Southwest Michigan

BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting
5250 Lovers Lane, Portage, MI 49002
Dial-in: 1-844-655-0022
Access Code: 738 811 844
August 9, 2019
9:30 am to 11:00 am
8/5/19

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d) (pg.1)**
3. **Consent Agenda**
    - July 12, 2019 SWMBH Board Meeting Minutes (d)
4. **Operations Committee**
    - Operations Committee Minutes June 26, 2019 (d)
5. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?
    - Michigan Mission Based Performance Indicator System (MMBPIS) (J. Gardner) (d)
6. **Board Actions to be Considered**
    - Closed Session to review Counsel Opinion (10:15-11am-R. Parmenter via phone)
7. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?
    - BG002 Management Delegation (d)
8. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
    - BEL-005 Treatment of Plan Members (M. Walker) (d)

9. Board Education

a. Fiscal Year 2020 Budget Preview (T. Dawson)
b. Managed Care Functional Review – Provider Network Management Update (M. Todd)
c. CMH Review Scores (d) (M. Todd)
d. Substance Abuse Prevention and Treatment Update (J. Smith) (d)
e. Substance Use Disorder Oversight Policy Board Update (R. Hazelbaker, Chair, SUDOPB)

10. Communication and Counsel to the Board

a. Consolidated Fiscal Year 2019 Year to Date Financial Statements (T. Dawson) (d)
b. Cass-Woodlands Authority Status (B. Casemore) (d)
c. Lakeshore Regional Entity (B. Casemore) (d)
d. Board Member Attendance Roster (d)
e. 2019-2020 Policy Governance Proficiency Program (d)
f. MDHHS Press Release-State recommends 84-bed facility at Caro (d)
g. Caro Center Evaluation (d-portal only)
h. Blue Cross Blue Shield sued for $40 million (d)
i. Fiscal Year 2020 Behavioral Health Capitation Rate Development (d-portal only)
j. Performance Indicator Acknowledgement Letters (d)
k. Michigan Health Endowment Fund Access Study (d)
l. 2019 Aetna Delegation Audit Report (d)

11. Public Comment

12. Adjournment

Next SWMBH Board Meeting and Budget Hearing
September 13, 2019
9:30 am - 11:30 am
Kalamazoo Valley Community College Groves Center
7107 Elm Valley Drive, Room B1100
Kalamazoo, MI 49009

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
July 12, 2019
9:30 am-11:00 am
5250 Lovers Lane, Suite 200, Portage, MI 49002
Draft: 7/15/19

Members Present: Tom Schmelzer, Ed Meny, Susan Barnes, Robert Nelson, Mary Myers, Moses Walker

Members present via phone: Angie Price

Guests: Bradley Casemore, Executive Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Rob Moerland, Chief Information Officer, SWMBH; Jon Houtz, Pines Behavioral Health Alternate; Ric Compton, Riverwood; Brad Sysol, Summit Pointe; Debra Hess, Van Buren CMH; Jeannie Goodrich, Summit Pointe; Nancy Johnson, Riverwood; Richard Thiemkey, Barry County CMH; Michael McShane, Woodlands BHN; Sue Germann, Pines BH; Jeff Patton, KCMHSAS; Patricia Guenther, KCMHSAS; Rhea Freitag, Behavioral Health Waiver & Clinical Quality Manager, SWMBH; Mike Kenny, NAMI; Michelle Jorgboyan, Senior Operations Specialist, SWMBH

Guests present via phone: Kris Kirsch, St. Joseph County CMHSAS

Welcome Guests

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

Public Comment

Mike Kenny addressed the attendees.

Agenda Review and Adoption

Motion	Mary Myers moved to accept the agenda with one change of moving BEL-005 to the August SWMBH Board meeting.
Second	Edward Meny
Motion Carried	

Consent Agenda

Motion	Robert Nelson moved to approve the Customer Advisory Committee nomination, Eric Davis of Van Buren County for a two-year term.
Second	Moses Walker
Motion Carried	

Motion	Edward Meny moved to approve the June 14, 2019 Board meeting minutes as presented.
Second	Susan Barnes
Motion Carried	

Operations Committee

Operations Committee Minutes May 22, 2019

Debra Hess presented the report as documented. Minutes accepted.

Operations Committee Report

Debra Hess presented the report as documented.

Operations Committee Self Evaluation

Debra Hess presented the report as documented. Tom Schmelzer commented the Board's appreciation of the Operations Committee's work, noting that the SWMBH Board trusts the Operations Committee implicitly and their work is helpful to the Board and Board governance.

Ends Metrics Updates

Autism Spectrum Disorder (ASD) Update

Rhea Freitag reported as documented. Discussion followed. Board requested more detail on ASD metric. Rhea Freitag will provide requested detail at the August Board meeting.

Executive Limitations Review

BEL-005 Treatment of Plan Members

Policy BEL-005 Treatment of Plans was moved to the August Board meeting.

Board Education

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

Tracy Dawson reported that there is nothing new to report this month and there will be an update at next month's Board meeting.

Single Audit Financial Audit Change

Tracy Dawson reported that there was one finding this year. The requested change was made and submitted. Discussion followed.

Fiscal Year 2018 Service Use Analysis (SUE) meeting update

Tracy Dawson reported that the 6/18/19 SUE meeting was well attended, each CMHSP participated. Local, regional, processes, procedures, and levels of care were discussed.

Third Party Information Technology Security Assessment Results

Rob Moerland reported as documented. Discussion followed. Rob Moerland also announced his resignation stating his last day with SWMBH is July 19th. Tom Schmelzer thanked Rob Moerland for his expertise and wished him well on behalf of the Board.

Communication and Counsel to the Board

Consolidated Fiscal Year 2019 Year to Date Financial Statements

Tracy Dawson reported as documented noting the differences between 2019 and 2018 statements. Tracy Dawson thanked the CMHSPs for all their hard work. Brad Casemore added that the Region has been cautious and careful in cost reductions that do not affect the consumer's services.

Michigan Consortium for Healthcare Excellence

Brad Casemore reported as documented. Discussion followed.

September 13, 2019 SWMBH Board Budget Public Hearing

Brad Casemore noted that the September 13th SWMBH Board Budget Public Hearing agenda was included in the packet for the member's review.

Public Policy Legislative Initiative Update

Ric Compton shared that the spring event was a success and the next meeting will incorporate both Board Retreat information and Legislative Event information.

Board Member Attendance Roster

Tom Schmelzer reported as documented. Brad Casemore noted that the semi-annual attendance report will be mailed out to each CMHSP CEO and CMHSP Board Chair.

298 Pilots

Brad Casemore reported as documented. Discussion followed.

MI Health Link Evaluation

Brad Casemore reported as documented. Discussion followed.

Lakeshore Regional Entity PIHP Contract Cancellation

Brad Casemore reported as documented. Discussion followed.

Articles

Brad Casemore noted two articles of interest included in the packet.

Public Comment

Richard Thiemkey stated that he appreciated this Region versus other Regions in their sophisticated methods, outcomes and evaluations, which the other Regions do not have. He also appreciated the collaboration of SWMBH with the CMHSPs. Mike Kenny congratulated SWMBH on their excellent work stating that this PIHP should take over the Lakeshore Regional Entity and lead the State as an example.

Adjournment

Motion	Susan Barnes moved to adjourn at 10:35 am.
Second	Mary Myers
Motion Carried	

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: June 26, 2019
9:00am-2:00pm

Members Present –Sue Germann, Jane Konyndyk, Richard Thiemkey, Ric Compton, Kris Kirsch, Kathy Sheffield, and Bradley Casemore

Guests – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Alona Wood, QAPI Specialist, SWMBH; Moira Kean, Director of Clinical Improvement, SWMBH; Robert Moerland, Chief Information Officer, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH; Mary Green, VBCMH, and Kim Rychener and Shaun Fields, Summit Pointe.

Guests present via conference call – Alan Bolter, CMHAM

Call to Order – Brad Casemore began the meeting at 9:00 am.

Review and approve agenda – Agenda was approved as presented.

Review and approve minutes from 5/22/19 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2019 YTD Financials – Tracy Dawson reported as documented. Research into Autism service planning and costs is ongoing. Updates to the Operations Committee in July and August.

Service Use Evaluation (SUE) III Meeting Debrief – Tracy Dawson reported as documented. Finance Committee reviewing reports at their July 1 meeting. Discussion followed.

MCG Installation Update – Moira Kean updated the group on recent discussions with MCG regarding product purchased by Michigan Consortium for Healthcare Excellence. The movement towards implementation is slow and MCG is working with PCE on systems interface.

MDHHS Behavioral Health Fee Development – Tracy Dawson reported that there have been no new developments.

Recipient Rights (RR) Delegated Administration – Jane Konyndyk discussed RR handled as managed care on the budget. Group discussed and agreed that even though RR is not delegated managed care the cost is not enough to move and moving the cost would not bring down the expense line.

Public Policy Environment – Alan Bolter gave the group the following updates:

- State House and Senate budget meetings are ongoing
- Legislative agreement and negotiations with new governor pending

- Proposed gas tax of .45 per gallon for repairing roads statewide per Governor
- Legislative boilerplate developments
- Budget language negotiations
- Local match draw down
- Autism to receive a 5% increase in one proposed budget, 3% in another
- 298 Memo delaying implementation until 10/1/20, noting some implementation issues: data sharing, work flow, networking, rates, UM claims, rates
- Lakeshore Regional Entity update
- General Fund (GF) Fiscal Year 2020- and 5-year projections on changes in GF funding

July Operations Committee Meeting Planning – Brad Casemore reviewed July 31 Operations Committee agenda and asked for additions and feedback for offsite meeting. Group agreed on location and agenda as presented.

County Resolution on FY 20 Boilerplate Section 928 on Local Match – Brad Casemore reported as documented and highlighted concerns with the resolution asking group to be aware if their county is thinking to adopt this resolution. Discussion followed.

Autism Spectrum Disorder (ASD) Services Analysis – Moira Kean reported as documented. Discussion followed, and the group asked for another update at the July Operations Committee meeting, including recommendations and financial impacts of parity/changes in ASD services. The Operations Committee supports the ASD team to keep moving the system forward.

Care Management Technologies (CMT) Contract – Brad Casemore reviewed the cost of the CMT contract and let the group know that it may not be renewed due to low use at CMHSPs. Discussion followed. Group to discuss at local CMHSPs and Operations Committee to decide at the July Operations Committee meeting.

Incompetent to Stand Trial Issues – Kim Rychener reported as documented. Discussion followed.

Managed Care Functional Review (MCFR) Provider Network Management (PNM) – Mila Todd reported that the regional PNM reviewed credentialing and shared site reviews at the recent MCFR meetings identifying areas of improvement. The next MCFR PNM meeting will review network adequacy and provider training.

Fiscal Year 2020 Budget Development Updates, MDHHS and SWMBH– Tracy Dawson stated that there is another meeting on June 30th. No rates announced yet. Steve Finch emailed templates to CMHSPs and are due back to SWMBH by July 23.

Prevention Direct Services – Brad Casemore reported as documented noting that SWMBH is not in compliance regarding prevention direct services, some CMHSPs do not have any of the five services noted in the Medicaid Provider Manual. Discussion followed, and group asked the Regional Clinical Programs workgroup to review, research and report back to Operations Committee at the September meeting.

Parent Support Partner Service and Youth Peer Support Service Provision – Mila Todd stated that reports were completed and submitted to the State.

Fiscal Year 2020 Prepaid Inpatient Health Plan (PIHP) and Community Mental Health (CMH) Contract Development – Mila Todd stated that contract development is ongoing. PIHPs are waiting on Global Assessment of Individuals Needs and County of Financial Responsibility language, and Performance Bonus Incentive Program (PBIP) metrics. Brad Casemore noted that the PBIP would be noted as local funds in the CMHSP contract.

Centers for Medicaid and Medicare Services (CMS) and the Office of Inspector General's (OIG) – Mila Todd reviewed recent news from CMS regarding OIG activities.

Autism Alliance Data Request – Mila Todd stated that the first request was denied and the second amended request was granted. Autism Alliance has asked clarifying questions and SWMBH is drafting a response.

Data Model Exchange Submission Status and Reports review – Encounters and Behavioral Health Treatment Episode Data Set (BH TEDS) Rob Moerland reported as documented. Rob Moerland to email a weekly report on Fridays to Operations Committee.

Outstanding Development Items Streamline Health Systems (SHS) and PCE – Rob Moerland stated that work with both SHS and PCE are ongoing. Discussion followed.

Michigan Mission Based Performance Indicator System CMH Detail – Alona Wood reported as documented noting areas where SWMBH and CMHSPs are below State benchmarks. Discussion followed.

Michigan Mission Based Performance Indicator System Revisions – Alona Wood reported as documented. Discussion followed.

HSAG and other Reviews Updates – Alona Wood reported as documented.

Global Assessment of Individual's Needs (GAIN) – Brad Casemore noted no new developments with DHHS regarding GAIN.

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

EDIT Charter Revisions – Brad Casemore discussed memo and membership request from DHHS asking that each PIHP appoint one CMH staff and one PIHP staff as EDIT representatives. The Operations Committee agreed that the CMHSP representative would be Ed Sova of KCMHSAS.

Kalamazoo Psychiatric Hospital (KPH) Visit – Brad Casemore updated the group on a recent visit to KPH and reviewed the KPH census report which will be provided to SWMBH and then to CMHSPs. Discussion followed.

MDHHS and MHL Dual Demonstration Expansion – Brad Casemore stated that PIHPs are meeting with MDHHS on July 1 and will report back to the Operations Committee at the July meeting.

Centerpointe Crisis Residential – Jane Konyndyk discussed current contract for 10 beds and that KCMHSAS is amending the contract next year to 5 beds. Discussion followed.

Adjourned – Meeting adjourned at 1:00pm

Southwest Michigan
BEHAVIORAL HEALTH

Performance Measurement Period (MMBPIS)

April 1st, 2019 – June 30th, 2019

August 9th, 2019 SWMBH
Board Meeting

Objective/Results

Objective:

State defined indicators that are aimed at measuring access, quality of services and provide benchmarks for the state of Michigan and all (10) PIHPs.

Regional Status Update:

28/34 Total Performance Indicators in 2019 have met the State Standard of 95%. (*through 2/4 quarters*)

SWMBH Board Ends Metric:

92% of MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 19. (currently at 82.3%)

FY2019 MMBPIS Results

MMBPIS Indicator Description	Q1 2019	Q2 2019
Pre-Admission Screening Children	98.93%	98.48%
Pre-Admission Screening Adults	99.36%	96.38%
Request to Intake MI Children	99.35%	98.87%
Request to Intake MI Adults	99.21%	98.97%
Request to Intake DD Children	96.77%	100.00%
Request to Intake DD Adults	100.00%	100.00%
Request to Intake SA	98.39%	96.60%
First Service MI Children	94.61%	95.26%
First Service MI Adults	96.00%	97.11%
First Service DD Children	91.23%	100.00%
First Service DD Adults	100.00%	93.10%
First Service SA	95.83%	91.70%
IP Follow Up Children	100.00%	100.00%
IP Follow Up Adults	98.62%	97.01%
Detox Follow Up	93.98%	94.64%
IP Recidivism Children	3.77%	4.26%
IP Recidivism Adults	10.00%	6.49%
Overall Results	**14/17**	**14/17**

Individual Results by CMHSP Indicator #1

Indicator 1a		Q1	Q2
Pre-Admission Screening	**SWMBH**	**98.93%**	**99.49%**
CHILDREN	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	98.55%	100.00%
	Riverwood	100.00%	98.39%
	St. Joe	100.00%	100.00%
	Summit Pointe	94.74%	100.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Indicator 1b		Q1	Q2
Pre-Admission Screening	**SWMBH**	**99.36%**	**97.90%**
ADULTS	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	98.59%	99.35%
	Riverwood	100.00%	95.63%
	St. Joe	100.00%	96.43%
	Summit Pointe	99.26%	96.35%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Individual Results by CMHSP
Indicator #2a & 2b

Indicator 2a		Q1	Q2
Request to Intake	**SWMBH**	**99.35%**	**98.87%**
MI CHILDREN	Barry	93.94%	100.00%
	Pines	100.00%	97.22%
	Kalamazoo	100.00%	99.07%
	Riverwood	100.00%	97.10%
	St. Joe	100.00%	100.00%
	Summit Pointe	99.29%	99.12%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Indicator 2b		Q1	Q2
Request to Intake	**SWMBH**	**99.21%**	**98.97%**
MI ADULTs	Barry	92.68%	97.22%
	Pines	97.89%	99.26%
	Kalamazoo	99.25%	100.00%
	Riverwood	100.00%	98.41%
	St. Joe	100.00%	100.00%
	Summit Pointe	99.66%	98.57%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Individual Results by CMHSP
Indicator #2c & 2d

Indicator 2c		Q1	Q2
Request to Intake	**SWMBH**	**96.77%**	**100.00%**
DD CHILDREN	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	90.91%	100.00%
	Riverwood	100.00%	100.00%
	St. Joe	100.00%	100.00%
	Summit Pointe	100.00%	100.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Indicator 2d		Q1	Q2
Request to Intake	**SWMBH**	**100.00%**	**100.00%**
DD ADULTS	Barry	100.00%	#DIV/0!
	Pines	100.00%	100.00%
	Kalamazoo	100.00%	100.00%
	Riverwood	100.00%	100.00%
	St. Joe	100.00%	100.00%
	Summit Pointe	100.00%	100.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Individual Results by CMHSP Indicator #3a & 3b

Indicator 3a		Q1	Q2
First Service	**SWMBH**	**94.61%**	**95.26%**
MI CHILDREN	Barry	100.00%	100.00%
	Pines	100.00%	96.88%
	Kalamazoo	97.22%	96.83%
	Riverwood	92.00%	88.57%
	St. Joe	96.15%	90.48%
	Summit Pointe	90.43%	94.29%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Indicator 3b		Q1	Q2
First Service	**SWMBH**	**97.91%**	**97.11%**
MI ADULTS	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	98.39%	99.20%
	Riverwood	99.11%	93.88%
	St. Joe	100.00%	91.18%
	Summit Pointe	95.81%	96.32%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Individual Results by CMHSP
Indicator #3c & 3d

Indicator 3c		Q1	Q2
First Service	**SWMBH**	**91.23%**	**100.00%**
DD CHILDREN	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	80.00%	100.00%
	Riverwood	88.24%	100.00%
	St. Joe	100.00%	100.00%
	Summit Pointe	100.00%	100.00%
	Van Buren	#DIV/0!	100.00%
	Woodlands	#DIV/0!	100.00%

Indicator 3d		Q1	Q2
First Service	**SWMBH**	**100.00%**	**93.10%**
DD ADULTS	Barry	100.00%	#DIV/0!
	Pines	100.00%	100.00%
	Kalamazoo	100.00%	100.00%
	Riverwood	100.00%	75.00%
	St. Joe	100.00%	88.89%
	Summit Pointe	100.00%	100.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	#DIV/0!

Individual Results by CMHSP Indicator #4a(a) & 4a(b)

Indicator 4a(a)		Q1	Q2
IP Follow Up	**SWMBH**	**100.00%**	**97.44%**
CHILDREN	Barry	100.00%	100.00%
	Pines	100.00%	100.00%
	Kalamazoo	100.00%	90.91%
	Riverwood	100.00%	100.00%
	St. Joe	100.00%	100.00%
	Summit Pointe	100.00%	100.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Indicator 4a(b)		Q1	Q2
IP Follow Up	**SWMBH**	**98.62%**	**96.65%**
ADULTS	Barry	100.00%	100.00%
	Pines	95.45%	100.00%
	Kalamazoo	100.00%	98.04%
	Riverwood	96.55%	95.00%
	St. Joe	100.00%	100.00%
	Summit Pointe	97.14%	90.00%
	Van Buren	100.00%	100.00%
	Woodlands	100.00%	100.00%

Individual Results by CMHSP Indicator #10a & 10b

Indicator 10a		Q1	Q2
IP Recidivism	**SWMBH**	**3.77%**	**4.26%**
CHILDREN	Barry	0.00%	0.00%
	Pines	0.00%	20.00%
	Kalamazoo	7.69%	0.00%
	Riverwood	0.00%	0.00%
	St. Joe	0.00%	0.00%
	Summit Pointe	9.09%	0.00%
	Van Buren	0.00%	25.00%
	Woodlands	0.00%	0.00%

Indicator 10b		Q1	Q2
IP Recidivism	**SWMBH**	**10.00%**	**6.49%**
ADULTS	Barry	13.33%	0.00%
	Pines	16.22%	21.43%
	Kalamazoo	15.56%	9.09%
	Riverwood	0.00%	0.00%
	St. Joe	11.54%	9.09%
	Summit Pointe	9.59%	5.49%
	Van Buren	9.52%	0.00%
	Woodlands	7.14%	10.00%

SWMBH
Substance Abuse Indicators

Substance Abuse Indicators		Q1	Q2
Indicator 2e -- Request to Intake	SWMBH	**98.39%**	**96.55%**
Indicator 3e -- First Service	SWMBH	**95.83%**	**91.70%**
Indicator 4b -- Detox Follow Up	SWMBH	**93.98%**	**94.64%**

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: 11.18.2013	Last Review Date: 08.10.18	Past Review Dates: 8.08.14, 08.14.15. 8.12.16, 8.11.17

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

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

I. **PURPOSE:**

To clearly define the Treatment of Plan Members by SWMBH

II. **POLICY:**

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

III. **STANDARDS:**

Accordingly the EO may not:

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

Southwest Michigan
BEHAVIORAL HEALTH

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

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

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

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

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

Standards: Accordingly, the EO may not;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Related items offered for review:

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

- 2019 SWMBH-PatientNewsletter

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

SFY 2020 Behavioral Health Capitation Rate Development Update

State of Michigan, Department of Health and Human Services

Presented by:
Chris T. Pettit, FSA, MAAA
Principal and Consulting Actuary

Jeremy A. Cunningham, FSA, MAAA
Consulting Actuary

Colin R. Gray, FSA, MAAA
Actuary

JULY 24, 2019

Milliman

Agenda

- Introduction and Background Information
- Overview of Capitation Rate Development
- Entity Specific Factors

Introduction and Background Information

Introduction / Background: Overview

- **Statewide capitation rates for DAB, TANF, and HMP populations developed separately by population for those receiving physical health services through a Medicaid health plan (MHP Enrolled) vs. through the fee-for-service benefit (MHP Unenrolled)**
- **Primary data sources**
  - SFY 2018 Medicaid eligibility
  - SFY 2018 PIHP submitted encounter data
  - SFY 2018 PIHP submitted MUNC reports and financial status reports
  - SFY 2018 FFS claims data
- **CWP and SED 1915(c) Waiver populations included in managed care using historical FFS claims data and PIHP submitted financial status reports**

Service changes under new waivers

1915(b)(3) services are transitioning to 1915(i), unless otherwise stated below

Nighttime supervision
- New service for 1915(c) for those meeting medical necessity

Peer services and supports coordination
- *Becoming state plan services*

Non-Family Training
- New service available for HSW enrollees

Fiscal intermediary
- Transitioning to 1915(c) Waiver service for qualifying enrollees

Overview of Capitation Rate Development

Overview of Capitation Rate Development

Adjustments to base experience for SFY 2020

Adjust to reflect MUNC reports	• We have adjusted the expenditures to reflect MUNC reported values. • The unit cost reported on the encounter data was adjusted to reflect the MUNC reported unit cost across all encounters for a given procedure code • The underlying utilization from the encounter data was less than 3% different than MUNC reported values.
Autism treatment prevalence	• The number of beneficiaries receiving ABA has continued to increase materially, but has dropped slightly from 90 beneficiaries per month to approximately 75 new ABA recipients on average each month • We will make an explicit adjustment to include these projected new ABA recipients in the SFY 2020 capitation rates
Remove IMD stays > 15 days	• We have removed IMD and non-IMD costs associated with IMD stays of more than 15 days in a given month
Other adjustments	• We have removed spend-down amounts embedded in the MUNC reports • We have removed first and third party liability expected to be collected, but included in the MUNC report

Policy and program changes for SFY 2020

Waiver Service Additions	• **Nighttime Supervision**: MDHHS requested information from the PIHPs to support the development of this program adjustment. Increased base experience by approximately • **Non-Family Training**: This is a new service for the HSW population
GAIN	• Assumed the cost of providing the GAIN assessment is approximately double historical costs
Department of Corrections	• Increased base experience to reflect SUD services delivered through the department of corrections, primarily in the HMP population • We will make an explicit adjustment to the HMP SUD risk factor to account for the anticipated treatment prevalence change, given DOC beneficiaries are not distributed equally across the state
Autism fee schedule implementation	• $50 per hour for behavioral technicians • We will reprice the encounter data to the fee schedule, which will result in a decrease to the base experience
Direct Care Wage increase of $0.25 per hour	• We have included approximately 12% (6% gross-up to $0.27 and 6.75% administrative load) for employer related costs

Prospective Trend Rates

TABLE 6: ESTIMATED ANNUAL TREND RATES

SERVICE CATEGORY	DAB	TANF	HMP
Mental Health State Plan	3.0%	3.5%	3.5%
Autism	2.5%	2.5%	2.5%
Mental Health 1915(i)	3.0%	3.5%	3.5%
Substance Abuse State Plan	5.0%	5.0%	5.0%
Children's Waiver Program	2.0%	2.0%	2.0%
Habilitation Supports Waiver	2.0%	2.0%	2.0%
Serious Emotional Disturbances	2.0%	2.0%	2.0%

- Project from midpoint of experience period to midpoint of rating period
  - April 2018 to April 2020
- Data Sources
  - Historical data
  - BLS data
  - Medical CPI

Non-benefit expense assumptions for SFY 2020

TABLE 10: SFY 2020 NON-BENEFIT EXPENSE LOADS

	ADMINISTRATIVE ALLOWANCE		
POPULATION	**VARIABLE**	**FIXED**	**IPA**
DAB	4.50%	$ 8.11	$ 1.20
TANF	4.50%	$ 0.98	$ 1.20
HMP	6.75%		$ 1.20
HSW	4.25%		
SED	4.25%		
CWP	4.25%		

- Administrative allowances were increased to 6.75% in composite for HMP and non-HMP
- Risk margin was increased to 0.75%

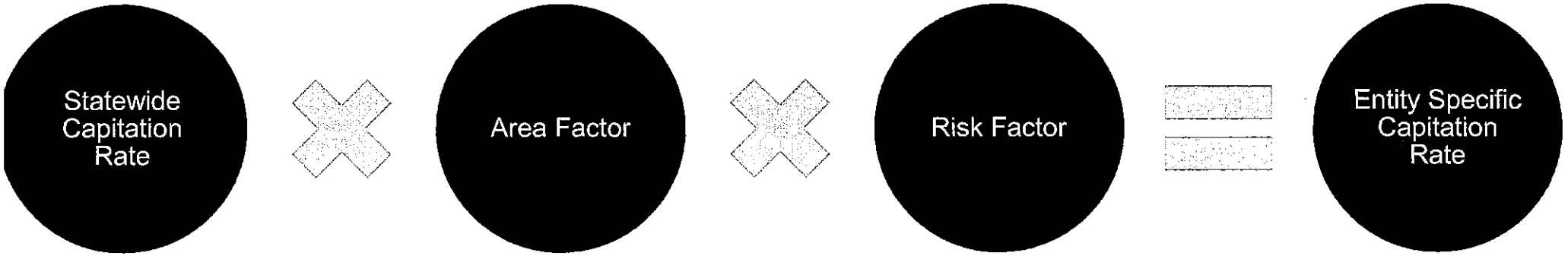
Capitation Payment to Eligibility Month Ratio

Effective October 1, 2019, MDHHS will begin making capitation payments for members who become retroactively eligible for a given month for up to six months for all populations.

Capitation Payment to Eligibility Month Ratio				
Population	SFY 2019	Percentage of Population Enrolled in MHP	SFY 2020 MHP Enrolled	SFY 2020 MHP Unenrolled
DAB	0.96	50%	1.000	0.995
TANF	0.96	80%	1.000	0.995
HMP	0.95	80%	1.000	0.995
HSW	0.98	40%	0.995	0.995

Entity Specific Factors

Entity Specific Capitation Rates



Area Factor Development

We considered the following components for inclusion in the area factors:

Transportation	Wages	Administrative economies of scale

- Based on discussions with MDHHS, we have decided to move forward with only including the transportation factor
- There was not a clear one-to-one relationship between the services covered under the contract and the BLS job titles
- BLS wage relativities were not always consistent with other sources regarding cost of living
- Detroit-Wayne had the highest wage and Northcare had the lowest wage based on the BLS survey results
- The wages have an inverse relationship with the administrative economies of scale of a PIHP

Transportation Factor Development Methodology

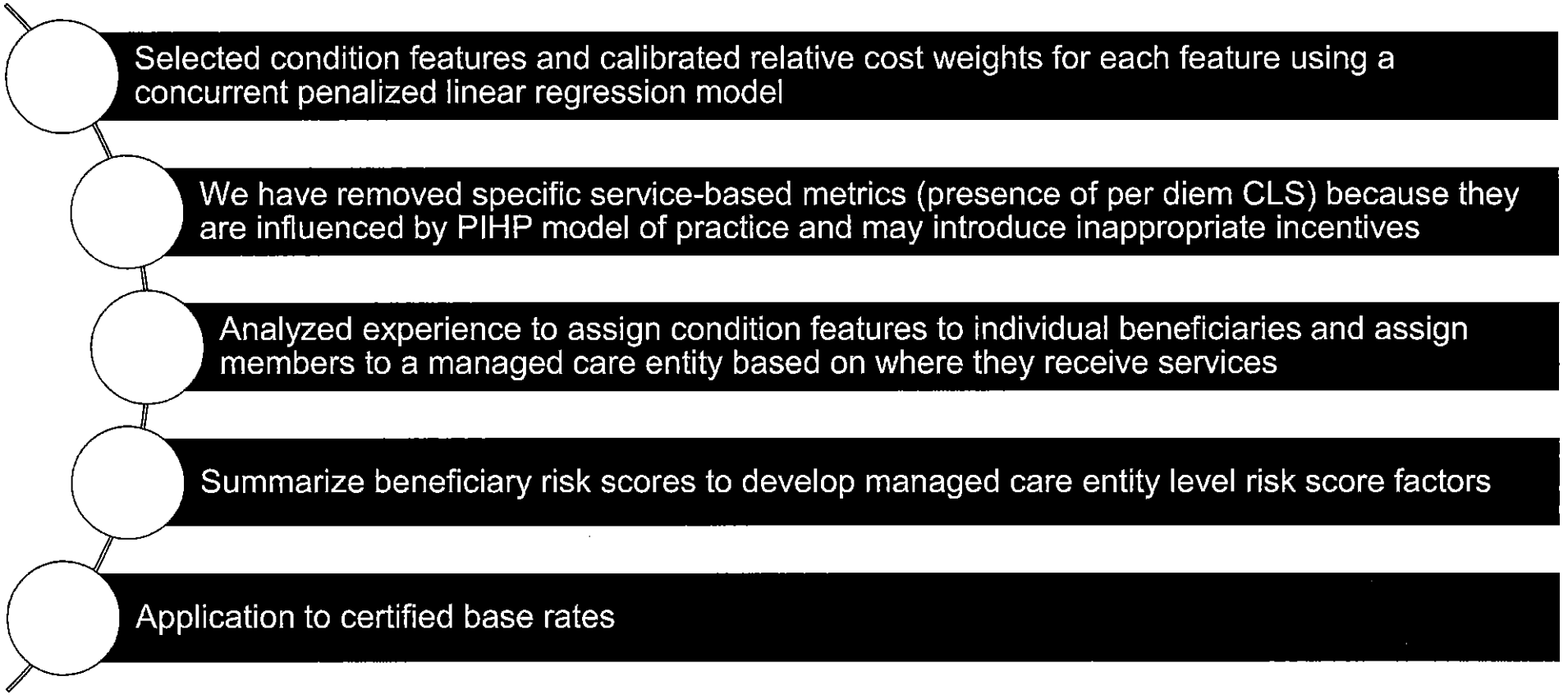
- Utilize *simplified* independent model for each of the top procedure codes
  - Understand average transportation costs, including time and vehicle costs
- Develop average non-billable travel time assumptions for urban (10 minutes), urban/rural (20 minutes), and rural (40 minutes)
  - This does not include staff travel time to work (e.g. H2016 will not have staff travel)
- Multiply statewide utilization by the rate for each service to get the expenditure difference and corresponding factor for each of the three scenarios
- Classify CMHSPs into one of the three categories (urban, urban/rural, and rural) based on the population density and then composite to the PIHP level
- This methodology will continue to be refined as part of the fee schedule development for future rate setting periods.

Transportation Factor Results

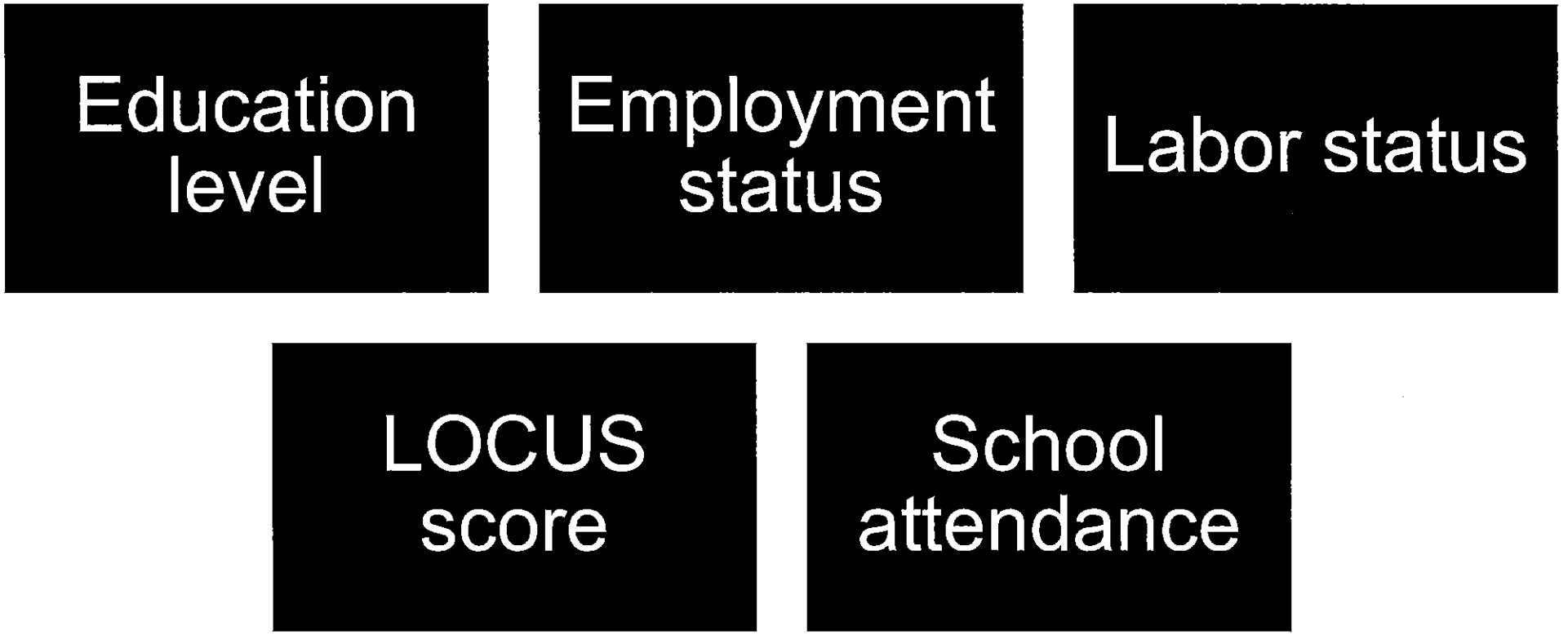
TABLE 5: REGIONAL FACTORS BY PIHP

PIHP	% URBAN	% URBAN/RURAL	% RURAL	REGIONAL FACTOR
NorthCare	0.0%	0.0%	100.0%	1.084
Northern Michigan	0.0%	33.2%	66.8%	1.059
Lakeshore	49.5%	45.0%	5.5%	0.995
Southwest	29.9%	70.1%	0.0%	0.998
Mid-State	38.9%	58.1%	3.0%	0.997
Southeast	87.2%	12.8%	0.0%	0.976
Detroit-Wayne	100.0%	0.0%	0.0%	0.971
Oakland	100.0%	0.0%	0.0%	0.971
Macomb	100.0%	0.0%	0.0%	0.971
Region 10	59.1%	34.9%	6.0%	0.991
Statewide	**32.7%**	**63.2%**	**4.1%**	**1.000**

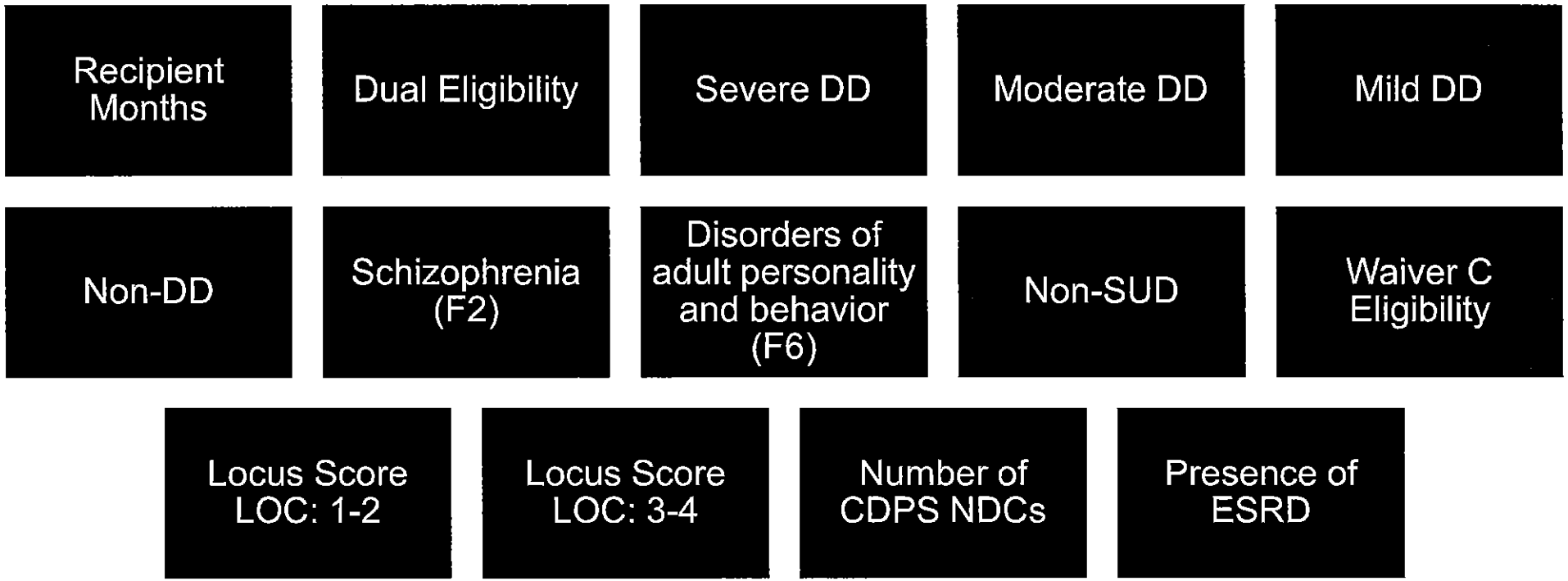
SFY 2020 Risk Adjustment Methodology



Risk Adjustment: BH-TEDS Predictive Variables



Risk Adjustment: Key Predictive Variables – DAB MH



Risk Adjustment: Results

SFY 2020 BH Capitation Rate Setting Entity Specific Revenue Percentage Change - SFY 2019 to SFY 2020				
PIHP	Risk Adjustment Impact	Area Factor Impact	Composite Impact	Assuming 50% Blend with Prior
Northcare Network	(4.2%)	3.4%	(1.0%)	(0.5%)
Northern Michigan Regional Entity	2.2%	0.7%	2.9%	1.5%
Lakeshore Regional Entity	7.1%	0.4%	7.6%	3.8%
Southwest Michigan Behavioral Health	(7.8%)	(1.1%)	(8.7%)	(4.4%)
Mid-State Health Network	(0.0%)	(2.6%)	(2.7%)	(1.3%)
CMH Partnership of Southeast Michigan	4.8%	(1.0%)	3.8%	1.9%
Detroit Wayne Mental Health Authority	(2.6%)	(2.7%)	(5.3%)	(2.6%)
Oakland County CMH Authority	1.0%	0.2%	1.2%	0.6%
Macomb County CMH Services	1.7%	0.2%	1.9%	0.9%
Region 10 PIHP	3.6%	1.7%	5.4%	2.7%

Note: Results are subject to change and represent draft regression model impacts

Risk Adjustment: Next Steps

Provide risk adjustment methodology report

- Risk factor development
- PIHP vs. Statewide prevalence reports by population and benefit

Provide beneficiary level data

- Inclusive of all variables included in risk adjustment
- Includes the risk score assigned to each beneficiary

Limitations and Qualifications

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved July 10, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Milliman

Thank you

August 1, 2019

This serves as a brief update on fiscal year 2020 (begins 10/1/19) rate setting, its impact on our region, and future directional needs. Please review and discuss at CMH management teams and at regional Committees. Tracy and I are willing to attend to discuss, upon invitation. The rate certification letter has not yet been released and DHHS gave no ETA as recently as yesterday, when asked. Many of these items are not yet finalized, so please be aware there some could yet be change. **SWMBH is proposed to receive the largest Risk Adjustment downward of a 4.4% reduction. This would be after Trend Rate increases as shown below.** We are not yet able to reasonably predict FY 2020 capitation revenue for the region. The Governor has asked for a $50 million current FY 2019 supplemental for PIHPs. It is not clear if this will be approved by the legislature in this amount, or a different amount and how it will be distributed across PIHPs. Key points for awareness and action are in **bold**. We will keep you informed as this all develops.

- DHHS MSA has become much more involved and now controls PIHP rate setting whereas DHHS BHDDA used to. The entire FY 2019 data set was used, including encounters, BHTEDS, MUNCs, etc.
- Capitation rates are now being calculated for both enrolled (in a MHP) and unenrolled, largely as a result of 298 Pilots, which have again been postponed until October 1, 2020.
- SEDW and CWP are going state-wide and are being placed into PIHPs instead of CMHs.
- 75 new Autism cases per month state-wide have been built into the rates.
- Rates are being reduced approximately 4% state-wide, as MDHHS will now adjust capitation payments retroactively up to 6 months; prior approach was to gross up the payments via an estimate. DHHS claims this will be budget neutral state-wide, but it is likely to have varying impact at each PIHP.
- Milliman disallowed any behavior tech encounter cost above $50, as expected.
- Contribution to risk margin increased from .6% to .75%, still wholly inadequate.
- **DHHS is now requiring more frequent financial reports which of course must be tied directly to encounters and BHTEDS submitted to and accepted by DHHS.**
- **Diagnosis/diagnoses used for actuary evaluation purposes comes from claim/encounter, not from BHTEDS.**
- **DHHS and Milliman are awaiting FY 2019 mid-year MUNCs, etc. on August 30. This could inform a FY 2020 rate adjustment, which could help our Region. Submission of claims/encounters and BHTEDS with accurate LOCUS scores for October 1, 2018 to March 31, 2019 must be accelerated and completed soon**.
- DHHS Milliman will soon provide 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 big component of FY 2020 rates. DHHS and Milliman say CAFAS and SIS scores will soon be used to make Risk Adjustments to capitation payments.**
- PIHPs have provided to MDHHS Execs, 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.
- Nighttime supervision is being added as a 1915c service.
- Peer services and supports coordination are becoming state plan services.
- Non-Family Training will be a new service for HSW enrollees.
- Claims/encounters for IMD stays above 15 days were stripped from the MCA expense basis.
- Doubling of SUD assessment cost due to GAIN was included.
- No acknowledgement of eligibilty migration from MCA DAB to MCA TANF or to MHP was made by DHHS or Milliman.
- Estimated Annual Service Cost Trends ranged from 2.0% for CWP, SEDW, HSW to 5.0% for SUD state plan. Autism was 2,5% and MH state plan was 3.0 % DAB, 3.5% TANF, and 3.5% HMP.
- Non-benefit administrative expense loads continue to be low with HSW, SEDW and CWP at 4.25%, DAB/TANF at 4.5% and HMP at 6.75%.
- Area Factor for Transportation was included, recognizing urban, urban/rural and rural geographies. Our factor was .998 very near a 1.00 state average. We have made (as has CMHAM) recommendation on using a known, objective categorization of Michigan counties. If adopted by Milliman, this should help us but won't be material.
- **Risk Adjustors from BHTEDS used were Education level, Employment status, Labor status, LOCUS score, and school attendance. It is imperative that BHTEDS are complete, accurate and timely in these and all other fields.**
- **Risk Adjustment Variables used for MH DAB rates included # recipient months served; I/DD: none, mild, moderate, severe; schizophrenia; disorders of personality and behavior; SUD/non-SUD; C Waiver eligibility; LOCUS score; # of medical diagnoses and Rxs; and presence/absence of ESRD. It is imperative that BHTEDS are complete, accurate and timely in these and all other fields.**
- DHHS expects few losses in HMP in FY 2020 as a result of failures to maintain and report required work/community engagement obligations. Losses likely to accelerate in FY 2021.
- DHHS and Milliman continually repeat that they need more complete/accurate/timely encounters BHTEDS etc.

Bradley P. Casemore, *MHSA, LMSW, FACHE*
Executive Officer

Southwest Michigan
BEHAVIORAL HEALTH

Fiscal year 2019(October 1, 2018- September 30, 2019) SWMBH Participant Community Mental Health Site Review Summary Results

August 9th, 2019 SWMBH
Board Meeting

Subcontractual Relationships & Delegation

- Managed Care Rules require the following (42 CFR §438.230):
  - PIHPs remain ultimately responsible for adhering to and complying with the terms of their contract with the State;
  - All contracts between the PIHP and a subcontractor must be in writing and specify:
    - Any delegated activities or obligations, and related reporting responsibilities;
    - That the subcontractor agrees to perform the delegated activities in compliance with the PIHP's contract obligations;
    - A method for revocation of the delegation of activities or obligations, or specify other remedies in instances where the PIHP determines that the subcontractor has not performed satisfactorily;
    - That the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and contract provisions.
- FY19 MDHHS-PIHP Contract requires annual monitoring (Attachment P.7.9.1)
  - XV. The PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which is has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of it subcontractors.

Subcontractual Relationships & Delegation

How does SWMBH satisfy these requirements:

Written Delegation Memorandum Of Understanding with each participant CMHSP, which specify:

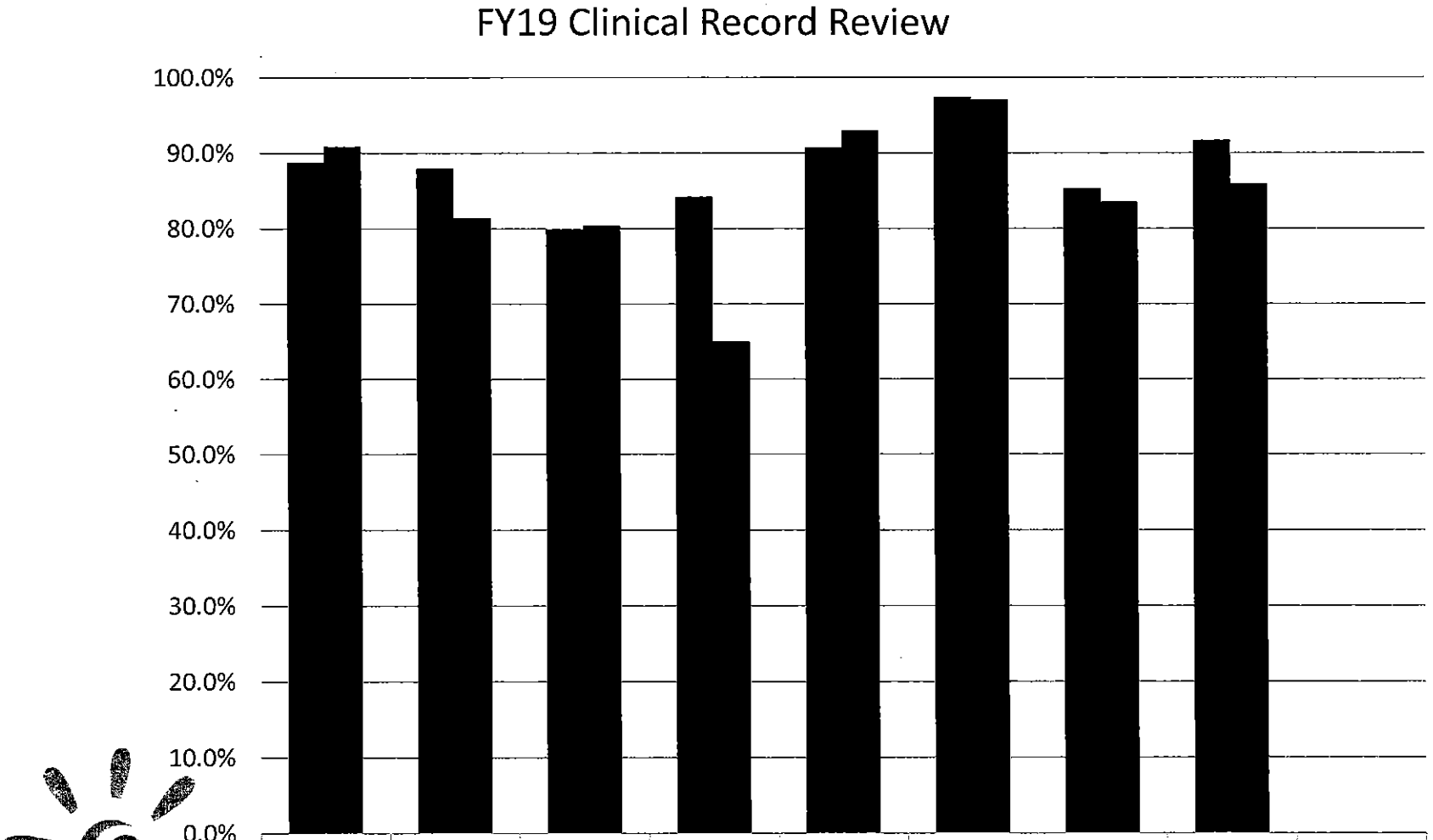
- SWMBH is ultimately responsible for its obligations under its MDHHS contract;
- Which activities are delegated to the participant CMHSP;
- Applicable reporting responsibilities;
- Method for revocation of a delegated activity, as well as other remedies in instances where SWMBH has determined a CMHSP has not performed satisfactorily.

Annual Participant CMHSP Site Reviews

CMHSP Site Review Process

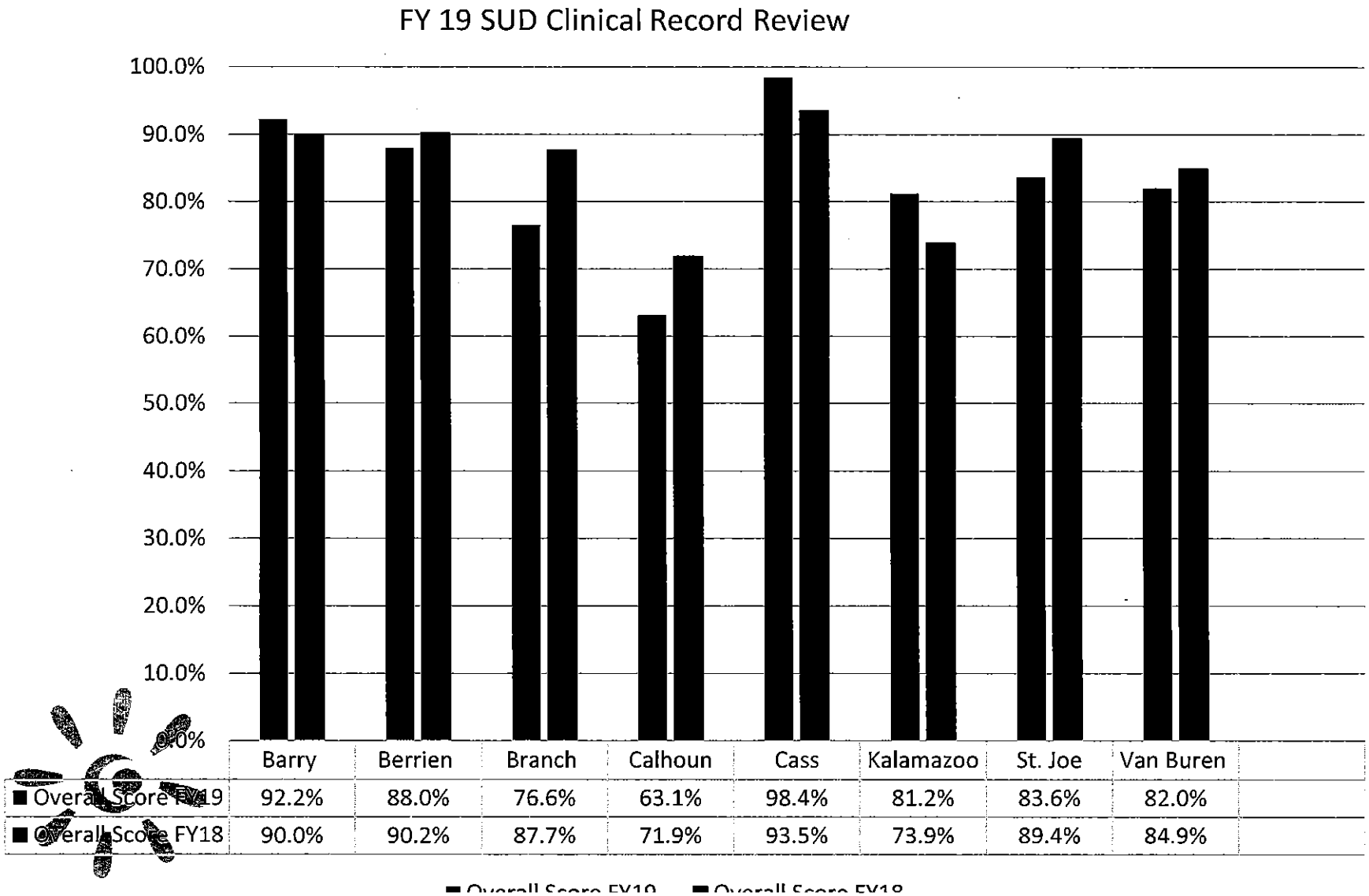
- Conducted annually
- Combination of a desk audit and on-site review
- Reviews all delegated functions
  - Any functions that are not in full compliance with MDHHS, 42 CFR § 438 (Managed Care), and SWMBH requirements require corrective action plans to be submitted by the participant CMHSP and approved by SWMBH
- SWMBH monitors select clinical programs each year for program and staffing fidelity, and adherence to MDHHS contractual requirements for specialty services
  - Clinical requirements not meeting 90% compliance require corrective action plans
- SWMBH staff work with participant CMHSP staff throughout the year to implement improvements in areas needing attention

Clinical Record Review
Overall Scores by CMHSP



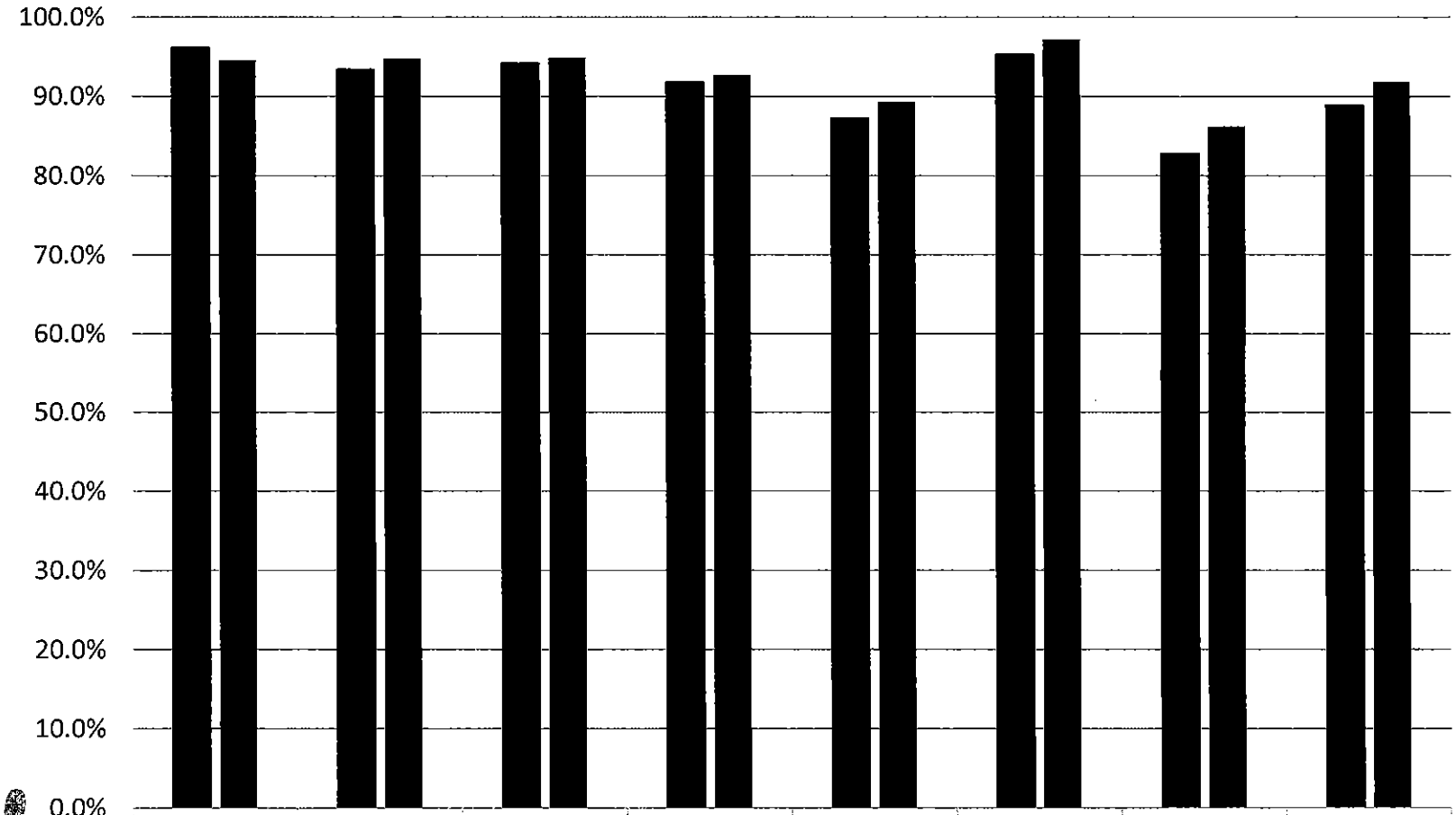
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY19	88.8%	88.0%	79.9%	84.2%	90.7%	97.4%	85.3%	91.7%
Overall Score FY18	90.9%	81.4%	80.4%	65.0%	93.0%	97.1%	83.5%	85.9%

SUD Clinical Record Review
Overall Scores by CMHSP



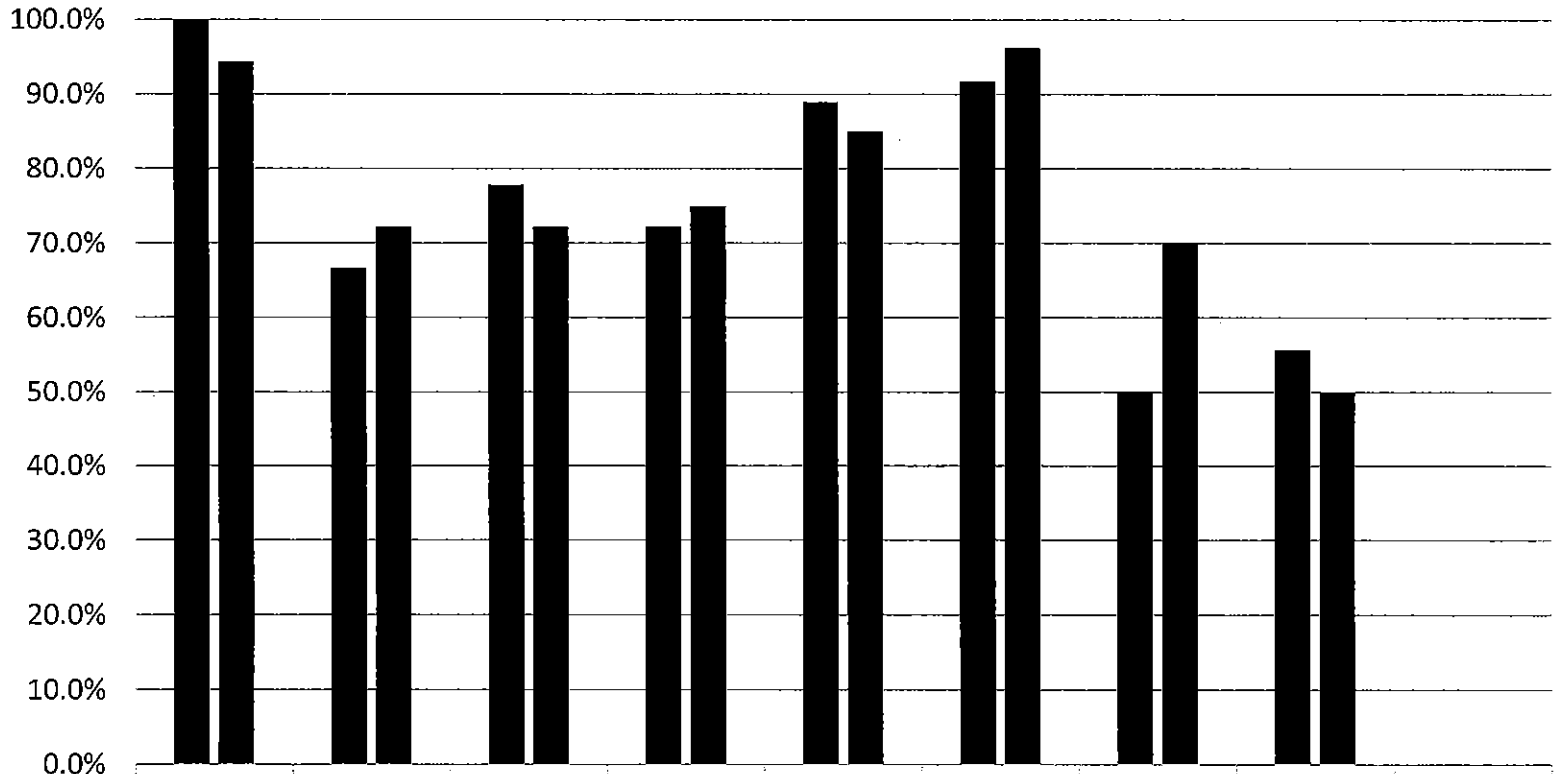
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY19	92.2%	88.0%	76.6%	63.1%	98.4%	81.2%	83.6%	82.0%
Overall Score FY18	90.0%	90.2%	87.7%	71.9%	93.5%	73.9%	89.4%	84.9%

Delegated / Administrative Function Review Overall Scores by CMHSP



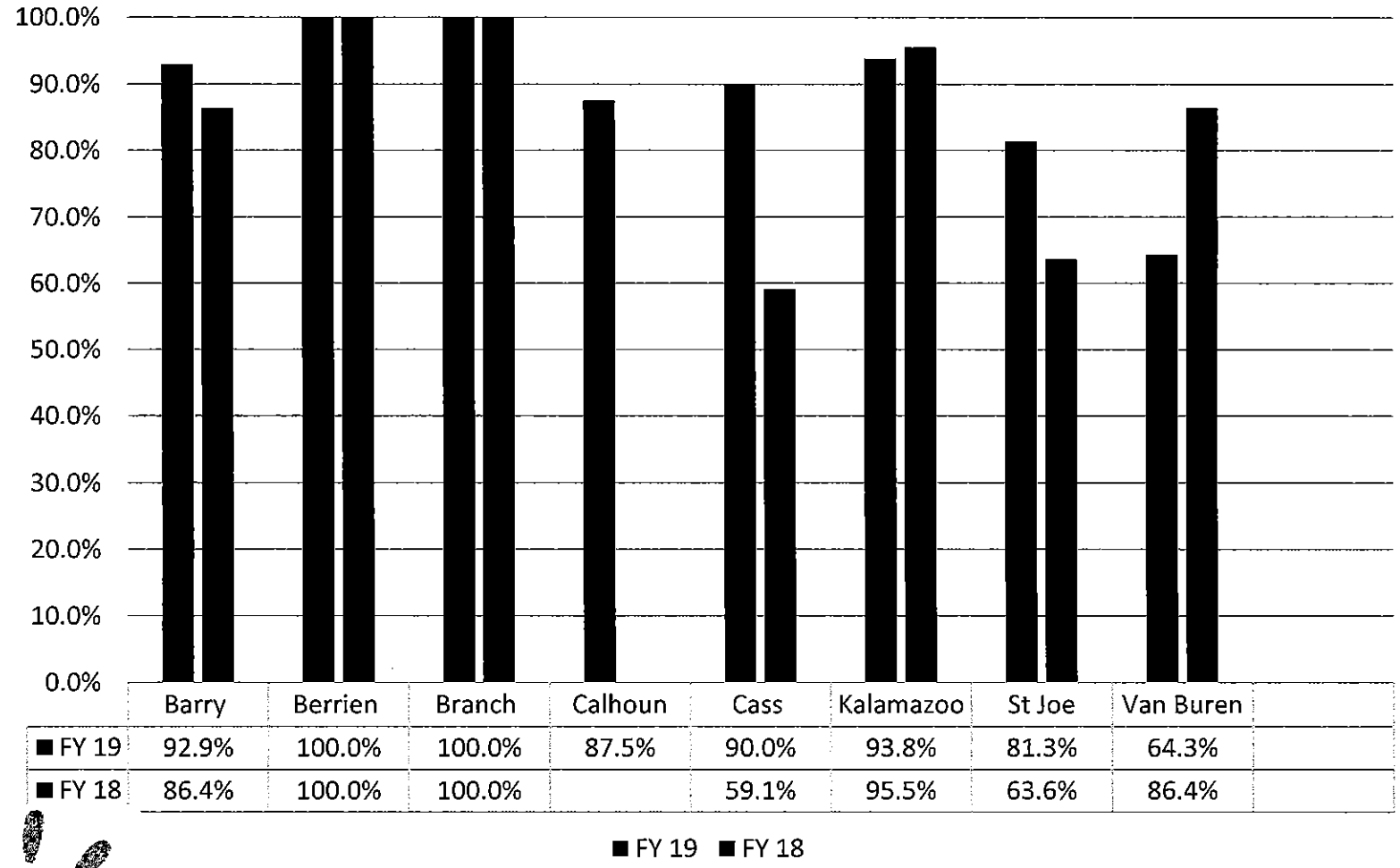
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joe	Van Buren
Overall Score FY19	96.2%	93.4%	94.2%	91.8%	87.3%	95.3%	82.8%	88.9%
Overall Score FY18	94.6%	94.8%	94.9%	92.7%	89.3%	97.2%	86.2%	91.8%

CMHSP Oversight and Monitoring: Utilization Management and Access



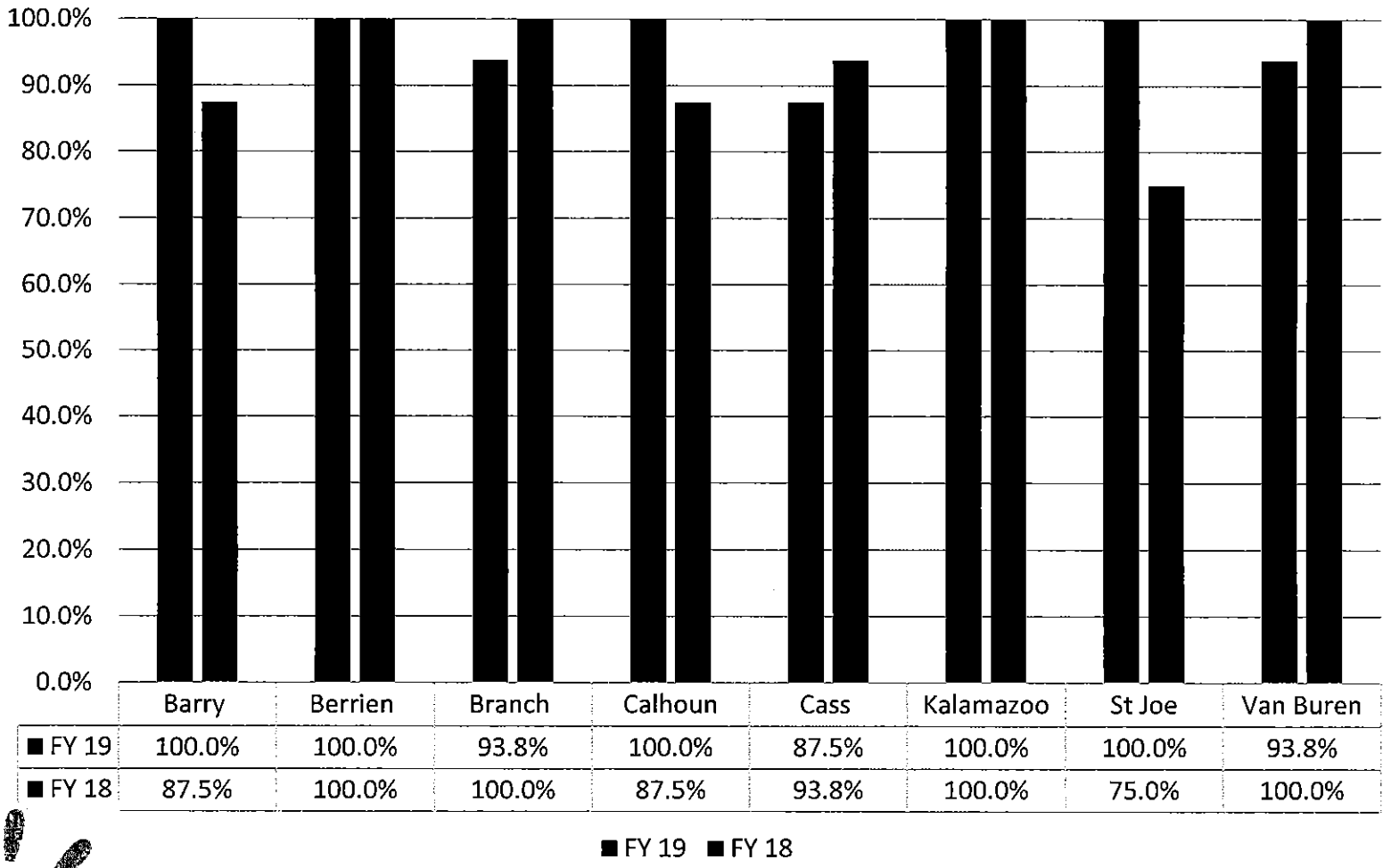
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
■ FY 19	100.0%	66.7%	77.8%	72.2%	88.9%	91.7%	50.0%	55.6%
■ FY 18	94.4%	72.2%	72.2%	75.0%	85.0%	96.2%	70.0%	50.0%

CMHSP Oversight and Monitoring Claims



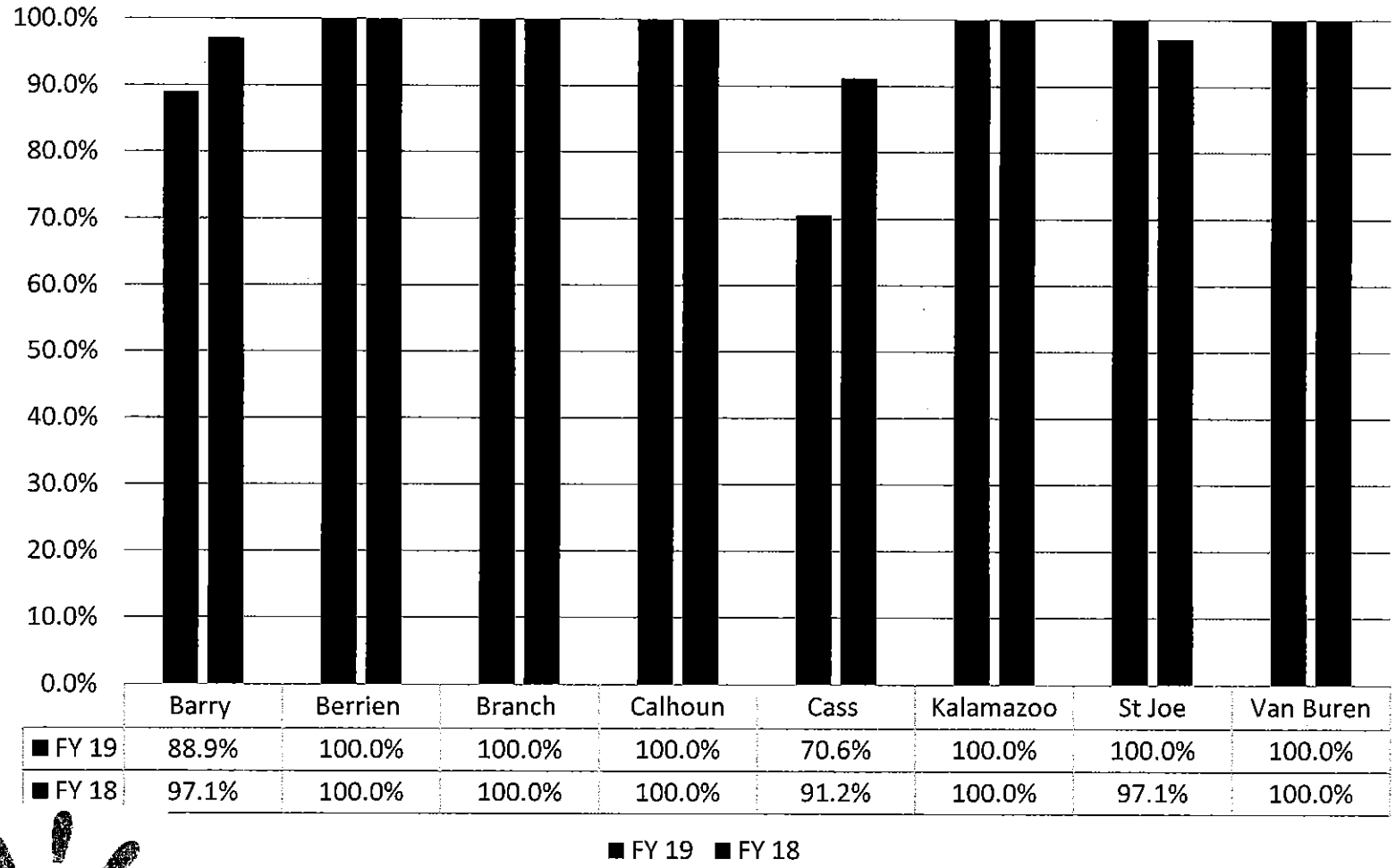
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	92.9%	100.0%	100.0%	87.5%	90.0%	93.8%	81.3%	64.3%
FY 18	86.4%	100.0%	100.0%		59.1%	95.5%	63.6%	86.4%

CMHSP Oversight and Monitoring Compliance Program



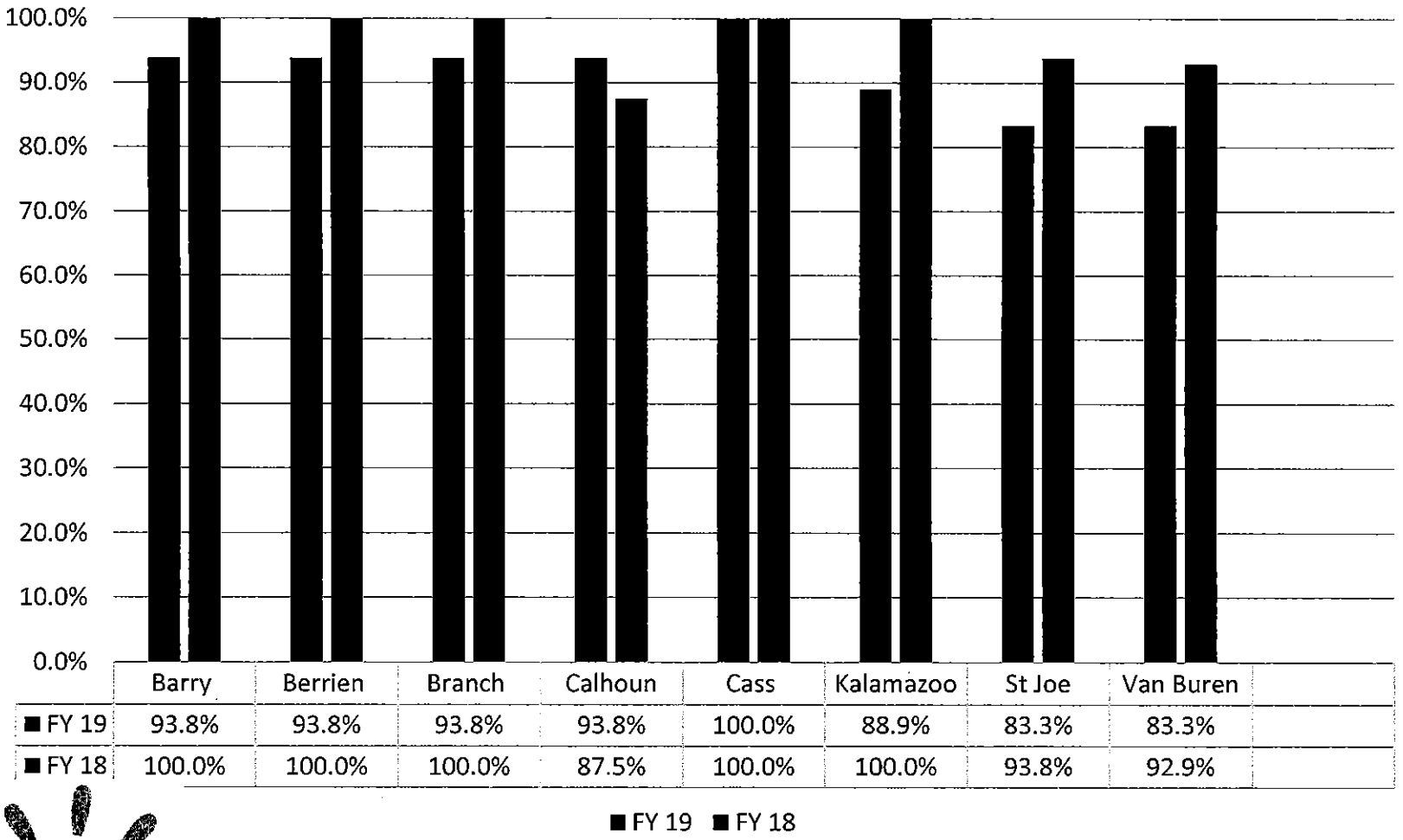
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	100.0%	93.8%	100.0%	87.5%	100.0%	100.0%	93.8%
FY 18	87.5%	100.0%	100.0%	87.5%	93.8%	100.0%	75.0%	100.0%

CMHSP Oversight and Monitoring Credentialing



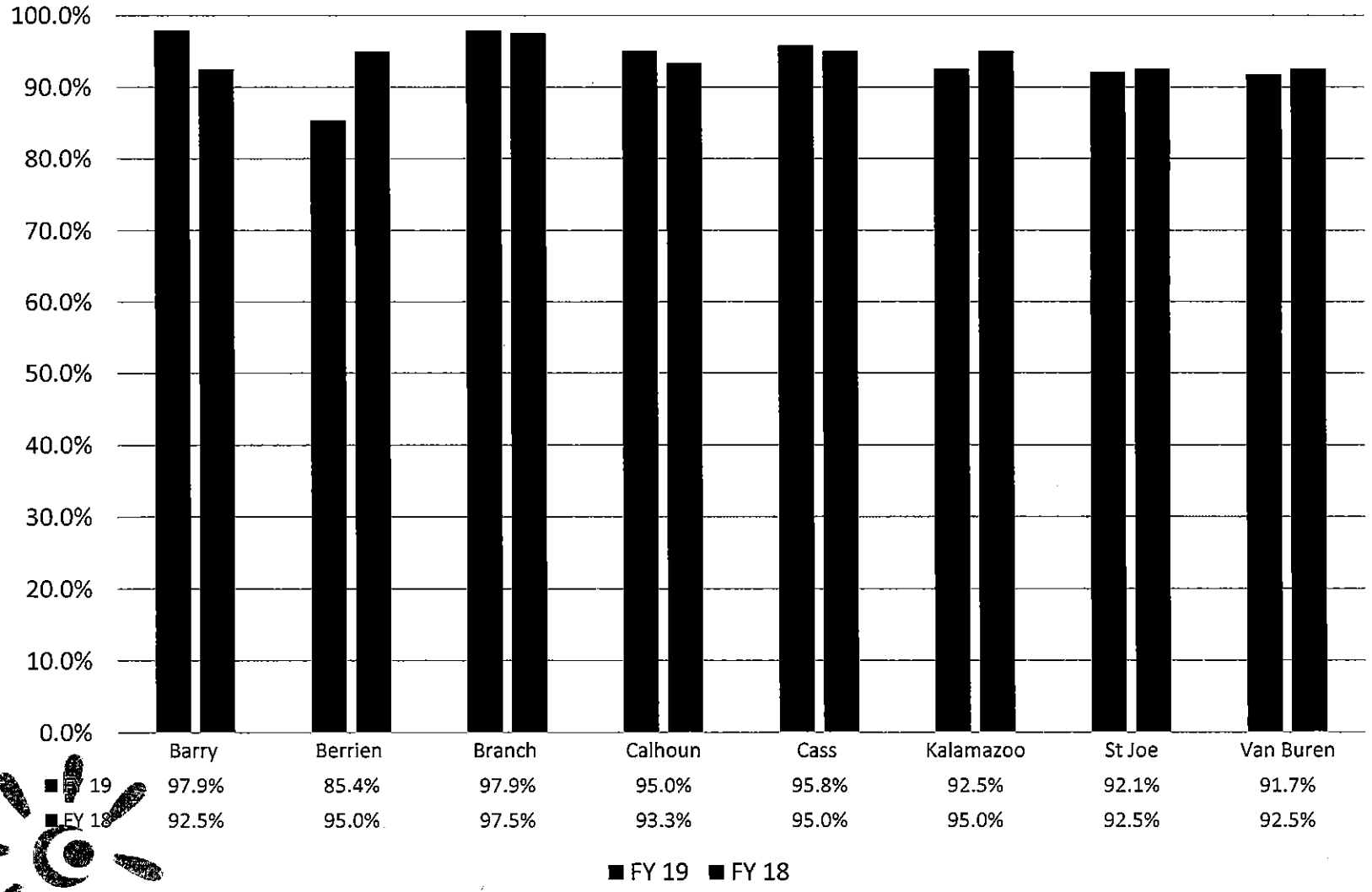
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	88.9%	100.0%	100.0%	100.0%	70.6%	100.0%	100.0%	100.0%
FY 18	97.1%	100.0%	100.0%	100.0%	91.2%	100.0%	97.1%	100.0%

CMHSP Oversight and Monitoring Customer Services

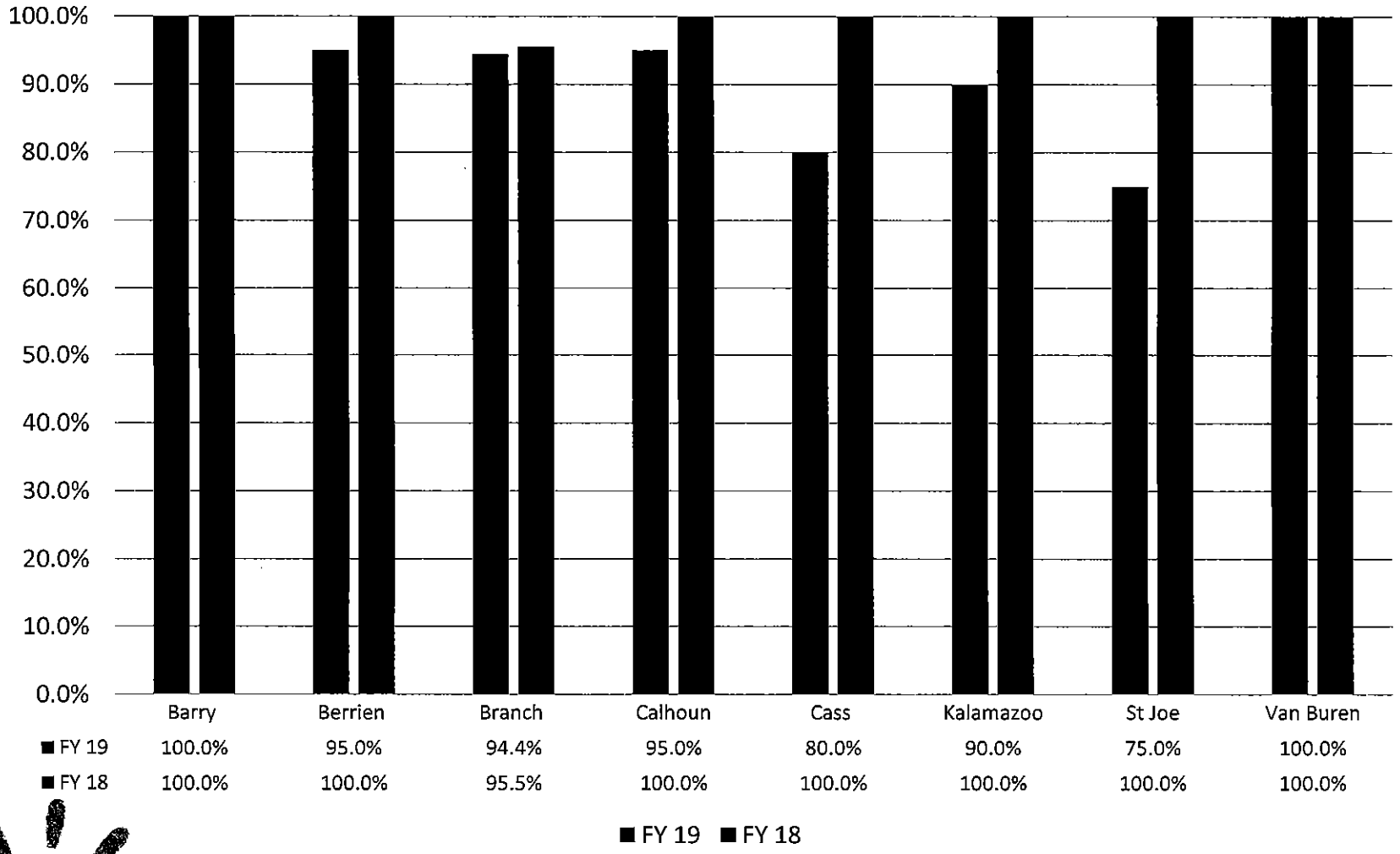


	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
■ FY 19	93.8%	93.8%	93.8%	93.8%	100.0%	88.9%	83.3%	83.3%
■ FY 18	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	93.8%	92.9%

CMHSP Oversight and Monitoring Grievances and Appeals

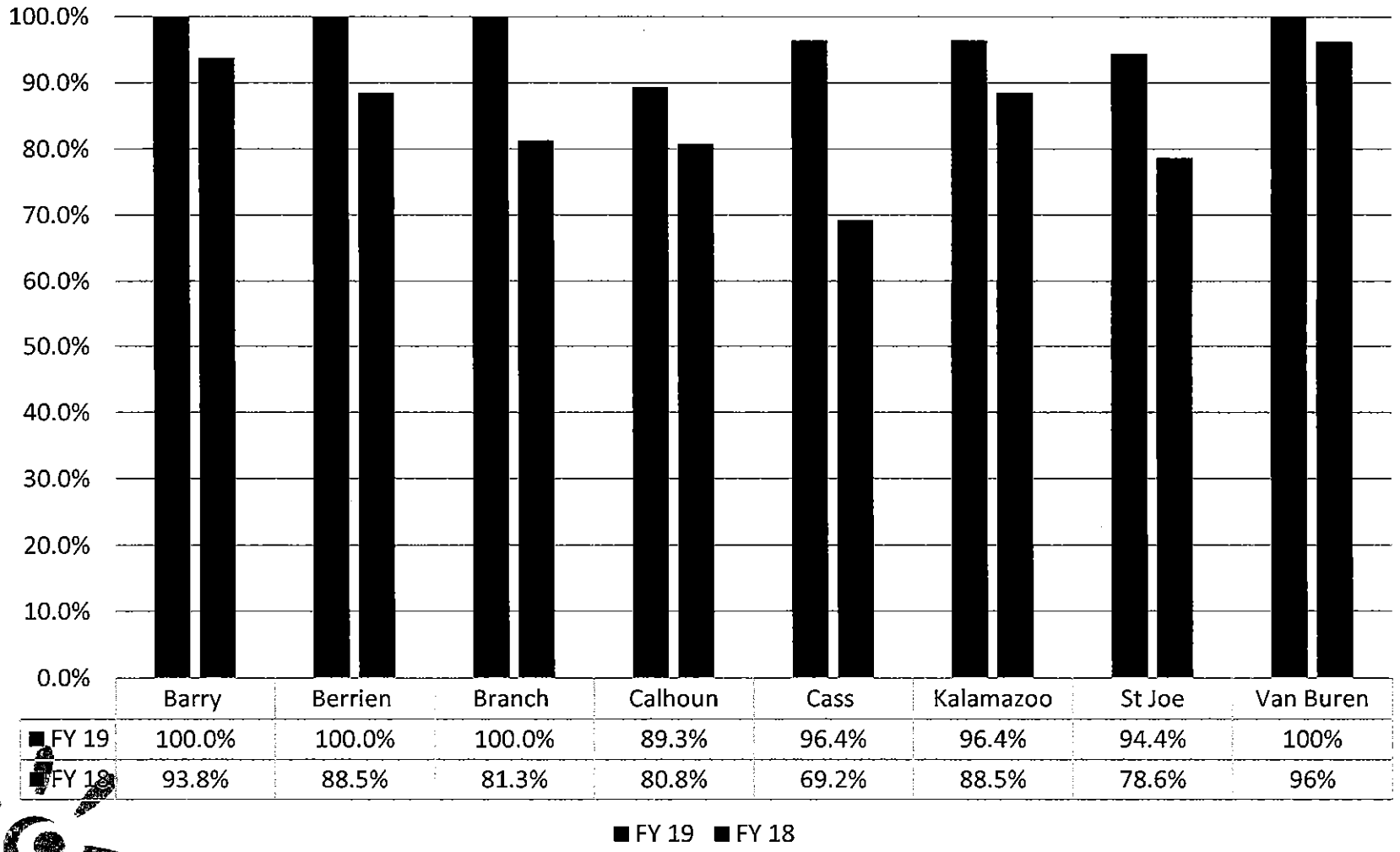


CMHSP Oversight and Monitoring Provider Network



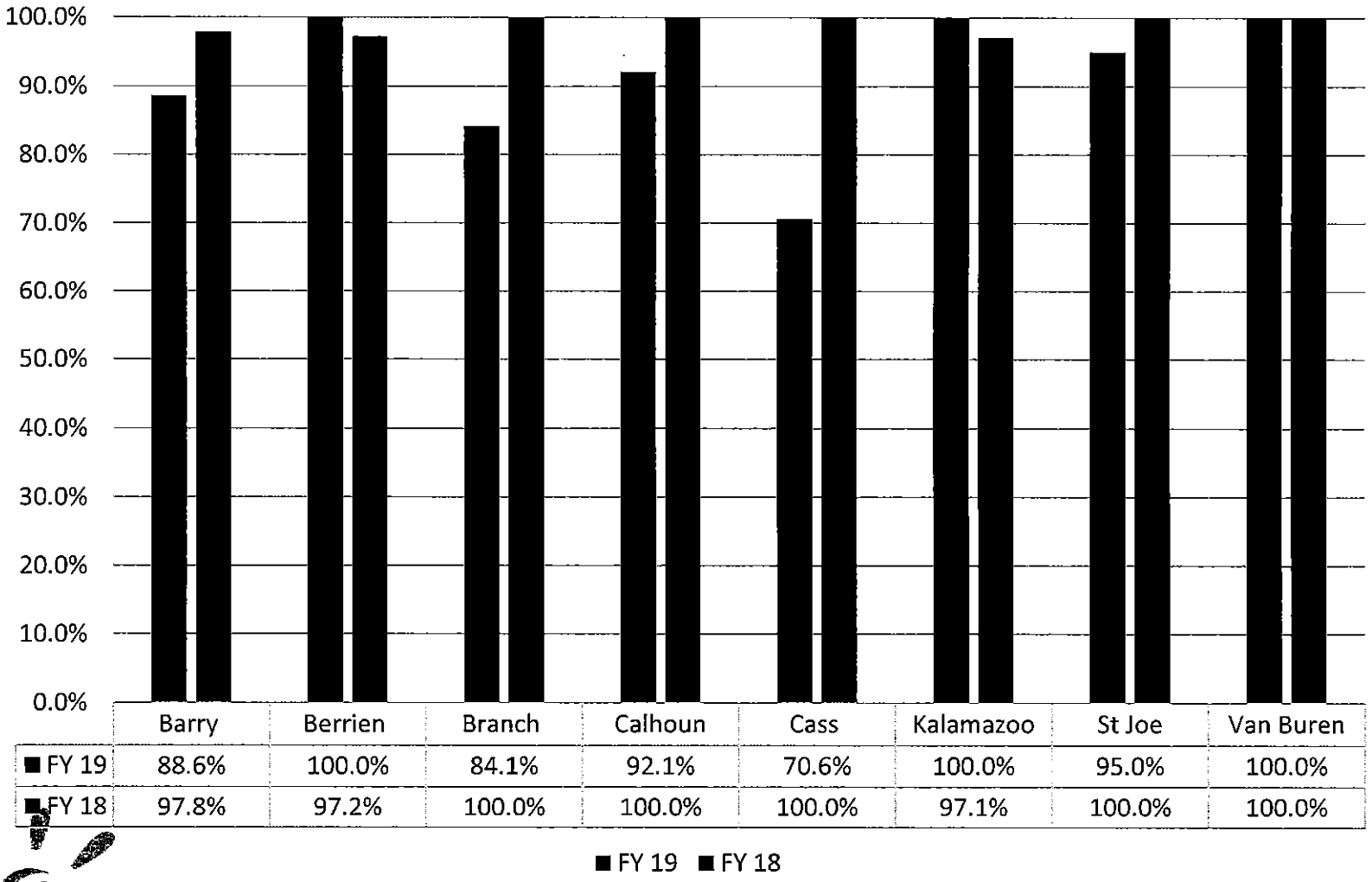
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	95.0%	94.4%	95.0%	80.0%	90.0%	75.0%	100.0%
FY 18	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%

CMHSP Oversight and monitoring Quality Improvement



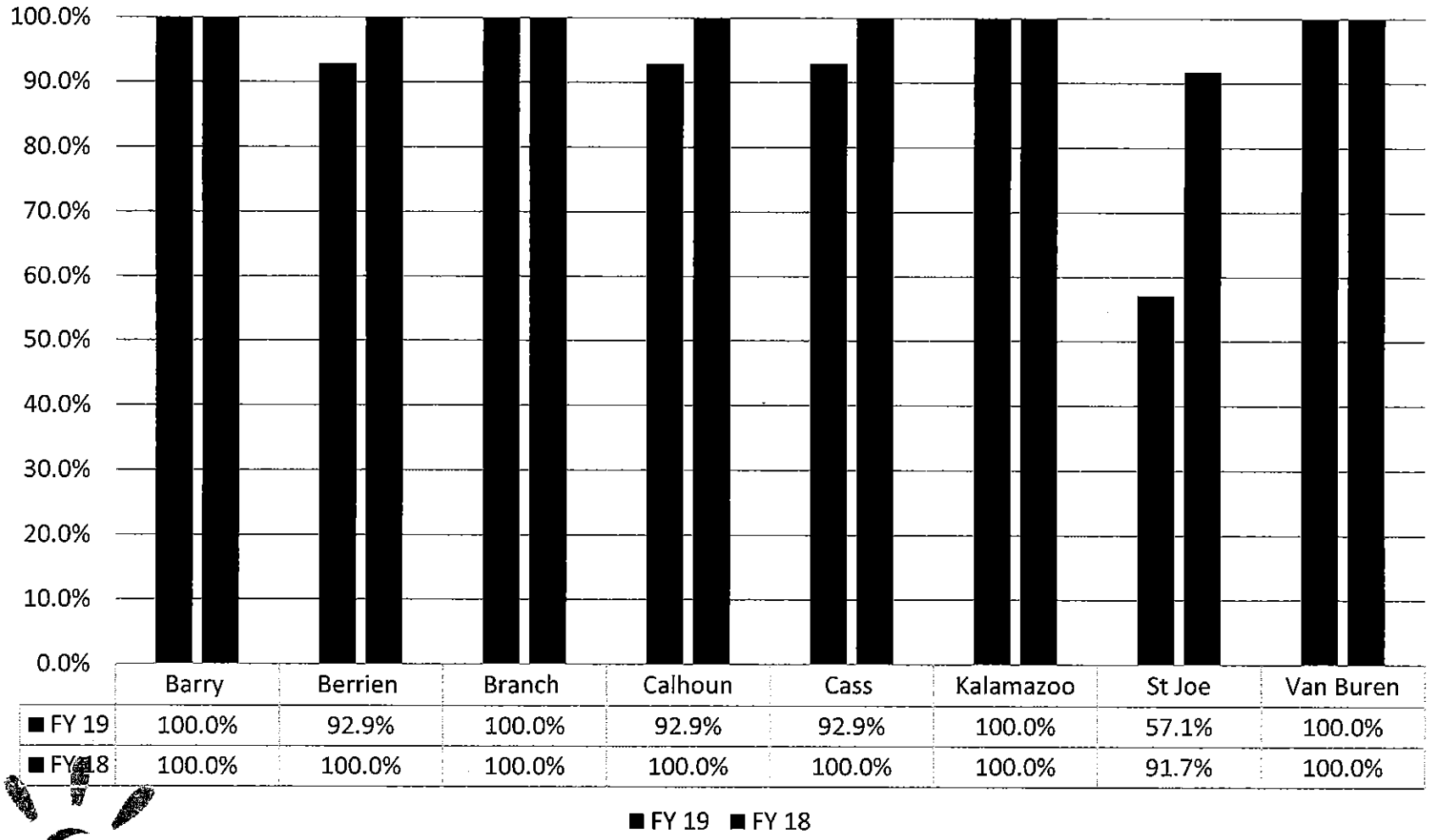
	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100%
FY 18	93.8%	88.5%	81.3%	80.8%	69.2%	88.5%	78.6%	96%

CMHSP Oversight and Monitoring
Staff Training



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	88.6%	100.0%	84.1%	92.1%	70.6%	100.0%	95.0%	100.0%
FY 18	97.8%	97.2%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%

CMHSP Oversight and Monitoring
SUD Administrative



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	92.9%	100.0%	92.9%	92.9%	100.0%	57.1%	100.0%
FY 18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%

Southwest Michigan
BEHAVIORAL HEALTH

Substance Abuse Prevention & Treatment Updates

Fiscal Year 2018; Fiscal Year 2019 (October-March)

August 9th, 2019 SWMBH Board Meeting

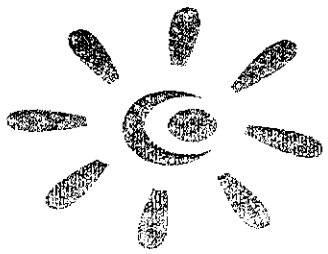
SAPT Update

Overview of Treatment Data/Highlights:

- SWMBH served 5,400 unique customers last fiscal year (10/1/17-9/30/18)
- Alcohol continues to be the leading primary substance of abuse for the region
- Heroin and other opiates are the second leading primary substance of abuse for the region
- Admissions for methamphetamine continue to trend up and are the third leading primary substance abuse for the region

Prevention Highlights:

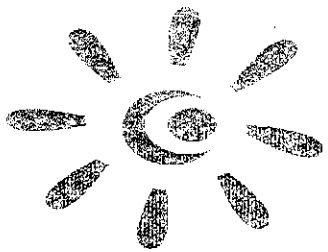
- Partnership for Success Grant (PFS) – additional federal funding that focuses on underage drinking, prescription drug abuse prevention, and identification of high-risk individuals (St. Joe and Van Buren counties).
- Synar Compliance – Federal legislation that monitors underage access to tobacco; SWMBH compliance rate for FY19: 93.1%. (goal is 80%)
- Continued expansion of evidence-based prevention programming through opioid grants



SAPT Update

Naloxone Overdose Prevention Program:

- *Community Based Program –*
  - Number of People Trained:
    - 2017: 2052
    - 2018: 2127
    - 2019: 880 (Jan-Mar 2019)
  - Naloxone Kits Distributed:
    - 2017: 1482
    - 2018: 1624
    - 2019: 719 (Jan-Mar 2019)
  - Successful Reversals Reported:
    - 2017: 40
    - 2018: 25
    - 2019: 7 (Jan-Mar 2019)

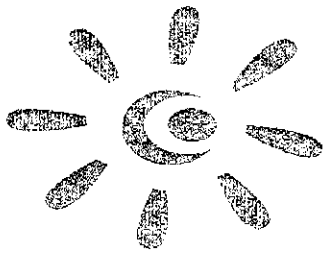


SAPT Update

Naloxone Overdose Prevention Program:

First Responder Program –

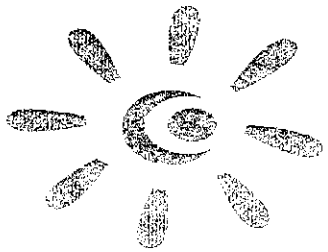
- 63 police departments, 25 fire departments
- Number of reversals reported by law enforcement agencies since January 2016: 249
  - 284 interventions (naloxone was used)
  - 249 reversals (2016: 39, 2017: 93, 2018; 117, 2019: 24 Jan-Mar)
  - 21 fatalities (already deceased when intervention occurred)
  - 14 no-impact (overdose was not caused by opioid)
- Enhanced program last year by moving to a "train the trainer" model. There are now 132 trainers (87 law enforcement, 45 fire departments)
- Expansion to fire departments continues under grant funding



SAPT Update

Utilizing Grant Resources to respond to the Opioid Epidemic

- State Targeted Response to the Opioid Epidemic Grant:
  - Strengthening Families – Iowa Model
  - Implementation/Expansion of Naloxone Overdose Program
  - Motivational Interviewing in Medication Assisted Treatment (MAT) Programs
  - Expansion of Recovery Coaches
  - Project ASSERT
  - Expansion and enhancement of MAT: Pines Behavioral Health and Victory Clinical Services



SAPT Update

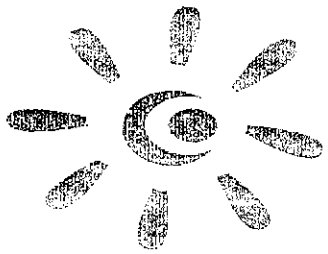
Utilizing Grant Resources to respond to the Opioid Epidemic

- State Opioid Response:
  - Prevention Program Expansion: Guiding Good Choices and Project Towards No Drug Abuse
  - Expand community-based naloxone program and first responders to include fire departments
  - Implementing SBIRT utilizing Recovery Coaches in primary care settings
  - Jail Services – Behavioral health navigator and medication assisted treatment
  - Enhancement of Recovery Housing Services

SAPT Update

Implementation of Gambling Disorder Prevention

- Grant from MDHHS to address gambling disorder and prevention
- Gambling Disorder Prevention Specialist hired April 2019
- First year focus: assessing readiness/awareness of communities about gambling disorders, begin to collect data
- Second year focus: implement targeted prevention campaigns and education, expanding provider network for treatment



	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 6/30/2019			P09FYTD19	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			193,228,864	150,993,998	23,083,394	9,048,271	2,561,076	6,128,487	1,413,638	-	-	-	
17	DHHS Incentive Payments			488,190	488,190	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			345,846	-	-	-	-	294,052	-	51,794	-	-	
19	Interest Income - Working Capital			148,931	-	-	-	-	-	-	148,931	-	-	
20	Interest Income - ISF Risk Reserve			36,011	-	-	-	-	-	-	36,011	-	-	
21	Local Funds Contributions			1,622,265	-	-	-	-	-	-	1,622,265	-	-	
22	Other Local Income			182,324	-	-	-	-	-	-	182,324	-	-	
23														
24	**TOTAL REVENUE**			196,052,431	151,482,188	23,083,394	9,048,271	2,561,076	6,422,539	1,413,638	2,041,325	-	-	
25														
26	**EXPENSE**													
27	Healthcare Cost													
28	Provider Claims Cost			16,811,288	2,630,266	4,306,233	-	2,789,307	5,694,636	1,390,846	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			156,686,242	128,897,995	14,337,896	11,804,418	1,234,140	411,791	-	-	-	-	
30	HICA and Use Tax Expense			1,943,144	1,865,719	77,425	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	1,695,169	-	-	(1,695,169)	-	-	-			
33														
34	Total Healthcare Cost			175,545,540	135,194,015	18,721,555	11,804,418	2,328,279	6,106,427	1,390,846	-	-	-	
35	Medical Loss Ratio (HCC % of Revenue)			90.6%	89.2%	81.1%	130.5%	90.9%	95.6%	98.4%				
36														
37	Administrative Cost													
38	Purchased Professional Services			507,040	-	-	-	-	-	-	507,040	-	-	
39	Administrative and Other Cost			5,561,407	-	-	-	-	-	-	5,560,484	-	923	
41	Depreciation			82,230	-	-	-	-	-	-	82,230	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	100,691	-	(100,691)	-	-	
43	Allocated Indirect Pooled Cost			0	-	-	-	-	-	-	923	-	(923)	
44	Delegated Managed Care Admin			11,814,213	9,757,693	1,074,287	889,072	93,161	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			(0)	4,564,765	647,055	409,679	139,636	215,422	-	(5,976,557)	-	-	
46														
47	Total Administrative Cost			17,964,890	14,322,457	1,721,342	1,298,752	232,797	316,113	-	73,429	-	-	
48	Admin Cost Ratio (MCA % of Total Cost)			9.3%	9.6%	8.4%	9.9%	9.1%	4.9%	0.0%	3.1%			
49														
50	Local Funds Contribution			1,622,265	-	-	-	-	-	-	1,622,265	-	-	
51														
52	**TOTAL COST after apportionment**			195,132,695	149,516,472	20,442,897	13,103,170	2,561,076	6,422,539	1,390,846	1,695,694	-	-	
53														
54	**NET SURPLUS before settlement**			919,736	1,965,716	2,640,497	(4,054,899)	-	-	22,791	345,631	-	-	
55	Net Surplus (Deficit) % of Revenue			0.5%	1.3%	11.4%	-44.8%	0.0%	0.0%	1.6%	16.9%			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(22,791)	-	-	-	-	-	(22,791)	-			
59	ISF Risk Reserve Abatement (Funding)			(36,011)	-	-	-	-	-	-	(36,011)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			-	(1,965,716)	(2,089,183)	4,054,899	-	-	-	-			
62	**NET SURPLUS (DEFICIT)**			860,933	-	551,314	-	-	-	-	309,619	-	-	
63	*HMP & Autism is settled with Medicaid*													
64														
65	SUMMARY OF NET SURPLUS (DEFICIT)													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			551,314	-	551,314	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			309,619	-	-	-	-	-	-	309,619	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			860,933	-	551,314	-	-	-	-	309,619	-	-	
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 6/30/2019			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%*	79.1%	77.2%	79.3%	74.4%	75.2%	82.2%	81.6%	80.7%	79.3%
7	Subcontract Revenue		150,993,998	9,391,126	141,602,872	5,756,499	28,068,115	7,417,584	26,268,195	7,729,377	43,138,496	9,625,343	13,599,264
8	Incentive Payment Revenue		488,190	34,393	453,797	18,003	34,000	22,826	70,353	3,754	270,359	16,499	18,003
9	**Contract Revenue**		**151,482,188**	**9,425,519**	**142,056,669**	**5,774,501**	**28,102,115**	**7,440,410**	**26,338,548**	**7,733,131**	**43,408,854**	**9,641,842**	**13,617,266**
10													
11	External Provider Cost		96,929,478	2,630,266	94,299,212	3,046,577	18,062,659	4,805,085	16,380,178	4,478,135	34,363,212	5,828,203	7,335,163
12	Internal Program Cost		36,574,462	-	36,574,462	2,607,348	7,612,295	1,980,369	7,130,431	2,371,759	5,690,194	3,514,595	5,667,470
13	SSI Reimb, 1st/3rd Party Cost Offset		(746,158)	-	(746,158)	(53,455)	(148,160)	(37,255)	(176,842)	(9,829)	(230,511)	(21,475)	(68,631)
14	HICA & Use Tax, HRA		1,970,585	1,970,585	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		367,868	367,868	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**135,096,234**	**4,968,718**	**130,127,515**	**5,600,471**	**25,526,793**	**6,748,199**	**23,333,767**	**6,840,065**	**39,822,896**	**9,321,323**	**12,934,002**
17	**Medical Loss Ratio (HCC % of Revenue)**		**89.2%**	**52.7%**	**91.6%**	**97.0%**	**90.8%**	**90.7%**	**88.6%**	**88.5%**	**91.7%**	**96.7%**	**95.0%**
18													
19	**Managed Care Administration**		**14,415,618**	**4,564,765**	**9,850,853**	**454,534**	**2,000,118**	**555,134**	**1,573,507**	**521,334**	**3,339,464**	**550,743**	**856,021**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.6%**	**3.1%**	**6.6%**	**7.5%**	**7.3%**	**7.6%**	**6.3%**	**7.1%**	**7.7%**	**5.6%**	**6.2%**
21													
22	**Contract Cost**		**149,511,852**	**9,533,483**	**139,978,369**	**6,055,004**	**27,526,911**	**7,303,333**	**24,907,273**	**7,361,399**	**43,162,359**	**9,872,066**	**13,790,023**
23	**Net before Settlement**		**1,970,336**	**(107,964)**	**2,078,300**	**(280,503)**	**575,204**	**137,077**	**1,431,275**	**371,732**	**246,495**	**(230,224)**	**(172,757)**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		(1,965,716)	112,584	(2,078,300)	280,503	(575,204)	(137,077)	(1,431,275)	(371,732)	(246,495)	230,224	172,757
28	**Net after Settlement**		**4,620**	**4,620**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		146,279	146,279	146,279	7,549	28,563	8,108	27,444	8,537	38,598	11,994	15,486
32	Revenue PMPM		$ 115.06	$ 7.16	$ 107.90	$ 84.99	$ 109.32	$ 101.96	$ 106.64	$ 100.65	$ 124.96	$ 89.32	$ 97.70
33	Expense PMPM		$ 113.57	$ 7.24	$ 106.33	$ 89.12	$ 107.08	$ 100.08	$ 100.84	$ 95.81	$ 124.25	$ 91.45	$ 98.94
34	Margin PMPM		$ 1.50	$ (0.08)	$ 1.58	$ (4.13)	$ 2.24	$ 1.88	$ 5.79	$ 4.84	$ 0.71	$ (2.13)	$ (1.24)
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		146,279	146,279	146,279	7,549	28,563	8,108	27,444	8,537	38,598	11,994	15,486
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)		(2,128)	(2,128)	(2,128)	28	(409)	(329)	(469)	(13)	(525)	(228)	(183)
43	% Variance - Fav / (Unfav)		-1.4%	-1.4%	-1.4%	0.4%	-1.4%	-3.9%	-1.7%	-0.2%	-1.3%	-1.9%	-1.2%
44													
45	**Contract Revenue before settlement**												
46	Actual		151,482,188	9,425,519	142,056,669	5,774,501	28,102,115	7,440,410	26,338,548	7,733,131	43,408,854	9,641,842	13,617,266
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)		(1,569,449)	(3,506,010)	1,936,561	227,218	205,012	(51,512)	626,221	418,860	84,947	236,115	189,700
49	% Variance - Fav / (Unfav)		-1.0%	-27.1%	1.4%	4.1%	0.7%	-0.7%	2.4%	5.7%	0.2%	2.5%	1.4%
50													
51	**Healthcare Cost**												
52	Actual		135,096,234	4,968,718	130,127,515	5,600,471	25,526,793	6,748,199	23,333,767	6,840,065	39,822,896	9,321,323	12,934,002
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)		7,890,692	2,778,814	5,111,878	231,662	1,813,004	421,210	774,801	102,516	1,168,735	407,496	192,454
55	% Variance - Fav / (Unfav)		5.5%	35.9%	3.8%	4.0%	6.6%	5.9%	3.2%	1.5%	2.9%	4.2%	1.5%
56													
57													

	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 6/30/2019			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													
58	**Managed Care Administration**												
59	Actual		14,415,618	4,564,765	9,850,853	454,534	2,000,118	555,134	1,573,507	521,334	3,339,464	550,743	856,021
60	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
61	Variance - Favorable / (Unfavorable)		1,023,705	661,182	362,522	(20,244)	37,847	43,600	166,445	10,631	106,432	56,700	(38,889)
62	% Variance - Fav / (Unfav)		6.6%	12.7%	3.5%	-4.7%	1.9%	7.3%	9.6%	2.0%	3.1%	9.3%	-4.8%
63													
64	**Total Contract Cost**												
65	Actual		149,511,852	9,533,483	139,978,369	6,055,004	27,526,911	7,303,333	24,907,273	7,361,399	43,162,359	9,872,066	13,790,023
66	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
67	Variance - Favorable / (Unfavorable)		8,914,397	3,439,996	5,474,401	211,418	1,850,851	464,810	941,246	113,147	1,275,168	464,196	153,566
68	% Variance - Fav / (Unfav)		5.6%	26.5%	3.8%	3.4%	6.3%	6.0%	3.6%	1.5%	2.9%	4.5%	1.1%
69													
70	**Net before Settlement**												
71	Actual		1,970,336	(107,964)	2,078,300	(280,503)	575,204	137,077	1,431,275	371,732	246,495	(230,224)	(172,757)
72	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)
73	Variance - Favorable / (Unfavorable)		7,344,948	(66,014)	7,410,962	438,636	2,055,862	413,298	1,567,467	532,008	1,360,115	700,311	343,265
74													
75													

	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 6/30/2019			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													
76	**Healthy Michigan Plan**			*HCC%*	8.7%	12.7%	6.5%	12.6%	12.0%	7.6%	7.5%	9.8%	6.4%
77	**Contract Revenue**		23,083,394	4,291,151	18,792,243	938,637	3,864,806	892,552	3,451,120	992,860	5,326,937	1,449,222	1,876,109
78													
79	External Provider Cost		11,985,363	4,306,233	7,679,129	359,574	926,980	646,812	1,718,031	292,088	2,844,628	451,072	439,744
80	Internal Program Cost		6,658,767	-	6,658,767	559,909	1,173,837	492,712	1,993,635	344,461	814,168	677,111	602,934
81	HICA & Use Tax		77,425	77,425	-	-	-	-	-	-	-	-	-
82	**Total Healthcare Cost**		18,721,555	4,383,658	14,337,896	919,484	2,100,816	1,139,524	3,711,667	636,548	3,658,996	1,128,183	1,042,679
83	**Medical Loss Ratio (HCC % of Revenue)**		81.1%	102.2%	76.3%	98.0%	54.4%	127.7%	107.5%	64.1%	68.7%	77.8%	55.6%
84													
85	**Managed Care Administration**		1,721,342	647,055	1,074,287	74,625	164,607	93,742	250,295	48,516	306,836	66,658	69,008
86	**Admin Cost Ratio (MCA % of Total Cost)**		8.4%	3.2%	5.3%	7.5%	7.3%	7.6%	6.3%	7.1%	7.7%	5.6%	6.2%
87													
88	**Contract Cost**		20,442,897	5,030,714	15,412,184	994,109	2,265,423	1,233,265	3,961,962	685,064	3,965,832	1,194,840	1,111,687
89	**Net before Settlement**		2,640,497	(739,563)	3,380,060	(55,472)	1,599,383	(340,714)	(510,842)	307,795	1,361,105	254,381	764,422
90													
91	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
92	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
93	Contract Settlement / Redistribution		(2,089,183)	1,290,876	(3,380,060)	55,472	(1,599,383)	340,714	510,842	(307,795)	(1,361,105)	(254,381)	(764,422)
94	**Net after Settlement**		551,314	551,314	-	-	-	-	-	-	-	-	-
95													
96	**Eligibles and PMPM**												
97	Average Eligibles		50,106	50,106	50,106	2,514	10,251	2,394	9,062	2,976	14,069	3,840	5,000
98	Revenue PMPM		$ 51.19	$ 9.52	$ 41.67	$ 41.49	$ 41.89	$ 41.42	$ 42.31	$ 37.07	$ 42.07	$ 41.93	$ 41.69
99	Expense PMPM		45.33	11.16	34.18	43.94	24.56	57.23	48.58	25.58	31.32	34.57	24.71
100	Margin PMPM		$ 5.86	$ (1.64)	$ 7.50	$ (2.45)	$ 17.34	$ (15.81)	$ (6.26)	$ 11.49	$ 10.75	$ 7.36	$ 16.99
101													
102	**Healthy Michigan Plan**												
103	**Budget v Actual**												
104													
105	**Eligible Lives (Average Eligibles)**												
106	Actual		50,106	50,106	50,106	2,514	10,251	2,394	9,062	2,976	14,069	3,840	5,000
107	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
108	Variance - Favorable / (Unfavorable)		(1,463)	(1,463)	(1,463)	1	(160)	(37)	(106)	1	(983)	(77)	(104)
109	% Variance - Fav / (Unfav)		-2.8%	-2.8%	-2.8%	0.1%	-1.5%	-1.5%	-1.2%	0.0%	-6.5%	-2.0%	-2.0%
110													
111	**Contract Revenue before settlement**												
112	Actual		23,083,394	4,291,151	18,792,243	938,637	3,864,806	892,552	3,451,120	992,860	5,326,937	1,449,222	1,876,109
113	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
114	Variance - Favorable / (Unfavorable)		1,313,133	529,002	784,131	69,196	231,391	48,631	228,697	(33,373)	39,728	86,576	113,285
115	% Variance - Fav / (Unfav)		6.0%	14.1%	4.4%	8.0%	6.4%	5.8%	7.1%	-3.3%	0.8%	6.4%	6.4%
116													
117	**Healthcare Cost**												
118	Actual		18,721,555	4,383,658	14,337,896	919,484	2,100,816	1,139,524	3,711,667	636,548	3,658,996	1,128,183	1,042,679
119	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
120	Variance - Favorable / (Unfavorable)		124,238	(23,888)	148,127	116,082	65,524	(190,152)	(138,816)	100,278	187,213	(254,198)	262,197
121	% Variance - Fav / (Unfav)		0.7%	-0.5%	1.0%	11.2%	3.0%	-20.0%	-3.9%	13.6%	4.9%	-29.1%	20.1%
122													
123	**Managed Care Administration**												
124	Actual		1,721,342	647,055	1,074,287	74,625	164,607	93,742	250,295	48,516	306,836	66,658	69,008
125	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
126	Variance - Favorable / (Unfavorable)		82,900	65,866	17,035	2,488	(3,123)	(14,458)	7,563	7,942	16,490	(12,088)	12,221
127	% Variance - Fav / (Unfav)		4.6%	9.2%	1.6%	3.2%	-1.9%	-18.2%	2.9%	14.1%	5.1%	-22.2%	15.0%

	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 6/30/2019			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													
128													
129	**Total Contract Cost**												
130	Actual		20,442,897	5,030,714	15,412,184	994,109	2,265,423	1,233,265	3,961,962	685,064	3,965,832	1,194,840	1,111,687
131	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
132	Variance - Favorable / (Unfavorable)		207,139	41,977	165,161	118,570	62,400	(204,609)	(131,254)	108,220	203,703	(266,286)	274,418
133	% Variance - Fav / (Unfav)		1.0%	0.8%	1.1%	10.7%	2.7%	-19.9%	-3.4%	13.6%	4.9%	-28.7%	19.8%
134													
135	**Net before Settlement**												
136	Actual		2,640,497	(739,563)	3,380,060	(55,472)	1,599,383	(340,714)	(510,842)	307,795	1,361,105	254,381	764,422
137	Budget		1,120,226	(1,310,542)	2,430,767	(243,237)	1,305,592	(184,736)	(606,285)	232,948	1,117,674	434,092	376,719
138	Variance - Favorable / (Unfavorable)		1,520,272	570,979	949,292	187,765	293,791	(155,978)	97,443	74,847	243,431	(179,710)	387,703
139													
140		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 6/30/2019			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													
141	**Autism Specialty Services**			*HCC%*	7.2%	6.2%	9.8%	8.3%	6.8%	3.9%	5.7%	5.8%	9.5%
142	Contract Revenue		9,048,271	84,438	8,963,833	474,331	1,669,450	497,023	1,635,191	406,104	2,645,301	736,293	900,141
143													
144	External Provider Cost		9,971,572	-	9,971,572	1,760	3,144,703	735,853	858,229	323,355	2,803,792	664,963	1,438,917
145	Internal Program Cost		1,832,847	-	1,832,847	446,403	1,759	18,490	1,249,356	1,987	-	8,016	106,835
146	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
147	Total Healthcare Cost		11,804,418	-	11,804,418	448,163	3,146,462	754,344	2,107,585	325,342	2,803,792	672,979	1,545,752
148	Medical Loss Ratio (HCC % of Revenue)		130.5%	0.0%	131.7%	94.5%	188.5%	151.8%	128.9%	80.1%	106.0%	91.4%	171.7%
149													
150	Managed Care Administration		1,298,752	409,679	889,072	36,373	246,537	62,055	142,124	24,797	235,120	39,762	102,304
151	Admin Cost Ratio (MCA % of Total Cost)		9.9%	3.1%	6.8%	7.5%	7.3%	7.6%	6.3%	7.1%	7.7%	5.6%	6.2%
152													
153	Contract Cost		13,103,170	409,679	12,693,491	484,536	3,392,999	816,399	2,249,709	350,139	3,038,912	712,741	1,648,056
154	Net before Settlement		(4,054,899)	(325,241)	(3,729,658)	(10,206)	(1,723,549)	(319,376)	(614,519)	55,965	(393,611)	23,552	(747,915)
155	Contract Settlement / Redistribution		4,054,899	325,241	3,729,658	10,206	1,723,549	319,376	614,519	(55,965)	393,611	(23,552)	747,915
156	Net after Settlement		-	0	(0)	-	-	-	-	-	-	-	-
157													
158		x											
159	**SUD Block Grant Treatment**			*HCC%*	0.2%	0.7%	0.4%	0.3%	0.0%	0.4%	0.0%	0.7%	0.4%
160	Contract Revenue		6,128,487	5,134,238	994,249	68,582	356,755	26,220	-	106,119	203,371	143,447	89,755
161													
162	External Provider Cost		5,694,636	5,694,636	-	-	-	-	-	-	-	-	-
163	Internal Program Cost		411,791	-	411,791	51,802	143,814	31,518	-	37,060	2,499	75,340	69,759
164	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
165	Total Healthcare Cost		6,106,427	5,694,636	411,791	51,802	143,814	31,518	-	37,060	2,499	75,340	69,759
166	Medical Loss Ratio (HCC % of Revenue)		99.6%	110.9%	41.4%	75.5%	40.3%	120.2%	0.0%	34.9%	1.2%	52.5%	77.7%
167													
168	Managed Care Administration		22,060	22,060	-	-	-	-	-	-	-	-	-
169	Admin Cost Ratio (MCA % of Total Cost)		0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
170													
171	Contract Cost		6,128,487	5,716,696	411,791	51,802	143,814	31,518	-	37,060	2,499	75,340	69,759
172	Net before Settlement		-	(582,458)	582,458	16,781	212,941	(5,298)	-	69,060	200,872	68,107	19,996
173	Contract Settlement		-	582,458	(582,458)	(16,781)	(212,941)	5,298	-	(69,060)	(200,872)	(68,107)	(19,996)
174	Net after Settlement		-	(0)	-	-	-	-	-	-	-	-	-
175													
176		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 6/30/2019			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													
177	**SWMBH CMHP Subcontracts**												
178	Subcontract Revenue		189,254,150	18,900,954	170,353,197	7,238,048	33,959,125	8,833,379	31,354,506	9,234,460	51,314,105	11,954,305	16,465,269
179	Incentive Payment Revenue		488,190	34,393	453,797	18,003	34,000	22,826	70,353	3,754	270,359	16,499	18,003
180	**Contract Revenue**		189,742,340	18,935,347	170,806,994	7,256,051	33,993,125	8,856,205	31,424,859	9,238,214	51,584,464	11,970,804	16,483,272
181													
182	External Provider Cost		124,581,048	12,631,135	111,949,913	3,407,911	22,134,341	6,187,750	18,956,438	5,093,578	40,011,832	6,944,238	9,213,824
183	Internal Program Cost		45,477,867	-	45,477,867	3,665,463	8,931,705	2,523,090	10,373,422	2,755,266	6,506,861	4,275,062	6,446,999
184	SSI Reimb, 1st/3rd Party Cost Offset		(746,158)	-	(746,158)	(53,455)	(148,160)	(37,255)	(176,842)	(9,829)	(230,511)	(21,475)	(68,631)
185	HICA & Use Tax, HRA		2,048,010	2,048,010	-	-	-	-	-	-	-	-	-
186	MHL Cost in Excess of Medicare FFS Cost		367,868	367,868	-	-	-	-	-	-	-	-	-
187	**Total Healthcare Cost**		171,728,634	15,047,012	156,681,621	7,019,919	30,917,885	8,673,584	29,153,018	7,839,015	46,288,183	11,197,824	15,592,192
188	**Medical Loss Ratio (HCC % of Revenue)**		90.5%	79.5%	91.7%	96.7%	91.0%	97.9%	92.8%	84.9%	89.7%	93.5%	94.6%
189													
190	**Managed Care Administration**		17,457,772	5,643,560	11,814,213	565,532	2,411,262	710,931	1,965,927	594,647	3,881,419	657,163	1,027,333
191	**Admin Cost Ratio (MCA % of Total Cost)**		9.2%	3.0%	6.2%	7.5%	7.2%	7.6%	6.3%	7.1%	7.7%	5.5%	6.2%
192													
193	**Contract Cost**		189,186,406	20,690,572	168,495,834	7,585,451	33,329,147	9,384,515	31,118,945	8,433,662	50,169,602	11,854,987	16,619,525
194	**Net before Settlement**		555,934	(1,755,225)	2,311,159	(329,400)	663,979	(528,310)	305,915	804,551	1,414,861	115,817	(136,253)
195													
196	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
197	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
198	Contract Settlement		-	2,311,159	(2,311,159)	329,400	(663,979)	528,310	(305,915)	(804,551)	(1,414,861)	(115,817)	136,253
199	**Net after Settlement**		555,934	555,934	(0)	(0)	0	-	0	(0)	(0)	0	(0)
200													
201													

	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 6/30/2019			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													
202	**State General Fund Services**			*HCC%*	4.8%	3.3%	3.9%	4.4%	6.0%	5.8%	5.2%	3.1%	4.3%
203	Contract Revenue				8,038,400	488,841	1,372,633	466,850	1,559,678	471,484	2,703,492	333,929	641,493
204													
205	External Provider Cost				3,088,908	59,208	369,060	117,487	314,429	292,060	1,675,187	237,254	24,223
206	Internal Program Cost				4,883,857	179,367	899,967	284,045	1,543,398	191,469	984,318	116,715	684,578
207	SSI Reimb, 1st/3rd Party Cost Offset				(116,988)	-	-	-	-	-	(116,988)	-	-
208	**Total Healthcare Cost**				7,855,777	238,575	1,269,027	401,532	1,857,827	483,530	2,542,518	353,969	708,800
209	**Medical Loss Ratio (HCC % of Revenue)**				97.7%	48.8%	92.5%	86.0%	119.1%	102.6%	94.0%	106.0%	110.5%
210													
211	**Managed Care Administration**				663,403	21,735	110,940	36,567	139,007	40,455	239,128	23,391	52,179
212	**Admin Cost Ratio (MCA % of Total Cost)**				7.8%	8.3%	8.0%	8.3%	7.0%	7.7%	8.6%	6.2%	6.9%
213													
214	**Contract Cost**				8,519,179	260,310	1,379,967	438,098	1,996,834	523,985	2,781,646	377,360	760,979
215	**Net before Settlement**				(480,779)	228,531	(7,334)	28,752	(437,156)	(52,501)	(78,154)	(43,431)	(119,486)
216													
217	Other Redistributions of State GF				(93,072)	34,136	-	(201)	(3,589)	-	(100,476)	-	(22,943)
218	Contract Settlement				(240,224)	(219,459)	-	(20,764)	-	-	-	-	-
219	**Net after Settlement**				(814,075)	43,208	(7,334)	7,786	(440,745)	(52,501)	(178,630)	(43,431)	(142,429)
220													

R-137-19

Chair Benjamin amended M-137-19 amended M-137-19 to a resolution R-137-19. Chair Benjamin moved, seconded by Commissioner Dyes, to approve the following resolution:

WHEREAS, the Mental Health needs of our County residents are of critical importance, and

WHEREAS, our veterans, agricultural families, and youth are known to be significantly at risk, and

WHEREAS, the prevalence of major depressive episodes, alcohol, opioid, gambling and other addictions is increasingly common and destructive, and

WHEREAS, there is a shortage and an ongoing challenge of attracting and retaining professional staff, and

WHEREAS, long-term Funding for mental health services is an issue under serious study statewide and frequently noted by the Michigan Association of Counties, and

WHEREAS, the Cass County Board of Commissioners wants to assure the dedicated staff of Woodlands Behavioral Health of our appreciation for their ongoing dedication, and

WHEREAS, the Cass County Board of Commissioners also wants to express its' commitment to maintaining stability and providing the best possible services to staff and residents.

NOW THEREFORE BE IT RESOLVED that the Cass County Board of Commissioners approves the engagement of a consultant by the County Administrator and Chief Judge to evaluate the mental health services, finances, needs, and facilities currently offered by Woodlands Behavioral Health and provide a report by October 17, 2019.

The Chair instructed the Clerk to call roll:

Yes (6): Commissioners Grice, Marchetti, Benjamin, Ausra, Dyes and File.

No (0): None.

Absent (1): Commissioner Cobb.

Resolution R-137-19 carried by roll call vote.

R- 136-19

RESOLUTION DISSOLVING

COMMUNITY MENTAL HEALTH AUTHORITY

WHEREAS, on December 19, 1996 the Cass County Board of Commissioners created the Cass County Mental Health Authority pursuant to the Mental Health Code section 205, MCL 330.1205; and

WHEREAS, the duration of the Cass County Community Mental Health Authority is perpetual unless dissolved or terminated by the Cass County Board of Commissioners; and

WHEREAS, termination by the County may be accomplished by an official notification from the Board of Commissioners to the State Department of Mental Health; and;

WHEREAS, termination by the Board of Commissioners shall be effective one (1) year following the receipt of notification by the State Department of Mental Health unless the director of the department consents to earlier termination; and

NOW THEREFORE BE IT RESOLVED that the Cass County Board of Commissioners vote to terminate the existence of the Cass County Mental Health Authority and directs the County Administrator to communicate this to the Director of the State Department of Mental Health.

BE IT FURTHER RESOLVED that the Cass County Board of Commissioners directs their County Administrator to notify Cass County Community Mental Health Authority (dba Woodlands Behavioral Healthcare Network) of this resolution.

ADOPTED THIS 18th DAY OF July , 2019.

ATTEST:

Monica McMichael, Clerk
COUNTY OF CASS

Robert Benjamin, Chairperson
CASS COUNTY BOARD OF
COMMISSIONERS

2019-934 Pages: 1
FILED Cass County, Michigan
Monica McMichael, County Clerk
07/19/2019 09:25 AM
Receipt #146525 Fee BOCResolution

RESOLUTION

CASS COUNTY COMMUNITY MENTAL HEALTH SERVICES BOARD

WHEREAS, Act 258 of the Public Acts of 1974 as amended, commonly known as the Mental Health Code, was enacted among other things, to establish county community mental health programs; and

WHEREAS, said Code was enacted for the additional purpose delineating state and county financial responsibility for public mental health services; and

WHEREAS, pursuant to Section 116 (2) (b) of the Mental Health Code, it is the objective of the Department of Mental Health to "shift the primary responsibility for the direct delivery of public mental health services from the State to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area"; and

WHEREAS, the Board of Commissioners endeavors to affirm and renew its commitment to make quality mental health services readily available to each of its residents in the most economical and efficient manner possible; and

WHEREAS, the Board of Commissioners, in its effort to provide services, desires to specify the powers and duties under which said program shall operate;

NOW THEREFORE BE IT RESOLVED as follows:

I.
PURPOSE

There is hereby created a Cass County Community Mental Health Authority pursuant to the Mental Health Code, Section 205, MCL 330.1205. The purpose and power to be exercised by the Community Mental Health Authority shall be to comply with and carry out the provisions of the Mental Health Code. The existing Cass County Community Mental Health Services Program is dissolved upon the effective date of the creation of the Authority. The following persons are hereby appointed as Board Members of said Cass County Community Mental Health Authority and shall serve in accordance with the provisions of the Michigan Mental Health Code for the terms noted:

	Name	Term
1.	Jan Kairis	3/31/97
2.	Ruth Newton	3/31/97
3.	Robert Eady	3/31/97
4.	Nila Wells	3/31/97

5.	Phyllis Howard	3/31/98
6.	David Taylor	3/31/98
7.	James Brown	3/31/98
8.	LaVerne Carnegie	3/31/98
9.	Cindy Underwood	3/31/99
10.	Arthur L. Colvin	3/31/99
11.	Fred Leet	3/31/99
12.	Merri Terbough	3/31/99

II.

COMMUNITY MENTAL HEALTH AUTHORITY POWERS

In addition to other powers of a community mental health services program as set forth in the Mental Health Code, a community mental health authority has all of the following powers:

a) To fix and collect charges, rates, rents, fees, or other charges and to collect interest.

b) To make purchases and contracts.

c) To transfer, divide, or distribute assets, liabilities, or contingent liabilities, unless the community mental health authority is a single-county community mental health services program and the county has notified the department of its intention to terminate participation in the community mental health services program.

d) To accept gifts, grants, or bequests and determine the manner in which those gifts, grants, or bequests may be used consistent with the donor's request.

e) To acquire, own, operate, maintain, lease, or sell real or personal property. Before taking official action to sell residential property, however, the authority shall do all of the following:

   i) Implement a plan for alternative housing arrangements for recipients residing on the property.

   ii) Provide the recipients residing on the property or their legal guardians, if any, an opportunity to offer their comments and concerns regarding the sale and planned alternatives.

   iii) Respond to those comments and concerns in writing.

f) To do the following in its own name:

   i) Enter into contracts and agreements.

   ii) Employ staff.

   iii) Acquire, construct, manage, maintain, or operate buildings or improvements.

iv) Acquire, own, operate, maintain, lease, or dispose of real or personal property, unless the community mental health authority is a single-county mental health services program and the county has notified the department of its intention to terminate participation in the community mental health services program.

v) Incur debts, liabilities, or obligations that do not constitute the debts, liabilities, or obligations of the creating county or counties.

vi) Commence litigation and defend itself in litigation.

g) To invest funds in accordance with statutes regarding investments.

h) To set up reserve accounts, utilizing state funds in the same proportion that state funds relate to all revenue sources, to cover vested employee benefits including but not limited to accrued vacation, health benefits, the employee payout portion of accrued sick leave, if any, and worker's compensation. In addition, an authority may set up reserve accounts for depreciation of capital assets and for expected future expenditures for an organizational retirement plan.

i) To develop a charge schedule for services provided to the public and utilize the charge schedule for first and third-party payers. The charge schedule may include charges that are higher than costs for some service units by spreading non-revenue service unit costs to revenue-producing service unit costs with total charges not exceeding total costs. All revenue over cost generated in this manner shall be utilized to provide services to priority populations.

j) To determine the method and extent to which the Community Mental Health Authority establishes and the manner in which it secures and maintains any and all forms of insurance, including, but not limited to, group and/or separate insurances, and self-insurance and/or reinsurance, for the Authority's purposes and protection, as required by and/or as otherwise permitted by law.

k) All powers, duties, obligations, rights and protections not mentioned herein but otherwise provided by the Mental Health Code are included here by reference.

III.
DURATION AND TERMINATION

a) The duration of the existence of the Cass County Community Mental Health Authority shall be perpetual unless dissolved or terminated by the Board of Commissioners. Termination by the County may be accomplished by an official notification from the Board of Commissioners to the State Department of Mental Health. The date of termination shall be one (1) year following the receipt of such notification by the State Department of Mental Health, unless the director of the department consents to earlier termination. In the interim between notification and official termination, the County's participation in the community mental health services program shall be maintained in good faith.

b) As of the December 31, 1996, the net financial assets in the Mental Health Special Revenue Fund shall be made available by Cass County to the Authority and will be returned to Cass County if the Authority is dissolved or terminated. All other remaining assets net of liabilities shall be transferred to the community mental health services program or programs that replace the authority.

IV.
LIABILITY FOR LEASE

TRANSFER OF CONTRACTS AND LEASES. With the dissolution of the existing Cass County Community Mental Health Services Program, all contracts regarding mental health services and leases for premises leased for mental health service sites and contracts/leases obligations, including financial payments, thereto will be transferred to the Community Mental Health Authority. If applicable and where possible, the Community Mental Health Authority shall obtain a novation of contracts and leases."

The Cass County Community Mental Health Authority shall be liable for all remaining lease payments associated with the Work Activity Center according to the established lease payment schedule.

V.
EMPLOYEES

Upon the creation of a Cass County Community Mental Health Authority, the employees of the former community mental health services program shall be transferred to the new authority and appointed as employees subject to all rights and benefits for 1 year. Such employees of the new community mental health authority shall not be placed in a worse position by reason of the transfer for a period of 1 year with respect to workers' compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or any other benefit that the employee enjoyed as an employee of the former community mental health services program. Employees who are transferred shall not by reason of the transfer have their accrued pension benefits or credits diminished.

Employees of the Community Mental Health Authority shall be public employees.

VI.
OTHER

All assets, debts, and obligations of the county community mental health agency including but not limited to equipment, furnishings, supplies, cash, and other personal property, shall be transferred to the community mental health authority.

All the privileges and immunities from liability and exemptions from laws, ordinances, and rules that are applicable to county community mental health agencies and their board members, officers, and administrators, and county elected officials and employees of county government are retained by the authority and the board members, officers, agents, and employees of an authority created under this section. The privileges, immunities, and exemptions granted under this subdivision do not include the immunity granted to a county under subsection (6) of section 205 of the Mental Health Code.

The Cass County Community Mental Health Authority shall:

a) Provide to each county creating the authority and to the department a copy of an annual independent audit performed by a certified public accountant in accordance with governmental auditing standards issued by the comptroller of the United States.

b) Be responsible for all executive administration, personnel administration, finance, accounting, and management information system functions. The authority may discharge this responsibility through direct staff or by contracting for services.

Cass County in creating a community mental health authority is not liable for any intentional, negligent, or grossly negligent act or omission, for any financial affairs, or for any obligation of a community mental health authority, its board, employees, representatives, or agents.

The Cass County Community Mental Health Authority shall not levy any type of tax or issue any type of bond in its own name or financially obligate any unit of government other than itself.

An employee of the Cass County Community Mental Health Authority is not a county employee. The Cass County Community Mental Health Authority is the employer with regard to all laws pertaining to employee and employer rights, benefits, and responsibilities.

As a public governmental body, the Cass County Community Mental Health Authority is subject to the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws, and the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws, except for those documents produced as a part of the peer review process required in section 143a and made confidential by section 748(9).

VII.
AMENDMENTS

This resolution may be amended only by the Board of Commissioners, providing that any such amendments shall be consistent with provision of the Mental Health Code, as existing or as subsequently amended.

VIII.
CONFLICT OF PROVISIONS

If there is any conflict between this resolution and the Mental Health Code, as existing or as subsequently amended, the Mental Health Code shall prevail, and those provisions of this agreement inconsistent therewith shall be deemed of no effect.

This enabling resolution is not effective until filed with the Secretary of State and the County Clerk and until the certification of the Michigan Department of Community Health is received pursuant to the requirements of the Mental Health Code.

ADOPTED THIS 19th **DAY OF** DECEMBER, **1996**

ATTEST:

Ann L. Simmons

Ann L. Simmons, Clerk
COUNTY OF CASS

Mary L. Peoples

Mary L. Peoples, Chairperson
CASS COUNTY BOARD OF COMMISSIONERS

I HAVE COMPARED THIS COPY with the original record thereof now remaining in my office, and have found the said copy to be a true and correct transcript therefrom, and of the whole of such original record.

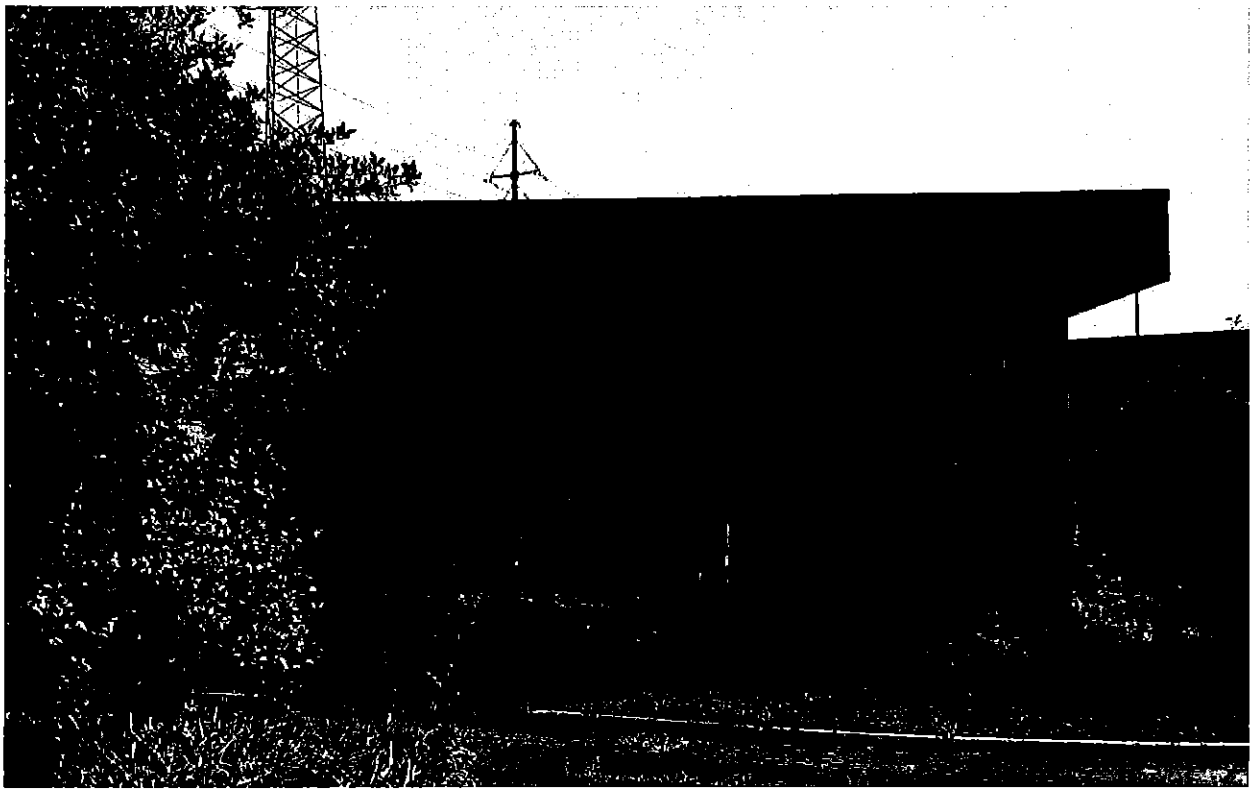
In Testimony Whereof I have set my hand and affixed the seal of said Court, at Cassopolis, Michigan

This 22nd day of January A.D. 19 97

Ann L. Simmons, Clerk

bocmentaldoc

MANY LOSERS AS COUNTY COMMISSIONERS KILL PROPERTY SALE



For almost three years, MEC has worked in earnest with Woodlands Behavioral Health Network (WBHN) on the purchase of our 901 E. State Street facility. WBHN approached us with an interest in the building in 2016, after we broke ground on our new Decatur Road headquarters. At the time, Woodlands staff worked out of three leased facilities, and their board and leadership believed consolidating their operations would allow for expansion; better coordination of service delivery; and cost savings in the areas of lease payments, maintenance and upkeep, and utilities and technology infrastructure.

In December 2016, the WBHN board voted and approved an offer of $2.4 million for the purchase of the 901 facility, and immediately began the process of seeking and securing funding approval from the USDA. In good faith, we put significant time and money into improvements to the facility, including re-roofing, improving storm water retention, and sealing public parking areas.

For reasons unknown to us and after three years of good-faith work between WBHN and MEC, Cass County chose to get involved in June. Jeff Carmen, interim Cass County Administrator, and Robert Benjamin, Chair of the Cass County Commissioners, stepped in and began questioning the details of the purchase, despite the fact that an independent appraisal conducted in 2016 supported the offer price. In response, the 12-member WBHN

Board took another vote on June 25, re-affirming the purchase agreement by a vote of 8-2 (one board member abstained and one was absent; County Commissioners Mike Grice and Skip Dyes were the two dissenting votes). While we believed this provided the final green light to close the deal by August 1 as required by USDA, County leadership pursued even more conversation with WBHN and forced yet another board vote. On July 3 the board once again reaffirmed the purchase agreement by a vote of 9-2 (one board member was absent and Grice and Dyes were again the dissenting votes). This is all after Grice and Dyes raised no objections at the May 28, 2019 board meeting to support a motion in favor of awarding a $1 million contract for construction renovations at the 901 facility.

What happened in the following days appears to be a gross breach of democratic principles as the Cass County Board of Commissioners took the extreme measure of unanimously voting to terminate WBHN's authority status, after they had been an independent authority for 22 years. This move obligates the county to a $12 million budget line item by taking on WBHN as a county department. If the County proceeds with the termination, the USDA will withdraw the previously-approved loan.

There is much speculation about the motives of the County Commissioners, but as of now it appears they have single-handedly stopped the sale of our 901 property, despite the fact that two autonomous entities entered into a good-faith purchase agreement. As a result, MEC loses three years of opportunity to have its facility on the market, impacting the electric customers who own the cooperative and its assets. But this is more than just a lost opportunity for MEC. Other losers include:

- WBHN and those they serve as they lose opportunities to expand local mental health services and create a more efficient and effective consolidated operation. They also are saddled with significant debt resulting from the architects and other contractors hired to assist with the expected move.
- The Village of Cassopolis as they lose significant financial investment to solidify employment while improving a large, highly-visible and centrally-located anchor facility.
- Cass County and future economic development efforts as the USDA will be less inclined to loan or grant funds to a community fraught with political instability.
- Cass County residents as they collectively take on the $12 million budget of an agency that successfully served the mental health needs of the community as an independent authority for 22 years.

Three years ago MEC made a financial commitment to Cass County by investing in a brand new facility, and the resulting MEC-WBHN agreement represented a win-win for Cass County and its residents. Today, no winners remain and many are left questioning the leadership of their local community. **Email your county commissioners** to let them know Cass County deserves better.

MAC
MICHIGAN ASSOCIATION OF COUNTIES
110 W. Michigan Ave., Suite 200
Lansing, MI 48933
517-372-5374 Fax 517-482-4599
www.micounties.org
Stephan W. Currie, Executive Director

Aug. 2, 2019

Mr. Robert Gordon
Director
Michigan Department of Health and Human Services
333 S. Grand Ave.
Lansing, MI 48909

RE: Lakeshore Regional Entity Developments

Director Gordon,

The Michigan Association of Counties (MAC) is deeply concerned by the process outlined in the Michigan Department of Health and Human Services (MDHHS) press release dated July 26, 2019 — specifically that portion of the process that calls for a new board to be established by MDHHS. The press release indicates eight appointments out of 15 members for the proposed new regional board would be made by MDHHS and not the region, counties, CMHSPs or communities served.

This would be a drastic departure from the current local governance structure — and a violation of the Mental Health Code.

Over the years, state legislation has transferred greater levels of responsibility for mental health services from the state to local governments. Rooted in the Mental Health Code, county boards create single- or multi-county community mental health (CMH) agencies, by an enabling resolution, and the community mental health services board is appointed by the county boards of commissioners. Further, the authority to form a regional entity (prepaid inpatient health plan) rests within the board of commissioners and, by extension, members of the CMH boards who appoint members to the regional entity board. The resulting PIHP boards are ultimately responsible to the served communities, their local CMHSPs and their counties.

MAC understands the department's goal of having greater involvement in the management of the Medicaid benefit in the Lakeshore Regional Entity (LRE) Region; we welcome that opportunity, as does the LRE Board. MAC supports federal, state and county partnerships to optimize funding and policy to ensure optimal services are being provided to our most vulnerable citizens.

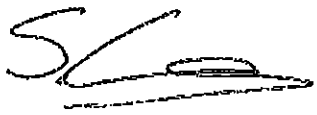
However, we cannot support the proposed board structure, and assert the local governance structure should be preserved.

The LRE has, in partnership with Beacon Health Options, created a promising public-private partnership. But the state is blocking implementation. This is unfortunate, as counties and the CMH local structure have been driven, due to severe underfunding by the state and *allegations* of "mismanagement," to engage with private providers and create a solution to ensure no disruption in service for Medicaid consumers.

MAC encourages the state to allow this new public-private partnership to move forward and lead as an example of collaboration, rather than impede and cause more uncertainty for residents.

We encourage the department's involvement in management, without eliminating local public control. The people we serve deserve local accountability by those they elect and to have the support of the state to maintain this unique and transparent structure recognized nationally over the past 50 years of development.

Respectfully,



Stephan W. Currie
Executive Director

SWC/mk

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

FOR IMMEDIATE RELEASE:
July 26, 2019

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

MDHHS announces composition of board to oversee Region 3 PIHP; seeks individuals interested in serving

LANSING, Mich. – The Michigan Department of Health and Human Services (MDHHS) today announced the composition of the Prepaid Inpatient Health Plan (PIHP) Region 3 board and is seeking nominations for board members by Aug. 15.

Together with MDHHS, the new board will oversee the activities of West Michigan's PIHP to ensure sound management and to protect individuals receiving services.

The department developed the new board proposal following the cancellation of the contract with Lakeshore Regional Entity (LRE) after several years of poor performance. In recent months, Beacon Health Options has been operating with LRE to provide managed care support to the Region 3 Community Mental Health Services Programs (CMHSPs). Based on feedback from the CMHSPs about the value of this partnership, MDHHS will seek to establish a contract with Beacon that allows this work to continue. The new board will oversee Beacon's work. After listening to public feedback, MDHHS has added fiduciary powers to the Board.

"A board with public representation, diverse stakeholders and critical responsibilities will help achieve the goal all of us share: delivering better services to the residents of West Michigan," said Robert Gordon, MDHHS director. "By operating under FOIA and open meetings laws, the board will also make decision making more transparent and accountable."

The Region 3 PIHP Board will include the following members:

- 5 representatives from the CMHSPs in the region.
- 1 representative of county governments in the region.
- 1 individual or family member of an individual receiving services from the PIHP.
- 1 member of an advocacy group representing individuals with behavioral health needs or intellectual and developmental disabilities.
- 3 representatives of MDHHS.
- 3 individuals with expertise in behavioral health or intellectual developmental disability services and/or administration.
- 1 representative of the contracted PIHP.

- MORE -

Board members will be appointed to a one-year term that begins Oct. 1, 2019 and ends Sept. 30, 2020. Each CMHSP in the region will appoint one representative, the county boards of commissioners will appoint one representative, and the contracted PIHP will appoint one representative. MDHHS will appoint all other representatives. Additional information is available in the Region 3 PIHP Board details document.

Individuals interested in serving on the board should complete an online application by Aug. 15 to nominate themselves.

CMHSPs, the county boards of commissioners and the contracted PIHP shall notify MDHHS of their appointments by Sept. 1. MDHHS will announce board membership in early September.

###

Region 3 PIHP Board Details

Role of the Board

Together with the Michigan Department of Health and Human Services (MDHHS), the new Board will serve in both a fiduciary governance and oversight role over the Pre-paid Inpatient Health Plan (PIHP) in Region 3 to ensure sound management and protection of individuals receiving services. The Board will supervise the contracted PIHP entity, ensuring that there is a smooth transition of services, individuals are receiving appropriate levels of care, providers are being paid timely, and there is sound fiscal management.

The Board will have traditional fiduciary powers of a governance board, including to review and approve sub-capitated budgets; set and monitor execution of an annual strategic plan; establish, amend, or terminate contracts administered by the PIHP; and approve changes to PIHP policies and procedures. The Board will be able to monitor performance of the PIHP across all areas, including service access, quality, network adequacy, provider rates, financial management, and legal and regulatory compliance. It will have the ability to make inquiries, request data, ask questions, and issue public reports independent of the Department. Members of the public and individuals receiving services will be able to raise concerns to the Board.

In addition, MDHHS is committed to maintaining public oversight for the delivery of supports and services. The Board shall appoint an interim services review committee – an external body to review any denials or reduction of services or supports as an additional layer of protection for individuals (details below).

Board composition

The Board will include the following members: 5 representatives from the Community Mental Health Services Programs (CMHSPs) in the region; 1 representative of County governments in the region; 1 individual or family member of an individual receiving services from the PIHP; 1 member of an advocacy group representing individuals with behavioral health needs or intellectual and developmental disabilities; 3 representatives of the Michigan Department of Health and Human Services; 3 individuals with expertise in behavioral health or intellectual developmental disability services and/or administration; and 1 representative of the contracted PIHP.

Board selection

Each CMHSP in the region shall appoint one representative. The County Boards of Commissioners of Mason, Lake, Oceana, Muskegon, Ottawa, Kent, and Allegan shall jointly appoint one representative. The contracted PIHP shall appoint one representative. The Department of Health and Human Services shall appoint other representatives. Individuals who would like to serve on the board should apply at the following link by August 15 to nominate themselves.

CMHSPs, the County Boards of Commissioners, and the contracted PIHP shall notify MDHHS of their appointments by September 1, 2019. MDHHS will publicly publish the board membership list in early September.

Terms of board service

Board members shall be appointed to serve for 1 year (October 1, 2019 to September 30, 2020). Once appointed, Board members will be subject to removal only for just cause.

Open meetings and FOIA

The Board will be subject to the Open Meetings Act and the Freedom of Information Act (FOIA).

Review of Services Determinations

Pursuant to the Managed Care Regulations, the PIHP will comply with the managed care requirements and have a single grievance and appeal process at the PIHP. Individuals may appeal any adverse benefit determination as defined under the managed care regulations to the PIHP and will have the right to request a State Fair Hearing after receiving notice that the PIHP intends to uphold the adverse benefit determination or fails to comply with the notice and timing requirements for an appeal.

Additionally, the Board shall establish an interim independent service review committee in this region, comprised of practitioners. At the request of individuals receiving services, such a committee would conduct a clinically oriented paper review of adverse benefit decisions. The committee would have the power to make binding decisions with respect to care, without cost to the individual and without altering timeframes applicable to state fair hearings or disruption to the continuation of benefits.

Response to MDHHS "Lakeshore Regional Entity Contract Termination FAQs"
Completed by LRE and LRE Member CMHs and Community Mental Health Association of Michigan

Background: On June 28, 2019, MDHHS contacted the five CMH members of the Lakeshore Regional Entity (LRE) to inform them of their intent to terminate its contract with the LRE and assign management of the region to Beacon Health Options, the current private management partner of the LRE. Shortly after that contact, MDHHS released a press release and sent formal letters to the LRE and the member CMHs.

On July 10, 2019, a member of another PIHP shared a document entitled "Lakeshore Regional Entity Contract Termination FAQs" with the LRE CEO. This document was produced by MDHHS and shared with a variety of stakeholders including legislators, stakeholders, and county officials from the 7-county region. MDHHS did not share the document directly with any member of the LRE or any of the LRE CMH CEOs. After reviewing the MDHHS Frequently Asked Questions (FAQ) document and comparing with our own experience, it became clear that the FAQ presented a one-sided narrative of the situation in the LRE Region.

This document shares, side by side, the FAQ information presented by MDHHS (left side) compared to the actual data from the LRE and its member CMHs (right side).

MDHHS Statements re LRE Contract Termination FAQs		LRE Data re MDHHS Statements
BACKGROUND		
What is happening to the Lakeshore Regional Entity (LRE)? To provide quality behavioral health services on a sustainable basis for West Michigan, the Michigan Department of Health and Human Services (MDHHS) is cancelling its contract with Lakeshore Regional Entity (LRE) as of September 30, 2019. MDHHS will establish a new pre-paid inpatient health plan (PIHP) in the region, building on recent work there with Beacon Health Options. MDHHS intends to keep the region intact and will initiate temporary state management when the contract with LRE ends. The state will seek to establish a new PIHP to serve beneficiaries.		MDHHS is proposing to: • terminate the state's contract with the Lakeshore Regional Entity. LRE is the public managed care plan (a Prepaid Inpatient Health Plan (PIHP) in federal terms) that manages the Medicaid behavioral health benefit for the counties on the west side of the state; • contract directly with Beacon Health Options, a private managed care company currently managing the Medicaid behavioral health benefit in a partnership with LRE; • eliminate the Lakeshore Board of Directors and replace it with an advisory board formed by the state; • have the State hold the contract, directly with Beacon, for FY 2020, with another of the State's public managed care plans or a private behavioral healthcare plan taking on this managed care role, from the State, for FY 2021. MDHHS staff, in a discussion with the Regions 5 CMH CEOs and the Community Mental Health Association of Michigan (CMHAM) on June 28th, outlined three aims that they hope to accomplish with their proposal: 1. Greater involvement, by the State, in the management of the Medicaid benefit in the LRE region

		2. Changing the make-up of the LRE Board of Directors 3. Re-examining the role of LRE staff in their partnership with Beacon, in the management of Medicaid behavioral healthcare benefit
Why did MDHHS cancel the contract with Lakeshore? MDHHS decided to terminate the contract based on many factors. Some were related to finances: five years of financial deficits, failure to address the deficits, the lack of a current risk management strategy and the lack of a plan to cover their portion of a projected $16 million deficit. The termination also reflects performance issues despite multiple years of corrective action plans and weaker member outcomes relative to other regions on key metrics like inpatient hospitalization. For example, with respect to the Healthy Michigan Plan population for which data is readily available, Lakeshore serves a significantly smaller share of eligible members than the state average, has a higher inpatient hospitalization rate than the state average, and has the highest per member costs of any region statewide.		The LRE was able to address its deficit for FY 2014, FY 2015 and FY 2016. The first year that MDHHS was required to contribute to the LRE's deficit was FY 2017. **Healthy Michigan Plan (HMP) Numbers Served:** MDHHS states that the LRE served a smaller share of Healthy Michigan members in FY 2018 when compared to the state average (1.92% of eligible members vs. state average of 2.64%). LRE and Beacon staff were not able replicate this data point. Using LRE enrollment and capitation details along with FY 2018 HMP utilization as reported to MDHHS in the encounter data and on the Medicaid Utilization Net Cost (MUNC) Report, LRE data shows that **there were 96,983 eligible Healthy Michigan members in the region during the fiscal year, and that 7637 members received services. This is an annual penetration rate of 7.87%.** **Healthy Michigan Member Cost Per Month:** In addition, MDHHS states that LRE's per recipient per month costs are the highest in the state ($1,701) compared to the state average of $1,122. LRE and Beacon staff were also not able to replicate this data point. Utilizing LRE MUNC Report, for FY 2018, LRE data shows a **monthly average cost of $360 per Healthy Michigan consumer served during the fiscal year.** Annually this equates to an average of $4,321 for each consumer served. The annual average cost per consumer has decreased over the past three fiscal years from $5,033 cost per consumer to $4,321. **Inpatient Utilization:** MDHHS raises the issue of higher utilization of inpatient services for FY 2018 for persons eligible for the Healthy Michigan program. The contract that LRE has in place with Beacon Health Options is already conducting continued stay reviews for all high level of care services, including community inpatient. This was initiated in February 2019 and was implemented for all CMHs in May 2019. Nearly all admissions are being reviewed/audited for appropriateness (over 95%). The findings show that 94.7% of admissions have been considered to meet medical necessity and 5.3% either Beacon disagrees with a decision or believes that insufficient information was available. Efforts to assure most appropriate high level of care services has resulted in a decrease in length of stay by 1 day for inpatient, and half a day for crisis residential. Enhanced UM and Clinical Care are showing benefits for best practice. We have also started to see a decreasing trend in the number of admissions into inpatient services. **In summary, concerns regarding inpatient utilization have been addressed through significant system development in the region through the LRE/Beacon/CMHSP collaboration.**

Lakeshore has taken some actions (like bringing in Beacon to help) to address ongoing issues. Given this progress, why did DHHS decide to terminate Lakeshore's contract and eliminate the current board? While the current board's recent decision to involve Beacon was a positive step, it was not enough to address our deep concerns arising from that board's record over many years, as detailed above. Given that record, the best path forward for West Michigan residents is for MDHHS to oversee the region directly. We value public input and oversight, and therefore are establishing a new board to assist us in overseeing Beacon's contract. This board will include membership from the CMHs, but also other representatives. Many of the issues in LRE have stemmed from the PIHP not being able to hold its member CMHs accountable and not taking actions like centralizing managed care functions and adopting consistent utilization management procedures. Diversifying the board membership to include a broader group of behavioral health stakeholders will allow it to better hold the CMHs accountable and manage services in the region. By July 26, DHHS will provide more guidance on our plans for selecting the board.		The LRE revised its governance structure and submitted to MDHHS in FY 2017. It was subsequently approved by MDHHS in April 2017. The roster of Board members offers more diversity than what MDHHS requires of other PIHPs across the state. The Board membership includes CMH Board Members, regional providers, recipients of services and/or family members of recipients, individuals working in the court system, individuals working in the healthcare system broadly, corrections officials, and business owners. The Board roster is available upon request. The revised "board" structure that MDHHS is proposing is ***advisory*** in nature, reporting to the State rather than serving as a Public Oversight Board accountable to the communities served for the operations of the region. It is not locally appointed and does not serve in the capacity of a public governance Board. LRE and member CMHSPs have proposed making any changes MDHHS recommends to its Board structure and membership to address their specific concerns related to governance and accountability. MDHHS' remaining concerns could be addressed while retaining publicly appointed governance and without threatening the foundational public nature of the PIHP in Michigan. For example, this could be a continuation of the current, locally appointed Board with an expansion of two or three additional members, all appointed by the State.
Why is LRE being singled out when other PIHPs have had financial problems? The ongoing significant overspending and poor performance in Lakeshore Regional Entity is an outlier compared to the rest of the state. The Department has requested additional funding for the PIHPs in 2019, and it is reviewing options and consulting with stakeholders		Data regarding LRE performance on the issues identified by MDHHS is presented above. **Revenue Factors Impacting LRE financial situation:** LRE's financial situation is not unique. LRE was the first of the PIHPs to experience the impact of systemic underfunding due to a variety of factors. These revenue factors are described below: • **Home and Community Based Waiver (HCBW) Slots:** This Medicaid program is designed for IDD individuals with higher levels of support needs. LRE has 602 slots available (2.2 slots per

on further steps to improve stability and performance within the PIHPs. However, these steps would not be sufficient to address Lakeshore's longstanding problems.		1000 Medicaid enrollees). The state average is 3.23 slots per 1000 Medicaid enrollees. **If LRE were at the state average there would be an additional 273 slots for the region, bringing in an estimated $14.3 million annually.** Regional coordinators report that there are many who would meet criteria and need for this program, and additional slots would be filled in short order if there was more equality in how this benefit had been rolled out historically. • **Traditional Medicaid vs Healthy Michigan:** There are several factors with traditional Medicaid that led to lower revenues for the region. Primarily, LRE is paid per enrollee for two types of Medicaid beneficiaries: DAB (Disabled Aged and Blind) and TANF (Temporary Assistance for Needy Families). The State and their actuary determine the amount of funding each region will receive for the year and then allocates those dollars over the DAB and TANF enrollees. The actuary determined the rates per DAB and TANF based on prior years' enrollments. In FY 2017 the primary concern for LRE was that the regional DAB enrollments dropped by more than 1,140 enrollees per month compared to FY2016 as individuals with higher need signed up for Healthy Michigan (an easier process for enrollees). DAB funding is paid on average of $257 per person per month, which equates to more than **$3.5 million** in lost revenue annually. • **Internal Service Fund**: When Lakeshore Regional Entity was formed in January 2014, the Member CMHs contributed $11.2M in Risk Reserves from prior years. Region 3 (LRE) is the third largest PIHP region in terms of Medicaid Enrollments, but Risk Reserves were the 9th lowest out of the 10 PIHPs. This gave LRE less room to be able to fund deficits that occurred within our region. It is also true that there was no funding in the rates to finance the reserve system as is paid to the Medicaid Health Plans. • **Healthy Michigan:** In 2015, the LRE's revenue for Healthy Michigan was $28M (net of taxes). Expenses were much lower as many enrollees were not involved with the Mental Health system before Healthy Michigan was created. LRE could build some reserves in FY 2014 and FY 2015. In FY2016, MDHHS reduced HMP revenue to $18.4M (Net of taxes) to enable LRE to spend some of those reserves. The region had expenses of $26.2M and used up a significant portion of those reserves, with the understanding that funding would be increased to cover future expenses. This has not occurred. There is a common belief among PIHPs, CMHSPs, and providers that the system is underfunded and 6 of 10 PIHPs ran Healthy Michigan deficits for FY 2018.

		It is important to note: **LRE was able to address its deficit for FY 2014, FY 2015 and FY 2016. The first year that MDHHS was required to contribute to LRE's deficit was FY 2017.** On July 24, 2019 MDHHS and its actuarial firm, Milliman, presented the new actuarially sound methodology for FY2020 based on updated FY 2018 data. This model is based on risk variables and was developed in a collaborative manner with the PIHPs and CMHSPs. Preliminary data presented by Milliman suggests that LRE will receive the highest level of increase from FY 2019 to FY 2020 (7.6% if the model is fully implemented) that it has received since its inception. This increase in revenue in conjunction with LRE's collaboration with Beacon Health Options would place the Lakeshore Regional Entity in a very strong position. MDHHS' contract action against LRE is unnecessary given the more equitable funding formula.
NEXT STEPS		
What will happen next in the region? DHHS intends to keep the region intact and will seek to establish a contract with Beacon that will allow its current work to continue. The contract would include all public policy requirements currently in place for PIHPs, including consumer protections. For legal reasons, DHHS will hold the contract with Beacon and will be ultimately accountable for ensuring Beacon's compliance and performance. However, DHHS will rely on a public board to advise the Department in reviewing budgets, monitoring service delivery, and ensuring compliance with legal requirements. DHHS will act quickly on issues identified by the Board.		On July 10th, PIHPs from around the state issued a statement to MDHHS denouncing its decision and actions regarding LRE. On July 11th, the five LRE Member CMHs sent a letter to MDHHS expressing deep concern regarding MDHHS' action, siting examples of our regional success and requesting an opportunity to continue reaping the benefits of the public-private partnership between LRE and Beacon. The CMHs received a letter back from MDHHS on July 19th, stating it would be moving forward with its proposed action regarding LRE and further justifying its intention to disassemble LRE Board and the region's public governance. On July 11th, Greg Moore, Attorney from Dickinson and Wright, sent a letter to MDHHS demanding MDHHS retract its cancellation of the LRE contract and meet with LRE and regional CMH CEOs to discuss alternative courses of action. In the absence of requested action from MDHHS within 5 days, the letter indicates that LRE will pursue its right to an official hearing. MDHHS responded to that letter on July 19th indicating they have no intention of retracting their decision and refusing a meeting with the LRE and/or CMH CEOs. On July 26th the LRE submitted a "Notice of Hearing Pursuant to MCL 24.271 and 330. 1232b" to MDHHS and specifically Director Gordon of the Michigan Department of Health and Human Services.

How will individuals be protected during and after the transition to the new PIHP? Individuals receiving services from community mental health service providers in this region will continue to receive the medically necessary services authorized in their person-centered plans of care and retain access to their existing providers. MDHHS hopes that improved governance and oversight in the Lakeshore region will result in enhanced quality of services for beneficiaries, and that improved financial management will make more funds available to reinvest in services and ensure the long-term financial sustainability of the region. The process for the closeout of a PIHP after termination is outlined in MDHHS's contract with Lakeshore Regional Entity. This process, which will run through December 31, 2019, will ensure a smooth handoff of responsibilities and closeout of the new PIHP entity. Lakeshore is contractually bound to assure continuity of care during the closeout process. DHHS is committed to ensuring that people and providers do not experience disruptions, and will be actively overseeing the process.		The LRE Board, LRE CEO, CMH Boards, CMH CEOs and Beacon remain 100% committed to no disruption in services to consumers in the region during this period of disagreement with MDHHS. Although the region will take all necessary and appropriate action to maintain the public system, this distraction will not disrupt our delivery medically necessary, therapeutically appropriate services to Medicaid consumers. Furthermore, we remain collectively committed to maintaining and strengthening our public-private partnership as a vehicle to achieve the best possible outcomes to the people we serve. Allegations of "mismanagement" are addressed in other places in this document.
How will SUD payments be handled, if not through LRE? Will Beacon serve as the CMHE? Under the Mental Health Code, Beacon cannot currently serve as the CMHE. We have several options we're looking at for how the SUD benefits will be managed.		The complexities created by MDHHS' proposed solution for LRE are exemplified in the issue of CMHE. Reassigning or alternate management of the CMHE status for LRE would disrupt the following: existing provider relationships, well-functioning SUD management, the SUD Advisory Board, and the relationships of the LRE/CMHE with the 7 counties within the region. The alternate proposal of the LRE CEO, CMH CEOs, and Beacon regarding a shared 3-party contract between the LRE, Beacon, and MDHHS does not disrupt the CMHE status of LRE, the existing functionality of the SUD management and delivery system, or the relationships between the 7 counties and LRE SUD Advisory Board.
THE NEW BOARD		

How will the new board be structured? Who will be on it and how will members be selected? Board membership will include representation from the CMHs, the counties, advocates and individuals receiving services. In the coming weeks, DHHS will engage with stakeholders and legislators, and by July 26, DHHS will put forward our more detailed plan for the composition, selection, and powers of the new board. The Board will be fully established prior to October 1, 2019.		The revised "board" structure MDHHS is proposing is ***advisory*** in nature, reporting to the State, rather than serving as a Public Oversight Board accountable to the communities served, for the operations of the region. It is not locally appointed and does not serve in the capacity of a public governance board. The LRE and member CMHs have proposed making additional changes to its Board structure and membership to address their specific concerns related to governance and accountability. Indeed, the LRE has already modified its Board governance on three occasions refining the accountability, representation and experience of the Board. Each time MDHHS has indicated its approval of these refinements. MDHHS' new concerns could be addressed just as easily while retaining publicly appointed governance and without threatening the foundational public nature of the PIHP in Michigan. For example, this could be a continuation of the current, locally appointed Board with an expansion of two or three additional members, all appointed by the State.
What powers and level of independence will the board have? DHHS will hold the contract with Beacon and will be ultimately accountable for ensuring Beacon's compliance and performance as required by the Mental Health Code. However, DHHS will rely on the board to advise the Department to ensure that Beacon is performing well, with a smooth transition of services, where people are receiving appropriate levels of care, providers are being paid timely, and there is sound fiscal management. DHHS will act quickly on issues identified by the Board. Once appointed, Board members will be subject to removal only for just cause. The Board will be able to make inquiries, request data, ask questions, and publicly report independently of the department.		This proposal eliminates local public governance of the public behavioral health system – one of the foundations of Michigan's nationally recognized behavioral health system for the past 50 years – and replaces it with a state-appointed advisory group. Please see above.
What role will the CMHs, counties, and advocates have in the appointment process?		This proposal eliminates local public governance of the public behavioral health system – one of the foundations of Michigan's nationally recognized behavioral health system for the past 50 years – and replaces it with a state-appointed advisory group.

DHHS will work collaboratively with the counties and stakeholders to select board members. More details about the board structure and appointment process will be released on July 26.		
ADDITIONAL QUESTIONS		
Does this plan require the approval of the local county boards of commission? Or the legislature? Under the Mental Health Code, DHHS holds the contracts with regional entities serving as the Medicaid Specialty service Pre-paid Inpatient Health Plans (PIHP). The Mental Health code permits the department to terminate any PIHP contract for failure to substantively comply with regulatory requirements and therefore does not need county or legislative approval to terminate a contract or initiate a new one. We will be engaging the legislature and the counties throughout this process and look forward to working in partnership to determine the best path forward.		While the state has the authority to terminate contracts, it does not have the right to do so based on claims of failure that do not comport with the facts. LRE has not failed to substantively comply with regulatory requirements. In fact, it is in complying with Medicaid regulatory requirements, in the face of inadequate funding by MDHHS, that has led to the fiscal distress faced by LRE. The LRE will pursue its right to an official hearing. The PIHP serving the region currently served by Lakeshore, must be a regional entity, in compliance with the Michigan Mental Health Code given that the regional entity provides the legal structure for retention of the local county-based public body as the core of the state's statutorily defined public mental health system (http://legislature.mi.gov/doc.aspx?mcl-330-1204b). Additionally, the Regional Entity structure is the structure recognized by CMS, via the 1915(b) and (c) waivers and now the 1115 waiver and 1915i state plan amendment, as the entities that serve as the state's PIHPs. This structure - a local, county-based public body - will be a bedrock component of any newly emerging financing, risk management, service delivery, and governance structure.
Is the DHHS going to absorb the past and current deficits of the LRE? What will happen to those financial obligations? DHHS will continue to work with the legislature to address the state and local share of LRE's deficits.		On July 24, 2019 MDHHS and its actuarial firm, Milliman, proposed the new actuarially sound methodology for FY2020 based on updated FY 2018 data. This model is based on risk variables and was developed in a collaborative manner with the PIHPs and CMHSPs. Preliminary data presented by Milliman suggests that LRE will receive the highest level of increase from FY 2019 to FY 2020 (7.6% if the model is fully implemented) that it has received since its inception. This increase in revenue in conjunction with the collaboration with Beacon Health Options would place Lakeshore Regional Entity in a very strong position. MDHHS contract action against LRE is unnecessary given the more equitable funding formula. There have been offers made and since withdrawn to commit local funds (PA2 as well as resources loaned from foundations and other private organizations) to assist with filling the gap between the obligations and our risk reserve. Our position is that counties have contributed their required local match funds and beyond that it is not appropriate to supplant the State's fiscal

		responsibility to provide the benefits required by a federally funded entitlement program. This is especially true where benefits are unilaterally expanded by the State without a foundation of adequate expense analysis and appropriate rate development.
What is the long-term plan for the region? MDHHS will evaluate the arrangement with Beacon throughout FY20 in order to support and inform decisions about the management of the region in future fiscal years. The state will also immediately begin the formal procurement process to establish management for FY21.		The LRE has already put in place a viable collaboration through its contract with Beacon Health Options. The LRE, CMHs, and Beacon are unified in direction and plan and have built a unique model for consideration in Michigan. MDHHS should allow this unique model to develop according to projection and evaluate impact of the model at established times in the course of the implementation.
How does this decision about LRE affect the section 298 pilot programs happening in the region? Two of the CMHs in the Lakeshore region are participating in the Section 298 pilot program. That program is testing financial integration through the Medicaid Health Plans to see if it improves integration of the systems. In the pilots, the DHHS is contracting directly with the MHPs to manage the physical and behavioral health of their members, and the MHPs in turn contract directly with the CMHs for the specialty behavioral health services (bypassing the PIHPs). Therefore the change in management of the PIHP will have much less effect in those counties after the pilot launches.		The two CMH members that are part of LRE and part of section 298 are HealthWest (HW) and West Michigan Community Mental Health (WMCMH). The action proposed by MDHHS will require significant administrative burden to implement changes for all CMHs in the region. Some specific examples include administrative work will need to occur relative to establishing contracts with Beacon, changing relationships with MDHHS, and shifting administrative functions in whatever way the State's advisory board for the region requires of Beacon and the CMHs. These impacts will be especially difficult for HW and WMCMH as they are simultaneously working, with very limited resources, to alter many key administrative functions to align with the management functions and expectations of the 298 Pilot. It also creates an additional layer of confusion for providers and stakeholders within the system as, within the course of a 15-month period, these functions and mechanisms will potentially change twice.
Is there a systemic funding issue across all of the PIHPs? If so, what is DHHS doing to address it? The supplemental resources requested by the Governor would address a significant portion of current funding issues. Beyond that, the department is working closely with our actuaries and the PIHPs and CMHs to		The fiscal distress that LRE has experienced for the last several years (and those of several other Michigan public managed care plans (PIHPs)) is the result of the systemic underfunding of those PIHPs. As underscored by a recent analysis carried out by the Community Mental Health Association of Michigan, those PIHPs, like LRE, facing the direst fiscal crises, received, over the past four years, either a revenue cut or only a modest increase even when the Healthy Michigan Plan enrollment was growing.

understand the reasons for the recent deficits. We are hopeful that a better understanding of current costs and utilization will allow us to better ensure that funding meets the needs, that all entities are operating efficiently and effectively, and that PIHPs and CMHs are working with providers to improve cost-effectiveness. We are working to identify system improvements to address these issues and look forward to collaborating with stakeholders and the legislature on them in the coming months.		In the case of LRE, if Lakeshore had received the same level of rate increases as those PIHPs not suffering such fiscal distress, LRE's revenues, in FY 2018 would have been $49 million greater than received in FY 2018. This level of revenues would have prevented the fiscal distress faced by LRE. Such appropriate revenue increases would have prevented the fiscal distress experienced by the other PIHPs as well. It is key to recognize that the revenue increases received by the appropriately funded PIHPs are not the problem. The revenue increases to the state's PIHPs, even those that are appropriately funded, in fact were very small, given the dramatic growth in the HMP population over this period. The problem lies in the lack of revenue increases provided to the system as a whole and especially acute for those with the lowest revenue gains over the past four years. MDHHS' proposal does not get to the root cause of the fiscal distress of LRE nor of the other public health plans facing such distress – inadequate funding over a sustained period. Without adequate funding, as required by the Michigan Mental Health Code and Michigan's Medicaid Plan, the Lakeshore Regional Entity system and others who have been underfunded - regardless of the greater involvement of the State in the operation of the local public system - will be unable to pay providers and provide behavioral healthcare services to persons entitled to such services. For the State to propose the termination of its contract with LRE, eliminating the local publicly governed managed care body for the region's public mental health system - as a result the State's underfunding of that regional entity is fiscally, ethically, and politically ironic - an irony not lost on the stakeholders to this system.

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

as of 7/12/19

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

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

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The deadline to register is September 15, 2019. A maximum of sixteen participants are accepted. Sign up now!

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Michigan Department of Health & Human Services

MDHHS

Michigan Department of Health & Human Services

Press Release

FOR IMMEDIATE RELEASE: July 30, 2019

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

State recommends 84-bed facility at Caro, relocation of beds to other state hospitals, increasing community-based resources

LANSING, Mich. – Following a review by an independent consulting firm, the Michigan Department of Health and Human Services (MDHHS) is recommending an 84-bed facility in Caro; reopening units at existing state hospitals; and increasing resources into community-based programs to help serve individuals in need of mental health services.

The MDHHS recommendation would continue funding levels for the current 794 beds statewide. This would include realigning current funding through the following actions:

- Maintain an 84-bed facility at Caro, via either large-scale modernization or new construction. An 84-bed facility will be close to the current census and will reflect the state's approach to hospital unit design, utilization for patients and construction. Staff needed to support the facility, professional and nonprofessional, will remain at current levels.
- Shift the remaining 61 beds to other existing state hospitals closer to major population centers. Existing facilities have closed units that can be brought back into use at a limited cost.
- Pursue additional resources into community-based services sufficient to care for more than 55 additional high-acuity individuals.

"These recommendations will sustain and strengthen the Caro community's historic role in providing psychiatric care," said MDHHS director Robert Gordon. "They will also improve the quality of mental health services at state hospitals, while expanding community-based care. Finally, the recommendations will achieve their results at significantly lower cost than the legislature previously anticipated, allowing for additional investment in other urgent health priorities."

Based on preliminary estimates, the capital costs associated with renovation or a new build at Caro is estimated at $40-$65 million and renovating other existing facilities at under $20 million. No

capital costs would be associated with the community-based investment. Based on these estimates, capital costs of these recommendations will be $30-$55 million less than the $115 million authorized by the legislature.

In 2017, the state legislature authorized financing to construct a new hospital on the Caro site. The new Caro Psychiatric Hospital was scheduled to be completed in 2021 and serve 200 adults, an increase of 50 beds from the existing facility.

Concerns about staffing and accessibility to communities caused state officials to pause the Caro Center Reconstruction project in March 2019 to allow for an outside consultant to review the project and recommend next steps to best meet the needs of Michigan's citizens. Myers & Stauffer was tasked with analyzing the process which led to plans for a new Caro hospital, to engage in fact finding and to support further decision-making. A copy of Myers & Stauffer's final report is available online.

###

Modern Healthcare

July 31, 2019 03:57 PM | UPDATED 16 HOURS AGO

Blue Cross Michigan sued for $40 million for alleged unpaid behavioral health claims

Jay Greene

The lawsuit contends that the Michigan Blues have either underpaid or wrongfully denied claims related to substance abuse and other behavioral health disorders.

Four substance-abuse treatment centers in Michigan owned by U.S. Addiction Services sued Blue Cross Blue Shield of Michigan on Wednesday for more than $40 million in unpaid claims involving more than 4,000 patients, according to a lawsuit filed in U.S. District Court for the Western District of Michigan.

A spokesman for New York-based law firm Napoli Shkolnik PLLC, which is representing the plaintiff, said one of the providers was forced to close and the other

three turned patients away because Blue Cross "refused to provide meaningful coverage for addiction treatment."

Blue Cross said in a written statement: "We are currently reviewing this lawsuit that was just filed today. It appears to be a complaint by four treatment facilities, three of which are not in our network, and are dissatisfied with their reimbursement. BCBSM is confident it followed all appropriate reimbursement methodologies. Blue Cross believes that the best interests of patients are served when insurers, employers and providers of care work together to keep access to quality care affordable.

The insurer added, "Blue Cross is working with community organizations and providers across the state to help address the opioid crisis, including expanding a successful pilot program to treat opioid addiction with two Michigan treatment facilities."

The lawsuit, which is also asking for punitive damages and injunctive relief, contends that the Michigan Blues have either underpaid or wrongfully denied claims related to substance abuse and other behavioral health disorders.

In the face of the opioid epidemic, it is more important than ever that America's health insurers play their part in mitigating the havoc that they facilitated by paying for the prescription opioids that precipitated this public health crisis," Matt Lavin, a partner with Napoli Shkolnik, said in an email to Crain's.

The four centers are Serenity Point Recovery in Marne, which has closed; A Forever Recovery, Battle Creek; Behavioral Rehabilitation Services, Harrison; and Best Drug Rehabilitation, Manistee. U.S. Addiction Services, which also owns two other treatment centers in Ohio and Indiana.

Since June 2016, Blue Cross allegedly cut benefits and denied claims related to substance abuse and other behavioral health issues, the lawsuit said.

Lavin said Blue Cross paid the centers $900 per day for inpatient residential treatment before June 2016, but while the opioid crisis was escalating dropped the per day payment to $150.

"In most cases, the rates paid by (Blue Cross Michigan) for these services are below the actual cost to providers of offering services" and below Medicaid rates, the lawsuit said.

As a result, some of the patients treated at the centers and their families have been presented with surprise bills when they believed that treatment would be covered.

Serenity said in the lawsuit that it has tried to negotiate a settlement but Blue Cross executives rejected the proposal.

"Blue Cross Michigan sued for $40 million for alleged unpaid behavioral health claims" *originally appeared in* ***Crain's Detroit Business****.*

Inline Play

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lovers Lane, Suite 200, Portage, MI 49002
P: 800-676-0423
F: 269-883-6670

Jeff Patton
2030 Portage Rd.
Kalamazoo, MI 49001

July 23rd, 2019

Dear Jeff,

Southwest Michigan Behavioral Health would like to take the opportunity to recognize you and your organization for continued excellence in meeting standards of Michigan's Mission-Based Performance Indicator System (MMBPIS) over the course of this fiscal year. Our reports demonstrate that Kalamazoo Community Mental Health achieved 14 of 14 metrics over the second quarter of fiscal year 2019 for metrics 1, 2, 3, 4(a), and 10.

Meeting these performance standards demonstrates the dedication to providing an optimal system of care for Medicaid beneficiaries of Southwest Michigan, serves as a benchmark for continuous improvement, and may influence internal performance incentives in the future. Please continue striving for excellence in both areas of clinical performance and data reporting for MMBPIS going forward. We look forward to seeing your reported figures for the third quarter. If SWMBH can be of any assistance, please do not hesitate to contact the PIHP Quality Program.

Best regards,

Brad Casemore
Executive Officer
Southwest Michigan Behavioral Health

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lovers Lane, Suite 200, Portage, MI 49002
P: 800-676-0423
F: 269-883-6670

Kathy Sheffield
960 M-60 E
Cassopolis, MI 49031

July 23, 2019

Dear Kathy,

Southwest Michigan Behavioral Health would like to take the opportunity to recognize you and your organization for continued excellence in meeting standards of Michigan's Mission-Based Performance Indicator System (MMBPIS). Our reports demonstrate that Woodlands Behavioral Health had achieved 14 of 14 metrics over the second quarter of fiscal year 2019 for metrics 1, 2, 3, 4(a), and 10.

Meeting these performance standards demonstrates the dedication to providing an optimal system of care for Medicaid beneficiaries of Southwest Michigan, serves as a benchmark for continuous improvement, and may influence internal performance incentives in the future. Please continue striving for excellence in both areas of clinical performance and data reporting for MMBPIS going forward. We look forward to seeing your reported figures for the third quarter. If SWMBH we can be of any assistance, please do not hesitate to contact the PIHP Quality Program.

Best regards,

Brad Casemore
Executive Officer
Southwest Michigan Behavioral Health

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lovers Lane, Suite 200, Portage, MI 49002
P: 800-676-0423
F: 269-883-6670

Richard Thiemkey
500 Barfield Dr.
Hastings, MI 49058

July 22nd, 2019

Dear Richard,

Southwest Michigan Behavioral Health would like to take the opportunity to recognize you and your organization for continued excellence in meeting standards of Michigan's Mission-Based Performance Indicator System (MMBPIS) over the course of this fiscal year. Our reports demonstrate that Barry County Community Mental Health achieved 14 of 14 metrics over the second quarter of fiscal year 2019 for metrics 1, 2, 3, 4(a), and 10.

Meeting these performance standards demonstrates the dedication to providing an optimal system of care for Medicaid beneficiaries of Southwest Michigan, serves as a benchmark for continuous improvement, and may influence internal performance incentives in the future. Please continue striving for excellence in both areas of clinical performance and data reporting for MMBPIS going forward. We look forward to seeing your reported figures for the third quarter. If SWMBH can be of any assistance, please do not hesitate to contact the PIHP Quality Program.

Best regards,

Brad Casemore
Chief Executive Officer
Southwest Michigan Behavioral Health

MICHIGAN HEALTH ENDOWMENT FUND

ACCESS STUDY REVEALS GAPS IN CARE

The Health Fund partnered with Altarum to research access to behavioral healthcare in Michigan, and the resulting study reveals a pressing need for expansion of care.

38% of Michigan residents with a mental illness and 80% with a substance use disorder are not receiving treatment, accounting for hundreds of thousands of people. The final report, released today, describes various barriers to care, including cost, lack of transportation, and public awareness and perceptions about behavioral healthcare. It also makes various suggestions on what can be done to address those barriers.

The Health Fund commissioned and funded the study to better understand the state of access to behavioral healthcare amid rising rates of mental illness and substance use disorder in Michigan and across the country. We have various resources related to the study available on our website, including:

- The full study
- A blog post summarizing the data
- A toolkit for sharing on social media
- A landing page with links to briefs and one pagers

Please take a few minutes to read the findings and share with your networks.

Delegated Utilization Management Oversight Report

Provider Organization Name: Southwest Michigan Behavioral Health							**Date of Delegation Committee:** 07/01/2019	
Review Date:	05/16/2019	**Current Delegation Level**			☒ **Delegated**		☐ **Non-Delegated**	
Aetna Auditor	Rachel Godwin/ Loretta Coffman	**Type of Entity - PIHP**			☐ **IPA/PO**		☐ **MSO**	☒ **Other**
Delegate Representative	Jonathan Gardner	**Type of Audit**	☐ Pre-K	☒ Annual	☐ Re-audit	☐ Shared Audit	☐ Validation Audit*	☐ CAP F/U
Markets	Aetna Better Health Premier Plan of Michigan	**NCQA - UM- Certification/HP – Accreditation- Medicare MBHO Accreditation**					Effective: 03/02/2018	Expiration: 03/02/2021
Does the Provider Organization have sub-delegates? ☐ Yes ☒ No		**List of all the sub-delegates:**						

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

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

AETNA OPERATIONAL AUDIT

Auditor: Cynthia Arzich will conduct an on site visit later in 2019

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

Audit Deficiencies:

UTILIZATION MANAGEMENT AUDIT

Auditor: Rachel Godwin

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
1. UM 1 UTILIZATION MANAGEMENT STRUCTURE	Full
2. UM 2 CLINICAL CRITERIA FOR UM DECISIONS	Full
3. UM 3 COMMUNICATION SERVICES	Full
4. UM 4 APPROPRIATE PROFESSIONALS	Full
5. UM 5 TIMELINESS OF UM DECISIONS	Full
6. UM 6 CLINICAL INFORMATION	Full
7. UM 7 DENIAL NOTICES	Full
8. UM 11 SATISFACTION WITH UM PROCESS	Full
9. UM 12 EMERGENCY SERVICES	Full
10. UM15 SUBDELEGATION OVERSIGHT	NA
Total Percentage of Compliance = 100%	**Total Level of Compliance:** Full
CMS Criteria	**CMS Results [Met/Not Met or NA]**

Requests for Expedited Organizational Determinations	Met
Adverse Pre-Service Organizational Determinations	Met
Sub-Delegation (Agreement)	NA

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

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

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

Comment: SWMBH received NCQA Accreditation in March 2018. No file review necessary

Audit deficiciencies: None

CASE MANAGEMENT AUDIT

Auditor: Rachel Godwin

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

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

Comment: SWMBH received NCQA Accreditation in March 2018. No file review necessary.

Audit Deficiencies: None

CREDENTIALING AUDIT

Auditor: Loretta Coffman

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

Comment: SWMBH received NCQA Accreditation in March 2018. No file review necessary

Audit Deficiencies: None

GRIEVANCE AND APPEALS AUDIT

Auditor: Rachel Godwin

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
UM 8: Policies for Appeals	Full
UM 9: Appropriate Handling of Appeals	Full
RR 2: Policies and Procedures for Complaints and Appeals	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full
CMS Criteria	
1. Meet timeframes for Appeals and Grievance as it applies to Members	NA – no member appeals
2. Meet timeframes for Appeals and Grievance as it applies to Providers	NA – no provider appeals
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Comment: SWMBH received NCQA Accreditation in March 2018. No file review necessary, there were no member appeals or grievances in 2018.

Audit Deficiencies: None

Recommended Delegated Functions

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

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

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

Report Submitted by: Rachel Godwin Date: 07/01/2019

Committee Summary