Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar video and audio please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
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: 7/2/20

1. **Welcome Guests/Public Comment**

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

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

4. **Consent Agenda**

   a. June 12, 2020 SWMBH Board Meeting Minutes (d) p. 3
   b. June 12, 2020 SWMBH Board Planning Meeting Minutes (d) p. 9

5. **Operations Committee**

   a. Operations Committee Minutes May 27, 2020 (d) p. 12
   b. Operations Committee Quarterly Report (D, Hess) (d) p. 16

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**

   a. External Auditor Selection (T. Dawson)
   b. BG-008 Board Member Job Description - Board Policy & Alternate Voting – Management Proposal (d) p. 17

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 (T. Dawson) (to be displayed)
b. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 20
c. Michigan Health Endowment Fund Grant Update (M. Kean) (d) p. 28
d. MI Health Link Renewal (B. Casemore) (d) p. 31

11. Communication and Counsel to the Board

a. 2020-2023 SWMBH Regional Strategic Plan (B. Casemore) (d) p. 33
b. Aetna Annual Delegation Audit Results (B. Casemore) (d) p. 57
c. COVID-19 Impact on Fiscal Year 2021 State Budget (B. Casemore) (d) p. 61
d. August 14, 2020 Board Agenda (d) p. 64
e. August 14, 2020 Board Planning Retreat (d) p. 66
f. September 11, 2020 SWMBH Board Budget Public Hearing (B. Casemore)
g. October 2, 2020 Fifth Annual Regional Healthcare Policy Forum (B. Casemore) (d) p. 68
h. Board Member Attendance Roster (d) p. 69
i. Board Member Attendance to CMHSPs (January-July)
j. August Board Direct Inspection: BEL-005 Treatment of Plan Members (M. McShane)

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
Location to be Announced
9:30 am - 11:00 am

SWMBH Board Planning Retreat following the Board Meeting after a 15-minute break

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
June 12, 2020
9:30 am-11:30 am
GoTo Webinar and Conference Call
Draft: 6/15/20

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; Jane Konyndyk, ISK; Kris Kirsch, St. Joseph CMH; Mary Middleton, Woodlands Board Alternate; 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 9:32 am, introductions were made, and Edward welcomed the group.

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to accept the agenda with a comment from Brad Casemore that the Budget Assumptions agenda item would be presented at the July Board meeting.	
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

Financial Interest Disclosure Handling

Mila Todd reported she received a completed SWMBH Financial Interest Disclosure Statement that was signed by Mary Middleton on June 3, 2020 in which the following Financial Interests were disclosed:

- Inherent conflict from simultaneous service on Woodlands' and SWMBH's Boards; and
- Serves as the CEO of Cassopolis Family Clinic Network, a provider with which SWMBH is pursuing a contract for Substance Use Disorder services to SWMBH customers, which will be reimbursed using Medicaid funds.

Motion — Patrick Garrett moved that a conflict of interest exists, the Board is not able to obtain a more advantageous transaction or arrangement from someone other than Ms. Middleton, the financial interests disclosed by Ms. Middleton are not so substantial as to be likely to affect the integrity of the services SWMBH can expect to receive from her, and the following restrictions should be put in place:

1. The standard restriction concerning recusal when a dispute arises between Woodlands and SWMBH; and
2. Ms. Middleton shall not take part in any deliberations or vote in any matter than directly involves Cassopolis Family Clinic Network.

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

Consent Agenda

Motion — Tom Schmelzer moved to approve the revised May 8, 2020 Board meeting minutes as presented.

Second — Susan Barnes

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

Motion Carried

Operations Committee

Operations Committee Minutes April 22, 2020

Edward Meny noted the minutes as documented. Minutes accepted.

Ends Metrics

Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder who are taking Antipsychotic Medications

Moira Kean and Jonathan Gardner reported as presented, noting SWMBH achieved 76.44% and the metric to achieve was 80%. Discussion followed.

Motion	Sue Barnes moved that the data is relevant and compelling, the executive officer is not in compliance and the ends may need possible revisions and improvement.	
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		

Fiscal Year 2020 Performance Bonus Incentive Program

Jonathan Gardner reported as presented, noting this is a Board update that does not require a Board motion and approval.

Board Actions to be Considered

None

Board Policy Review

BG-012 Open Meetings Act and Freedom of Information

Edward Meny reported as documented.

Motion	Tom Schmelzer moved that the Board is in compliance and Policy BG-008 Open Meetings Act and Freedom of Information Act do not 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

Executive Limitations Review

BEL-002 Financial Conditions

Tom Schmelzer reviewed the policy as documented and noted supporting documents he reviewed regarding the policy.

Motion	Thomas Schmelzer moved that the Executive Officer is in compliance and Policy BEL-002 Financial Conditions does not need revision.	
Second	Susan Barnes	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

BEL-006 Investments

Patrick Garrett reviewed the policy as documented.

Motion	Patrick Garrett moved that the Executive Officer is in compliance and Policy BEL-006 Investments 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

BEL-007 Compensation and Benefits

Robert Nelson reviewed the policy as documented.

Motion	Robert Nelson moved that the Executive Officer is in compliance and Policy BEL-002 Financial Conditions does not need revision.	
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 Education

Fiscal Year 2021 Budget Development Calendar

Tracy Dawson reported as documented.

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented noting the revenue increase due to a MDHHS rate adjustment and savings moved into the internal service fund.

Fiscal year 2019 Performance Bonus Incentive Program disbursements to CMHs

Tracy Dawson reported as documented.

Auditor Procurement

Tracy Dawson stated that today is the last day for request for proposal responses and she will report on the proposals at the July Board meeting.

Health Services Advisory Group External Quality Review Results

Jonathan Gardner reported as documented noting that SWMBH ranked #1 among the PIHPs in the State of Michigan on percentage results. Robert Nelson congratulated SWMBH.

Regional Gambling Assessment and Plans

Justin Rolin reported as documented. Discussion followed.

Center for Healthcare Integration and Innovation (CHI2) "Tradition of Excellence and Innovation"

Brad Casemore reported as documented.

Communication and Counsel to the Board

Community Mental Health Association of Michigan System Transformation

Brad Casemore reported as documented.

Provider Payments & Risk Corridor

Brad Casemore reported as documented.

MDHHS 90 Day Follow-Up to the 1915(c) Home and Community Based Services (HCBS) Corrective Action Plan

Brad Casemore reported as documented.

Advocates Letter

Brad Casemore reported as documented.

July 10, 2020 Board Agenda

Brad Casemore reported as documented.

Board Member Attendance Roster

Brad Casemore reported as documented.

Public Comment

Robert Nelson inquired about COVID-19 and future funding shortfalls. Brad Casemore responded that this will be addressed at the August Board planning session.

Erik Krogh asked if future changes in law enforcement policy would result in changes at the CMH level on how they would provide services. Brad Casemore responded that CMHs already do some crisis intervention and that changes could be implemented if law enforcement changes are passed.

Adjournment

Motion	Erik Krogh moved to adjourn at 11:11am
Second	All
Motion Carried	

SWMBH Board Discussion & Planning Session Minutes

Date: Friday, June 12, 2020
11:45 am – 1:00 pm

Welcome and Introductions:

Brad welcomed the attendees and clarified that this meeting was to highlight issues including environment changes, federal and state status and policy changes, budgeting, etc., and is open for comments and discussion. Current efforts between the 10 Regional PIHPs, CMHSPs, and the Community Mental Health Association of Michigan will be noted.

How the World has Changed Open Discussion – Brad Casemore & All:

SWMBH is currently in the process of preparing the 2020-2023 Strategic Planning proposal to present at the SWMBH Board Retreat on August 14, 2020. A draft of the document will be provided to the SWMBH Board at the July 10, 2020 SWMBH Board meeting. All Regional Committees and the Operations Committee will also receive copies.

Issues:

Financial Condition:

State of Michigan general fund financial status: Deficit for the current year is $3B and is anticipated to be the same or higher for the 2021 Budget year beginning 10/2/20. The State is required to have a balanced budget. There is approximately $1B in the rainy-day fund. The Legislature has the prerogative as to its distribution.

State of Michigan is currently in layoff status, one day a week, with their employees through July 25, 2020.

The Federal government has been spending trillions of dollars due to Covid-19. This money continues to add to the debt service.

Regional Entity financials that impact CMHSPs -- New actuarial rate was announced 6/12/20.

Behavioral Health services have decreased and expenses for March, April, May, and June will also decrease resulting in a lower Medical Loss Ratio. Target range has been 85-90%. Region 4 has been in high 80s. The question is whether actuarial will take the Covid-19 impact into consideration. 2020 could be an artificial windfall year, but the question is whether this temporary new normal will depress the 2021 and 2022 rates.

CMHSPs are cost settled through 9/30/20, however, Providers in Autism, SUD, etc., continue to be impacted. No services have seen reduced income. Many non-profits have the ability to access provider supports actions. CMHSPs have been receiving provider invoices saying they should still be paid. Information provided on the conference call with Providers and the Center for Medicare/Medicaid Services was taken out of context when the statement was made that Providers needed to be paid sub-capitation based on historical cash flow. However, this process required the States to make it a directive. Currently Michigan does not have this process as a State directive. MDHHS has asked for a Provider Network Stability Plan. Region 4 has established a

committee comprised of members of the PIHP and CMHSPs to address the issue. Mila Todd is developing guidelines for future processes.

Direct Care Workers Wages -- A $2 and $3 wage increase has been proposed in the Legislature. Awaiting the vote.

Covid-19 Impact:
SWMBH is in 100% Work From Home status. A Return to Work plan has been developed based on the directives of the CDC, FEMA, and the Governor's Executive Orders. No current reports of staff member with Covid-19, nor their family members.

Public Health Transformation:
Before Covid-19, MDHHS was on a clear path for Public Health Transformation – a carve-in plan. Inclusive of the options this plan identified Specialty Integrated Plans (SIP). During the State Budget review, the Governor vetoed the line item for the Public Health Transformation Program. The Department is expected to release an announcement concerning the Public Health Transformation Program. A statement from MDHHS is forthcoming announcing that SIPS are not being pursued this year but rather the focus will be on the issues listed below.

Behavioral Health Development Disability Administration:
Al Jansen has been appointed the new Senior Deputy Director for BHDDA. He has announced that they are establishing a 1-year Strategic Goal Plan for BHDDA.

Topics will include the following:

- Increased access to and utilization of data – LOCUS scores
- Reviewing and addressing primary health care and Behavioral Health disparities and healthcare access inequities for persons of color
- Improving and enhancing of a wide range of services including behavioral health prevention efforts
- Enhancing Integration of physical and behavioral healthcare – focus on Behavioral Health Homes, Certified Community Behavioral Health Clinics and Opioid Health Homes (CCBHCs), and Opioid Health Homes
    - State of Michigan to be certified soon
- Addressing systems of care
    - Telehealth
- Addressing Governance – moving away from active system redesign
- Focusing on Beneficiaries views and interests
    - Lack of advocacy representatives

Al Jansen will attend June 24, 2020 Operations Committee meeting.

We continue to see the diminishment of influence and authority of BHDDA. The 2021 boilerplate has changed the administration of contracts from BHDDA. Statements have been made that state PIHPs need to work like MHPs. Acceleration of use of reports to adjust capitation payments. Milliman is significantly involved.

Question: What is the comparison between serving the consumer in-person vs. telehealth. What is reimbursement process, are services comparable, is it working well, is there a difference for provider payment, how is it monitored.
Response: Telehealth is monitored through audits.

Question: Have we tracked client responses of telehealth vs. face-to-face.
Response-1: May be somewhat too early to tell. A staff survey has identified challenges with technology, (internet, Wi-Fi, etc.). Zoom has been used as a tool.

Response-2: Have waived some of the length of time required in that some customers need daily contact. Many creative ideas have been implemented – Facebook groups with restricted access, delivered lunches creating another point of contact. Overall, many services have developed well to telehealth.

Updates:

Covid Waves

1) Physical treatment on communities
2) Financial problems
3) Addiction effects – relapses

SUD Providers – Held at SWMBH. Changes in rates.

SWMBH Grant from MHEF – Grant has slowed due to Covid.

MI Health Link – Michigan is a federal demonstration MH state with the contract ending 12/31/2020. State and Federal are going to extend for 1 year of status quo. ICO – Aetna and Meridian. SWMBH is intending to go for one year.

NCQA – Two of 10 PIHPs have NCQA Accreditation. SWMBH received full 3-year accreditation. Currently in the renewal process.

CCBHC and Health Homes – SWMBH was asked by the State to be an expansion region. SWMBH has contracted with the State. SWMBH then contracts with Opioid Health Homes partners. Kalamazoo and Calhoun are the two counties involved. Program begins 10/1/20.

Complex Care Management Proposal – Ten PIHPs agreed to be involved with a complex care management proposal for those individuals who are unenrolled. Brad is taking the executive lead for the proposal. Currently the process is developing the model. Sarah Esty and Robert Gordon from MDHHS are interested.

Public Policy Efforts – Brad has been continuing contact with State Legislators. The event scheduled for April 2020 has been moved to October 2020. This year the House of Representatives is up for reelection.

SWMBH continues to be driven by the Mission, Market, and Margin.

2020-2023 SWMBH Regional Strategic Business Plan – The draft of the plan will be provided to the Operations Committee at their June 24, 2020 meeting. After comments from the Operations Committee, the draft will be provided to both the SWMBH Board at the July 10, 2020 SWMBH Board meeting and to each Regional Committee in July. After all comments are considered, the final document will be provided at the SWMBH Board Retreat on August 14, 2020.

SWMBH Board Retreat – August 14, 2020. Directly following the SWMBH Board Meeting.

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: May 27, 2020
9:00am-11:00am

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

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, 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 9:02 am.

Review and approve agenda – Agenda approved.

Review and approve minutes from 4/22/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported as documented noting the increase in revenue from the State. Autism continues upside down and CMH CFOs are continuing to review costs.

Fiscal Year 2020 Encounter Volumes – 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 stated that the State cancelled the scheduled meeting, are reviewing how EQI would replace other reports and how MUNC to EQI doesn't fit.

2019 Performance Bonus Incentive Program Local Disbursements – Tracy Dawson reported as documented.

Fiscal Year 2021 Budget Assumption – Tracy Dawson stated that SWMBH does not know revenue dollars and are using last years revenue numbers for 2021 budget, which will be discussed at the June 1st Regional Finance Committee meeting.

Cost Allocation Workgroup – Pat Davis shared that the group continues reviewing State templates and some expected changes could mean extensive rework of general ledger processes.

Navigators Transitions from Inpatient Psychiatric October 1 Grant Work Plan – Moira Kean reviewed key points of the grant; reported that planning has begun under the Regional Clinical Practices sub-workgroup. Richard Thiemkey asked about staffing. Moira Kean answered that the staffing model for the grant is a major decision point that needs to be made, but there are multiple ways it could look, including funding of partial positions at a CMH. Discussion followed.

BH TEDS, LOCUS and FY 20 PBIP status – Natalie Spivak and Jonathan Gardner reported as documented and highlighted the following:

- It is critical that our BH TEDS and LOCUS data is accurate and MDHHS/SWMBH performance benchmarks are achieved. BH TEDS Completion Rates (Board Ends Metric 97%), LOCUS accuracy, scores and completion Rates (Board Ends Metric 95%).
- Milliman is adjusting calculations to include BH TEDS and LOCUS data into capitation rates as early as FY21. If we don't have quality/accurate data, this will affect all of our future funding.
- Age changes on FUH- 30-day metric: Child = 6-17 and Adult = 18+
- MDHHS is currently formulating a PBIP metric incentive targeted toward reducing racial/ethnic disparities. Jonathan provided slides that show SWMBH data from 2018 in comparison to other PIHP and State performance.
- Data will be stratified by race/ethnicity and plans will be incentivized to reduce disparity between the index population and at least one minority group.
- SWMBH still collecting information from CMHSP's for large narrative report due to MDHHS on November 15, 2020. This is being discussed during the QMC meetings.

MI Health Link Renewal – Brad Casemore shared that the renewal process continues through June due to Medicaid Health Plans delay in providing up to date financial data/status.

Data Certification of each submission – Natalie Spivak reported as documented.

Governor's $2 / $3 per hour direct care wage increase for April, May and June – Tracy Dawson shared that the state has not provided any information on the $3 increase and SWMBH along with the CMHSPs continue to work on the $2 per hour increase implementation.

DHHS BHDDA Funding: Revised PIHP Risk Corridor and provider payments – Tracy Dawson reported as documented.

SUD and other Release of Information Authorization web handling update – Natalie Spivak updated the group on consent to share information and use of remote signatures. SWMBH is negotiating with DocuSign.

Invite Al Jansen to Operations Committee Meeting – Brad Casemore asked the Committee's preference to invite Al Jansen, Senior Deputy Director, Behavioral Health and Developmental Disabilities (BHDDA) to an Operations Committee meeting. Group agreed and Brad Casemore will contact Al Jansen on his availability to join a future meeting.

CCBHC Ideas – Brad Casemore reported as documented.

ASD Guidelines Update – Moira Kean stated that some aspects of the guidelines are not being implemented now due to COVID-19. Jeremy Franklin will be reaching out to each CMHSP to discuss a tentative implementation date of July 1, 2020.

Fiscal Year 2020 – 2021 PIHP - DHHS Contract Development – Mila Todd stated DHHS indicated that it will be issuing a new MDHHS-PIHP contract boilerplate for Fiscal Year 2021. SWMBH followed up with MDHHS as to whether the pandemic response would delay the contract release and was told the PIHPs would receive the new FY21 boilerplate very soon.

Fiscal Year 2021 CMH Contract Development Calendar – Mila Todd shared once SWMBH receives the new boilerplate, it will be used to inform development of the FY21 PIHP-CMH contracts and issue a calendar.

Managed Care Functional Review - Provider Network Management – Mila Todd stated that review and implementations are on hold right now due to COVID-19. CMH site reviews for the current review cycle will not be conducted on site. SWMBH/CMHSP screen sharing and remote file reviews are being discussed.

2018-2019 Provider Payments for BHDDA – Natalie Spivak stated she responded to DHHS' request for providers tax ID numbers sending 368 tax ID and MPI numbers to DHHS.

Health Services Advisory Group (HSAG) External Quality Review (EQR) – Jonathan Gardner reported as documented and thanked the CMHSPs for their hard work reporting that SWMBH scored number one in the State of Michigan on HSAGs EQR.

- SWMBH scored a 90% overall, which achieves the Board Ends Metric target of 90% compliance.
- SWMBH also scored the highest amongst all 10 Michigan PIHP's.
- This is a tremendous credit toward our Regions collaborative progress and improvement.
- These results are now published on the MDHHS website.
- The 2020 audit process will consist of a review of 2017-2018 and 2018-2019 Corrective Action Plans and Recommendations.

MHEF KHC Grant Update – Moira Kean stated that collaboration between SWMBH, Integrated Service of Kalamazoo and Primary Care Physicians continues regarding steps on how to move the program forward during COVID-19.

Opioid Health Homes (OHH) Update – Brad Casemore shared that the OHH Handbook and OHH Concept paper were modified by MDHHS again. Once changes are finalized, a draft contract will be sent to OHH partners. Conference call with MDHHS is scheduled for June 3rd. Training on OHH is tentatively scheduled for August 25th and 26th.

June SWMBH Board Agenda – Brad Casemore noted the agenda in the packet for the Committee's review.

June SWMBH Board Planning Session – Brad Casemore noted the agenda in the packet for the Committee's review.

Fiscal Year 2020-2023 Strategic Business Plan Timelines – Brad Casemore stated that the strategic plan was 80% complete pre-COVID-19 and post-COVID-19 revisions are being made for discussion at the June Operations Committee meeting.

August Board Planning Session Update – Brad Casemore reminded the group of the August 14th SWMBH Board Planning Session.

Adjourned – Meeting adjourned at 10:52 am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Board Report
Quarterly Report for April, May, June 2020
Board Date 7/10/20

Action items:

- Reviewed and discussed COVID-19 responses including ongoing sharing among the CEOs of resources, plans and support
- Reviewed PIHP distribution process for personal protective equipment to CMHSPs

Discussion items:

- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some of the topics from this quarter included:
    - Reviewed year to date financial reports, actions being taken to decrease expenditures, and reviewed state level actions which impact financials
    - Reviewed Fiscal Year 2021 Budget Development Calendar and Assumptions
    - Reviewed Fiscal Year 2020-2021 Contract Status/Updates
    - Reviewed Performance Bonus Incentive Program Fiscal Year 2019 Local Disbursements and Fiscal Year 2020 Performance Bonus Incentive Program developments
    - Reviewed State changes regarding Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI)
    - Reviewed Fiscal Year 2020 Encounter Volumes
    - Reviewed Individuals with Developmental Disabilities (I/DD) Level of Care (LOC) Guidelines
    - Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status and review
    - Reviewed Autism Spectrum Disorder Services reports and recommended guidelines
    - Reviewed Grant Updates
    - Reviewed and discussed various State and Milliman rate setting documents and Cost Allocation Workgroup updates
    - Reviewed Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and External Quality Review
    - Reviewed 2019 Customer Satisfaction Results Remediation Plans
    - Reviewed Provider Stability Plan and MDHHS Funding (CMH General Fund and PIHP Risk Corridor)
    - Reviewed MI Health Link renewal
    - Reviewed Premium Pay process and guidance for direct care workers
    - Reviewed Governor's direct care increase for April, May and June of 2020
    - Reviewed Managed Care Functional Review Provider Network Management Recommendations
    - Reviewed State death audit recoupments and various delays and issues regarding these recoupments
    - Reviewed renewal process of Substance Use Disorder Oversight Policy Board Intergovernmental Contract which is set to expire on 12/31/20.
    - Reviewed 2020-2023 SWMBH Strategic Imperative Descriptions, Priorities and Timelines
    - Reviewed upcoming SWMBH Board planning meetings

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-008	Pages: 1
Subject: Board Member Job Description	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 03.14.2014	Last Review Date: 9/13/19	Past Review Dates: 2.13.15, 2/12/16, 1/13/17,2/9/18

I. **PURPOSE:**
To define the role and responsibility of the SWMBH Board.

II. **POLICY:**
Specific job outputs of the Board, as informed agents of ownership, are those that ensure appropriate organizational performance.

III. **STANDARDS:**
To distinguish the Board's own unique job from the jobs of its staff, the Board will concentrate its efforts on the following job "products" or outputs:

1. The link between Southwest Michigan Behavioral Health and Participant counties.

2. Written governing policies which, at the broadest levels, address:
   a. Accomplishments/Results/Ends: Organizational products, impacts, benefits, outcomes, recipients, and their relative worth (what good for which needs at what cost).
   b. Executive Limitations: Constraints on executive authority, which establish the prudence and ethics boundaries within which all executive activity and decisions must take place.
   c. Governance Process: Specification of how the Board conceives carries out and monitors its own task.
   d. Board-EO Delegation: How Board expectations are assigned and properly monitored; the EO role, authority and accountability.

3. ~~3.~~ The assurance of organizational and EO performance.

4. Alternate Board Members. Section 4.14 Alternates/Designees of the SWMBH Bylaws states "The Participant CMHSP Boards may appoint official designees to serve in place of their appointed Regional Entity Board member in the event that a Regional Entity Board member is unable to attend a regularly scheduled meeting. This designee shall have full voting rights for the purpose of the meeting he/she is designated to attend." This means that an Alternate may not vote if the primary Board member is in attendance unless a. the primary Board member is conflicted out of the specific issue

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which is the subject of the vote by virtue of their Board Conflict of Interest handling restrictions, or b. the primary member recuses themselves for stated or unstated reasons.

Commented [MT(1]: PLEASE CLARIFY: you mean the overall Board COI handling policy, correct? This statement is not limited to the restrictions contained on the COI Waiver true?

IV. **ORIENTATION:**

New Board Members shall be offered/required to complete an initial orientation for purposes of enhancing their knowledge of the roles and responsibilities of SWMBH as an agency, and their understanding to assist in governance decision-making.

Specifically, they shall be provided the following information:

- **Governance Documents (Hierarchical)**
  - o SWMBH Board Bylaws
  - o SWMBH-CMH Sub-Contracts with Attachments
  - o SWMBH Operating Agreement
  - o SWMBH Operations Committee Charter
  - o Standing SWMBH Committee Charters
    - Finance Committee
    - Quality Management Committee (QMC)
    - Utilization Management Clinical Practices Committee (RUMCP)
    - Provider Network Management Committee (PNM)
    - Health Information Services Committee (Regional IT/RITC)
    - Customer Services Committee
    - Regional Compliance Coordinating Committee
  - o Michigan Consortium of Healthcare Excellence Bylaws (MCHE)

- **Ends, Proofs and Strategy**
  - o Previous and Current Years' SWMBH Board Ends and Proofs
  - o SWMBH Strategic Planning Document
  - o SWMBH Finance Plans
  - o Key Regional Plans
    - QAPI
    - UM
    - Program Integrity-Compliance
    - Financial and Risk Management
    - SUD Strategic Plan
    - Population Health Integrated Care

- **Context**
  - o SWMBH General PowerPoint
  - o Operations Committee Roster
  - o Last 3 months of Operations Committee Meeting Minutes
  - o Current SWMBH Board Meeting Calendar and Roster
  - o Current SWMBH SUD-OPB Meeting Calendar and Roster

- **Conflict of Interest Material (COI)**
  o CMH Resolution to Appoint CEO to SWMBH Operations Committee
  o CMH CEO Conflict of Interest Waiver
  o CMH CEO Financial Interest Disclosure

In addition, new Board Members will be offered a live briefing at SWMBH by each functional area leader.

	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 5/31/2020			P08FYTD20	8									
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			187,074,385	142,348,267	24,454,010	11,283,931	2,328,689	5,261,066	1,398,423	-	-	-	
17	DHHS Incentive Payments			472,306	472,306	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			1,073,380	-	-	-	-	1,073,380	-	-	-	-	
19	Interest Income - Working Capital			75,059	-	-	-	-	-	-	75,059	-	-	
20	Interest Income - ISF Risk Reserve			3,741	-	-	-	-	-	-	3,741	-	-	
21	Local Funds Contributions			1,150,795	-	-	-	-	-	-	1,150,795	-	-	
22	Other Local Income			168,413	-	-	-	-	-	-	168,413	-	-	
24	**TOTAL REVENUE**			**190,018,078**	**142,820,572**	**24,454,010**	**11,283,931**	**2,328,689**	**6,334,446**	**1,398,423**	**1,398,008**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			15,798,387	2,473,266	4,117,791	-	2,943,770	5,260,898	1,002,663	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			144,598,911	119,135,614	13,612,967	10,143,705	1,013,725	692,900	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			1,916,347	1,916,347	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			2,710,708	2,710,708	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,831,624	-	-	(1,831,624)	-	-	-			
34	**Total Healthcare Cost**			**165,024,353**	**128,067,558**	**17,730,758**	**10,143,705**	**2,125,871**	**5,953,798**	**1,002,663**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**88.0%**	**89.7%**	**72.5%**	**89.9%**	**91.3%**	**113.2%**	**71.7%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			301,003	-	-	-	-	-	-	301,003	-	-	
39	Administrative and Other Cost			4,927,272	-	-	-	-	-	-	4,927,209	-	62	
41	Depreciation			59,483	-	-	-	-	-	-	59,483	-	-	
42	Functional Cost Reclassification			0	-	-	-	-	185,224	-	(185,224)	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	62	-	(62)	
44	Delegated Managed Care Admin			11,100,893	9,213,970	1,038,666	771,417	76,840	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	3,871,156	564,420	322,903	125,978	195,423	-	(5,079,880)	-	-	
46														
47	**Total Administrative Cost**			**16,388,651**	**13,085,126**	**1,603,086**	**1,094,320**	**202,818**	**380,647**	**-**	**22,653**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.3%**	**8.3%**	**9.7%**	**8.7%**	**6.0%**	**0.0%**	**2.8%**			
49														
50	Local Funds Contribution			1,150,795	-	-	-	-	-	-	1,150,795	-	-	
51														
52	**TOTAL COST after apportionment**			**182,563,798**	**141,152,685**	**19,333,844**	**11,238,026**	**2,328,689**	**6,334,445**	**1,002,663**	**1,173,448**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**7,454,280**	**1,667,888**	**5,120,166**	**45,905**	**-**	**1**	**395,760**	**224,560**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**3.9%**	**1.2%**	**20.9%**	**0.4%**	**0.0%**	**0.0%**	**28.3%**	**16.1%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(395,760)	-	-	-	-	-	(395,760)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,741)	-	-	-	-	-	-	(3,741)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			(1)	2,414,995	(2,369,090)	(45,905)	-	(1)	-	-			
62	**NET SURPLUS (DEFICIT)**			**7,054,778**	**4,082,883**	**2,751,076**	**-**	**-**	**-**	**-**	**220,819**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
64														
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			6,833,959	4,082,883	2,751,076	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			220,819	-	-	-	-	-	-	220,819	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			**7,054,778**	**4,082,883**	**2,751,076**	**-**	**-**	**-**	**-**	**220,819**	**-**	**-**	
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 5/31/2020			8									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	**Medicaid Specialty Services**			*HCC%*	79.4%	78.2%	78.4%	80.5%	74.8%	79.9%	82.5%	85.4%	77.4%
7	Subcontract Revenue		142,348,267	10,340,342	132,007,925	5,549,819	25,726,241	7,186,644	24,083,850	7,251,181	40,585,352	8,954,081	12,670,755
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**		**142,820,572**	**10,513,016**	**132,307,556**	**5,576,823**	**25,743,185**	**7,207,824**	**24,162,214**	**7,254,828**	**40,714,548**	**8,973,142**	**12,674,991**
10													
11	External Provider Cost		90,211,926	2,473,266	87,738,660	2,911,393	17,847,082	4,239,334	15,805,926	3,991,355	30,346,194	6,225,198	6,372,179
12	Internal Program Cost		32,959,809	-	32,959,809	1,847,739	6,568,459	1,787,601	6,913,558	2,133,376	5,796,865	3,048,716	4,863,494
13	SSI Reimb, 1st/3rd Party Cost Offset		(554,230)	-	(554,230)	(9,660)	(111,310)	(26,211)	(105,051)	(32,262)	(205,813)	(21,043)	(42,880)
14	Insurance Provider Assessment Withhold (IPA)		4,627,055	4,627,055	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		741,059	741,059	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**127,985,620**	**7,841,380**	**120,144,240**	**4,749,473**	**24,304,231**	**6,000,725**	**22,614,432**	**6,092,469**	**35,937,245**	**9,252,871**	**11,192,793**
17	**Medical Loss Ratio (HCC % of Revenue)**		**89.6%**	**74.6%**	**90.8%**	**85.2%**	**94.4%**	**83.3%**	**93.6%**	**84.0%**	**88.3%**	**103.1%**	**88.3%**
18													
19	**Managed Care Administration**		**13,161,966**	**3,871,156**	**9,290,810**	**509,154**	**1,744,266**	**533,008**	**1,523,487**	**531,211**	**3,116,659**	**610,381**	**722,644**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**2.7%**	**6.6%**	**9.7%**	**6.7%**	**8.2%**	**6.3%**	**8.0%**	**8.0%**	**6.2%**	**6.1%**
21													
22	**Contract Cost**		**141,147,586**	**11,712,536**	**129,435,050**	**5,258,627**	**26,048,497**	**6,533,733**	**24,137,919**	**6,623,680**	**39,053,905**	**9,863,252**	**11,915,437**
23	**Net before Settlement**		**1,672,986**	**(1,199,520)**	**2,872,507**	**318,196**	**(305,312)**	**674,091**	**24,295**	**631,148**	**1,660,643**	**(890,110)**	**759,554**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		2,414,995	5,287,502	(2,872,507)	(318,196)	305,312	(674,091)	(24,295)	(631,148)	(1,660,643)	890,110	(759,554)
28	**Net after Settlement**		**4,087,982**	**4,087,982**	**0**	-	-	-	-	-	-	-	-
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		150,399	150,399	150,399	7,702	28,989	8,444	28,535	8,920	39,562	12,422	15,825
32	Revenue PMPM		$ 118.70	$ 8.74	$ 109.96	$ 90.51	$ 111.00	$ 106.70	$ 105.84	$ 101.67	$ 128.64	$ 90.29	$ 100.12
33	Expense PMPM		$ 117.31	$ 9.73	$ 107.58	$ 85.35	$ 112.32	$ 96.72	$ 105.74	$ 92.82	$ 123.39	$ 99.25	$ 94.12
34	Margin PMPM		$ 1.39	$ (1.00)	$ 2.39	$ 5.16	$ (1.32)	$ 9.98	$ 0.11	$ 8.84	$ 5.25	$ (8.96)	$ 6.00
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		150,399	150,399	150,399	7,702	28,989	8,444	28,535	8,920	39,562	12,422	15,825
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		1,992	1,992	1,992	181	17	7	622	370	439	200	156
43	% Variance - Fav / (Unfav)		1.3%	1.3%	1.3%	2.4%	0.1%	0.1%	2.2%	4.3%	1.1%	1.6%	1.0%
44													
45	**Contract Revenue before settlement**												
46	Actual		142,820,572	10,513,016	132,307,556	5,576,823	25,743,185	7,207,824	24,162,214	7,254,828	40,714,548	8,973,142	12,674,991
47	Budget		136,045,900	11,494,692	124,551,207	4,930,918	24,797,425	6,659,486	22,855,402	6,501,574	38,510,140	8,360,647	11,935,615
48	Variance - Favorable / (Unfavorable)		6,774,673	(981,677)	7,756,349	645,905	945,760	548,338	1,306,812	753,253	2,204,408	612,496	739,376
49	% Variance - Fav / (Unfav)		5.0%	-8.5%	6.2%	13.1%	3.8%	8.2%	5.7%	11.6%	5.7%	7.3%	6.2%
50													
51	**Healthcare Cost**												
52	Actual		127,985,620	7,841,380	120,144,240	4,749,473	24,304,231	6,000,725	22,614,432	6,092,469	35,937,245	9,252,871	11,192,793
53	Budget		127,099,490	6,886,695	120,212,794	5,184,118	24,302,042	6,372,808	21,429,838	6,171,183	36,437,005	8,647,840	11,667,961
54	Variance - Favorable / (Unfavorable)		(886,130)	(954,685)	68,554	434,645	(2,189)	372,083	(1,184,595)	78,714	499,760	(605,031)	475,168
55	% Variance - Fav / (Unfav)		-0.7%	-13.9%	0.1%	8.4%	0.0%	5.8%	-5.5%	1.3%	1.4%	-7.0%	4.1%
56													
57	**Managed Care Administration**												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2020			8									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
58	Actual		13,161,966	3,871,156	9,290,810	509,154	1,744,266	533,008	1,523,487	531,211	3,116,659	610,381	722,644
59	Budget		13,723,843	4,645,286	9,078,556	386,035	1,811,524	532,208	1,546,624	472,858	3,063,019	539,949	726,340
60	Variance - Favorable / (Unfavorable)		561,877	774,130	(212,254)	(123,119)	67,259	(800)	23,137	(58,353)	(53,641)	(70,432)	3,696
61	% Variance - Fav / (Unfav)		4.1%	16.7%	-2.3%	-31.9%	3.7%	-0.2%	1.5%	-12.3%	-1.8%	-13.0%	0.5%
62													
63	**Total Contract Cost**												
64	Actual		141,147,586	11,712,536	129,435,050	5,258,627	26,048,497	6,533,733	24,137,919	6,623,680	39,053,905	9,863,252	11,915,437
65	Budget		140,823,332	11,531,981	129,291,351	5,570,153	26,113,566	6,905,016	22,976,461	6,644,041	39,500,024	9,187,789	12,394,301
66	Variance - Favorable / (Unfavorable)		(324,254)	(180,555)	(143,699)	311,526	65,069	371,283	(1,161,458)	20,361	446,119	(675,463)	478,864
67	% Variance - Fav / (Unfav)		-0.2%	-1.6%	-0.1%	5.6%	0.2%	5.4%	-5.1%	0.3%	1.1%	-7.4%	3.9%
68													
69	**Net before Settlement**												
70	Actual		1,672,986	(1,199,520)	2,872,507	318,196	(305,312)	674,091	24,295	631,148	1,660,643	(890,110)	759,554
71	Budget		(4,777,433)	(37,289)	(4,740,144)	(639,235)	(1,316,141)	(245,530)	(121,059)	(142,467)	(989,884)	(827,142)	(458,686)
72	Variance - Favorable / (Unfavorable)		6,450,419	(1,162,231)	7,612,650	957,431	1,010,829	919,621	145,354	773,615	2,650,528	(62,968)	1,218,240
73													
74													

22

	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 5/31/2020			8									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	**Healthy Michigan Plan**			*HCC%*	9.0%	11.9%	8.9%	7.7%	11.6%	7.0%	7.4%	8.8%	9.1%
76	**Contract Revenue**		**24,454,010**	**5,416,879**	**19,037,132**	**913,223**	**3,921,227**	**889,505**	**3,421,760**	**1,134,883**	**5,409,807**	**1,491,598**	**1,855,128**
77													
78	External Provider Cost		11,772,745	4,117,791	7,654,954	269,077	1,717,232	216,949	1,753,183	126,814	2,457,387	401,984	712,326
79	Internal Program Cost		5,958,013	-	5,958,013	452,729	1,055,775	355,137	1,747,252	408,643	785,276	550,154	603,048
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**17,730,758**	**4,117,791**	**13,612,967**	**721,806**	**2,773,007**	**572,086**	**3,500,435**	**535,457**	**3,242,663**	**952,138**	**1,315,374**
82	**Medical Loss Ratio (HCC % of Revenue)**		**72.5%**	**76.0%**	**71.5%**	**79.0%**	**70.7%**	**64.3%**	**102.3%**	**47.2%**	**59.9%**	**63.8%**	**70.9%**
83													
84	**Managed Care Administration**		**1,603,086**	**564,420**	**1,038,666**	**77,379**	**199,013**	**50,815**	**235,817**	**46,687**	**281,220**	**62,809**	**84,925**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.9%**	**5.4%**	**9.7%**	**6.7%**	**8.2%**	**6.3%**	**8.0%**	**8.0%**	**6.2%**	**6.1%**
86													
87	**Contract Cost**		**19,333,844**	**4,682,211**	**14,651,633**	**799,185**	**2,972,020**	**622,901**	**3,736,252**	**582,144**	**3,523,883**	**1,014,947**	**1,400,299**
88	**Net before Settlement**		**5,120,166**	**734,668**	**4,385,499**	**114,038**	**949,207**	**266,604**	**(314,492)**	**552,739**	**1,885,924**	**476,651**	**454,829**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,369,090)	2,016,409	(4,385,499)	(114,038)	(949,207)	(266,604)	314,492	(552,739)	(1,885,924)	(476,651)	(454,829)
93	**Net after Settlement**		**2,751,076**	**2,751,076**	-	-	-	-	-	-	-	-	-
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		51,854	51,854	51,854	2,515	10,719	2,437	9,264	3,174	14,560	4,062	5,123
97	Revenue PMPM	$	58.95	$ 13.06	$ 45.89	$ 45.39	$ 45.73	$ 45.62	$ 46.17	$ 44.69	$ 46.45	$ 45.91	$ 45.26
98	Expense PMPM		46.61	11.29	35.32	39.72	34.66	31.95	50.41	22.93	30.25	31.24	34.17
99	Margin PMPM	$	12.34	$ 1.77	$ 10.57	$ 5.67	$ 11.07	$ 13.67	$ (4.24)	$ 21.77	$ 16.19	$ 14.67	$ 11.10
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		51,854	51,854	51,854	2,515	10,719	2,437	9,264	3,174	14,560	4,062	5,123
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)		284	284	284	3	309	6	95	199	(493)	145	20
108	% Variance - Fav / (Unfav)		0.6%	0.6%	0.6%	0.1%	3.0%	0.3%	1.0%	6.7%	-3.3%	3.7%	0.4%
109													
110	**Contract Revenue before settlement**												
111	Actual		24,454,010	5,416,879	19,037,132	913,223	3,921,227	889,505	3,421,760	1,134,883	5,409,807	1,491,598	1,855,128
112	Budget		19,351,343	3,344,133	16,007,211	772,837	3,229,703	750,152	2,864,376	912,207	4,699,741	1,211,241	1,566,955
113	Variance - Favorable / (Unfavorable)		5,102,667	2,072,746	3,029,921	140,387	691,525	139,353	557,384	222,676	710,066	280,358	288,172
114	% Variance - Fav / (Unfav)		26.4%	62.0%	18.9%	18.2%	21.4%	18.6%	19.5%	24.4%	15.1%	23.1%	18.4%
115													
116	**Healthcare Cost**												
117	Actual		17,730,758	4,117,791	13,612,967	721,806	2,773,007	572,086	3,500,435	535,457	3,242,663	952,138	1,315,374
118	Budget		16,751,816	3,875,351	12,876,465	920,502	1,925,636	843,886	3,175,867	654,956	3,418,853	776,875	1,159,890
119	Variance - Favorable / (Unfavorable)		(978,942)	(242,440)	(736,502)	198,696	(847,372)	271,800	(324,568)	119,500	176,189	(175,263)	(155,484)
120	% Variance - Fav / (Unfav)		-5.8%	-6.3%	-5.7%	21.6%	-44.0%	32.2%	-10.2%	18.2%	5.2%	-22.6%	-13.4%
121													
122	**Managed Care Administration**												
123	Actual		1,603,086	564,420	1,038,666	77,379	199,013	50,815	235,817	46,687	281,220	62,809	84,925
124	Budget		1,603,771	633,708	970,064	68,545	143,541	70,475	229,207	50,185	287,400	48,506	72,204
125	Variance - Favorable / (Unfavorable)		685	69,287	(68,602)	(8,834)	(55,472)	19,660	(6,610)	3,498	6,180	(14,303)	(12,721)
126	% Variance - Fav / (Unfav)		0.0%	10.9%	-7.1%	-12.9%	-38.6%	27.9%	-2.9%	7.0%	2.2%	-29.5%	-17.6%

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2020			8									
3	*(For Internal Management Purposes Only)*			*ok*									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
127													
128	**Total Contract Cost**												
129	Actual		19,333,844	4,682,211	14,651,633	799,185	2,972,020	622,901	3,736,252	582,144	3,523,883	1,014,947	1,400,299
130	Budget		18,355,587	4,509,059	13,846,529	989,048	2,069,176	914,361	3,405,074	705,141	3,706,253	825,381	1,232,094
131	Variance - Favorable / (Unfavorable)		(978,257)	(173,152)	(805,104)	189,862	(902,844)	291,460	(331,178)	122,997	182,370	(189,566)	(168,205)
132	% Variance - Fav / (Unfav)		-5.3%	-3.8%	-5.8%	19.2%	-43.6%	31.9%	-9.7%	17.4%	4.9%	-23.0%	-13.7%
133													
134	**Net before Settlement**												
135	Actual		5,120,166	734,668	4,385,499	114,038	949,207	266,604	(314,492)	552,739	1,885,924	476,651	454,829
136	Budget		995,756	(1,164,926)	2,160,682	(216,211)	1,160,526	(164,209)	(540,698)	207,065	993,488	385,859	334,861
137	Variance - Favorable / (Unfavorable)		4,124,410	1,899,594	2,224,817	330,249	(211,319)	430,813	226,206	345,673	892,436	90,792	119,967
138													
139		x											

24

	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 5/31/2020			8									
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%*	6.7%	5.2%	8.8%	8.3%	7.0%	5.7%	5.4%	2.6%	8.8%
141	**Contract Revenue**		11,283,931	19,874	11,264,057	553,921	2,130,262	627,531	2,048,773	563,799	3,323,224	910,248	1,106,299
142													
143	External Provider Cost		8,779,024	-	8,779,024	-	2,725,406	617,300	1,174,969	430,829	2,352,512	280,613	1,197,395
144	Internal Program Cost		1,364,682	-	1,364,682	316,892	2,707	2,495	956,910	1,705	-	4,569	79,404
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		10,143,705	-	10,143,705	316,892	2,728,113	619,795	2,131,878	432,534	2,352,512	285,182	1,276,799
147	**Medical Loss Ratio (HCC % of Revenue)**		89.9%	0.0%	90.1%	57.2%	128.1%	98.8%	104.1%	76.7%	70.8%	31.3%	115.4%
148													
149	**Managed Care Administration**		1,094,320	322,903	771,417	33,972	195,791	55,053	143,620	37,713	204,022	18,813	82,434
150	**Admin Cost Ratio (MCA % of Total Cost)**		9.7%	2.9%	6.9%	9.7%	6.7%	8.2%	6.3%	8.0%	8.0%	6.2%	6.1%
151													
152	**Contract Cost**		11,238,026	322,903	10,915,123	350,864	2,923,904	674,848	2,275,499	470,247	2,556,533	303,995	1,359,233
153	**Net before Settlement**		45,905	(303,029)	348,934	203,057	(793,642)	(47,317)	(226,726)	93,551	766,691	606,253	(252,934)
154	Contract Settlement / Redistribution		(45,905)	303,029	(348,934)	(203,057)	793,642	47,317	226,726	(93,551)	(766,691)	(606,253)	252,934
155	**Net after Settlement**		-	0	(0)	-	-	-	-	-	-	-	-
156													
157		x											
158	**SUD Block Grant Treatment**			*HCC%*	0.4%	0.9%	1.1%	0.8%	0.0%	0.8%	0.0%	1.2%	0.3%
159	**Contract Revenue**		5,261,066	4,340,279	920,787	60,962	315,337	23,307	-	98,423	180,774	127,508	114,476
160													
161	External Provider Cost		5,260,898	5,260,898	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		692,900	-	692,900	55,000	342,574	59,805	-	61,820	1,994	130,473	41,234
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		5,953,798	5,260,898	692,900	55,000	342,574	59,805	-	61,820	1,994	130,473	41,234
165	**Medical Loss Ratio (HCC % of Revenue)**		113.2%	121.2%	75.3%	90.2%	108.6%	256.6%	0.0%	62.8%	1.1%	102.3%	36.0%
166													
167	**Managed Care Administration**		(692,733)	(692,733)	-	-	-	-	-	-	-	-	-
168	**Admin Cost Ratio (MCA % of Total Cost)**		-13.2%	-13.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	**Contract Cost**		5,261,065	4,568,165	692,900	55,000	342,574	59,805	-	61,820	1,994	130,473	41,234
171	**Net before Settlement**		1	(227,886)	227,887	5,962	(27,237)	(36,499)	-	36,603	178,780	(2,965)	73,242
172	Contract Settlement		(1)	227,886	(227,887)	(5,962)	27,237	36,499	-	(36,603)	(178,780)	2,965	(73,242)
173	**Net after Settlement**		(0)	(0)	-	-	-	-	-	-	-	-	-
174													
175		x	(0)										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
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2	For the Fiscal YTD Period Ended 5/31/2020			8									
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		183,347,273	20,117,374	163,229,900	7,077,926	32,093,068	8,726,987	29,554,383	9,048,285	49,499,157	11,483,435	15,746,658
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**		**183,819,579**	**20,290,047**	**163,529,532**	**7,104,930**	**32,110,012**	**8,748,167**	**29,632,748**	**9,051,931**	**49,628,353**	**11,502,497**	**15,750,894**
180													
181	External Provider Cost		116,024,592	11,851,954	104,172,638	3,180,471	22,289,720	5,073,584	18,734,078	4,548,998	35,156,093	6,907,796	8,281,900
182	Internal Program Cost		40,975,404	-	40,975,404	2,672,360	7,969,515	2,205,039	9,617,720	2,605,544	6,584,134	3,733,912	5,587,180
183	SSI Reimb, 1st/3rd Party Cost Offset		(554,230)	-	(554,230)	(9,660)	(111,310)	(26,211)	(105,051)	(32,262)	(205,813)	(21,043)	(42,880)
184	Insurance Provider Assessment Withhold (IPA)		4,627,055	4,627,055	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		741,059	741,059	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**161,813,881**	**17,220,068**	**144,593,813**	**5,843,171**	**30,147,925**	**7,252,412**	**28,246,746**	**7,122,280**	**41,534,414**	**10,620,665**	**13,826,200**
187	**Medical Loss Ratio (HCC % of Revenue)**		**88.0%**	**84.9%**	**88.4%**	**82.2%**	**93.9%**	**82.9%**	**95.3%**	**78.7%**	**83.7%**	**92.3%**	**87.8%**
188													
189	**Managed Care Administration**		**15,166,639**	**4,065,746**	**11,100,893**	**620,505**	**2,139,070**	**638,876**	**1,902,924**	**615,611**	**3,601,901**	**692,003**	**890,003**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**2.3%**	**6.3%**	**9.6%**	**6.6%**	**8.1%**	**6.3%**	**8.0%**	**8.0%**	**6.1%**	**6.0%**
191													
192	**Contract Cost**		**176,980,520**	**21,285,815**	**155,694,706**	**6,463,676**	**32,286,995**	**7,891,288**	**30,149,670**	**7,737,891**	**45,136,315**	**11,312,667**	**14,716,203**
193	**Net before Settlement**		**6,839,059**	**(995,767)**	**7,834,826**	**641,253**	**(176,983)**	**856,879**	**(516,923)**	**1,314,041**	**4,492,038**	**189,829**	**1,034,691**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(1)	7,834,825	(7,834,826)	(641,253)	176,983	(856,879)	516,923	(1,314,041)	(4,492,038)	(189,829)	(1,034,691)
198	**Net after Settlement**		**6,839,058**	**6,839,058**	**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 5/31/2020			8									
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%*	4.5%	3.7%	2.8%	2.7%	6.6%	6.6%	4.7%	2.0%	4.4%
202	**Contract Revenue**				**7,472,887**	**481,476**	**1,283,152**	**458,002**	**1,343,589**	**344,129**	**2,452,414**	**396,382**	**713,743**
203													
204	External Provider Cost				2,487,347	74,422	99,908	52,359	484,949	327,913	1,287,455	97,148	63,193
205	Internal Program Cost				4,323,939	152,338	765,563	145,645	1,516,336	174,616	866,641	123,217	579,582
206	SSI Reimb, 1st/3rd Party Cost Offset				(120,197)	-	-	-	-	-	(120,197)	-	-
207	**Total Healthcare Cost**				**6,691,090**	**226,760**	**865,471**	**198,005**	**2,001,285**	**502,529**	**2,033,900**	**220,365**	**642,776**
208	**Medical Loss Ratio (HCC % of Revenue)**				**89.5%**	**47.1%**	**67.4%**	**43.2%**	**149.0%**	**146.0%**	**82.9%**	**55.6%**	**90.1%**
209													
210	**Managed Care Administration**				**569,763**	**26,840**	**69,995**	**19,736**	**149,355**	**47,672**	**193,546**	**16,271**	**46,347**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.6%**	**7.5%**	**9.1%**	**6.9%**	**8.7%**	**8.7%**	**6.9%**	**6.7%**
212													
213	**Contract Cost**				**7,260,852**	**253,600**	**935,466**	**217,741**	**2,150,640**	**550,201**	**2,227,446**	**236,636**	**689,123**
214	**Net before Settlement**				**212,035**	**227,876**	**347,686**	**240,261**	**(807,051)**	**(206,072)**	**224,968**	**159,746**	**24,620**
215													
216	Other Redistributions of State GF				(58,655)	-	-	-	-	-	-	-	(58,655)
217	Contract Settlement				(998,460)	(221,675)	(283,528)	(238,110)	-	-	(102,347)	(152,801)	-
218	**Net after Settlement**				**(845,080)**	**6,201**	**64,158**	**2,151**	**(807,051)**	**(206,072)**	**122,621**	**6,945**	**(34,035)**
219													

27

Quarterly Program Update

Improving Care Integration for Unenrolled Seniors in Kalamazoo County
Southwest Michigan Behavioral Health | G-1904-144636 | Program Officer: Lynda Zeller
Due: 7/1/2020

1. **Please provide a *brief* update (no more than three paragraphs) on your grant award, including progress made on the goals and objectives you outlined in your proposal.**

Over the last three months, in-person contacts related to the Kalamazoo Health Conditions program were suspended, in accordance with Governor Whitmer's Stay-Home, Stay-Safe order. In-person contacts have been recently resumed when deemed necessary (as of June 15th), with safety precautions and social distancing measures in place. We have had ongoing telephonic and video involvement with enrolled participants related to their self-management goals and care coordination needs, as well as support and education related to COVID-19. With input from our corporate counsel, we developed protocols and consents for electronic information sharing. We have continued to encourage the use of mobile health management tools (myStrength and Relias) for health goals and chronic condition self-management. We've also continued coordination and collaboration with physical healthcare providers related to mutually served members.

Southwest Michigan Behavioral Health (SWMBH) Kalamazoo Health Connections (KHC) program engaged Public Sector Consultants (PSC) to develop a survey to measure participant satisfaction—including quality of care, access to services, and interpersonal interactions. This tool was based upon validated, reliable, and standardized measures, including SWMBH Complex Case Management 2019 Member Survey, which SWMBH created based on the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Satisfaction Survey. Additional survey tools were considered in the development of KHC Satisfaction Survey. KHC began to implement satisfaction surveys on June 12th. We have received many responses and will be reviewing and analyzing that data throughout the project, to inform the model and our approach with participants.

2. **Is the project proceeding on-schedule, as anticipated in your work plan? If not, comment on the circumstances affecting your grant.**

The project is proceeding on-schedule with some levels of modifications. Like many other healthcare entities, SWMBH and KHC are continuously assessing and implementing changes to policies, procedures, workflows and plans related to the COVID-19 pandemic and are subject to modifications based upon changing facts and upstream federal and state guidance as well as best practices.

Given the pandemic and the uncertainty of its future course, it is almost certain we will not achieve the 160 Participants Goal for the course of the Pilot. The table below shows quarterly

enrollment against a year-to-date estimation of the original project target enrollment of 160 individuals. Our enrollment has been negatively affected by the COVID 19 pandemic, but since outreach attempts have been resumed as of June 15th, we are beginning to enroll new individuals (one person has agreed to start, and two more are tentative).

Quarter	# Eligible persons outreached for program participation	# Enrolled after outreach	% Enrolled after outreach	Percent of 160 goal population enrolled	# Disenrolled during quarter
Year 1, Quarter 1 10/1/2019-12/31/2019	41	7	17.1%	4.4%	0
Year 1, Quarter 2 1/1/20-3/31/2020	107	6	5.6%	8.1%	2
Year 1, Quarter 3 4/1/20-6/30/2020	10	1	10.0%	8.8%	2
Total	**158**	**14**	**8.9%**	**8.8%**	**4**

We will monitor the situation and provide Grant Participant revised number estimates in our next Report. We assume MHEF does not want us to reduce Program staff. We request a senior staff level phone review shortly after our next Report.

3. Have you run into any unexpected challenges? Would you like technical assistance?
Aside from the challenges related to the pandemic mentioned above, an ongoing challenge has been the unexpected complexity of the exclusion criteria for the grant population. Certain exclusion parameters (e.g., Medicare advantage enrollment) are not available in our report resources, so they require manual look ups; and some exclusionary factors can change from month to month, increasing risk of out-reaching to individuals who aren't actually eligible. For those individuals who are eligible, only about 9% of those outreached (14 out of 158) have agreed to participate in the program. We have reworked our initial talking points in attempt to be more appealing and engaging with potential participants.

Participant utilization of the self-management support and disease education materials available through Relias and myStrength programs on their grant-issued iPhones has been lower than expected. KHC staff continue to explore ways to identify content that is meaningful and helpful to individuals. The KHC team finds ways to engage participants in meeting personal health goals through mechanisms other than the phones, as needed. For some of our program participants, use of the smart phones is hampered by physical conditions (limited vision or dexterity for some, and inability to converse over the phone with one participant due to throat cancer). At this time, we do not require technical assistance.

4. Please provide a brief budget update for the grant including any unexpected budget variances.

The grant is being fully utilized as planned and has been a resource to its recipient in response to Covid-19. Any overages on the report are considered in-kind contributions provided by SWMBH. Since the last time reporting there has not been any significant budget variances.

See attachment.

5. Do you anticipate needing to make any amendments to your original proposal? If so, do you need to amend the work plan, budget, or measurements? Please explain.

At this point, we don't anticipate needing to amend the original proposal. We are cautiously monitoring enrollment and are actively collaborating with partner, Integrated Services of Kalamazoo (ISK) to ramp up outreach efforts. We will monitor the situation and provide Grant Participant revised number estimates in our next Report.

6. Please share any additional comments, insights, and lessons learned.

A fully executed data use agreement was received on July 1, 2020, to allow sharing of Medicare data between SWMBH and MDHHS. Once data is received, we plan to utilize the Medicare data for evaluation of the program and risk stratification / participant identification.

Western Michigan University's (WMU's) Homer Stryker M.D. School of Medicine has been providing clinical consultation and evaluation support to the KHC Steering Committee and program staff. Program medical directors for the grant were named in November 2019, with Dr. Bangalore Ramesh representing Psychiatry and Dr. Stephanie Ellwood representing Family Medicine. Additionally, Dr. Rajiv Tandon, chair of WMU's Department of Psychiatry, has been providing study design consultation as part of the KHC Evaluation Committee, and serves on the Steering Committee. Finally, in June 2020, KHC program staff began receiving monthly clinical consultation through "stand up" sessions with Rola Aamar, PhD, LMFT, of Relias. These supports have been valuable in guiding the development of the program as we get to know our grant population and identify successes and barriers.

SWMBH

Memo

To: SWMBH Board draft 5-18-20

From: Bradley P. Casemore, CEO

cc: T. Dawson, M. Todd

Date: June 5, 2020

Re: SWMBH MI Health Link Extension

MI Health Link (MHL) is the federal CMS and state MDHHS dual eligibles Demonstration formally known as Financial Alignment Initiative. Very early on in SWMBH's history the Region formally expressed interest to MDHHS to participate. The three-year Demonstration went live in March 2015 and was subsequently extended through December 31, 2020. SWMBH has been one of four PIHP Regions involved, the others being Detroit-Wayne, Macomb and Upper Peninsula. We negotiated and have contracts with the two Integrated Care Organizations (ICOs) also involved in Region 4 – Meridian Health Plan and Aetna Better Health.

Michigan, with federal CMS approval has extended the Demonstration for five more years, largely in its current form.

We have decided to continue our participation in the MHL Demonstration with the two ICOs. We are in the midst of cost settlement and Agreement review & revision with both ICOs.

This decision to continue is largely based upon the following:

- Favorable financial results resulting in modest local savings for SWMBH.
- Contractual and operational exposure to Meridian and Aetna, showing our competencies and successes.
- Additional voluntary fee for service opportunities for our CMHs.
- Operational experience and skill development not otherwise available in healthcare information exchange, shared care coordination, Complex Care Management and more.
- A deep and broad view into ICO philosophy, practices, strengths and weaknesses.

- Achievement of full three-year National Committee on Quality Assurance (NCQA) Managed Behavioral Health Organization (MBHO) Accreditation, a significant competitive advantage for our Region now and into the future.
- Operational and Policy exposure to and with additional components of MDHHS not otherwise achievable enhancing our credibility and value with senior executives in MDHHS Medical Service Administration.

This is not to say the MHL Demonstration has been flawless on the part of CMS, MDHHS, ICOs or SWMBH. Nor has it fully lived up to the original objectives. Program Evaluation from CMS and MDHHS is unfortunately sparse. Nevertheless, there are success stories for persons served and a greater enlightenment among the ICOs about the complexities and needs of our specialty services populations and our competencies in managing services for persons with intellectual and developmental disabilities, mild to moderate mental illness and substance use disorders.

I wanted you to be aware of this decision. As always, we will keep you updated on its status.

Federal Website

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination

State Website

https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html

Southwest Michigan Behavioral Health Regional Strategic Business Plan

2020 - 2023

Prepared by Bradley P. Casemore, CEO
WITH MANY ABLE OTHERS

Southwest Michigan Behavioral Health Regional Strategic Business Plan

Fiscal and Calendar Years 2020 – 2023

DRAFT CONFIDENTIAL version 6/18/20

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Executive Summary

Healthcare and behavioral healthcare are at an evolutionary disrupted crossroad. Federal and state policy, politics and fiscal strains mandate significant modifications to healthcare service eligibility, payer responsibilities, and individual responsibility. Michigan's public behavioral health system has received deep and broad criticism from Advocacy Group Representatives, the legislature and the public, largely without basis. Systemic flaws emanating from legacy federal and state policy, statutes and regulations go largely unaddressed by legislative and executive branch leaders who prefer to obsess on system symptoms rather than fundamental causes.

While there was an overt plan from the Whitmer Administration's MDHHS to do away with PIHPs as of September 30, 2022 the COVID-19 pandemic has further stressed available subject matter experts and resources. MDHHS has said the pursuit of major public behavioral health system transformation to Specialty Integrated Plans (SIPs). Some in the public health system rejoice assuming *status quo* or minor modifications in state policy. Others see this development as more threatening believing the abandonment of SIPs especially the publicly led Model encouraged to CMHAM by MDHHS Director Gordon in January 2020 (see Attachment A) combined with a dire Michigan General Fund deficit position for the foreseeable future creates a widened opening for Medicaid Health Plans and their advocates in the legislature to simply move to a straight carve-in by October 1, 2023.

Regardless the reader's view on this dichotomous path prediction we owe it to our stakeholders to discuss, deliberate and decide the multi-year strategic plan for our Regional Entity and Participant CMHs. Due to the pandemic we are several months behind our planned schedule and have many more current variables to consider as well as a less than clear future state. Thus, active engagement, introspection and candor amongst all participating leaders is required. Conversations will fall into two main categories: What development needs to our CMHs must be successful in the future and how does SWMBH support this; and What role, if any, do the Participant CMHs see for SWMBH in the event the PIHPs are terminated or consolidated?

Key Facts and Recommendations found herein include but are not limited to the following:

- The carve-in remains a material threat.

- Regionalism is less in favor than ever; state-wide coverage and competence is almost a keystone for future success.
- Significant interaction amongst the Regional Entity Participants including direct contact from SWMBH CEO to CMH Boards.
- PIHP staff are dear resources under performance pressures, undeserved external criticism and increasing opportunities elsewhere; they must be retained.
- SWMBH our region and our CMHs have developed and maintained performance and reputations amongst related thought leaders superior to the majority of PIHPs and CMHs.
- SWMBH has significant latitude for new and expanded roles under the Michigan Mental Health Code 330.1204(b) and its Bylaws.
- SWMBH's financial situation has improved greatly with the MDHHS acknowledgement of under-funding and the revised fiscal year 2020 capitation rates.
- CMH leaders and Boards need adequate time without SWMBH present to openly deliberate many of these existential questions. Resourcing with knowledgeable external experts is recommended.

We invite the reader to become and stay actively involved and constructive in these discussions. After all, the eight CMHs "own" SWMBH and only they can significantly modify our course from the current.

Why the Need for Planning?

To some the previously announced expiration date for PIHPs of October 2022 seems a long way away and the likelihood of major system change seems remote or even improbable. While we can discuss, differ and perhaps achieve consensus on these core predictions we must not be dissuaded from collaborative regional exploration of two key questions:

A. What is the likely future state for CMHSPs after implementation of Specialty Integrated Plans (SIPs) or a carve-in are implemented and what role, if any does the region want SWMBH to play in the identification and implementation of opportunistic CMHSP changes and transitions?

B. What is the future state for the Regional Entity SWMBH after implementation of SIPs or a carve in for opportunities and value to the Participant CMHSPs?

Some major system reforms will emerge in the short-, medium- and long-terms. As the originators of the Regional Entity SWMBH only the Participant CMHs and ultimately the Regional Entity Board can speak definitively on the questions above.

Thus, the urgency of pondering these questions. While it is problematic to make the wrong decisions, it is equally problematic to make the right decisions too slowly. Thorough

deliberations take time and effort. All transformations necessary at both CMHSPs and SWMBH are complex with significant need for attention and resources.

This does not mean that incrementalism is discarded. There are certain steps and milestones that maintain evolutionary pace and positive directionality without prohibiting future modifications in response to environmental market changes and/or internal review and resourcing revisions.

SWMBH has assembled an unparalleled group of staff who are subject matter and stylistic experts with lives, homes and families. Soon current Health Plans, new market entry Health Plans and other opportunistic agencies will begin to actively poach these experts, if they have not yet begun to do so already. Absent a reasonably clear and public Board endorsement of a future beyond 10/1/22 there is little reason for SWMBH staff to remain with us past an increasingly near-term milestone date. As staff resources diminish so does the probability of realistic pursuit of future options.

We have collectively developed significantly resourced and sophisticated healthcare information exchange and healthcare data analytics, management information-business intelligence, National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO) Accreditation and other differentiating characteristics from most Regional Entities/PIHPs. Maintenance and development of these assets are significant and many of these vendor resources have upcoming renewal and resourcing considerations. Future success is not possible without these being leading edge.

New enterprises, business models, alliances, opportunities, threats and financing are certain. Design, development and deployment of related changes require commitment and persistence as well as deep and broad communications. Most especially, they take time.

The way forward in the starkest terms is the proverbial fork in the road: downsize the Regional Entity throughout fiscal years 2021 and 2022 and shut out the lights asap after 10/1/22 or 10/1/23 *or* support and resource sincere exploration of the following:

A. What is the likely future state for CMHSPs after implementation of Specialty Integrated Plans, a straight carve-in or hybrid deleting or diminishing PIHPs and what role, if any does the region want SWMBH to play in the exploration of CMH threats & opportunities, changes and transitions?

B. What is the future state for the Regional Entity SWMBH in opportunities and value to the Participant CMHSPs, and what role, if any does the region want SWMBH to play in the exploration of changes and transitions?

SWMBH CEO is now posing these questions to the Participant Members as embodied in the Board and CMH CEOs for affirmative or negative replies and/or revisions. Strength and stamina are required of all.

SWMBH is a Regional Entity created under the Michigan Mental Health Code 330.1204(b), attached to this document. ***This section explicitly grants a wide range of powers*** *including "The power, privilege, or authority that the participating community mental health services share in common and may exercise separately under this Act, whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity." And "The power to accept funds, grants, gifts, or services from the federal government or federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source." And "The power to enter into a contract with a participating community mental health services program for any service to be performed for, by or from the participating community mental health services program." And "The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually."*

Please note that current SWMBH Regional Entity Bylaws Article II Purposes and Powers 2.1 Purposes states **"Additional purposes may be added by the Regional Entity Board".**

Please see Attachment B for a Strengths, Weaknesses, Opportunities and Threats analysis for SWMBH and the Region as developed by SWMBH. Management proposes a CMH leadership only session facilitated by external subject matter experts to perform and report out this same exercise.

SWMBH Overview TURN THIS SECTION INTO AN ATTACHMENT

SWOT

Strengths

- Good, strong, dedicated, hardworking, high capacity, competent staff
- Competent management team
- NCQA MBHO Accreditation
- Historical knowledge
- Dedicated to persons served
- Consistently score highest amongst other PIHPs on audits/reviews and state reporting measures
- Great relationships with ICOs and community partners
- External partners realize their jobs will become more difficult without SWMBH
- Developed and established business processes
- Visibility & credibility at MDHHS and legislature
- Took lead, facilitated major projects at/for state level implementation
- Risk takers
- Excellent CMHs
- Highly collaborative regional culture
- Solid working relationships with our Participant CMHSPs
- Participated with MHL project, first in state

- First adopter of Coordinating Agency role 9 months before others; established precedents and early subject matter expertise
- Seen as a Leader among PIHPs
- Excellent reputation
- Located under one roof
- Oversight & experience of Specialty Populations
- EMR Platform agnostic
- Possibly Only PIHP Using Tableau?
- Understanding of the level of oversight needed and attempt to reduce CMH burdens related thereto
- Experienced with Data Exchange/Data Handling
- Secure Date Center Nearby
- Safety Net
- Partnerships with other safety net entities
- Resources for the neediest
- CMHs have already broadened their scope
- Insight into consumer details
- Peer Support
- PCE is fast at making state reporting changes
- Community Relations
- Progressive
- Responsive
- Partnerships
- Innovation
- Experience with Specialty Populations
- Identified as Specialty Providers for State
- More Grants
- Creative approaches to Wellness
- Care about their clients
- Great Care Coordination
- Live safety net for years
- Increased willingness to take a Regional approach to solve issues

Weaknesses

- Over Ambitious
- Too Many Initiatives
- Take on Too Much
- Time Lost on New Projects
- Workloads with Projects are too Many and are Difficult to Manage
- Lack of Advocacy Group Recognition
- MDHHS few comparison's/reports that highlight PIHP performance
- Attrition of staff
- Streamline dependency, little bench strength

- Lack of Structured/Consistent Marketing/Promotion
- CMHs Varying in evolution
- Costs above market rates
- Some CMHs are not majority percentage Providers
- Modest collaboration in IT
- Staff turnover
- Two Vendor software systems

Opportunities

- Streamlining requests for information and reports to eliminate duplication
- Make a case for scoring/ranking methodology based on past/present performance with contractually obligated metrics and results
- Value Based Purchasing
- Demonstrating value of behavioral Health services to stakeholders
- Examine opportunities with other organizations to create a health alliance (hospitals, FQHCs, Tribes, CMHSPs)
- Second check ASO services
- Partner with Health Plan
- Develop Center(s) of Excellence for export of expertise for hire
- Process Improvement – Report Request, Onboarding, Project Planning
- Predictive Analytics
- Better Data Warehouse
- Opportunity for ICOs, MHPs, SIPs
- Clinical expertise with Specialty Population
- Coordination of Care between Medical & Behavioral Health
- Focus on Wellness/Whole Health
- CMHs to Become Great Providers
- Keep an ASO

Threats

- Staff Exodus
- Knowledge leaving
- Brain drain
- Difficulty to obtain new staff
- MDHHS and some in legislature preconceived notion that MHPs hold the keys to the future and will be one size fits all for the system
- How to collaborate with others without hurting chances
- Lack of Member CMHSP support for out of Region business
- MHPs, ICOs, SIPs doing benefits management
- Other ASOs – Optum, Beacon
- Too much duplication
- Reporting burden from ICOs

- PIHP Board says go away
- Can't compete with private sector without clear value differentiators
- Privatization of Healthcare in Michigan
- Quality will be looked at
- Standards will be looked at
- Large Providers Like Hope, Pine Rest, etc.
- County Match
- Overhead high
- SWMBH roles and experience from MHL not clearly known/valued

Special Circumstances

There are several special circumstances the SWMBH Board would need to handle if SWMBH were to cease to exist. There are others yet uncontemplated.

MI Health Link

SWMBH hold two delegated benefits management contracts with MI Health Link (the Medicare-Medicaid dual eligibles federal-state demonstration) Integrated Care Organizations (also with traditional Medicaid managed care and other products in Michigan) Aetna Better Health and Meridian of Michigan Health Plan. These contracts have been in place since 2015 and continue at least through the end of calendar year 2021. These contracts, their terms and conditions, financial arrangements and operations at SWMBH to support them are complex, scrutinized by many and have a political aspect to them. Very few in the state understand the Demonstration and PIHP roles, duties, benefits and exposures. These contracts are not transferable to CMHs and have a minimum six month no-cause termination notice period.

Substance Use Disorder Prevention and Treatment

SWMBH holds all substance abuse prevention and treatment (SAPT) provider contracts. SAPT providers are especially scarce, deal and fragile. Few in the state know how to operationalize the Prevention requirements. These contracts are not readily transferable to CMHs.

Master Healthcare Information Exchange, Healthcare Data Analytics and Management Information-Business Intelligence Operations and Agreements

With the participation and support of CMHs our region has expended many millions of dollars for healthcare information exchange, healthcare data analytics and management information-business intelligence, with significant benefit to SWMBH and our CMHs. These efforts have enabled performance success in all areas including but not limited to MMBPIS, Performance Bonus Incentive earnings, Health Services Advisory Group top-shelf Audit results, MHL Integrated Care Organization delegation review success, and more. By design and fiscal prudence contracts with partners and vendors (MIHIN, Relias PopHealth, Tableau, etc.) rest at SWMBH. These contracts and especially the data flows, exchanges and reports would all have to be reworked at material expense, assuming these vendors would pursue individual CMH

contracts. If they did, the base expenses would certainly be higher, and the direct and opportunity conversion costs would be high. Losses of these technologies and products would be a significant strategic and tactical loss for the region.

As required by MDHHS all Data Use Agreements (DUAs) which are required to receive or access any state data rest with SWMBH. SWMBH in turn executes DUAs with CMHs. The DUA development and execution processes are significant. It is uncertain if anyone at the state has an awareness of this impact of PIHP extinction.

Governance Issues

Some 16 months ago we considered, and the SWMBH Board approved exploring a SWMBH role in managing the unenrolled population in Section 298 counties which are outside our region. We noted that the SWMBH Bylaws restrict the "geographic region" in which it can operate to our current eight counties. While the SWMBH Board readily approved enabling Bylaws changes, the SWMBH CEO's approach to four CMH Boards resulted in two Participant Boards rejecting the revisions formally and two reserving judgement until more information was available. Given that SWMBH Regional Entity Bylaws require unanimous consent from all eight Participant CMH Board, the effort was dropped. The SWMBH approval of the revisions still stand; the SWMBH Board has not rescinded them.

Regardless of the magnitude of any system transformation changes, the Regional Entity system and PIHPs have clearly fallen out of favor by most in Lansing. More importantly, all Health Plans will experience consolidation and a future predominately state-wide market presence. For any risk or non-risk Health Plan partner or administrative service organization contractor to be considered let alone valued it must have a state-wide presence or at least a geographic presence which mirrors that of the Health Plan partner target.

***Board Action Required**: An early decision by the SWMBH Board to consider is whether to authorize the SWMBH CEO to begin Bylaws revisions conversations with Participant CMH Boards of Directors using currently Board-approved revised Bylaws or a freshened review and revision. Management recommends that this become an early topic of deliberation, and that the Board again review and approve or revise the approved freshened Bylaws to permit expansion of SWMBH pursuits to state-wide and begin meeting with Participant CMHSP Boards on this topic.*

Alliances and Partnerships

SWMBH is a founding Member of Michigan Consortium for Healthcare Excellence (MCHE) as were all ten Regional Entities/PIHPs. MCHE now has nine Participant Regional Entities/PIHPs, all bur Northern Michigan Regional Entity. MCHE has proven to be a useful vehicle for group purchasing and state-wide initiative organization and resourcing. It is conceivable that MCHE may become a vehicle for further Regional Entity initiatives protective of CMHSPs. Thus, our participation as a Member ought to be continued.

When we considering pursuit of Section 298 Pilot regions benefits management for unenrolled Medicaid beneficiaries, we co-developed a SWMBH majority-controlled public-private partnership with a national well-regarded Health Plan. Design details included Governance and management roles & authorities, financial arrangements and more. While this effort ceased long ago, connection to that Health Plan or other private partners can be considered and pursued.

If DHHS maintains the Regional Entity/PIHP system but with a lesser number of Regional Entities/PIHPs we would want to be ready with our Plan and leadership for consolidation.

Other options exist, and each should be identified and vetted.

Less formal arrangements have been and will continue to be useful. Examples include bi-lateral and multi-lateral RE/PIHP shared services arrangements, evolving to common healthcare information exchange, healthcare data analytics and management information – business intelligence systems, etc. These have and can continue to occur within CEO authority under Board Policy guidance.

SWMBH Financial Status

Medicaid funds generally can be used to pursue state-mandated or state-supported systemic transformations, including the exploration and resourcing of behavioral and physical health care integration programs, healthcare information exchange, healthcare data analytics, etc. Medicaid funds generally cannot be used to develop and operationalize new Regional Entity business lines or directly support new SWMBH Customer acquisition. Medicaid funds can be used to support CMHs transitions to the new realities and ready themselves further for administrative cost reductions, value-based purchasing success, leadership and change management development. It is a certainty that SWMBH Medicaid Internal Reserve Fund (ISF) balance, if any, at 9/30/22 (or any PIHP close-out date) will revert to the state. This amount will be reported to MDHHS on 2/28/23 and cost settled at some unknown date thereafter, historically years after the fact. Thus, absent a local funds capital infusion by Member CMHSPs, SWMBH will rely on its Local Fund Balance earned through the PIHP Performance Bonus Incentive Pool and margin on the MI Health Link program for its capital support of business line development and customer acquisition, if these objectives and efforts are approved by the SWMBH Board. We are currently in cost reconciliation discussions with the MI Health Link Integrated Care Organizations and will have an estimate of SWMBH Local Fund Balance soon.

Marketplace & Industry Overview

Publicly funded healthcare costs in Michigan exceed $13 billion annually. Twelve Medicaid Health Plans cover approximately 2.1 million Medicaid and Healthy Michigan Plan eligibles. The subset of 335,000 eligibles with severe mental illness, serious emotional disturbance, substance use disorders, intellectual and developmental disabilities and autism spectrum disorders are served under contract to Prepaid Inpatient Health Plans (PIHP) such as SWMBH with a state-

wide annual expense of approximately $2.8 billion for an average of $8,500 per eligible annually. Please note that annual specialty services cost per person served varies widely from $1,000 as a low-end outlier and $240,000 as a high-end outlier.

Forty-six Community Mental Health Services Programs provide or contract for virtually all publicly funded services under contract to ten PIHPs, except for General Fund services, roughly 5% of a CMH budget. Seven PIHPs are multi-CMH and three PIHPs are both PIHPs and CMHSPs (Detroit-Wayne, Oakland and Macomb).

MDHHS said the Specialty Integrated Plan reform will occur before the mandatory Medicaid Health Plan re-bid in fiscal year 2023. This places additional urgency for MDHHS in assuring SIP go-live 10/1/22. It is anticipated that during the MHP re-bid new Medicaid Health Plans for non-specialty public eligibles will attempt to enter the Michigan market and that the number of Michigan MHPs is likely to settle in at 7-9 from the current 11. Leading contenders for future operations include Meridian (owned by Centene), United Health Care Community Plan, Aetna Better Health, Priority Health Plan, McLaren Health Plan, Health Alliance Plan and Upper Peninsula Health Plan with Molina being evenly handicapped. Thus, there will be active involvement of current MHPs *and interested new entrants* considering and developing SIPs and/or other models as a competitive advantage for the re-bid.

Michigan's participation in the federal Financial Alignment Initiative is called MI Health Link and combines funding and benefits management for dual eligibles (Medicare & Medicaid) into a single Medicaid Health Plan known as an Integrated Care Organization began in spring 2015. Intended as a three-year Demonstration, CMS and Michigan extended it through 12/31/2020. SWMBH is one of four out of ten PIHPs that have participated in the MI Health Link Demonstration with two ICOs – Meridian and Aetna. CMS, MDHHS and the ICOs have extended the Demonstration for another five years through 12/31/25. Note: MDHHS recently announced that the extension will now be through December 31, 2021 due to COVID-19 distractions and complications, with active pursuit of a multi-year extension thereafter.

Our performance in this Demonstration has benefited our enrollees and the ICOs such that our participation into 2021 is certain. We have seen no evidence of ICOs ceasing their Agreements with us. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination

Michigan Healthcare Policy Environment

In the fiscal year 2020 budget supplemental related to COVID-19, the Governor vetoed a wide range of funded programs and initiatives. One item vetoed was the Public Behavioral Health System Transformation $5 million line item which was intended to support 15 FTEs and consultants. In addition, MDHHS staff have been furloughed a day a week for several months and this is likely to continue. Thus, MDHHS has neither the funds nor the resources to focus well on Transformation. The new MHDDH Senior Deputy for BHDDA has said he believes the

Administration will make some clarifying Policy regarding its Public Behavioral Health Transformation views and intent by early June.

Many believe that the lack of resources for Specialty Integrated Plan (SIP) development combined with the FY '20 and FY '21 combined $6-7 billion projected state deficit which must be remedied will make more legislators and the Governor's office more receptive to a pure carve-in sooner rather than later, skipping the SIP approach altogether.

MDHHS had set a clear policy direction of desiring Specialty Integrated Plans (SIPs) which combine financially and contractually the physical health and behavioral health benefits, capitation funding, accountability and risk into a single Plan. MDHHS has cited the states of Arizona, Arkansas and North Carolina as each having elements and/or results attractive to them. We continue to produce Intel on these three states. Thus, SIPs are carve-in Plans despite some persons avoiding that moniker. MDHHS had expressed a desire for a "publicly-led SIP" with an explicit written invitation to CMHAM in early January 2020 to begin work on such a vehicle. There is no evidence that the public system has made efforts in this regard. It is certain that subsets of public system PIHPs, CMHs and Providers have deeply explored public-private partnership models with Health Plans and related others. MDHHS has made it plain that a publicly led SIP must meet all current Michigan Insurance Code requirements for MCOs. MDHHS has also made explicit the necessity to revise the Mental Health Code and Public Health Code to support SIPs. MDHHS claims they began the statutory review internally some months ago. We have encouraged them to continue to review in the light of day and in a widely inclusive manner.

The public behavioral health system, MDHHS and leaders in the Legislature acknowledge that the current statutory environment does not permit a publicly led SIP so work on Michigan statutory language revisions has begun in the Legislature, executive branch and across the public behavioral health system. Connectivity across these efforts appears to be non-existent. It is certain that MHPs and their Association MAHP are deeply and broadly involved in statutory reviews with their own interests top of mind.

Early criticism of the MDHHS SIP plan comes from many quarters and falls into several main categories, few of which are new:

- Privatization, reduction in services and profiteering by current and future MHPs
- Inadequate requirements for genuine participation in governance and management from persons served, their loved ones and formal advocacy group representatives
- Low level of acknowledgment by legislature and MDHHS of statutory change process complexity, politics and resource/time consumption and need for joint stakeholder efforts
- Minimal to non-existent mention or consideration of the place for substance use disorders treatment and prevention, Block Grant and PA2 funding for substance abuse

treatment and prevention, or the statute requiring county involvement in PA2 budgets via Substance Use Disorder Oversight Policy Boards.

- Minimal acknowledgement from MDHHS of significant direct, indirect and opportunity transition costs of standing up new entities, creating new ventures, closing seven regional PIHPs and materially down-sizing three stand-alone PIHPs.
- Minimal acknowledgement from MDHHS and the legislature that MDHHS lacks the capacities and competencies to successfully manage changes of these magnitudes.
- Lack of MDHHS details or "meat on the bone". MDHHS replies that a stakeholder involvement process will inform more detailed policy and decision-making around the reforms.

Per MDHHS major topics under review include:

- Management of the unenrolled and Medicare-Medicaid Dual eligible population
- SUD funding and care delivery system
- Regional versus state-wide SIPs
- CMH safety net services vs SIP services and blended funding model
- Requirements to serve as a SIP
- SIP procurement process
- Care Management Model in SIPs
- Quality Metrics and Performance Reporting
- Rate structure
- Eligibility criteria for SIP enrollment
- Enrollment and transition process for beneficiaries
- Recipient Rights structure for SIPs
- And many more…

The upcoming Medicaid Health Plan renewal cycle is as follows:

- Current MHP contracts expire 9/30/2020
- A maximum of three one-year extensions is possible through 9/30/21, 9/30/22 and a mandatory rebid completion finalization date for new Plans to begin 9/30/23.

The renewal and rebid process historically has consumed significant MDHHS and OTMB resources as well as that of current and new entrant Plans and has occurred over a scheduled time frame of 2.5 +/- years.

Note: On May 27, MDHHS Senior Deputy for Behavioral Health and Developmental Disabilities Administration Al Jansen said he expected soon a letter from senior DHHS executives announcing a cessation of public behavioral health system transformation efforts. This communication has not yet been published.

Note: On June 11 MDHHS Senior Deputy for Behavioral Health and Developmental Disabilities Administration Al Jansen said the BHDDA key goal areas for the next year (paraphrased) are:

- Increase access to and use of data
- Review and address health disparities and healthcare access inequities for persons of color
- Enhance behavioral health prevention efforts
- Enhance integration of physical and behavioral healthcare with a focus on Behavioral Health Homes, Certified Community Behavioral Health Clinics and Opioid Health Homes
- Enhance alternative systems of care including but not limited to tele-health and other remote methods
- Address Governance; move away from active system design "we are moving away from active system redesign"
- Focus on beneficiaries

Planning Assumptions

NOTE: See modifying comments above. Assumptions under revision due to COVID-19 pandemic in discussions with internal stakeholders and external knowledgeable others.

These assumptions are based on the foundational assumptions that a. the MDHHS Vision will survive and transition to SIPs on 10/1/22; b. the statutory & regulatory barriers will be revised to become permissive to the establishment of a publicly led SIP; and c. that numerous Plans of varying natures such as Medicaid Health Plans, Integrated Care Organizations for Medicaid-Medicare dual eligibles, Specialty Integrated Plans, Medicare Advantage Plans and the like will thrive well beyond 1/1/22.

- PIHPs, including SWMBH will lose their PIHP MDHHS Agreement and funds at 9/30/22.
- Member CMHSPs created the Regional Entity SWMBH; only they can remove that status achieved under Mental Health Code Act 258 of 1974 section 330.1204b.
- SWMBH has latitude in designing its future, subject to approval by the SWMBH Board. See Mental Health Code see Act 258 of 1974 section 330.1204b Regional Entity in Appendices.
- There is no opportunity for SWMBH to unilaterally develop and propose a Specialty Integrated Plan. Assuming support and invitation from Member CMHSPs, SWMBH can participate in and support CMHSP considerations related to SIPs and/or be a Participant in the design and development of a SIP.
- *Beginning immediately and accelerating over time the probability of SWMBH management and line staff departures continues to grow higher.* Once SIPs begin to congregate and aggregate, they will poach PIHP subject matter experts and leaders with increasing aggressiveness. As 9/30/22 grows nearer it is a certainty that most staff will depart, absent a clear pathway for SWMBH to new business lines and new customers.

- Any proposal must be vetted by and supported by a majority of Member CMHSP CEOs and address identified and new CMHSP concerns including but not limited to value to CMHSPs; little or no financial risk to CMHSPs; and the like.
- All business opportunity proposals will require a *pro forma* budget.

The Emerging New World for CMHSPs

Using October 1, 2022 as a future date one can somewhat predict the business environment for CMHSPs. PIHPs will be gone having begun to atrophy as early as January 1, 2021 or sooner. Investments in PIHP supports of staff, information technology, clinical & program initiatives will have been severely curtailed at October 1, 2020 and ceased at October 1, 2021. Reversion by SWMBH to PIHP contractual mandates only will begin October 1, 2021 at the latest.

Medicaid and Healthy Michigan Plan in whatever form they exist - or not - will aggregate physical health and behavioral health into Specialty Integrated Plans or a straight carve-in. DHHS is likely to require Plans to contract with CMHs *as well as permit any other providers of their choice* and to fund Plans for behavioral health services in capitation based upon set fee schedules and actuarial estimates of utilization times enrollees equating to Plan capitation total dollars. Plans will refuse to pay providers above fee schedule rates except perhaps in the most extreme circumstances for Plans to acquire rare clinical resources. Plans will move risk to CMHSP and other providers via some or all the following and other mechanisms: volume-assured discounts, Value Based Purchasing, Incentives, Sanctions, Alternative Payment Methods, etc. CMHSPs who fail to assess, scope and significantly reduce expenses and unit rates will immediately find themselves in a negative margin situation without recourse to others for remediation. Local Fund Balances are likely to be quickly used.

Plans will desire to contract for varying commodity benefits management services such as provider network management. It is highly unlikely that Plans will be willing to contract with each CMHSP singly, rather Plans will demand state-wide or mega-regional benefits management and contracting mechanisms or in many instances perform all behavioral health functions in-house or contract with a single state-wide private or perhaps public entity. Plans are unlikely to delegate authorities to CMHSPs and are unlikely to purchase benefits management services from an agency not NCQA MBHO Accredited. Regardless, administrative fees will be low PMPMs and CMHSP and/or RE/MBHO up-side gainsharing will be available only if specifically negotiated with details into the Agreement.

Despite assurances to the contrary history has shown an inability of the legislative and executive branches to reduce statutory, regulatory and contractual burdens all of which carry significant expense for the public behavioral health system. MHPs have been very aggressive in limiting and tightly specifying their beneficiaries, service arrays and obligations to reduce the state spend “proving efficiencies and savings” while leaving so-called Community Benefit roles to the state and presumably to the CMHSPs. Given these contractions one must ponder the

minimum size and scope necessary for a CMHSP to remain independent. Some CMHSPs may consider consolidations with other CMHSPs.

CMHSPs will retain General Fund contracts for state hospital and safety net services which are yet to be fully defined, let alone costed with a financing model. The probability these services will be properly scoped, defined and funded is low, leaving CMHSPs to perform a "floor" of community services with little ability to go beyond these. This will put further pressure on CMHs to perform financially and open them up to even more criticism as CMHs must contract, not expand both fee for service and community benefit services. The required county match now being incrementally reduced will have disappeared altogether. This relieves counties of statutory financial obligations to CMH and may serve to paradoxically increase county interest in and oversight of CMH or reduce it further largely based upon county dynamics.

Expansions in numbers of state hospital beds will have come on line further expanding utilization and expenses for CMHs, most likely without commensurate General Fund increases to support the added utilization.

CMHSPs may continue to perform at their discretion Medicare, Medicaid fee for service, BCBSM and other commercial services under contract at set rates. Objective analyses of Mission versus Margin for these services will need to occur, with receipt of adequate fees/rates, underwriting with slim GF dollars, contracting or ceasing these and other non-mandatory services.

Few outside the public behavioral health system grasp the difference between and dynamics around Medicaid entitlements, "priority populations," and Ability to Pay General Fund services. CMHs would be wise to assure their community stakeholders and policymakers are clear on these and supportive of or at least tolerant of service array modifications related to finances *and* become or remain active advocates for CMH funding in Lansing.

Grant projects and funds may become more attractive to CMHs. This may increase the need to be competitive and competent in securing and managing these projects. On the other hand, some Grants prohibit allocation of indirect costs to the Grants, further pressuring the CMH cost structure.

More CMHSPs and counties will have considered, pursued or achieved county mental health millages to complement state funds. This will further exacerbate the dreaded dis-uniformity of benefits across counties.

Per MDHHS documents CMHs should expect:

- Continue serving as safety net for all citizens
- Be part of provider network for all SIPs
- An opportunity for expanded role as leader(s) of SIP(s) managing both behavioral health and physical health needs

Per MDHHS changes CMHs will need to make include:

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

SWMBH CEO attended with several SWMBH CEOs a "298 Lessons Learned" session with the four 298 CMH CEOs. Key points included:

- The group mostly did not even discuss BH service delivery. CMHs did do a few client tracer/movement studies to inform the MHPs.
- MHPs do not grasp public system roles, benefits and costing. They claim public system administration expenses are too high. MDHHS is on a fast track to alter CMH/PIHP costing and payments to be more like that for MHPs. MHPs are pressing for the BH unit cost state rates to become "fee screens" upon which they are paid and can dictate rates to BH providers, including CMHSPs and inpatient psych providers.
- MHPs are all about their current and future enrollees. "Population Health" to them means their beneficiaries, not the larger community.
- MHPs are over-confident about their care coordination and care management resources, functions and results.
- Many but not all MHPs were willing to shed mild moderate mental health to the 298 CMHs.
- They are adamant that they will not pay for so-called safety net and community benefit CMH activities. They are heavily focused on Community Living Supports issues given the preponderance of costs in this area state-wide.
- SUD was a particularly complex conversation, with MHPs split on their desire to manage it, especially Block Grant and PA2 services. They do not want the cost exposure related to SUD.
- MDHHS largely sees unenrolled, duals and SUD as an after-thought deferred to future discussion.
- MHPs want I/DD services and capitation.
- MHPs were very sophisticated in developing and producing data tables and charts to make their points.
- MHPs want nothing to do with CMHSP General Fund issues.
- The group discussed the problems caused by spend-downs, MHP enrollee movement, beneficiary movement between Medicaid and Healthy Michigan Plan, GF, etc. Problems were identified with few or no solutions.
- MHPs are highly competitive and loath to reveal their business processes, performance data, etc.

- MHPs seem to understand the fragility of the BH provider network and many MHPs expressed desire to contract for (not "delegate") BH provider network management.
- MDHHS was largely unable (and/or unwilling) to produce any objective data about BH or MHPs to inform the discussion.
- Sub group discussion areas included Policy, Finance, Provider Network, Technology, Case Management/Care Management, and Reporting.
- MHPs were aghast at the types and volumes of data CMHs/PIHPs must report to MDHHS. Their position was oppositional to the reporting burdens.
- Some MHPs openly expressed opposition to Self-Determination, Person-Centered Planning, Independent Facilitation and Fiscal Intermediaries. Some went so far as to say they would get those removed from Mental Health Code and MDHHS Policy directives.
- National Plans said it can take 6 months to get approval for a Business Associate Agreement and 18 months to get technology/data systems development achieved.
- Don't confuse MHPs with their Association MAHP. MAHP is there to be aggressive and inflammatory. Most all MHP representatives were competent and caring about health services effectiveness.
- Legislative leaders are always involved and influential, sometimes apparently sometimes not.
- MAHP/MHPs have always received the full raw files Milliman uses for rate-setting and they have their own actuaries under contract to inform rate discussions with MDHHS to their favor.

Losses and Needs *Attachment under construction*

Please see Attachment C for a CMH Losses and Needs Table developed by SWMBH. This document summarizes what CMHs can expect to disappear (Losses) if SWMBH disappears and our views on potential CMH Needs if SWMBH disappears. Management proposes a CMH leadership only session facilitated by external subject matter experts to perform and report out this same exercise.

Market Analysis (largely a Placeholder for now awaiting Board authorization to invest in development)

Current Market Overview

Current Customers

- CMHSPs
- Integrated Care Organizations (ICOs) Meridian (now owned by Centene www.centene.com) and Aetna Better Health.

Potential New Customers

- Specialty Integrated Plans (SIP, under development)
- Medicaid Health Plans (MHP)
- Medicare Advantage Plans
- Workers Compensation Plans
- Auto Insurers
- Hospitals & Health Systems
- Accountable Care Organizations (ACO)
- Federally Qualified Health Centers
- Rural Health Centers
- School-based Health Centers
- Individual, aggregated or incorporated Provider Groups
- Hospital, health system and Primary Care Physician groups
- State of Michigan MDHHS, MDOC and other Departments
    - MDHHS
        - Substance abuse treatment Medicaid and Healthy Michigan and Block Grant benefits management
        - Substance abuse Prevention services
    - MDOC
        - Community substance abuse services for supervisees (parolees and probationers)

Current Business Lines – to be completed

Potential New Business Lines for CMHs, Provider Groups, Health Plans

- Recruitment, employment, management and deployment of physicians, psychologists and other clinical staff
- Recruitment, employment, management and deployment of provider auditors, claims processors and other administrative staff
- County millage pursuit subject matter experts and technical assistance
- Philanthropy (fund raising) subject matter experts and technical assistance
- Grant and United Way pursuit subject matter experts and technical assistance
- Analyses and enhancements of external provider services such as Personal Care, Community Living Services, Supported Employment, Skill Building, Supported Independent Living, etc.
- Design and development of Value Based Purchasing (VBP) and Alternative Payment Methods (APMs)
- Joint contracting with MHPs for mild to moderate mental health services management and other commercial payer BH services
- Shared General Counsel, Labor Counsel, etc.
- Shared and joint Program Integrity-Compliance Program
- Provider contract development and negotiations
- Payer contract negotiations
- Shared and joint enrollee rights and protections program

- Shared and joint Complex Care Management
- Complex case consultation
- Evidence-based practices installation, training and monitoring
- Management Information – Business Intelligence support
- Program Portfolio Analyses
- New Program Analyses
- Scaling and replication of successful Programs
- Sales and services to non-SWMBH CMHs
- Healthcare Information Exchange support
- Healthcare Data Analytics support
- Strategic Planning support
- Public Relations, Media Relations and Marketing support
- Group Purchasing support
- Etc.

Note: Only one or more SWMBH CMH(s) need to be interested to consider each option; it need not be all eight.

A special opportunity in multi-regional or state-wide management of gambling disorder prevention and treatment is possible.

A special opportunity in multi-regional or state-wide management of substance abuse prevention and treatment is possible.

One or more PIHPs may drop out of the MI Health Link Demonstration, creating expansion opportunity(ies) for us to become the behavioral health benefits manager for one or more of those Regions or ICOs.

The unenrolled population is a particularly problematic issue for the state, and has multiple related access, quality, and care coordination business opportunities. Prior to the pandemic, all ten PIHPs agreed to design for MDHHS a NCQA MBHO adherent Complex Care Management program for persons with severe mental illness and one or more chronic medical conditions. MDHHS Director Gordon and his Senior Chief Deputy for Policy and Planning were scheduled to attend the April regional Entity/PIHP CEO meeting but canceled due to the pandemic. Regardless, PIHPs continue with detailed design documentation.

Competitive Analysis

There is a high likelihood that other current Regional Entities, new CMH-sponsored, CMHA, Provider Groups and related agencies will develop similar approaches to post 9/30/22 opportunities in behavioral health benefits management and other value-added activities with an intent to sell various Administrative Service Organization (ASO) solutions. The ten RE/PIHP Directors met on February 14, 2020 for a discussion of system issues.

Multiple well-known national Managed Behavioral Health Organizations have had eyes on our Medicaid managed care program for decades and contact with key leaders in Michigan and

Medicaid Health Plans for decades making assertive pitches for their ASO offerings and capital funds. Top contenders include but are not limited to Beacon Health Options www.beaconhealthoptions.com Magellan www.magellanhealth.com Envolve www.envolvehealth.com Optum www.optum.com See Appendix D. for a list of NCQA MBHO Accredited entities. These national for-profit companies have long histories, sophisticated offerings complementing behavioral health benefits management, intense promotional pitches, and significant capital funds. A credible case will have to made to prospective Customers for why SWMBH is as or more attractive than these firms. We should not rule out future partnership(s) with one or more of these firms.

Key strengths SWMBH & CMHs must have at industry standard or better levels to assure chance at success include, but are not limited to:

- Sophisticated Information Systems & Technologies
    - All HIPAA Standard Transactions
    - Health Information Exchange connectivity (MIHIN)
    - Healthcare Data Analytics such as Care Management Technologies
    - Management Information and Business Intelligence
- Industry Standard or better finance and accounting reporting and business intelligence
- Industry Standard or better clinical productivity
- Real time client assessment scores, treatment history, physical health status and physical health services avoidance/reduction savings estimates
- Ability to adopt Alternative Payment Methods (APMs) as Provider and perhaps as Payer
- Evidence-based clinical pathways, protocols and guidelines with automated surveillance of adherence
- Automated clinical and administrative alerts
- Functionality and Outcomes assessments, scores and analyses
- Proofs of performance internal and external reporting
- Catalogue and brief descriptions of current and planned integrated care initiatives across our region
- To be continued

Sales and Marketing

This section is reserved for a future date when the SWMBH Board approves additional effort. This development will necessitate competencies not currently available at or to SWMBH. In simple terms the process includes **S**egmenting, **T**argeting, **R**esearching, **A**ppraising and **P**laying with the **4P**s of **P**roduct, **P**rice, **P**lace and **P**romotion.

Ownership

Provided that the current Member CMHSPs do not relinquish their Membership in SWMBH, they will remain the Participants with the Regional Entity structure intact and the Governing

Body (Board) made up of appointed representatives from each Participant CMH Board. It is conceivable that any individual CMHs could depart SWMBH under the rules of the Bylaws. We recommend that the region's CMHSP leaders not dismiss the idea of inviting other CMHSPs into the Regional Entity as equals or as Tier 2 Members, with Tier 2 not yet defined but conceptually having less authority and thus risk that a Founding Member.

Operations

This section is reserved for a future date when the SWMBH Board approves additional effort. A full consideration of actual and potential business lines, customers, volumes and margin expectations will drive the operational design.

Mandatory Enabling Decisions

There are certain deliberations and decisions which need to occur at and with the Board to provide authorization and visible support to the SWMBH EO in these endeavors. The first is Board authorization to pursue Bylaws revisions to expand geographic reach with Participant CMHSPs. The second is Board review, modification and approval of varying severable parts of this Strategic Business Plan. The third is Board authorization to begin the Customer identification process. These decision points will inform and drive current and future staff behavior; more staff will likely remain with SWMBH if there is visible Board support for a future beyond lights out on 9/30/22.

Proposed Milestones and Timelines

Discussion and deliberation with and amongst the Board and Operations Committee will commence in February culminating with the August Board planning meeting and September and October Board deliberations. It is during this time and ideally no later that the Board must affirmatively authorize management to proceed with a. [1]Regional Entity Bylaws revisions attempts enlarging geographic service area at each Member CMHSP Board of Directors; and b. business line design (not yet development) concurrent with customer mining. Each of these require substantial resources, primarily from SWMBH EO, other SWMBH senior managers, external Subject Matter Experts and Member CMHSP talent.

Exhibits

- **A.** Key Milestones Timetable
- **B.** PIHP Map
- **C.** MHP Map
- **D.** MHP eligibles in SWMBH counties
- **E.** Current MDHHS Reform documents

[1] It is our assessment that an ability to be an attractive ASO services provider beyond our current geography is very nearly a mandate for the possibility of future business lines for additional customers. Be they SIPs, ICOs, MHPs, CMHSPs, or other customers, it is almost a certainty that they will require multi-regional or state-wide performance of delegated or contracted benefits management or population health contractual obligations.

a. January 7, 2020 MDHHS Gordon letter to CMHAM Sheehan

Appendices

A. Definitions and Acronyms
   a. Administrative Service Organization (ASO)
   b. Care Coordination
   c. CMHSP
   d. Specialty Integrated Plan
   e. Medicaid Health Plan
   f. CMHAM
   g. MAHP

B. Michigan Mental Health Code 330.1204b Regional entity statute

mcl-330-1204b.pdf

C. Michigan Mental Health Code <citation> SUDOPBs, etc.

D. NCQA MBHO Accredited List https://reportcards.ncqa.org/#/other-health-care-organizations/list?p=1&program=Managed%20Behavioral%20Healthcare%20Organization

E. SWMBH Bylaws and Bylaws as revised by SWMBH Board

F. Michigan Medicaid Health Plans service regions

Key Milestones Table

Topic	What	Whom	By When	Notes

Provider Organization Name: Southwest Michigan Behavioral Health							**Date of Delegation Committee:** 07/13/2020	
Review Date:	06/16/2020	**Current Delegation Level**			☒ **Delegated**		☐ **Non-Delegated**	
Aetna Auditor	Cheryl Ford/ Loretta Coffman (Credentialing)	**Type of Entity - PIHP**			☐ **IPA/PO**		☐ **MSO**	☒ **Other**
Delegate Representative	Jonathan Gardner	**Type of Audit**	☐ Pre-K	☒ Annual	☐ Re-audit	☐ Shared Audit	☐ Validation Audit*	☐ CAP F/U
Markets	Aetna Better Health Premier Plan of Michigan		**NCQA - UM- Certification/HP – Accreditation- Medicare MBHO Accreditation**				Effective: 03/02/2018	Expiration: 03/02/2021
Does the Provider Organization have sub-delegates? ☐ Yes ☒ No			**List of all the sub-delegates:**					

The Aetna Delegation Oversight *Data Collection Tool* or *State Shared Audit Tool* was used to record the results of the delegated entity. Results are reported by category. The following summarizes the results of the audit performed:

*Items reviewed for Pre-Delegation Audits: ☒ Policies & Procedures ☐Files ☒ Minutes ☒Ongoing Monitoring Activities ☒Delegation Documents

AETNA OPERATIONAL AUDIT

Auditor: Cynthia Arzich will conduct an on site visit later in 2020

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
Customer Service	NA
Claims Processing :	
Section I: Claim Department Management	TBD
Section II: Claim Processing	TBD
Section III: Claim System Capabilities	TBD
Section IV: Performance Compliance	TBD

Audit Deficiencies:

UTILIZATION MANAGEMENT AUDIT

Auditor: Cheryl Ford

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

CMS Criteria	CMS Results [Met/Not Met or NA]
Requests for Expedited Organizational Determinations	Met
Adverse Pre-Service Organizational Determinations	Met
Sub-Delegation (Agreement)	NA

Section 11	Medicaid Results [Met/Not Met or NA]
AETNA Policy	Met

Medicare Standards	Medicare Results [Met/Not Met or NA]
Medicare Fast Track Appeal Process	Met
Analysis of Under and Over Utilization	Met

State Criteria	State Results [Met/Not Met or NA]
1.Michigan	Met

Comment: SWMBH received NCQA Accreditation auto credit. No file review necessary

Audit deficiciencies: None

CASE MANAGEMENT AUDIT

Auditor: Cheryl Ford

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

CMS Criteria	CMS Results [Met/Not Met or NA]
1. Timely Communication of Clinical Information-Ensure continuity and coordination of care	Met
2. Continuity of Care Through Community Arrangements	Met
3. The delegate's policies specify whether services are coordinated by the enrollee's primary care provider or through some other means.	Met
4. The delegate ensures continuity and coordination of care through measures to ensure that enrollees: are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they make take to promote their health	Met
5. Level II face to face Assessment conducted within 15 days.	Met
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Comment: SWMBH received NCQA Accreditation auto credit. No file review necessary**.**

Audit Deficiencies: None

CREDENTIALING AUDIT

Auditor: Loretta Coffman

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

Comment: SWMBH received NCQA Accreditation auto credit. No file review necessary

Audit Deficiencies: None

GRIEVANCE AND APPEALS AUDIT

Auditor: Rachel Godwin

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
UM 8: Policies for Appeals	Full
UM 9: Appropriate Handling of Appeals	Full
RR 2: Policies and Procedures for Complaints and Appeals	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full
CMS Criteria	
1. Meet timeframes for Appeals and Grievance as it applies to Members	Met
2. Meet timeframes for Appeals and Grievance as it applies to Providers	Met
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Comment: SWMBH received NCQA Accreditation auto credit. No file review necessary.

Audit Deficiencies: None

Recommended Delegated Functions

Claims Processing	TBD
Utilization Management	Full
Case Management	Full
Credentialing	Full
Grievance and Appeals	Full

☐ **Re-Audit* or ☐ CAM follow up**	
☐ 30 days due date:	
☐ 120 days due date:	Choose date
☐ 180 days due date:	Choose Date

***If Re-audit, please add applicable REC code in MOT**

Report Submitted by: Cheryl Ford Date: 06/17/2020

COVID and the Impact on FY21 State Budget

Written on June 22, 2020

Three months after Michigan began shutting down due to the COVID-19 pandemic, the State continues on its path to reopening under the Governor's MI Safe Start Plan; a six-phase regional economic plan to reopen the state. The plan separated the State into eight regions, allowing each region to progress at its own pace. Starting June 10, regions 6 and 8 (northern Michigan and the Upper Peninsula) graduated to Phase 5, "Containing," which amongst other things allows the reopening of salons, movie theaters, and gyms subject to safety protocols and social distancing. Although the remainder of the state is currently in phase 4 "Improving," the Governor has publicly discussed her desire to move the remainder of the State into phase 5 before the 4th of July.

As previously discussed, COVID-19 has devastated the State's current year budget and the pending FY21 budget. In May, the Consensus Revenue Estimating Conference (CREC) reported an estimated loss of $6.28 billion; a $3.2 billion deficit for the current fiscal year and a $3 billion deficit for FY21. The State's revenue has plummeted as a result of reduced state sales and income tax revenue, and mass business closures in response to the COVID-19 pandemic.

With Michigan dealing with its first budget deficit since the Great Recession, the state's FY21 budget process has stalled following COVID-19. Two-thirds of $3B in coronavirus relief funds allocated to Michigan through the CARES Act has not been spent. The Governor

continues to lobby Congress to allow all states flexibility when allocating CARES Act money. Currently these monies are restricted and state's cannot use any of the relief funds as revenue replacement. In addition to hoping flexibility's are soon provided for CARES Act spending, Michigan is also patiently waiting to see if Congress provides additional relief money to states and local governments.

After the FY20 budget process was completed in Fall 2019, the legislature and Governor agreed to a July 1 deadline for the state budget going forward. However, due to the unprecedented impact on the state due to COVID-19, the legislature has begun the process of amending the newly implemented statute to delay the July 1 self-imposed deadline until 2021. This delay will provide the legislature and Governor time throughout the Summer and early Fall to negotiate a FY21 budget, with the State's fiscal year starting on October 1, 2020. Recently the Legislature passed SB 690, a supplemental budget bill aimed at addressing COVID-19 impacts to the state. The bill allocates a portion of the federal relief funding from the CARES Act Michigan received from the Federal Government. The bill includes, but is not limited to: $115M for a small business restart grant program; $100M to cover the reimbursement of hazard pay for first responders; $25M for PPE grants; $120M to cover a $2 raise to direct care workers from July 1 to September 30; $29.1M to the State's unemployment insurance agency; $5.1M for a $100 per diem increase in inpatient psychiatric hospital rate for Medicaid patients and $4M for grants to organizations that provide services for victims of domestic violence, sexual assault, stalking, and other crimes that cause physical injury or fear for physical safety.

On the election front, the August primary will be here before we know. In last month's *Insights* article on Lansing, we discussed the record March 2020 Presidential Primary turn out and the large increase in absentee voting. In 2018, voters passed a ballot proposal that now allows all voters to cast absentee ballots. In a move that was highly criticized by some Republicans, Michigan's Secretary of State Jocelyn Benson proactively mailed 5.7 million absentee ballot applications to most Michigan registered voters. Record turn-out is expected for both the August 4 primary and November 3 general elections.

Legislatively, only the House of Representatives is up for election this year. Twenty-one incumbent Representatives who are running for reelection (12 Democrats & 9 Republicans) have a primary challenger. It is likely all incumbents will win their primary races, however, there are a few districts where the incumbents could be in trouble. Mitchell Research & Communication survey data shows that as we further re-open Michigan's economy people are also feeling more comfortable with candidates visiting via "door to door" campaigning. Social media, direct mail, and other media outlets are going to be much stronger components of campaigns this year than in previous years.

The Legislature continues to meet for committees and session days while adhering to social distancing safety guidelines. Thus far the House has limited session to 1-2 days each week, while the Senate continues to meet 2-3 times each week. Session is expected to continue throughout June with a tentative summer break recess scheduled for July.

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 call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
August 14, 2020
9:30 am to 11:00 am
Draft: 5/18/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Consent Agenda**
   - July 10, 2020 SWMBH Board Meeting Minutes (d)
5. **Operations Committee**
   - Operations Committee Minutes June 24, 2020 (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**
   - None
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - BG-002 Management Delegation (d)
9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   - BEL-005 Treatment of Plan Members (d) (M. McShane)

10. Board Education

a. Fiscal Year 2021 Draft Budget (d) (T. Dawson)
b. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson)
c. Provider Network Report (d) (M. Todd)
d. Substance Use Disorder Oversight Policy Board Update (d) (J. Smith)
e. September 11, 2020 SWMBH Board Budget Public Hearing (B. Casemore)
f. Updated Strategic Plan (d) (B. Casemore)
g. System Reform Part 5 (d) (B. Casemore)

11. Communication and Counsel to the Board

a. September 11, 2020 Board Agenda (d)
b. Board Member Attendance Roster (d)
c. September Board Policies: BEL-009 Global Executive Constraints (E. Meny); EO-001 Executive Role& Job Description; BG-008 Board Member Job Description

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
September 11, 2020
9:30 am - 11:00 am

Board Planning Retreat

Friday, August 14, 2020
Location -- TBD

Vs. 6-25-20

Objectives:	**1) Environmental Scan**
	2) Implications and Ramifications of Environmental Scan
	3) Identify Course of Action for SWMBH Regional Entity
9:00 am-9:30 am	***Full Breakfast***
9:30 am–10:30 am	**SWMBH Board Meeting**
10:30 am-10:45 am	***Break***
10:45 am-11:00 am	**Board Retreat**
	Welcome, Introductions, and Session Objectives (Scott Dzurka)
11:00 am-12:00 noon	**Environmental Scan**
	Elizabeth Hertel, Chief Deputy Director of Administration (Tentative)
	Michigan Department of Health and Human Services
	• **Overview of the state and regional healthcare policy landscape** • **MDHHS Reform Objectives and Status** • **Questions and Discussion**
12:00 pm-12:45 pm	**Lunch Break**

12:45 pm – 1:30 pm	**Alan Bolter, Associate Director -- confirmed** **Community Mental Health Association of Michigan** • **Overview of the state and regional healthcare policy landscape** • **Fiscal Year 2021 budget highlights** • **Questions and discussion**
1:30 pm-2:30 pm	**Brian Thiel & Judith Zink, Capitoline Consulting (via video) -- Confirmed** • **Federal Health Policy** • **Overview of the federal Presidential and Congressional elections** • **Questions and Discussion**
2:30 pm-3:30 pm	**Discussion, summary and next steps (Scott Dzurka)**
3:30 pm	**Adjourn**

*** * * * * * ***

Participants:

*** SWMBH Board and Board Alternates**

*** CMHSP CEOs**

*** SWMBH Chief Financial Officer, Chief Compliance & Privacy Officer, Chief Information Officer, Chief Administrative Officer, Director of Quality Assurance and Performance Improvement, Director of Clinical Quality, Director of SUD Services**

*** SWMBH Consumer Advisory Committee Chair/Vice Chair**

*** SWMBH Substance Use Disorder Oversight Policy Board Chair/Vice Chair**

*** NAMI Southwest Michigan**

Materials:

SAMHSA Strategic Plan FY2019-FY2023

NIHCM Foundation – Mental Health Trends & Outlook

Capitoline Federal Summary

Southwest Michigan
BEHAVIORAL HEALTH

Fifth Annual Regional Healthcare Policy Forum

Invitees: Community Mental Health Service Providers and Persons Served, Elected and Appointed State, County, and Local Officials

Date: Friday, October 2, 2020

Location: Radisson Hotel

100 W. Michigan, Kalamazoo, MI

Panelists:

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

*Mary Whiteford, (R-80), Michigan House of Representatives. Chair, Health & Human Services Appropriations Subcommittee

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

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

*Sherri Boyd, Executive Director, The ARC Michigan

*Kevin Fischer, Executive Director, NAMI-MI

Purpose/Objectives
Looking to the Future . . .

- Explore the dynamics of upcoming federal elections
- Explore the impacts of COVID-19 on Healthcare including fiscal realities
- Explore the MDHHS Plan for System Transformation in healthcare and the Public Behavioral Health Care Systems

Facilitator: Scott Dzurka, Vice President
Public Sector Consultants

8:30--9:00 am	Registration and Continental Breakfast
9:00--9:15 am	Welcome & Introductions Scott Dzurka
9:15 – 10:00	Federal elections update. Brian Thiel and Judith Zink, Capitoline Consulting
10:00 —12:15 noon	Discussion & Conversation with Panelists
12:15--12:45 pm	Light Hors D'oeuvres and Conversation

Registration: Eventbrite Invite Forthcoming

Parking Vouchers Available

vs 6.25.20

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)												
Mary Middleton (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 6/12/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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