Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
August 14, 2020
9:30 am to 11:00 am
Draft: 8/7/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Consent Agenda**
   - July 10, 2020 SWMBH Board Meeting Minutes (d) p. 3
5. **Operations Committee**
   - Operations Committee Minutes June 24, 2020 (d) p. 6
6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   - Nothing scheduled
7. **Board Actions to be Considered**
   - Auditor Selection (T. Dawson) (d) p. 9
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
   - BG-002 Management Delegation (d) p. 10
9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   - BEL-005 Treatment of Plan Members (M. McShane) (d) p. 11

10. Board Education

a. Fiscal Year 2021 Budget Preview (T. Dawson) (d) p. 17
b. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 19
c. Substance Use Disorder Oversight Policy Board Update (Randall Hazelbaker, Chairman and J. Smith) (d) p. 27
d. September 11, 2020 SWMBH Board Budget Public Hearing Update (B. Casemore)
e. Updated Strategic Business Plan (B. Casemore) (d) p. 28
f. Racial/Ethnic Health Disparities Report (B. Casemore) (d) p. 80
g. Provider Network Stability (M. Todd and T. Dawson)

11. Communication and Counsel to the Board

a. MDHHS Behavioral Health Strategic Planning Pillars (d) p. 89
b. September 11, 2020 Board Agenda (d) p. 90
c. Board Member Attendance Roster (d) p. 92
d. September Board Direct Inspection: BEL-009 Global Executive Constraints (E. Meny)

12. Public Comment

13. Adjournment

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

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

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

Next SWMBH Board Meeting
September 11, 2020
9:30 am - 11:00 am

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
July 10, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 7/13/20

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

Guests Present via phone: Bradley Casemore, Executive Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Ric Compton, Riverwood; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Alternate; Kris Kirsch, St. Joseph CMH; Mary Middleton, Woodlands Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH

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

Public Comment
None

Agenda Review and Adoption
Brad Casemore requested changes to the agenda:

7a. Board Actions to be Considered -- External Auditor Selection – Moved to Section 11. Communications and Counsel
7b. Board Actions to be Considered – BG-008 Board Member Job Description Management Proposal – Removed from agenda
7 Board Actions to be Considered – Add August 14, 2020 SWMBH Board Retreat

Motion	Robert Nelson moved to accept the agenda with changes from Brad Casemore.	
Second	Tom Schmelzer	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Financial Interest Disclosure Handling

Mila Todd reported she has submitted a completed SWMBH Conflict of Interest Statement, signed by Ed Meny, stating on June 12, 2020, the Board passed a resolution in which it determined that it is not, with reasonable efforts, able to obtain a more advantageous transaction or arrangement from a person or entity other than Mary Middleton, and the Financial Interest disclosed on the Statement is not so substantial as to be likely to affect the integrity of services which the Entity may expect from Mary Middleton, and granted this Conflict of Interest Waiver accepting the terms described below:

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

Consent Agenda

Motion	Erik Krogh moved to approve both the June 12, 2020 Board meeting minutes and the June 12, 2020 SWMBH Board Planning Meeting Minutes as presented.	
Second	Bob Nelson	
Roll call vote	Bob Nelson	yes
	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes
Motion Carried		

Operations Committee

Operations Committee Minutes May 27, 2020

Edward Meny noted the minutes as documented. Minutes accepted.

Operations Committee Quarterly Report

Deb Hess reported.

Ends Metrics

None

Board Actions to be Considered

August 14, 2020 SWMBH Board Planning Meeting

Brad presented the issues surrounding the August 14, 2020 date for the SWMBH Board Planning Session. Board Members also presented concerns. Decision was unanimous to postpone August 14, 2020 SWMBH Board Planning Meeting until October 9, 2020, understanding that the environment of Covid-19 would determine the future date.

Board Policy Review

None

Executive Limitations Review

None

Board Education

Fiscal Year 2021 Budget Assumptions

Brad presented a PPT presentation provided by Tracy Dawson. Additional information was requested regarding the FY21 Projected Annual Average Medicaid Eligibility vs Final FY19. Brad is to provide additional data for the next Board Meeting.

Fiscal Year 2020 Year to Date Financial Statements

Brad Casemore reported as documented noting surpluses in the Healthy Michigan and Medicaid Specialty. Brad cautioned that this is an artificial picture.

Michigan Health Endowment Fund Grant Update

Moira Kean reported on the Quarterly Program Update and the impact of the Governor's Stay-Home, Stay-Safe order and the modifications made. The challenges include the unexpected complexity of the exclusion criteria for the grant population.

MI Health Link Renewal

Brad reported SWMBH's intentions to renew the MI Health Link Program for 5 more years. The program has been successful, financially sound, and has served the clients. Requirements of the program have developed our knowledge, skills, and abilities and has placed us in a position to be recognized by the State.

Communication and Counsel to the Board

2020-2023 SWMBH Regional Strategic Plan

Brad introduced the 2020-2023 SWMBH Regional Strategic Plan. He has continued to stay in close contact with the state officials. A major concern is the state's financial situation and the impact on our industry. Stakeholders are diligently marketing, continuing to refer to the overhead of the public behavioral health system. A key topic on the agenda is governance. Brad encouraged interaction with elected officials by all individuals. A final version of the Strategic Plan will include updated environmental issues.

External Auditor Selection

Brad provided an overview of the selection process. He reminded the Board that they have an opportunity to recommend an auditor.

Miscellaneous

Remaining topics under Communication and Counsel to the Board have documents attached in the Board packet.

Adjournment

Motion Erik Krogh moved to adjourn at 11:11am

Second Bob Nelson

Unanimous Voice Vote

Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: June 24, 2020 9:00am-11:00am

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

Guests present via phone – Allen Jansen, Senior Deputy Director, Behavioral Health and Developmental Disabilities Administration; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Beth Guisinger, Manager of Utilization Management & Call Center, SWMBH; Brad Sysol, Summit Pointe, Jane Konyndyk, Integrated Services of Kalamazoo; Pat Davis, Integrated Services of Kalamazoo

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

Review and approve agenda – Agenda approved.

Review and approve minutes from 5/27/20 Operations Committee Meeting – Minutes were approved by the Committee.

On-Call Physician – Ric Compton reviewed Riverwood's current on-call processes and expenses. Anne Wickham stated that Master Level Clinicians can do authorizations and admissions, but a physician must do any denials. Discussion on potential regional cost savings ensued. Group discussion followed with an agreement to revisit the topic as desired.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson reported as documented noting the increase in revenue from the State due to correct rates. Per the State, this month's payment will be late. Autism expense is down due to not being able to provide services during the pandemic. Discussion followed.

Fiscal Year 2021 Milliman Rate Letters and Capitation Revisions – Tracy Dawson reported as documented.

Fiscal Year 2020 Encounter Volumes – Tracy Dawson reported as documented and reminded group that these reports are available to each CMSHP on Tableau. Brad reinforced the importance of Encounters, BHTEDS, Q Records, LOCUS, etc. to our future funding levels.

Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI) – Tracy Dawson and Natalie Spivak shared that the State's MUNC forms are not ready and the due date was moved to August for periods April, May and June. The State has stated that training will be provided.

Fiscal Year 2021 Budget Assumptions – Tracy Dawson reported as documented noting that this is a first draft. As rates are disclosed from the State the Budget Assumptions will be revised.

Cost Allocation and Rate Development Workgroup – Pat Davis reviewed the Milliman Behavioral Health Development Fee Project Status Report as documented. The changes proposed would mean big changes and an extensive rework of general ledger processes and safety net function reviews. Brad Casemore encouraged each CMHSP CEO to fully review the report and discuss with management teams and that the report will be reviewed at applicable Regional Committees.

MI Health Link Renewal – Brad Casemore shared that DHHS and CMS approved a five-year extension and then two weeks ago revised to a one-year extension with a 3-4-year revised extension. SWMBH intends to continue into 2021.

Provider Stability Plan – Mila Todd reported as documented and thanked Jen Poole and Pat Davis for their work on the Provider Stability Plan workgroup. This item will be discussed further at the July Operations Committee meeting.

Fiscal Year 2020-2023 Strategic Business Plan draft – Brad Casemore asked the CMHSP CEOs to review the document and provide him feedback for discussion and revisions at the July Operations Committee meeting. This is an evolving document. It will be introduced to SWMBH Board in July and will serve as primary discussion content for August 14 Board Planning Session. He invited phone or video meetings with CMH CEOs and or their management teams.

Behavioral Health Treatment Episode Data Set Report – Natalie Spivak reported as documented. The completeness, timeliness and accuracy of these are critical.

Mediation Law in the Mental Health Code – Brad Casemore noted the document in the packet and stated that this is not a PIHP issue, but CMHSPs can review and discuss at regional member services committee meetings.

Allen Jansen, Senior Deputy Director, Behavioral Health and Developmental Disabilities Administration (BHDDA) – Brad Casemore introduced Allen Jansen. Allen Jansen reviewed his 30 history in the Public Mental Health System which included work at Pine Rest, Hope Network, Network 180, interim CEO at Kalamazoo Psychiatric Hospital, Board Member of Lakeshore Regional Entity and interim CEO at Lakeshore Regional Entity. He noted his personal and professional experiences in the field. Allen Jansen discussed his first 100 days as Senior Deputy Director of BHDDA working with Director Gordon on the proposed redesign of the public behavioral health system. He shared his thoughts about the diminished roles that PIHPs and Advocates played in the proposal and the lack of understanding of behavioral health in the Dept. Allen Jansen shared the following thoughts:

- This an opportunity to strengthen the profile of behavioral health and explore ways to integrate with physical health
- This is a target rich environment
- Governor Whitmer's office is interested in behavioral health as the profile has risen there due to response from COVID-19 hot and warm lines

- Legislators care about behavioral health but do not have enough appreciation for CMH work done
- Director Gordon plans to end the proposed public behavioral health system redesign which leaves the door open for creative responses and alternate model considerations
- For Fiscal Year 2020 the CARES Act will fill in funding shortfalls
- For Fiscal Year 2021 it will be a devastating year with everything being a target for cuts
- No major strategic plans submitted for carve in models
- More funding shortfalls and information in August after revenue estimates come out

Fiscal Year 2021 Budget Development Calendar – Tracy Dawson reported as documented.

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd stated the new boilerplate was received and SWMBH's review noted no substantial changes. Any downstream implications will be incorporated into the PIHP/CMH contracts for discussion.

2019 Customer Satisfaction Results Remediation Plans – Jonathan Gardner reported as documented.

MHEF KHC Grant Update – Moira Kean stated that due to COVID-19 Stay at Home orders no outreach or face to face work occurred. June 6th the Stay at Home orders were lifted and starting June 13th the team restarted outreach to potential new members.

Opioid Health Homes (OHH) Update – Brad Casemore stated that the OHH is beginning in Kalamazoo and Calhoun counties. Contracts are being drafted between SWMBH and Summit Pointe and SWMBH and Victory Clinical Services, a budget was drafted and the OHH Coordinator position was posted.

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

Reminder Budget Public Hearing September 11 – Brad Casemore reminded the group of the SWMBH Budget Public Hearing on September 11th at a location yet to be determined.

CMHAM Recommendations – Brad Casemore shared the recommendations as an FYI to the group.

SWMBH HQ Happenings – Brad Casemore asked if CMHSPs still wanted to receive the daily SWMBH HQ Happenings. If they do not want to receive the daily emails, please let Michelle Jacobs know and she will remove your name from the distribution list.

MIHIN COVID Lab Results – Brad Casemore shared that Natalie Spivak will cover this topic at the July Operations Committee meeting.

Appendix K – Brad Casemore noted the documents in the packet noting that SWMBH is reviewing and this topic will be discussed at the July Operations Committee meeting.

Substance Use Disorder (SUD) Consent Form – Natalie Spivak stated that an electronic SUD Consent Form is being finalized and will be available on the SWMBH website for provider use.

Adjourned – Meeting adjourned at 11:32am

August 7, 2020

To: SWMBH Board of Directors

From: Bradley P. Casemore, CEO
Tracy Dawson, CFO

Subject: Recommendation to the SWMBH Board for External Audit services.

Recommendation: We are recommending the SWMBH Board approve Roslund, Prestage and Company to be SWMBH's financial and compliance auditors for fiscal year 2021, 2022 and 2023, with 1-year options for up to three years.

A Request for Proposal was released on May 15th, 2020 on our website and sent to four known firms. All responses were due to SWMBH on June 12th. An RFP Audit committee was formed of 3 individuals. We received two responses.

The Audit Selection Committee met on June 25th and discussed the proposals and scoring. Roslund, Prestage received a 5.0 out of 5.0 score on the categories of price, audit experience, PIHP/CMHSP financial knowledge and references. The other bidder received 4.1 out of 5.0.

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board- Policy Global Board	Policy Number: BG-002	Pages: 1
Subject: Management Delegation	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☐ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
11.18.2013	08.09.19	8.08.14, 08.14.15. 8.12.16, 8.11.17, 8.10.18

I. **PURPOSE:**

To establish official connections with SWMBH Executive Officer and other SWMBH staff.

II. **POLICY:**

The Board's sole official connection to the operational organization, its achievements and conduct will be through its chief executive officer, titled Executive Officer. *The Fiscal Officer and Chief Compliance Officer shall have direct access to the Board.

III. **STANDARDS:**

*Verbatim from Bylaws: 7.1 Executive Officer. The Regional Entity shall have at a minimum an Executive Officer, and a Fiscal Officer. The Regional Entity Board shall hire the Executive Officer; and the Executive Officer shall hire and supervise the Fiscal Officer. Both positions shall have direct access to the Regional Entity Board

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
For the period May 2019 to July 2020

Policy Number: BEL-005
Policy Name: Treatment of Plan Members
Assigned Reviewer: Mike McShane

Policy Purpose: To clearly define the Treatment of Plan Members by Southwest Michigan Behavioral Health (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 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 informational files at SWMBH are appropriately and securely stored, with "need-to-know" access to Protected Health Information (PHI) that is limited by 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. Logins 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 (Natalie Spivak) as required under HIPAA regulations. SWMBH has a set of privacy, security and confidentiality related policies. Staff receive, sign acknowledgements for, and undergo annual training that also includes 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. Both clinical areas of SWMBH are 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.

There is very 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. Milliman has produced and published an analytic tool 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 member self-support tools, such as MyStrength, have been promoted throughout the region at both the provider and member 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).

Through various methodologies, including geo-mapping, SWMBH assesses the adequacy of our Provider Network no less than annually. For MHL services, this report has been delayed due to COVID-19. For Medicaid services, SWMBH is contractually obligated to provide network adequacy reports to MDHHS periodically upon request, and to adhere to MDHHS adequacy standards. This allows the SWMBH region to adjust as necessary to member needs. SWMBH is also able to assess and track any deficiencies with timeliness/access to care with our providers through the MMBPIS. We can identify challenges and barriers members may encounter.

This year's Customer Satisfaction results were favorable and were found to be achieved at the May 13, 2020 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 member 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, thirty-six (36) 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 thirty-six (36) incidents assessed, one incident was identified as rising to the level of a HIPAA breach and necessitating notification to the affected members 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 regular 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, members sign to acknowledge receipt of the handbook. There are no known Member complaints related to this topic for the period under consideration.

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:

- Michigan Mission Based Performance Indicator Trending Analysis 2019
- MDHHS Letter regarding Network Adequacy Report
- Customer Handbook 2020
- November 2019 and February 2020 Customer Advisory Committee Minutes
- March 2020 SWMBH Member Newsletter

The assigned SWMBH Behavioral Health Board direct inspector, Mr. McShane, was offered further contact with the EO, Chief Administrative Officer and Manager of Customer 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:	Last Review Date:	Past Review Dates:
12.20.2013	8/9/19	12.12.14, 1/8/16, 3/10/17, 3/18/18

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.

August 7, 2020
SWMBH Board Update: Fiscal Year 2021 Revenue

This serves as a brief update on fiscal year 2021 (begins 10/1/20) rate setting, its impact on our region, and future directional needs. Please review and discuss at CMH management teams and at regional Committees. The rate certification letter has been released and DHHS. Given the numerous changes by MDHHS in our current fiscal year not making final corrections until May 2020 and not receiving direct care wage payment until September we are developing our revenue model in a very conservative manner until we can be assured the payment amounts in the rate certification are what we are being paid. **SWMBH is proposed to receive an increase but will not count on those dollars until we receive our first payment.** Given the on-going COVID-19 situation we will have to see how the rates are affected.

- DHHS MSA continues to be involved and now controls PIHP rate setting whereas DHHS BHDDA used to. The entire FY 2019 data set was used, including encounters, BHTEDS, MUNCs, and LOCUS scores etc.
- Capitation rates are now being calculated for both enrolled (in an MHP) and unenrolled.
- 50 new Autism cases per month state-wide have been built into the rates, a reduction from 75.
- Milliman continued behavior tech encounter cost at $50.
- Last year DHHS had intended to require more frequent financial reports from PIHPs throughout the year but due to their numerous payment errors and lack of training and templates for submission the requirement did not happen. We expect to have to produce more frequent request in ‘21.
- Diagnosis/diagnoses used for actuary evaluation purposes comes from claim/encounter, not from BHTEDS.
- DHHS and Milliman determined that LOCUS reporting was at a high enough rate to include in the rate determination process as a measure of individual and aggregate acuity, and thus service need and capitation payment adjustments.
- DHHS and Milliman have provided a beneficiary level detail file revealing the data they used to calculate Risk Adjustment Factors. Regional analysis will be necessary to understand and improve reporting of Risk Adjustment Factors.
- LOCUS scores were a component of FY 2021 rates. DHHS and Milliman say CAFAS and SIS scores will soon be used to make Risk Adjustments to capitation payments. **The important of complete, accurate and timely reporting of all encounters, BHTEDS and assessment scores to SWMBH cannot be overstated.**
- PIHPs have provided to MDHHS Executives, MSA, BHDDA and Milliman a long list of recent and upcoming unfunded mandates of significant magnitude.
- PIHPs have repeatedly pointed out that PBIP has not been funded as a true bonus program but operates as a sanction avoidance program.
- Estimated Annual Service Cost Trends ranged from 0.0% for Autism to 1.5% Substance Abuse, 1915© Waivers and MH state plan for DAB/TANF and HMP.

- Non-benefit administrative expense loads continue to be low with HSW, SEDW and CWP at 4.25%, DAB/TANF at 4.5% with fixed amount of $8.23 per eligible for DAB and $.99 for TANF and HMP at 6.75%.
- Area Factor for Transportation was included, recognizing urban, urban/rural and rural geographies. Our factor is 1.005 virtually at the 1.00 state average.
- DHHS and Milliman continually repeat that they need more complete/accurate/timely encounters, BHTEDS etc.

	E	F	G	H	J	K	L	M	N	O	P	Q	R	S
1	***Southwest Michigan Behavioral Health***				***Mos in Period***									
2	For the Fiscal YTD Period Ended 6/30/2020			**P09FYTD20**	**9**									
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			215,681,929	165,018,054	28,015,391	12,838,695	2,610,121	5,851,189	1,348,479	-	-	-	
17	DHHS Incentive Payments			472,306	472,306	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			1,140,970	-	-	-	-	1,140,970	-	-	-	-	
19	Interest Income - Working Capital			75,920	-	-	-	-	-	-	75,920	-	-	
20	Interest Income - ISF Risk Reserve			3,843	-	-	-	-	-	-	3,843	-	-	
21	Local Funds Contributions			1,294,644	-	-	-	-	-	-	1,294,644	-	-	
22	Other Local Income			189,455	-	-	-	-	-	-	189,455	-	-	
24	**TOTAL REVENUE**			**218,859,066**	**165,490,359**	**28,015,391**	**12,838,695**	**2,610,121**	**6,992,160**	**1,348,479**	**1,563,862**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			17,513,028	2,695,166	4,641,629	-	3,193,554	5,826,169	1,156,510	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			162,497,349	134,081,737	15,281,913	11,232,861	1,156,305	744,533	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			2,170,992	2,170,992	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			2,710,708	2,710,708	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,966,397	-	-	(1,966,397)	-	-	-			
34	**Total Healthcare Cost**			**184,892,077**	**143,625,000**	**19,923,542**	**11,232,861**	**2,383,462**	**6,570,702**	**1,156,510**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**85.5%**	**86.8%**	**71.1%**	**87.5%**	**91.3%**	**112.3%**	**85.8%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			314,363	-	-	-	-	-	-	314,363	-	-	
39	Administrative and Other Cost			5,568,453	-	-	-	-	-	-	5,568,301	-	152	
41	Depreciation			66,879	-	-	-	-	-	-	66,879	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	205,198	-	(205,198)	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	152	-	(152)	
44	Delegated Managed Care Admin			12,500,160	10,387,206	1,168,928	856,275	87,752	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			-	4,367,779	636,230	358,706	138,907	216,379	-	(5,718,001)	-	-	
46														
47	**Total Administrative Cost**			**18,449,856**	**14,754,985**	**1,805,158**	**1,214,980**	**226,659**	**421,577**	**-**	**26,496**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.1%**	**9.3%**	**8.3%**	**9.8%**	**8.7%**	**6.0%**	**0.0%**	**2.8%**			
49														
50	Local Funds Contribution			1,294,644	-	-	-	-	-	-	1,294,644	-	-	
51														
52	**TOTAL COST after apportionment**			**204,636,577**	**158,379,985**	**21,728,700**	**12,447,841**	**2,610,121**	**6,992,279**	**1,156,510**	**1,321,140**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**14,222,490**	**7,110,375**	**6,286,691**	**390,854**	**-**	**(120)**	**191,969**	**242,721**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**6.5%**	**4.3%**	**22.4%**	**3.0%**	**0.0%**	**0.0%**	**14.2%**	**15.5%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(191,849)	-	-	-	-	-	(191,849)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,843)	-	-	-	-	-	-	(3,843)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	3,876,006	(3,485,152)	(390,854)	-	120	(120)	-			
62	**NET SURPLUS (DEFICIT)**			**14,026,798**	**10,986,380**	**2,801,539**	**-**	**-**	**-**	**-**	**238,879**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
64														
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			13,772,108	10,970,569	2,801,539	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			254,690	15,811	-	-	-	-	-	238,879	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			**14,026,798**	**10,986,380**	**2,801,539**	**-**	**-**	**-**	**-**	**238,879**	**-**	**-**	
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 6/30/2020			**9**									
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%*	79.6%	77.7%	78.2%	80.7%	75.2%	80.7%	82.5%	85.3%	78.0%
7	Subcontract Revenue		165,018,054	11,664,425	153,353,629	6,450,835	29,932,823	8,363,737	27,936,598	8,370,126	47,192,187	10,408,237	14,699,085
8	Incentive Payment Revenue		472,306	172,674	299,632	27,004	16,944	21,180	78,365	3,646	129,196	19,062	4,236
9	**Contract Revenue**		**165,490,359**	**11,837,098**	**153,653,261**	**6,477,839**	**29,949,767**	**8,384,917**	**28,014,963**	**8,373,773**	**47,321,383**	**10,427,298**	**14,703,321**
10													
11	External Provider Cost		101,595,212	2,695,166	98,900,046	3,261,528	19,545,136	4,667,354	18,487,528	4,612,608	34,034,250	6,978,522	7,313,119
12	Internal Program Cost		36,954,102	-	36,954,102	2,073,539	7,389,907	1,999,623	7,758,689	2,297,863	6,566,963	3,426,680	5,440,839
13	SSI Reimb, 1st/3rd Party Cost Offset		(622,202)	-	(622,202)	(9,993)	(135,068)	(29,790)	(106,872)	(32,262)	(227,046)	(22,185)	(58,986)
14	Insurance Provider Assessment Withhold (IPA)		4,881,700	4,881,700	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		722,340	722,340	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**143,531,152**	**8,299,205**	**135,231,947**	**5,325,075**	**26,799,976**	**6,637,187**	**26,139,345**	**6,878,209**	**40,374,168**	**10,383,017**	**12,694,972**
17	**Medical Loss Ratio (HCC % of Revenue)**		**86.7%**	**70.1%**	**88.0%**	**82.2%**	**89.5%**	**79.2%**	**93.3%**	**82.1%**	**85.3%**	**99.6%**	**86.3%**
18													
19	**Managed Care Administration**		**14,842,737**	**4,367,779**	**10,474,958**	**571,189**	**1,945,790**	**590,324**	**1,738,515**	**596,811**	**3,519,169**	**690,932**	**822,228**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.4%**	**2.8%**	**6.6%**	**9.7%**	**6.8%**	**8.2%**	**6.2%**	**8.0%**	**8.0%**	**6.2%**	**6.1%**
21													
22	**Contract Cost**		**158,373,889**	**12,666,984**	**145,706,905**	**5,896,263**	**28,745,765**	**7,227,510**	**27,877,860**	**7,475,021**	**43,893,336**	**11,073,949**	**13,517,200**
23	**Net before Settlement**		**7,116,470**	**(829,886)**	**7,946,356**	**581,576**	**1,204,002**	**1,157,407**	**137,103**	**898,752**	**3,428,047**	**(646,651)**	**1,186,121**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		3,876,006	11,822,362	(7,946,356)	(581,576)	(1,204,002)	(1,157,407)	(137,103)	(898,752)	(3,428,047)	646,651	(1,186,121)
28	**Net after Settlement**		**10,992,476**	**10,992,476**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
32	Revenue PMPM		$ 121.78	$ 8.71	$ 113.07	$ 92.90	$ 114.25	$ 109.87	$ 108.67	$ 103.86	$ 132.40	$ 92.97	$ 102.99
33	Expense PMPM		$ 116.54	$ 9.32	$ 107.22	$ 84.56	$ 109.65	$ 94.70	$ 108.14	$ 92.72	$ 122.81	$ 98.74	$ 94.69
34	Margin PMPM		$ 5.24	$ (0.61)	$ 5.85	$ 8.34	$ 4.59	$ 15.17	$ 0.53	$ 11.15	$ 9.59	$ (5.77)	$ 8.31
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
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)		2,586	2,586	2,586	227	156	43	731	408	588	240	193
43	% Variance - Fav / (Unfav)		1.7%	1.7%	1.7%	3.0%	0.5%	0.5%	2.6%	4.8%	1.5%	2.0%	1.2%
44													
45	**Contract Revenue before settlement**												
46	Actual		165,490,359	11,837,098	153,653,261	6,477,839	29,949,767	8,384,917	28,014,963	8,373,773	47,321,383	10,427,298	14,703,321
47	Budget		153,051,637	12,931,529	140,120,108	5,547,283	27,897,104	7,491,922	25,712,327	7,314,271	43,323,907	9,405,728	13,427,567
48	Variance - Favorable / (Unfavorable)		12,438,722	(1,094,431)	13,533,153	930,556	2,052,664	892,995	2,302,635	1,059,502	3,997,476	1,021,571	1,275,754
49	% Variance - Fav / (Unfav)		8.1%	-8.5%	9.7%	16.8%	7.4%	11.9%	9.0%	14.5%	9.2%	10.9%	9.5%
50													
51	**Healthcare Cost**												
52	Actual		143,531,152	8,299,205	135,231,947	5,325,075	26,799,976	6,637,187	26,139,345	6,878,209	40,374,168	10,383,017	12,694,972
53	Budget		142,986,926	7,747,532	135,239,394	5,832,132	27,339,797	7,169,409	24,108,567	6,942,581	40,991,631	9,728,820	13,126,456
54	Variance - Favorable / (Unfavorable)		(544,226)	(551,673)	7,447	507,058	539,821	532,223	(2,030,777)	64,372	617,464	(654,197)	431,484
55	% Variance - Fav / (Unfav)		-0.4%	-7.1%	0.0%	8.7%	2.0%	7.4%	-8.4%	0.9%	1.5%	-6.7%	3.3%
56													
57	**Managed Care Administration**												
58	Actual		14,842,737	4,367,779	10,474,958	571,189	1,945,790	590,324	1,738,515	596,811	3,519,169	690,932	822,228
59	Budget		15,439,323	5,225,947	10,213,376	434,290	2,037,965	598,734	1,739,952	531,965	3,445,896	607,442	817,132
60	Variance - Favorable / (Unfavorable)		596,586	858,168	(261,582)	(136,899)	92,175	8,410	1,437	(64,846)	(73,273)	(83,490)	(5,096)

	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 6/30/2020			**9**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
61	% Variance - Fav / (Unfav)		3.9%	16.4%	-2.6%	-31.5%	4.5%	1.4%	0.1%	-12.2%	-2.1%	-13.7%	-0.6%
62													
63	**Total Contract Cost**												
64	Actual		158,373,889	12,666,984	145,706,905	5,896,263	28,745,765	7,227,510	27,877,860	7,475,021	43,893,336	11,073,949	13,517,200
65	Budget		158,426,249	12,973,479	145,452,770	6,266,422	29,377,762	7,768,143	25,848,519	7,474,546	44,437,527	10,336,262	13,943,588
66	Variance - Favorable / (Unfavorable)		52,359	306,495	(254,135)	370,158	631,996	540,633	(2,029,341)	(474)	544,191	(737,687)	426,389
67	% Variance - Fav / (Unfav)		0.0%	2.4%	-0.2%	5.9%	2.2%	7.0%	-7.9%	0.0%	1.2%	-7.1%	3.1%
68													
69	**Net before Settlement**												
70	Actual		7,116,470	(829,886)	7,946,356	581,576	1,204,002	1,157,407	137,103	898,752	3,428,047	(646,651)	1,186,121
71	Budget		(5,374,612)	(41,950)	(5,332,662)	(719,139)	(1,480,658)	(276,221)	(136,192)	(160,276)	(1,113,620)	(930,535)	(516,022)
72	Variance - Favorable / (Unfavorable)		12,491,082	(787,936)	13,279,018	1,300,715	2,684,660	1,433,628	273,295	1,059,028	4,541,667	283,884	1,702,143
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 6/30/2020			**9**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
75	***Healthy Michigan Plan***			*HCC%*	9.0%	12.6%	9.2%	7.9%	11.4%	6.9%	7.3%	8.9%	8.6%
76	**Contract Revenue**		**28,015,391**	**6,211,277**	**21,804,113**	**1,046,622**	**4,495,051**	**1,019,491**	**3,910,202**	**1,321,460**	**6,180,702**	**1,705,258**	**2,125,328**
77													
78	External Provider Cost		13,235,661	4,641,629	8,594,032	350,524	1,973,510	250,274	1,972,331	126,814	2,723,010	464,595	732,974
79	Internal Program Cost		6,687,880	-	6,687,880	510,348	1,191,807	400,180	1,975,707	459,076	864,605	618,459	667,698
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**19,923,542**	**4,641,629**	**15,281,913**	**860,871**	**3,165,317**	**650,454**	**3,948,039**	**585,890**	**3,587,615**	**1,083,054**	**1,400,673**
82	**Medical Loss Ratio (HCC % of Revenue)**		**71.1%**	**74.7%**	**70.1%**	**82.3%**	**70.4%**	**63.8%**	**101.0%**	**44.3%**	**58.0%**	**63.5%**	**65.9%**
83													
84	**Managed Care Administration**		**1,805,158**	**636,230**	**1,168,928**	**92,340**	**229,815**	**57,853**	**262,582**	**50,837**	**312,710**	**72,071**	**90,719**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.9%**	**5.4%**	**9.7%**	**6.8%**	**8.2%**	**6.2%**	**8.0%**	**8.0%**	**6.2%**	**6.1%**
86													
87	**Contract Cost**		**21,728,700**	**5,277,859**	**16,450,841**	**953,212**	**3,395,132**	**708,307**	**4,210,621**	**636,727**	**3,900,326**	**1,155,125**	**1,491,391**
88	**Net before Settlement**		**6,286,691**	**933,418**	**5,353,273**	**93,411**	**1,099,918**	**311,184**	**(300,419)**	**684,733**	**2,280,376**	**550,133**	**633,937**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(3,485,152)	1,868,121	(5,353,273)	(93,411)	(1,099,918)	(311,184)	300,419	(684,733)	(2,280,376)	(550,133)	(633,937)
93	**Net after Settlement**		**2,801,539**	**2,801,539**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
97	Revenue PMPM		$ 59.44	$ 13.18	$ 46.27	$ 45.73	$ 46.10	$ 45.96	$ 46.49	$ 45.87	$ 46.73	$ 46.22	$ 45.57
98	Expense PMPM		46.11	11.20	34.91	41.65	34.82	31.93	50.07	22.10	29.49	31.31	31.98
99	Margin PMPM		$ 13.34	$ 1.98	$ 11.36	$ 4.08	$ 11.28	$ 14.03	$ (3.57)	$ 23.77	$ 17.24	$ 14.91	$ 13.59
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
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)		796	796	796	31	424	34	176	226	(356)	183	78
108	% Variance - Fav / (Unfav)		1.5%	1.5%	1.5%	1.2%	4.1%	1.4%	1.9%	7.6%	-2.4%	4.7%	1.5%
109													
110	**Contract Revenue before settlement**												
111	Actual		28,015,391	6,211,277	21,804,113	1,046,622	4,495,051	1,019,491	3,910,202	1,321,460	6,180,702	1,705,258	2,125,328
112	Budget		21,770,261	3,762,149	18,008,112	869,441	3,633,416	843,921	3,222,423	1,026,232	5,287,209	1,362,646	1,762,825
113	Variance - Favorable / (Unfavorable)		6,245,129	2,449,128	3,796,001	177,181	861,635	175,570	687,779	295,228	893,493	342,612	362,504
114	% Variance - Fav / (Unfav)		28.7%	65.1%	21.1%	20.4%	23.7%	20.8%	21.3%	28.8%	16.9%	25.1%	20.6%
115													
116	**Healthcare Cost**												
117	Actual		19,923,542	4,641,629	15,281,913	860,871	3,165,317	650,454	3,948,039	585,890	3,587,615	1,083,054	1,400,673
118	Budget		18,845,793	4,359,770	14,486,023	1,035,565	2,166,340	949,372	3,572,850	736,826	3,846,209	873,985	1,304,876
119	Variance - Favorable / (Unfavorable)		(1,077,749)	(281,859)	(795,890)	174,694	(998,977)	298,918	(375,188)	150,936	258,594	(209,069)	(95,797)
120	% Variance - Fav / (Unfav)		-5.7%	-6.5%	-5.5%	16.9%	-46.1%	31.5%	-10.5%	20.5%	6.7%	-23.9%	-7.3%
121													
122	**Managed Care Administration**												
123	Actual		1,805,158	636,230	1,168,928	92,340	229,815	57,853	262,582	50,837	312,710	72,071	90,719
124	Budget		1,804,243	712,921	1,091,322	77,113	161,483	79,284	257,858	56,458	323,325	54,569	81,230
125	Variance - Favorable / (Unfavorable)		(915)	76,691	(77,606)	(15,227)	(68,332)	21,432	(4,724)	5,621	10,615	(17,502)	(9,489)
126	% Variance - Fav / (Unfav)		-0.1%	10.8%	-7.1%	-19.7%	-42.3%	27.0%	-1.8%	10.0%	3.3%	-32.1%	-11.7%
127													
128	**Total Contract Cost**												
129	Actual		21,728,700	5,277,859	16,450,841	953,212	3,395,132	708,307	4,210,621	636,727	3,900,326	1,155,125	1,491,391

	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 6/30/2020			**9**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
130	Budget		20,650,036	5,072,691	15,577,345	1,112,678	2,327,823	1,028,656	3,830,708	793,284	4,169,535	928,554	1,386,105
131	Variance - Favorable / (Unfavorable)		(1,078,664)	(205,168)	(873,496)	159,467	(1,067,309)	320,350	(379,912)	156,557	269,209	(226,571)	(105,286)
132	% Variance - Fav / (Unfav)		-5.2%	-4.0%	-5.6%	14.3%	-45.9%	31.1%	-9.9%	19.7%	6.5%	-24.4%	-7.6%
133													
134	**Net before Settlement**												
135	Actual		6,286,691	933,418	5,353,273	93,411	1,099,918	311,184	(300,419)	684,733	2,280,376	550,133	633,937
136	Budget		1,120,226	(1,310,542)	2,430,767	(243,237)	1,305,592	(184,736)	(608,285)	232,948	1,117,674	434,092	376,719
137	Variance - Favorable / (Unfavorable)		5,166,465	2,243,960	2,922,505	336,648	(205,674)	495,919	307,866	451,785	1,162,702	116,041	257,218
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 6/30/2020			**9**									
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4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
140	***Autism Specialty Services***			*HCC%*	6.6%	5.2%	8.7%	8.0%	6.9%	5.1%	5.5%	2.6%	8.7%
141	**Contract Revenue**		**12,838,695**	**(983)**	**12,839,678**	**632,436**	**2,422,927**	**714,463**	**2,328,286**	**665,214**	**3,779,759**	**1,036,474**	**1,260,119**
142													
143	External Provider Cost		9,737,942	-	9,737,942	-	2,986,516	651,879	1,352,239	430,829	2,681,952	307,033	1,327,495
144	Internal Program Cost		1,494,919	-	1,494,919	357,543	3,094	2,499	1,041,808	1,758	-	4,516	83,701
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**11,232,861**	**-**	**11,232,861**	**357,543**	**2,989,610**	**654,378**	**2,394,046**	**432,587**	**2,681,952**	**311,548**	**1,411,196**
147	**Medical Loss Ratio (HCC % of Revenue)**		**87.5%**	**0.0%**	**87.5%**	**56.5%**	**123.4%**	**91.6%**	**102.8%**	**65.0%**	**71.0%**	**30.1%**	**112.0%**
148													
149	**Managed Care Administration**		**1,214,980**	**358,706**	**856,275**	**38,352**	**217,058**	**58,202**	**159,227**	**37,535**	**233,769**	**20,732**	**91,400**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.8%**	**2.9%**	**6.9%**	**9.7%**	**6.8%**	**8.2%**	**6.2%**	**8.0%**	**8.0%**	**6.2%**	**6.1%**
151													
152	**Contract Cost**		**12,447,841**	**358,706**	**12,089,136**	**395,895**	**3,206,668**	**712,580**	**2,553,273**	**470,122**	**2,915,721**	**332,280**	**1,502,596**
153	**Net before Settlement**		**390,854**	**(359,689)**	**750,543**	**236,541**	**(783,741)**	**1,884**	**(224,987)**	**195,093**	**864,037**	**704,194**	**(242,477)**
154	Contract Settlement / Redistribution		(390,854)	359,689	(750,543)	(236,541)	783,741	(1,884)	224,987	(195,093)	(864,037)	(704,194)	242,477
155	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.4%	0.8%	1.1%	0.6%	0.0%	0.8%	0.0%	1.3%	0.3%
159	**Contract Revenue**		**5,851,189**	**4,819,641**	**1,031,549**	**68,582**	**354,755**	**26,220**	**-**	**110,726**	**203,371**	**143,447**	**124,449**
160													
161	External Provider Cost		5,826,289	5,826,169	120	120	-	-	-	-	-	-	-
162	Internal Program Cost		744,413	-	744,413	56,467	370,772	52,406	-	68,526	2,543	152,781	40,918
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**6,570,702**	**5,826,169**	**744,533**	**56,587**	**370,772**	**52,406**	**-**	**68,526**	**2,543**	**152,781**	**40,918**
165	**Medical Loss Ratio (HCC % of Revenue)**		**112.3%**	**120.9%**	**72.2%**	**82.5%**	**104.5%**	**199.9%**	**0.0%**	**61.9%**	**1.3%**	**106.5%**	**32.9%**
166													
167	**Managed Care Administration**		**(719,393)**	**(719,393)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-12.3%**	**-12.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**5,851,309**	**5,106,776**	**744,533**	**56,587**	**370,772**	**52,406**	**-**	**68,526**	**2,543**	**152,781**	**40,918**
171	**Net before Settlement**		**(120)**	**(287,136)**	**287,016**	**11,995**	**(16,018)**	**(26,186)**	**-**	**42,200**	**200,828**	**(9,334)**	**83,531**
172	Contract Settlement		120	287,136	(287,016)	(11,995)	16,018	26,186	-	(42,200)	(200,828)	9,334	(83,531)
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 6/30/2020			**9**									
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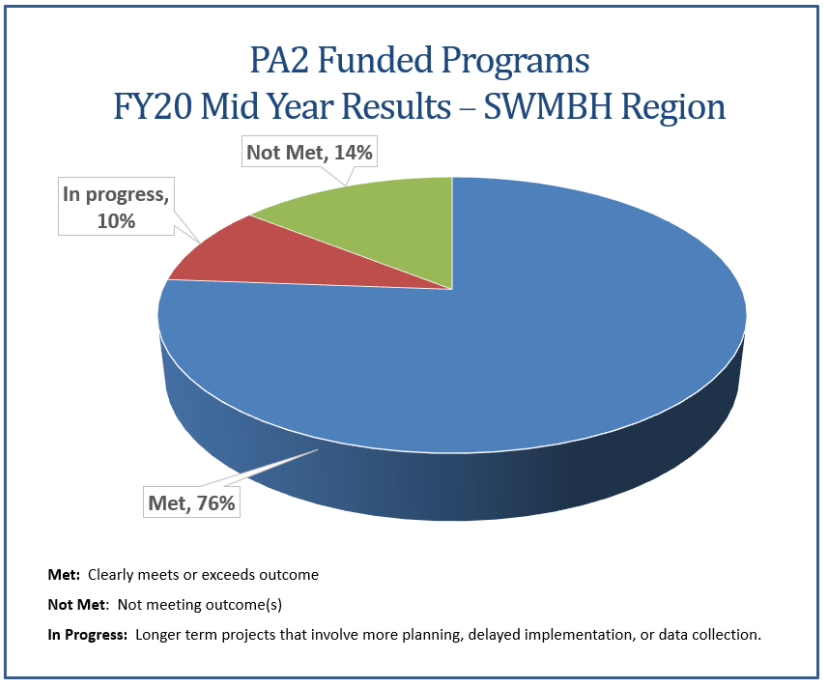
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		211,723,329	22,694,359	189,028,969	8,198,475	37,205,555	10,123,911	34,175,086	10,467,526	57,356,019	13,293,415	18,208,981
178	Incentive Payment Revenue		472,306	172,674	299,632	27,004	16,944	21,180	78,365	3,646	129,196	19,062	4,236
179	**Contract Revenue**		**212,195,634**	**22,867,033**	**189,328,601**	**8,225,479**	**37,222,499**	**10,145,091**	**34,253,451**	**10,471,173**	**57,485,214**	**13,312,477**	**18,213,217**
180													
181	External Provider Cost		130,395,105	13,162,964	117,232,141	3,612,172	24,505,163	5,569,507	21,812,098	5,170,251	39,439,212	7,750,149	9,373,588
182	Internal Program Cost		45,881,314	-	45,881,314	2,997,897	8,955,580	2,454,707	10,776,204	2,827,223	7,434,111	4,202,436	6,233,156
183	SSI Reimb, 1st/3rd Party Cost Offset		(622,202)	-	(622,202)	(9,993)	(135,068)	(29,790)	(106,872)	(32,262)	(227,046)	(22,185)	(58,986)
184	Insurance Provider Assessment Withhold (IPA)		4,881,700	4,881,700	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		722,340	722,340	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**181,258,257**	**18,767,004**	**162,491,253**	**6,600,076**	**33,325,675**	**7,994,425**	**32,481,430**	**7,965,212**	**46,646,278**	**11,930,400**	**15,547,758**
187	**Medical Loss Ratio (HCC % of Revenue)**		**85.4%**	**82.1%**	**85.8%**	**80.2%**	**89.5%**	**78.8%**	**94.8%**	**76.1%**	**81.1%**	**89.6%**	**85.4%**
188													
189	**Managed Care Administration**		**17,143,482**	**4,643,322**	**12,500,160**	**701,881**	**2,392,663**	**706,378**	**2,160,324**	**685,183**	**4,065,649**	**783,735**	**1,004,347**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**2.3%**	**6.3%**	**9.6%**	**6.7%**	**8.1%**	**6.2%**	**7.9%**	**8.0%**	**6.2%**	**6.1%**
191													
192	**Contract Cost**		**198,401,739**	**23,410,326**	**174,991,414**	**7,301,957**	**35,718,338**	**8,700,803**	**34,641,754**	**8,650,395**	**50,711,926**	**12,714,136**	**16,552,105**
193	**Net before Settlement**		**13,793,895**	**(543,293)**	**14,337,188**	**923,522**	**1,504,161**	**1,444,288**	**(388,303)**	**1,820,778**	**6,773,288**	**598,342**	**1,661,112**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		120	14,337,307	(14,337,188)	(923,522)	(1,504,161)	(1,444,288)	388,303	(1,820,778)	(6,773,288)	(598,342)	(1,661,112)
198	**Net after Settlement**		**13,794,015**	**13,794,015**	**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 6/30/2020			**9**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	4.5%	3.6%	2.8%	2.8%	6.6%	6.6%	4.6%	2.0%	4.5%
202	**Contract Revenue**				**8,470,837**	**541,661**	**1,443,546**	**515,919**	**1,513,830**	**458,839**	**2,758,966**	**445,930**	**792,146**
203													
204	External Provider Cost				2,700,509	76,436	89,875	48,339	554,931	366,441	1,403,323	103,167	57,997
205	Internal Program Cost				4,969,102	172,972	870,440	180,901	1,734,877	192,608	1,006,648	140,270	670,385
206	SSI Reimb, 1st/3rd Party Cost Offset				(142,474)	-	-	-	-	-	(142,474)	-	-
207	**Total Healthcare Cost**				**7,527,136**	**249,408**	**960,316**	**229,240**	**2,289,808**	**559,048**	**2,267,497**	**243,437**	**728,382**
208	**Medical Loss Ratio (HCC % of Revenue)**				**88.9%**	**46.0%**	**66.5%**	**44.4%**	**151.3%**	**121.8%**	**82.2%**	**54.6%**	**92.0%**
209													
210	**Managed Care Administration**				**640,336**	**29,679**	**78,529**	**22,936**	**168,724**	**52,941**	**216,759**	**18,133**	**52,635**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.6%**	**7.6%**	**9.1%**	**6.9%**	**8.7%**	**8.7%**	**6.9%**	**6.7%**
212													
213	**Contract Cost**				**8,167,472**	**279,087**	**1,038,845**	**252,176**	**2,458,532**	**611,989**	**2,484,256**	**261,570**	**781,017**
214	**Net before Settlement**				**303,365**	**262,574**	**404,701**	**263,743**	**(944,702)**	**(153,150)**	**274,710**	**184,360**	**11,129**
215													
216	Other Redistributions of State GF				(65,454)	-	-	-	-	-	-	-	(65,454)
217	Contract Settlement				(1,164,788)	(255,598)	(332,524)	(261,289)	-	-	(136,762)	(178,615)	-
218	**Net after Settlement**				**(926,878)**	**6,976**	**72,177**	**2,454**	**(944,702)**	**(153,150)**	**137,948**	**5,745**	**(54,326)**
219													

Substance Use Disorder Oversight Policy Board Update

PA2 Liquor Tax Budget Oversight

- Continue to review and approve budget contracts and amendments for PA2 funded programming
    - Any new requests or budget amendments for programming funded under PA2 go before this board
- Mid-year evaluation (October – March) of all program's performance metrics were presented at the May 18, 2020 SUDOPB meeting.
- Summary of the Mid-Year Evaluation is as follows:
    - SWMBH has 25 contracted agencies providing 55 different programs
    - 177 outcomes were reviewed
    - 76% of programs were meeting meet their outcomes
    - COVID 19 has impacted some providers ability to conduct services (e.g.: jail services, community outreach, etc.)



- FY21 PA2 budget planning is actively occurring
- FY21 PA2 budget vote will occur on September 14, 2020 and will be held virtually this year. Meeting will start at 3:00.

SUD Licensing Applications

- Continue to review new SUD license applications submitted to the Department of Licensing and Regulatory Affairs and make recommendations.

Southwest Michigan Behavioral Health Regional Strategic Business Plan

2020 – 2023

Vs. 8-7-20

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

Contents

Appendices

A. MDHHS Director Gordon Letter to CMHAM

Gordon - CMHAM 1-7-20 Letter.pdf

B. Michigan Mental Health Code 330.1204b Regional entity statute

Mental Health Code 330.1204b Regional E

C. Michigan Mental Health Code 330.1287 Substance Use Disorder Oversight Policy Board

Mental Health Code 330.1287 SUD.pdf

D. SWMBH Bylaws DATE Adopted 4-3-13

SWMBH Bylaws Adopted 4-3-13.pdf

E. SWMBH Bylaws as revised by SWMBH Board DATE Adopted 12-11-28

SWMBH Bylaws Revision Proposal 12-

SWMBH Bylaws Final Adopted 12-11-18.pd

F. NCQA MBHO Accredited List

Michigan Based Health Plans With NC

G. Michigan Medicaid Health Plans Service Regions

Medicaid Health Plan Regions.pdf

H. Prepaid Inpatient Health Plan Map

FY14 PIHP map.pdf

Glossary of Terms

Acronyms	Definitions
A B C	
APM	Alternative Payment Method
ASO	Administrative Services Organization
BH	Behavioral Health
BHDDA	Behavioral Health Development Disability Administration
CCM	Complex Care Management
CEO	Chief Executive Officer
CMHAM	Community Mental Health Association of Michigan
CMHSP	Community Mental Health Service Provider
CMS	Center for Medicare & Medicaid Services
D E F	
DUA	Data Use Agreement
EMR	Electronic Medical Record
EO	Executive Officer
FQHC	Federal Qualified Health Clinic
FTE	Full Time Employee
G H I	
GF	General Fund
HIPPA	Health Insurance Portability and Accountability Act
HMP	Healthy Michigan Plan
HSAG	Health Services Advisory Group
ICO	Integrated Care Organization
I/DD	Intellectual Developmental Disabilities
ISF	Internal Reserve Fund
J K L	
M N O	
MAHP	Michigan Association of Health Plans
MBHO	Managed Behavioral Health Organization
MCHE	Michigan Consortium for Healthcare Excellence
MCO	Managed Care Organization
MDHHS	Michigan Department of Health & Human Services
MHL	Mi Health Link (Medicare-Medicaid dual eligibles federal-state demonstration)
MHP	Medicaid Health Plan

MIBI	Management Information & Business intelligence
MiHIN	Michigan Health Information Network
MMBPIS	Michigan Mission Based Performance Indicator System
NCQA	National Committee for Quality Assurance
OTMB	Office of Technology, Management, and Budget

P Q R

PIHP	Prepaid Inpatient Health Plan
PMPM	Per Member/Per Month
RE	Regional Entity

S T U

SAPT	Substance Abuse Prevention and Treatment
SIP	Specialty Integrated Plan
SUD	Substance Use Disorder
SWMBH	Southwest Michigan Behavioral Health
SWOT	Strengths, Weaknesses, Opportunities, and Threats

V W X Y Z

VBP	Value-Based Purchasing

Southwest Michigan Behavioral Health

Our Mission

"SWMBH strives to be Michigan's preeminent benefits manager and integrative health partner, assuring regional health status improvements, quality, trust, and CMHSP participant success"

Our Vision

"An optimal quality of life in the community for everyone"

Our Triple Aim

Improving Patient Experience of Care| Improving Population Health |

Reducing Per Capita Cost

Executive Summary

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

While there was an overt plan by the Michigan Department of Health and Human Services (MDHHS) from the Governor Whitmer Administration to do away with Prepaid Inpatient Health Plans (PIHP) as of September 30, 2022, the COVID-19 pandemic has further stressed available subject matter experts and resources. In January 2020, MDHHS Director Gordon disclosed and encouraged a proposal of a publicly led Model to Community Mental Health Association of Michigan (CMHAM) (Appendix A). He identified the pursuit of a major public behavioral health system transformation into Specialty Integrated Plans (SIPs). Some in the public health system rejoice assuming *status quo* or minor modifications in State policy. Others see this development as more threatening, believing the abandonment of the proposed SIPs, combined with a dire Michigan General Fund deficit position for the foreseeable future, creates a widened opening for Medicaid Health Plans (MHP) and their advocates in the Legislature to simply move to a straight carve-in by October 1, 2023.

Regardless the reader's view on this dichotomous path prediction, we owe it to our stakeholders to discuss, deliberate, and decide the multi-year strategic plan for our Regional Entity and Participant Community Mental Health Service Providers (CMHSP). The Pandemic has imposed additional issues including the following:

a) we are several months behind our planned schedule
b) we have additional current variables to consider
c) we have a less than clear view of our future state.

This environment requires active engagement, introspection, and candor amongst all participating leaders. Conversations will fall into two main categories:

Decision

1) CMHSPs' Success – Development needs of our CMHSPs to be successful in the future – How does SWMBH support these needs?

2) Southwest Michigan Behavioral Health's (SWMBH) Future – Participant CMHSPs' evaluation of the future role of SWMBH in the event the PIHPs are terminated or consolidated.

The development of the multi-year strategic plan requires Key Facts and Recommendations to be considered.

Key Facts and Recommendations

- The carve-in remains a material threat.
- Regionalism is less in favor than ever; state-wide coverage and competence is almost a keystone for future success.
- Significant interaction amongst the Regional Entity Participants is vital, including direct contact from SWMBH Executive Officer to CMHSP Boards.
- PIHP staff must be retained. They are valuable resources under performance pressures, undeserved external criticism, and presented with an increasing number of opportunities elsewhere.
- Amongst related thought leaders, SWMBH, our Region, and our CMHSPs have developed and maintained performance and reputations that is superior to the majority of PIHPs and CMHSPs.
- SWMBH has significant latitude for new and expanded roles under the Michigan Mental Health Code 330.1204(b) and its Bylaws.
- SWMBH's financial situation has improved greatly with the MDHHS acknowledgement of under-funding and the revised fiscal year 2020 capitation rates.
- CMHSP leaders and Boards need adequate time to openly deliberate many of these existential questions, independent of SWMBH. Resourcing with knowledgeable external experts is recommended.
- Others . . .

We invite the reader to be actively involved and constructive during these discussions. After all, the eight CMHSPs "own" SWMBH and only they can significantly modify our course from the current status.

Why the Need for Planning?

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

Specialty Integrated Plan (SIPs) or a straight carve-in or hybrid is implemented, resulting in deleting or diminishing the PIHPs, there are key questions requiring deliberation.

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

Decision

1. What will be the future state for CMHSPs?

   A.) What role, if any, does the Region want SWMBH to pursue in the exploration of identification and implementation of CMHSP threats, opportunities, changes, and transitions?

2. What will be the future state for the Regional Entity SWMBH in opportunities and value to the Participant CMHSPs?
   A. What role, if any, does the Region want SWMBH to pursue in the exploration of changes and transitions?

_____

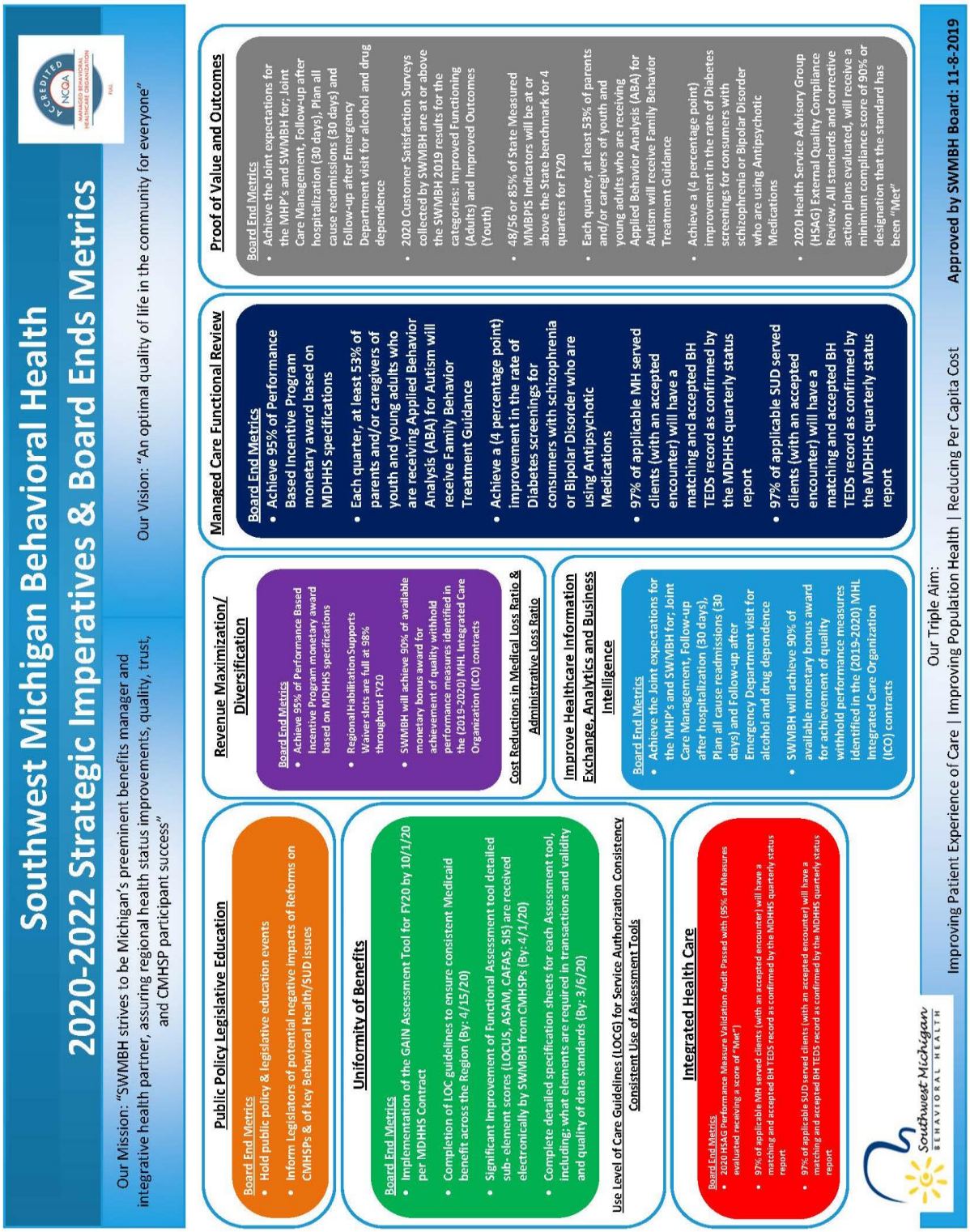
Thus, the urgency of pondering these questions. While it is problematic to make the wrong decisions, it is equally problematic to make the right decisions too slowly. Thorough deliberations take time and effort. All transformations necessary at both CMHSPs and SWMBH are complex with significant need for attention and resources.

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

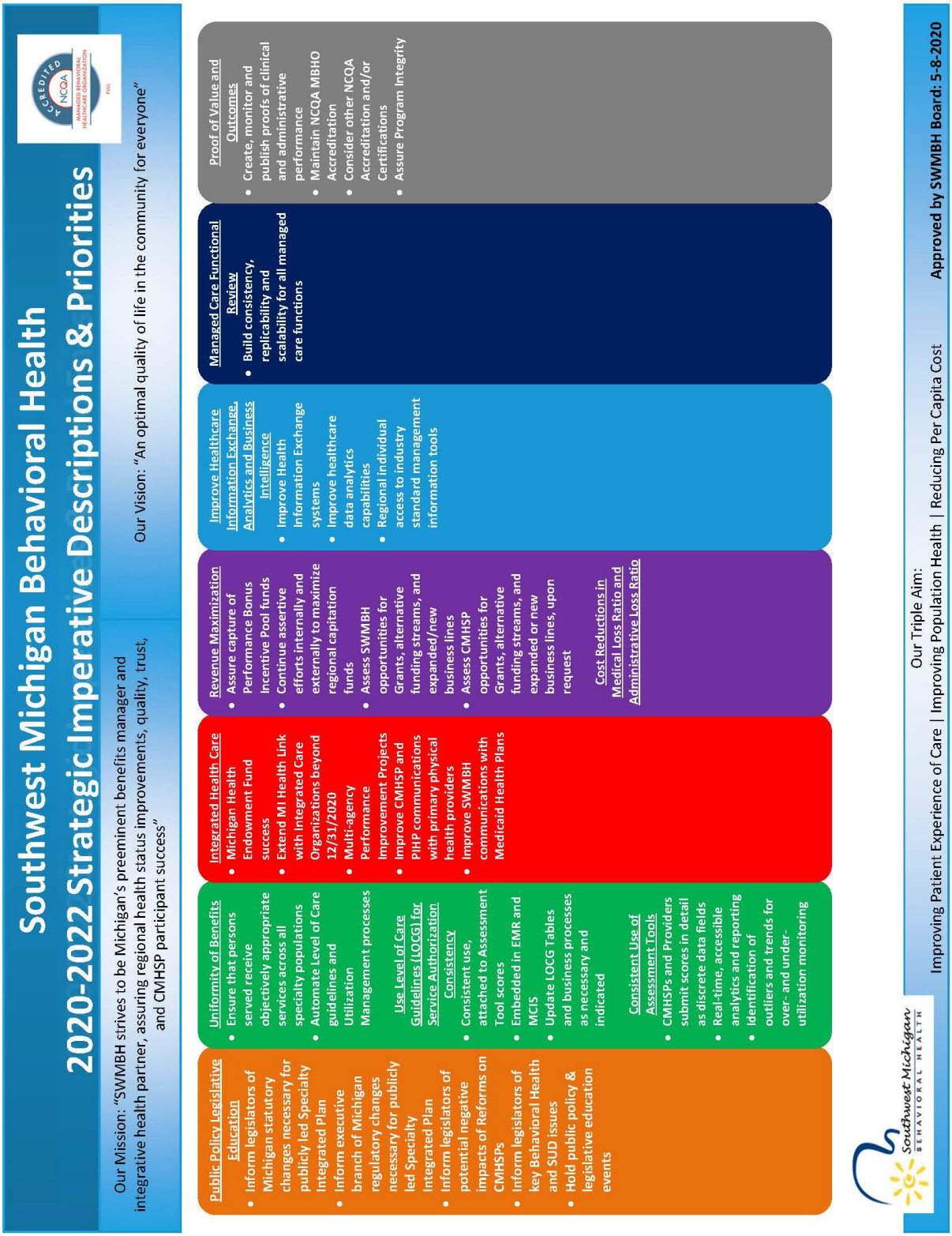
SWMBH has assembled an unparalleled group of staff who are subject matter and stylistic experts with lives, homes, and families. Soon current Health Plans, new market entry Health Plans, and other opportunistic agencies will begin to actively poach these experts, if they haven't already. Absent a reasonably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

This same staff, adhering to SWMBH's Mission Statement, Vision Statement, and Triple Aim, works in conjunction with the Region's CMHSPs, SWMBH Board members, and additional Stakeholders to develop and monitor the 2020-2022 Strategic Imperatives and Board Ends Metrics.

SWMBH Strategic Imperatives and Board Ends Metrics – Board Approved 11-8-2019



2020 – 2022 Strategic Imperatives Descriptions & Priorities – Board Approved 5-8-2020



Collectively we have developed and achieved significantly resourced and sophisticated healthcare information exchange and healthcare data analytics, Management Information & Business Intelligence (MIBI), National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO) Accreditation, and other differentiating characteristics from most Regional Entities/PIHPs. Maintenance and development of these assets are significant. Many of these vendor resources have upcoming renewal and resourcing considerations. Future success is not possible without these being leading edge.

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

The way forward is the proverbial fork in the road.

Decision

1. Downsize the Regional Entity throughout fiscal years 2021 and 2022 and shut out the lights asap after 10/1/22 or 10/1/23 *or,*

2. Support and resource sincere exploration of the following:
    A. Identify the future state for CMHSPs
        - Pursue identification and implementation of CMHSP threats, opportunities, changes, and transitions
    B. Identify the future state for the Regional Entity SWMBH
        - Pursue changes and transitions

As the SWMBH EO I am now posing these questions to the Participant Members as embodied in the Board and CMHSP CEOs for affirmative or negative replies and/or revisions. Strength and stamina are required of all.

Governing Documents to be Considered

MENTAL HEALTH CODE (EXCERPT) – Act 258 of 1974 – 330.1204b Regional Entity

SWMBH is a Regional Entity created under the Michigan Mental Health Code 330.1204(b), (Appendix B). **This section explicitly grants a wide range of powers** including the following:

330.1204b, Section 204b (2)(a) -- *"The power, privilege, or authority that the participating community mental health services share in common and may*

exercise separately under this Act, whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity."

330.1204b, Section 204b (2)(c) *"The power to accept funds, grants, gifts, or services from the federal government or federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source."*

330.1204b, Section 204b (2)(d) *"The power to enter into a contract with a participating community mental health services program for any service to be performed for, by or from the participating community mental health services program."*

330.1204b, Section 204b (2)(e) *"The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually."*

MENTAL HEALTH CODE (EXCERPT) – Act 258 of 1974 – 330.1287 Substance Use Disorder Oversight Policy Board

SWMBH has established a Substance Use Disorder Oversight Policy Board and as a coordinating agency adheres to Act 258 of 1974 – 330.1287 (Appendix C).

SWMBH Regional Entity Bylaws

The current SWMBH Regional Entity Bylaws state: (Appendix D)

Article II Purposes and Powers, Section 2.1 *Purpose states* ***". . . Additional purposes may be added by the Regional Entity Board".***

Strengths, Weaknesses, Opportunities, and Threats

SWMBH Senior Leaders brainstormed the exercise Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT) for both SWMBH and the Region. The following pages display a chart that is a compilation of sincere and candid feedback:

Displayed on next page

Strengths	Strengths
• Good, strong, dedicated, hardworking, high capacity, competent staff • Competent management team • NCQA MBHO Accreditation • Historical knowledge • Dedicated to persons served • Consistently score highest amongst other PIHPs on audits/reviews and State reporting measures • Great relationships with Integrated Care Organizations (ICO) and community partners • External partners realize their jobs will become more difficult without SWMBH • Developed and established business processes • Visibility & credibility at MDHHS and Legislature • Took lead, facilitated major projects at/for State level implementation • Risk takers • Excellent CMHSPs • Highly collaborative Regional culture • Solid working relationships with our Participant CMHSPs • Participated with Michigan Health Link project, first in State • First adopter of Coordinating Agency role 9 months before others; established precedents and early subject matter expertise • Seen as a Leader among PIHPs	• Excellent reputation • Located under one roof • Oversight & experience of Specialty Populations EMR Platform agnostic • Possibly Only PIHP Using Tableau? • Understanding of the level of oversight needed and attempt to reduce CMHSP burdens related thereto • Experienced with Data Exchange/Data Handling • Secure Date Center Nearby • Safety Net • Partnerships with other safety net entities • Resources for the neediest • CMHSPs have already broadened their scope • Insight into consumer details • Peer Support • PCE Systems is fast at making State reporting changes • Community Relations • Progressive • Responsive • Partnerships • Innovation • Experience with Specialty Populations • Identified as Specialty Providers for State • More Grants • Creative approaches to Wellness • Care about their clients • Great Care Coordination • Live safety net for years • Increased willingness to take a Regional approach to solve issues

Weaknesses	Weaknesses
• Over Ambitious • Too Many Initiatives • Take on Too Much • Time Lost on New Projects • Workloads with Projects are too many and are difficult to manage • Lack of Advocacy Group Recognition • MDHHS few comparison's/reports that highlight PIHP performance • Attrition of staff	• Streamline dependency, little bench strength • Lack of Structured/Consistent Marketing/Promotion • CMHSPs Varying in evolution • Costs above market rates • Some CMHSPs are not majority percentage Providers • Modest collaboration in IT • Staff turnover • Two Vendor software systems

Threats	Threats
• Staff Exodus • Knowledge leaving • Brain-drain • Difficulty to obtain new staff • MDHHS and some in Legislature preconceived notion that MHPs hold the keys to the future and will be one size fits all for the system • How to collaborate with others without hurting chances • Lack of Member CMHSP support for out of Region business • Medicaid Health Plans (MHP), ICOs, SIPs doing benefits management	• Other ASOs – Optum, Beacon • Too much duplication • Reporting burden from ICOs • PIHP Board says go away • Cannot compete with private sector without clear value differentiators • Privatization of Healthcare in Michigan • Quality will be looked at • Standards will be looked at • Large Providers Like Hope, Pine Rest, etc. • County Match • Overhead high • SWMBH roles and experience from MHL not clearly known/valued

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

Management proposes the CMHSP Leadership brainstorm this same exercise under the facilitation of an external subject matter expert. The results of the combined reports can be valuable guidance as critical decisions lay ahead.

Special Circumstances

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

MI Health Link Demonstration

Beginning in Spring 2015, Michigan participated in the Federal Financial Alignment Initiative MI Health Link (MHL) which combines funding and benefits management for dual eligibles, (Medicare & Medicaid), into a single Medicaid Health Plan known as an Integrated Care Organization. Intended as a three-year Demonstration, the Center for Medicare & Medicaid Services (CMS) and Michigan Department of Health and Human Services extended it through 12/31/2020.

Of the ten PIHPs, SWMBH is one of four that has participated in the MI Health Link Demonstration in conjunction with two Integrated Care Organizations (ICOs) – Meridian and Aetna. CMS, MDHHS, and the ICOs have extended the Demonstration for another five years through 12/31/25. Note: MDHHS recently announced that the extension will now be through December 31, 2021 due to COVID-19 distractions and complications, with active pursuit of a multi-year extension thereafter.

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

SWMBH holds delegated benefits management contracts, one with MI Health Link (MHL) and two with Integrated Care Organizations (ICOs), Aetna Better Health and Meridian of Michigan Health Plan. Mi Health Link is a Medicare-Medicaid dual eligibles Federal-State demonstration. Aetna Better Health and Meridian of Michigan Health Plan also provide traditional Medicaid managed care along with other products in Michigan.

SWMBH operations support these complex contracts, complying with their terms and conditions and financial arrangements. Because Mi Health Link encompasses a political aspect, it is scrutinized by many. Very few individuals in the State understand the Demonstration and the PIHP roles, duties, benefits, and exposures. These contracts are not transferable to CMHSPs and the contract contains a minimum six-month no-cause termination notice period.

Substance Use Disorder Prevention and Treatment

SWMBH holds all Substance Abuse Prevention and Treatment (SAPT) provider contracts. SAPT providers are especially scarce, dear, (??) and fragile. Few in the State know how to operationalize the Prevention requirements. These contracts are not readily transferable to CMHSPs.

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

With the participation and support of CMHSPs our Region has expended many millions of dollars for healthcare information exchange, healthcare data analytics, and management information & business intelligence, resulting in significant benefit to SWMBH and our CMHSPs. These efforts have enabled performance success in all areas including, but not limited to, Michigan Mission Based Performance Indicator System (MMBPIS), Performance Bonus Incentive earnings, Health Services Advisory Group (HSAG) top-shelf Audit results, MHL Integrated Care Organization delegation review success, and more. By design and fiscal prudence, contracts with partners and vendors rest at SWMBH -- (Michigan Health Information Network (MIHIN), Relias PopHealth, Tableau, etc.). Assuming these vendors would pursue individual CMHSP contracts, these contracts, data flows, exchanges, and reports would all have to be reworked at material expense. If this process is pursued, the base expenses would certainly be higher and the direct and opportunity conversion costs would be high. Losses of these technologies and products would be a significant, strategic, and tactical loss for the Region.

MDHHS requires all Data Use Agreements (DUAs) rest with SWMBH. These agreements are required to receive or access any State data. SWMBH, in turn, executes the DUAs with the CMHSPs. The DUA development and execution processes are significant. It is uncertain if the State is aware of this impact created by PIHP extinction.

Governance Issues

Approximately 16 months ago the SWMBH Board considered and approved exploring a SWMBH role in managing the unenrolled population in Section 298 counties outside of our Region. The SWMBH Bylaws restrict operations to the “geographic region” of our current eight counties. At that time, the SWMBH Board readily approved enabling Bylaws changes. (Appendix ****) The SWMBH Executive Officer approached four CMHSP Boards. The results were two Participant CMHSP Boards formally rejected the revisions and two Participating CMHSP Boards reserved rendering a decision pending the availability of more information. Given that SWMBH Regional Entity Bylaws require unanimous consent from all eight Participant CMHSP Boards, the proposal was dropped. The SWMBH Board approval of the revisions still stands; the SWMBH Board has not rescinded them.

Regardless of the magnitude of any system transformation changes, the Regional Entity System and PIHP design has clearly fallen out of favor by most in Lansing. More importantly, all Health Plans will experience consolidation and a predominately state-wide market presence. For any risk or non-risk Health Plan partner or Administrative Service Organization (ASO) contractor to be considered and valued, it must have a state-wide presence or at a minimum a geographic presence which mirrors that of the Health Plan partner target.

Decision

Board Action Required: An early decision for the SWMBH Board to consider is whether to authorize the SWMBH EO to begin Bylaws revisions conversations with Participant CMHSP Boards of Directors using either the current Board-approved revised Bylaws or a freshened review and revision. The SWMBH EO recommends that this become an early topic of deliberation.

1) SWMBH Bylaws Revisions
    a. The SWMBH Board review and approve the current Board-approved revised Bylaws, or
    b. The SWMBH Board revise and approve freshened Bylaws which permit expansion of SWMBH pursuits to state-wide
2) SWMBH Board directs the SWMBH EO to begin meeting with Participant CMHSP Boards on this topic.

Alliances and Partnerships

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

The Section 298 Initiative was introduced by the State in February 2016 as the management of the specialty behavioral health benefits for individuals in our Region who are not enrolled in a Medicaid Health Plan. At that time, we considered pursuit of this initiative and co-developed a SWMBH majority-controlled public-private partnership with a national well-regarded Health Plan. Design details included governance and management roles and authorities, financial arrangements, and more. Even though this effort has ceased, connection to that Health Plan or other private partners could be considered and pursued.

If MDHHS maintains the Regional Entity/PIHP system, but with a lesser number of Regional Entities/PIHPs, we would want to be ready with our Plan and leadership for consolidation. Other options exist and each should be identified and vetted.

Less formal arrangements have been and will continue to be useful. Examples include, but are not limited to, bi-lateral and multi-lateral Regional Entity/PIHP shared services arrangements, evolution to common healthcare information exchange, healthcare data analytics, and management information & business intelligence systems. These arrangements have occurred and can continue to occur within SWMBH EO authority under Board Policy guidance.

SWMBH Financial Status

Usage of Medicaid funds can generally be used to pursue State-mandated or State-supported systemic transformations. These activities include the exploration and resourcing of behavioral and physical health care integration programs, healthcare information exchange, healthcare data analytics, etc. Generally, Medicaid funds cannot be used to develop and operationalize new Regional Entity business lines or directly support new SWMBH Customer acquisition. Medicaid funds can be used to support CMHSPs' transitions to the new realities and to further ready themselves for administrative cost reductions, value-based purchasing success, and leadership and change management development.

On 9/30/22, or any PIHP close-out date, it is a certainty that SWMBH Medicaid Internal Reserve Fund (ISF) balance, if any, will revert to the State. This amount will be reported to MDHHS on 2/28/23 and cost settled at some unknown date thereafter. Historically this cost settlement is completed years after the fact.

If these objectives and efforts are approved by the SWMBH Board and in the absence of a capital infusion of local funds by Member CMHSPs, SWMBH will rely on its Local Fund Balance earned through the PIHP Performance Bonus Incentive Pool and its margin on the MI Health Link program for its capital support of business line development and customer acquisition. Currently we are involved in cost reconciliation discussions with the MI Health Link Integrated Care Organizations and will have an estimate of SWMBH Local Fund Balance soon.

Marketplace & Industry Overview

Michigan Healthcare Policy Environment

In the fiscal year 2020 budget supplemental related to COVID-19, the Governor vetoed a wide range of funded programs and initiatives. One item vetoed was the Public Behavioral Health System Transformation $5 million line item which was intended to support 15 Full-Time Employees (FTEs) and consultants. In addition, beginning May 17, 2020 through July 25, 2020, MDHHS staff have been furloughed one day a week. It appears that this is likely to continue. Thus, MDHHS has neither the funds nor the resources to focus on Systems Transformation.

The State has a requirement to present a balanced budget. Because of this, many believe that the lack of resources for Specialty Integrated Plan (SIP) development, combined with the FY '20 and FY '21 combined $6-7 billion projected State deficit, will make more Legislators and the Governor's office more receptive to a pure carve-in sooner rather than later, thereby skipping the SIP approach altogether.

Multiple presentations have revealed information regarding the focus of MDHHS. The following topics are detailed below:

- Behavioral Health Key Goals for 2021
- MDHHS Behavioral Health Strategic Plan Pillars
- MDHHS Major Topics Under Review
- 7-22-20 Michigan Association of Health Plans Conference
- 2020-2023 Information Technology Industry Scan

On June 11, 2020, Al Jansen provided a list of the **Key Goals for 2021** (paraphrased).

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

In July 2020 MDHHS announced their **Behavioral Health Strategic Plan Pillars** as follows:

I. Drive improved outcomes and more funding to the front lines through streamlined oversight PIHP/CMHSP accountability reforms.
I. Integrate physical and behavioral health care at the point of service with a person-centered approach and inclusion of social determinates of health.
I. Ensure all Michiganders have access to behavioral health, mental health and substance use prevention, treatment, services and follow up services for the best quality life.
I. Provide people with outreach, service delivery, and access to behavioral health services at their preferred locations and mechanisms. *Consider telehealth and telephone services utilized during COVID-19.*
I. Provide quality and time efficient patient care flow from community to residential treatment or institution, (hospital, juvenile detention centers, jail) to community with individualized clinical treatment.

This year MDHHS also identified the following **Major Topics Under Review**:

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

At the **7-22-20 Michigan Association of Health Plans Conference** panelists presented an environmental update. Included in the group were Director Robert Gordon, Michigan Department of Health and Human Services and Chief of Staff Jonathan Warsh, Michigan Department of Health and Human Services – Strategic Priorities and Overall Performance Management. Each panelist's presentation is bulleted below followed by questions from the audience:

- **Robert Gordon**, Director -- MDHHS
    - New Focus
        - Addressing disparities
            - Focus of underlying social disparities
                - Working with MHP to assure Community Health Workers (CMH) are used effectively
                - Partner with MHP to help more people enroll in programs
            - Sustain focus on infant health
                - Post-Partum treatment
            - Training of racial awareness
        - Budgeting
            - Deliver healthcare with quality and sustainable results
            - Support the move of payment to value-based service in Medicaid and alternative payment models
            - Priorities from before changed
                - Believe in improvement of Behavior Health
                    - Sustaining network of providers
                    - Opioid abuse
                    - BH care access
            - Focus -- Efficiency, quality

Questions –

- Behavioral Health Transformation may not look like it did in Fall 2019. Is there an update?
    - Still believe broader system is needed but Department is addressing immediate needs of Covid-19
    - Focusing on services, access, disparities, building on gains and needs through alternative methods, and need for system to be effective, efficient, and valuable.

- **Jonathan Warsh**, Chief of Staff – MDHHS/Strategic Priorities and Overall Performance Management
    - Medicaid Response and continued partnerships in the future
        - Action
            - Access to care – Telehealth/access, platforms, Face to Face exemptions
            - Investment in social determinants of health

Questions –

- Why are substance abuse benefits carved out?
    - Significant effort to change that – no update at this time

Another area impacting the Healthcare Industry is the **2020-2023 Information Technology Industry Scan.**

1. Payers, providers, and patients will collaborate more closely to redesign healthcare as a platform, not as a series of disconnected events. They will align all efforts on a common goal: positive patient and population outcomes. Technology will help accelerate this transformation by enabling seamless and secure data sharing, from the patient to the provider to the payer.
2. Predictive analytics, big data, and machine learning have become the norm using real-time data in combination with predictive analytics to identify patients for targeted interventions and improved health behaviors.
3. There is a shift from healthcare organizations having control of the data to patients being able to access and exchange their data for their own benefit.
4. Interoperability is a major focus in health tech innovation: patients will always receive care across multiple venues, and secure data exchange is key to providing continuity of care. Standardized approaches can provide the technological foundations for data sharing, extending the functionality of EHRs and other technologies that support connected care.
5. Consumer-assistive and consumer-led technologies are the norm including but not limited to smart phones, wearable devices, social groups, and chatbot supports.
6. There must be an increased emphasis on social determinants of health with results and incentives aligned across payers, provider, and patients.

7. The ability for staff to aggregate and analyze complete, accurate and timely real-time data from multiple sources is essential to produce better outcomes and reduce costs.
8. The new vision for healthcare for 2020 and beyond will not just focus on access, quality, and affordability but also on predictive, preventive, and outcome-based care models promoting social and financial inclusion.

Specialty Integrated Plan (SIP)

Publicly funded healthcare costs in Michigan exceed $13 billion annually. Twelve Medicaid Health Plans cover approximately 2.1 million Medicaid and Healthy Michigan Plan eligibles. The subset of 335,000 eligibles with severe mental illness, serious emotional disturbance, substance use disorders, intellectual and developmental disabilities, and autism spectrum disorders are served under contract to Prepaid Inpatient Health Plans (PIHPs), such as SWMBH, with a state-wide annual expense of approximately $2.8 billion, an average of $8,500 annually per eligible. It is significant to note that annual specialty services cost per person served varies widely, ranging from $1,000 as a low-end outlier to $240,000 as a high-end outlier.

Excluding General Fund services, forty-six Community Mental Health Services Providers provide or contract for all publicly funded services under their contracts to ten PIHPs, estimated at 5% of a CMHSP budget. Of the ten PIHPs, seven are multi-CMHSP and three are both PIHPs and CMHSPs, (Detroit-Wayne, Oakland, and Macomb).

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

MDHHS had set a clear policy direction of desiring Specialty Integrated Plans (SIPs). This direction would combine both financially and contractually the physical health and behavioral health benefits, capitation funding, accountability, and risk into a single Plan. MDHHS has cited the states of Arizona, Arkansas, and North Carolina as each having elements and/or results attractive to them. We continue to produce Intel on these three states. Despite some persons

avoiding that moniker, SIPs are carve-in Plans. In early January 2020 MDHHS expressed a desire for a "publicly-led SIP" and supported their expression with an explicit written invitation to the Community Mental Health Association of Michigan (CMHAM) to begin working on such a vehicle. There is no evidence that the public system has made efforts in this regard. It is certain that subsets of the public system, PIHPs, CMHSPs, and Providers, have deeply explored public-private partnership models with Health Plans and related others. MDHHS has made it plain that a publicly led SIP must meet all current Michigan Insurance Code requirements for Managed Care Organizations (MCO). MDHHS has also made explicit the necessity to revise the Mental Health Code and Public Health Code to support SIPs. MDHHS claims that internally they began the statutory review some months ago. We have encouraged them to continue to review in the light of day and in a widely inclusive manner.

The public behavioral health system, MDHHS, and leaders in the Legislature acknowledge that the current statutory environment does not permit a publicly let SIP. Work on Michigan statutory language revisions has begun in the Legislature, Executive Branch, and across the public behavioral health system. Connectivity across these efforts appears to be non-existent. It is certain that Medicaid Health Plans (MHP) and their Association, Michigan Association of Health Plans (MAHP), are deeply and broadly involved in statutory reviews with their own interests top of mind.

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

Criticism of MDHHS SIP Plans

- Privatization, reduction in services and profiteering by current and future MHPs
- Inadequate requirements for genuine participation in governance and management from persons served, their loved ones, and formal advocacy group representatives
- Low level of acknowledgment by Legislature and MDHHS of statutory change process complexity, politics, and resource/time consumption and the need for joint stakeholder efforts
- Minimal to non-existent mention or consideration of the place for substance use disorders treatment and prevention, Block Grant and PA2 funding for substance abuse treatment and prevention, or the statute requiring county involvement in PA2 budgets via Substance Use Disorder Oversight Policy Boards.
- Minimal acknowledgement from MDHHS of significant direct, indirect and opportunity transition costs of standing up new entities, creating new ventures, closing seven regional PIHPs, and materially down-sizing three stand-alone PIHPs.

- Minimal acknowledgement from MDHHS and the Legislature that MDHHS lacks the capacities and competencies to successfully manage changes of these magnitudes.
- Lack of MDHHS details or "meat on the bone". MDHHS replies that a stakeholder involvement process will inform more detailed policy and decision-making around the reforms.

Upcoming Medicaid Health Plan Renewal Cycle

Medicaid Health Plan Renewal Cycle

Current MHP Contract	9/30/2020 Expiration
1st Year Extension	9/30/2021 Expiration
2nd Year Extension	9/30/2022 Expiration
3rd Year Extension	9/30/2023 Expiration
Mandatory Rebid Completion Finalization Plan Due	9/30/2023

Historically, the renewal and rebid process has consumed significant MDHHS and Office of Technology, Management, and Budget (OTMB) resources as well as that of current and new entrant Plans and has occurred over a scheduled time frame of 2.5 +/- years.

Planning Assumptions

Issues and Consequences to be Addressed

- The MDHHS Vision will survive and transition to SIPs will begin on 10/1/22
- The statutory & regulatory barriers will be revised to become permissive to the establishment of a publicly led SIP
- Numerous Plans of varying natures such as Medicaid Health Plans, Integrated Care Organizations for Medicaid-Medicare dual eligibles, Specialty Integrated Plans, Medicare Advantage Plans and the like will thrive well beyond 1/1/22
- PIHPs, including SWMBH, will lose their PIHP MDHHS Agreement and funds at 9/30/22.
- Member CMHSPs created the Regional Entity SWMBH; only they can remove that status achieved under Mental Health Code Act 258 of 1974 section 330.1204b.
- SWMBH has latitude in designing its future, subject to approval by the SWMBH Board. (Appendix B)
- There is no opportunity for SWMBH to unilaterally develop and propose a Specialty Integrated Plan. Assuming support and invitation from Member CMHSPs, SWMBH can participate in and support CMHSP considerations related to SIPs and/or be a Participant in the design and development of a SIP.
- Beginning immediately and accelerating over time, the probability of SWMBH management and line staff departures continues to grow higher. Once SIPs begin to congregate and aggregate, they will poach PIHP subject matter experts and leaders with increasing aggressiveness. As 9/30/22 grows nearer and absent a clear pathway for SWMBH to pursue new business lines and new customers, it is a certainty that most staff will depart.
- Any proposal must be both vetted by and supported by a majority of Member CMHSP CEOs. This proposal must address identified and new CMHSP concerns, including but not limited to value to CMHSPs, little or no financial risk to CMHSPs, and the like.
- All business opportunity proposals will require a *pro forma* budget.

The Emerging New World for CMHSPs

Using October 1, 2022 as a future date, one can somewhat predict the business environment for CMHSPs. PIHPs will be non-existent having begun to atrophy as early as January 1, 2021 or

sooner. Investments in PIHP support of staff, information technology, and both clinical and program initiatives will have been severely curtailed beginning October 1, 2020 and ceased by October 1, 2021. At the latest, reversion by SWMBH to only PIHP contractual mandates will begin October 1, 2021.

Medicaid and Healthy Michigan Plan (HMP), in whatever form they exist or not, will aggregate physical health and behavioral health into Specialty Integrated Plans or straight carve-in. MDHHS is likely to require Plans to contract with CMHSPs *as well as permit any other providers of their choice.*

This new model is likely to result in the following ramifications:

- Plans will refuse to pay providers above the fee schedule rates except perhaps in the most extreme circumstances where Plans must acquire rare clinical resources.
- Plans will move risk to CMHSPs and other providers via some or all the following mechanisms:
    - Volume-Assured Discounts * Value Based Purchasing
    - Incentives * Sanctions
    - Alternative Payment Methods * Others . . .
- CMHSPs who fail to assess, scope, and significantly reduce expenses and unit rates will immediately find themselves in a negative margin situation without recourse to others for remediation. Local Fund Balances are likely to be quickly used.
- Plans will desire to contract for varying commodity benefits management services such as provider network management.
    - It is highly unlikely that Plans will be willing to contract with each CMHSP singly, rather Plans will demand state-wide or mega-regional benefits management and contracting mechanisms.
    - In many instances Plans will perform all behavioral health functions in-house or contract with a single state-wide private or perhaps public entity.
    - Plans are unlikely to delegate authorities to CMHSPs and are unlikely to purchase benefits management services from an agency not NCQA MBHO Accredited.
    - Regardless, administrative fees will be low Per Member Per Month (PMPM) and CMHSP and/or RE/MBHO up-side gainsharing will be available only if specifically negotiated with details into the Agreement.

Despite assurances to the contrary, history has shown an inability of the Legislative and Executive Branches to reduce statutory, regulatory, and contractual burdens, all of which carry significant expense for the public behavioral health system. MHPs have been very aggressive in limiting and tightly specifying their beneficiaries, service arrays, and obligations to reduce the State spend, “proving efficiencies and savings”, while leaving so-called Community Benefit roles to the State and presumably to the CMHSPs. One must ponder the minimum size and scope necessary for a CMHSP to remain independent. Some CMHSPs may consider consolidations with other CMHSPs.

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

Expansions in the numbers of State hospital beds will become available, further expanding utilization and expenses for CMHSPs. This will most likely be without commensurate General Fund (GF) increases to support the added utilization.

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

Few outside the public behavioral health system grasp the difference between and dynamics around Medicaid entitlements, “priority populations,” and Ability to Pay General Fund services. CMHSPs would be wise to assure their community stakeholders and policymakers have a clear understanding of these and are supportive of, or at least tolerant of, service array modifications related to finances. This knowledge will enable them to become, or remain, active advocates for CMHSP funding in Lansing.

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

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

MDHHS documents state CMHSPs should have the following expectations:

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

MDHHS states changes CMHSPs will need to make include:

- Forming new partnerships to serve as managed care entities
- Building new (provider) networks, clinical expertise, capital reserves, and managed care functions
- Adjusting accounting and billing

Section 298 Initiative

SWMBH EO, along with several SWMBH CMHSP CEOs, attended a discussion titled “298 Lessons Learned”. Four of the 298 CMHSP CEOs presented the following key points:

298 Lessons Learned

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

- Subgroup discussion areas included Policy, Finance, Provider Network, Technology, Case Management/Care Management, and Reporting.
- MHPs were aghast at the types and volumes of data CMHSPs/PIHPs must report to MDHHS. Their position was oppositional to the reporting burdens.
- Some MHPs openly expressed opposition to Self-Determination, Person-Centered Planning, Independent Facilitation, and Fiscal Intermediaries. Some went so far as to say they would get those removed from Mental Health Code and MDHHS Policy directives.
- National Plans said it can take 6 months to get approval for a Business Associate Agreement and 18 months to get technology/data systems development achieved.
- Do not confuse MHPs with their Association, Michigan Association of Health Plans (MAHP). MAHP is there to be aggressive and inflammatory. Most of the MHP representatives were competent and caring about health services effectiveness.
- Legislative leaders are always involved and influential, sometimes apparently, sometimes not.
- MAHP/MHPs have always received the full raw files Milliman uses for rate-setting. They utilize their own contracted actuaries to inform rate discussions with MDHHS to their favor.

Losses and Opportunities

Impact to Region 4's CMHSPs in Proposed Transformation

Developed by the SWMBH Leadership Team, the Losses and Opportunities chart details the following two scenarios of the future and the impact on Region 4's CMHSPs:

- Processes, Systems, and Services Lost for CMHSPs if SWMBH disappears
- Processes, Systems, and Services Opportunities Available and Expanded for CMHSPs and Potential Partners if SWMBH is redefined

It is proposed that CMHSP Leadership perform this same exercise, facilitated by an external subject matter expert.

SWMBH Regional Planning

Losses and Opportunities

Quality Assurance & Performance Improvement		
Question:	**Losses for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**

1. What will CMHSPs lose if the PIHP contract is not renewed?	• Guidance/assistance from SWMBH for audits (ensuring standards are met by critiquing responses/show proofs)
	  ○ MDHHS Administrative audit, SUD audit, HSW, CWP, SEDW audits, DHIP
	  ○ HSAG PMV & HSAG EQR
	  ○ ICOs (?)
	• State reporting guidance/submissions
	  ○ MMBPIS
	  ○ CI/SE
	  ○ Jail Diversion
	  ○ BTRC
	  ○ MHL
	• Performance Bonus Incentive Metrics
	  ○ Formulation & submission of annual PBIP report ($1.8 million)
	  ○ MHL Quality Withhold Metrics ($110k)
	  ○ Additional grants/funding sources
	  ○ Vendor support & contract negotiation
	• No advocation at the State for changes involving contractual obligations (Performance Indicator updates, etc)
	• No Regional & individual survey administration/analysis
	  ○ CMHSP's would have to complete on their own
	  ○ Annual Consumer Satisfaction Survey (contractually obligated)
	  ○ RSA-r Survey
	  ○ Regional committee surveys
	• Data Analysis & access to reports
	  ○ Encounter reports
	  ○ BH TEDS reports
	  ○ Access to service reports
		• Experienced in Lean and Six Sigma, Quality can offer dedicated project manager(s) to reduce errors and eliminate waste/non value-added activities, resulting in "true" complete/accurate/timely results
		• MMBPIS/CISE/BTRC/Jail Diversion tracking
		• Survey administration/thorough analysis

	○ Enrollment by business line reports • Resources & support ○ Portal/website access ○ Tableau ○ Training tools	
Question:	**Continuing Needs for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost?	• Analytic support • Survey/project management support • Accreditation/CARF support • Audit management/facilitation support • State reporting liaison • Training/resources support	• Report development • Knowledge of accreditation guidelines • Project management • Knowledge of state and federal contractual requirements
Question:	**Continuing Needs for Potential Partners**	**Offerings for Potential Partners (Resources/Skills Available)**
3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• FQHC's • ICO's/Medicaid health plans • Private MH/SUD orgs (i.e. Beacon, Horizon, Skywood Recovery) • Local health systems (Bronson, Borgess, etc) • Tribal health systems • Corporate entities • Health care consulting companies	• Data analysis • Lean Six Sigma experience • Project management
Customer Service		
Question:	**Losses for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed?	• Extensive knowledge within SWMBH of the managed care regulations • Guidance/assistance for audits/reviews ensuring standards are met ○ Medicaid or Medicare Providers ○ HSAG or Accreditations ▪ URAC ▪ NCQA • Contract Management • Authorization/management of SUD services ○ Health Plans	• Experienced in URAC and NCQA

	• Fair Hearing coordination and representation • Coordinated regional outreach such as newsletters and handbooks	
Question:	**Continuing Needs for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**

2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost?	• SUD Grievances/Appeals for the Region including SUD Providers who are not CMHSPs
	• Fair Hearings – SWMBH contracts with an attorney for more challenging cases as well as overall facilitation allowing the CMHSPs to assist the member with the hearing while minimizing conflict of interest
	• Handbooks management – SWMBH develops, updates, manages, and covers expenses
	• Acts as buffer for HSAG Audits
	• MHL management of referrals/authorizations for care
	• Peer Recover Coach/Specialist acts as a liaison between the Department and regional peers, disseminating information, educational opportunities, and is a resource for the region
	• Guidance where direction/guidance of State requirements
	  ○ Creation of policies
	  ○ Template documents	

Question:	**Continuing Needs for Potential Partners**	**Offerings for Potential Partners (Resources/Skills Available)**
3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• SUD Grievances/Appeals for the Region • Fair Hearings • MHL management of referrals/authorizations for care • Peer Recover Coach/Specialist acts as a liaison between the Department and regional peers, disseminating information, educational opportunities, and in a resource for the region • Guidance where direction/guidance of State requirements ○ Creation of policies	• Fair Hearing coordination and representation could be an ASO function

	○ Template documents	
Clinical		
Question:	**Losses for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed?	• Without SWMBH there is no hub for regional collaboration • There is potential to waste resources through lack of collaboration at a regional level • Private Duty Nursing Authorizations ○ review of documentation by an RN to confirm medical necessity • Collaboration with health plans ○ Collaboration and coordination with MHPs/ICOs for high risk, high cost populations, resulting in decreased emergency department and inpatient utilization ○ Meet state requirements ○ Meet member needs ○ Coordinate with PCPs and other providers for high-risk members • Population Health Management ○ Identification of unmet needs that lead to process change ○ Quality Improvement Plans/implementation ○ Review of high-risk members that leads to treatment plan changes when needed • State collaboration and management of requirements ○ CMHSPs would have to attend all state meetings ○ Create their own reports with significant data and determine ways to meet the reporting requirements	• Clinical staff's diverse knowledge and skills allows for administrative duties to be completed without excessive duplication while creating valuable results with minimal errors. • Registered Nurses for consultation and to meet certain requirements (e.g., PDN) • Data compilation and analysis • Clinical Improvement planning specific to State metrics • Survey administration/thorough analysis • Access to comparative analytics with like counties (e.g., large vs small CMHs in the Southwest Michigan area). • Technical Assistance and Support for Autism, SEDW, CWP and HSW. • Technical Assistance for Medicaid services. • BCBA case consultation

	• Health Plan collaboration and reporting requirements
	  ○ CMHSPs would have to plan and attend meetings frequently with health plans
	  ○ Work toward improvement measures with health plans
	• Resources & support
	  ○ CMT
	  ○ Complex Case Management
	  ○ Data Analytics
	• Development of Level of Care system based on regional needs and regional data
	• Training Support
	  ○ Pertinent clinical trainings based on requirements and specific needs of the population and staff
	  ○ Cost-free clinical trainings and CEUs for CMHs, providers, and staff
	• Regional slot utilization management for all waivers, which impacts budgets and service access
	• SIS Assessors who are completely conflict free
	• Clinical Quality and Substance Use Disorder quality monitoring for CMSHP
	• Program Approval Oversight
	  ○ Wraparound, Home-Based, Crisis Residential, ACT ,etc.
	• Clinical Quality oversight for many providers to include
	  ○ Applied Behavioral Analysis Providers
	  ○ Crisis Residential Providers
	  ○ Inpatient Units within the Region
	  ○ Substance Use Providers within the Region
	• Home and Community Based Services
	  ○ Project management of all Home and Community Based Services activities	

	▪ Provisional Approval Process ▪ Survey Management ▪ Remediation ▪ Technical Assistance to providers and CMSHPs • Applied Behavioral Analysis ○ Clinical Quality and oversight ○ Access to BCBA for Consultation ○ Technical Assistance to providers and CMHSPs ○ Quality management and oversight to achieve Federal Compliance	
Question:	**Continuing Needs for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost?	• Continued development of programs/grants that are innovative and develop new ways to meet member needs • Collaboration and Coordination with physical health and behavioral health providers • Coordination with inpatient units (hospital and stand-alone) • Data collection needs • Analytic support • Survey/project management support • Accreditation support • State regulation and requirement liaison • Training/resources support	• Data collection and analysis • Report development • Knowledge/Research of accreditation guidelines • Project management • Knowledge of state and federal contractual requirements • Policy development based on extensive regulations
Questions:	**Continuing Needs for Potential Partners**	**Offerings for Potential Partners (Resources/Skills Available)**
3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• FQHC's • ICO's/Medicaid health plans • Private MH/SUD orgs (i.e. Beacon, Horizon, Skywood Recovery) • Local health systems (Bronson, Borgess, etc) • Tribal health systems	• Registered Nurse knowledge and skills ○ Medication reviews ○ Clinical assessment • Clinical collaboration • Policy development based on extensive regulations

	• Health care consulting companies	• Data analysis • Project management
Finance		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs Continuing Needs for Potential Partners**	**Offerings for CMHSPs (Resources/Skills Available) Offerings for Potential Partners (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost? 3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• Single voice to advocate at the State level • State Reporting for all reports handled by SWMBH • Compliance Audit cost covered	
Information Technology		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost?	• SIS Staff Assessors and data we collect for them • Tableau licensing and reports • Data validation – edits we run against their data before sending to the State • IT resources with lots of experience • SWMBH Data Warehouse • SWMBH can absorb data from Streamline & PCE. CMHSPs will have to rely on vendors in the future for reporting. -- CMHSP data processing support costs may go up • Lose centralized management of CC360, Champs, Waivers, etc. • Quality measure, HSAG, ICO audits and similar tasks which are done by	• SWMBH can make the data warehouse available to the CMHSPs • Automation of data submission. SWMBH can improve the data frequency, timing, and quality • MUNC reporting • Provider network management and adjudication and payment of claims

	PHIP will have to be managed by CMHSP • MUNC and FSR prepared by IT and Finance will be responsibility of CMHSP	
Questions:	**Continuing Needs for Potential Partners**	**Offerings for Potential Partners (Resources/Skills Available)**
3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.		• FQHCs already do Behavioral Health and SUD treatment and need help with data analytics, dashboards and reporting to the state and CMS. • Area Agency on Aging need help with care coordination among hospitals and FQHCs and could use help with data transfer between state system and disparate EMRs • Homeless Shelters – possibly assist with SUD treatment, capture and reporting of data. • Nursing Homes and Hospice, Home Health Agencies – capture and reporting of data (most have very small or no IT staff)
SUD Prevention/Treatment		
Questions:	**Losses for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed?	• Expertise of the PIHP: Prevention Programming, PA2, waivers (Autism, Habitation Supports (HAB), etc.) • SUD Task Force infrastructure • Centralized UM for detox, residential and methadone, reviews for In Patient admits, • Reporting management – will potentially be required to report directly State of MI, loss of Technical Assistance by PIHP • Possible loss of capitation and move to fee for service model	

	• Will potentially take on financial risk • Loss of influence with payor – potentially no board representation, membership on various committees and workgroups. Loss of ownership in how services are designed, implemented. • Advocacy at the State level	
Questions:	**Continuing Needs for CMHSPs**	**Offerings for CMHSPs (Resources/Skills Available)**
2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost?	• CMHSPs will need to transition to a new environment, new way of doing business. CMHSPs will be required to be nimble and flexible to effectively make these changes. • CMHSPs will have potentially new standards, reporting mechanisms, and contractual expectations • CMHSPs may be in the position to have to train the SIP	
Questions:	**Continuing Needs for Potential Partners**	**Offerings for Potential Partners (Resources/Skills Available)**
3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• Grants and Waiver Management – Waiver Support Application, Autism, HAB, Opioid Health Homes. • Benefits Management Organization	

Utilization Management Call Center		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs Continuing Needs for Potential Partners**	**Offerings for CMHSPs (Resources/Skills Available) Offerings for Potential Partners (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost? 3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• Regular, daily guidance from UM. CMHSPs regularly contact UM regarding situations that they are unsure how to handle and frequently call and e-mail UM staff to discuss issues. • The benefit of remote UM is there is a different perspective in determining medical necessity since it is a 3rd party and not the provider determining which services are medically appropriate. • Required additional staff to accommodate SUD customers – intake/screens, authorizing services, etc. • Loss of training opportunities • Advocates at the state/federal level • Parity between counties • Loss of assistance with BH TEDS, ensuring metrics are met, care coordination with managed care plans • Acute Care UM SUD Detox/Residential UM • Unclear what would happen to MHL but as providers to ICOs they would have significant reporting capability needs • Management of SUD in general. Currently CMHSPs are sub-capped providers and do no administration functions	• Training opportunities • Utilize for CMS/state guidance • SAPT Dept – Narcan distribution, education, SUD Grants!! • So many SUD related things – harm reduction: needle exchange, safe injecting sites, Narcan training, etc. • Continued MI Health Link coordination for behavioral health/SUD treatment • Any UM or program management could be ASO function

Provider Network		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs Continuing Needs for Potential Partners**	**Offerings for CMHSPs (Resources/Skills Available) Offerings for Potential Partners (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost? 3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• Management of Inpatient and Crisis Residential contracts, including rate negotiations • Crisis Residential Site Reviews • Standardized provider boilerplate development; standardized provider review tools development • Maintenance of Provider Directory • Organizational credentialing of inpatient, crisis residential, and autism providers	
Compliance		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs Continuing Needs for Potential Partners**	**Offerings for CMHSPs (Resources/Skills Available) Offerings for Potential Partners (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost? 3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• Monthly excluded provider monitoring • Ownership & Control Disclosure maintenance and screening • Medicaid Services Verification (presumably will fall to the CMHSPs in the absence of the PIHP)	

Operations		
Questions:	**Losses for CMHSPs Continuing Needs for CMHSPs Continuing Needs for Potential Partners**	**Offerings for CMHSPs (Resources/Skills Available) Offerings for Potential Partners (Resources/Skills Available)**
1. What will CMHSPs lose if the PIHP contract is not renewed? 2. What continuing and new needs might CMHSPs have if the PIHP contract at SWMBH is lost? 3. Also consider what other non-CMHSP entities and agencies might be attracted by what we do and include those ideas being specific.	• A few CMHSPs use SWMBH MCIS for claims processing and provider contract Management • CMHSPs will need to develop their own process for accepting 837 claims through a clearinghouse for inpatient if they retain that management • All Contracts that are managed for region and paid by the PIHP such as MyStrength or Relias (CMT) • Access to Subject Matter Experts who are contacted weekly by CMHSPs for resources • SWMBH as an Intermediary with staff, providers, others	• Use of SWMBH MCIS for claims processing and provider contract management • Use of processes for accepting 837 claims through a clearinghouse for inpatient if contract management is retained • Contact management for MyStrength or Relias (CMT)

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

Current Market Overview

The follow charts are an overview of the current market and identify Current Customers, Potential New Customers, Current Business Lines, and Potential Business Lines.

Current Customers

- Community Mental Health Service Providers
- Integrated Care Organizations
    - Meridian (Centene – www.Centene.com
    - Aetna Better Health

Potential New Customers

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

Current Business Lines – to be completed

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

- Recruitment, employment, management, and deployment of physicians, psychologists, and other clinical staff
- Recruitment, employment, management, and deployment of provider auditors, claims processors, and other administrative staff
- County millage pursuit subject matter experts and technical assistance
- Philanthropy (fund raising) subject matter experts and technical assistance
- Grant and United Way pursuit subject matter experts and technical assistance
- Analyses and enhancements of external provider services such as Personal Care, Community Living Services, Supported Employment, Skill Building, Supported Independent Living, etc.
- Design and development of Value Based Purchasing (VBP) and Alternative Payment Methods (APMs)
- Joint contracting with MHPs for mild to moderate mental health services management and other commercial payer BH services
- Shared General Counsel, Labor Counsel, etc.
- Shared and joint Program Integrity-Compliance Program
- Provider contract development and negotiations
- Payer contract negotiations
- Shared and joint enrollee rights and protections program
- Shared and joint Complex Care Management
- Complex case consultation
- Evidence-based practices installation, training, and monitoring
- Management Information – Business Intelligence support
- Program Portfolio Analyses
- New Program Analyses
- Scaling and replication of successful programs
- Sales and services to non-SWMBH CMHSPs
- Healthcare Information Exchange support
- Healthcare Data Analytics support
- Strategic Planning support
- Public Relations, Media Relations, and Marketing support
- Group Purchasing support
- Others . . .

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

Special Opportunities

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

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

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

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

Competitive Analysis

With an intent to sell various Administrative Service Organizations (ASO) solutions, it is highly likely that other current Regional Entities (RE), new CMHSP-sponsored Community Mental Health Association of Michigan (CMHAM) Provider Groups, and related agencies will develop similar approaches addressing post 9/30/22 opportunities in behavioral health benefits management and other value-added activities. The ten RE/PIHP Directors met on February 14, 2020 for a discussion of system issues.

For decades multiple, well-known, national Managed Behavioral Health Organizations have had eyes on our Medicaid managed care program. These MBHOs have maintained contact with key leaders in Michigan and Medicaid Health Plans, continually making assertive pitches for their ASO offerings and capital funds. Top contenders include but are not limited to the following:

- Beacon Health Options www.beaconhealthoptions.com
- Magellan www.magellanhealth.com
- Envolve www.envolvehealth.com
- Optum www.optum.com

See Appendix F for a list of NCQA MBHO Accredited entities.

These national for-profit companies have long histories, sophisticated offerings complementing behavioral health benefits management, intense promotional pitches, and significant capital funds. A credible case will have to made to prospective Customers for why SWMBH is as, or

more, attractive than these firms. We should not rule out future partnership(s) with one or more of these firms.

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

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

Sales and Marketing

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

Ownership

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

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

Operations

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

Mandatory Enabling Decisions

There are certain deliberations and decisions which need to occur to provide authorization and visible support to the SWMBH EO in these endeavors.

Decision

Board Action Required:

1) Board authorization to pursue Bylaws revisions to expand geographic reach with Participant CMHSPs.
2) Board review, modification, and approval of varying severable parts of this Strategic Business Plan.
3) Board authorization to begin the Customer Identification Process.

These decision points will inform and drive both current and future staff behavior; more staff will likely remain with SWMBH if there is visible Board support for a future beyond lights out on 9/30/22.

Decision

Board Action Required: It is during this time, and ideally no later, that the Board must affirmatively authorize management to proceed with the following:

1) Regional Entity Bylaws revisions attempts enlarging geographic service area at each Member CMHSP Board of Directors –See Note Below
2) Business line design (not yet developed) concurrent with customer mining

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Each of these require substantial resources, primarily from SWMBH EO, other SWMBH senior managers, external Subject Matter Experts and Member CMHSP talent.

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

Behavioral Health & Developmental Disabilities Administration
Bureau of Community Based Services

Prepaid Inpatient Health Plan – Medicaid Health Plan
Shared Metrics
Health Equity Reports

Southwest Michigan Behavioral Health

June 2020

Produced by:
Program Development, Consultation & Contracts Division

Follow-Up after Emergency Department (ED) Visit for Alcohol and Other Drug Dependence (FUA)

Measure
The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.

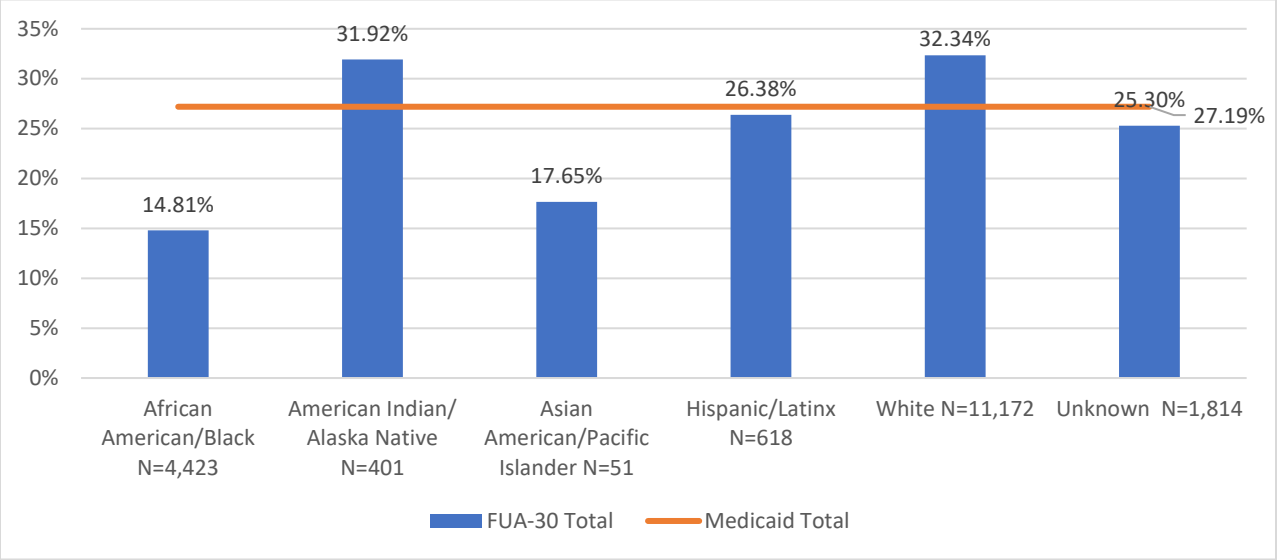
Objective
Reduce Racial/Ethnic Disparities

Measurement Period
January 2018 – December 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Annually

Figure 1: CY 2018, FUA-30 Statewide Medicaid Total by Race/Ethnicity



Note: *For the FUA measure, N equals a count of ED events, not individuals. For this reason, the same person could be in one of these demographic categories more than once.*

Table 1: CY 2018, FUA-30 Statewide Medicaid Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Michigan Medicaid Total	5,027	18,479	27.20
African American/Black	655	4,423	14.81
American Indian/Alaska Native	128	401	31.92
Asian American/Pacific Islander	9	51	17.60
Hispanic/Latinx	163	618	26.38
White	3,613	11,172	32.34
Unknown	459	1,814	25.3

Table 2: CY 2018, FUA-30 SWMBH Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Southwest Michigan Behavioral Health Total	509	1,736	29.32
African American/Black	49	298	16.44
American Indian/Alaska Native*	N/A	N/A	N/A
Asian American/Pacific Islander*	N/A	N/A	N/A
Hispanic/Latinx*	N/A	N/A	N/A
Unknown	N/A	N/A	N/A
White	404	1,218	33.17

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Table 3: CY 2018, FUA-30 PIHP-MHP Combination Rates by Race/Ethnicity*

PIHP-MHP Combination	Race/Ethnicity	Numerator	Denominator	Rate%
AET-Southwest Michigan Behavioral Health	White	15	30	50.00
MCL-Southwest Michigan Behavioral Health	White	27	95	28.42
MER-Southwest Michigan Behavioral Health	African American / Black	15	130	11.54
MER-Southwest Michigan Behavioral Health	Unknown	7	36	19.44
MER-Southwest Michigan Behavioral Health	White	165	487	33.88
MOL-Southwest Michigan Behavioral Health	White	11	45	24.44
PRI-Southwest Michigan Behavioral Health	White	51	150	34.00
UNI-Southwest Michigan Behavioral Health	African American / Black	18	55	32.73
UNI-Southwest Michigan Behavioral Health	White	62	229	27.07

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Follow-Up after Hospitalization for Mental Illness – 30 days (FUH) Adult

Measure
The percentage of discharges for individuals age twenty-one (21) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.

Objective
Reduce Racial/Ethnic Disparities

Measurement Period
January 2018 – December 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Annually

Figure 2: CY 2018, FUH-30 Adult Statewide Medicaid Total by Race/Ethnicity

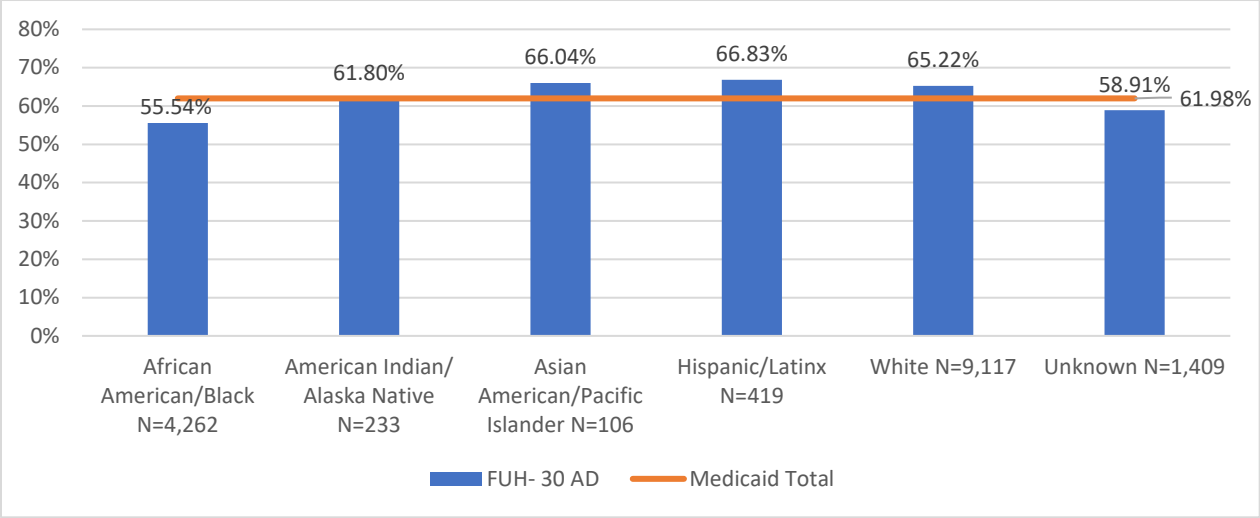


Table 4: CY 2018, FUH-30 Adult Statewide Medicaid Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Michigan Medicaid Total	9,626	15,534	61.98
African American / Black	2,367	4,262	55.54
American Indian / Alaska Native	144	233	61.80
Asian American	59	94	62.77
Hispanic/Latinx	280	419	66.83
White	5,946	9,117	65.22
Unknown	830	1,409	58.91

Table 5: CY 2018, FUH-30 Adult SWMBH Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Southwest Michigan Behavioral Health Total	620	920	67.39
African American / Black	108	165	65.45
American Indian/Alaska Native*	N/A	N/A	N/A
Asian American/Pacific Islander*	N/A	N/A	N/A
Hispanic/Latinx	N/A	N/A	N/A
Unknown	38	65	58.46
White	444	647	68.62

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Table 6: CY 2018, FUH-30 Adult PIHP-MHP Combination Rates by Race/Ethnicity*

PIHP-MHP Combination	Race/Ethnicity	Numerator	Denominator	Rate%
UNI-Southwest Michigan Behavioral Health	African American / Black	21	37	56.76
UNI-Southwest Michigan Behavioral Health	White	68	103	66.02

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Follow-Up after Hospitalization for Mental Illness – 30 days (FUH) Child

Measure
The percentage of discharges for individuals ages six (6) to 20, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.

Objective
Reduce Racial/Ethnic Disparities

Measurement Period
January 2018 – December 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Annually

Figure 3: CY 2018, FUH-30 Child Statewide Medicaid Total by Race/Ethnicity

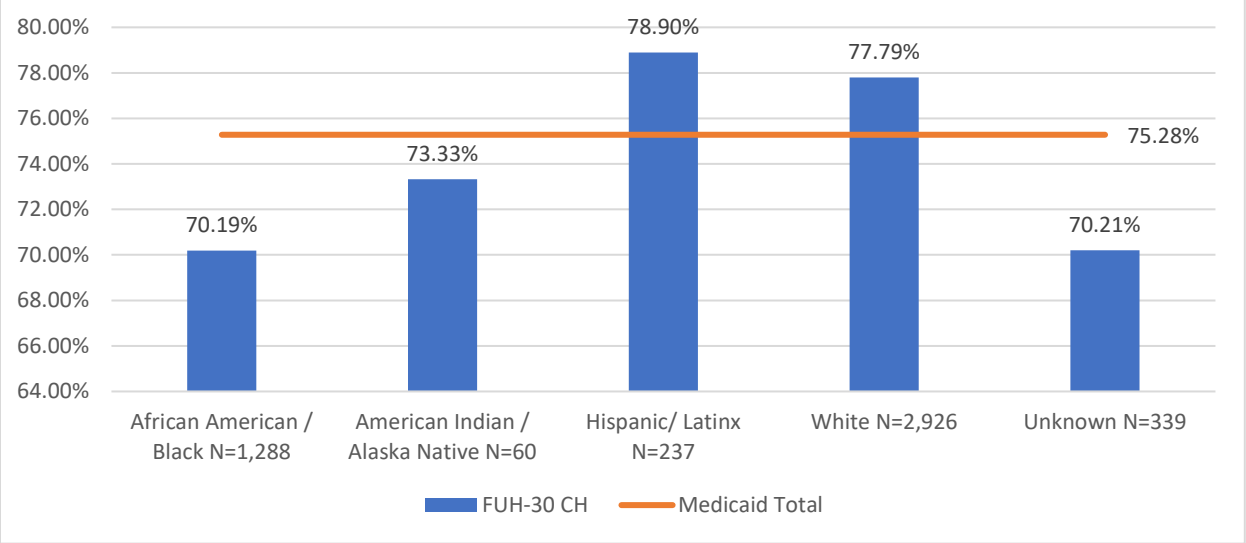


Table 7: CY 2018, FUH-30 Child Statewide Medicaid Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid Total	3,673	4,879	75.28%
African American / Black	904	1,288	70.19%
American Indian / Alaska Native	44	60	73.33%
Hispanic/ Latinx	187	237	78.90%
White	2,276	2,926	77.79%
Unknown	238	339	70.21%

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Table 8: CY 2018, FUH-30 Child SWMBH Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate
Southwest Michigan Behavioral Health Total	180	237	75.95
African American / Black	53	71	74.65
American Indian / Alaska Native	N/A	N/A	N/A
Hispanic/ Latinx	N/A	N/A	N/A
Unknown	25	32	78.12
White	186	231	80.52

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Table 9: CY 2018, FUH-30 Child PIHP-MHP Combination Rates by Race/Ethnicity

PIHP-MHP Combination	Race/Ethnicity	Numerator	Denominator	Rate%
MER-Southwest Michigan Behavioral Health	White	69	79	87.34

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Plan All-Cause Acute 30-Day Readmissions (PCR)

Measure
The percentage of acute inpatient stays during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Objective
Reduce Racial/Ethnic Disparities

Measurement Period
January 2018 – December 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Annually

Figure 4: CY 2018, PCR-30 Statewide Medicaid Total by Race/Ethnicity

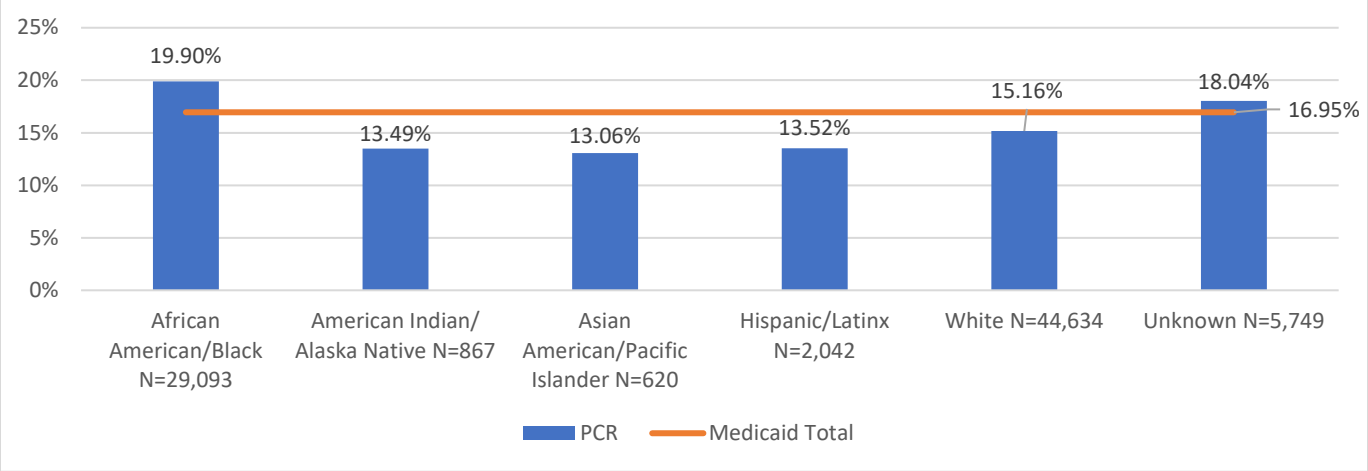


Table 10: CY 2018, PCR-30 Statewide Medicaid Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Michigan Medicaid Total	14,068	83,005	16.95
African American / Black	5,789	29,093	19.90
American Indian / Alaska Native	117	867	13.49
Asian American	74	562	13.17
Hispanic/Latinx	276	2,042	13.52
Native Hawaiian & Other Pacific Islander	7	58	12.07
White	6,768	44,634	15.16
Unknown	1,037	5,749	18.04

Table 11: CY 2018, PCR-30 SWMBH Adult Total by Race/Ethnicity

Medicaid Program	Numerator	Denominator	Rate%
Southwest Michigan Behavioral Health Total	807	5,381	15.00
African American / Black	247	1,219	20.26
American Indian/Alaska Native*	N/A	N/A	N/A
Asian American/Pacific Islander*	N/A	N/A	N/A
Hispanic/Latinx	17	139	12.23
Unknown	85	358	23.74
White	452	3,597	12.57

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

Table 12: CY 2018, PCR-30 Adult PIHP -MHP Combination Rate by Race/Ethnicity*

PIHP-MHP Combination	Race/Ethnicity	Numerator	Denominator	Rate%
MCL-Southwest Michigan Behavioral Health	WHITE	16	157	10.19
MER-Southwest Michigan Behavioral Health	AFRICAN AMERICAN / BLACK	141	577	24.44
MER-Southwest Michigan Behavioral Health	HISPANIC	6	56	10.71
MER-Southwest Michigan Behavioral Health	UNKNOWN	43	145	29.66
MER-Southwest Michigan Behavioral Health	WHITE	238	1,770	13.45
MOL-Southwest Michigan Behavioral Health	WHITE	5	38	13.16
PRI-Southwest Michigan Behavioral Health	UNKNOWN	6	35	17.14
PRI-Southwest Michigan Behavioral Health	WHITE	20	238	8.40
UNI-Southwest Michigan Behavioral Health	AFRICAN AMERICAN / BLACK	21	198	10.61
UNI-Southwest Michigan Behavioral Health	UNKNOWN	10	57	17.54
UNI-Southwest Michigan Behavioral Health	WHITE	63	596	10.57

*Only racial/ethnic combinations with numerators >=5 and or denominators >=30 are shown

MDHHS Behavioral Health Strategic Planning Pillars – July 2020

I. Drive improved outcomes and more funding to the front lines through streamlined oversight PIHP/CMHP accountability reforms.
II. Integrate physical and behavioral health care at the point of service with a person-centered approach and inclusion of social determinates of health.
III. Ensure all Michiganders have access to behavioral health, mental health and substance use prevention, treatment, services and follow up services for the best quality life.
IV. Provide people with outreach, service delivery, and access to behavioral health services at their preferred locations and mechanisms. *Consider telehealth and telephone services utilized during COVID-19.*
V. Provide quality and time efficient patient care flow from community to residential treatment or institution (hospital, juvenile detention centers, jail) to community with individualized clinical treatment.

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
September 11, 2020
9:30 am to 11:00 am
Draft: 8/6/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Recess Board Meeting**
5. **Fiscal Year 2021 Budget Public Hearing**
6. **Reconvene Board Meeting**
7. **Consent Agenda**
   - August 14, 2020 SWMBH Board Meeting Minutes (d)
8. **Operations Committee**
   - Operations Committee Minutes July 22, 2020 (d)
9. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
   a. Health Services Advisory Group (HSAG) – Performance Measure Validation (PMV) (J. Gardner) (d)
   b. Behavioral Health (BH) Treatment Episode Data Set (TEDS) (J. Gardner) (d)
   c. Health Services Advisory Group Performance Improvement Project (M. Kean) (d)
10. **Board Actions to be Considered**
    - Fiscal Year 2020-2021 SWMBH Budget (d)
11. **Board Policy Review**
    Is the Board in Compliance? Does the Policy Need Revision?
    a. BG-008 Board Member Job Description (d)
    b. EO-001 Executive Role & Job Description (d)

12. Executive Limitations Review

Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?

- BEL-009 Global Executive Constraints (E. Meny) (d)

13. Board Education

a. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d)
b. Fiscal Year 2020 CMH Site Review Results (M. Todd) (d)
c. Compliance Role and Function (M. Todd)
d. Integrated Care (M. Kean)

14. Communication and Counsel to the Board

a. October 9, 2020 Board Agenda (d)
b. Board Member Attendance Roster (d)
c. October Board Policies: BEL-008 Communication and Counsel (T. Schmelzer) Succession

15. Public Comment

16. Adjournment

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

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

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

Next SWMBH Board Meeting
October 9, 2020
9:30 am - 11:00 am

and

SWMBH Board Planning Session
October 9, 2020
To begin 15 minutes after the adjournment of the SWMBH Board Meeting

2020 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Robert Nelson (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Patrick Garrett (Calhoun)												
Michael McShane (Cass)												
Erik Krogh (Kalamazoo)												
Janet Bermingham (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Randy Hyrns (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Mary Middleton (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 7/10/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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