Southwest Michigan

BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial-in: 1-844-655-0022
Access Code: 738 811 844
July 12, 2019
9:30 am to 11:00 am

1. **Welcome Guests/Public Comment**

2. **Agenda Review and Adoption (d) (pg.1)**

3. **Consent Agenda**

    a. Customer Advisory Committee Nomination (d) (pg.3)
    b. June14, 2019 SWMBH Board Meeting Minutes (d) (pg.4)

4. **Operations Committee**

    a. Operations Committee Minutes 5-22-19 (d) (pg.8)
    b. Operations Committee Report (d) (pg.11)
    c. Operations Committee Self Evaluation (d) (pg.12)

5. **Ends Metrics Updates (*motion required)**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

    - Autism Spectrum Disorder Update (d) (R. Freitag) (pg.17)

6. **Board Actions to be Considered**

    - None Scheduled

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

    - None scheduled

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

    - BEL-005 Treatment of Plan Members (M. Walker) (d) (pg.18)

9. **Board Education**

    a. Fiscal Year 2020 Budget Assumptions and Rates Targets (attachment) (T. Dawson)
    b. Single Audit, Financial Audit Change (T. Dawson)
    c. Fiscal Year 2018 Service Use Analysis (SUE) meeting update (T. Dawson/M. Kean)
    d. Third Party IT Security Assessment Results (d) (R. Moerland) (pg. 24)

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

    a. Consolidated Fiscal Year 2019 Year to Date Financial Statements (d) (T. Dawson) (pg.39)
    b. Michigan Consortium for Healthcare Excellence (d) (B. Casemore) (pg.47)
    c. September 13, 2019 SWMBH Board Budget Public Hearing (d) (B. Casemore) (pg.51)
    d. Public Policy—Legislative Initiative Update (R. Compton)
    e. Board Member Attendance to CMHSPs (d) (B. Casemore) (pg.53)
    f. 298 Pilots (d) (B. Casemore) (pg.54)
    g. MI Health Link Evaluation (d) (B. Casemore) (pg.58)
    h. Lakeshore Regional Entity PIHP Contract Cancellation (d) (pg.62)
    i. Articles (d) (pg.64)
    j. August: BEL-009 Global Executive Constraints (T. Schmelzer)
    k. August: BEL-008 Communication and Counsel (P. Garrett)

11. **Public Comment**

12. **Adjournment**

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

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lovers Lane, Portage, MI 49002
Phone: 800-676-0423

Date: June 18, 2019

Agenda Item

Southwest Michigan Behavioral Health Customer Advisory Committee

Recommendation for Membership

It is the recommendation of the Southwest Michigan Behavioral Health Executive Officer that the following individuals be appointed to a two-year term ending September 30, 2020

Name	County
Eric Davis	Van Buren

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
June 14, 2019
9:30 am-11:00 am
5250 Lovers Lane, Suite 200, Portage, MI 49002
Draft: 6/17/19

Members Present: Tom Schmelzer, Ed Meny, Susan Barnes, Robert Nelson, Pat Guenther, Mary Myers, Patrick Garrett, Angie Price

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Rob Moerland, Chief Information Officer, SWMBH; Jonathan Gardner, Director of QAPI, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Moira Kean, Director of Clinical Quality, SWMBH; Kris Kirsch, St. Joseph County CMHSAS; Jeannie Goodrich, Summit Pointe; Karen Lehman, Woodlands BHN Alternate; Richard Thiemkey, Barry County CMH; Michael McShane, Woodlands BHN; Michelle Jorgboyan, Senior Operations Specialist, SWMBH

Guests via phone: Debra Hess, Van Buren CMH

Welcome Guests

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

Public Comment

No public comment.

Agenda Review and Adoption

Motion	Edward Meny moved to accept the agenda with moving agenda items 5b and 9b to July's Board Meeting.
Second	Mary Myers
Motion Carried	

Conflict of Interest Management – Angie Price and Mary Green

Mila Todd reviewed the financial interests disclosed by Angie Price and Mary Green. Angie Price disclosed only the inherent conflict that exists from serving simultaneously on the CMH and SWMBH Boards. Mary Green disclosed only the inherent conflict of simultaneously being employed by Van Buren CMH and serving as the Van Buren CMH alternate to the SWMBH Operations Committee. The SWMBH Board moved that it is not above to secure a more advantageous arrangement with someone other than Angie Price or Mary Green, that the conflicts disclosed are not likely to affect the integrity of the services that SWMBH may expect to receive from Angie Price or Mary Green, and that Conflict of Interest Waivers should be granted.

Motion	Patrick Garrett
Second	Susan Barnes

Motion Carried

Consent Agenda

Motion Patrick Garrett moved to approve the May 10, 2019 Board Meeting minutes as presented.

Second Robert Nelson

Motion Carried

Operations Committee

Operations Committee Minutes April 24, 2019

Tom Schmelzer asked for comments or questions. Minutes accepted.

Ends Metrics Updates

Managed Care Functional Review: Utilization Management

Anne Wickham presented the report as documented. Discussion followed.

Regional Habilitation Supports Waiver Slots Update

Rhea Freitag presented the report as documented. Discussion followed.

Assessment Tools

Moira presented the report as documented and asked the Board to approve two extensions.

Motion Edward Meny moved to extend 100% implementation of Global Assessment of Individual's Needs (GAIN) assessment tool metrics completion date by one year to 10/1/2020.

Second Robert Nelson

Motion Carried

Motion Edward Meny moved to extend 100% implementation of MCG metrics completion date by one year to 4/15/2020.

Second Robert Nelson

Motion Carried

Board Actions to be Considered

Board Planning Session Follow Up

Jonathan Gardner reported as documented. Brad Casemore stated that this data will be used to develop next year's end metrics as well as department and regional committee goals. Discussion followed.

Board Policy Review

BEL-012 Open Meetings Act and Freedom of Information Act

Mila Todd reviewed the policy as documented.

Motion Edward Meny moved that the Board is in compliance with BEL-012 Open Meetings Act and Freedom of Information Act and the policy does not need revision.

Second Patrick Garrett
Motion Carried

Executive Limitations Review

BEL-002 Financial Conditions

Edward Meny reported as documented and provided an additional handout for the record with his thoughts on the review.

Motion Edward Meny moved that the Executive Officer is in compliance with the policy BEL-002 Financial Conditions and the policy does not need revision.
Second Susan Barnes
Motion Carried

BEL-006 Investments

Robert Nelson reported as documented noting that all investments are rated above average.

Motion Robert Nelson moved that the Executive Officer is in compliance with the policy BEL-006 Investments and the policy does not need revision.
Second Edward Meny
Motion Carried

Board Education

Mid-Year Program Integrity Compliance Report

Mila Todd reported as documented. Discussion followed.

Fiscal Year 2020 Environmental Scan, Strategic Imperatives and Budget Assumptions version 2

Tracy Dawson reported as documented. Discussion followed.

Service Use Evaluation III

Tracy Dawson reported as documented. Discussion followed.

Information System/Information Technology Update

Rob Moerland reported as documented. Discussion followed.

Communication and Counsel to the Board

Consolidated Fiscal Year 2019 Year to Date Financial Statements

Tracy Dawson reported as documented thanking the CMHSPs for their work on reducing costs, noting that revenue is up 6 million and expenses are down 2.4 million.

Autism Update

Tracy Dawson reported as documented noting that research and work is continuing around encounters, levels of care, and coding issues. Discussion followed.

Board Member Attendance Roster

Tom Schmelzer reported as documented, noting the importance of Board attendance.

Articles

Brad Casemore noted two articles of interest, one regarding the PIHP structural deficit for fiscal year 2018 and 2019 and one memo from DHHS regarding the Summit Pointe audit and fund distribution. Discussion followed.

Public Comment

No public comment

Adjournment

Motion	Pat Guenther moved to adjourn at 11:00 am.
Second	Edward Meny
Motion Carried	

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: May 22, 2019
9:00am-2:00pm

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

Members Present via phone conference – Kathy Sheffield

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Moira Kean, Director of Clinical Improvement, SWMBH; Robert Moerland, Chief Information Officer, SWMBH; Joel Smith, Director of SUD and Prevention Services, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; and Brad Sysol, Summit Pointe.

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

Review and approve agenda – Agenda was approved as presented.

Review and approve minutes from 4/24/19 Operations Committee Meeting – Minutes were approved by the Committee with revisions to Performance Based Incentive Program (PBIP) earnings section.

Fiscal Year 2019 YTD Financials – Tracy Dawson reported as documented. Brad Casemore announced that SWMBH will be receiving $1.454 million as a result of Summit Pointe's audit. Funds will be paid to each CMHSP in June.

2018 Service Use Evaluation (SUE) Review – Tracy Dawson reported that the SUE is complete and a meeting will be scheduled to review and analyze the reports.

MCG Installation Update – Moira shared a recent onsite meeting with MCG where SWMBH and MCG exchanged issues and concerns regarding implementation of the statewide parity system. The State moved the implementation date to 10/1/19. Discussion followed.

MDHHS Behavioral Health Fee Development – Tracy Dawson reported on the recent Milliman visit to SWMBH, KCMHSAS and Summit Pointe. Milliman visit was to gather information. Discussion followed.

SWMBH Public Policy-May 17th Event Debrief – Brad Casemore asked for feedback regarding event. Discussion followed and feedback was positive.

SWMBH Board Retreat Debrief – Brad Casemore asked for feedback regarding May 10th SWMBH Board Retreat. Discussion followed and feedback was positive.

Brad to see Meridian Sean Kendall/topics discussion – Brad Casemore shared his meeting with Sean Kendall will focus on MI Health Link, contract obligations on PBIP regarding integrated care teams, and environmental policy and predictions. Brad asked group for any additional items. None were stated.

Utilization Management (UM) Managed Care Functional Review (MCFR) – Anne Wickham presented an update on the Substance Use Disorder (SUD) sub workgroup and noted focus issues of duplicate entries, Michigan Mission Based Performance Indicator System (MMBPIS) requirements, and Global Assessment of Individual's Needs (GAIN) implementation. Anne stated that the next MCFR will be with Regional Provider Network, which has a kick off meeting scheduled for May 23.

Severe Emotional Disturbance (SED) and Mental Illness in Adults (MIA) Levels of Care – Moira Kean presented as documented. Discussion followed.

Fiscal Year 2020 Budget Development – Tracy Dawson presented as documented.

Autism Benefits Assessment (ABA) Project – Scope and Deliverable – Brad Casemore reviewed the history of ABA Services, diagnosis and uniformity of benefits. Moira Kean shared that meetings will be starting soon to research project scope and deliverables. Moira asked group to email her names of staff that should be part of this project. Discussion followed.

Parent Support Partner Service and Youth Peer Support Service Provision – Mila Todd reported as documented. Mila is confirming accuracy, contacting CMHSPs Provider Network, and reporting back to the State.

Fiscal Year 2020 Community Mental Health Contract Development – Mila Todd shared that they are working on Amendment #3 and finalizing fiscal year 2020 at a May 24 meeting. Redline version provider contracts should be sent by the end of June. Mila also shared recent contact by Autism Alliance of Michigan regarding requests for information. Discussion followed.

Data Model Exchange Submission Status and Reports review – Encounters and Behavioral Health Treatment Episode Data Set (BH TEDS) Rob Moerland reviewed BH TEDS encounter data and BH TEDS missing fields reports. Discussion followed.

Outstanding Development Items Streamline Health Systems – Rob Moerland stated that Streamline Health Systems is beginning work on both American Society of Addiction Medicine (ASAM) and 278 issues.

Veteran Navigator – Anne Wickham asked group to email her who would be a good contact at each CMHSP regarding Veterans issues and noted that the SWMBH Veterans Navigator needs to do a Military Cultural Competency Training at each CMHSP. Discussion followed.

Global Assessment of Individual's Needs (GAIN) Implementation Status – Joel Smith reviewed proposed GAIN implementation date of 10/1/20 and additional GAIN trainings that are coming up this summer. Discussion followed.

Grant Status/Updates – Joel Smith reviewed status of the State Targeted Response grant and the State Opioid Response grant.

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

June 26th Operations Committee Meeting – Brad Casemore noted that Debbie Hess will not be attending the June 26th Operations Committee Meeting and he will act as chair for that meeting.

MSU Michigan Health Policy Forum – Brad Casemore and Sue Germann attended the May 20th Forum and shared their perspectives on the event. Discussion followed.

Adjourned – Meeting adjourned at 1:35 pm

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Operations Committee Board Report
Quarterly Report for April, May and June 2019
Board Date 07/12/19

Action items:

- Approved Operations Committee Self-Evaluation results and made several small changes to Operations Committee's processes
- Commissioned task force to assess causal relationships in Autism services variations among CMHs and providers, and report findings, with recommendations to address discrepancies in service provision
- Approved appointment of Kalamazoo CMH staff person as representative of SWMBH area CMHs on state workgroup

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 and actions being taken to decrease expenditures
  - Reviewed Budget Assumptions and SWMBH/CMHSPs visits
  - Reviewed FY19 Contract Status/Updates
  - Reviewed Performance Based Incentive Pool 2018 Earnings
  - Reviewed Public Policy Committee Status/Updates
  - Managed Care Information Systems (MCIS) status, needs, and deadline
  - Assessment Tools and Behavioral Health (BH) Treatment Episode Data Set (TEDS) status and review
  - Utilization Management (UM) Managed Care Functional Review (MCFR) Steering Committee and Workgroup progress, recommendations, and implementation
  - Reviewed Autism Spectrum Disorder Services reports
  - Reviewed Grant Updates
  - Various updates from MDHHS regarding proposed Global Assessment of Individual's Needs (GAIN) implementation
  - Reviewed various SWMBH Policies
  - MDHHS 298 Unenrolled Updates
  - Review of MDHHS required Statewide Utilization Parity (MCG implementation)
  - Review 2019-2020 Board Ends Metrics – Strategic Imperatives
  - Reviewed Crisis residential services available in the region
  - Review of Service Use Evaluation (SUE) 2018 Reports
  - Reviewed results of Michigan Mission Based Performance Indicator System and state proposed changes to these standards
  - Hosted Alan Bolter of CMHAM who gave an update on state budget negotiations and other state policy matters
  - Reviewed Prevention Direct Services and Peer Services in region

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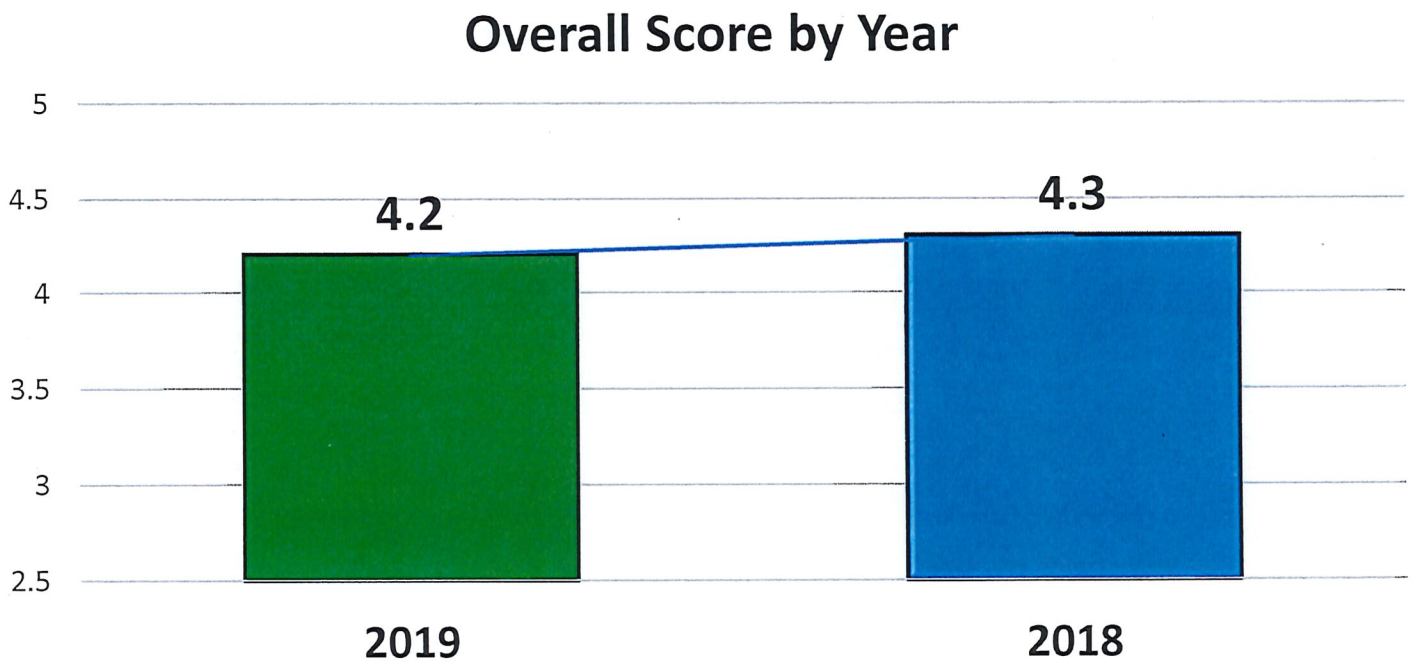
2018 Operations Committee Annual Self-Evaluation Summary Report

May 10, 2019

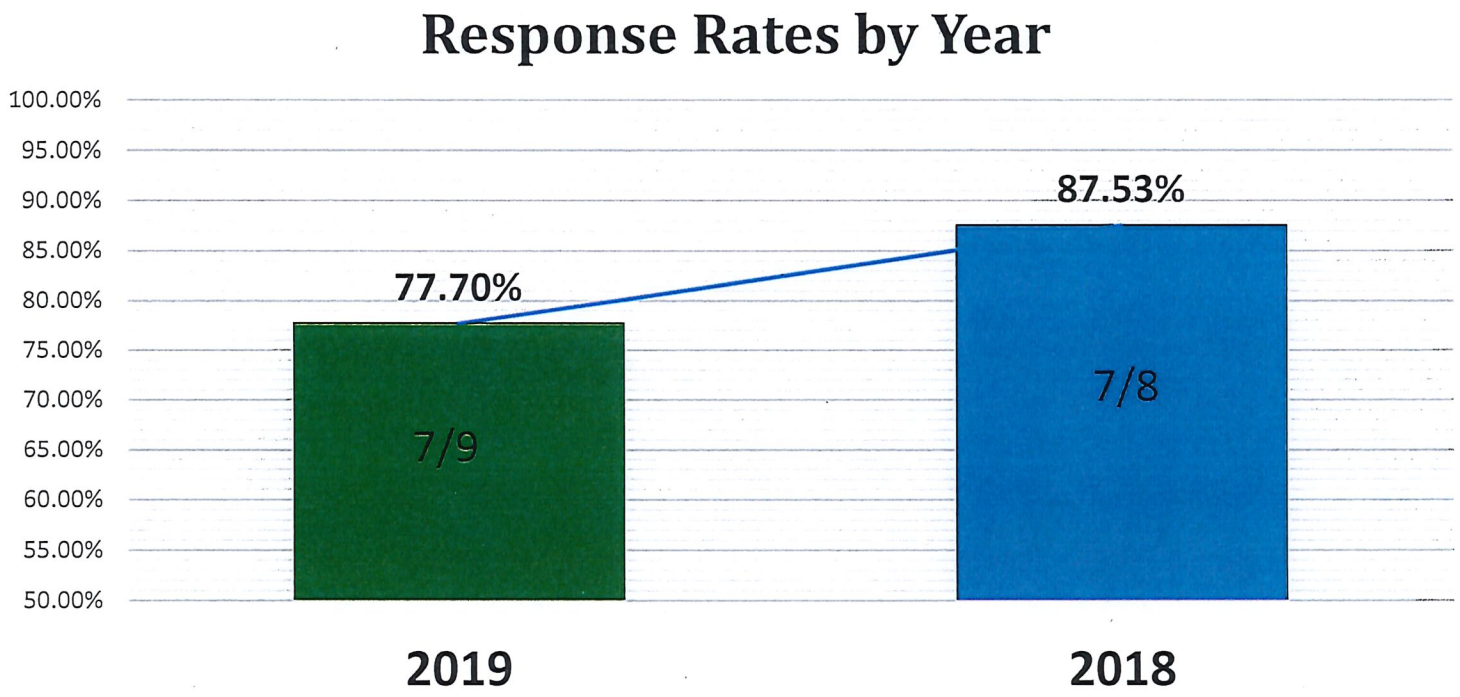
Operations Committee
Self Evaluation Summary Report

The Operations Committee performed its annual self-evaluation in March 2019 by confidential score submissions. The Scoring system was a 5 point scale, with 5 being strongly agree and 1 being strongly disagree. The overall average score for 16 questions is shown below, as well as a comparison of the previous years overall score.



Operations Committee
Self Evaluation Summary Report

- 2019 Self Evaluation = 77.7% response rate (7/9).
- 2018 Self Evaluation = 87.5% response rate (7/8).
- 9 of 16 questions saw a decrease in overall agreement, in comparison to 2018 Self Evaluation results.



Operations Committee
Self Evaluation Summary Report

The following are the (8) Categories and (16) Questions Represented on the Survey:

Goals or Purpose of Committee

1. All committee members understand the goals and purpose of our committee.

2. There is alignment between SWMBH's Goals, Mission, Vision & Values, and the purpose, scope and deliverables taken and/or the decisions made by the committee.

Support for the Committee

3. Our committee has adequate resources to support its function.

4. Our committee has the respect and support of key stakeholders (Board, Committees, Staff, etc.) within our organization.

Time and Location of Meetings

5. Our meetings are held regularly and with appropriate frequency.

6. Our meetings begin and end as scheduled.

Time and Location of Meetings

7. The length of our meetings is appropriate and respectful of the agenda.

8. We receive the meeting agenda and materials in advance of the meeting to allow for appropriate review and preparation

Operations Committee Self Evaluation Summary Report

Time and Location of Meetings

9. We consistently use our meeting time well. Issues get the time and attention proportionate to their importance.

10. The location where our meetings are held is conducive to positive group interaction and discussion.

11. The location where our meetings are held, provides suitable A/V support for our needs.

Attendance

12. Attendance at our meetings is consistent and members arrive on time.

Recording/Minutes

13. The minutes of our meetings are accurate and reflect the discussion, next steps and/or action items articulated by the members.

Membership

14. Our members treat each other with respect and courtesy.

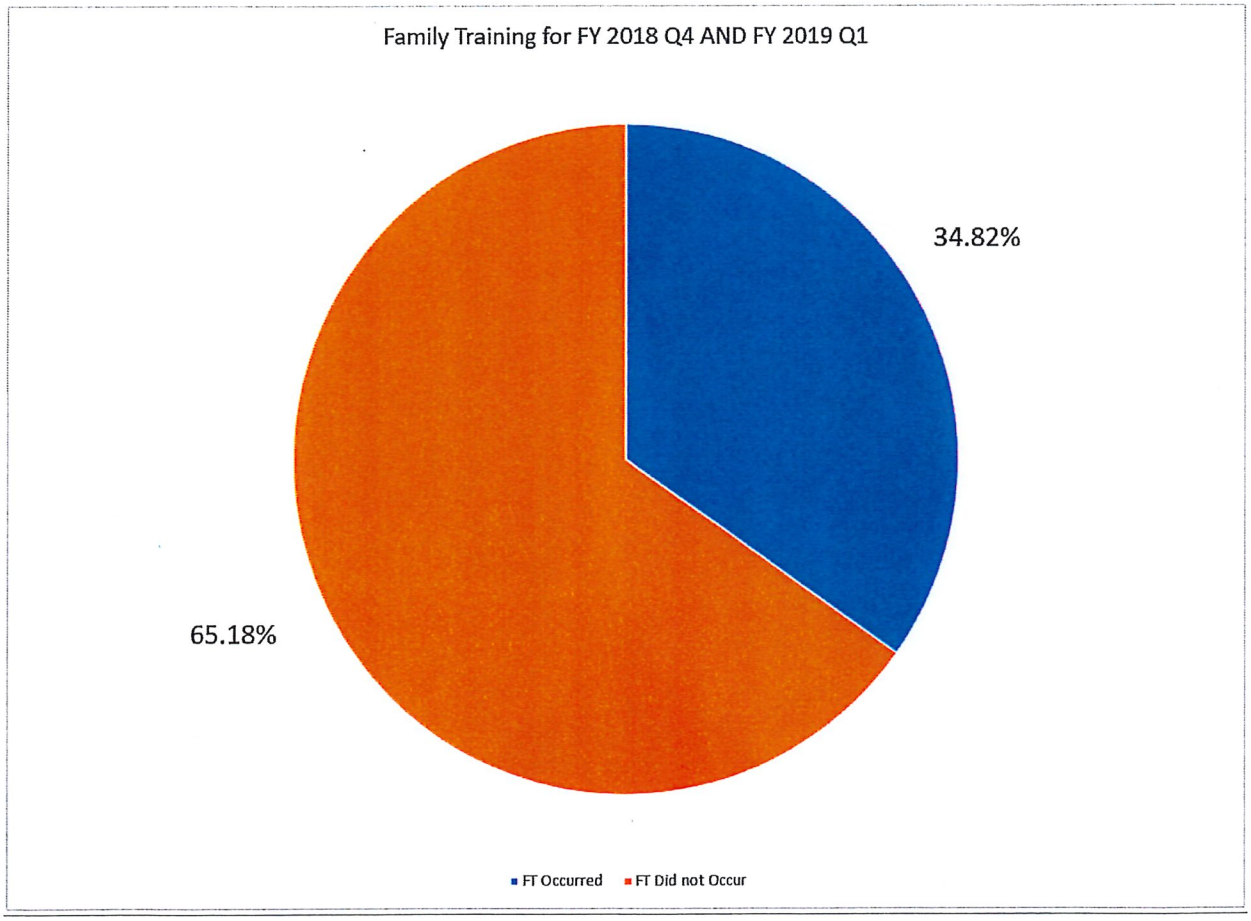
15. Our members come to meetings prepared and ready to contribute.

16. As a general rule, when I speak I feel listened to and that my comments are valued.

Family training is indicated to be one of the best ways to help clients receiving ABA services generalize the skills to the home environment. As such, improving the rate of provision for Family Training is a priority for the State, SWMBH, our CMHSP Partners, and our contracted ABA Providers.

8. At least 18% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Treatment Guidance at least once per quarter. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/18 - 9/30/19) Board Report Date: November 8, 2019 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter # of youth/young adults receiving ABA services	Current Baseline: 12% Source Query Codes: Individual: 0370T Group: 0371T

According to the SWMBH Encounter Data, as of 6/27/2019, 34.82% of our clients with encounter data received Family Training at least once per quarter when they were receiving ABA services.



Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy	Policy Number: BEL-005	Pages: 1
Subject: Treatment of Plan Members	Required By: Policy Governance	Accountability: SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 12.20.2013	Last Review Date: 3/9/18	Past Review Dates: 12.12.14, 1/8/16, 3/10/17

I. **PURPOSE:**

To clearly define the Treatment of Plan Members by SWMBH

II. **POLICY:**

With respect to interactions with Plan members, the SWMBH EO shall not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy.

III. **STANDARDS:**

Accordingly the EO may not:

1. Use forms or procedures that elicit information for which there is no clear necessity.
2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.
3. Fail to inform the Board of the status of uniform benefits across the region or fail to assist Participant CMHs towards compliance.
4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.
5. Fail to establish with Plan members a clear contract of what may be expected from SWMBH including but not limited to their rights and protections.
6. Fail to inform Plan members of this policy or to provide a grievance process to those plan members who believe that they have not been accorded a reasonable interpretation of their rights under this policy.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
For the period April 2018 to April 2019

Policy Number: BEL-005
Policy Name: Treatment of Plan Members
Assigned Reviewer: Moses Walker

Policy Purpose: To clearly define the Treatment of Plan Members by SWMBH.

Policy: With respect to interactions with Plan members, the SWMBH EO shall not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy.

EO Comment: I broadly interpret "Plan Member" as any past, present or potential future beneficiary of SWMBH-managed supports and services, including MI Health Link dual eligible (Medicare-Medicaid with Aetna Better Health and Meridian Health Plan as Integrated Care Organizations). Strictly speaking, our contractual obligations apply only to those in active Medicaid, Healthy Michigan, MI Health Link enrollment, or in Block Grant substance abuse prevention and treatment services. Enrollee Rights and Protections regulations for Medicaid are codified primarily in the federal Managed Care Regulations directly and via our contract with MDHHS, and in Michigan statute for persons with substance use disorders. Enrollee rights and protections for persons with Medicare, under the new MI Health Link program, are similarly codified in federal statute and regulations as well as the SWMBH contract with our two Integrated Care Organizations. Additional privacy, security and confidentiality protections are codified in multiple federal and state regulations.

Standards: Accordingly, the EO may not;

1. Use forms or procedures that elicit information for which there is no clear necessity.

EO Response: SWMBH requires no involuntary forms or procedures for which there is no clear necessity of Members other than those required by statutory, regulatory or contractual obligations. There are no Member complaints known to SWMBH related to this issue for the time period under consideration.

2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.

EO Response: All electronic and paper member information files at SWMBH are appropriately and securely stored, with "need-to-know" access to paper and electronic Protected Health Information (PHI) limited as related to job function(s). Managed Care Information System and other electronic storage access to PHI is strictly limited, individually assigned by job functions and auditable by individual. Log-ins and passwords are required for network and managed care information system applications; passwords are "change-forced" every ninety (90) days.

SWMBH has a designated Privacy Officer (Mila Todd) and Security Officer (Robert Moerland) as required under HIPAA regulations. SWMBH has a set of privacy, security and confidentiality related policies which staff receive, sign acknowledgements for, and undergo annual training related to, including federal regulations related to proper safeguarding and release of information rules for substance abuse information (42 CFR Part 2). Signed staff attestations will be made available upon request of the Reviewer. Paper records are stored in supervised locked cabinets within sight of staff. The main clinical area of SWMBH is further protected with a digital key lock with restricted access to the pass code. There are no known Member complaints or compliance inquiries stemming from SWMBH related to this issue in the period under consideration.

3. Fail to inform the Board of the status of uniform benefits across the region or fail to assist Participant CMHs towards compliance.

EO Response: The Board has periodically received penetration and access reports indicative of basic Uniform Benefit markers such as readiness of access, timeliness of care, utilization data and other measures. SWMBH completed, circulated and deliberated with multiple Committees several analytic reports on Service Use Evaluation (SUE); these were reviewed with the Board on 6/8/2018.

Little legitimate Michigan PIHP comparative data for benchmarking SWMBH benefits use exists in the area of utilization, especially where assessment of functioning, level of care and outcome is concerned. We continue to work with MDHHS and counterpart Regional Entities to prepare and present comparative data. There has recently emerged an analytic tool produced and published by Milliman which has more comparative data than was available in the past. Multiple evidence-based practices, (trauma informed care, seeking safety, helping men recovery, cognitive behavioral therapy, dialectical behavior therapy, motivational interviewing, parent management training), and consumer self-support tools, such as MyStrength, have been promoted throughout the region at both the provider and consumer level. Additional common functional assessment tools have been identified and installed region wide, such as LOCUS and ASAM for adult mental health and adult co-occurring (mental health and substance use disorders).

A network adequacy analysis is completed annually which includes geo-mapping of where providers are in relation to where consumers live. This information has been reviewed and addressed with the Performance Measure indicators meeting thresholds as proof of sufficient providers. SWMBH has initiated needs-based funding analyses which compare affiliates on penetration and utilization rates. Key to this effort will be the ongoing installation, real-time electronic reporting and analyses of common functional assessment, level of care and outcomes measurement tools across the Region.

This year's Customer Satisfaction results were favorable and were found to be achieved at the March 8, 2019 Board meeting. There are no Member complaints registered by or to SWMBH related to the issue of lack of uniform benefit for the period under consideration. All consumer complaints, grievances and appeals are tracked and trended by SWMBH. SWMBH reviews and, if warranted, defends actions on termination, reduction, suspension, or denials of services at the Fair Hearing.

4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.

EO Response: All electronic and non-electronic information transmission activities and network design and protections take place under applicable federal and state law and regulations, and established policies. Staff are instructed to manually encrypt all outgoing emails containing PHI by simply typing "[ecrypt]" into either the subject line or message body. If the outside agency uses Transport Layer Security (TLS), we can instruct our email system to utilize this encryption tunneling protocol instead.

Data transmission with external trading partners occurs via encryption with passwords, inspection of technical systems and actual processes are overseen by the Security Officer and Privacy Officer.

For the time period under review, forty-nine (49) actual or potential privacy incidents were reported and investigated by the Program Integrity and Compliance Department. Each incident was thereafter reviewed and considered by the SWMBH Breach Response Team which completed a Breach Risk Assessment Tool utilizing factors enumerated by the Federal Rules (45 CFR 164.402(2)) to assess the probability that the protected health information involved was compromised. These incidents are reported to the Board periodically during the Program Integrity and Compliance Program updates.
Of the forty-nine (49) incidents assessed, one incident was identified as rising to the level of a HIPAA breach and necessitating notification to the affected consumers and to the Office for Civil Rights (OCR). This notification occurred within 60 days of the end of the calendar year during which the breach occurred, pursuant to HIPAA and SWMBH Policy.

5. Fail to establish with Plan members a clear contract of what may be expected from SWMBH including but not limited to their rights and protections.

EO Response: The SWMBH Member Handbook delineates what services are mandatory, optional and alternative by Benefit Plan. It also states SWMBH's expectations of Providers in their Treatment of Plan Members. Ongoing Member education occurs via Newsletters and periodic EO and Leadership attendance at the SWMBH Customer Advisory Council. Periodic newsletters are prepared and distributed that update changes or clarify information to educate Plan Members. At intake, consumers sign to acknowledge receipt of the handbook. There are no known Member complaints related to this topic for the period under consideration.
During the review period one complaint was filed by a member to the State Office of Civil Rights (OCR). The complaint alleged a violation of the Americans with Disabilities Act. The OCR investigated, and the complaint was found to be unsubstantiated.

6. Fail to inform Plan members of this policy or to provide a grievance process to those plan members who believe that they have not been accorded a reasonable interpretation of their rights under this policy.

EO Response: The SWMBH Member Handbook delineates what issues are subject to complaints, grievance and appeals, as well as how to access the related processes. Member newsletters periodically reinforce this policy and how to file complaints, appeals and grievances. Participant CMH Customer Services representatives have been trained in their delegated roles and they receive ongoing oversight and monitoring from SWMBH. In addition, Customer Services, Provider Network Development, Clinical Quality, Compliance, and Quality Assurance and Program Integrity staff make periodic visits to affiliate CMHSPs and providers to monitor this as well. The SWMBH Customer Services Department completes, at a minimum, an annual complaint, grievance and appeal report that is provided to each Participant CMH for review, and annually to the SWMBH Board. The Treatment of Plan Members Policy is posted at SWMBH and reviewed in person with new staff by the EO. This Policy is available to all staff on the Shared Network Drive.

Related items offered for review:

- 2018 QAPI- UM Evaluation Overview for Board 4.12.19
- Breach Response Risk Assessment tool1
- 2018 Network MHL Network Adequacy Analysis
- Region 4 Network Adequacy Implementation Plan- FINAL
- Customer Handbook 2019 English
- SWMBH MI Health Link Handbook 2019
- CS FY data 2017-2018
- February and May Customer Advisory Committee Minutes

- 2019 SWMBH-PatientNewsletter

The assigned SWMBH Behavioral Health Board direct inspector, Mr. Walker, was offered further contact with the EO, Chief Administrative Officer and Manager of Customer Services.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

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INFORMATION TECHNOLOGY SECURITY ASSESSMENT

BOARD OF DIRECTORS REPORT
JUNE 2019

PROVIDED BY:

OPEN SYSTEMS TECHNOLOGIES

OST

An Information Technology Security Assessment was conducted for Southwest Michigan Behavioral Health on the 20th of June 2019. This report summarizes the ratings and recommendations related to this assessment.

Seventy-Nine (79) network devices were comprehensively scanned using a variety of tools. The team has determined that 5 high/critical vulnerabilities exist within the SWMBH network environment. A weighted vulnerability index of 0.063 has been assigned and a determination has been made that the exploitability related to the reported vulnerabilities is "Low".

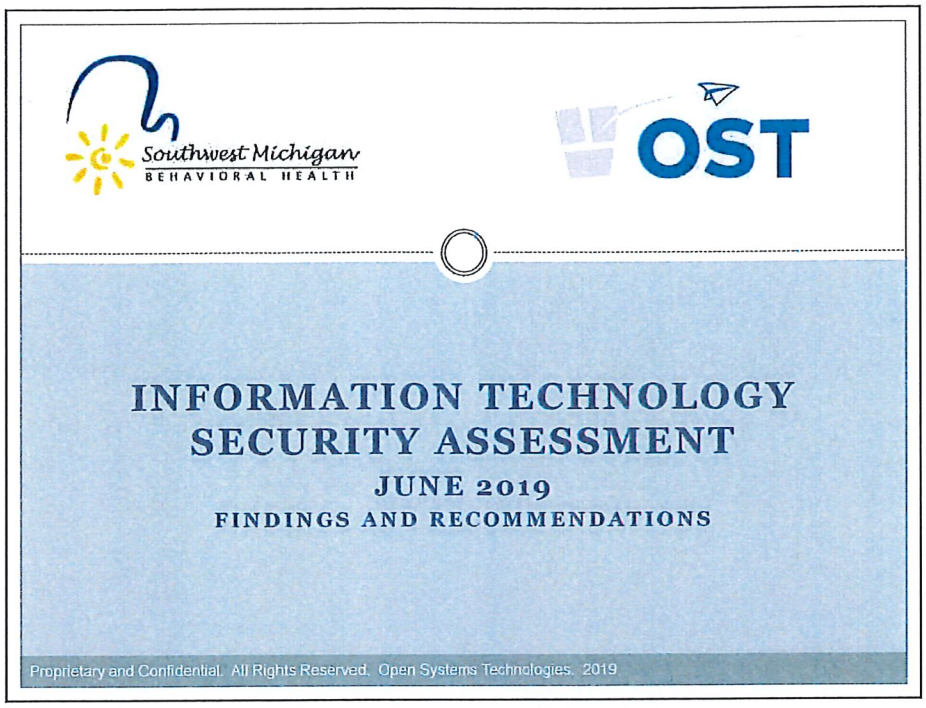
OST has provided the organization with detailed recommendations and information on how to reduce the risks that were identified from this assessment process.

Overall, SWMBH has been assigned a security rating of 7.8. A potential rating of 8.5 is possible. Improvements to the Final Security Rating will occur as IT related risk is removed from the organization.

A Periodic Security Assessment is recommended for June 2020.

Sincerely,

W. Scott Montgomery
Security Practice Manager
Open Systems Technologies


Southwest Michigan
BEHAVIORAL HEALTH
OST
INFORMATION TECHNOLOGY SECURITY ASSESSMENT
JUNE 2019
FINDINGS AND RECOMMENDATIONS
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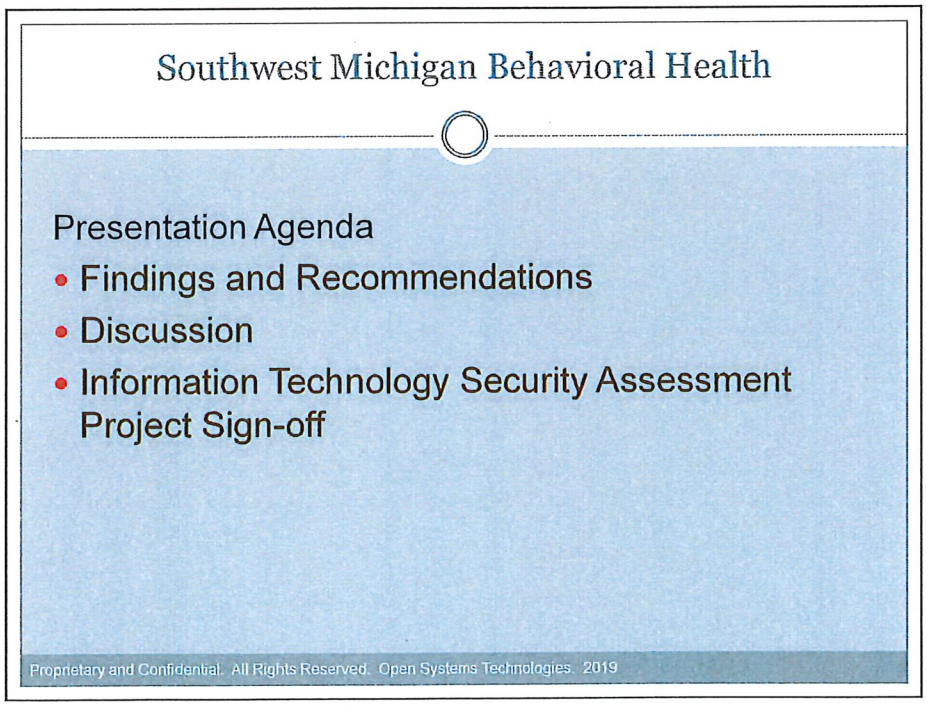
1


Southwest Michigan Behavioral Health
Presentation Agenda
Findings and Recommendations
Discussion
Information Technology Security Assessment Project Sign-off
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2

Findings and Recommendations

This presentation provides a summary of the activity that was performed as part of the Information Technology Security Assessment.

Specific technical details have purposely been left out of this presentation.

Please refer to the accompanying USB Flash Drive for all detail related to the information presented here.

3

Acknowledgements

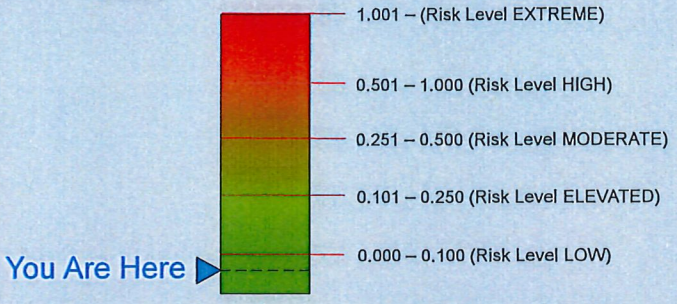
- Solid firewall protection.
- Low vulnerability index.
- Internet/Web filtering.

4

Findings and Recommendations

5 High/Critical Vulnerabilities identified on 79 IP Addresses

Vulnerability Index = 0.063



5

Findings and Recommendations

Security Issues

- Dropbear SSH vulnerabilities reported on two systems/devices.
- Authenticated scanning reports some missing updates (Oracle Java, Adobe Flash, etc.)
- One system/device reports the use of "public" as an SNMP Community String.
- SSL Version 2 and 3 Detected.

6

Findings and Recommendations

Physical Security Issues

Physical security is risk has been assigned a rating of Low.

7

Findings and Recommendations

Virus Protection

Antivirus was detected and up-to-date on each system.

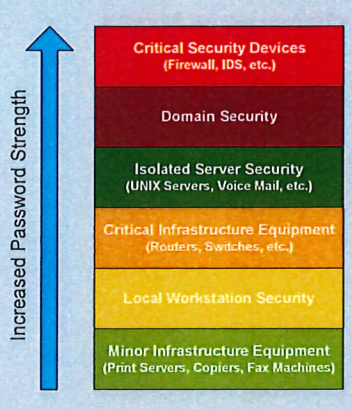
8

Findings and Recommendations

Classification

Provide unique passwords at all security levels within an enterprise.

Strong passwords should be used at all levels, but should also increase in complexity as the device(s) becomes more critical to overall security.



9

Findings and Recommendations

SpyWare

Spyware (Malware) protection: Workstations with internet access are prone to spyware infection. Spyware is quickly becoming a serious issue and is difficult to block. Spyware detection and removal tools are necessary to reduce the risk from this new threat.

Spyware can cause a wide variety of issues from slow, sluggish computer operation to key-logging.

Antivirus installation and web filtering are working to reduce this security threat by blocking and detecting many SpyWare variants.

10

Findings and Recommendations

External Exposure

The external vulnerability scanning and penetration testing processes did not identify any high or critical security issues.

11

Findings and Recommendations

System/Software Updates

The Windows Update process should be run on every Windows device. A minimum monthly process should be implemented to keep these systems up to date with the latest security patches.

This process is necessary for all workstations running Windows 7 and above. Microsoft Servers should Windows 2008 Server or higher.

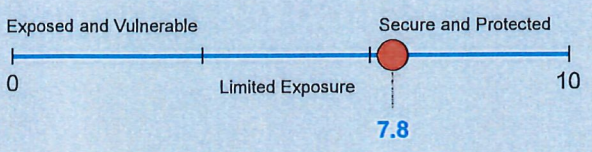
Microsoft support for the Windows 95, 98, ME, NT, 2000 and XP environment has reached an end. Windows 2003 Server has reached end-of-life. No further security patches will be made available for these operating systems.

Third-party applications should remain as up-to-date as possible. Update priorities should be placed on browser software, including plugins and all Adobe products.

12

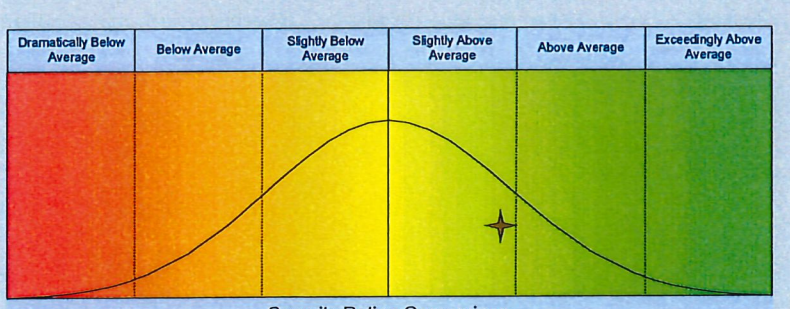
Final Security Rating

Final Security Rating



13

Statistical Distribution



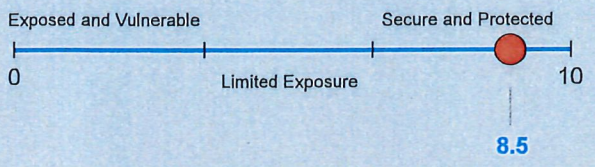
Security Rating Comparison

When compared to the overall security of similar organizations, you are rated Slightly Above Average.

14

Potential Security Rating

Final Network Security Rating can be increased upon implementation of recommendations shown on the next slide.



15

Recommendations (Prioritized)

- Upgrade to Dropbear SSH version 2016.74 or later to fix the reported vulnerabilities.
- Acquire O365 licensing to implement MFA and conditional access to prevent logins and activity from non-required geographies.
- Harden Microsoft Servers by removing un-necessary application software. Specifically software reporting vulnerabilities and missing updates/patches (Oracle Java, Adobe Flash, etc.)
- Disable the SNMP service on the remote host if you do not use it, or configure an organization-specific string.
- Update third party application software on workstations. Primarily Adobe Flash and Oracle Java. Review detailed scanning reports for all update requirements.
- Consult the application's documentation to disable SSL 2.0 and 3.0. Use TLS 1.1 (with approved cipher suites) or higher instead.

16

Recommendations (Advisable)

- A Periodic Security Assessment is recommended for June 2020.

Optimum security can be achieved by implementing these recommendations.

17

Discussion

18

Project Sign-Off

- Sign-Off document provides authorization for OST to close this project.
- Communicates satisfaction with project deliverables.

19

Conclusion

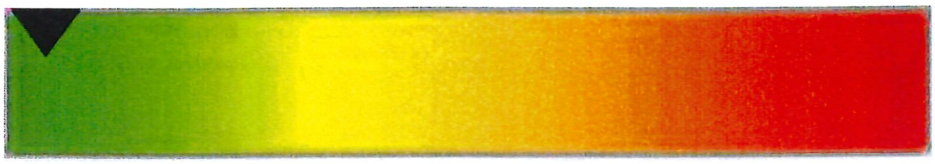
- Next steps?....

Thank You

20

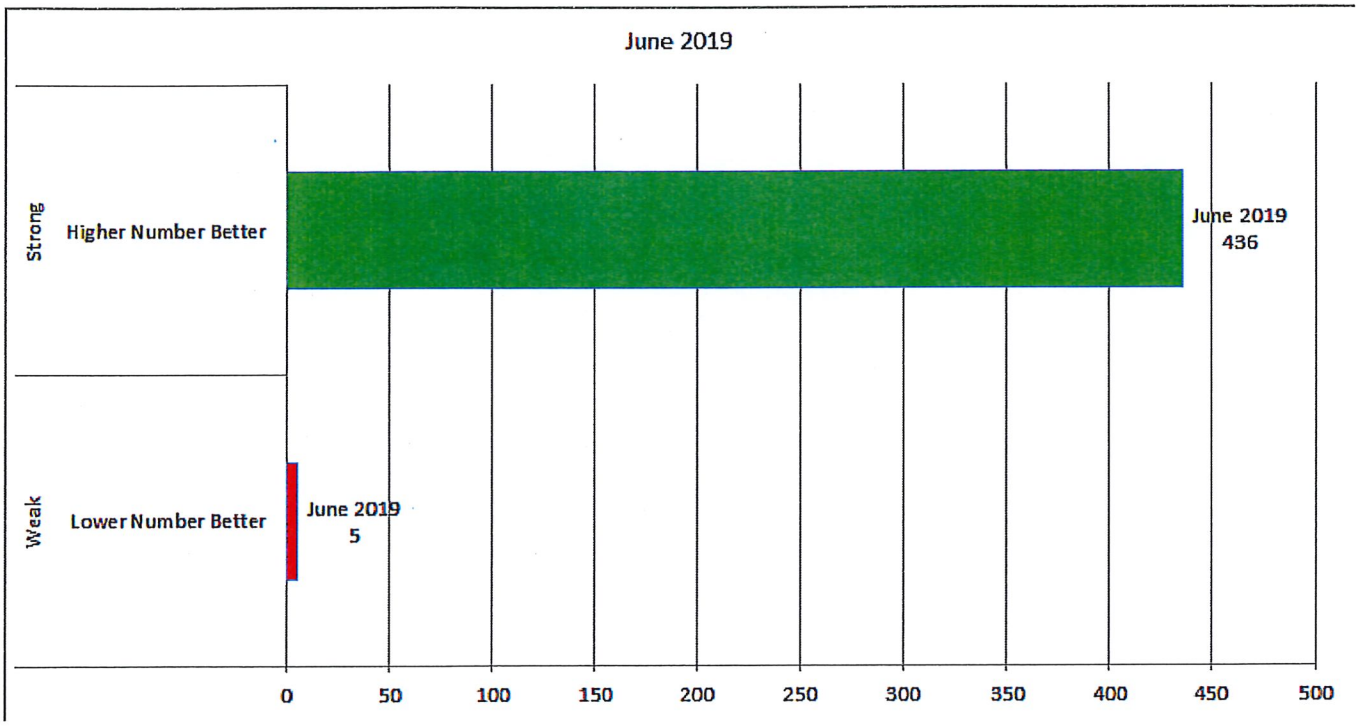
The following ratings have been assigned to the organization based on the information gathered and analyzed during this assessment process.

Domain Password Strength



Security Risk Level Low

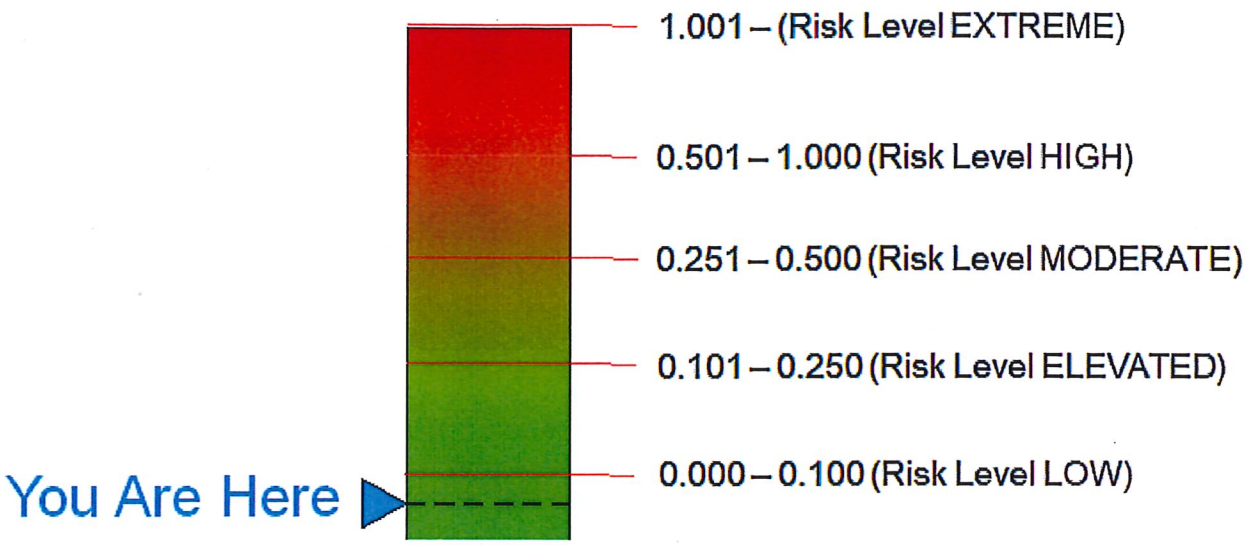
Password Strength History



Physical Security

Security Risk Level Low

System Vulnerability Index (Current 0.063)



Exploitability

Security Risk Level Low

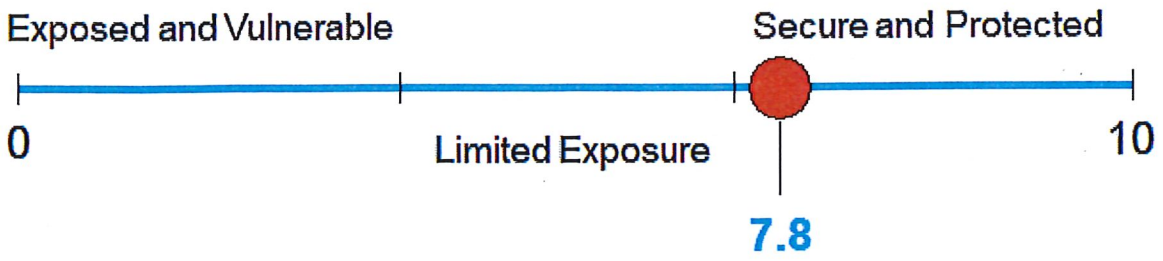
Wireless Networking Risk

Security Risk Level Low

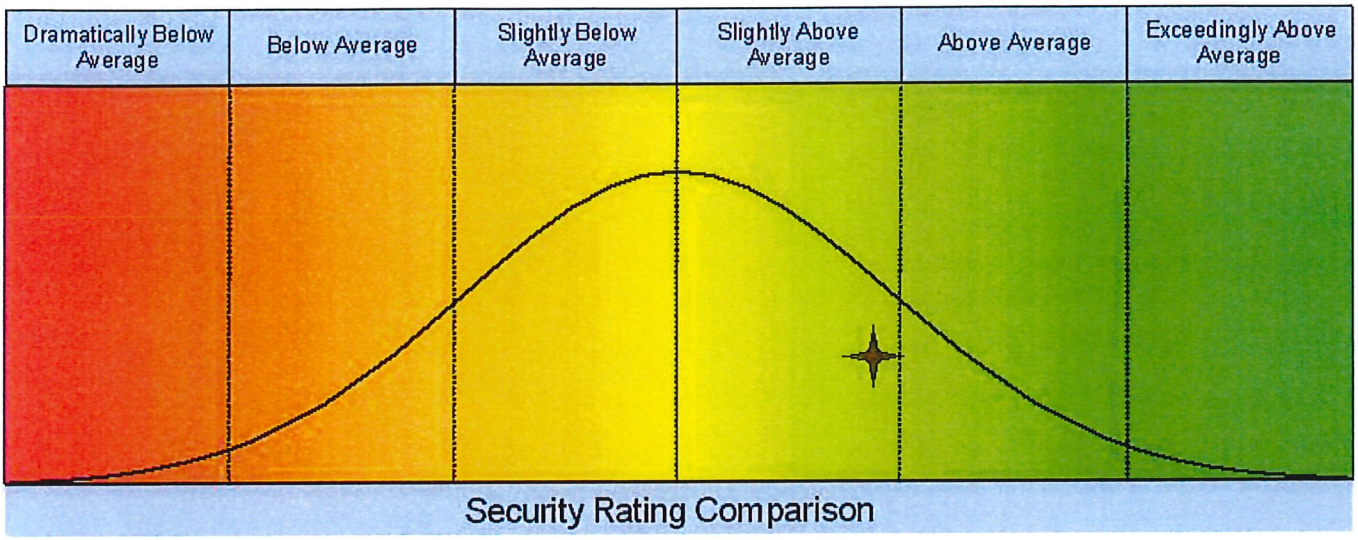
MalWare/Zero Day Virus Risk

Security Risk Level Elevated

Final Security Rating (Possible Maximum Rating of 8.5)



Comparative Results by Industry



	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	**Southwest Michigan Behavioral Health**					*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2019			P08FYTD19		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			172,032,650		134,121,276	20,572,974	8,041,791	2,263,368	5,815,127	1,218,115	-	-	-	
17	DHHS Incentive Payments			488,190		488,190	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			237,067		-	-	-	-	202,647	-	34,420	-	-	
19	Interest Income - Working Capital			127,585		-	-	-	-	-	-	127,585	-	-	
20	Interest Income - ISF Risk Reserve			34,850		-	-	-	-	-	-	34,850	-	-	
21	Local Funds Contributions			1,442,013		-	-	-	-	-	-	1,442,013	-	-	
22	Other Local Income			182,324		-	-	-	-	-	-	182,324	-	-	
23															
24	**TOTAL REVENUE**			174,544,680		134,609,466	20,572,974	8,041,791	2,263,368	6,017,774	1,218,115	1,821,193	-	-	
25															
26	**EXPENSE**														
27	Healthcare Cost														
28	Provider Claims Cost			15,612,879		2,563,795	3,893,129	-	2,461,372	5,376,596	1,317,988	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			139,513,943		114,693,724	12,937,151	10,434,502	1,096,468	352,098	-	-	-	-	
30	HICA and Use Tax Expense			1,710,234		1,632,810	77,425	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-		1,502,131	-	-	(1,502,131)	-	-	-			
33															
34	Total Healthcare Cost			156,941,923		120,497,324	16,907,705	10,434,502	2,055,709	5,728,694	1,317,988	-	-	-	
35	Medical Loss Ratio (HCC % of Revenue)			91.0%		89.5%	82.2%	129.8%	90.8%	98.5%	108.2%				
36															
37	Administrative Cost														
38	Purchased Professional Services			448,978		-	-	-	-	-	-	448,978	-	-	
39	Administrative and Other Cost			5,012,075		-	-	-	-	-	-	5,011,239	-	836	
41	Depreciation			73,053		-	-	-	-	-	-	73,053	-	-	
42	Functional Cost Reclassification			-		-	-	-	-	85,440	-	(85,440)	-	-	
43	Allocated Indirect Pooled Cost			(0)		-	-	-	-	-	-	836	-	(836)	
44	Delegated Managed Care Admin			10,563,201		8,717,035	972,190	790,930	83,046	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			-		4,106,934	589,479	365,468	124,613	203,640	-	(5,390,134)	-	-	
46															
47	Total Administrative Cost			16,097,307		12,823,969	1,561,669	1,156,398	207,659	289,080	-	58,532	-	-	
48	Admin Cost Ratio (MCA % of Total Cost)			9.3%		9.6%	8.5%	10.0%	9.2%	4.8%	0.0%	3.1%			
49															
50	Local Funds Contribution			1,442,013		-	-	-	-	-	-	1,442,013	-	-	
51															
52	**TOTAL COST after apportionment**			174,481,243		133,321,294	18,469,374	11,590,900	2,263,368	6,017,774	1,317,988	1,500,545	-	-	
53															
54	**NET SURPLUS before settlement**			63,437		1,288,173	2,103,599	(3,549,110)	-	-	(99,873)	320,648	-	-	
55	Net Surplus (Deficit) % of Revenue			0.0%		1.0%	10.2%	-44.1%	0.0%	0.0%	-8.2%	17.6%			
56															
57	Prior Year Savings			-		-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			99,873		-	-	-	-	-	99,873	-			
59	ISF Risk Reserve Abatement (Funding)			(34,850)		-	-	-	-	-	-	(34,850)			
60	ISF Risk Reserve Deficit (Funding)			157,338		157,338	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-		(1,445,510)	(2,103,599)	3,549,110	-	-	-	-			
62	**NET SURPLUS (DEFICIT)**			285,797		-	-	-	-	-	-	285,797	-	-	
63	*HMP & Autism is settled with Medicaid*														
64															
65	SUMMARY OF NET SURPLUS (DEFICIT)														
66	Prior Year Unspent Savings			-		-	-	-	-	-	-	-			
67	Current Year Savings			-		-	-	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-		-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			285,797		-	-	-	-	-	-	285,797	-	-	
70															
71	**NET SURPLUS (DEFICIT)**			285,797		-	-	-	-	-	-	285,797	-	-	
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 5/31/2019			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%*	79.1%	76.7%	79.7%	73.9%	75.6%	82.3%	81.3%	80.9%	79.2%
7	Subcontract Revenue		134,121,276	10,099,761	124,021,515	5,045,990	24,604,920	6,531,595	22,978,902	6,685,338	37,827,008	8,437,882	11,909,880
8	Incentive Payment Revenue		488,190	44,967	443,223	7,429	34,000	22,826	70,353	3,754	270,359	16,499	18,003
9	**Contract Revenue**		134,609,466	10,144,728	124,464,738	5,053,419	24,638,920	6,554,421	23,049,256	6,689,092	38,097,367	8,454,381	11,927,882
10													
11	External Provider Cost		86,442,101	2,563,795	83,878,306	2,744,570	16,125,632	4,304,893	14,514,398	3,955,233	30,633,643	5,146,291	6,453,647
12	Internal Program Cost		32,597,549	-	32,597,549	2,306,285	6,839,255	1,794,259	6,352,663	2,095,607	4,998,477	3,136,509	5,074,496
13	SSI Reimb, 1st/3rd Party Cost Offset		(689,548)	-	(689,548)	(43,767)	(146,777)	(33,752)	(157,377)	(25,197)	(202,745)	(21,475)	(58,460)
14	HICA & Use Tax, HRA		1,737,675	1,737,675	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		322,617	322,617	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		120,410,394	4,624,087	115,786,307	5,007,087	22,818,110	6,065,400	20,709,684	6,025,643	35,429,375	8,261,325	11,469,683
17	**Medical Loss Ratio (HCC % of Revenue)**		89.5%	45.6%	93.0%	99.1%	92.6%	92.5%	89.8%	90.1%	93.0%	97.7%	96.2%
18													
19	**Managed Care Administration**		12,907,015	4,106,934	8,800,080	389,762	1,831,920	485,133	1,408,984	470,212	2,960,926	488,046	765,098
20	**Admin Cost Ratio (MCA % of Total Cost)**		9.7%	3.1%	6.6%	7.2%	7.4%	7.4%	6.4%	7.2%	7.7%	5.6%	6.3%
21													
22	**Contract Cost**		133,317,409	8,731,022	124,586,387	5,396,850	24,650,030	6,550,533	22,118,668	6,495,855	38,390,301	8,749,371	12,234,780
23	**Net before Settlement**		1,292,057	1,413,707	(121,649)	(343,430)	(11,110)	3,888	930,588	193,237	(292,934)	(294,990)	(306,898)
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(1,445,510)	(1,567,160)	121,649	343,430	11,110	(3,888)	(930,588)	(193,237)	292,934	294,990	306,898
28	**Net after Settlement**		(153,453)	(153,453)	(0)	-	-	-	-	-	-	-	-
~~29~~													
30	**Eligibles and PMPM**												
31	Average Eligibles		146,440	146,440	146,440	7,565	28,596	8,126	27,474	8,544	38,632	11,995	15,508
32	Revenue PMPM		$ 114.90	$ 8.66	$ 106.24	$ 83.50	$ 107.70	$ 100.82	$ 104.87	$ 97.86	$ 123.27	$ 88.10	$ 96.14
33	Expense PMPM		$ 113.80	$ 7.45	$ 106.35	$ 89.17	$ 107.75	$ 100.77	$ 100.63	$ 95.04	$ 124.22	$ 91.18	$ 98.62
34	Margin PMPM		$ 1.10	$ 1.21	$ (0.10)	$ (5.67)	$ (0.05)	$ 0.06	$ 4.23	$ 2.83	$ (0.95)	$ (3.07)	$ (2.47)
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		146,440	146,440	146,440	7,565	28,596	8,126	27,474	8,544	38,632	11,995	15,508
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)		(1,967)	(1,967)	(1,967)	44	(376)	(311)	(439)	(6)	(491)	(227)	(161)
43	% Variance - Fav / (Unfav)		-1.3%	-1.3%	-1.3%	0.6%	-1.3%	-3.7%	-1.6%	-0.1%	-1.3%	-1.9%	-1.0%
44													
45	**Contract Revenue before settlement**												
46	Actual		134,609,466	10,144,728	124,464,738	5,053,419	24,638,920	6,554,421	23,049,256	6,689,092	38,097,367	8,454,381	11,927,882
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)		(1,436,433)	(1,349,964)	(86,469)	122,501	(158,506)	(105,065)	193,854	187,518	(412,773)	93,734	(7,732)
49	% Variance - Fav / (Unfav)		-1.1%	-11.7%	-0.1%	2.5%	-0.6%	-1.6%	0.8%	2.9%	-1.1%	1.1%	-0.1%
50													
51	**Healthcare Cost**												
52	Actual		120,410,394	4,624,087	115,786,307	5,007,087	22,818,110	6,065,400	20,709,684	6,025,643	35,429,375	8,261,325	11,469,683
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)		6,689,095	2,262,608	4,426,487	177,030	1,483,932	307,408	720,154	145,540	1,007,631	386,515	198,278
55	% Variance - Fav / (Unfav)		5.3%	32.9%	3.7%	3.4%	6.1%	4.8%	3.4%	2.4%	2.8%	4.5%	1.7%
56													
57	**Managed Care Administration**												
58	Actual		12,907,015	4,106,934	8,800,080	389,762	1,831,920	485,133	1,408,984	470,212	2,960,926	488,046	765,098

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5													
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)		816,828	538,352	278,476	(3,727)	(20,396)	47,075	137,640	2,646	102,092	51,903	(38,758)
61	% Variance - Fav / (Unfav)		6.0%	11.6%	3.1%	-1.0%	-1.1%	8.8%	8.9%	0.6%	3.3%	9.6%	-5.3%
62													
63	**Total Contract Cost**												
64	Actual		133,317,409	8,731,022	124,586,387	5,396,850	24,650,030	6,550,533	22,118,668	6,495,855	38,390,301	8,749,371	12,234,780
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)		7,505,923	2,800,960	4,704,963	173,303	1,463,536	354,483	857,794	148,186	1,109,723	438,418	159,520
67	% Variance - Fav / (Unfav)		5.3%	24.3%	3.6%	3.1%	5.6%	5.1%	3.7%	2.2%	2.8%	4.8%	1.3%
68													
69	**Net before Settlement**												
70	Actual		1,292,057	1,413,707	(121,649)	(343,430)	(11,110)	3,888	930,588	193,237	(292,934)	(294,990)	(306,898)
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)		6,069,490	1,450,996	4,618,494	295,804	1,305,030	249,418	1,051,647	335,704	696,950	532,152	151,788
73													
74													

41

	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 5/31/2019			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%*	8.8%	12.2%	6.5%	12.4%	11.9%	7.9%	7.9%	9.8%	6.7%
76	Contract Revenue		20,572,974	3,714,089	16,858,884	837,672	3,444,127	795,236	3,075,064	992,860	4,751,488	1,288,085	1,674,352
77													
78	External Provider Cost		10,692,575	3,893,129	6,799,446	292,943	817,664	562,208	1,475,755	274,343	2,548,469	387,982	440,082
79	Internal Program Cost		6,137,705	-	6,137,705	506,645	1,057,824	452,194	1,781,669	307,230	895,255	612,701	524,188
80	HICA & Use Tax		77,425	77,425	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		16,907,705	3,970,554	12,937,151	799,587	1,875,488	1,014,402	3,257,424	581,573	3,443,724	1,000,684	964,270
82	**Medical Loss Ratio (HCC % of Revenue)**		82.2%	106.9%	76.7%	95.5%	54.5%	127.6%	105.9%	58.6%	72.5%	77.7%	57.6%
83													
84	**Managed Care Administration**		1,561,669	589,479	972,190	62,242	150,571	81,136	221,619	45,383	287,801	59,116	64,323
85	**Admin Cost Ratio (MCA % of Total Cost)**		8.5%	3.2%	5.3%	7.2%	7.4%	7.4%	6.4%	7.2%	7.7%	5.6%	6.3%
86													
87	**Contract Cost**		18,469,374	4,560,033	13,909,341	861,829	2,026,059	1,095,538	3,479,043	626,956	3,731,525	1,059,800	1,028,593
88	**Net before Settlement**		2,103,599	(845,944)	2,949,543	(24,156)	1,418,068	(300,301)	(403,979)	365,903	1,019,963	228,285	645,759
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(2,103,599)	845,944	(2,949,543)	24,156	(1,418,068)	300,301	403,979	(365,903)	(1,019,963)	(228,285)	(645,759)
93	**Net after Settlement**		(0)	(0)	-	-	-	-	-	-	-	-	-
94													
95	Eligibles and PMPM												
96	Average Eligibles		50,234	50,234	50,234	2,524	10,276	2,399	9,083	2,982	14,112	3,839	5,019
97	Revenue PMPM		$ 51.19	$ 9.24	$ 41.95	$ 41.49	$ 41.89	$ 41.44	$ 42.32	$ 41.63	$ 42.09	$ 41.94	$ 41.70
98	Expense PMPM		45.96	11.35	34.61	42.69	24.65	57.09	47.88	26.29	33.05	34.51	25.62
99	Margin PMPM		$ 5.23	$ (2.11)	$ 7.34	$ (1.20)	$ 17.25	$ (15.65)	$ (5.56)	$ 15.34	$ 9.03	$ 7.43	$ 16.08
100													
101	**Healthy Michigan Plan**												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
105	Actual		50,234	50,234	50,234	2,524	10,276	2,399	9,083	2,982	14,112	3,839	5,019
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)		(1,336)	(1,336)	(1,336)	11	(134)	(32)	(85)	7	(940)	(78)	(84)
108	% Variance - Fav / (Unfav)		-2.6%	-2.6%	-2.6%	0.4%	-1.3%	-1.3%	-0.9%	0.2%	-6.2%	-2.0%	-1.6%
109													
110	Contract Revenue before settlement												
111	Actual		20,572,974	3,714,089	16,858,884	837,672	3,444,127	795,236	3,075,064	992,860	4,751,488	1,288,085	1,674,352
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)		1,221,630	369,957	851,674	64,835	214,424	45,085	210,688	80,653	51,747	76,845	107,397
114	% Variance - Fav / (Unfav)		6.3%	11.1%	5.3%	8.4%	6.6%	6.0%	7.4%	8.8%	1.1%	6.3%	6.9%
115													
116	Healthcare Cost												
117	Actual		16,907,705	3,970,554	12,937,151	799,587	1,875,488	1,014,402	3,257,424	581,573	3,443,724	1,000,684	964,270
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)		(155,889)	(95,203)	(60,686)	120,915	50,148	(170,516)	(81,557)	73,383	(24,871)	(223,808)	195,620
120	% Variance - Fav / (Unfav)		-0.9%	-2.5%	-0.5%	13.1%	2.6%	-20.2%	-2.6%	11.2%	-0.7%	-28.8%	16.9%
121													
122	Managed Care Administration												
123	Actual		1,561,669	589,479	972,190	62,242	150,571	81,136	221,619	45,383	287,801	59,116	64,323
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)		42,102	44,229	(2,127)	6,304	(7,030)	(10,661)	7,588	4,802	(401)	(10,610)	7,881
126	% Variance - Fav / (Unfav)		2.6%	7.0%	-0.2%	9.2%	-4.9%	-15.1%	3.3%	9.6%	-0.1%	-21.9%	10.9%
127													

	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 5/31/2019			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													
128	Total Contract Cost												
129	Actual		18,469,374	4,560,033	13,909,341	861,829	2,026,059	1,095,538	3,479,043	626,956	3,731,525	1,059,800	1,028,593
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)		(113,787)	(50,974)	(62,813)	127,219	43,118	(181,176)	(73,969)	78,185	(25,272)	(234,419)	203,501
132	% Variance - Fav / (Unfav)		-0.6%	-1.1%	-0.5%	12.9%	2.1%	-19.8%	-2.2%	11.1%	-0.7%	-28.4%	16.5%
133													
134	Net before Settlement												
135	Actual		2,103,599	(845,944)	2,949,543	(24,156)	1,418,068	(300,301)	(403,979)	365,903	1,019,963	228,285	645,759
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)		1,107,843	318,982	788,861	192,054	257,542	(136,092)	136,719	158,838	26,475	(157,574)	310,898
138													
139		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2019			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%*	7.1%	6.1%	9.6%	9.1%	6.6%	4.0%	5.7%	5.8%	9.3%
141	Contract Revenue		8,041,791	30,425	8,011,366	422,102	1,477,944	443,072	1,450,017	406,104	2,354,357	656,786	800,983
142													
143	External Provider Cost		8,820,505	-	8,820,505	-	2,736,088	733,848	705,523	288,177	2,499,794	588,051	1,269,024
144	Internal Program Cost		1,613,997	-	1,613,997	397,229	1,696	16,367	1,114,384	1,771	-	6,639	75,911
145	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
146	Total Healthcare Cost		10,434,502	-	10,434,502	397,229	2,737,785	750,215	1,819,907	289,947	2,499,794	594,690	1,344,935
147	Medical Loss Ratio (HCC % of Revenue)		129.8%	0.0%	130.2%	94.1%	185.2%	169.3%	125.5%	71.4%	106.2%	90.5%	167.9%
148													
149	Managed Care Administration		1,156,398	365,468	790,930	30,921	219,799	60,005	123,817	22,626	208,914	35,132	89,715
150	Admin Cost Ratio (MCA % of Total Cost)		10.0%	3.2%	6.8%	7.2%	7.4%	7.4%	6.4%	7.2%	7.7%	5.6%	6.3%
151													
152	Contract Cost		11,590,900	365,468	11,225,433	428,150	2,957,584	810,220	1,943,725	312,574	2,708,709	629,822	1,434,650
153	Net before Settlement		(3,549,110)	(335,043)	(3,214,067)	(6,048)	(1,479,640)	(367,147)	(493,707)	93,530	(354,352)	26,964	(633,667)
154	Contract Settlement / Redistribution		3,549,110	335,043	3,214,067	6,048	1,479,640	367,147	493,707	(93,530)	354,352	(26,964)	633,667
155	Net after Settlement		-	0	-	-	-	-	-	-	-	-	-
156													
157		x											
158	**SUD Block Grant Treatment**			*HCC%*	0.2%	0.7%	0.4%	0.4%	0.0%	0.5%	0.0%	0.7%	0.3%
159	Contract Revenue		5,815,127	4,933,640	881,487	60,962	315,337	23,307	-	93,817	180,774	127,508	79,783
160													
161	External Provider Cost		5,376,596	5,376,596	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		352,098	-	352,098	46,122	126,832	32,166	-	33,228	2,467	70,760	40,525
163	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
164	Total Healthcare Cost		5,728,694	5,376,596	352,098	46,122	126,832	32,166	-	33,228	2,467	70,760	40,525
165	Medical Loss Ratio (HCC % of Revenue)		98.5%	109.0%	39.9%	75.7%	40.2%	138.0%	0.0%	35.4%	1.4%	55.5%	50.8%
166													
167	Managed Care Administration		86,433	86,433	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		1.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	Contract Cost		5,815,127	5,463,029	352,098	46,122	126,832	32,166	-	33,228	2,467	70,760	40,525
171	Net before Settlement		-	(529,389)	529,389	14,840	188,506	(8,859)	-	60,589	178,307	56,748	39,258
172	Contract Settlement		-	529,389	(529,389)	(14,840)	(188,506)	8,859	-	(60,589)	(178,307)	(56,748)	(39,258)
173	Net after Settlement		-	-	-	-	-	-	-	-	-	-	-
174													
175		x	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2019			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		168,551,168	18,777,915	149,773,253	6,366,727	29,842,328	7,793,210	27,503,984	8,178,118	45,113,627	10,510,261	14,464,998
178	Incentive Payment Revenue		488,190	44,967	443,223	7,429	34,000	22,826	70,353	3,754	270,359	16,499	18,003
179	**Contract Revenue**		**169,039,358**	**18,822,882**	**150,216,476**	**6,374,155**	**29,876,328**	**7,816,036**	**27,574,337**	**8,181,872**	**45,383,986**	**10,526,760**	**14,483,000**
180													
181	External Provider Cost		111,331,777	11,833,520	99,498,257	3,037,513	19,679,384	5,600,949	16,695,676	4,517,753	35,681,906	6,122,324	8,162,753
182	Internal Program Cost		40,701,349	-	40,701,349	3,256,280	8,025,606	2,294,986	9,248,716	2,437,835	5,896,198	3,826,609	5,715,119
183	SSI Reimb, 1st/3rd Party Cost Offset		(689,548)	-	(689,548)	(43,767)	(146,777)	(33,752)	(157,377)	(25,197)	(202,745)	(21,475)	(58,460)
184	HICA & Use Tax, HRA		1,815,100	1,815,100	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		322,617	322,617	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**153,481,296**	**13,971,237**	**139,510,059**	**6,250,025**	**27,558,214**	**7,862,183**	**25,787,015**	**6,930,391**	**41,375,360**	**9,927,458**	**13,819,412**
187	**Medical Loss Ratio (HCC % of Revenue)**		**90.8%**	**74.2%**	**92.9%**	**98.1%**	**92.2%**	**100.6%**	**93.5%**	**84.7%**	**91.2%**	**94.3%**	**95.4%**
188													
189	**Managed Care Administration**		**15,711,515**	**5,148,314**	**10,563,201**	**482,925**	**2,202,290**	**626,273**	**1,754,420**	**538,221**	**3,457,642**	**582,294**	**919,135**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**3.0%**	**6.2%**	**7.2%**	**7.4%**	**7.4%**	**6.4%**	**7.2%**	**7.7%**	**5.5%**	**6.2%**
191													
192	**Contract Cost**		**169,192,811**	**19,119,552**	**150,073,259**	**6,732,950**	**29,760,504**	**8,488,456**	**27,541,435**	**7,468,612**	**44,833,001**	**10,509,752**	**14,738,548**
193	**Net before Settlement**		**(153,453)**	**(296,669)**	**143,216**	**(358,795)**	**115,824**	**(672,420)**	**32,902**	**713,260**	**550,985**	**17,008**	**(255,548)**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		-	143,216	(143,216)	358,795	(115,824)	672,420	(32,902)	(713,260)	(550,985)	(17,008)	255,548
198	**Net after Settlement**		**(153,453)**	**(153,453)**	**(0)**	**-**	**0**	**-**	**(0)**	**(0)**	**(0)**	**(0)**	**0**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 5/31/2019			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%*	4.7%	4.3%	3.8%	4.2%	5.9%	5.3%	5.1%	2.8%	4.6%
202	Contract Revenue				7,145,292	434,576	1,220,118	414,977	1,386,380	419,096	2,403,104	296,825	570,216
203													
204	External Provider Cost				2,701,018	128,614	268,092	97,588	270,553	254,336	1,441,934	191,896	48,005
205	Internal Program Cost				4,289,464	153,189	815,992	243,775	1,346,581	136,536	878,612	96,298	618,481
206	SSI Reimb, 1st/3rd Party Cost Offset				(100,863)	-	-	-	-	-	(100,863)	-	-
207	**Total Healthcare Cost**				6,889,618	281,804	1,084,083	341,363	1,617,134	390,872	2,219,683	288,194	666,485
208	**Medical Loss Ratio (HCC % of Revenue)**				96.4%	64.8%	88.9%	82.3%	116.6%	93.3%	92.4%	97.1%	116.9%
209													
210	**Managed Care Administration**				584,131	24,345	97,363	30,283	122,053	33,612	208,048	19,042	49,384
211	**Admin Cost Ratio (MCA % of Total Cost)**				7.8%	8.0%	8.2%	8.1%	7.0%	7.9%	8.6%	6.2%	6.9%
212													
213	**Contract Cost**				7,473,749	306,149	1,181,446	371,646	1,739,187	424,484	2,427,731	307,236	715,869
214	**Net before Settlement**				(328,457)	128,427	38,672	43,331	(352,807)	(5,388)	(24,627)	(10,411)	(145,653)
215													
216	Other Redistributions of State GF				(98,270)	31,147	-	(191)	(7,179)	-	(101,464)	-	(20,582)
217	Contract Settlement				(156,580)	(120,361)	-	(36,219)	-	-	-	-	-
218	**Net after Settlement**				(583,307)	39,213	38,672	6,920	(359,987)	(5,388)	(126,091)	(10,411)	(166,235)
219													

Southwest Michigan
BEHAVIORAL HEALTH

Michigan Consortium for Healthcare Excellence
SWMBH Executive Officer Board Report

Inclusive of non-MCHE PIHP Collaborations
For period January 2019 through June 2019

July 12, 2019

MCHE Activity January 2019 – June 2019

Board Meetings

- January 10, 2019
- March 7, 2019
- May 2, 2019

External Contacts Under Development or Complete

- Statewide Portal-Support with Oakland County Community Mental Health Authority-completed
- Statewide Utilization Management Parity Software system selected-MCG-completed
- Michigan Department of Corrections (MDOC) Substance Use Disorder (SUD) - each PIHP will have a contract with MDOC for community-based MDOC sponsored and paid SUD services for supervisees (parolees and probationers). Now evolving to inclusion of DOC SUD into PIHP DHHS Agreement.

Ongoing

- Continue work with Michigan Association of Community Mental Health (MACMH) regarding Substance Abuse Prevention and Treatment public policy advocacy and lobbying and roles of Michigan Consortium for Healthcare Excellence
- Continue to attend and work with Advocates regarding Self Determination, Person Centered Planning, and Fiscal Intermediaries
- Provided ten PIHP Fiscal Year 2018 and Fiscal Year 2019 YTD financial status to many stakeholders.

MCHE Activity January 2019 – June 2019

Initiatives

Ongoing Work Groups

- Managed Care Regulations (all Prepaid Inpatient Health Plans (PIHPs)-Terminated; work completed.
- Reciprocity: Direct Care Worker Training (all PIHPs). PIHP MOU signed.
- Reciprocity: Provider Reviews and Audits (all PIHPs).. Underway for more provider types.
- Behavioral Health Advocate Community Representatives (all PIHPs)
- SAPT (Substance Abuse Prevention and Treatment) Advocacy
- Statewide Portal
- Inpatient Psychiatric Bed Inventory Management-waiting on DHHS

Why Collaborate?

- Enhance public policy influence via collective consensus views and advocacy with executive branch
- Enhance collective and individual relations with Advocacy groups and individuals
- Share scarce resources
- Share operational and performance information for quality improvement and benchmarking
- Reduce provider burdens and provider administrative costs
- Reduce PIHP administrative costs
- Identify and pursue system opportunities

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
Kalamazoo Valley Community College Groves Center
7107 Elm Valley Drive, Room B1100
Kalamazoo, MI 49009
Dial in: 1-844-655-0022
Access Code: 738 811 844
September 13, 2019
9:30 am to 11:30 am
6/24/19

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d) (pg.1)**
3. **Recess Board Meeting**
4. **Fiscal Year 2020 Budget Public Hearing**
5. **Reconvene Board Meeting**
6. **Consent Agenda**
   - August 9, 2019 SWMBH Board Meeting Minutes (d)
7. **Operations Committee**
   - Operations Committee Minutes July 31, 2019 (d)
8. **Ends Metrics Updates (*motions required)**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   a. MDHHS Home and Community Based Service Reporting (d) (M. Kean)
   b. *Fiscal Year 2019 Performance Improvement Project – Health Services Advisory Group (HSAG) Review (d) (M. Kean)
   c. Performance Bonus Incentive Program (d) (J. Gardner)
9. **Board Actions to be Considered**
   - Fiscal Year 2020 Budget Draft (attachment) (T. Dawson)
10. **Board Policy Review**
    Is the Board in Compliance? Does the Policy Need Revision?
    - BG008 Board Member Job Description (d)
11. **Executive Limitations Review**
    Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
    - Nothing scheduled
12. **Board Education**
    a. TBD

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

    a. Consolidated Fiscal year 2019 Year to Date Financial Statements (d) (T. Dawson)
    b. MHEF Grant Outcome (B. Casemore)
    c. Board Member Attendance Roster (d)
    d. October: EO-002 Monitoring Executive Performance (d)

14. **Public Comment**

15. **Adjournment**

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

2019 SWMBH Board Member & Board Alternate Attendance												
Name:	January	February	March	April	May	June	July	August	September	October	November	December
Board Members:												
Robert Nelson (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Mary (Mae) Myers (Cass)												
Moses Walker (Kalamazoo)												
Cathi Abbs (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Karen Lehman (Cass)												
Patricia Guenther (Kalamazoo)												
Angie Price (St. Joe)												
Angie Dickerson (Van Buren)												

as of 6/14/19

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

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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

FOR IMMEDIATE RELEASE
June 14, 2019

CONTACT: Lynn Sutfin
517-241-2112
SutfinL1@michigan.gov

MDHHS announces delay of Section 298 pilot implementation

LANSING, Mich. – The Michigan Department of Health and Human Services (MDHHS) and Section 298 pilot participants are delaying implementation of the Section 298 Initiative until Oct. 1, 2020 in order to complete design of the financial integration pilot model.

The initiative is a statewide effort to improve the integration of physical health services and specialty behavioral health services in Michigan. It is based upon Section 298 in Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 207 of 2018.

As part of the initiative, the Michigan legislature directed MDHHS to implement up to three pilots to test the financial integration of Medicaid-funded physical health and specialty behavioral health services.

Progress has been made on the initiative, including developing a proposed care management workflow; identifying an approach to key public policy needs; and defining key data sharing requirements critical to whole-person care. However, further work is still needed to reach agreements on risk-management and ownership of the specialty behavioral health provider network; utilization management, claims processing and other managed care responsibilities; and rates and payment structures.

Following resolution of these items, time will be needed to secure federal Centers for Medicare & Medicaid Services waiver approval, establish new contracts, finalize technology and reporting changes, establish new payment flows and potentially create new legal structures and undergo accreditation reviews. An Oct. 1, 2019 agreement on outstanding elements and design of the integrated model is being targeted to allow time for these implementation activities.

Due to this decision, the proposed renewal applications for Children's Waiver Program, Habilitation Supports Waiver and Waiver for Children with Serious Emotional Disturbances have been revised to reflect that waiver changes regarding the 298 site implementation initiative will not be submitted to CMS at this time. The revised waivers will be posted on June 14 and public comments will be accepted until July 15.

For more information about the initiative, visit Michigan.gov/stakeholder298.

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STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING
ROBERT GORDON
DIRECTOR

June 6, 2019

Dear Legislative Leaders,

We, the leaders of the participating CMHSPs and MHPs and the Department of Health and Human Services, write to you today with an update on the status of the financial integration pilots established in Section 298 of P.A. 107 of 2017.

Since the passage of the Act, we have been working to reach collective consensus on a model for full integration to be tested in the pilot, and to define and make all of the technological, regulatory, contractual, and other changes needed for implementation. We have made progress in a number of areas, including the development of a proposed Care Management Workflow based on lead/shared responsibilities, identifying a recommended training vehicle and approach relative to key public policy needs, and defining key data sharing requirements critical to whole-person care.

However, we have not yet reached agreement on a model for the end-state of integration. At this time, there is not agreement on the definition of integration nor agreement on the structural framework of the pilots. Major outstanding questions remain regarding risk-management and ownership of the specialty provider network; utilization management, claims, and other managed care responsibilities; rates, and payment, structures. To facilitate rate, payment and risk structures decisions we need time to address overall adequacy of rates and define a shared savings model. Following resolution of these items, there will still remain significant implementation work and lead time needed to secure federal (CMS) waiver approval, establish new contracts amongst ourselves and with our providers, finalize technology and reporting changes, establish new payment flows, and potentially create new legal structures and undergo accreditation reviews.

In light of this, we request your support for our plan to delay implementation of the Section 298 pilots so that we may continue working to resolve the outstanding structural questions. We propose to work towards an agreement by October 1, 2019 on a more detailed model for full financial integration (including yet to be defined terms and conditions including operational, medical management, utilization management and network management) that allows for MHPs to effectively manage, in partnership with contracted CMHSPs and providers, the whole health of the enrolled Medicaid beneficiaries. Pending successful resolution of a detailed model for full financial integration, we propose to launch the pilots no later than October 1, 2020. In the meantime, we will work together to pursue opportunities to implement a number of the proposed activities that came out of the 298 workgroup process to support system

coordination and improve readiness for pilot implementation in 2020. These include, but are not limited to, new care coordination workflows and data-sharing.

We remain committed to full financial integration, and to working together on this pilot. We appreciate your flexibility in allowing us the time necessary to prepare for a successful launch, and look forward to continuing to collaborate on a holistic approach to improve access to care, overall health outcomes, and experience for Medicaid beneficiaries in Michigan.
Best,

Doris J. Mannas
CEO UnitedHealthcare

Julia B Rupp
CEO HealthWest

President/COO Meridian

Mary L Clark, RN, VP
McLaren Health Plan

Executive Director
West Michigan CMH

Director, MDHHS

Buff Donovan, LMSW, ACSW
Director of Behavioral Health, Health Alliance Plan

Michigan Department of Health & Human Services

MDHHS

Michigan Department of Health & Human Services

Press Release

FOR IMMEDIATE RELEASE: June 14, 2019

CONTACT: Lynn Sutfin, 517-241-2112, Sutfinl1@michigan.gov

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Michigan Medicare-Medicaid Plan Quality Withhold Analysis Results

Demonstration Year 1 (Calendar Years 2015 – 2016)

The Medicare-Medicaid Financial Alignment Initiative (FAI) seeks to better serve people who are dually eligible for Medicare and Medicaid by testing person-centered, integrated care models. In order to ensure that dually eligible individuals receive high quality care and to encourage quality improvement, both Medicare and Medicaid withheld a percentage of their respective components of the capitation rate paid to each Medicare-Medicaid Plan (MMP) participating in a capitated model demonstration under the FAI. MMPs are eligible for repayment of the withheld amounts subject to their performance on a combination of CMS Core and State-Specific quality withhold measures.[1] For each measure, MMPs earn a "met" or "not met" designation depending on their achieved rate relative to the benchmark level. Based on the total number of measures met, MMPs receive a quality withhold payment according to the following tiered scale:

Percent of Measures Met	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

This report provides the results of the quality withhold analysis for MMPs in the MI Health Link demonstration for Demonstration Year (DY) 1, which includes Calendar Years (CY) 2015 and 2016 (when a demonstration year crosses two calendar years, the quality withhold analysis is conducted separately for each calendar year). On the following pages, Table 1 (2015) and Table 4 (2016) provide results for each CMS Core measure; Table 2 (2015) and Table 5 (2016) provide results for each State-Specific measure; and Table 3 (2015) and Table 6 (2016) provide summary results for the quality withhold analysis. When interpreting this information, note that some measures are designed to be competitive (e.g., the benchmark for the CMS Core Assessments measure is calculated separately for each demonstration based on the rate achieved by the highest scoring MMP minus ten percentage points); therefore, an MMP's performance may be considered adequate even if its rate did not meet the benchmark level.

For more information about the quality withhold methodology, measures, and benchmarks, refer to the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1 and the Michigan Quality Withhold Technical Notes for DY 1. These documents are available on the CMS website at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html.

[1] CMS Core measures apply consistently across all capitated model demonstrations, unless a certain measure is inapplicable due to differences in demonstration design or timing/enrollment constraints. State-Specific measures apply to a specific capitated model demonstration. Note that the number, type, and complexity of State-Specific measures vary depending on key areas of interest for the respective demonstration.

CY 2015 Quality Withhold Results

Table 1: CMS Core Measure Results – CY 2015

Medicare-Medicaid Plan	CW1 – Assessments	CW2 – Consumer Governance Board	CW4 – Encounter Data
	Benchmark: 83%	Benchmark: 100% Compliance	Benchmark: 80%
Aetna Better Health of Michigan, Inc.	Met	Met	Not Met
AmeriHealth Michigan, Inc.	Met	Not Met	Not Met
HAP Midwest Health Plan, Inc.	Not Met	Not Met	Not Met
Meridian Health Plan of Michigan, Inc.	Not Met	Met	Not Met
Michigan Complete Health, Inc.	Met	Met	Met
Molina Healthcare of Michigan, Inc.	Not Met	Met	Not Met
Upper Peninsula Health Plan, LLC	Not Met	Not Met	Not Met

Table 2: Michigan State-Specific Measure Results – CY 2015

Medicare-Medicaid Plan	MIW1 – Care Transition Record Transmitted to Health Care Professional	MIW3 – Members with Documented Discussions of Care Goals
	Benchmark: Timely and accurate reporting, plus submission of a narrative	Benchmark: 75%
Aetna Better Health of Michigan, Inc.	Met	Not Met
AmeriHealth Michigan, Inc.	Met	Not Met
HAP Midwest Health Plan, Inc.	Met	Met
Meridian Health Plan of Michigan, Inc.	Met	Met
Michigan Complete Health, Inc.	Met	Met
Molina Healthcare of Michigan, Inc.	Met	Not Met
Upper Peninsula Health Plan, LLC	Met	Not Met

Table 3: Quality Withhold Analysis Summary Results – CY 2015

Medicare-Medicaid Plan	# of Measures in Analysis			# of Measures Met			% of Measures Met			% of Withhold Received
	Core	State	Total	Core	State	Total	Core	State	Total	
Aetna Better Health of Michigan, Inc.	3	2	5	2	1	3	67%	50%	60%	75%
AmeriHealth Michigan, Inc.	3	2	5	1	1	2	33%	50%	40%	50%
HAP Midwest Health Plan, Inc.	3	2	5	0	2	2	0%	100%	40%	50%
Meridian Health Plan of Michigan, Inc.	3	2	5	1	2	3	33%	100%	60%	75%
Michigan Complete Health, Inc.	3	2	5	3	2	5	100%	100%	100%	100%
Molina Healthcare of Michigan, Inc.	3	2	5	1	1	2	33%	50%	40%	50%
Upper Peninsula Health Plan, LLC	3	2	5	0	1	1	0%	50%	20%	25%
Michigan Averages	**3**	**2**	**5**	**1**	**1**	**3**	**38%**	**71%**	**51%**	**61%**

CY 2016 Quality Withhold Results

60

Table 4: CMS Core Measure Results – CY 2016

Medicare-Medicaid Plan	CW1 – Assessments	CW2 – Consumer Governance Board	CW3 – Customer Service[2]	CW4 – Encounter Data	CW5 – Getting Appointments and Care Quickly[2]
	Benchmark: 84%	Benchmark: 100% Compliance	Benchmark: 86%	Benchmark: 80%	Benchmark: 74%
Aetna Better Health of Michigan, Inc.	Met	Met	Met	Met	Met
AmeriHealth Michigan, Inc.	Met	Met	Met	Met	Not Met
HAP Midwest Health Plan, Inc.	Not Met	Met	Met	Not Met	Not Met
Meridian Health Plan of Michigan, Inc.	Met	Met	Met	Not Met	Met
Michigan Complete Health, Inc.	Not Met	Met	N/A	Met	Met
Molina Healthcare of Michigan, Inc.	Met	Met	Met	Met	Met
Upper Peninsula Health Plan, LLC	Met	Met	Met	Not Met	Met

[2] CMS Core measures CW3 and CW5 are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. For these measures, "N/A" indicates that the MMP's score had very low reliability. In such cases, the measure was removed from the quality withhold analysis.

Table 5: Michigan State-Specific Measure Results – CY 2016

Medicare-Medicaid Plan	MIW1 – Care Transition Record Transmitted to Health Care Professional	MIW2 – Care for Older Adults – Medication Review	MIW3 – Members with Documented Discussions of Care Goals
	Benchmark: Timely and accurate reporting, plus submission of a narrative	Benchmark: 70%	Benchmark: 75%
Aetna Better Health of Michigan, Inc.	Met	Met	Not Met
AmeriHealth Michigan, Inc.	Met	Not Met	Met
HAP Midwest Health Plan, Inc.	Met	Not Met	Met
Meridian Health Plan of Michigan, Inc.	Met	Met	Met
Michigan Complete Health, Inc.	Met	Not Met	Met
Molina Healthcare of Michigan, Inc.	Met	Met	Met
Upper Peninsula Health Plan, LLC	Met	Met	Met

Table 6: Quality Withhold Analysis Summary Results – CY 2016

Medicare-Medicaid Plan	# of Measures in Analysis			# of Measures Met			% of Measures Met			% of Withhold Received
	Core	State	Total	Core	State	Total	Core	State	Total	
Aetna Better Health of Michigan, Inc.	5	3	8	5	2	7	100%	67%	88%	100%
AmeriHealth Michigan, Inc.	5	3	8	4	2	6	80%	67%	75%	75%
HAP Midwest Health Plan, Inc.	5	3	8	2	2	4	40%	67%	50%	50%
Meridian Health Plan of Michigan, Inc.	5	3	8	4	3	7	80%	100%	88%	100%
Michigan Complete Health, Inc.	4	3	7	3	2	5	75%	67%	71%	75%
Molina Healthcare of Michigan, Inc.	5	3	8	5	3	8	100%	100%	100%	100%
Upper Peninsula Health Plan, LLC	5	3	8	4	3	7	80%	100%	88%	100%
Michigan Averages	**5**	**3**	**8**	**4**	**2**	**6**	**79%**	**81%**	**80%**	**86%**

Michigan Department of Health & Human Services

MDHHS

Michigan Department of Health & Human Services

Press Release

FOR IMMEDIATE RELEASE: June 28, 2019

CONTACT: Lynn Sutfin, 517-241-2112, SutfinL1@michigan.gov

MDHHS issues contract cancellation notice to Lakeshore Regional Entity, seeks to establish new PIHP

LANSING, Mich. – To provide quality behavioral health services on a sustainable basis for West Michigan, the Michigan Department of Health and Human Services (MDHHS) is cancelling its contract with Lakeshore Regional Entity (LRE) and will establish a new pre-paid inpatient health plan (PIHP) in the region, building on recent work there with Beacon Health Options.

LRE is the PIHP for Allegan, Ottawa, Kent, Muskegon, Oceana, Mason and Lake counties. Medicaid behavioral health specialty services are administered through PIHPs, which are managed care entities required to provide all medically necessary services through community mental health authorities (CMHs).

MDHHS notified LRE of its intent to cancel the contract on April 25. MDHHS later received a response from LRE and met with multiple stakeholders in the region. After reviewing the response, MDHHS decided to terminate the contract based on many factors. Some were related to finances: five years of financial deficits, failure to address the deficits the lack of a current risk management strategy and the lack of a plan to cover their portion of a projected $16 million deficit. The termination also reflects performance issues despite multiple years of corrective action plans and weaker member outcomes relative to other regions on key metrics like inpatient hospitalization.

"Michigan residents deserve access to behavioral health services that are accessible, affordable and effective, and Michigan taxpayers deserve a system that manages our tax dollars efficiently," said MDHHS Director Robert Gordon. "Following many years of poor performance and financial mismanagement that stands out among PIHPs, we believe it is clear that LRE is not the right entity to deliver services for West Michigan residents in need. The success of our public system depends on effective management. With a new approach, building on LRE's recent work with Beacon, the region can achieve better outcomes for people while operating on a sustainable basis."

LRE has consistently overspent its budget since 2015, and the state has had to provide supplemental funding to cover LRE's shortfalls in the last two years. This year's projected shortfall would require additional financial assistance from the state for a third year.

Recognizing projected shortfalls in a number of PIHP regions, MDHHS has requested supplemental funding from the legislature for all PIHPs for 2019, consistent with actuarial soundness. However, that funding will not fully address LRE's funding shortfall nor its management challenges.

MDHHS intends to keep the region intact and will initiate temporary state management when the contract with LRE ends. The state will seek to establish a new PIHP to serve beneficiaries.

Over the last few months, Beacon Health Options has been operating with LRE to provide managed care support to the CMHs. Due to the progress being made by the work with Beacon Health Options and the value of this partnership reported by CMHs, MDHHS will seek to establish a temporary contract with Beacon that will allow this work to continue until such time as a PIHP contract may be formally procured.

The new, temporary contract would include all public policy requirements currently in place for PIHPs, including consumer protections, and preserve public oversight. MDHHS will establish a public board to oversee Beacon's contract and ensure compliance and service delivery, in conjunction with MDHHS, which will hold the contract. Board membership will include representation from the CMHs, the counties, advocates and individuals receiving services.

Individuals receiving services from community mental health service providers in this region will continue to receive the medically necessary services authorized in their person-centered plans of care and retain access to their existing providers.

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- LRE Contract Notice.pdf

CMS BLOG
https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility

June 25, 2019
By Seema Verma, Administrator, Centers for Medicare & Medicaid Services

Medicaid Program Integrity: A Shared and Urgent Responsibility

The Medicaid program has grown from $456 billion in 2013 to an estimated $576 billion in 2016, largely fueled by a mostly federally financed expansion of the program to more than 15 million new working age adults. For these adults, the estimated cost per enrollee grew about 7 percent from FY2017 to 2018, compared to about 0.9 percent for other enrollees. With this historic growth comes a commensurate and urgent responsibility by CMS on behalf of the American taxpayers to ensure sound stewardship and oversight of our program resources. While the primary responsibility for ensuring proper payments in Medicaid lies with states, CMS plays a significant role in supporting states' efforts and holding them accountable through appropriate oversight and increased transparency.

That's why the Trump Administration has proposed numerous changes to the Medicaid program such as improving overpayment collection when states pay for ineligible beneficiaries, streamlining provider terminations to remove bad actors, and consolidating provider enrollments in Medicaid and the Children's Health Insurance Program (CHIP) to improve efficiency.

One year ago we took a significant step to address these challenges when we released a Medicaid Program Integrity Strategy based on the three pillars of flexibility, accountability and integrity. Our strategy seeks to reduce Medicaid improper payments across states to protect taxpayer dollars. To do so, the strategy includes stronger audit and oversight functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules. As we mark the first anniversary, we can point to several initiatives that are improving transparency and accountability for the Medicaid program, enabling increased data sharing and more robust analytic tools, and reducing Medicaid improper payments across states.

CMS Information Bulletin: Oversight of State Medicaid Claiming and Program Integrity Expectations. This bulletin, issued last week, sets out CMS' higher expectations for states to ensure the accuracy of eligibility determinations and federal funding at the appropriate

matching rate to improve accountability for Medicaid program integrity performance. The bulletin is particularly important for states that have expanded or may be considering expanding their Medicaid programs to the new adult group, which is financed with 90% or more in federal funding. CMS will issue additional guidance to help states improve their program integrity performance.

Disallowing Unallowable Claims of Federal Funding. CMS closely monitors how states draw down and expend federal Medicaid funding to ensure it complies with all applicable laws and regulations. When states do not voluntarily return federal funds associated with unallowable claims, CMS can recover them by issuing a disallowance. Over the last 18 months, the Trump Administration has worked through an inherited backlog of potential disallowances where CMS, Office of Inspector General (OIG), or state oversight activities identified potentially unallowable state claims. We are taking action to resolve a number of these potential disallowances. Since 2017 we issued **approximately $900 million** in disallowances. We are committed to achieving more expeditious resolution of these issues to prevent new backlogs from developing in the future, thereby ensuring federal funds are repaid in a timely manner.

Increased Audits and Oversight. We are conducting eligibility audits of state beneficiary eligibility determinations in states identified as high risk by previous OIG and state audit findings (beginning in California, New York, Kentucky, and Louisiana) to hold states accountable for more accurate beneficiary eligibility determinations. In addition, we are working with all states to implement the revised Medicaid Eligibility Quality Control (MEQC) program, which allows for continuous oversight of states' eligibility determinations during their off-cycle Payment Error Rate Measurement (PERM) years. We are also auditing Medicaid managed care plans' financial reporting and Medical Loss Ratios (MLRs) to ensure plans aren't being overpaid, including reviews of high-risk vulnerabilities identified by the Government Accountability Office (GAO) and OIG. As of December 31, 2018, prior CMS efforts led to CMS **recovering $9.63 billion from California** in relation to our efforts to ensure appropriate payments to managed care plans specific to the new adult group.

Data Sharing and Partnerships. Strong data collection and analysis will enable smarter efforts to tackle fraud, waste, and abuse. We are enhancing data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. We are now collecting and optimizing enhanced Medicaid data from all states and two territories through the Transformed Medicaid Statistical Information System (T-MSIS). New efforts to use this data to detect fraud, waste, and abuse represent the first use of T-MSIS data for program integrity purposes, moving CMS closer to its goal of comprehensive, timely, national analytic data for Medicaid.

Education, Technical Assistance and Collaboration. The best way to manage improper payments is to help states avoid them at the outset. As part of CMS' work to provide guidance and assistance for state implementation of the Medicaid Managed Care Final Rule from 2016, CMS released guidance in 2018 regarding Medicaid provider screening and enrollment for Medicaid managed care organization network providers. To further educate and collaborate with states, CMS engages in the following activities:

- CMS' Medicaid Integrity Institute (MII) provides training and education to more than 1,000 state Medicaid program integrity staff annually. Course topics include provider screening and enrollment, managed care, and personal care services.
- CMS has engaged with states to share over a dozen promising practices that were identified and submitted by states on various program integrity practices covering

provider and beneficiary enrollment, managed care, fraud and abuse referrals, and high-risk providers.

- CMS conducts State Program Integrity Reviews to assess the effectiveness of the state's program integrity efforts, including its compliance with federal statutory and regulatory requirements. The reviews also assist in identifying effective state program integrity activities and sharing best practices with other states. As a result of the opioid desk reviews, several states have acknowledged the need to increase their opioid-related audit activity and have engaged with the Unified Program Integrity Contractors (UPICs) to develop projects to address this weakness.
- The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations that aims to detect and prevent healthcare fraud through data and information sharing. As of this month, the HFPP includes 41 state and local partners, including a number of states that are submitting data for cross-payer studies.

Reducing Improper Payments The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP and produces error rates for each program. In 2019, for the first time since 2014, we will be reporting the improper payment rate for people who are improperly enrolled in Medicaid and CHIP.

Future Initiatives

CMS continues to collaborate with states in implementing the new and enhanced program integrity initiatives from the Medicaid Program Integrity Strategy, as well as look for new areas of vulnerability and opportunity to support state efforts to meet high program standards. Our upcoming efforts will include:

- A proposed comprehensive update to Medicaid's fiscal accountability regulations, to increase states' accountability for supplemental payments. The update includes additional state reporting, clearer financial definitions, and stronger federal guidance to ensure that states use supplemental payments properly.
- A proposed regulation to further strengthen the integrity of the Medicaid eligibility determination process, including enhanced requirements around verification, monitoring changes in beneficiary circumstances, and eligibility redetermination.
- Additional guidance on the Medicaid Managed Care Final Rule from 2016 to further state implementation and compliance with program integrity safeguards, such as reporting overpayments and possible fraud.
- Release of improvements to the Medicaid and CHIP Scorecard—a dashboard of program measures that increases public transparency about the programs' administration and outcomes. The improvements include two program integrity measures to enhance transparency and continue to provide states with performance measures related to their Medicaid programs. Examples of such program integrity measures may include measures based on state initiation of collaborative investigations with their UPIC, state participation in the HFPP at any level, and performance data derived from improper payment drivers.
- Conduct provider screening on behalf of states for Medicaid-only providers to improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of error as measured by PERM.
- Medicaid provider education through Targeted Probe and Educate—which identifies providers who have high error rates and educates them on billing requirements—to

reduce aberrant billing, as well as education provided through Comparative Billing Reports—which show providers their billing patterns compared to their peers.
- Audit state claiming of federal matching dollars to address areas that have been identified as high-risk by GAO and OIG, as well as other behavior previously found detrimental to the Medicaid program.

As we give states the flexibility they need to make Medicaid work best in their communities, integrity and oversight must be at the forefront of our role. Beneficiaries depend on Medicaid and the Trump Administration is committed to the program's long-term viability. We are using the tools we have to hold states accountable as we work with them to keep Medicaid sound and safeguarded for beneficiaries. These initiatives are the vital steps necessary to respond to Medicaid's evolving landscape and fulfill our responsibility to beneficiaries and taxpayers.

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Press Office
Centers for Medicare & Medicaid Services

All Providers,

As a reminder, all Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. The Michigan Department of Health and Human Services (MDHHS) conducts post-payment reviews to verify services, providers, settings, and appropriate billing. Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying of all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained. Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. The records are to be retained for a period of not less than seven years from the date of service, regardless of change in ownership or termination of participation in Medicaid for any reason.

For further clarification regarding post-payment review please visit the www.Michigan.gov/MedicaidProviders >> select Policy, Letters & Forms >> select Medicaid Provider Manual >> General Information for Providers Chapter, section 15.1.