Medicaid waste/fraud/abuse we see no scenario in which we can certify the inpatient psychiatric encounters with this approach.

DHHS could consider allowing CMHs/PIHPs to make direct payment for certified and documented COVID-19 expense **not covered thorough other means**. We believe PIHPs can do this unilaterally now without DHHS review or approval.

We do not understand the statement "***still considering this for all facilities*** *due to social distancing requirements impact on hospital census."* Does this signal a BHDDA intention to expand this approach to "all facilities"?

We object philosophically to state-mandated rate determinations and requirements even in these times as it is a clear violation of boundaries.

Do we think hospitals will advocate strongly for this approach to continue beyond September 30, 2020 if there is any remaining COVOD-19 incidence at all?

We recommend BHDDA considers achieving the same or similar objectives through the MDHHA Hospital Rate Adjustment (HRA) process.

Other

We do not support an asymmetrical risk corridor for fiscal year 2020 or for any fiscal year. The public behavioral health system has shown itself capable of managing significant financial risk and protecting the state from said risk, with a few exceptions. It can be argued that had the public behavioral health system been funding properly, relieved of administrative burdens and not suffered the constant imposition of rate-setting variable revisions and additions with vague intent and haphazard execution the entire system would be fiscally sound.

An asymmetrical risk corridor diminishes the motivation for the public health system and if implemented reflects a major dismissal of faith in the public behavioral health system by MDHHS.

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

DATE: May 14, 2020

TO: Bradley Casemore, Executive Officer, Southwest Michigan Behavioral Health
Regional CMHSP Affiliate Directors

FROM: Morgan VanDenBerg, Manager Federal Compliance Section
Division of Quality Management & Planning
Bureau of Community Based Services

SUBJECT: Michigan Department of Health and Human Services (MDHHS) 90 Day Follow Up to the 1915 (c) HCBS Waivers/Corrective Action Plan (CAP) of Southwest Michigan Behavioral Health PIHP/Region 4

This memo is to advise that the MDHHS site review staff has conducted a follow-up site review of the Southwest Michigan Behavioral Health PIHP/Region 4, March 4 through May 14, 2020. During this visit, staff reviewed the implementation status and effectiveness of the CAP for the Habilitation Supports Waiver (HSW), Children's Waiver program (CWP) and the Waiver for Children with Serious Emotional Disturbance (SEDW) submitted to MDHHS as a result of the initial site visits that took place from June 3 – 28, 2019.

The review staff assessed whether the actions taken by the PIHP were effective in correcting the findings noted during the initial site review. The review staff found the actions taken by the PIHP were effective in correcting the findings noted during the initial site review. Thank you for providing additional information/clarification on your agency's plan of correction, during this visit.

It was a pleasure collaborating with your staff.

Thank you.

cc:

Brenna Ellison	Jamelah Earle	Lori Caputo
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June 1, 2020

The Hon. Gretchen Whitmer, Governor
State of Michigan
PO Box 30013
Lansing, MI 48909

The Hon. Chris Kolb, Budget Director
State of Michigan
KolbC1@michigan.gov

Dear Governor Whitmer and Budget Director Kolb:

We write about the difficult budget situation Michigan is experiencing. Our hope is that Congress provides states with funding that can be used to fill budget holes, and are encouraging our national organizations to advocate for the additional funding. We also know there are no guarantees that the funding will be given in a way that addresses our concerns.

Should Michigan have to make major cuts, we agree with former Budget Directors Emerson & Walsh (Bridge Magazine, May 13) that, "Rather than arbitrary or 'across the board' cuts, however, services should first be prioritized. The health, safety and security of the public should be at the top. We…should also review our social safety net, understand its failings and strengthen it where necessary."

The state must prioritize health care and mental health care in making near-term budget decisions. This means preserving Medicaid-funded services and meeting critical General Fund needs. The state must also learn lessons that the pandemic -- imposing grave collective trauma on our state – has taught us, and the state must address the structural shortcomings in our health care and mental health systems in the long-run.

The COVID-19 pandemic has necessarily revealed the cracks in both our privately funded and publicly funded health care and behavioral health care systems. The crisis has demonstrated that we lack a health care system that works for all. Michigan stands out as being the highest state in the country for Twitter references about depression and anxiety (MLive, May 12); Pine Rest Christian Mental Health Services has reported in a new study that the pandemic could yield a 32% increase in Michigan suicides (MLive, April 27); nearly half of Americans report the coronavirus situation is harming their mental health (Washington Post, May 4); a March 27-29 national poll of 1,062 individuals by McKinsey & Company found high levels of depression/anxiety distress (McKinsey report, 2020); a federal mental health hotline experienced more than a 1,000% increase in April 2020 calls compared to April '19 (MLive, May 16); children and youth are cut off from mental health care through schools (Detroit Free Press, May 17); the World Health Organization says there is a high prevalence of mental distress in countries across the globe due to the pandemic (CNN, May 14); and the US Census Bureau reports a third of Americans are showing signs of clinical anxiety or depression (Washington Post, May 26).

With more and more people losing income and employment-based health insurance, Medicaid is the last lifeline for health care. Medicaid is an entitlement program, with a promise of certain

coverages to individuals who meet eligibility requirements and apply for the program. We must continue to meet the demands of that commitment. Thus, we respectfully urge that Medicaid health care be protected to the maximum degree possible.

One particular Medicaid requirement that needs attention – something our organizations have worked on for years – is the protection Michigan has had since 2004 on access to Medicaid prescriptions for persons experiencing mental illness, epilepsy, HIV-AIDs, conditions requiring organ transplant and (to a partial degree) cancer. This has allowed vulnerable citizens with serious conditions to escape the dangerous practices of prior authorization, step therapy and therapeutic substitution. A legislatively required Michigan Department of Health and Human Services (MDHHS) psychotropic medication workgroup recommended in February '19 that the state continue to carve out Medicaid psychotropic medications (including anti-seizure and substance use drugs) from Medicaid Health Plans (MHPs). Attempting to save a modest amount of money here, per department data, will cost more in the long run because of not matching the right medications to vulnerable consumers' circumstances.

In keeping with the values of equity in healthcare access for all, we call to your attention some vital needs that can only be addressed by state General Fund (GF) dollars:

1. Non-Medicaid Funding for Community Mental Health Services Providers (CMHSPs): The amount allocated for FY-20 ($125 million) is already lower than needed. The well-being of our constituents cannot bear any cuts to this line and reductions would be catastrophic. The Flinn Foundation, Detroit, reported in 2019 a 10% reduction in CMH mental illness clients over a five-year period, during which budget cuts occurred. Individuals so affected have no other service and support alternatives. Further cuts to this line will add more to the rolls of those dropped from service.

2. Community substance use disorder prevention, education & treatment: Much, if not all, of this $109 million line is for serving those not covered by Medicaid. Here, too, cuts would be catastrophic. (Note: Per March 26 and May 1 reports from Metro Times and MLive, Michigan beer and alcohol sales showed considerable March spikes, and the Detroit Free Press April 2 reported that national alcohol sales spiked 55% for the week ending March 21 compared to 12 months prior.)

3. State psychiatric hospitals and forensic mental health services: 75% of this budget section is supported by GF. We cannot do without the Forensic Center, given the great number of people with mental health-related conditions who encounter the justice system. And regarding our state psychiatric hospitals, only one is for children (which suggests it must remain), and the three we have left for adults leave us with one of the worst per capita adult bed rates in the nation (per the Treatment Advocacy Center, Virginia). State hospital beds are the only source at this time of intermediate- and longer-term stays. Private psychiatric hospitals and psychiatric beds in community hospitals (both of which can receive Medicaid reimbursement) offer an average length of stay that is less than a week, which is too short to appropriately reduce symptoms for many. (Note: Based on 2015-19 death reports to LARA from private psychiatric

hospitals and psychiatric units in community hospitals, over 50 Michigan residents during this period died, often from suicide, within days of discharge from such hospitals.) Additionally, we do not have near enough community resources at present to provide the levels of service intensity needed by those who could leave state hospitals if such resources were more plentiful. Further, our system lacks consistency in making community services that presently exist more available and accessible to promote recovery and avoid re-hospitalization. These issues have grown more pronounced in the pandemic; now is not the time for service reductions.

We also respectfully suggest that the current environment represents opportunities for long-term planning toward new health care strategies. By this, we don't mean the proposed MDHHS "behavioral health transformation" SIPs (Specialty Integrated Plans), which have not to date gained support from the mental health community.

In planning for the future, here are some of the key items we have an opportunity to address:

1. We must better coordinate behavioral and non-behavioral health care services at the points which they are delivered. This is not at all guaranteed by the "financial integration" proposals from MDHHS. It is guaranteed by recognizing that many of us operate within multiple environments. These include public and private health care, hospitals, schools, workforce, justice system settings, nursing homes, assisted living, homeless shelters and more.

2. Several of the environments above are congregate settings that have proven deadly in the world of COVID-19, which may be with us for a long time. We need to help people leave a number of these settings when it is safe and appropriate to do so, with adequate compensatory service available in communities. Jails, prisons, and juvenile justice facilities are filled with mental health-related conditions, some of which do not necessarily warrant incarceration/detention. (As of early May, Michigan was one of the top two sates nationally for prison COVID deaths – Detroit Free Press, May 9.) Mental health-related conditions also dominate the homeless population, and Michigan Coalition Against Homelessness has said, "Our shelter and outreach staff…don't have the space, medical and sanitation equipment, funding or other resources to adequately provide for individuals seeking assistance" (GONGWER, April 1). Protective, intensive psychiatric care of reasonable length is presently available only through old and crowded state hospitals. (As of early April, there were 100 COVID-19 cases in these facilities – MLive, April 9.) And nursing home problems have exploded (at least 23% of the state's COVID deaths – GONGWER, May 27) while many residents of these facilities would prefer to be in their own home if available MIChoice waiver slots were used and funding of the program expanded.

3. If we are serious about health care integration, we must do something to make behavioral health parity real, including better monitoring and enforcement by our state of federal mental health parity law. A McKinsey analysis of insurance claims found 23% of the US insured population have behavioral health diagnoses, yet only 7% of national health care dollars are spent on behavioral services (McKinsey report, 2020).

4. We need to comprehensively evaluate the transparency, accountability, and performance of major publicly funded health care players like MHPs, CMHSPs and Prepaid Inpatient Health Plans (PIHPs). We should not automatically be tied to any of these systems.

5. We need to significantly improve person-centered planning, self-determination, and family-driven/youth-guided planning – across the entire spectrum of publicly funded health care. Services and supports are not and cannot be effective if recipients and their families are shut out of advocating for what they want and prefer.

6. Publicly funded health care must have independent case management and independent rights protection, grievances and appeals. The state's new CMH mediation law (PA 55 of 2020) is a step in the right direction, but there is still much to be done so that health care managers and providers are not judge and jury of consumer complaints. Michigan must move toward the implementation of case management that is truly "conflict free" and that contains the elements that are required by the federal government. This has not happened.

7. We need to protect the support mechanisms that have been developed over the years for persons with developmental or intellectual disabilities. At the same time, we must strengthen those same types of supports for adults experiencing mental illness and children and youth with emotional disturbance.

8. We must have a much higher degree of uniformity in service delivery and in the availability of services across the state in publicly funded health care. It is unacceptable that people in different parts of the state are not given the same opportunities and services because of where they happen to live, who their service managers are, and which providers happen to be in those managers' networks.

We recognize that the pandemic has brought forth myriad issues and challenges that necessitate consideration of human service budget cuts. At the same time, we cannot forget that the same individuals who have required, but not necessarily received, access to an array of services and supports pre-pandemic continue to require access to those services and supports, perhaps with even greater intensity. Although the world has significantly changed since the first case of COVID-19 was diagnosed in our state, for individuals with mental health-related conditions, positive change has not yet been forthcoming. The time is now to begin developing such change.

Thank you for your thoughtful attention to the issues that have been raised in this correspondence. We would be pleased to further discuss them with you at your convenience.

Sincerely,

Sherri Boyd, The Arc-Michigan

Jane Shank, Assn. for Children's Mental Health

Brianna Romines, Epilepsy Foundation of Mich.

Marianne Huff, Mental Health Assn. in Mich.

Norm DeLisle, Mich. Disability Rights Coalition

Patricia Streeter, J.D., Mich. Partners in Crisis

Michelle Roberts, Mich. Protection & Advocacy Service

cc: Meghan Groen
The Hon. Jim Stamas
The Hon. Shane Hernandez
The Hon. Curtis Hertel
The Hon. Jon Hoadley
The Hon. Members of the House & Senate DHHS Appropriations Subcommittees
Robert Gordon
Farah Hanley
Elizabeth Hertel

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:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
July 10, 2020
9:30 am to 11:00 am
Draft: 5/27/20

1. **Welcome Guests/Public Comment**

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

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

4. **Consent Agenda**

   - June 12, 2020 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   a. Operations Committee Minutes May 27, 2020 (d)
   b. Operations Committee Quarterly Report (d)

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

   - None

7. **Board Actions to be Considered**

   - BG-008 Board Member Job Description-Board Policy & Alternate Voting (d)

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

   - None

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

   - None

10. Board Education

a. Fiscal Year 2021 Budget Assumptions and Rates Target (d) (T. Dawson)
b. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson)
c. Michigan Health Endowment Fund Grant Update (d) (M. Kean)
d. September 11, 2020 SWMBH Board Budget Public Hearing (B. Casemore)
e. MI Health Link Renewal (B. Casemore) (d)
f. System Reform Part 4 (d) (B. Casemore)

11. Communication and Counsel to the Board

a. August 14, 2020 Board Agenda (d)
b. Board Member Attendance Roster (d)
c. Board Member Attendance to CMHSPs (January-June) (d)
d. August Board Policies: BEL-005 Treatment of Plan Members (M. McShane); BG-002 Management Delegation

12. Public Comment

13. 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
August 14, 2020
9:30 am - 11:00 am

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 5/8/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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