Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting
SWMBH – 5250 Lovers Lane, Suite 200 Portage, MI, 49002
Please join the meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/482157965
You can also dial in using your phone.
United States: +1 (646) 749-3122
Access Code: 482-157-965
Monday, July 15, 2019
4:00-5:30

1. **Welcome and Introductions (Randall Hazelbaker)**
2. **Public Comment**
3. **COI/FID – Gary Tompkins (Calhoun County Commissioner) (Mila Todd)**
4. **Agenda Review and Adoption (Randall Hazelbaker)** (d) (pg.1)
5. **Consent Agenda (Randall Hazelbaker)**
   - May 20, 2019 Meeting Minutes (d) (pg.2)
6. **Board Education**
   a) Fiscal Year 18/19 YTD Financials – (Garyl Guidry) (d) (pg.5)
   b) PA2 Utilization FY19 YTD - (Garyl Guidry) (d) (pg.6)
   c) FY20 PA2 Budget Updates (Joel Smith)
   d) Synar Report Update (Achiles Malta) (d)(pg.7)
7. **Board Actions to be Considered (Randall Hazelbaker)**
   - None
8. **Board Action (Randall Hazelbaker)**
   - FY18/19 PA2 Budget Amendment – Western Michigan University Behavioral Health Services; Kalamazoo County (d) (pg.8)
9. **Communication and Counsel**
   a) 298 Update (Brad Casemore) (d) (pg.15)
   b) Lakeshore Regional Entity (Brad Casemore) (d) (pg.19)
10. **Legislative and Policy Updates (Brad Casemore)**
    - Various Articles (d) (pg.21)
11. **Adjourn**

The meeting will be held in compliance with the Open Meetings Act, 1976 PA 267, MCL 15.261 to 15.275

Southwest Michigan

BEHAVIORAL HEALTH

Substance Use Disorder
Oversight Policy Board (SUDOPB) Meeting Minutes
5250 Lovers Lane, Suite 200. Portage, MI, 49002
January 21, 2019
4:00 – 5:30 pm
Draft: 5/28/19

Members Present: Randall Hazelbaker (Branch County); Richard Godfrey (Van Buren County); Daniel Doehrman (Kalamazoo County) Michael Majerek, (Berrien County); Kathy-Sue Dunn (Calhoun County); Skip Dyes (Cass County); Gary Tompkins (Calhoun County) Ben Geiger (Barry County); Don Meeks (Berrien County)

Members Absent: Lisa White (Kalamazoo County); Tara Smith (Cass County); Paul Schincariol (Van Buren County); Allen Balog (St. Joseph County)

Staff Present: Joel Smith, Director of SUD Services, SWMBH; Garyl Guidry, Financial Analyst, SWMBH; Achiles Malta, Regional Coordinator for SUD Prevention Services, SWMBH; Justin Rolin, Gambling Disorder Prevention Specialist, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH

Welcome and Introductions
Randall Hazelbaker called the meeting to order at 4:04 pm. Introductions were made.

Public Comment
None.

Agenda Review and Adoption

Motion	Richard Godfrey moved to approve the agenda.
Second	Kathy-Sue Vette
Motion carried	

Consent Agenda

Motion	Gary Tompkins moved to accept the March 18, 2019 meeting minutes.
Second	Richard Godfrey
Motion carried	

Board Education

Fiscal Year 18/19 YTD Financials
Garyl Guidry reviewed the year to date financials as documented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, PA2, and PA2 carryforward.

PA2 Overview and Budget
Joel Smith reported as documented.

2020 PA2 Budget Calendar
Garyl Guidry reported as documented.

PA2 Utilization FY19 YTD
Garyl Guidry reviewed the report as documented noting carry forward and counties that are using funds that are projected to lower their PA2 carry forward.

Fiscal Year 18/19 Mid Year PA2 Report
Joel Smith reported as documented. Discussion followed.

State Opioid Response Grant
Joel Smith reported as documented noting the grant award is for $370,000 and runs from 6/1/19 through 9/30/20.

State Targeted Response Grant
Joel Smith reported as documented noting that the this is a three year, no cost, award.

Partnership for Success Site Reviews
Achiles Malta reported on this specialty grant that benefitted Van Buren and St. Joseph counties. Discussion followed.

Gambling Disorder Prevention Specialist
Joel Smith introduced Justin Rolin, SWMBH Gambling Disorder Specialist. Justin's position is funded through a grant from the State of Michigan. Justin Rolin discussed his role in developing Gambling Disorder Prevention and Treatment programs, strategies and services, level of awareness, and county needs assessments. Discussion followed.

Board Action

September 16, 2019 SUDOPB Public Hearing Meeting
Joel Smith proposed to move the SUDOPB Public Hearing meeting to September 9th at 3pm siting budget and contract constraints.

Motion	Daniel Doehrman moved that the SUDOPB Public Hearing meeting be moved to 9/9/19 at 3pm.
Second	Richard Godfrey
Motion Carried	

Communication and Counsel

Legislative and Policy Updates
Joel Smith reviewed the articles as documented. Richard Godfrey discussed the SWMBH May 17th legislative event. Discussion followed.

Adjourn

Motion	Daniel Doehrman moved to adjourn meeting.
Second	Don Meeks
Motion Carried	

Meeting adjourned at 5:35 pm

Southwest Michigan Behavioral Health

Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2019

For the Fiscal YTD Period Ended 5/31/2019

	MEDICAID				Healthy MI			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	51,552	102,970	98,814	4,156	100,431	174,263	162,870	11,393
Berrien	403,157	409,114	223,870	185,243	699,564	712,566	449,104	263,462
Branch	103,267	105,038	95,044	9,993	128,766	164,388	126,337	38,051
Calhoun	464,298	421,040	387,390	33,650	682,468	646,708	530,685	116,023
Cass	97,713	120,256	90,669	29,587	171,837	203,703	157,505	46,198
Kazoo	499,497	559,697	223,484	336,213	916,367	998,025	383,158	614,867
St. Joe	165,794	157,835	51,165	106,669	262,347	266,756	209,913	56,844
Van Buren	206,855	213,758	40,911	172,847	355,699	344,996	106,004	238,992
DRM	1,613,814	1,616,685	2,156,455	(539,770)	2,477,055	2,486,510	3,162,452	(675,942)
Grand Total	3,605,949	3,706,391	3,367,802	338,588	5,794,535	5,997,916	5,288,028	709,887

	BLOCK GRANT				PA2			
	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	244,059	244,059	187,142	56,917	44,540	49,098	15,908	33,190
Berrien	646,782	646,782	430,866	215,916	287,940	250,009	207,957	42,053
Branch	186,611	186,611	109,553	77,058	74,567	43,764	53,266	(9,503)
Calhoun	561,526	561,526	471,966	89,560	345,614	221,610	277,791	(56,181)
Cass	215,697	215,697	134,732	80,965	45,320	49,353	45,866	3,487
Kazoo	1,032,475	1,032,475	866,584	165,891	630,490	440,486	600,796	(160,310)
St. Joe	252,799	252,799	202,746	50,052	91,467	67,340	88,406	(21,065)
Van Buren	314,530	314,530	214,695	99,836	111,164	96,455	27,999	68,456
DRM	736,510	776,666	1,794,388	(1,017,722)				
STR	928,976	928,976	670,559	258,417				
Gambling Prev.	125,789	125,789	8,008	117,781				
PFS	101,363	101,363	111,951	(10,588)				
SDA	85,479	85,479	128,219	(42,740)				
Admin/Access	158,706	158,706	281,072	(122,366)				
Grand Total	5,774,971	5,815,127	5,815,127	0	1,631,101	1,218,115	1,317,988	(99,873)

PA2 Carryforward

	Current Utilization	Prior Year Balance	Projected Year End Balance
Barry	33,190	428,430	461,620
Berrien	42,053	406,850	448,903
Branch	(9,503)	346,818	337,315
Calhoun	(56,181)	586,699	530,518
Cass	3,487	352,325	355,812
Kazoo	(160,310)	1,963,706	1,803,396
St. Joe	(21,065)	240,077	219,012
Van Buren	68,456	219,880	288,337
Grand Total	(99,873)	4,544,786	4,444,913

Legend

DRM - Detox, Residential, and Methadone

PFS - Partnerships for Success

SDA - State Disability Assistance

Program	FY19 Approved Budget	Utilization FY 19 Oct-May	PA2 Remaining	YTD Utilization	Projection	
Barry	**66,810.00**	**15,908**	**50,902**	**24%**	**26,330.48**	**39%**
BCCMHA - Prevention Services	30,000	-	30,000	0%	-	0%
BCCMHA - Outpatient Services	36,810	15,908	20,902	43%	26,330.48	72%
Berrien	**431,909.56**	**181,810**	**250,100**	**42%**	**300,926.78**	**70%**
Abundant Life - Healthy Start	68,300	44,340	23,960	65%	68,300.00	100%
Berrien County - Drug Treatment Court	15,000	-	15,000	0%	-	0%
Berrien County - Trial courts	43,919	-	43,919	0%	-	0%
Berrien MHA - Riverwood	6,700		6,700	0%	-	0%
CHC - Jail	34,000	18,379	15,621	54%	30,420.05	89%
CHC - Niles Family & Friends	6,000	1,092	4,908	18%	1,807.18	30%
CHC - Wellness Grp	9,752	849	8,903	9%	1,405.59	14%
CHC - Women's Recovery House	72,117	39,818	32,299	55%	65,905.36	91%
Harbortown - Juvenile and Detention Ctr	76,122	10,532	65,590	14%	17,432.74	23%
Berrien County Health Department - Prevention Ser	100,000	66,800	33,200	67%	100,000.00	100%
Branch	**111,850.30**	**44,581**	**67,269**	**40%**	**73,789.85**	**66%**
Pines BHS - Jail Case Management	72,473	33,065	39,408	46%	54,728.42	76%
Pines BHS - Outpatient Treatment	37,377	11,181	26,197	30%	18,505.70	50%
Pines BHS - WSS	2,000	336	1,664	17%	555.72	28%
Calhoun	**518,421.00**	**242,720**	**275,701**	**47%**	**401,742.70**	**77%**
Calhoun County 10th Dist Drug Sobriety Court	160,000	89,502	70,498	56%	148,141.31	93%
Calhoun County 10th Dist Veteran's Court	6,524	4,380	2,144	67%	6,524.00	100%
Calhoun County 37th Circuit Drug Treatment Court	226,497	98,572	127,925	44%	163,153.51	72%
Haven of Rest	50,400	33,600	16,800	67%	50,400.00	100%
Michigan Rehabilitation Services - Calhoun	25,000	16,666	8,334	67%	25,000.00	100%
Summit Pointe - Jail	25,000	-	25,000	0%	-	0%
Summit Pointe - Juvenile Home	25,000	-	25,000	0%	-	0%
Cass	**67,980.00**	**40,132**	**27,848**	**59%**	**66,426.04**	**98%**
Woodlands - Meth Treatment and Drug Court Outp:	67,980	40,132	27,848	59%	66,426.04	98%
Kalamazoo	**945,734.82**	**480,570**	**465,165**	**51%**	**795,425.74**	**84%**
8th District Probation Court	7,000	1,287	5,713	18%	2,130.21	30%
8th District Sobriety Court	28,000	6,834	21,166	24%	11,311.58	40%
8th District Young Adult Diversion Court	5,000	744	4,256	15%	1,231.45	25%
9th Circuit Drug Court	60,000	37,960	22,040	63%	60,000.00	100%
CHC - Adolescent Services	21,373	13,449	7,924	63%	21,373.00	100%
CHC - Bethany House	57,720	26,558	31,162	46%	43,957.42	76%
CHC - New Beginnings	77,627	51,778	25,849	67%	77,627.00	100%
CHC - Healing House	45,000	10,120	34,880	22%	16,750.43	37%
Gryphon Gatekeeper - Suicide Prevention	20,000	-	20,000	0%	-	0%
Gryphon Helpline/Crisis Response	36,000	18,000	18,000	50%	29,793.10	83%
Interact - IDDT	26,600	6,594	20,006	25%	10,914.24	41%
KCHCS Healthy Babies	85,615	40,018	45,598	47%	66,235.86	77%
KCHCS Womens Support	1,385	-	1,385	0%	-	0%
KCMHSAS - EMH	56,400	32,900	23,500	58%	54,455.17	97%
KCMHSAS - FUSE	25,000	16,667	8,333	67%	25,000.00	100%
KCMHSAS - Mental Health Court	65,000	37,917	27,083	58%	62,758.66	97%
KCMHSAS - Oakland Drive Shelter	34,000	22,667	11,333	67%	34,000.00	100%
KPEP Social Detox	60,000	13,300	46,700	22%	22,013.79	37%
Michigan Rehabilitation Services - Kalamazoo	17,250	11,500	5,750	67%	17,250.00	100%
Prevention Works - Task Force	50,000	28,561	21,439	57%	47,274.02	95%
Recovery Institute - Recovery Coach	60,623	40,969	19,654	68%	60,623.00	100%
WMU - BHS SBIRT	46,747	13,884	32,863	30%	22,981.11	49%
WMU - BHS Text Messaging	6,000	1,964	4,036	33%	3,250.49	54%
WMU - Jail Groups	53,395	46,900	6,495	88%	53,395.00	100%
St. Joseph	**137,200.00**	**65,757**	**71,443**	**48%**	**108,838.63**	**79%**
3B District - Sobriety Courts	8,000	1,155	6,845	14%	1,911.72	24%
CHC - Hope House	32,000	25,624	6,376	80%	25,624.00	80%
CMH - Court Ordered Drug Testing	43,200	23,556	19,644	55%	38,989.04	90%
CMH Jail Program	54,000	15,422	38,578	29%	25,526.28	47%
Van Buren	**166,745.55**	**18,666**	**148,080**	**11%**	**30,895.35**	**19%**
Van Buren CMHA	141,746	-	141,746	0%	-	0%
Van Buren County Drug Treatment Court	25,000	18,666	6,334	75%	25,000.00	100%
Totals	**2,446,651.23**	**1,090,144**	**1,356,508**	**45%**	**1,706,412.71**	**70%**

Southwest Michigan
BEHAVIORAL HEALTH

2019 Synar Summary

Overview of Synar Tobacco Compliance Checks:

- The "Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act" of July 1992 includes the Synar Amendment (Section 1926), which requires states to create a Youth Tobacco legislation (MI-YTA), verify retailer compliance level annually, and report it to the Department of Health and Human Services.
- Minimum compliance rate expected from each state is 80%.
- States who fail to demonstrate a minimum compliance rate of 80% stand to lose as much as 40% of their allocated block grant funding (penalty incurred in the following FY)
- Each year, the Michigan Department of Health and Human Services (MDHHS) randomly selects tobacco retailers of each county, and assigns PIHPs to conduct covert compliance inspections of these retailers during a specific time of the year (this year: 6/1/19 - 6/30/19).
- In addition to the Synar Compliance Inspections, the PIHP conducts year-round compliance checks and education efforts of tobacco retailers, alcohol retailers and vaping devices retailers in each county. These efforts are focused on supporting retailers in maintaining compliance with legislation that restricts youth access to these substances.

2019 Results:

- SWMBH was tasked with conducting Synar inspections of 30 retailers (1 assigned retailer was out of business)
- Compliance rate: 27/29 (93.1%)
- NOTE: The compliance rate of our region has been above the 80% mark for the past 11 years. Synar Compliance rate of past three cycles:
    - 2019: 93.1%
    - 2018: 96.5%
    - 2017: 88.6%

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
ALCOHOL TAX PLAN - FY19

	Approved Budget FY 19 Oct - Sep	Amended Budget FY 19 Oct - Sep	Inc/(Dec) over approved FY 19 Budget
Revenue:			
Prior Year(s) Carryover	4,575,621	4,518,166	(57,455)
PA2 Revenue	1,827,172	1,827,172	-
Total Revenue	**6,402,793**	**6,345,338**	**(57,455)**
Expenses:			
RESIDENTIAL TREATMENT SERVICES	246,347	246,347	-
OUTPATIENT TREATMENT SERVICES	1,964,304	1,966,804	2,500
PREVENTION SERVICES	236,000	236,000	-
Total Expenses	**2,446,651**	**2,449,151**	**2,500**
Total Carryover	**3,956,141**	**3,896,187**	**(59,955)**

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
KALAMAZOO COUNTY
ALCOHOL TAX PLAN - FY19

	Approved Budget FY 19 Oct - Sep	Actual Expense FY 19 Oct - Jan	Amended Budget FY 19 Oct - Sep	Inc/(Dec) over approved FY 19 Budget
Revenue:				
Prior Year(s) Carryover	1,997,303	1,963,706	1,997,303	-
PA2 Revenue	660,729	660,730	660,729	-
Total Revenue	**2,658,032**	**2,624,436**	**2,658,032**	**-**
Expenses:				
RESIDENTIAL TREATMENT SERVICES				
CHC - New Beginnings	77,627	26,384	77,627	-
CHC - Bethany House	57,720	13,902	57,720	-
CHC - Healing House	45,000	5,231	45,000	-
KCMHSAS - Oakland Drive Shelter	34,000	11,333	34,000	-
OUTPATIENT TREATMENT SERVICES				
8th District Sobriety Court	28,000	1,941	28,000	-
8th District Young Adult Diversion Court	5,000	744	5,000	-
8th District Probation Court	7,000	1,287	7,000	-
9th Circuit Drug Court	60,000	14,216	60,000	-
CHC - Adolescent Services	21,373	6,877	21,373	-
GFM - Contingency Management	-	-	2,500	2,500
Interact - IDDT	26,600	2,059	26,600	-
KCHCS Healthy Babies	87,000	20,122	87,000	-
KCMHSAS - EMH	56,400	18,800	56,400	-
KCMHSAS - FUSE	25,000	8,333	25,000	-
KCMHSAS - MH Court	65,000	21,667	65,000	-
KPEP Social Detox	60,000	6,700	60,000	-
MRS	17,250	5,750	17,250	-
Recovery Institute - Recovery Coach	60,623	14,133	60,623	-
WMU - BHS Integrated	-		-	-
WMU - Jail Groups	53,395	17,770	73,395	20,000
WMU - BHS SBIRT	46,747	7,807	26,747	(20,000)
WMU - BHS Text Messaging	6,000	982	6,000	-
			-	-
PREVENTION SERVICES			-	-
Gryphon Gatekeeper - Suicide Prevention	20,000	-	20,000	-
Gryphon Helpline/Crisis Response	36,000	12,000	36,000	-
Prevention Works - Task Force	50,000	16,204	50,000	-
Total Expenses	**945,735**	**234,243**	**948,235**	**2,500**
Total Carryover	**1,712,297**	**2,390,193**	**1,709,797**	**(2,500)**

Note(s)

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

PROGRAM BUDGET SUMMARY

POPULATION(S):	☐ MIA	☐ SED	☐ DDA	☐ DDC	☑ SA

PROGRAM:			CFDA #	DATE PREPARED:
Kalamazoo County Jail Services			NA	7/5/2018
CONTRACTOR NAME:			BUDGET PERIOD:	
Behavioral Health Services/WMU			From: 10/01/18	To: 09/30/19
MAILING ADDRESS (Number and Street):			BUDGET AGREEMENT:	
1000 Oakland Drive			☑ ORIGINAL	☑ AMENDMENT
CITY:	STATE:	ZIP CODE:	AMENDMENT NO:	FEDERAL TAX ID:
Kalamazoo	MI	49008	1	38-6007327

EXPENDITURE CATEGORY	Kalamazoo County Jail	0	0	TOTAL BUDGET
1. SALARIES AND WAGES	-	-	-	-
2. FRINGE BENEFITS	-	-	-	-
3. TRAVEL	-	-	-	-
4. SUPPLIES AND MATERIALS	1,145.00	-	-	**1,145.00**
5. CONTRACTUAL	-	-	-	-
6. EQUIPMENT	-	-	-	-
7. UTILITIES	-	-	-	-
8. INSURANCE	-	-	-	-
9. REPAIRS AND MAINTENANCE	-	-	-	-
10. RENTAL/ LEASE	-	-	-	-
11. OTHER EXPENSES	72,250.00	-	-	**72,250.00**
12. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-11)	$ 73,395.00	$ -	$ -	**$ 73,395.00**
13. INDIRECT COSTS Rate %	-	-	-	-
14. TOTAL EXPENDITURES FUNDED (Sum of Lines 12-13)	**$ 73,395.00**	$ -	$ -	**$ 73,395.00**
SOURCE OF FUNDS				
15. FEES AND COLLECTIONS				-
16. SWMBH				-
17. LOCAL/MATCH				-
18. BLOCK GRANT				-
19. PA2	68,395.00			**68,395.00**
20. OTHER(S)				-
21. TOTAL FUNDING	**$ 68,395.00**	$ -	$ -	**$ 68,395.00**

SECTION 2.3.: ABILITY TO PAY DETERMINATION	☐ YES	☑ NO
SECTION 2.4: COORDINATION OF BENEFITS	☐ YES	☑ NO

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH
PROGRAM BUDGET - COST DETAIL

PROGRAM:	BUDGET PERIOD:	DATE PREPARED:
Kalamazoo County Jail Services	From: 10/01/18 To: 09/30/19	07/05/18
CONTRACTOR NAME:	BUDGET AGREEMENT:	AMENDMENT NO:
Behavioral Health Services/WMU	☑ ORIGINAL ☑ AMENDMENT	1

1. SALARIES AND WAGES POSITION DESCRIPTION	COMMENTS	FTE REQUIRED	TOTAL SALARY
1. TOTAL SALARIES AND WAGES		0.000	$ -

2. FRINGE BENEFITS (SPECIFY)	COMPOSITE RATE %				
☑ FICA	☐ HEALTH INS	☐ HEARING INS	☐ SHORT TERM DISB		-
☐ UNEMPLOY INS	☐ LIFE INS	☐ DENTAL INS	☐ LONG TERM DISB		
☐ RETIREMENT	☐ VISION INS	☐ WORK COMP	☐ OTHER: specify		
2. TOTAL FRINGE BENEFITS				$	-

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)	
3. TOTAL TRAVEL	$ -

4. SUPPLIES AND MATERIALS (Specify if category exceeds 10% of Total Expenditures)	
Treatment Workbooks (120@ $4.95 + tax and shipping)	645.00
Program Supplies (paper, pencils, copier toner, copier ink)	500.00
4. TOTAL SUPPLIES AND MATERIALS	$ 1,145.00

5. CONTRACTUAL (Subcontracts) Name	Address	Amount
5. TOTAL CONTRACTUAL		$ -

6. EQUIPMENT (Specify)	Amount
6. TOTAL EQUIPMENT	$ -
7. UTILITIES (Specify)	
7. TOTAL UTILITIES	$ -
8. INSURANCE (Specify)	
8. TOTAL INSURANCE	$ -
9. REPAIRS AND MAINTENANCE (Specify)	
9. TOTAL REPAIRS AND MAINTENANCE	$ -
10. RENTAL/LEASE (Specify)	
10. TOTAL RENTAL/LEASE	$ -

11. OTHER EXPENSES (Specify)	Amount
Bus Tokens (500 @ $1.75)	875.00
Assessments (100 @ $150)	20,000.00
Counseling sessions (75 @ $85)	6,375.00
Group Counseling sessions (200 @ $150.00)	45,000.00
Peer Support (486 units @ $12.50 per unit)	
11. TOTAL OTHER EXPENSES	$ 72,250.00

12. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-11)			$ 73,395.00
13. INDIRECT COSTS			
	INDIRECT RATE	0.00%	-
13. TOTAL INDIRECT COSTS			$ -
14. TOTAL EXPENDITURES FUNDED (Sum of Lines 12-13)			**$ 73,395.00**

WESTERN MICHIGAN UNIVERSITY BEHAVIORAL HEALTH SERVICES

Kalamazoo County Jail Substance Use Disorder Services

Work Plan

Scope of Agreement

Western Michigan University Behavioral Health Services (BHS) agrees to undertake, perform, and complete the services outlined within this agreement using SWMBH administered PA2 funding not to exceed **$73,395.00** during the grant period of October 1, 2018 and September 30, 2019.

Licensure

The Provider will maintain a substance abuse license as required by section 6321 of P.A. 368 of 1978.

Accreditation

It is preferred the Provider will be accredited by one of the following accrediting bodies: Joint Commission on Accreditation of Health Care (JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); Council on Accreditation of Services for Families and Children (COA); American Osteopathic Association (AOA); or National Committee on Quality Assurance (NCQA).

Services

Alcohol and other drug use is commonly found among individuals with a history of criminal conduct. Research and various surveys show that from 50% to 80% of offenders have a history of problems with alcohol and other drug use and substance abuse. An estimated 58% of offenders under MDOC jurisdiction report substance abuse histories. A significant number within this group have serious substance use problems consistent with a substance use disorder (SUD) diagnosis moderate to severe. Individuals with SUDs, particularly those within the criminal justice system, often have poor problems solving skills, affect regulation problems, faulty thinking, lack of self-control, failure to consider consequences, and low frustration tolerance. Therefore, a combination of interventions and treatment strategies are warranted to address these issues.

Effective treatment provides the offender with the opportunity to make positive changes in their behavior. Treatment for the individual with the dual disorder of SUD and criminal behavior utilizes motivation enhancement strategies, cognitive behavioral approaches, and focuses on dynamic risk factors as promising targets for change. Treatment initiated with a clinical assessment and motivational enhancement activities, the treatment regimen employs cognitive behavioral approaches such as cognitive restructuring, social skill development, effective relapse prevention skills, skillful thinking training, and recidivism prevention approaches and the importance of developing community supports such as AA or NA.

Services will include: assessment, group therapy, individual discharge planning, and recovery coach support services. Group therapy will utilize two evidence-based practice programming (Interactive Journaling-Breaking the Cycle-Getting Started Workbook and ATTC curriculum "Motivational Groups for Community Substance Abuse Groups").

Procedures

- Targeted populations are those clients that have an anticipated length of incarceration from 21-30 days.
- All clients requesting treatment services will complete an assessment by BHS clinical

staff.

- Group therapy will be provided twice a week for 4-5 weeks.
- Group sessions will be 90 minutes in length and will be an open group, allowing individuals to enter treatment following assessment.
- Groups will be separated by gender.
- Individuals will participate in an individual session prior to release from jail. This session will focus on discharge planning, referral and linking to community-based services, continuation of care, and development of a relapse prevention plan.
- BHS staff will contact individuals within seven days of their discharge to determine if arrangements for continued care have been made and to offer assistance where needed.
- A discharge summary will be provided to the Kalamazoo County Sheriff's office reporting dates of treatment while incarcerated, nature and status at discharge, recommendation for continued care, and provider name for aftercare services.
- Peer Support services will be offered to all program participants at the time of their release from jail. Information concerning recovery coaching/peer support services will be distributed to all program participants while they are engaged in the program.

Outcome Measures

- Ninety-five (95%) of program participants will attend at least 6 group sessions during their length of stay in jail.
- At least 75% of program participants that had a completed discharge plan will engage in community-based treatment following discharge as evidenced by attending at least three treatment sessions. A treatment session may be defined as: assessment, individual counseling and/or group therapy.
- For clients seen in a final treatment discharge session where aftercare/community-based treatment is recommended, and the client is open to seek continued care, 100% will have a completed discharge/aftercare plan.
- 95% of program participants that successfully complete at least 6 group sessions will be linked with recovery coaching/peer support services

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

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.

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
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STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

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,

Denise L. Moreau
CEO UnitedHealthcare

Julia B Rupp
CEO HealthWest

President/COO Meridian

David Russell
CEO Genesee Health System

Mary L Clark, RN, VP
McLaren Health Plan

VP State Markets
Priority Health

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 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

CRAIN'S DETROIT BUSINESS

May 19, 2019 12:03 AM

Michigan HMOs, led by Blue Care Network, earn record net income in 2018

JAY GREENE

- Blue Care Network increased net income by 3.3% in 2018 to $250.6 million
- But eight plans reported lower net income and four plans lost money
- Nationally, health insurers had banner year, but must refund customers $1.4 billion for excessively priced premiums

Michigan's health insurers earned record profits in 2018, a year in which they raised many types of premiums steeply in anticipation of changes to Obamacare.

Muted increases in payment for care led several of them to make higher profits on coverage than allowed and will have to pay refunds to customers.

Led by Blue Care Network, which earned $250.6 million in net income in 2018 for a 5.9 percent margin, Michigan's 21 health plans made a total of $500.4 million last year for a 3 percent margin, topping 2017's record of $452.1 million, according to data from the Michigan Department of Insurance and Financial Services.

Underwriting income was even better, totaling $587.4 million in 2018 for a 3.4 percent total margin. Without Blue Care Network, however, net income for the remaining 15 plans totaled $233.1 million for a 1.9 percent total margin.

"Overall plans have been tried to be more competitive and as a result we have been able to manage health care costs and drive down administrative expenses. The result has been increase in net income on average," said Dominick Pallone, executive director of the Michigan Association of Health Plans. MAHP represents most of the health plans except for the two Michigan Blues' plans.

Pallone said he is uncertain how the state will judge last year's HMO financial performance when setting Medicaid rates later this year for 2020.

Michigan Association of Health Plans

Dominick Pallone

"It is too early to tell exactly what effect the financial situations for HMOs will have on rate development for Plan Year 2020," he said. "For the individual and small group markets, plans are still currently working on early projections for rates. Plans will continue to do their best to continue to keep rates moderated, and there are a lot of factors that go into rate determinations."

Over the past five years, Michigan's health plans have steadily improved net income and enrollment. But total underwriting revenue declined 2.8 percent to $17.1 billion in 2018 from $17.6 billion in 2017. Revenue growth also was flat in 2016 because Medicaid membership slowed as the economy grew. After Healthy Michigan Medicaid was established in 2014 under the Affordable Care Act, the state's 11 Medicaid health plans increased revenue significantly the next two years.

Six health plans in 2018 experienced revenue declines. They include Health Alliance Plan of Michigan ($359.5 million), Meridian ($213.5 million), UnitedHealthcare Community Plan ($191.9 million). On the other hand, Blue Care Network ($658.2 million) and Priority Health ($164.9 million) saw increases in revenue.

"Some of this might be explained by a slow decline in enrollment in Medicaid over the last two years as the economy has improved," Pallone said. "The state (also) has continued to aggressively impose managed care savings (payment cuts) within the Medicaid rates ... under the expectation that managed care entities need to continuously find efficiencies."

Still, over the past decade, total enrollment in health plans has grown 31 percent to more than 3.45 million as employers and individuals seek lower costs and increasingly accept more tightly controlled network rules.

Net income also has steadily increased during that period, especially starting in 2015 — the first full year after Obamacare's Medicaid expansion began.

Pallone contends those overall numbers are distorted by Blue Care Network's massive net income tallies.

"Absent Blue Care, the rest of the HMOs are below where we were in 2015, the first full year of Healthy Michigan Medicaid," Pallone said. "It's fair to say the Blues have had two years of steady growth, but the rest of the HMOs only really saw 2018 as a growth year for net income, but still haven't gotten back to 2015 levels."

For example, Michigan HMOs, excluding Blue Care, earned $312.7 million in 2015, but only a total of $211.7 million and $233.1 million in 2017 and 2018, respectively.

Nationally, health insurers had a banner year as they set premium prices an average 26 percent higher in 2018 after threats to end Obamacare by President Donald Trump and leading Republicans. While final numbers for 2018 are not complete, health insurers were projected to earn more last year than the record $161 billion in profits netted in 2017. Another reason for the high profits was that per person claim expenses increased by only 7 percent in 2018, much lower than expected.

Based on rules under the Affordable Care Act, many health insurers must refund customers $1.4 billion for excessively priced premiums, according to a recent study by Kaiser Health. It will be the largest payment to consumers since ACA was approved in 2010.

Under Obamacare, health insurers must spend at least 80 percent of premium revenue on claims or quality improvements as required by the ACA. The average share of health premiums paid out in claims fell from 82 percent in 2017 to 70 percent in 2018, Kaiser said.

A Crain's review found several health plans fell under 80 percent and are expected to issue refunds. They included Blue Cross Complete (78.8 percent), Trusted Health Plan (71.9 percent), Molina Healthcare of Michigan (77.7 percent) and UnitedHealthcare (79.7 percent).

"There was a lot of uncertainty going into 2018," Pallone said. "Claims were flat last year. When we looked at individual market for 2018, rates went up dramatically, but in 2019 they have been fairly moderate, and a slight reduction for some."

Michigan's net income leaders

Michigan's health plans varied greatly in total revenue, profitability, enrollment and administrative expenses percent. But eight of 17 reported lower net income, and four plans lost money.

Blue Care Network, the state's largest health plan with 738,000 members, increased net income 3.3 percent to $250.6 million in 2018. BCN increased enrollment 7 percent in 2018.

"Blue Care Network had a strong year in 2018 with membership growth for the sixth straight year, increased revenue due to membership growth, and effective management of health costs for our customers," said Jim Kallas, BCN's vice president and treasurer, in a statement.

Blue Cross Blue Shield of Michigan

James Kallas

"Our membership at year-end 2018 was at 916,000 members which includes commercial, self-funded and Medicare members. Achieving membership gains speaks to the efforts we've made as a company to improve our customers' experience and provide health insurance products that improve our members' lives, while supporting our community."

Kallas said BCN has cut premiums for small-business employers four times since July 2017, accounting for an average 2.6 percent premium reduction.

"Blue Care Network is an outlier here," Pallone said. "I would say (BCN's financial performance) is a byproduct of their market dominance and of Blue Cross as a whole. They have an ability to leverage (size to extract lower provider rates). We hope that employers and individuals will be mindful of that as they move to purchase in 2020."

No. 2 by net income was Priority Health with $123.8 million in net income, a 57.3 percent increase from $78.7 million in 2017. Total enrollment at Priority was 514,000, a 1 percent drop from the year before.

"Priority Health's financial performance is a reflection of the company's commitment to enhance its product portfolio, reduce the occurrence of unnecessary health care

costs and keep administrative costs low," Mary Anne Jones, its CFO, said in an email to Crain's. "We continue to see growth across the company, we ended 2018 with more than 782,000 members, up from 779,000 last year, and are well-positioned for continued success in the future."

Priority Health's total membership also includes about 268,000 enrollees from PH Insurance Co., PH Choice and self-funded employer plans.

On the other hand, Meridian Healthcare of Michigan, which was acquired last summer by WellCare Health Plans inc. for $2.5 billion, lost $87 million in 2018, mostly because of charges against its balance sheet resulting from the merger.

For example, general administrative expenses increased substantially in 2018 to $241.2 million from $184.3 million. Like most plans, prescription drug costs also rose, going up to $338 million from $311 million. Total revenue dropped to $1.99 billion last year from $2.2 billion the prior year.

Because Tampa-based WellCare is undergoing a sale to Centene Corp. for $15 billion, officials for Meridian are prohibited from discussing the 2018 financial year.

Pallone, who said he also was unable to talk with Meridian officials, said he believes Meridian incurred some one-time administrative costs, which included paying legal and consulting fees, additional staff time negotiating and closing the merger.

No. 3 in net income was Molina Healthcare of Michigan, which generated $97.5 million in net income, a 195 percent increase over $33 million in 2017. Molina's enrollment was 369,000 as of March 30, a 3.6 percent decline from 383,000 on Dec. 31.

While Molina did not comment on Michigan results, the Long Beach, Calif.-based investor-owned company overall earned $198 million of net income on revenue of $371 million during the first quarter of 2019. Net income per diluted share increased to $2.99 from $1.64 in the first quarter of 2018.

"These results are a testament to the achievability of the second phase of our strategy, which is to sustain the attractive margin position we had built in 2018," said Joe Zubretsky, president and CEO, in a statement. "While certainly not conclusive,

our first quarter results validate our position that durable financial and operational improvement can and should allow us to sustain these margins, all while we begin to grow the top line again."

Fourth was Blue Care Complete, a Medicaid HMO that earned $31.4 million last year, an 84 percent increase over $17.1 million in 2018. Enrollment was 209,000 in 2018, a 0.3 percent increase from the prior year.

"Blue Cross Complete's administrative cost containment and focused interventions in our coverage area contributed to positive results in 2018," said a statement from Blue Cross. "As stewards of taxpayer dollars, we're mindful of the trust placed within our care and seek to invest in the communities we serve, working with providers to deliver care that is as much social as it is clinical."

For example, our Blue Cross Complete outreach workers, called care connectors, help certain vulnerable members navigate the health care system. Care connectors assist members in their homes to understand how to use health care as well as connecting them to community resources that include transportation, housing, food, utilities and other non-medical factors that can impact an individual's health.

In 2018, Health Alliance Plan of Michigan earned $3.5 million in net income, a 60 percent decline from $8.7 million the previous year. HAP also took a $10.5 million underwriting loss in 2018 compared with a $3.9 million gain in 2017.

Total revenue also declined by $349 million to $1.47 billion. Some of the revenue losses were attributed to dropping money-losing contracts that contributed to a drop in membership by about 70,000 lives compared with 2017.

Despite the short-term financial hit, Terri Kline, HAP's CEO, said in an email to Crain's that the plan added Medicare Advantage members and increases its market share for the first time since 2010.

"HAP is extremely well-positioned for growth and sustainability and has right-sized its HMO line of business to position for long-term growth," Kline said. "Our improved financial strength can be measured by the fact that our risk-based capital is over 400

percent for each of our companies, which includes HAP (HMO), Alliance Health & Life (PPO), and HAP Midwest Health Plan (Medicaid)."

HAP Midwest also lost money in 2018, reporting a net loss of $5.4 million, a 400 percent drop from net income of $1.8 million in 2017.

But Kline said HAP is preparing for the future by adding key personnel in such departments as actuarial and analytics, risk management, underwriting, sales and account management.

Last November, HAP began moving about 1,100 employees to a new Troy building at 1414 E. Maple Road. HAP took about 180,000 square feet of the Troy building under a sublease from parent company Henry Ford Health System.

Administrative expenses holding steady

Contributing to the overall financial stability of plans was holding steady in total administrative costs, which averaged 12 percent for the plans last year. Administrative costs include scheduling, billing, claims processing, marketing and other overhead costs.

HAP Midwest had 21.6 percent while HAP had 12.3 percent of administrative expenses. Blue Care Network, the largest health plan, had 14.4 percent while its Blue Cross Complete Medicaid plan had 15.7 percent. On the other hand, Trusted Health plan recorded a 44.4 percent administrative expense as it lost $4.6 million for a -17.3 percent margin.

McLaren had the lowest percent administration at 6.7 percent as it earned$10.8 million for a 1.5 percent margin. Other plans recorded the following administrative expense: Molina, 7.1 percent; Priority, 11.6 percent; Meridian, 12.1 percent; and UnitedHealthcare had 16.6 percent.

Pallone said administrative expenses have averaged about 12 percent since about 2012, when the Affordable Care Act was implemented in the individual market.

Source URL: *https://www.crainsdetroit.com/health-care/michigan-hmos-led-blue-care-network-earn-record-net-income-2018*