Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
September 11, 2020
9:30 am to 11:00 am
Draft: 9/3/20

1. **Welcome Guests/Public Comment**
2. **Agenda Review and Adoption (d)**
3. **Financial Interest Disclosure Handling (M. Todd)**
4. **Consent Agenda**
   - August 14, 2020 SWMBH Board Meeting Minutes (d) p. 3
5. **Operations Committee**
   - Operations Committee Minutes July 22, 2020 (d) p. 7
6. **Ends Metrics Updates * Motion Required**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

   a. * Health Services Advisory Group – Performance Measure Validation (J. Gardner) (d) p. 10
   b. * Health Services Advisory Group – Performance Improvement Project (M. Kean) (d) p. 35
7. **Board Actions to be Considered**
   - None scheduled
8. **Board Policy Review**
   Is the Board in Compliance? Does the Policy Need Revision?

   a. BG-008 Board Member Job Description (d) p. 49
   b. EO-001 Executive Role & Job Description (d) p. 51
9. **Executive Limitations Review**
   Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?
   - BEL-009 Global Executive Constraints (E. Meny) (d) p. 52

10. Board Education

a. Fiscal Year 2020 Year to Date Financial Statements (T. Dawson) (d) p. 54
b. Fiscal Year 2021 Budget Preview (T. Dawson) (d) p. 62
c. Compliance Role and Function (M. Todd) (d) p. 70

11. Communication and Counsel to the Board

a. Asset Protection: Michigan Municipal Risk Management Authority (MMRMA) Insurance Renewal (T. Dawson) (d) p. 111
b. Consensus Revenue Estimating Conference (CREC) (B. Casemore) (d) p. 119
c. Strategic Business Plan Meeting Schedule (B. Casemore) (d) p. 120
d. October 9, 2020 Board Agenda (d) p. 121
e. Board Member Attendance Roster (d) 123
f. October Board Policies: BEL-008 Communication and Counsel (T. Schmelzer)
g. November Board: EO-002 Monitoring of Executive Officer Performance (Board Executive Committee)

12. Public Comment

13. Adjournment

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

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

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

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

and

SWMBH Board Planning Retreat
October 9, 2020
11:15 am – 1:15 pm

Southwest Michigan
BEHAVIORAL HEALTH

Draft Board Meeting Minutes
August 14, 2020
9:30 am-11:00 am
GoTo Webinar and Conference Call
Draft: 8/18/20

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

Guests Present via phone: Bradley Casemore, Executive Officer, SWMBH; Mila Todd, Chief Compliance and Privacy Officer, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance Performance and Improvement, SWMBH; Sarah Ameter, Customer Service Manager, SWMBH; Joel Smith, Substance Use Treatment & Prevention Director, SWMBH; Deb Hess, Van Buren CMH; Sue Germann, Pines Behavioral Health; Roger Pierce, Riverwood; Richard Thiemkey, Barry County CMH; Jon Houtz, Pines BH Alternate; Mary Middleton, Woodlands Board Alternate; Mary Ann Bush, Project Coordinator/Senior Operations Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH, Brad Sysol, Summit Pointe; Jeannie Goodrich, Summit Pointe; Jeff Patton, ISK; Randall Hazelbaker, Branch County

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

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to accept the agenda as presented.	
Second	Tom Schmelzer	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Financial Interest Disclosure Handling
None

Consent Agenda

Motion	Erik Krogh moved to approve the July 10, 2020 Board meeting minutes as presented.

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

Motion Carried

Operations Committee

Operations Committee Minutes June 24, 2020

Edward Meny noted the minutes as documented. Minutes accepted.

Ends Metrics

Nothing scheduled

Board Actions to be Considered

Auditor Selection

Tracy Dawson reported as documented. Discussion followed.

Motion	Tom Schmelzer moved to accept Roslund, Prestage and Company to be SWMBH's financial and compliance auditors for fiscal year 2021, 2022 and 2023, with 1-year options for up to three years.	
Second	Patrick Garrett	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes
	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Board Policy Review

BG-002 Management Delegation

Edward Meny reviewed the policy as documented.

Motion	Susan Barnes moved that the Board is in compliance and the Policy BG-002 Management Delegation does not need revision.	
Second	Patrick Garrett	
Roll call vote	Edward Meny	yes
	Tom Schmelzer	yes
	Pat Garrett	yes
	Michael McShane	yes

	Erik Krogh	yes
	Janet Bermingham	yes
	Susan Barnes	yes

Motion Carried

Executive Limitations Review

BEL-005 Treatment of Plan Members

Michael McShane reviewed policy as documented and noted various documents that he reviewed. Discussion followed.

Motion Mike McShane moved that the Executive Officer is in compliance, noting that with respect to interactions with Plan members, the Executive Officer does not allow conditions, procedures, or processes which are unsafe, disrespectful, undignified, unnecessarily intrusive, or which fail to provide appropriate confidentiality and privacy and Policy BEL-005 Treatment of Plan Members does not need revision.

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

Motion Carried

Board Education

Fiscal Year 2021 Budget Preview

Tracy Dawson reported as documented. Brad Casemore reviewed Milliman rate setting executive summary. Discussion followed.

Fiscal Year 2020 Year to Date Financial Statements

Tracy Dawson reported as documented.

Substance Use Disorder Oversight Policy Board (SUDOPB) Update

Randall Hazelbaker, SUDOPB Chair, reported as documented. Discussion followed.

September 11, 2020 SWMBH Board Budget Public Hearing Update

Brad Casemore reviewed SWMBH history of public hearing meetings and noted that upon reviewing mcl Act 43 SWMBH does not meet the requirement of a mandated public budget hearing. Brad Casemore reminded group that all board meetings are open to the public under the Open Meetings Act. Discussion followed.

Updated Strategic Business Plan

Brad Casemore and Mary Ann Bush reported as documented noting that the Strategic Business Plan is a working document with discussion and revisions forthcoming. Board planning sessions are being scheduled for October and November of 2020 and January of 2021. The planning sessions will be two hours in length and take place following the regularly scheduled Board meetings.

Racial/Ethnic Health Disparities Report
Moira Kean reported as documented.

Provider Network Stability
Mila Todd reported as documented noting processing of applications and use of funds.

Communication and Counsel to the Board

MDHHS Behavioral Health Strategic Planning Pillars
Brad Casemore noted the document is in the meeting materials for the Board's review.

September 11, 2020 Board Agenda
Brad Casemore noted the document is in the meeting materials for the Board's review.

Board Member Attendance Roster
Brad Casemore noted the document is in the meeting materials for the Board's review.

Adjournment

Motion Erik Krogh moved to adjourn at 11:15am
Second Michael McShane
Unanimous Voice Vote
Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: July 22, 2020 9:00am-11:00am

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

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Moira Kean, Director of Clinical Quality, SWMBH; Sarah Ameter, Customer Services Manager, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Brad Sysol, Summit Pointe, Jane Konyndyk, Integrated Services of Kalamazoo; Pat Davis, Integrated Services of Kalamazoo; Gale Hackworth, Consultant; Jarrett Cupp, St. Joseph CMH

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

Review and approve agenda – Agenda approved.

Review and approve minutes from 6/24/20 Operations Committee Meeting – Minutes were approved by the Committee.

Fiscal Year 2020 Year to Date Financials – Tracy Dawson noted that, due to lack of one CMH submission, financials are not completed. Tracy Dawson will email the group as soon as they are ready.

Fiscal Year 2020 Encounter Volumes – Tracy Dawson reported as documented and reminded group that these reports are available to each CMSHP on Tableau.

Medicaid Utilization Net Cost (MUNC)/Encounter Quality Improvement (EQI) – Tracy Dawson shared that EQI is gone for the moment due to issues at the State level.

Fiscal Year 2021 Budget Assumptions – Tracy Dawson reported no changes as SWMBH waits for real information from the State.

Cost Allocation and Rate Development Workgroup – Pat Davis stated the next scheduled meeting is in August. Discussion followed. Nothing new to report on the Rate Development Workgroup which is scheduled to meet on 7/23/20.

Behavioral Health Fee Schedule – Pat Davis reviewed proposed code and modifier changes. Discussion followed.

MCG Status – Moira Kean reviewed MDHHS parity plan history regarding inpatient authorizations, and medically necessary criteria. Gale Hackworth reported as documented noting software options that were reviewed/considered and status of implementation, both regionally and statewide.

Provider Stability Plan – Mila Todd reported as documented noting the plan was submitted and approved by MDHHS. SWMBH must submit monthly reports and ask each CHMSP to submit their provider stability efforts to her for compiling one report for MDHHS.

Michigan Health Information Network (MiHIN) COVID Lab Results – Natalie Spivak reported as documented.

Appendix K – Mila Todd reported as documented.

MI Health Link and 99441 – Ric Compton reviewed email as presented. Anne Wickham stated that 99441, 99442, and 99443 series of codes are not interchangeable with ENM codes as one series of codes are time and the other series of codes are encounters. Brad Casemore and Anne Wickham to research and discuss at next Operations Committee meeting. Discussion followed.

Behavioral Health and Developmental Disabilities Administration (BHDDA) Encounter Data Integrity Team (EDIT) Charter – Brad Casemore stated that an 8/19/20 meeting is scheduled with BHDDA to discuss the EDIT Charter and welcomes any CMHSP input.

Psychiatric Collaboration Care Model – Brad Casemore reported as documented.

Direct Care Wage (DCW) – Mila Todd stated Regional Finance and Regional Provider Network Management Committees worked to implement the DCW increase across the Region. Some challenges resulting from conflicting direction from MDHHS related to data reporting. SWMBH sent an email this week instructing CMHs to move ahead and add the increase to downstream provider rates for inclusion in the encounters.

Michigan Crisis and Access Line (MiCAL) – Brad Casemore reported as documented.

MDHHS Behavioral Health Strategic Planning Pillars – Brad Casemore reported as documented noting that PIHPs are meeting with MDHHS to provide input into proposed pillars.

Intergovernmental Contract – Brad Casemore stated that the current Intergovernmental Contract relating to PA2 funding expires on 12/31/20. A three-year contract renewal was sent to all eight counties on July 15, 2020.

Fiscal Year 2020-2021 PIHP MDHHS and PIHP/CMH Contract Development – Mila Todd stated nothing new for the Fiscal Year 2021 contract has been received. SMWBH is reviewing Fiscal Year 2020 amendment 4 contract language. SWMBH is meeting individually with each CMHSP on contracts for Fiscal Year 2021.

Managed Care Functional Review (MCFR) Provider Network Management (PNM) – Mila Todd stated that implementation of Phase 1 is complete with Phase 2 in development and scheduled to begin soon.

Level of Care Utilization Systems (LOCUS) Score Report – Natalie Spivak stated that there is no update yet and the Regional CIO group is meeting on 7/24/20 to discuss.

Beneficiary Needs Plans – Sarah Ameter discussed development of plans that would enhance the use of person-centered planning, independent facilitation, self-determination, recipient rights and appeals for customers. A regional committee is being formed to begin plan development. A summary will be sent out to the Operations Committee soon.

Opioid Health Homes (OHH) Update – Brad Casemore stated that the OHH is beginning in Kalamazoo and Calhoun counties October 1, 2020. Online OHH trainings are scheduled in August. Brad Casemore asked each CMHSP to consider implementing OHH in their county.

SWMBH Board Updates – Brad Casemore stated that the SWMBH Board voted to move their planning session from August to October. The Budget Public Hearing remains scheduled in September.

Public Policy Legislative Event – Brad Casemore stated that the Legislative Event has been rescheduled for October 16, 2020.

SWMBH/Meridian Meeting on Integrated Care – Brad Casemore stated that SWMBH and Meridian are meeting in August to discuss possible increased integration efforts.

Fiscal Year 2020-2023 Strategic Business Plan draft – Brad Casemore asked the CMHSP CEOs to review the draft document and provide him feedback for discussion and revisions. This is an evolving document which has been introduced to the SWMBH Board and will serve as primary discussion content for the October Board Planning Session. Discussion followed.

Adjourned – Meeting adjourned at 11:18 am

Board Ends Metric Updates – September 11, 2020

2020 Health Service Advisory Group (HSAG) Performance Measure Validation Audit Results

2020 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/20 - 6/30/20) Board Report Date: September 11, 2020 **Measurement:** Number of Critical Measures that achieved "Met" **(47)** Total number of Critical Measures Evaluated **(47)**	**Metric Achieved** 47/47 Standards Evaluated received a designation of; Met, Accepted or Reportable, which is 100% compliance.

Overall Results:

Scoring Category	Performance Results
Accepted	3/3 – 100% Data Integration, Data Control and Performance Indicator Documentation Elements Evaluated were ***"Accepted"*** and met full compliance standards.
Reportable	10/10 – 100% of Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications and the percentage reported.
Met	13/13 – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	10/10 – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance standards.
Met ***(new standard)***	11/11 – 100% New Indicator Readiness Review Findings **"Met"** full compliance standards. (*The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate)*

47/47 or 100% Of Total Elements Evaluated received a designation score of "Met", "Reportable", or "Accepted".

This meets *successful completion of our 2020 Board Ends Metric*, which indicates:
95% of Elements Evaluated/Measured, shall receive a score of "Met".

Proposed Board Motion for Metric Approval:

The data presented is Relevant and Compelling, the Executive Officer is in Compliance and the Ends needs no further Revision.

Michigan Department of Health and Human Services

State Fiscal Year 2020 Validation of Performance Measures for Region 4—Southwest Michigan Behavioral Health

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

August 26, 2020

Summary Report

Validation Overview

The Michigan Department of Health and Human Services (MDHHS) oversees and administers the Medicaid program in the State of Michigan. In 2013, MDHHS selected 10 behavioral health managed care organizations (MCOs) to serve as prepaid inpatient health plans (PIHPs). The PIHPs are responsible for managing Medicaid beneficiaries' behavioral healthcare, including authorization of services and monitoring of health outcomes and standards of care. The PIHPs serve members directly or through contracts with providers and community mental health services programs (CMHSPs).

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with PIHPs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of the mandatory external quality review (EQR) activities that Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with managed care organizations to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by PIHPs and to determine the extent to which performance measures reported by the PIHPs follow state and federal specifications and reporting requirements. According to CMS' *External Quality Review (EQR) Protocols, October 2019*,[1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a PIHP, or an external quality review organization (EQRO).

To meet the PMV requirements, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), the EQRO for MDHHS, to conduct the PMV for each PIHP. HSAG validated the PIHPs' data collection and reporting processes used to calculate performance indicator rates. MDHHS developed a set of performance indicators that the PIHPs were required to calculate and report.

[1] The Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 17, 2020.

Performance Indicators Validated

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 1 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of state fiscal year (SFY) 2020, which began October 1, 2019, and ended December 31, 2019. Table 2 lists the performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook. Since data were not available for three performance indicators (i.e., #2a, #2b, and #3) for SFY 2020, HSAG conducted a readiness review of information systems and processes used for data collection and reporting that will be used to calculate future performance indicator rates.

Table 1—List of Performance Indicators Calculated by PIHPs

Indicator		Sub-Populations	Measurement Period
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	1st Quarter SFY 2020
#2a*	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Not Applicable
#3*	The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing the non-emergent biopsychosocial assessment.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Not Applicable
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults	1st Quarter SFY 2020
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers	1st Quarter SFY 2020
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI & I/DD–Adults • MI & I/DD–Children	1st Quarter SFY 2020

MI = Mental Illness, I/DD = Intellectual and Developmental Disabilities, SUD = Substance Use Disorder

*New indicators for SFY 2020

Table 2—List of Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#2b*	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with substance use disorders.	• Medicaid–SUD	Not Applicable
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2020
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	• HSW Enrollees	1st Quarter SFY 2020
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2019
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2019
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• I/DD–Adults	SFY 2019
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	• MI–Adults	SFY 2019

*New indicators for SFY 2020

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. HSAG obtained a list of the indicators selected by MDHHS for validation. Indicator definitions and reporting templates were provided by MDHHS to HSAG.

In collaboration with MDHHS, HSAG prepared a documentation request letter that was submitted to the PIHPs. This documentation request letter outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance indicator calculated by the PIHP, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timeline for completion, and instructions for submission. HSAG also requested that each PIHP and related CMHSPs submit member-level detail files for review.

Following the PIHPs' receipt of the documentation request letter and accompanying documents, HSAG convened a technical assistance webinar with the PIHPs and CMHSPs. During this meeting, HSAG discussed the PMV purpose and objectives, reviewed the performance measures in the scope of the current year's PMV activities, and reviewed the documents provided to the PIHPs with the documentation request letter and PMV activities. Throughout the pre-Webex review phase, HSAG also responded to any audit-related questions received directly from the PIHPs.

Upon submission of the requested source code, completed ISCAT, additional supporting documentation, and member-level detail files, HSAG began a desk review of the submitted documents to determine any follow-up questions, potential concerns related to information systems capabilities or measure calculations, and recommendations for improvement based on the PIHPs' and CMHSPs' current processes. HSAG also selected a sample of cases from the member-level detail files and provided the selections to the PIHPs. The PIHPs and/or CMHSPs were required to provide HSAG screen shots from the source system to confirm data accuracy. HSAG communicated any follow-up questions or required clarification to the PIHP during this process.

HSAG prepared an agenda describing all PMV activities and indicating the type of staff (by job function and title) required for each session. This included special requests for system reviews for PIHPs and related CMHSPs, especially when multiple systems were used to collect and track measure-related data. The agendas were sent to the respective PIHPs prior to conducting the PMV via Webex.

Validation Team

HSAG's validation team was composed of a lead auditor and several validation team members. HSAG assembled the team based on the skills required for the validation of the PIHPs' performance indicators. Table 3 describes each team member's role and expertise.

Table 3—Validation Team

Name and Role	Skills and Expertise
Christopher Tax, MBA *Associate Director, Audits Operations, Data Science & Advanced Analytics (DSAA); Lead Auditor*	Multiple years of experience conducting financial audits and EQR with a focus on process efficiencies and integrity of documentation.
Elisabeth Hunt *Executive Director, DSAA Management; Secondary Auditor*	Multiple years of experience conducting audits, including readiness reviews; medical and pharmacy claims systems reviews; and data validation, analyses, and reporting.
Dan Moore, MPA *Source Code Reviewer*	Statistics, analysis, and source code/programming language knowledge.
Jacilyn Daniel, BS *Healthcare Quality Manager, DSAA; PIHP PMV Project Manager*	Multiple years of experience conducting audits related to performance measurement; electronic health records (EHR); medical billing; data integration and validation; and care management.
Matt Kelly, MBA *Healthcare Quality Manager, DSAA; Source Code Liaison*	Multiple years of systems analysis, quality improvement, data review and analysis, and healthcare industry experience.

Technical Methods of Data Collection and Analysis

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **Information Systems Capabilities Assessment Tool (ISCAT) and Mini-ISCAT**—The PIHPs and CMHSPs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) and Mini-ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs and CMHSPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs/CMHSPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHP performance indicator reports provided by MDHHS for the first quarter of SFY 2020. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

PMV Activities

HSAG conducted PMV via Webex with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The Webex activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the

session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.

- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s) and Mini-ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and Webex review, these data were also reviewed for verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the Webex and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the Webex meeting and reviewed the documentation requirements for any post-Webex activities.

HSAG conducted several interviews with key **Southwest Michigan Behavioral Health** staff members who were involved with any aspect of performance indicator reporting. Table 4 displays a list of **Southwest Michigan Behavioral Health** Webex review participants:

Table 4—List of Southwest Michigan Behavioral Health Webex Review Participants

Name	Title
Brad Casemore	Executive Officer
Anne Wickham	Operations Officer
Mila Todd	Chief Compliance Officer
Natalie Spivak	Chief Information Officer (CIO)
Jonathan Gardner	Director of Quality Assurance and Performance Improvement
Randy Paruch	Information Technology Project Manager
John Holland	Senior Systems Architect
Alona Wood	Quality Specialist
Andy Aardema	Applications and Systems Analyst
Ed Sova	CIO, Integrated Services of Kalamazoo (Kalamazoo)
Jason Villalta	CIO, Summit Pointe
Kyleen Gray	Quality Consultant, Summit Pointe
Mandi Quigley	Corporate Compliance Director, Summit Pointe
Peter Murphy	Business Intelligence and Systems Administration/Safety Officer, Berrien

Data Integration, Data Control, and Performance Indicator Documentation

Several aspects involved in the calculation of performance indicators are crucial to the validation process. These include data integration, data control, and documentation of performance indicator calculations. Each of the following sections describes the validation processes used and the validation findings. For more detailed information, please see Appendix A.

Data Integration

Accurate data integration is essential to calculating valid performance indicators. The steps used to combine various data sources, including claims/encounter data, eligibility data, and other administrative data, must be carefully controlled and validated. HSAG validated the data integration process used by the PIHP, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Although not related to the Q1 SFY 2020 reporting, HSAG has noted that **Southwest Michigan Behavioral Health** should ensure its source code is updated to include members with autism in performance indicator reporting for reporting periods starting April 1, 2020. Overall, HSAG determined that the data integration processes in place at **Southwest Michigan Behavioral Health** were:

☒ Acceptable
☐ Not acceptable

Data Control

The organizational infrastructure of a PIHP must support all necessary information systems. Each PIHP's quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. HSAG reviewed the data control processes used by **Southwest Michigan Behavioral Health**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, HSAG determined that the data control processes in place at **Southwest Michigan Behavioral Health** were:

☒ Acceptable
☐ Not acceptable

Performance Indicator Documentation

Sufficient and complete documentation is necessary to support validation activities. While interviews and system demonstrations can provide supplementary information, HSAG based most of the validation review findings on documentation provided by the PIHP. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance indicator calculations, and other related documentation. Overall, HSAG determined that the documentation of performance indicator calculations by **Southwest Michigan Behavioral Health** was:

☒ Acceptable

☐ Not acceptable

Validation/Readiness Review Results

HSAG evaluated **Southwest Michigan Behavioral Health**'s data systems for the processing of each type of data used for reporting the MDHHS performance indicators. General findings, strengths, and areas for improvement for **Southwest Michigan Behavioral Health** are indicated below.

Eligibility and Enrollment Data System Findings

HSAG had no concerns with how **Southwest Michigan Behavioral Health** received and processed eligibility data.

No major eligibility and enrollment system or process changes were noted for the measurement period. **Southwest Michigan Behavioral Health** received monthly eligibility full files and daily change files in an 834 file format via the State's secure file transfer protocol (FTP) site. Each file is packaged as an X12 file prior to the validation process to ensure that only accurate data were loaded into the PIHP's electronic medical record (EMR) system, Streamline's SmartCare EHR™ system.

Using an automated process, eligibility data were separated according to each CMHSP and moved into the corresponding data warehouse. Each CMHSP uploaded its enrollment data to its respective EMR system. For the measurement period under review, Barry County CMH was the only CMHSP to transition EMR vendors this year. Barry County moved from Streamline's SmartCare to Peter Chang Enterprises, Inc. (PCE). The PIHP identified no issues for the transition with the historical data being mapped correctly. It was noted that Barry County CMH was the fourth CMHSP to transition to PCE in the last few years.

The 834 eligibility files were matched against the 820 payment files by the PIHP. This process helped to ensure that each member for whom a payment was received had current, matching eligibility data. The CMHSPs used the 270/271 eligibility verification process. Providers, staff members, and PIHP affiliates performed real-time eligibility verification through the State's website. Adequate validation processes were in place to ensure data completeness and accuracy.

During the Webex review, **Southwest Michigan Behavioral Health** demonstrated the Streamline SmartCare system, from which the auditor identified that the capture of eligibility effective dates, termination dates, and historical eligibility spans, as well as identification of dual (Medicare-Medicaid) members, was appropriate.

Additionally, since the same processes were used for all performance indicators, HSAG had no concerns with how **Southwest Michigan Behavioral Health** received and processed eligibility and enrollment data as it relates to readiness for reporting the new indicators.

Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production

At the member's initial screening and during yearly updates, **Southwest Michigan Behavioral Health**'s affiliate CMHSPs manually entered the BH-TEDS data into their separate EMR systems, then into **Southwest Michigan Behavioral Health**'s SmartCare EHR; documented the responses on a paper version of the BH-TEDS record, then entered the information in SmartCare EHR; or the CMHSP entered the data directly into the PIHP's EMR. This year, Kalamazoo demonstrated a new registration document interface within the CMHSP system that will help pass more details onto BH-TEDS without additional entry. This should be a process improvement and limit the potential for some errors.

BH-TEDS data files were submitted to the State daily. After submission, the State provided a 5874D BH-TEDS response file containing explanations for any file rejections that occurred. To support quality control improvements, each CMHSP accessed the PIHP's data warehouse and obtained its corresponding response files.

For BH-TEDS data completeness, the PIHP implemented approximately 1,300 edits and checks of all BH-TEDS records prior to submission to MDHHS. In addition, the PIHP has implemented and developed various dashboards and reports using Tableau Data Analytics to allow their CMHSP partners and themselves check the completed rates and error rates on a continuous basis. Verification processes were already in place to meet the State's data accuracy requirements prior to submission to the State. Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes during the Webex review (i.e., Berrien Mental Health Authority [DBA Riverwood], Summit Pointe [CMHSP for Calhoun County], and Kalamazoo), no concerns were identified with the CMHSPs' adherence to the state-specified submission requirements. It was noted during the audit that all three CMHSPs were either performing over-read of the BH-TEDS entry via a monthly or quarterly summary report of errors that entails sampling or spot checking for deficiencies. Errors would be corrected manually if needed. All audited CMHSPs also indicated at least yearly training of employees on the BH-TEDS system to ensure education was provide on updates to the system. Error reports were monitored to enact additional training on a division level if tendencies were becoming noticeable.

After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted that two individual records contained data discrepancies related to member employment and income. In alignment with the prior recommendation, HSAG recommends **Southwest Michigan Behavioral Health** and the CMHSPs employ enhancements to the recently implemented validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered. This validation process should account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system, data entry errors, and discrepancies in wage and income values. HSAG also recommends that the PIHP and the CMHSPs clearly define the processes for entering the data into the PIHP's EMR and perform additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State.

PIHP Oversight of Affiliate Community Mental Health Centers

HSAG found that **Southwest Michigan Behavioral Health** had sufficient oversight of its eight affiliated CMHSPs.

Through consistent communications and committee meetings with representatives from the PIHP, each CMHSP, in conjunction with Streamline and PCE, facilitated the resolution of any issues and provided opportunities to collaborate on solutions regarding encounter, BH-TEDS data, or performance indicator reporting requirements. In addition, the PIHP performed a full evaluation of each CMHSP, which included Webex review and supporting document reviews for compliance with data capture and reporting requirements. The PIHP continued to use its site review tool to assist in monitoring each CMHSP's data completeness and accuracy as well as submission timeliness. The PIHP continued to use Tableau, the data visual analytics program, to track data submission volumes, timeliness, and accuracy. The PIHP's corrective action plan (CAP) system was noted as being extensive and delineated to addresses severity and continuous issues to correct indicator related concerns and other reportable documentation provided to MDHHS.

As it relates to Indicator #1, Kalamazoo has acknowledged errors by the employee conducting the preadmission screening as it relates to accurately recording a disposition date within the EMR system. Upon identification of this data integrity risk in the existing process, **Southwest Michigan Behavioral Health** immediately requested a CAP of Kalamazoo. To remediate this process risk, Kalamazoo has indicated that it will be adding signature validations to disallow blank times in the preadmission screening field as a CAP. After reviewing the member-level detail file provided by the PIHP, HSAG found four out of 338 cases that would be affected by this oversight, which accounts for a little over 1 percent of Kalamazoo's Q1 SFY 2020 records reported for this indicator. HSAG recommends that **Southwest Michigan Behavioral Health** monitor and verify the Kalamazoo CAP to ensure completeness of the information being captured for future reporting.

PIHP Actions Related to Previous Recommendations and Areas of Improvement

Based on the prior year's validation of performance measures, HSAG recommended that **Southwest Michigan Behavioral Health** monitor and verify the Kalamazoo CAP to ensure completeness of the information being captured for future reporting. In addition, HSAG recommends continuing to employ an over-read or validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered to account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system or if any data were keyed incorrectly.

Southwest Michigan Behavioral Health and the CMHSPs should pay particular attention to the BH-TEDS employment wage data entry process to avoid conflicting values in performance indicator data as calculated by MDHHS. Finally, HSAG also recommends that the PIHP and the CMHSPs clearly define the processes for entering the data into the PIHP's EMR and perform additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies two possible validation finding designations for performance indicators, which are defined in Table 5. For more detailed information, please see Appendix B.

Table 5—Designation Categories for Performance Indicators

Reportable (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Do Not Report (DNR)	This designation is assigned to indicators for which the PIHP rate was materially biased and should not be reported.

According to the protocol, the validation designation for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of DNR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., *Met*, *Not Met*, and *Not Applicable [NA]*) can be found in Appendix A—Data Integration and Control Findings, Appendix B—Denominator and Numerator Validation Findings, and Appendix C—Readiness Review Findings. Table 6 displays the indicator-specific review findings and designations for **Southwest Michigan Behavioral Health**.

Table 6—Indicator-Specific Review Findings and Designations for Southwest Michigan Behavioral Health

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#2a	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	The PIHP/CMHSPs demonstrated sufficient evidence of readiness to report and calculate this indicator in compliance with MDHHS Codebook specifications.	NA

Performance Indicator		Key Review Findings	Indicator Designation
#2b	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with substance use disorders.	The PIHP/CMHSPs demonstrated sufficient evidence of readiness to report and calculate this indicator in compliance with MDHHS Codebook specifications.	NA
#3	The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing the non-emergent biopsychosocial assessment.	The PIHP/CMHSPs demonstrated sufficient evidence of readiness to report and calculate this indicator in compliance with MDHHS Codebook specifications.	NA
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#6	The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

Performance Indicator		Key Review Findings	Indicator Designation
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

To further improve upon the accuracy and completeness of its performance indicator data, HSAG recommends **Southwest Michigan Behavioral Health** and the CMHSPs employ enhancements to the recently implemented validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered. This validation process should account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system, data entry errors, and discrepancies in wage and income values. HSAG also recommends that the PIHP and the CMHSPs clearly define the processes for entering the data into the PIHP's EMR and perform additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State.

Additionally, since the same BH-TEDS data entry and validation processes were used for all performance indicators, HSAG recommends **Southwest Michigan Behavioral Health** ensure accuracy of the BH-TEDS data to further support its readiness to report the new indicators.

Due to the identified errors for Indicator #1 that resulted in a CAP for Kalamazoo, HSAG recommends that **Southwest Michigan Behavioral Health** monitor and verify the Kalamazoo CAP to ensure completeness of the information being captured for future reporting.

HSAG recommends **Southwest Michigan Behavioral Health** retain the exact member-level detail data that was used for the final performance indicator rate calculation and reporting to MDHHS. These data

should be stored in a readily retrievable viewable file and only include **Southwest Michigan Behavioral Health**'s PIHP Medicaid beneficiaries. These retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid beneficiaries, exactly as reported to MDHHS in support of the performance indicators.

While MDHHS calculated the applicable performance indicators in compliance with MDHHS Codebook specifications, the raw data did not directly match the final performance indicator rates. HSAG therefore recommends MDHHS review the MDHHS Codebook for opportunities to clarify performance indicator specifications to ensure the PIHPs and MDHHS are able to align primary data sources' documentation directly to the final performance indicator rates as reported to MDHHS and calculated by the PIHPs, CMHSPs, and MDHHS. HSAG recommends MDHHS focus on adding additional details to define denominators, numerators, exclusions, and omissions for each performance indicator. MDHHS should further consider deploying additional validation steps in reviewing data.

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Southwest Michigan Behavioral Health
PMV Date:	June 15, 2020
Reviewers:	Christopher Tax and Elisabeth Hunt

Data Integration and Control Element	Met	Not Met	NA	Comments
Accuracy of data transfers to assigned performance indicator data repository				
The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance indicator data repository used to keep the data until the calculations of the performance indicators have been completed and validated.	☒	☐	☐	It has been noted that Integrated Services of Kalamazoo will implement a CAP to ensure completeness of data going forward.
Samples of data from performance indicator data repository are complete and accurate.	☒	☐	☐	It has been noted that Integrated Services of Kalamazoo will implement a CAP to ensure completeness and accuracy of Indicator #1 data going forward.
Accuracy of file consolidations, extracts, and derivations				
The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate.	☒	☐	☐	It was noted during the proof of service validation with the CMHSPs that exceptions and the compliant/non-compliant fields were missing or inaccurately manually entered within the member-level detail file provided to HSAG. The PIHP confirmed the accurate data were used for submission of performance indicator data to MDHHS.
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	☒	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	NA	Comments
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer.	☒	☐	☐	
If the PIHP uses a performance indicator data repository, its structure and format facilitates any required programming necessary to calculate and report required performance indicators.				
The performance indicator data repository's design, program flow charts, and source code enables analyses and reports.	☒	☐	☐	Although not related to the Q1 SFY 2020 reporting, the PIHP should ensure its source code is updated to remove the omission of members with autism from performance indicator reporting for reporting periods starting April 1, 2020.
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate.	☒	☐	☐	
Prescribed data cutoff dates are followed.	☒	☐	☐	
The PIHP retains copies of files or databases used for performance indicator reporting in case results need to be reproduced.	☒	☐	☐	While copies of the files were appropriately retained, HSAG recommends the PIHP also retain the member-level detail data for each indicator in a readily retrievable viewable file for its PIHP Medicaid beneficiaries. This retained data should be used for future PMV submission instead of generating new files as HSAG should receive the detailed data for the PIHP Medicaid beneficiaries, exactly as reported to MDHHS in support of the performance indicators.
The reporting software program is properly documented with respect to every aspect of the performance indicator	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	NA	Comments
data repository, including building, maintaining, managing, testing, and report production.				
The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix B. Denominator and Numerator Validation Findings

Reviewer Worksheet

PIHP Name:	Southwest Michigan Behavioral Health
PMV Date:	June 15, 2020
Reviewers:	Christopher Tax and Elisabeth Hunt

Denominator Validation Findings for Southwest Michigan Behavioral Health				
Audit Element	**Met**	**Not Met**	**NA**	**Comments**
For each of the performance indicators, all members of the relevant populations identified in the specifications are included in the population from which the denominator is produced.	☒	☐	☐	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance indicators.	☒	☐	☐	
The PIHP correctly calculates member months and member years if applicable to the performance indicator.	☐	☐	☒	Member month and member year calculations were not applicable to the indicators under the scope of the audit.
The PIHP properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and applied as specified in each performance indicator.	☒	☐	☐	It has been noted that Integrated Services of Kalamazoo will implement a CAP to ensure completeness of data going forward.
If any time parameters are required by the specifications for the performance indicator, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
Exclusion criteria included in the performance indicator specifications are followed.	☒	☐	☐	It was noted during the proof of service validation with the CMHSPs that exceptions and the compliant/non-compliant fields were missing or inaccurately manually entered within the

Denominator Validation Findings for Southwest Michigan Behavioral Health				
Audit Element	**Met**	**Not Met**	**NA**	**Comments**
				member-level detail file provided to HSAG. The PIHP confirmed the accurate data were used for submission of performance indicator data to MDHHS.
Systems or methods used by the PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not applicable to the indicators under the scope of the audit.

Numerator Validation Findings for Southwest Michigan Behavioral Health				
Audit Element	**Met**	**Not Met**	**NA**	**Comments**
The PIHP uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
['The PIHP avoids or eliminates all double-counted members or numerator events.	☒	☐	☐	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☒	☐	☐	
If any time parameters are required by the specifications for the performance indicator, they are followed (i.e., the indicator event occurred during the period specified or defined in the specifications).	☒	☐	☐	It has been noted that Integrated Services of Kalamazoo will implement a CAP to ensure completeness of data going forward.

Documentation Worksheet

New Measures for SFY 2020 (Effective April 1, 2020)

Indicator #2a

The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI–Adults, MI–Children, IDD–Adults, IDD–Children).

Indicator #2b

The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

Indicator #3

Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI–Adults, MI–Children, IDD–Adults, and IDD–Children).

PIHP Name:	Southwest Michigan Behavioral Health
PMV Date:	June 15, 2020
Reviewers:	Christopher Tax and Elisabeth Hunt

Data Integration and Control Element	Met	Not Met	NA	Comments
Accuracy of data transfers to assigned performance indicator data repository				
The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance indicator data repository used to keep the data until the calculations of the performance indicators have been completed and validated.	☒	☐	☐	
Samples of data from performance indicator data repository are complete and accurate.	☐	☐	☒	Samples were not available to review due to the Webex review occurring during the first reporting period for the new indicators.
Accuracy of file consolidations, extracts, and derivations				

Data Integration and Control Element	Met	Not Met	NA	Comments
The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate.	☒	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	☐	☐	☒	Actual results of file consolidations or extracts were not available to review due to the Webex review occurring during the first reporting period for the new indicators.
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database.	☒	☐	☐	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer.	☒	☐	☐	
If the PIHP uses a performance indicator data repository, its structure and format facilitates any required programming necessary to calculate and report required performance indicators.				
The performance indicator data repository's design, program flow charts, and source code enables analyses and reports.	☒	☐	☐	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate.	☒	☐	☐	
Prescribed data cutoff dates are followed.	☒	☐	☐	
The PIHP retains copies of files or databases used for performance indicator reporting in case results need to be reproduced.	☒	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance indicator data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Demographic Information			
Plan Name:	Region 4 - Southwest Michigan Behavioral Health		
Project Leader Name:	Moira Kean	Title:	Director of Clinical Quality
Telephone Number:	(800) 676-0423	E-mail Address:	moira.kean@swmbh.org
Name of Project:	***Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication***		
Submission Date:	6/30/2020		

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study topic was selected following the collection and analysis of the plan-specific data.
	2. Has the potential to affect consumer health, functional status, or satisfaction. The score for this element will be Met or Not Met.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIP has the potential to affect consumer health, functional status, or satisfaction.

Results for Step I

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	2	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study question was stated in simple terms using the recommended X/Y format.

Results for Step II

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs. The study population:**		
C*	1. Was accurately and completely defined and captured all consumers to whom the study question(s) applied. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP accurately and completely defined the study population. **General Comment**: The PIHP should use the most recent version of the HEDIS specifications available for each measurement period as appropriate.

Results for Step III

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. The study indicator(s):**		
C*	1. Were well-defined, objective, and measured changes in health or functional status, consumer satisfaction, or valid process alternatives.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study indicator was well-defined and objective and measured changes in health or functional status, consumer satisfaction, or processes. **General Comment**: The PIHP should use the most recent version of the HEDIS specifications available for each measurement period as appropriate.
	2. Included the basis on which the indicator(s) was adopted, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The study indicator was not internally developed.

Results for Step IV

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
V.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element will be scored Not Applicable [NA]). If sampling is used to select consumers in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	2. Included the title of the applicable study indicator(s).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	3. Included the population size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	4. Included the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	5. Included the margin of error and confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	6. Described in detail the method used to select the sample.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	7. Allowed for the generalization of results to the study population.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.

Results for Step V

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
7	0	0	0	7

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	0	0	0	2

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements to be collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The documentation included the data sources and data elements for collection.
C*	2. A clearly defined and systematic process for collecting data that included how baseline and remeasurement data were collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP specified a systematic method for collecting baseline and remeasurement data.
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP used administrative data collection only.
	4. An estimated degree of administrative data completeness percentage. Met = 80 - 100 percent complete Partially Met = 50 - 79 percent complete Not Met = <50 percent complete or not provided	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The estimated degree of administrative data completeness was between 80 percent and 100 percent, and the PIHP explained how it determined the administrative data completeness.

Results for Step VI

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
4	3	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP included accurate, clear, consistent, and easily understood information in the data table.
	2. Include a narrative interpretation that addresses all required components of data analysis and statistical testing.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP provided a narrative interpretation of results that included all required components. **General Comment**: The PIHP described an error in the SQL code used to calculate the study indicator; however, it was noted that the correction in the logic reduced the eligible population by 1,150 members. The reported denominator for the baseline performance demonstrates a decrease in the eligible population of 1,514 members. In the next annual submission, the PIHP should provide the rationale for the removal of the additional 364 members.
	3. Identified factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP identified and discussed factors that threatened the internal or external validity of the findings.

Results for Step VII

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	3	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP documented its causal/barrier analysis process, described its quality improvement (QI) team, processes/steps, and tools used.
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Identified barriers were prioritized based on data analysis and/or appropriate quality improvement processes.
C*	3. Interventions that were logically linked to identified barriers and will directly impact study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were logically linked to identified barriers and have the potential to impact study indicator outcomes.
	4. Intervention that were implemented in a timely manner to allow for impact of study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were implemented in a timely manner to allow for impact of the study indicator outcomes.
C*	5. Evaluation of individual interventions for effectiveness.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP described its process for evaluating the effectiveness of each intervention and included the evaluation results.
	6. Interventions that were continued, revised, or discontinued based on evaluation results.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Interventions were continued, revised, or discontinued based on evaluation for effectiveness of outcomes.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation		

Results for Step VIII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
6	6	0	0	0	3	3	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The remeasurement methodology was the same as the baseline methodology. **General Comment**: The PIHP described an error in the SQL code used to calculate the study indicator; however, it was noted that the correction in the logic reduced the eligible population by 1,150 members. The reported denominator for the baseline performance demonstrates a decrease in the eligible population of 1,514 members. In the next annual submission, the PIHP should provide the rationale for the removal of the additional 364 members.
	2. The documented improvement meets the State- or plan-specific goal.	☐ Met ☐ Partially Met ☑ Not Met ☐ NA	The PIHP did not achieve the plan-specific goal.
C*	3. There was statistically significant improvement over the baseline across all study indicators.	☐ Met ☐ Partially Met ☑ Not Met ☐ NA	The PIHP did not achieve statistically significant improvement over the baseline for the study indicator.

Results for Step IX

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	1	0	2	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	1	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. Sustained improvement cannot be assessed until statistically significant improvement over the baseline has been achieved across all study indicators, and a subsequent measurement period has been reported.

Results for Step X

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Table A-1—2019-2020 PIP Validation Tool Scores:
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication for Region 4 - Southwest Michigan Behavioral Health

Review Step		Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I.	Select the Study Topic(s)	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Define the Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	2	1	0	0	1	1	1	0	0	0
V.	Use Sound Sampling Techniques	7	0	0	0	7	2	0	0	0	2
VI.	Reliably Collect Data	4	3	0	0	1	2	1	0	0	1
VII.	Analyze Data and Interpret Study Results	3	3	0	0	0	1	1	0	0	0
VIII	Improvement Strategies	6	6	0	0	0	3	3	0	0	0
IX.	Assess for Real Improvement	3	1	0	2	0	1	0	0	1	0
X.	Assess for Sustained Improvement	1		Not Assessed			1	Not Assessed			
Totals for All Steps		**30**	**18**	**0**	**2**	**9**	**14**	**9**	**0**	**1**	**3**

Table A-2—2019-2020 PIP Validation Tool Overall Score:
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication for Region 4 - Southwest Michigan Behavioral Health

Percentage Score of Evaluation Elements Met*	**90%**
Percentage Score of Critical Elements Met**	**90%**
Validation Status***	***Not Met***

* The percentage score for all evaluation elements Met is calculated by dividing the total Met by the sum of all evaluation elements Met, Partially Met, and Not Met. The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** The percentage score of critical elements Met is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not Met.

*** Met equals high confidence/confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

Met: **High confidence/confidence in reported PIP results. All critical evaluation elements were Met, and 80 to 100 percent of all evaluation elements were Met across all activities.**

Partially Met: **Low confidence in reported PIP results. All critical evaluation elements were Met, and 60 to 79 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Partially Met.**

Not Met: **All critical evaluation elements were Met, and less than 60 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Not Met.**

Summary of Aggregate Validation Findings

[ ]	***Met***	[ ]	***Partially Met***	[X]	***Not Met***

Southwest Michigan
BEHAVIORAL HEALTH

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

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

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

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

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

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

3. The assurance of organizational and EO performance.

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

Specifically, they shall be provided the following information:

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

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

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

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

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

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: EO-001	Pages: 1
Subject: Executive Role and Job Description	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☒ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
03.14.2014	10.11.19	10.12.14, 10.9.15, 10.14.16, 10.13.17, 9.14.18

I. **PURPOSE:**

To define the executive role and job description.

II. **POLICY:**

The EO is accountable to the board acting as a body. The Board will instruct the EO through written policies or directives consistent with Board policies, delegating to the EO the interpretation and implementation of those policies and Ends.

III. **STANDARDS:**

Accordingly:

1. The Board will not give instructions to persons who report directly or indirectly to the EO.

2. The Board will not evaluate, either formally or informally, any staff other than the EO.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board Date September 11, 2020

Policy Number: BEL-009
Policy Name: Global Executive Constraint
Assigned Reviewer: Edward Meny

Policy

1) The Executive Officer (EO) shall not cause or allow any practice, activity, decision, or organizational circumstance, which is either illegal, imprudent or in violation of commonly accepted business and professional ethics or in violation of contractual obligations.

2) The EO is accountable to the board acting as a body. The board will instruct the EO through written policies or directives consistent with board policies, delegating to the EO the interpretation and implementation of those policies and Ends.

Executive Officer Response

1) The EO has not caused or allowed any practice, activity, decision, or organizational circumstance, which is either illegal, imprudent, in violation of commonly accepted business and professional ethics, or in violation of contractual obligations. This is evidenced by the absence of evidence or complaint of any of the above to the Board via Executive Officer self-report, by internal or external reviewers, staff, auditors or authorities. Ongoing monitoring and surveillance of SWMBH and performance by the EO, SWMBH staff and SWMBH contractors exists, with frequent cross-agency and cross-functional assignments and reports. This strengthens the avoidance and early detection of anything that is or could go amiss.

2) The board has instructed the EO clearly and diligently through written policies or formal directives consistent with board policies. The EO interpretation and implementation of those policies and Ends has relied on ongoing monitoring and reporting to the Board, periodic formal consideration of the Environmental Scan, Strategic Plan, Board Ends, Ends Interpretations and Metrics status. This is evidenced by ongoing Board review of specific Executive Limitations Board Polices, regular reports to the Board, and frequent interactions with the Board by other Senior Leaders.

-END-

Southwest Michigan
BEHAVIORAL HEALTH

Section:	Policy Number:	Pages:
Board- Policy Executive Limitations	BEL-009	1
Subject: Global Executive Constraint	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board

Effective Date:	Last Review Date:	Past Review Dates:
11.18.2013	09.13.19	9.12.14, 9.11.15, 9.9.16, 8.11.17,9.14.18

I. **POLICY:**

The Executive Officer (EO) shall not cause or allow any practice, activity, decision, or organizational circumstance which is either illegal, imprudent or in violation of commonly accepted business and professional ethics or in violation of contractual obligations.

III. **STANDARDS:**

1. The EO is accountable to the Board acting as a body. The Board will instruct the EO through written policies or directives consistent with Board policies, delegating to the EO the interpretation and implementation of those policies and Ends.

	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 7/31/2020			**P10FYTD20**	**10**									
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			239,778,785	183,330,527	31,287,976	14,275,586	2,889,462	6,496,924	1,498,310	-	-	-	
17	DHHS Incentive Payments			613,680	613,680	-	-	-	-	-	-	-	-	
18	Grants and Earned Contracts			1,212,355	-	-	-	-	1,212,355	-	-	-	-	
19	Interest Income - Working Capital			77,058	-	-	-	-	-	-	77,058	-	-	
20	Interest Income - ISF Risk Reserve			3,948	-	-	-	-	-	-	3,948	-	-	
21	Local Funds Contributions			1,438,493	-	-	-	-	-	-	1,438,493	-	-	
22	Other Local Income			210,497	-	-	-	-	-	-	210,497	-	-	
24	**TOTAL REVENUE**			**243,334,816**	**183,944,207**	**31,287,976**	**14,275,586**	**2,889,462**	**7,709,279**	**1,498,310**	**1,729,995**	**-**	**-**	
25														
26	**EXPENSE**													
27	**Healthcare Cost**													
28	Provider Claims Cost			19,473,972	3,033,600	5,327,125	-	3,417,217	6,405,642	1,290,389	-	-	-	
29	CMHP Subcontracts, net of 1st & 3rd party			181,488,411	149,088,224	17,433,143	12,839,506	1,280,755	846,783	-	-	-	-	
30	Insurance Provider Assessment Withhold (IPA)			2,428,474	2,428,474	-	-	-	-	-	-	-	-	
31	Medicaid Hospital Rate Adjustments			2,710,708	2,710,708	-	-	-	-	-	-	-	-	
32	MHL Cost in Excess of Medicare FFS Cost			-	2,053,555	-	-	(2,053,555)	-	-	-			
34	**Total Healthcare Cost**			**206,101,565**	**159,314,560**	**22,760,268**	**12,839,506**	**2,644,418**	**7,252,424**	**1,290,389**	**-**	**-**	**-**	
35	**Medical Loss Ratio (HCC % of Revenue)**			**85.7%**	**86.6%**	**72.7%**	**89.9%**	**91.5%**	**111.6%**	**86.1%**				
36														
37	**Administrative Cost**													
38	Purchased Professional Services			333,814	-	-	-	-	-	-	333,814	-	-	
39	Administrative and Other Cost			6,132,890	-	-	-	-	-	-	6,132,738	-	152	
41	Depreciation			74,275	-	-	-	-	-	-	74,275	-	-	
42	Functional Cost Reclassification			-	-	-	-	-	221,659	-	(221,659)	-	-	
43	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	152	-	(152)	
44	Delegated Managed Care Admin			13,937,249	11,526,041	1,336,118	977,882	97,208	-	-	-	-	-	
45	Apportioned Central Mgd Care Admin			0	4,786,989	716,223	404,035	147,836	235,195	-	(6,290,279)	-	-	
46														
47	**Total Administrative Cost**			**20,478,228**	**16,313,029**	**2,052,341**	**1,381,917**	**245,044**	**456,854**	**-**	**29,041**	**-**	**-**	
48	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.3%**	**8.3%**	**9.7%**	**8.5%**	**5.9%**	**0.0%**	**2.8%**			
49														
50	Local Funds Contribution			1,438,493	-	-	-	-	-	-	1,438,493	-	-	
51														
52	**TOTAL COST after apportionment**			**228,018,286**	**175,627,590**	**24,812,609**	**14,221,423**	**2,889,462**	**7,709,278**	**1,290,389**	**1,467,535**	**-**	**-**	
53														
54	**NET SURPLUS before settlement**			**15,316,529**	**8,316,617**	**6,475,367**	**54,163**	**-**	**0**	**207,922**	**262,461**	**-**	**-**	
55	**Net Surplus (Deficit) % of Revenue**			**6.3%**	**4.5%**	**20.7%**	**0.4%**	**0.0%**	**0.0%**	**13.9%**	**15.2%**			
56														
57	Prior Year Savings			-	-	-	-	-	-	-	-			
58	Change in PA2 Fund Balance			(207,922)	-	-	-	-	-	(207,922)	-			
59	ISF Risk Reserve Abatement (Funding)			(3,948)	-	-	-	-	-	-	(3,948)			
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-	-	-			
61	Settlement Receivable / (Payable)			(0)	3,713,611	(3,659,449)	(54,163)	-	(0)	-	-			
62	**NET SURPLUS (DEFICIT)**			**15,104,659**	**12,030,229**	**2,815,918**	**-**	**-**	**-**	**-**	**258,513**	**-**	**-**	
63	*HMP & Autism is settled with Medicaid*													
64														
65	**SUMMARY OF NET SURPLUS (DEFICIT)**													
66	Prior Year Unspent Savings			-	-	-	-	-	-	-	-			
67	Current Year Savings			14,308,306	11,492,388	2,815,918	-	-	-	-	-			
68	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-	-	-			
69	Local and Other Funds Surplus/(Deficit)			796,353	537,840	-	-	-	-	-	258,513	-	-	
70														
71	**NET SURPLUS (DEFICIT)**			**15,104,659**	**12,030,229**	**2,815,918**	**-**	**-**	**-**	**-**	**258,513**	**-**	**-**	
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 7/31/2020			10									
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%*	79.2%	77.4%	77.7%	80.3%	74.9%	79.6%	82.3%	84.4%	77.8%
7	Subcontract Revenue		183,330,527	12,736,542	170,593,985	7,212,142	33,296,835	9,311,405	31,090,080	9,349,951	52,439,820	11,558,357	16,335,395
8	Incentive Payment Revenue		613,680	178,498	435,182	34,946	28,593	33,887	118,606	3,646	183,733	26,475	5,295
9	**Contract Revenue**		**183,944,207**	**12,915,040**	**171,029,167**	**7,247,089**	**33,325,428**	**9,345,293**	**31,208,686**	**9,353,597**	**52,623,553**	**11,584,832**	**16,340,690**
10													
11	External Provider Cost		112,766,932	3,033,600	109,733,333	3,690,235	21,340,868	5,168,847	20,369,403	5,169,613	38,300,450	7,675,268	8,018,648
12	Internal Program Cost		41,296,403	-	41,296,403	2,347,470	8,246,991	2,263,171	8,619,809	2,509,885	7,313,884	3,784,445	6,210,748
13	SSI Reimb, 1st/3rd Party Cost Offset		(666,864)	-	(666,864)	(9,488)	(156,804)	(31,912)	(115,694)	(2,861)	(258,558)	(26,021)	(65,526)
14	Insurance Provider Assessment Withhold (IPA)		5,139,182	5,139,182	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		675,591	675,591	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**159,211,245**	**8,848,373**	**150,362,872**	**6,028,216**	**29,431,054**	**7,400,106**	**28,873,519**	**7,676,637**	**45,355,777**	**11,433,692**	**14,163,871**
17	**Medical Loss Ratio (HCC % of Revenue)**		**86.6%**	**68.5%**	**87.9%**	**83.2%**	**88.3%**	**79.2%**	**92.5%**	**82.1%**	**86.2%**	**98.7%**	**86.7%**
18													
19	**Managed Care Administration**		**16,410,237**	**4,786,989**	**11,623,249**	**650,984**	**2,145,910**	**649,918**	**1,923,789**	**656,500**	**3,883,518**	**770,150**	**942,481**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**2.7%**	**6.6%**	**9.7%**	**6.8%**	**8.1%**	**6.2%**	**7.9%**	**7.9%**	**6.3%**	**6.2%**
21													
22	**Contract Cost**		**175,621,482**	**13,635,362**	**161,986,120**	**6,679,200**	**31,576,963**	**8,050,024**	**30,797,307**	**8,333,137**	**49,239,294**	**12,203,842**	**15,106,352**
23	**Net before Settlement**		**8,322,725**	**(720,322)**	**9,043,047**	**567,888**	**1,748,465**	**1,295,269**	**411,378**	**1,020,460**	**3,384,259**	**(619,010)**	**1,234,338**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		3,713,611	12,756,658	(9,043,047)	(567,888)	(1,748,465)	(1,295,269)	(411,378)	(1,020,460)	(3,384,259)	619,010	(1,234,338)
28	**Net after Settlement**		**12,036,336**	**12,036,336**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		151,565	151,565	151,565	7,795	29,228	8,531	28,734	8,989	39,866	12,504	15,918
32	Revenue PMPM		$ 121.36	$ 8.52	$ 112.84	$ 92.97	$ 114.02	$ 109.55	$ 108.61	$ 104.06	$ 132.00	$ 92.65	$ 102.66
33	Expense PMPM		$ 115.87	$ 9.00	$ 106.88	$ 85.69	$ 108.04	$ 94.36	$ 107.18	$ 92.70	$ 123.51	$ 97.60	$ 94.90
34	Margin PMPM		$ 5.49	$ (0.48)	$ 5.97	$ 7.29	$ 5.98	$ 15.18	$ 1.43	$ 11.35	$ 8.49	$ (4.95)	$ 7.75
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		151,565	151,565	151,565	7,795	29,228	8,531	28,734	8,989	39,866	12,504	15,918
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)		3,158	3,158	3,158	274	256	94	821	439	743	282	249
43	% Variance - Fav / (Unfav)		2.1%	2.1%	2.1%	3.6%	0.9%	1.1%	2.9%	5.1%	1.9%	2.3%	1.6%
44													
45	**Contract Revenue before settlement**												
46	Actual		183,944,207	12,915,040	171,029,167	7,247,089	33,325,428	9,345,293	31,208,686	9,353,597	52,623,553	11,584,832	16,340,690
47	Budget		170,057,374	14,368,365	155,689,009	6,163,648	30,996,782	8,324,358	28,569,253	8,126,968	48,137,675	10,450,809	14,919,519
48	Variance - Favorable / (Unfavorable)		13,886,833	(1,453,325)	15,340,158	1,083,441	2,328,646	1,020,935	2,639,433	1,226,630	4,485,878	1,134,023	1,421,171
49	% Variance - Fav / (Unfav)		8.2%	-10.1%	9.9%	17.6%	7.5%	12.3%	9.2%	15.1%	9.3%	10.9%	9.5%
50													
51	**Healthcare Cost**												
52	Actual		159,211,245	8,848,373	150,362,872	6,028,216	29,431,054	7,400,106	28,873,519	7,676,637	45,355,777	11,433,692	14,163,871
53	Budget		158,874,362	8,608,369	150,265,993	6,480,147	30,377,552	7,966,010	26,787,297	7,713,979	45,546,257	10,809,800	14,584,951
54	Variance - Favorable / (Unfavorable)		(336,883)	(240,005)	(96,879)	451,931	946,498	565,904	(2,086,222)	37,342	190,480	(623,892)	421,080
55	% Variance - Fav / (Unfav)		-0.2%	-2.8%	-0.1%	7.0%	3.1%	7.1%	-7.8%	0.5%	0.4%	-5.8%	2.9%
56													
57	**Managed Care Administration**												

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 7/31/2020			**10**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
58	Actual		16,410,237	4,786,989	11,623,249	650,984	2,145,910	649,918	1,923,789	656,500	3,883,518	770,150	942,481
59	Budget		17,154,803	5,806,608	11,348,195	482,544	2,264,405	665,260	1,933,280	591,072	3,828,773	674,936	907,925
60	Variance - Favorable / (Unfavorable)		744,566	1,019,619	(275,053)	(168,440)	118,496	15,342	9,491	(65,428)	(54,744)	(95,214)	(34,556)
61	% Variance - Fav / (Unfav)		4.3%	17.6%	-2.4%	-34.9%	5.2%	2.3%	0.5%	-11.1%	-1.4%	-14.1%	-3.8%
62													
63	**Total Contract Cost**												
64	Actual		175,621,482	13,635,362	161,986,120	6,679,200	31,576,963	8,050,024	30,797,307	8,333,137	49,239,294	12,203,842	15,106,352
65	Budget		176,029,165	14,414,977	161,614,188	6,962,691	32,641,958	8,631,270	28,720,577	8,305,051	49,375,030	11,484,736	15,492,876
66	Variance - Favorable / (Unfavorable)		407,683	779,614	(371,932)	283,491	1,064,994	581,246	(2,076,730)	(28,086)	135,736	(719,106)	386,524
67	% Variance - Fav / (Unfav)		0.2%	5.4%	-0.2%	4.1%	3.3%	6.7%	-7.2%	-0.3%	0.3%	-6.3%	2.5%
68													
69	**Net before Settlement**												
70	Actual		8,322,725	(720,322)	9,043,047	567,888	1,748,465	1,295,269	411,378	1,020,460	3,384,259	(619,010)	1,234,338
71	Budget		(5,971,791)	(46,611)	(5,925,179)	(799,043)	(1,645,176)	(306,912)	(151,324)	(178,084)	(1,237,355)	(1,033,927)	(573,357)
72	Variance - Favorable / (Unfavorable)		14,294,515	(673,711)	14,968,226	1,366,932	3,393,640	1,602,181	562,703	1,198,544	4,621,614	414,917	1,807,695
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 7/31/2020			10									
3	*(For Internal Management Purposes Only)*			*ok*									
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	**Healthy Michigan Plan**			*HCC%*	9.2%	12.7%	9.0%	8.7%	11.4%	7.8%	7.7%	9.4%	8.7%
76	**Contract Revenue**		**31,287,976**	**6,522,106**	**24,765,870**	**1,198,089**	**5,127,427**	**1,172,691**	**4,371,014**	**1,486,171**	**7,077,496**	**1,907,515**	**2,425,465**
77													
78	External Provider Cost		15,212,967	5,327,125	9,885,842	406,686	2,099,675	354,319	2,191,479	218,860	3,201,520	572,327	840,976
79	Internal Program Cost		7,547,301	-	7,547,301	583,657	1,320,892	445,704	2,214,338	530,653	1,021,350	695,555	735,151
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**22,760,268**	**5,327,125**	**17,433,143**	**990,343**	**3,420,567**	**800,024**	**4,405,817**	**749,513**	**4,222,870**	**1,267,883**	**1,576,126**
82	**Medical Loss Ratio (HCC % of Revenue)**		**72.7%**	**81.7%**	**70.4%**	**82.7%**	**66.7%**	**68.2%**	**100.8%**	**50.4%**	**59.7%**	**66.5%**	**65.0%**
83													
84	**Managed Care Administration**		**2,052,341**	**716,223**	**1,336,118**	**106,947**	**249,404**	**70,262**	**293,551**	**64,098**	**361,577**	**85,402**	**104,877**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.3%**	**2.9%**	**5.4%**	**9.7%**	**6.8%**	**8.1%**	**6.2%**	**7.9%**	**7.9%**	**6.3%**	**6.2%**
86													
87	**Contract Cost**		**24,812,609**	**6,043,348**	**18,769,262**	**1,097,290**	**3,669,971**	**870,286**	**4,699,369**	**813,611**	**4,584,447**	**1,353,284**	**1,681,004**
88	**Net before Settlement**		**6,475,367**	**478,758**	**5,996,609**	**100,800**	**1,457,456**	**302,405**	**(328,354)**	**672,560**	**2,493,050**	**554,231**	**744,462**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(3,659,449)	2,337,160	(5,996,609)	(100,800)	(1,457,456)	(302,405)	328,354	(672,560)	(2,493,050)	(554,231)	(744,462)
93	**Net after Settlement**		**2,815,918**	**2,815,918**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		52,915	52,915	52,915	2,574	10,936	2,501	9,431	3,234	14,871	4,135	5,233
97	Revenue PMPM		$ 59.13	$ 12.33	$ 46.80	$ 46.54	$ 46.88	$ 46.89	$ 46.35	$ 45.95	$ 47.59	$ 46.13	$ 46.35
98	Expense PMPM		46.89	11.42	35.47	42.63	33.56	34.80	49.83	25.16	30.83	32.73	32.12
99	Margin PMPM		$ 12.24	$ 0.90	$ 11.33	$ 3.92	$ 13.33	$ 12.09	$ (3.48)	$ 20.79	$ 16.76	$ 13.40	$ 14.23
100													
101	**Healthy Michigan Plan**												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		52,915	52,915	52,915	2,574	10,936	2,501	9,431	3,234	14,871	4,135	5,233
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		1,346	1,346	1,346	62	526	70	262	259	(181)	218	129
108	% Variance - Fav / (Unfav)		2.6%	2.6%	2.6%	2.5%	5.1%	2.9%	2.9%	8.7%	-1.2%	5.6%	2.5%
109													
110	**Contract Revenue before settlement**												
111	Actual		31,287,976	6,522,106	24,765,870	1,198,089	5,127,427	1,172,691	4,371,014	1,486,171	7,077,496	1,907,515	2,425,465
112	Budget		24,189,179	4,180,166	20,009,013	966,046	4,037,128	937,690	3,580,470	1,140,258	5,874,676	1,514,051	1,958,694
113	Variance - Favorable / (Unfavorable)		7,098,796	2,341,940	4,756,857	232,043	1,090,299	235,001	790,544	345,913	1,202,820	393,464	466,771
114	% Variance - Fav / (Unfav)		29.3%	56.0%	23.8%	24.0%	27.0%	25.1%	22.1%	30.3%	20.5%	26.0%	23.8%
115													
116	**Healthcare Cost**												
117	Actual		22,760,268	5,327,125	17,433,143	990,343	3,420,567	800,024	4,405,817	749,513	4,222,870	1,267,883	1,576,126
118	Budget		20,939,770	4,844,189	16,095,581	1,150,628	2,407,044	1,054,858	3,969,834	818,696	4,273,566	971,094	1,449,862
119	Variance - Favorable / (Unfavorable)		(1,820,498)	(482,936)	(1,337,562)	160,285	(1,013,523)	254,834	(435,984)	69,182	50,696	(296,788)	(126,264)
120	% Variance - Fav / (Unfav)		-8.7%	-10.0%	-8.3%	13.9%	-42.1%	24.2%	-11.0%	8.5%	1.2%	-30.6%	-8.7%
121													
122	**Managed Care Administration**												
123	Actual		2,052,341	716,223	1,336,118	106,947	249,404	70,262	293,551	64,098	361,577	85,402	104,877
124	Budget		2,004,714	792,135	1,212,580	85,682	179,426	88,094	286,509	62,731	359,250	60,633	90,255
125	Variance - Favorable / (Unfavorable)		(47,627)	75,912	(123,539)	(21,265)	(69,978)	17,831	(7,042)	(1,366)	(2,326)	(24,769)	(14,622)
126	% Variance - Fav / (Unfav)		-2.4%	9.6%	-10.2%	-24.8%	-39.0%	20.2%	-2.5%	-2.2%	-0.6%	-40.9%	-16.2%

	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 7/31/2020			**10**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
127													
128	**Total Contract Cost**												
129	Actual		24,812,609	6,043,348	18,769,262	1,097,290	3,669,971	870,286	4,699,369	813,611	4,584,447	1,353,284	1,681,004
130	Budget		22,944,484	5,636,324	17,308,161	1,236,309	2,586,470	1,142,951	4,256,343	881,427	4,632,816	1,031,727	1,540,117
131	Variance - Favorable / (Unfavorable)		(1,868,125)	(407,024)	(1,461,101)	139,020	(1,083,501)	272,665	(443,026)	67,816	48,369	(321,558)	(140,887)
132	% Variance - Fav / (Unfav)		-8.1%	-7.2%	-8.4%	11.2%	-41.9%	23.9%	-10.4%	7.7%	1.0%	-31.2%	-9.1%
133													
134	**Net before Settlement**												
135	Actual		6,475,367	478,758	5,996,609	100,800	1,457,456	302,405	(328,354)	672,560	2,493,050	554,231	744,462
136	Budget		1,244,695	(1,456,158)	2,700,853	(270,264)	1,450,658	(205,262)	(675,872)	258,831	1,241,860	482,324	418,577
137	Variance - Favorable / (Unfavorable)		5,230,671	1,934,916	3,295,756	371,063	6,798	507,667	347,518	413,729	1,251,190	71,907	325,885
138													
139		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 7/31/2020			**10**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
140	***Autism Specialty Services***			*HCC%*	6.8%	5.1%	9.3%	7.6%	7.1%	5.7%	5.6%	2.6%	8.4%
141	**Contract Revenue**		**14,275,586**	**19,610**	**14,255,976**	**704,684**	**2,690,881**	**795,182**	**2,586,141**	**719,827**	**4,203,536**	**1,153,066**	**1,402,659**
142													
143	External Provider Cost		11,177,856	-	11,177,856	-	3,514,905	699,375	1,556,766	544,053	3,079,146	348,378	1,435,234
144	Internal Program Cost		1,661,650	-	1,661,650	398,635	4,072	2,496	1,161,893	1,807	-	5,479	87,268
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**12,839,506**	**-**	**12,839,506**	**398,635**	**3,518,977**	**701,871**	**2,718,659**	**545,860**	**3,079,146**	**353,856**	**1,522,502**
147	**Medical Loss Ratio (HCC % of Revenue)**		**89.9%**	**0.0%**	**90.1%**	**56.6%**	**130.8%**	**88.3%**	**105.1%**	**75.8%**	**73.3%**	**30.7%**	**108.5%**
148													
149	**Managed Care Administration**		**1,381,917**	**404,035**	**977,882**	**43,048**	**256,580**	**61,642**	**181,139**	**46,682**	**263,647**	**23,835**	**101,309**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.7%**	**2.8%**	**6.9%**	**9.7%**	**6.8%**	**8.1%**	**6.2%**	**7.9%**	**7.9%**	**6.3%**	**6.2%**
151													
152	**Contract Cost**		**14,221,423**	**404,035**	**13,817,388**	**441,684**	**3,775,557**	**763,513**	**2,899,798**	**592,541**	**3,342,793**	**377,691**	**1,623,811**
153	**Net before Settlement**		**54,163**	**(384,425)**	**438,588**	**263,000**	**(1,084,676)**	**31,669**	**(313,657)**	**127,286**	**860,743**	**775,375**	**(221,152)**
154	Contract Settlement / Redistribution		(54,163)	384,425	(438,588)	(263,000)	1,084,676	(31,669)	313,657	(127,286)	(860,743)	(775,375)	221,152
155	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.4%	0.8%	1.1%	0.7%	0.0%	0.8%	0.0%	1.3%	0.4%
159	**Contract Revenue**		**6,496,924**	**5,354,613**	**1,142,310**	**76,203**	**394,172**	**29,133**	**-**	**123,028**	**225,968**	**159,385**	**134,422**
160													
161	External Provider Cost		6,405,822	6,405,642	180	180	-	-	-	-	-	-	-
162	Internal Program Cost		846,603	-	846,603	62,283	399,911	60,677	-	79,777	2,266	170,357	71,333
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**7,252,424**	**6,405,642**	**846,783**	**62,463**	**399,911**	**60,677**	**-**	**79,777**	**2,266**	**170,357**	**71,333**
165	**Medical Loss Ratio (HCC % of Revenue)**		**111.6%**	**119.6%**	**74.1%**	**82.0%**	**101.5%**	**208.3%**	**0.0%**	**64.8%**	**1.0%**	**106.9%**	**53.1%**
166													
167	**Managed Care Administration**		**(755,501)**	**(755,501)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-11.6%**	**-11.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**6,496,923**	**5,650,141**	**846,783**	**62,463**	**399,911**	**60,677**	**-**	**79,777**	**2,266**	**170,357**	**71,333**
171	**Net before Settlement**		**0**	**(295,527)**	**295,528**	**13,740**	**(5,739)**	**(31,543)**	**-**	**43,252**	**223,701**	**(10,972)**	**63,089**
172	Contract Settlement		(0)	295,527	(295,528)	(13,740)	5,739	31,543	-	(43,252)	(223,701)	10,972	(63,089)
173	**Net after Settlement**		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175		x	-										

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	For the Fiscal YTD Period Ended 7/31/2020			**10**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		235,391,012	24,632,871	210,758,142	9,191,118	41,509,315	11,308,412	38,047,235	11,678,978	63,946,819	14,778,324	20,297,941
178	Incentive Payment Revenue		613,680	178,498	435,182	34,946	28,593	33,887	118,606	3,646	183,733	26,475	5,295
179	**Contract Revenue**		**236,004,692**	**24,811,369**	**211,193,323**	**9,226,064**	**41,537,908**	**11,342,299**	**38,165,841**	**11,682,625**	**64,130,553**	**14,804,798**	**20,303,236**
180													
181	External Provider Cost		145,563,577	14,766,366	130,797,211	4,097,101	26,955,448	6,222,541	24,117,648	5,932,525	44,581,115	8,595,973	10,294,858
182	Internal Program Cost		51,351,956	-	51,351,956	3,392,045	9,971,866	2,772,048	11,996,040	3,122,122	8,337,501	4,655,836	7,104,500
183	SSI Reimb, 1st/3rd Party Cost Offset		(666,864)	-	(666,864)	(9,488)	(156,804)	(31,912)	(115,694)	(2,861)	(258,558)	(26,021)	(65,526)
184	Insurance Provider Assessment Withhold (IPA)		5,139,182	5,139,182	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		675,591	675,591	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**202,063,443**	**20,581,140**	**181,482,303**	**7,479,657**	**36,770,509**	**8,962,677**	**35,997,995**	**9,051,786**	**52,660,059**	**13,225,788**	**17,333,832**
187	**Medical Loss Ratio (HCC % of Revenue)**		**85.6%**	**83.0%**	**85.9%**	**81.1%**	**88.5%**	**79.0%**	**94.3%**	**77.5%**	**82.1%**	**89.3%**	**85.4%**
188													
189	**Managed Care Administration**		**19,088,995**	**5,151,746**	**13,937,249**	**800,979**	**2,651,893**	**781,822**	**2,398,479**	**767,280**	**4,508,741**	**879,387**	**1,148,667**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**8.6%**	**2.3%**	**6.3%**	**9.7%**	**6.7%**	**8.0%**	**6.2%**	**7.8%**	**7.9%**	**6.2%**	**6.2%**
191													
192	**Contract Cost**		**221,152,438**	**25,732,886**	**195,419,552**	**8,280,637**	**39,422,402**	**9,744,499**	**38,396,474**	**9,819,066**	**57,168,800**	**14,105,175**	**18,482,500**
193	**Net before Settlement**		**14,852,254**	**(921,517)**	**15,773,771**	**945,428**	**2,115,506**	**1,597,800**	**(230,633)**	**1,863,559**	**6,961,753**	**699,624**	**1,820,736**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(0)	15,773,770	(15,773,771)	(945,428)	(2,115,506)	(1,597,800)	230,633	(1,863,559)	(6,961,753)	(699,624)	(1,820,736)
198	**Net after Settlement**		**14,852,254**	**14,852,254**	**-**	**(0)**	**(0)**	**-**	**0**	**0**	**-**	**(0)**	**(0)**
199													
200													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	For the Fiscal YTD Period Ended 7/31/2020			**10**									
3	*(For Internal Management Purposes Only)*			***ok***									
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	4.5%	4.0%	2.9%	2.8%	6.6%	6.1%	4.4%	2.4%	4.8%
202	**Contract Revenue**				**9,410,766**	**601,846**	**1,603,940**	**573,170**	**1,684,071**	**516,194**	**3,065,518**	**495,478**	**870,549**
203													
204	External Provider Cost				2,953,988	108,666	99,118	58,080	612,384	376,448	1,446,954	127,693	124,645
205	Internal Program Cost				5,562,978	200,132	995,216	196,591	1,913,894	211,822	1,096,635	194,103	754,586
206	SSI Reimb, 1st/3rd Party Cost Offset				(112,742)	-	-	-	-	-	(112,742)	-	-
207	**Total Healthcare Cost**				**8,404,224**	**308,798**	**1,094,334**	**254,671**	**2,526,278**	**588,270**	**2,430,847**	**321,796**	**879,231**
208	**Medical Loss Ratio (HCC % of Revenue)**				**89.3%**	**51.3%**	**68.2%**	**44.4%**	**150.0%**	**114.0%**	**79.3%**	**64.9%**	**101.0%**
209													
210	**Managed Care Administration**				**712,309**	**37,095**	**89,811**	**25,152**	**186,469**	**54,668**	**229,643**	**24,266**	**65,206**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.7%**	**7.6%**	**9.0%**	**6.9%**	**8.5%**	**8.6%**	**7.0%**	**6.9%**
212													
213	**Contract Cost**				**9,116,533**	**345,893**	**1,184,145**	**279,822**	**2,712,747**	**642,938**	**2,660,489**	**346,061**	**944,438**
214	**Net before Settlement**				**294,234**	**255,953**	**419,795**	**293,348**	**(1,028,676)**	**(126,744)**	**405,029**	**149,417**	**(73,889)**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(1,273,212)	(248,202)	(339,598)	(290,625)	-	-	(251,753)	(143,034)	-
218	**Net after Settlement**				**(978,978)**	**7,751**	**80,197**	**2,723**	**(1,028,676)**	**(126,744)**	**153,276**	**6,383**	**(73,889)**
219													

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Southwest Michigan Behavioral Health

For the Fiscal YTD Period Ended 9/30/2021

(For Internal Management Purposes Only)

FY21 Budget
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INCOME STATEMENT	For Board Consideration	FY21 Budget Current Status	Variance	FY20 Budget
REVENUE				
Contract Revenue				
Medicaid Capitation	215,804,527	215,804,527	-	209,466,803
Healthy Michigan Plan Capitation	34,989,442	34,989,442	-	32,039,762
Autism Services Capitation	17,346,549	17,346,549	-	12,559,000
Dual Eligibles Demonstration Project	3,480,161	3,480,161	-	3,414,767
SA Block Grant Funding	7,801,586	7,801,586	-	8,171,316
SA PA2 Funding	1,797,973	1,797,973	-	1,884,850
Contract Revenue	281,220,237	281,220,237	-	267,536,498
DHHS Incentive Payments	629,741	629,741	-	650,920
Grants and Earned Contracts	1,521,294	1,521,294	-	461,128
Interest Income - Working Capital	101,227	101,227	-	198,574
Interest Income - ISF Risk Reserve	5,123	5,123	-	48,015
Local Funds Contributions	2,163,020	2,163,020	-	2,163,020
Other Local Income	252,607	252,607	-	243,099
TOTAL REVENUE	**285,893,249**	**285,893,249**	**-**	**271,301,256**
EXPENSE				
Healthcare Cost				
Provider Claims Cost	22,226,948	22,226,948	-	22,415,051
CMHP Subcontracts, net of 1st & 3rd party	230,237,545	230,237,545	-	216,125,411
Insurance Provider Assessment Withhold (IPA)	2,894,655	2,894,655	-	2,590,858
Medicaid Hospital Rate Adjustments	3,614,277	3,614,277	-	139,821
MHL Cost in Excess of Medicare FFS Cost	-	-	-	-
Total Healthcare Cost	**258,973,426**	**258,973,426**	**-**	**241,271,141**
Medical Loss Ratio (HCC % of Revenue)	**91.9%**	**91.9%**	**0.0%**	**90.0%**
Administrative Cost				
Purchased Professional Services	731,240	731,240	-	623,000
Administrative and Other Cost	9,531,466	9,531,466	-	8,293,670
Depreciation	89,172	89,172	-	109,640
Functional Cost Reclassification	-	-	-	-
Allocated Indirect Pooled Cost	-	-	-	-
Delegated Managed Care Admin	16,870,489	16,870,489	-	14,585,702
Apportioned Central Mgd Care Admin	0	0	-	0
Total Administrative Cost	**27,222,366**	**27,222,366**	**-**	**23,612,012**
Admin Cost Ratio (MCA % of Total Cost)	**9.5%**	**9.5%**	**#DIV/0!**	**9.0%**
			-	
Local Funds Contribution	2,163,020	2,163,020	-	2,163,020
TOTAL COST after apportionment	**288,358,813**	**288,358,813**	**-**	**267,046,173**
NET SURPLUS before settlement	**(2,465,564)**	**(2,465,564)**	**-**	**4,255,082**
Net Surplus (Deficit) % of Revenue	**-0.9%**	**-0.9%**	**#DIV/0!**	**1.6%**
Prior Year Savings	2,579,282	2,579,282	-	
Change in PA2 Fund Balance	(255,959)	(255,959)	-	(30,389)
ISF Risk Reserve Abatement (Funding)	(5,123)	(5,123)	-	(48,015)
ISF Risk Reserve Deficit (Funding)	437,898	437,898	-	-
Settlement Receivable / (Payable)	(0)	(0)	-	(17,147)
NET SURPLUS (DEFICIT)	**290,534**	**290,534**	**-**	**4,159,531**

HMP & Autism is settled with Medicaid

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	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	**FY21 Budget**			12									
3	*(For Internal Management Purposes Only)*			*ok*	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
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%*	78.5%	72.1%	78.1%	77.9%	75.3%	80.5%	80.4%	85.4%	76.7%
7	Subcontract Revenue		215,804,527	13,220,774	202,583,753	8,515,492	39,491,663	11,020,705	36,969,636	11,016,487	62,301,149	13,758,894	19,509,726
8	Incentive Payment Revenue		629,741	252,180	377,560	36,005	45,385	36,308	120,000	4,862	115,000	20,000	-
9	**Contract Revenue**		**216,434,267**	**13,472,954**	**202,961,313**	**8,551,498**	**39,537,048**	**11,057,013**	**37,089,636**	**11,021,349**	**62,416,149**	**13,778,894**	**19,509,726**
10													
11	External Provider Cost		141,416,151	3,593,555	137,822,596	4,575,537	26,351,920	7,123,979	24,170,868	6,150,144	50,121,263	9,257,527	10,071,357
12	Internal Program Cost		52,535,213	-	52,535,213	3,374,849	10,105,695	3,180,420	10,402,452	3,358,145	9,427,321	5,141,647	7,544,686
13	SSI Reimb, 1st/3rd Party Cost Offset		(860,253)	-	(860,253)	(13,323)	(155,945)	(43,642)	(190,547)	(43,016)	(307,980)	(30,000)	(75,800)
14	Insurance Provider Assessment Withhold (IPA)		6,508,933	6,508,933	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		1,004,042	1,004,042	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**200,604,086**	**11,106,529**	**189,497,556**	**7,937,062**	**36,301,670**	**10,260,756**	**34,382,774**	**9,465,273**	**59,240,604**	**14,369,174**	**17,540,243**
17	**Medical Loss Ratio (HCC % of Revenue)**		**92.7%**	**82.4%**	**93.4%**	**92.8%**	**91.8%**	**92.8%**	**92.7%**	**85.9%**	**94.9%**	**104.3%**	**89.9%**
18													
19	**Managed Care Administration**		**21,426,644**	**7,417,424**	**14,009,220**	**591,926**	**2,674,245**	**866,979**	**2,352,332**	**861,137**	**4,720,823**	**899,797**	**1,041,981**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.7%**	**3.3%**	**6.3%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
21													
22	**Contract Cost**		**222,030,730**	**18,523,953**	**203,506,777**	**8,528,988**	**38,975,916**	**11,127,736**	**36,735,106**	**10,326,410**	**63,961,427**	**15,268,971**	**18,582,224**
23	**Net before Settlement**		**(5,596,463)**	**(5,050,999)**	**(545,464)**	**22,510**	**561,132**	**(70,723)**	**354,530**	**694,939**	**(1,545,278)**	**(1,490,077)**	**927,502**
24													
25	Prior Year Savings		2,579,282	2,579,282	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		2,579,282	2,033,819	545,464	(22,510)	(561,132)	70,723	(354,530)	(694,939)	1,545,278	1,490,077	(927,502)
28	**Net after Settlement**		**(437,898)**	**(437,898)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
32	Revenue PMPM		$ 119.45	$ 7.44	$ 112.01	$ 91.98	$ 113.11	$ 108.66	$ 107.90	$ 102.53	$ 130.98	$ 92.14	$ 102.50
33	Expense PMPM		$ 122.54	$ 10.22	$ 112.32	$ 91.73	$ 111.51	$ 109.35	$ 106.87	$ 96.06	$ 134.22	$ 102.10	$ 97.62
34	Margin PMPM		$ (3.09)	$ (2.79)	$ (0.30)	$ 0.24	$ 1.61	$ (0.69)	$ 1.03	$ 6.46	$ (3.24)	$ (9.96)	$ 4.87
35													
36	**Medicaid Specialty Services**												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
41	Budget		148,407	148,407	148,407	7,521	28,972	8,437	27,913	8,550	39,123	12,222	15,669
42	Variance - Favorable / (Unfavorable)		2,586	2,586	2,586	227	156	43	731	408	588	240	193
43	% Variance - Fav / (Unfav)		1.7%	1.7%	1.7%	3.0%	0.5%	0.5%	2.6%	4.8%	1.5%	2.0%	1.2%
44													
45	**Contract Revenue before settlement**												
46	Actual		216,434,267	13,472,954	202,961,313	8,551,498	39,537,048	11,057,013	37,089,636	11,021,349	62,416,149	13,778,894	19,509,726
47	Budget		204,068,849	17,242,038	186,826,811	7,396,377	37,196,138	9,989,229	34,283,103	9,752,361	57,765,210	12,540,970	17,903,422
48	Variance - Favorable / (Unfavorable)		12,365,418	(3,769,084)	16,134,502	1,155,121	2,340,909	1,067,784	2,806,533	1,268,988	4,650,939	1,237,924	1,606,304
49	% Variance - Fav / (Unfav)		6.1%	-21.9%	8.6%	15.6%	6.3%	10.7%	8.2%	13.0%	8.1%	9.9%	9.0%
50													
51	**Healthcare Cost**												
52	Actual		200,604,086	11,106,529	189,497,556	7,937,062	36,301,670	10,260,756	34,382,774	9,465,273	59,240,604	14,369,174	17,540,243
53	Budget		190,649,234	10,330,043	180,319,192	7,776,176	36,453,063	9,559,212	32,144,756	9,256,775	54,655,508	12,971,760	17,501,941
54	Variance - Favorable / (Unfavorable)		(9,954,851)	(776,487)	(9,178,364)	(160,886)	151,392	(701,544)	(2,238,017)	(208,498)	(4,585,096)	(1,397,414)	(38,301)
55	% Variance - Fav / (Unfav)		-5.2%	-7.5%	-5.1%	-2.1%	0.4%	-7.3%	-7.0%	-2.3%	-8.4%	-10.8%	-0.2%
56													
57	**Managed Care Administration**												

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	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	**FY21 Budget**			**12**									
3	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
58	Actual		21,426,644	7,417,424	14,009,220	591,926	2,674,245	866,979	2,352,332	861,137	4,720,823	899,797	1,041,981
59	Budget		20,585,764	6,967,929	13,617,834	579,053	2,717,287	798,312	2,319,936	709,287	4,594,528	809,923	1,089,510
60	Variance - Favorable / (Unfavorable)		(840,881)	(449,495)	(391,386)	(12,873)	43,041	(68,668)	(32,396)	(151,850)	(126,295)	(89,873)	47,528
61	% Variance - Fav / (Unfav)		-4.1%	-6.5%	-2.9%	-2.2%	1.6%	-8.6%	-1.4%	-21.4%	-2.7%	-11.1%	4.4%
62													
63	**Total Contract Cost**												
64	Actual		222,030,730	18,523,953	203,506,777	8,528,988	38,975,916	11,127,736	36,735,106	10,326,410	63,961,427	15,268,971	18,582,224
65	Budget		211,234,998	17,297,972	193,937,026	8,355,229	39,170,349	10,357,524	34,464,692	9,966,062	59,250,036	13,781,683	18,591,451
66	Variance - Favorable / (Unfavorable)		(10,795,732)	(1,225,981)	(9,569,750)	(173,759)	194,434	(770,212)	(2,270,414)	(360,348)	(4,711,391)	(1,487,287)	9,227
67	% Variance - Fav / (Unfav)		-5.1%	-7.1%	-4.9%	-2.1%	0.5%	-7.4%	-6.6%	-3.6%	-8.0%	-10.8%	0.0%
68													
69	**Net before Settlement**												
70	Actual		(5,596,463)	(5,050,999)	(545,464)	22,510	561,132	(70,723)	354,530	694,939	(1,545,278)	(1,490,077)	927,502
71	Budget		(7,166,149)	(55,933)	(7,110,215)	(958,852)	(1,974,211)	(368,295)	(181,589)	(213,701)	(1,484,826)	(1,240,713)	(688,029)
72	Variance - Favorable / (Unfavorable)		1,569,686	(4,995,065)	6,564,752	981,362	2,535,343	297,572	536,119	908,639	(60,452)	(249,364)	1,615,531
73													
74													

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	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	**FY21 Budget**			**12**									
3	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
75	***Healthy Michigan Plan***			*HCC%*	8.8%	10.4%	7.7%	8.0%	12.0%	7.3%	7.6%	8.3%	9.5%
76	**Contract Revenue**		**34,989,442**	**6,335,743**	**28,653,699**	**1,370,602**	**5,922,651**	**1,329,679**	**5,150,246**	**1,738,319**	**8,103,858**	**2,247,517**	**2,790,827**
77													
78	External Provider Cost		17,825,967	6,188,839	11,637,128	459,183	1,948,944	413,499	2,829,775	169,085	4,042,548	519,493	1,254,600
79	Internal Program Cost		9,603,986	-	9,603,986	684,206	1,608,993	640,663	2,657,235	694,404	1,537,475	873,668	907,342
80	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**27,429,953**	**6,188,839**	**21,241,114**	**1,143,389**	**3,557,938**	**1,054,162**	**5,487,010**	**863,489**	**5,580,023**	**1,393,161**	**2,161,942**
82	**Medical Loss Ratio (HCC % of Revenue)**		**78.4%**	**97.7%**	**74.1%**	**83.4%**	**60.1%**	**79.3%**	**106.5%**	**49.7%**	**68.9%**	**62.0%**	**77.5%**
83													
84	**Managed Care Administration**		**2,613,133**	**1,062,393**	**1,550,741**	**85,271**	**262,104**	**89,071**	**375,399**	**78,559**	**444,666**	**87,240**	**128,431**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.7%**	**3.5%**	**5.2%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
86													
87	**Contract Cost**		**30,043,086**	**7,251,231**	**22,791,855**	**1,228,660**	**3,820,041**	**1,143,233**	**5,862,409**	**942,048**	**6,024,689**	**1,480,401**	**2,290,373**
88	**Net before Settlement**		**4,946,356**	**(915,488)**	**5,861,844**	**141,942**	**2,102,610**	**186,446**	**(712,164)**	**796,271**	**2,079,169**	**767,116**	**500,454**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(4,946,356)	915,488	(5,861,844)	(141,942)	(2,102,610)	(186,446)	712,164	(796,271)	(2,079,169)	(767,116)	(500,454)
93	**Net after Settlement**		**0**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
97	Revenue PMPM		$ 55.68	$ 10.08	$ 45.60	$ 44.91	$ 45.56	$ 44.95	$ 45.93	$ 45.25	$ 45.95	$ 45.69	$ 44.88
98	Expense PMPM		47.81	11.54	36.27	40.26	29.38	38.65	52.28	24.52	34.16	30.09	36.84
99	Margin PMPM		$ 7.87	$ (1.46)	$ 9.33	$ 4.65	$ 16.17	$ 6.30	$ (6.35)	$ 20.73	$ 11.79	$ 15.59	$ 8.05
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
106	Budget		51,569	51,569	51,569	2,512	10,410	2,431	9,168	2,975	15,052	3,917	5,103
107	Variance - Favorable / (Unfavorable)		796	796	796	31	424	34	176	226	(356)	183	78
108	% Variance - Fav / (Unfav)		1.5%	1.5%	1.5%	1.2%	4.1%	1.4%	1.9%	7.6%	-2.4%	4.7%	1.5%
109													
110	**Contract Revenue before settlement**												
111	Actual		34,989,442	6,335,743	28,653,699	1,370,602	5,922,651	1,329,679	5,150,246	1,738,319	8,103,858	2,247,517	2,790,827
112	Budget		29,027,015	5,016,199	24,010,816	1,159,255	4,844,554	1,125,228	4,296,564	1,368,310	7,049,612	1,816,861	2,350,433
113	Variance - Favorable / (Unfavorable)		5,962,427	1,319,544	4,642,883	211,347	1,078,097	204,451	853,682	370,009	1,054,247	430,656	440,395
114	% Variance - Fav / (Unfav)		20.5%	26.3%	19.3%	18.2%	22.3%	18.2%	19.9%	27.0%	15.0%	23.7%	18.7%
115													
116	**Healthcare Cost**												
117	Actual		27,429,953	6,188,839	21,241,114	1,143,389	3,557,938	1,054,162	5,487,010	863,489	5,580,023	1,393,161	2,161,942
118	Budget		25,127,724	5,813,027	19,314,697	1,380,754	2,888,453	1,265,829	4,763,800	982,435	5,128,279	1,165,313	1,739,834
119	Variance - Favorable / (Unfavorable)		(2,302,229)	(375,812)	(1,926,417)	237,364	(669,484)	211,667	(723,210)	118,946	(451,744)	(227,848)	(422,108)
120	% Variance - Fav / (Unfav)		-9.2%	-6.5%	-10.0%	17.2%	-23.2%	16.7%	-15.2%	12.1%	-8.8%	-19.6%	-24.3%
121													
122	**Managed Care Administration**												
123	Actual		2,613,133	1,062,393	1,550,741	85,271	262,104	89,071	375,399	78,559	444,666	87,240	128,431
124	Budget		2,405,657	950,562	1,455,095	102,818	215,311	105,712	343,811	75,278	431,101	72,759	108,306
125	Variance - Favorable / (Unfavorable)		(207,476)	(111,831)	(95,645)	17,547	(46,792)	16,641	(31,589)	(3,281)	(13,566)	(14,481)	(20,125)
126	% Variance - Fav / (Unfav)		-8.6%	-11.8%	-6.6%	17.1%	-21.7%	15.7%	-9.2%	-4.4%	-3.1%	-19.9%	-18.6%

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1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	**FY21 Budget**			**12**									
3	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
127													
128	**Total Contract Cost**												
129	Actual		30,043,086	7,251,231	22,791,855	1,228,660	3,820,041	1,143,233	5,862,409	942,048	6,024,689	1,480,401	2,290,373
130	Budget		27,533,381	6,763,588	20,769,793	1,483,571	3,103,765	1,371,542	5,107,611	1,057,712	5,559,379	1,238,072	1,848,141
131	Variance - Favorable / (Unfavorable)		(2,509,705)	(487,643)	(2,022,062)	254,911	(716,277)	228,309	(754,798)	115,665	(465,309)	(242,329)	(442,233)
132	% Variance - Fav / (Unfav)		-9.1%	-7.2%	-9.7%	17.2%	-23.1%	16.6%	-14.8%	10.9%	-8.4%	-19.6%	-23.9%
133													
134	**Net before Settlement**												
135	Actual		4,946,356	(915,488)	5,861,844	141,942	2,102,610	186,446	(712,164)	796,271	2,079,169	767,116	500,454
136	Budget		1,493,634	(1,747,389)	3,241,023	(324,316)	1,740,789	(246,314)	(811,047)	310,598	1,490,232	578,789	502,292
137	Variance - Favorable / (Unfavorable)		3,452,722	831,901	2,620,821	466,258	361,820	432,760	98,883	485,674	588,937	188,327	(1,838)
138													
139		x											

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	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	**FY21 Budget**			**12**									
3	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
140	***Autism Specialty Services***			*HCC%*	7.3%	5.6%	9.6%	8.9%	6.9%	4.9%	7.2%	2.6%	8.8%
141	**Contract Revenue**		**17,346,549**	**-**	**17,346,549**	**849,223**	**3,284,013**	**959,862**	**3,152,368**	**895,902**	**5,108,548**	**1,398,199**	**1,698,436**
142													
143	External Provider Cost		15,283,003	-	15,283,003	-	4,463,446	1,175,846	1,459,963	574,439	5,302,991	424,994	1,881,325
144	Internal Program Cost		2,433,896	-	2,433,896	618,164	3,404	-	1,679,419	2,586	-	8,461	121,863
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**17,716,900**	**-**	**17,716,900**	**618,164**	**4,466,850**	**1,175,846**	**3,139,382**	**577,025**	**5,302,991**	**433,455**	**2,003,188**
147	**Medical Loss Ratio (HCC % of Revenue)**		**102.1%**	**0.0%**	**102.1%**	**72.8%**	**136.0%**	**122.5%**	**99.6%**	**64.4%**	**103.8%**	**31.0%**	**117.9%**
148													
149	**Managed Care Administration**		**1,996,723**	**686,195**	**1,310,528**	**46,101**	**329,061**	**99,353**	**214,784**	**52,497**	**422,590**	**27,143**	**119,000**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**10.1%**	**3.5%**	**6.6%**	**6.9%**	**6.9%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.9%**	**5.6%**
151													
152	**Contract Cost**		**19,713,623**	**686,195**	**19,027,428**	**664,265**	**4,795,910**	**1,275,199**	**3,354,166**	**629,522**	**5,725,581**	**460,598**	**2,122,187**
153	**Net before Settlement**		**(2,367,074)**	**(686,195)**	**(1,680,878)**	**184,957**	**(1,511,897)**	**(315,337)**	**(201,798)**	**266,380**	**(617,033)**	**937,601**	**(423,751)**
154	Contract Settlement / Redistribution		2,367,074	686,195	1,680,878	(184,957)	1,511,897	315,337	201,798	(266,380)	617,033	(937,601)	423,751
155	**Net after Settlement**		**(0)**	**(0)**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.7%	7.6%	1.0%	0.4%	0.0%	0.9%	0.0%	1.5%	0.3%
159	**Contract Revenue**		**7,801,586**	**6,468,777**	**1,332,809**	**91,443**	**473,006**	**37,629**	**-**	**147,634**	**271,161**	**192,262**	**119,674**
160													
161	External Provider Cost		6,644,470	6,644,470	-	-	-	-	-	-	-	-	-
162	Internal Program Cost		1,781,975	-	1,781,975	831,811	476,306	52,350	-	100,195	13,373	244,844	63,097
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**8,426,445**	**6,644,470**	**1,781,975**	**831,811**	**476,306**	**52,350**	**-**	**100,195**	**13,373**	**244,844**	**63,097**
165	**Medical Loss Ratio (HCC % of Revenue)**		**108.0%**	**102.7%**	**133.7%**	**909.6%**	**100.7%**	**139.1%**	**0.0%**	**67.9%**	**4.9%**	**127.3%**	**52.7%**
166													
167	**Managed Care Administration**		**(624,860)**	**(624,860)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**-8.0%**	**-8.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**7,801,585**	**6,019,610**	**1,781,975**	**831,811**	**476,306**	**52,350**	**-**	**100,195**	**13,373**	**244,844**	**63,097**
171	**Net before Settlement**		**0**	**449,167**	**(449,166)**	**(740,368)**	**(3,300)**	**(14,721)**	**-**	**47,439**	**257,788**	**(52,582)**	**56,577**
172	Contract Settlement		(0)	(449,167)	449,166	740,368	3,300	14,721	-	(47,439)	(257,788)	52,582	(56,577)
173	**Net after Settlement**		**-**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175		x	-										

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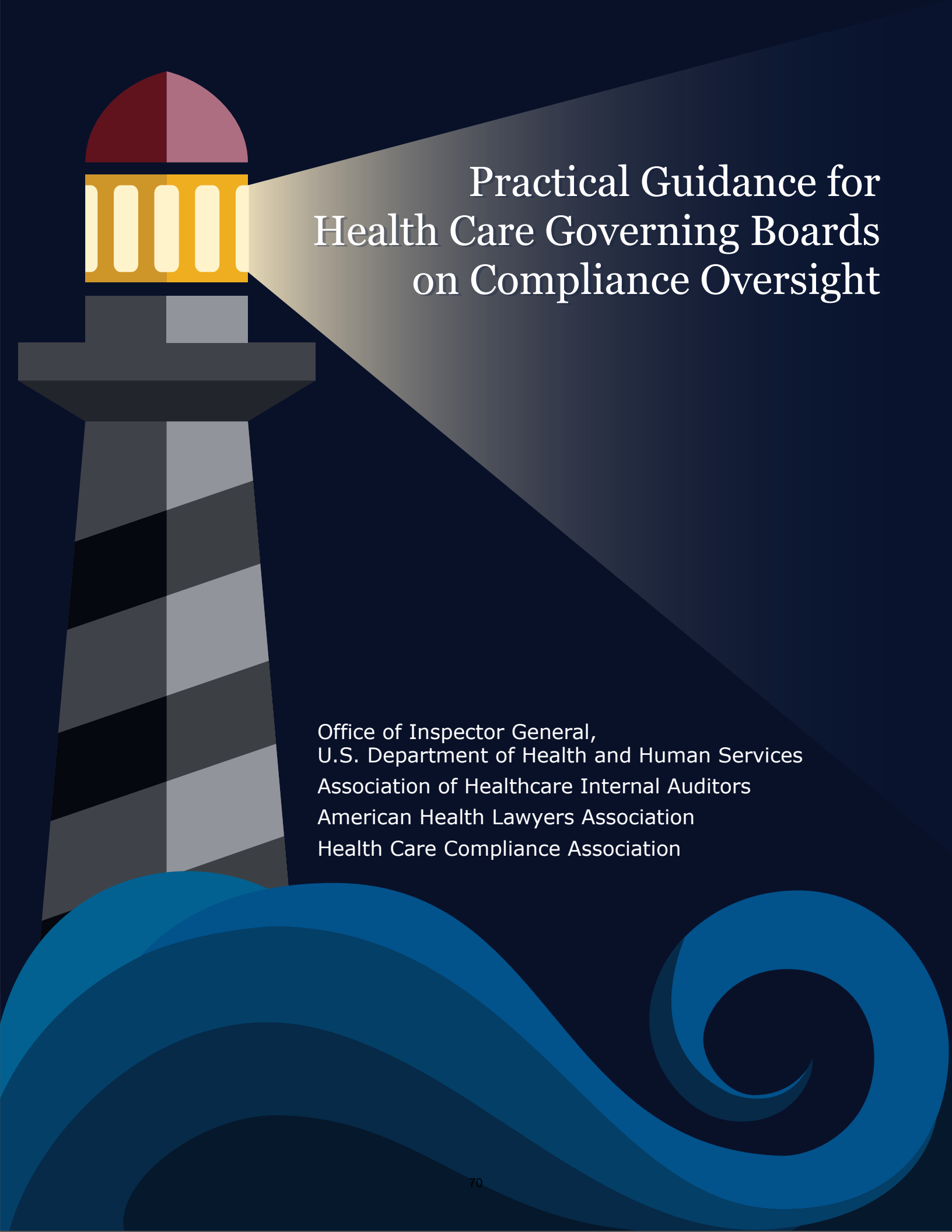
	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*									
2	**FY21 Budget**			12									
3	*(For Internal Management Purposes Only)*			*ok*	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		275,942,104	26,025,294	249,916,810	10,826,761	49,171,332	13,347,875	45,272,250	13,798,341	75,784,716	17,596,871	24,118,664
178	Incentive Payment Revenue		629,741	252,180	377,560	36,005	45,385	36,308	120,000	4,862	115,000	20,000	-
179	**Contract Revenue**		**276,571,844**	**26,277,474**	**250,294,370**	**10,862,766**	**49,216,717**	**13,384,183**	**45,392,250**	**13,803,203**	**75,899,716**	**17,616,871**	**24,118,664**
180													
181	External Provider Cost		181,169,590	16,426,863	164,742,727	5,034,720	32,764,310	8,713,324	28,460,607	6,893,668	59,466,802	10,202,014	13,207,282
182	Internal Program Cost		66,355,071	-	66,355,071	5,509,030	12,194,398	3,873,433	14,739,105	4,155,330	10,978,168	6,268,619	8,636,988
183	SSI Reimb, 1st/3rd Party Cost Offset		(860,253)	-	(860,253)	(13,323)	(155,945)	(43,642)	(190,547)	(43,016)	(307,980)	(30,000)	(75,800)
184	Insurance Provider Assessment Withhold (IPA)		6,508,933	6,508,933	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		1,004,042	1,004,042	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**254,177,383**	**23,939,838**	**230,237,545**	**10,530,427**	**44,802,763**	**12,543,115**	**43,009,165**	**11,005,982**	**70,136,990**	**16,440,634**	**21,768,470**
187	**Medical Loss Ratio (HCC % of Revenue)**		**91.9%**	**91.1%**	**92.0%**	**96.9%**	**91.0%**	**93.7%**	**94.8%**	**79.7%**	**92.4%**	**93.3%**	**90.3%**
188													
189	**Managed Care Administration**		**25,411,641**	**8,541,153**	**16,870,489**	**723,298**	**3,265,410**	**1,055,403**	**2,942,515**	**992,193**	**5,588,079**	**1,014,179**	**1,289,412**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.1%**	**3.1%**	**6.0%**	**6.4%**	**6.8%**	**7.8%**	**6.4%**	**8.3%**	**7.4%**	**5.8%**	**5.6%**
191													
192	**Contract Cost**		**279,589,024**	**32,480,990**	**247,108,034**	**11,253,724**	**48,068,173**	**13,598,518**	**45,951,681**	**11,998,174**	**75,725,070**	**17,454,813**	**23,057,881**
193	**Net before Settlement**		**(3,017,180)**	**(6,203,516)**	**3,186,336**	**(390,958)**	**1,148,544**	**(214,335)**	**(559,431)**	**1,805,029**	**174,646**	**162,059**	**1,060,782**
194													
195	Prior Year Savings		2,579,282	2,579,282	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(0)	3,186,336	(3,186,336)	390,958	(1,148,544)	214,335	559,431	(1,805,029)	(174,646)	(162,059)	(1,060,782)
198	**Net after Settlement**		**(437,898)**	**(437,898)**	**0**	**0**	**(0)**	**0**	**-**	**-**	**(0)**	**0**	**(0)**
199													
200													

DRAFT

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			***Mos in Period***									
2	**FY21 Budget**			**12**									
3	*(For Internal Management Purposes Only)*			***ok***	**CMHP SubC revenue is as reported by SWMBH. May not agree with SubC amounts reported by CMHPs.**								
4	***INCOME STATEMENT***		**Total SWMBH**	**SWMBH Central**	**CMH Participants**	**Barry CMHA**	**Berrien CMHA**	**Pines Behavioral**	**Summit Pointe**	**Woodlands Behavioral**	**Kalamazoo CCMHSAS**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	4.7%	4.4%	3.6%	4.8%	5.8%	6.4%	4.8%	2.2%	4.8%
202	**Contract Revenue**				**11,582,725**	**793,253**	**2,019,282**	**751,543**	**1,969,536**	**611,785**	**3,752,587**	**743,903**	**940,836**
203													
204	External Provider Cost				4,090,313	203,272	320,492	117,403	515,437	488,587	2,079,770	183,851	181,500
205	Internal Program Cost				7,314,666	278,709	1,367,260	515,334	2,134,405	267,389	1,636,790	193,631	921,148
206	SSI Reimb, 1st/3rd Party Cost Offset				(181,000)	-	-	-	-	-	(181,000)	-	-
207	**Total Healthcare Cost**				**11,223,979**	**481,981**	**1,687,752**	**632,737**	**2,649,842**	**755,976**	**3,535,560**	**377,482**	**1,102,648**
208	**Medical Loss Ratio (HCC % of Revenue)**				**96.9%**	**60.8%**	**83.6%**	**84.2%**	**134.5%**	**123.6%**	**94.2%**	**50.7%**	**117.2%**
209													
210	**Managed Care Administration**				**923,554**	**39,585**	**139,230**	**59,777**	**201,410**	**75,128**	**309,308**	**26,448**	**72,667**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.6%**	**7.6%**	**7.6%**	**8.6%**	**7.1%**	**9.0%**	**8.0%**	**6.5%**	**6.2%**
212													
213	**Contract Cost**				**12,147,532**	**521,566**	**1,826,982**	**692,514**	**2,851,253**	**831,105**	**3,844,868**	**403,930**	**1,175,315**
214	**Net before Settlement**				**(564,807)**	**271,687**	**192,300**	**59,029**	**(881,717)**	**(219,319)**	**(92,281)**	**339,973**	**(234,479)**
215													
216	Other Redistributions of State GF				(97,584)	-	-	-	-	-	-	-	(97,584)
217	Contract Settlement				(727,591)	(258,833)	(91,336)	(52,575)	-	-	-	(324,847)	-
218	**Net after Settlement**				**(1,389,982)**	**12,854**	**100,964**	**6,454**	**(881,717)**	**(219,319)**	**(92,281)**	**15,126**	**(332,063)**
219													



Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services
Association of Healthcare Internal Auditors
American Health Lawyers Association
Health Care Compliance Association

About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

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Introduction

Previous guidance[1] has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.[2] The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),[3] OIG's voluntary compliance program guidance documents,[4] and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."[5] The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to "the size of the organization."[6] In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.[7] Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.[8] Smaller organizations may meet their compliance responsibility by "using available personnel, rather than employing separate staff, to carry out the compliance and ethics program." Board members of such organizations may wish to evaluate whether the organization is "modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations."[9] The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations' compliance and ethics efforts than their larger counterparts.[10]

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

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7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.[11] OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.[12] Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

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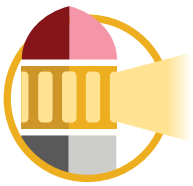
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 *See* Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:



The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,[13] and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.[14] While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;[15]

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13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

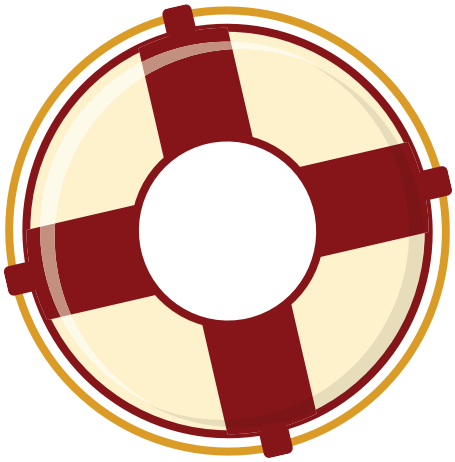
15 *See, generally, id.*

the same is true for internal audit.[16] To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is "monitoring and auditing to detect criminal conduct."[17] Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.[18]

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[19] offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

Compliance is an enterprise-wide responsiblity.

In an effort to support the concept that compliance is "a way of life," a Board may assess employee performance in promoting and adhering to compliance.[20] An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html.

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.[21] The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is "identified" or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to "identify" an overpayment.[22] However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization's compliance program may be in correcting and remediating compliance issues.

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21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is "identified" when a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.") disregard or deliberate ignorance of the overpayment."); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG's Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management's responses to identified violations of the organization's policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization's compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

23 *See* OIG, *Self-Disclosure Information*, http://oig.hhs.gov/compliance/self-disclosure-info.

24 *See id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).")

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

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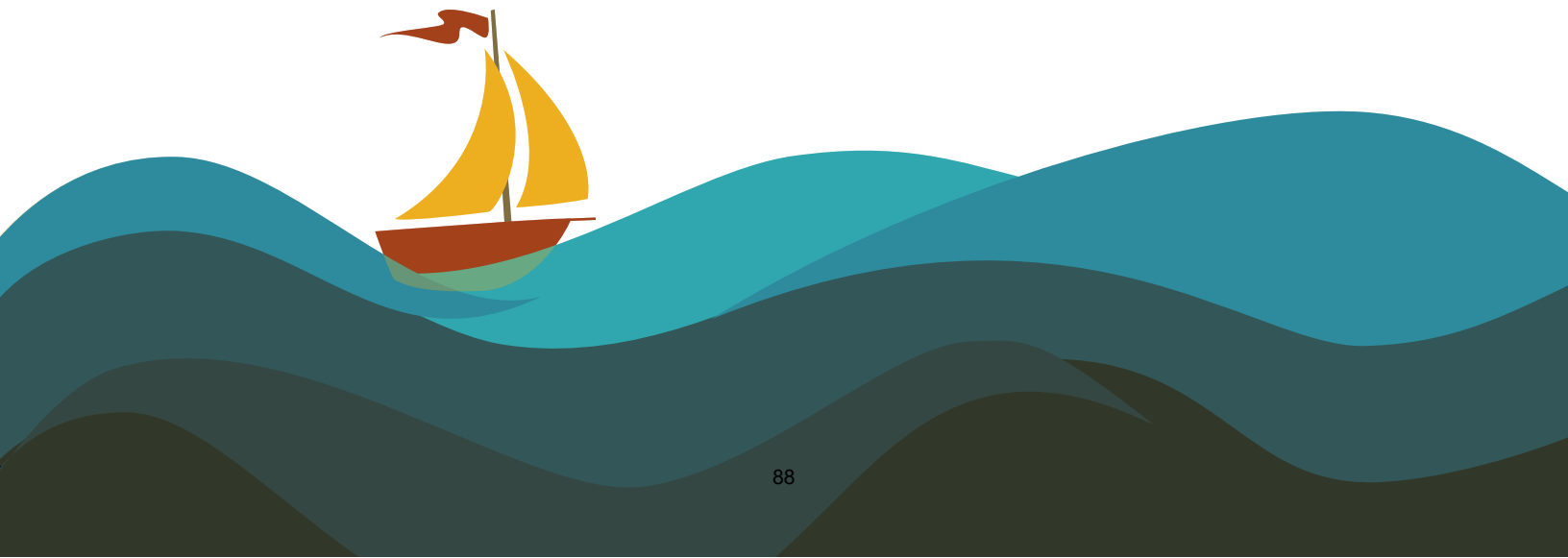
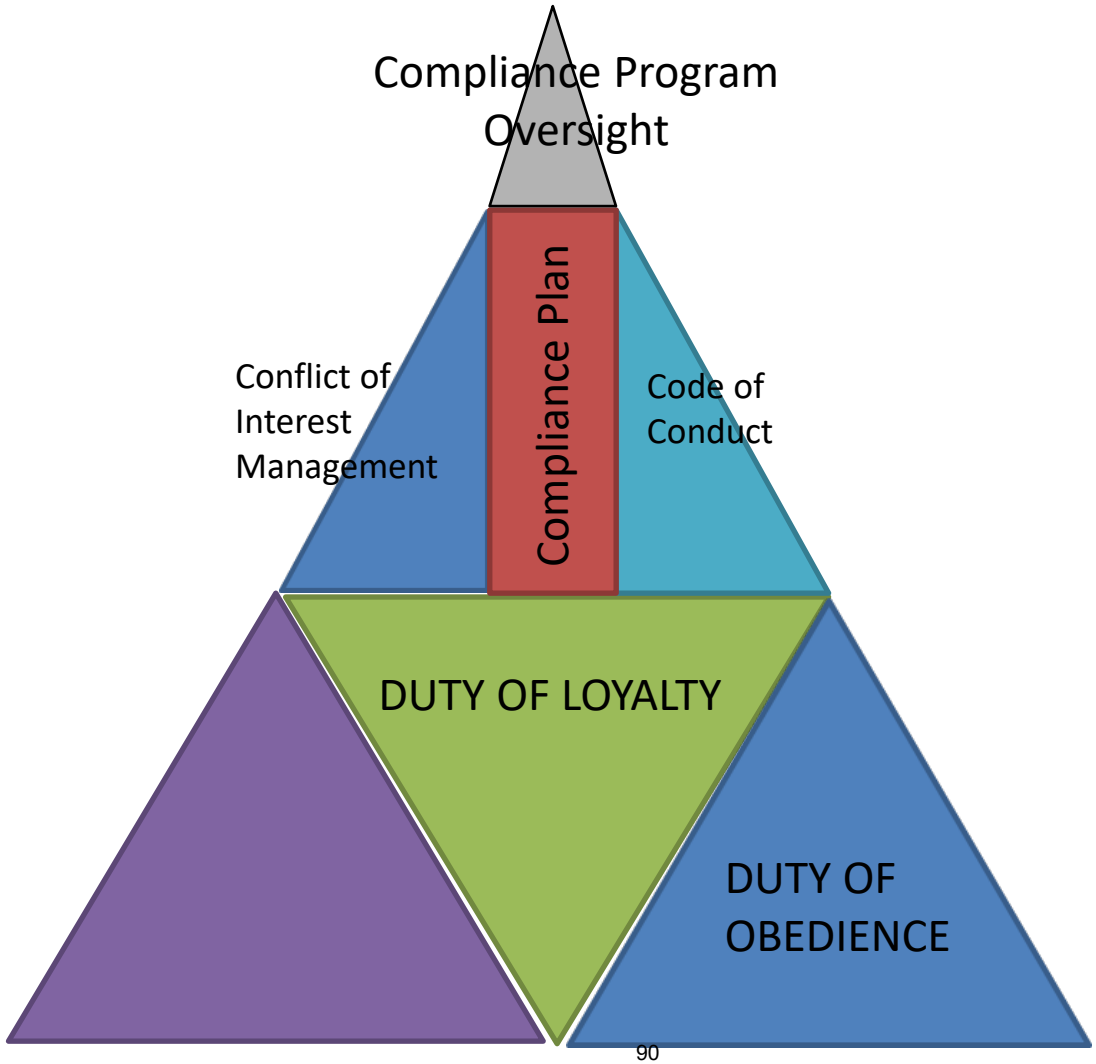


Corporate Compliance Role and Function

Board of Directors: Role & Function



Board of Directors: Role & Function

Board of Directors: Role & Function

- Examples – spouse is employed by a provider within SWMBH's provider network; you serve as a Board member for a contracted entity; child works for a SWMBH vendor.

- Chief Compliance Officer reviews and Board determines of a real or perceived COI exists.
- If no, no further action.
- If yes, Board evaluates what restrictions can be implemented so Board Member can continue service AND continue with actual/perceived COI, OR if the two positions are mutually exclusive (very rare).

Board of Directors: Role & Function

- Understanding and abiding by reporting obligations – duty to report actual/suspected fraud, waste, or abuse to the Chief Compliance Officer;
- Cooperating fully with any Compliance investigation;
- Remaining free of the influence of alcohol and illegal drugs while performing Board service;
- Abstaining from harassment and discrimination in any form;
- Remaining free from conflicts of interest;
- Maintaining confidentiality, when appropriate (subject to OMA);
- Not accepting or soliciting business courtesies or gifts meant to effect business decisions, nor any single gift of more than a $25 value or $300 value per year.

Board of Directors: Role & Function

Board Oversight Responsibilities

Making inquiries to ensure:

- (1) a corporate information and reporting system exists, and
- (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. *(In re Caremark Int'l, Inc. Derivative Litig. 698 A.2d 959 (Del. Ch. 1996)*).

Practical Guidance for Health Care Governing Boards on Compliance Oversight (Published April 20, 2015):

- "The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity."

Board Oversight Responsibilities

(1) a corporate information and reporting system exists…

- Designation of Chief Compliance Officer
  - Delegated day-to-day operational responsibility for the development and implementation of the compliance program
  - Direct access and accountability to the Board
  - Schedule for reporting included on the Board Calendar
- Reporting obligations, including Whistleblower protections, are well-publicized and communicated to Board members, staff, and network providers
  - Corporate Compliance Plan
  - SWMBH Code of Conduct
  - SWMBH Policy for reporting FWA

Board Oversight Responsibilities

(2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.

- Annually the Board reviews and prospectively approves the PI/C Corporate Compliance Plan.
  - Includes Audit & Monitoring Plan
- Bi-annual reports to the Board regarding PI/C investigations, breaches, and audits. Includes any reporting to outside entities.
- Annual PI/C Program Evaluation submitted to the Board to review program initiatives, changes, and improvements.
- Periodic updates as necessary.

Are you satisfied with the information you receive? If not, it is your responsibility to instruct management that you want more.

SWMBH Compliance Team

- SWMBH Program Integrity & Compliance Department
  - Four Compliance Specialists – Alison Strasser, Jordan Huyser, Shelley Cizio and one vacant position
  - Responsible for day-to-day operations of the Compliance Program
- SWMBH Compliance Committee
  - Comprised of SWMBH Senior leadership from varying departments, as well as a CMH CEO (presently Van Buren's Debbie Hess)
  - Responsible for oversight of Compliance Program activities
  - Meets monthly
- Regional Compliance Coordinating Committee
  - Compliance Officer from each CMHSP and SWMBH Compliance Dept.
  - Meets monthly to coordinate compliance activities across the Region
- Corporate Counsel
- PIHP Compliance Officers
  - Meet periodically to discuss compliance related issues

SWMBH Compliance Risks

- Fraud, Waste, and Abuse
- Appropriate and accurate coding of services
- Appropriate use of modifiers
- Proper credentials for clinicians providing service(s)
- Third Party Liability/Coordination of Benefits
- Excluded providers
- Privacy of Protected Health Information (PHI)

SWMBH Compliance Risks

- How does SWMBH manage Compliance Risks?
  - Routine audit & monitoring
    - Quarterly Medicaid claims review
    - Quarterly MHL claims review
    - SUD Reviews – Block Grant ATP and COB
  - Focused audits
    - As part of investigations
    - Necessitated by concerning findings and/or poor performance on a routine audit(s)
  - Well publicized reporting system
    - SWMBH internal, CMHSPs, entire provider network
  - Excluded provider monitoring
    - Prior to hire/contracting, monthly for all staff, “Screened Persons”, provider entities, and contractors that meet statutory threshold

SWMBH Compliance Risks

- How do we manage them? (continued)
  - Data Mining
    - Developed business processes as part of department goals this year, now ready for implementation to address:
      - Overlapping billing
      - Appropriate use of specific modifiers (in response to investigation findings)
      - Third party billing reviews
  - Training/Education & Effective lines of Communication
    - At hire, electronically annually, in-person annually during Compliance Week
    - Open-door policy for entire Compliance team
  - Breach Report and Review Process
    - Staff do a wonderful job reporting actual and suspected unauthorized uses and/or disclosures of PHI
    - Reviewed by SWMBH's Breach Response Team monthly
  - Quarterly reporting to the MI Office of Inspector General (OIG)

Board Compliance Reports

- Current schedule:
  - Bi-annual reports
    - Number, type, and outcome of investigations and breaches
    - Update on on-going compliance audits
  - Annual Corporate Compliance education
    - Refresher on Board's role
    - Highlight risks and how SWMBH addresses
  - Updates as needed
    - Anytime an external agency is involved, or when disclosure is required to an authoritative body
    - Any situations that would implicate the entity's Executive Officer
  - Board prospectively reviews and approves the Corporate Compliance Plan for the coming Fiscal Year
- Do you feel this meets your needs?
- Is there additional information you feel is necessary?

Code of Conduct

Important Phone Numbers

Compliance Hotline: (800) 783-0914

Mila C. Todd, Chief Compliance & Privacy Officer: (269) 488-6794

Southwest Michigan Behavioral Health Vision, Mission, Values and Behavioral Standards

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH VISION

To ensure persons with specialty care needs reside in their own community, have a quality and healthy lifestyle and are fully accepted.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH MISSION

To provide a community-based, integrated specialty care system for individuals and families with mental health, developmental disabilities and substance abuse needs that empowers people to succeed. To ensure all persons receiving our services have access to the highest quality care available.

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH VALUES

Customer Driven
Person-Centered
Recovery Oriented
Evidenced-Based
Integrated Care
Trust
Integrity

Transparency
Inclusive
Accessibility
Acceptability
Impact
Value
Culturally Competent & Diverse Workforce
High Quality Services
Regulatory Compliance

The Code of Conduct serves to function as a foundational document that details the fundamental principles, values and framework for action within Southwest Michigan Behavioral Health's (SWMBH) compliance program. The Code of Conduct articulates SWMBH's commitment to comply with all applicable Federal and State standards. The standards not only address compliance with statutes and regulations, but also set forth broad principles that guide employees in conducting business professionally and properly. The standards included in the Code of Conduct will promote integrity, support objectivity, and foster trust. Furthermore, the SWMBH standards of conduct will reflect a commitment to high quality health care delivery as evidenced by its conduct, of on-going performance assessment, improved outcomes of care, and respect for the rights of SWMBH's consumers.

SWMBH is committed to conducting its business in a manner that facilitates quality, efficiency, honesty, integrity, confidentiality, respect and full compliance with applicable laws and regulations. In order to achieve this goal, SWMBH recognizes that it must require its staff to maintain a standard of behavior that is both lawful and ethical. Accordingly,

- SWMBH will advise and train its staff about the applicable laws and requirements.
- SWMBH board members, administration, staff, participating CMHSP's and providers are expected to assume personal responsibility and accountability for understanding relevant laws, regulations and contract and grant requirements and for ensuring compliance.
- SWMBH management is committed to informing those under their supervision that they should comply with the applicable standards and, if they do not comply, appropriate disciplinary action will be taken.

Definitions

- Abuse: means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

- Fraud (per CMS): means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act.

- Fraud (per Michigan Medicaid): Michigan law permits a finding of Medicaid fraud based upon "constructive knowledge." This means that if the course of conduct "reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

- Waste: means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Reporting Violations

All staff or agents of the organization have the responsibility not only to comply with the laws and regulations but to ensure that others do as well. Any staff or agent who has firsthand knowledge of activities or omissions that may violate applicable laws and regulations is required to report such wrongdoing. Reporting suspected violations is mandatory, not optional. Staff will be informed that in some instances, failure to report a suspected violation may be the basis for disciplinary action against the staff. Corporate Compliance violations may be reported to the Chief Compliance Officer through either the hotline **(800) 783-0914**, e-mail, in person or in writing. All reports of wrongdoing shall be investigated to the extent necessary to determine their validity. No staff, provider or agent making such a report in good faith shall be retaliated against by SWMBH, staff, or agents and will be protected by the Michigan Whistleblower's Protection Act. Discipline for engaging in acts that violate applicable laws and regulations, making knowingly false reports, or discipline for any other performance–related reason unconnected to reporting potential violations is not retaliation.

Resources for Guidance

Staff or agents may seek clarification from the Compliance Program, organizational policies, or may direct questions to the Chief Compliance Officer through either the hotline, e-mail, in person or in writing.

Confidentiality

All staff or agents making reports are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigation. Nonetheless, anonymous reports are better than no report at all, and no report shall be refused or treated less seriously because the

reporter wishes to remain anonymous. Confidentiality and anonymity of the reporter/complainant and the content of the report will be preserved to the extent permitted by law and by the circumstances. Information about reports, investigations, or follow-up actions shall not be disclosed to anyone other than those individuals charged with responsibility in investigation and remedial action as well as legal counsel.

Examples of Fraud, Waste and Abuse That Should Be Reported

Examples of fraud, waste and abuse activities that should be reported include, but are not limited to, the following;

- Financial
    - Forgery or alteration of documents related to SWMBH services and/or expenditures (checks, contracts, purchase orders, invoices, etc.);
    - Misrepresentation of information on documents (financial records and medical records);
    - Theft, unauthorized removal, or willful destruction of SWMBH records or property;
    - Misappropriation of SWMBH funds or equipment, supplies or other assets purchased with Medicaid or Medicare funds; and
    - Embezzlement or theft

- Beneficiaries/Consumers:
    - Changing, forging or altering medical records;
    - Changing referral forms;
    - Letting someone else use their Medicaid or Medicare card to obtain SWMBH covered services;
    - Misrepresentation of eligibility status;
    - Identity theft;
    - Prescription diversion and inappropriate use;
    - Resale of medications on the black market;
    - Prescription stockpiling;

- Provider
    - Lying about credentials such as a college degree;
    - Billing for services that were not provided;
    - Billing a balance that is not allowed;
    - Double billing or upcoding;
    - Underutilization – not ordering or providing services that are medically necessary;
    - Overutilization – ordering or providing services in excess of what is medically necessary;

- Falsifying information (not consistent with the consumer's condition or medical record) submitted through a prior authorization or other service utilization oversight mechanism in order to justify coverage;
- Forging a signature on a contract or other document;
- Pre- or post-dating a contract or other document;
- Intentionally submitting a false claim;
- Changing, forging or altering medical records;
- Kickbacks, inducements and/or other illegal remunerations; and
- Illegal use of drug samples

Internal Investigation

All reports of wrongdoing, however received, shall be investigated and documented according to the Corporate Compliance Investigation Procedure. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within SWMBH who is not involved in the investigatory process or to anyone outside SWMBH without the prior approval of the Chief Compliance Officer. All staff and agents are expected to cooperate fully with investigation efforts.

Disciplinary Accountability and Consequences

SWMBH has formulated guidelines regarding the consequences and disciplinary action for staff who have failed to comply with SWMBH policies and procedures, Federal and State laws or the Corporate Compliance Plan. The disciplinary measures will vary depending upon the severity of the transgression. Sanctions could range from an oral warning to suspension, termination or financial penalties as appropriate.

Disciplinary actions will be taken in a fair, equitable, appropriate and consistent manner. All staff will be subject to the same disciplinary action for the commission of similar offenses.

Conflicts of Interest

In order to safeguard SWMBH's commitment to ethical and legal standards of conduct, Board Members, all officers, all senior management members, medical staff, and individuals with Board-designated powers and/or authority shall avoid any action that conflicts with the interests of the organization and refrain from being influenced by personal considerations in the performance of their duties. Unless properly disclosed and approved by SWMBH, it could be a conflict of interest to, but is not limited to:

- Have an interest in a publicly held company, vendor, customer or competitor of SWMBH;
- Work for, consult with or provide services to a competitor; and/or
- Use confidential information obtained for any person's personal gain or benefit.

Accordingly, staff/agents, officers, senior managers, and medical staff must disclose the existence and nature of any actual or potential conflict of interest on their Conflict of Interest Form or to the Chief Compliance Officer at the time of interview, orientation and annually thereafter and/or when a conflicting interest arises. All actual or potential conflicts of interest

disclosed shall be reviewed by the Chief Compliance Officer, according to previously identified criteria, to determine whether there is a conflict of interest.

Substance Abuse

To protect staff/agents and consumers, SWMBH is committed to an alcohol and drug-free environment. All staffs/agents must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drugs or alcohol, having an illegal drug in one's system, or using, possessing, or distributing/selling illegal drugs while on SWMBH's work time or property may result in immediate termination.

Harassment

Mutual respect among all staff members in the way we treat each other is expected. Each SWMBH staff/agent has the right to work in an environment free of harassment. Therefore, harassment of staff/agents in the work place by any person or in any form is prohibited by SWMBH. This includes sexual harassment; harassment based on sex, race, color, religion, national origin, citizenship, disability, age, sexual orientation, or any other protected category; or conduct such as ridicule or degrading comments to others which severely and adversely affect their work environment or interferes with their ability to perform their job. Alleged harassment should be reported to a member of the senior management team or to the Human Resources Director.

Confidentiality

SWMBH is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any consumer information to anyone other than a staff/agent or staff member involved in the care and treatment of that consumer. Any staff/agent who engages in the unauthorized disclosure of any information concerning a consumer may be subject to immediate termination. Staff/agents shall comply with the SWMBH Confidentiality Policy, the Michigan Mental Health Code, HIPAA Privacy requirements, and all other applicable laws and regulations.

To ensure that all consumer information remains confidential, staff/agents are required to comply with the following guidelines:

- Staff/agents shall not discuss any consumer in an external or internal environment where such information could be heard by unauthorized personnel or other consumer/visitors.
- If asked about a consumer by anyone other than staff/agents involved in the care or treatment of the consumer, staff/agents will disclose no information unless first obtaining the written consent of the consumer or the consumer's representative/legal guardian.
- Medical staff members and staff/agents may not have access to the records of any consumer unless they are involved in the care and treatment of the consumer, or if a legal or administrative reason exists requiring them to have access to those documents.

Political Activities and Contributions

SWMBH funds or resources are not to be used to contribute to political campaigns or for gifts or payments to any political party or any of their affiliated organizations. SWMBH resources include financial and non-financial donations of funds, products, or services to any political cause.

Staff/agents may make voluntary contributions provided they do not communicate that their contributions are from SWMBH.

At times, SWMBH may ask staff/agents to make personal contact with government officials or to write letters to present the organization's position on specific issues. In addition, it is part of the role of some SWMBH management to interface on a regular basis with government officials. Such activity is permissible provided that funds and resources are not contributed.

Marketing Practices

There are times when SWMBH directly markets services to potential consumers; however, the federal Anti-Kickback Statute of the Social Security Act makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive "remuneration" as an inducement to generate business compensated by the Medicaid or Medicare programs.

Under no circumstances will SWMBH offer free items or services that are not related to medical or health care. Moreover, any free items offered must have no monetary value.

SWMBH staff/agents will not engage in any prohibitive marketing activities. These activities include: the giving of gifts or payments to induce enrollments, discrimination of any kind, unsolicited door-to-door marketing, and contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.

Charitable Contributions

All charitable contributions must be made for the benefit of SWMBH and for the purpose of advancing SWMBH's mission. The Executive Officer will oversee all charitable contributions to ensure that they are administered in accordance with the donor's intent. All checks and other documents must be made payable to SWMBH and given to the Finance Department to deposit into the appropriate account.

Contractual/Financial Arrangements with Health Care Professionals

SWMBH is committed to ensuring that all contractual and financial arrangements with health care professionals are structured in accordance with Federal and State laws and other regulations and are in the best interests of the organization and the consumers it serves. In order to ethically and legally meet all standards regarding referrals and enrollments, SWMBH will strictly adhere to the following:

- SWMBH does not pay for referrals. Consumer referrals and enrollments will be accepted based solely on the consumer's clinical needs and our ability to render the needed services. SWMBH does not pay or offer to pay anyone for referrals or consumers. Violation of this policy may have grave consequences for the organization and the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

- SWMBH does not accept payments for referrals. No SWMBH staff/agent or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers.
- SWMBH does not use financial incentives to encourage barriers to care and services and/or decisions the result in underutilization. SWMBH does not reward practitioners, or other individuals conducting utilization review, for issuing denials of coverage or service. All utilization management decision-making is based only on the existence of coverage and appropriateness of care and service. Clinical decisions are based on the clinical features of the individual case and the medical necessity criteria.

Receiving Business Courtesies and Gifts

No staff/agent or officer shall accept or solicit any gifts, gratuities, loans (in nature of a gratuity), or favors of any kind from any individual, firm, or corporation doing business with or seeking to do business with SWMBH or any of its affiliates, if the gift is offered or appears to be offered in exchange for any type of favorable treatment or advantage. Specifically, no gifts or favors shall be accepted if valued in excess of $25, with a maximum of $300 per year, or intended to affect the recipient's business decisions with SWMBH. Perishable or consumable gifts, except for items of minimal value such as flowers, cookies or candy from consumers and/or family members given to a department or group are not subject to any specific limitation. Under no circumstances shall a direct care staff receive monetary gifts from consumers and/or family members. Consumers wishing to make a gift must follow the protocol for charitable contributions. If there are concerns regarding any staff's acceptance of gifts, the Chief Compliance Officer, in coordination with the SWMBH Compliance Committee, shall make the final decision.

There are some circumstances where staff are invited to an event at a vendor's expense to receive information about new products or services. Prior to accepting any such invitation, approval must be received from the Executive Officer. Accepting personal gifts and/or entertainment can sometimes be construed as an attempt to influence judgment concerning patient care or performance of other duties at SWMBH. It may also violate the anti-kickback statue or conflict of interest policy. To that end, no staff may accept any cash amount, or any single gift of more than $25 value with the total not to exceed $300 per year.

Community: **SW MI Bahavioral Health**

Renewal period: Oct 1, 2020 to Oct 1, 2021

	Total Contribution	**Property Totals**
Last Year	$45,381	$545,092
This Year	$46,624	$550,543
Total Change	$1,243	$5,451
% Change (+ -)	**2.7%**	**1.0%**

RAP Grants:

	Net Asset Distribution	**Loss Fund Distribution**	**Total**	
MMRMA Coverage 2013-14				**LZ**
MMRMA Coverage 2014-15				**KD**
2015 MMRMA Distribution:	$3,911	$2,149	$6,060	**KD**
2016 MMRMA Distribution:	$3,196	$1,511	$4,707	**KE**
2017 MMRMA Distribution:	$4,463	$2,095	$6,558	**MR**
2018 MMRMA Distribution:	$6,785	$3,802	$10,587	**KE**
2019 MMRMA Distribution:	$10,544	$4,950	$15,494	**KE**
2020 MMRMA Distribution:	$14,400	$4,187	$18,587	**MR**
	$43,299	**$18,694**	**$61,993**	

MICHIGAN MUNICIPAL RISK MANAGEMENT AUTHORITY
COVERAGE OVERVIEW

Member:	**South West Michigan Behavioral Health**	**Member No:**	**M0001669**
Date of Original Membership:	**October 1, 2013**		
Overview Effective Dates:	**October 01, 2020 To October 01, 2021**		
Member Representative:	**Tracy Dawson**	**Telephone #:**	**(269) 488-6442**
Regional Risk Manager:	**Ibex Insurance Agency**	**Telephone #:**	**(248) 538-0470**

A. Introduction

The Michigan Municipal Risk Management Authority (hereinafter "MMRMA") is created by authority granted by the laws of the State of Michigan to provide risk financing and risk management services to eligible Michigan local governments. MMRMA is a separate legal and administrative entity as permitted by Michigan laws. **South West Michigan Behavioral Health** (hereinafter "Member") is eligible to be a Member of MMRMA. **South West Michigan Behavioral Health** agrees to be a Member of MMRMA and to avail itself of the benefits of membership.

South West Michigan Behavioral Health is aware of and agrees that it will be bound by all of the provisions of the Joint Powers Agreement, Coverage Documents, MMRMA rules, regulations, and administrative procedures.

This Coverage Overview summarizes certain obligations of MMRMA and the Member. Except for specific coverage limits, attached addenda, and the Member's Self Insured Retention (SIR) and deductibles contained in this Coverage Overview, the provisions of the Joint Powers Agreement, Coverage Documents, reinsurance agreements, MMRMA rules, regulations, and administrative procedures shall prevail in any dispute. The Member agrees that any dispute between the Member and MMRMA will be resolved in the manner stated in the Joint Powers Agreement and MMRMA rules.

B. Member Obligation - Deductibles and Self Insured Retentions

South West Michigan Behavioral Health is responsible to pay all costs, including damages, indemnification, and allocated loss adjustment expenses for each occurrence that is within the Member's Self Insured Retention (hereinafter the "SIR"). **South West Michigan Behavioral Health's** SIR and deductibles are as follows:

Table I

Member Deductibles and Self Insured Retentions

COVERAGE	DEDUCTIBLE	SELF INSURED RETENTION
Liability	N/A	State Pool Member
Vehicle Physical Damage	$250 Per Vehicle	State Pool Member
Fire/EMS Replacement Cost	N/A	N/A
Property and Crime	$1,000 Per Occurrence	N/A
Sewage System Overflow	N/A	N/A

The member must satisfy all deductibles before any payments are made from the Member's SIR or by MMRMA.

The **South West Michigan Behavioral Health** is afforded all coverages provided by MMRMA, except as listed below:

1. Sewage System Overflow
2. Specialized Emergency Response Expense Recovery Coverage
3.
4.

All costs including damages and allocated loss adjustment expenses are on an occurrence basis and must be paid first from the Member's SIR. The Member's SIR and deductibles must be satisfied fully before MMRMA will be responsible for any payments. The most MMRMA will pay is the difference between the Member's SIR and the Limits of Coverage stated in the Coverage Overview.

South West Michigan Behavioral Health agrees to maintain the Required Minimum Balance as defined in the Member Financial Responsibilities section of the MMRMA Governance Manual. The Member agrees to abide by all MMRMA rules, regulations, and administrative procedures pertaining to the Member's SIR.

C. MMRMA Obligations - Payments and Limits of Coverage

After the Member's SIR and deductibles have been satisfied, MMRMA will be responsible for paying all remaining costs, including damages, indemnification, and allocated loss adjustment expenses to the Limits of Coverage stated in Table II. The Limits of Coverage include the Member's SIR payments.

The most MMRMA will pay, under any circumstances, which includes payments from the Member's SIR, per occurrence, is shown in the Limits of Coverage column in Table II. The Limits of Coverage includes allocated loss adjustment expenses.

Table II

Limits of Coverage

	Liability and Motor Vehicle Physical Damage	Limits of Coverage Per Occurrence		Annual Aggregate	
		Member	All Members	Member	All Members
1	Liability	10,000,000	N/A	N/A	N/A
2	Judicial Tenure	N/A	N/A	N/A	N/A
3	Sewage System Overflows	0	N/A	0	N/A
4	Volunteer Medical Payments	25,000	N/A	N/A	N/A
5	First Aid	2,000	N/A	N/A	N/A
6	Vehicle Physical Damage	1,500,000	N/A	N/A	N/A
7	Uninsured/Underinsured Motorist Coverage (per person)	100,000	N/A	N/A	N/A
	Uninsured/Underinsured Motorist Coverage (per occurrence)	250,000	N/A	N/A	N/A
8	Michigan No-Fault	Per Statute	N/A	N/A	N/A
9	Terrorism	5,000,000	N/A	N/A	5,000,000

	Property and Crime	Limits of Coverage Per Occurrence		Annual Aggregate	
		Member	All Members	Member	All Members
1	Buildings and Personal Property	1,550,543	350,000,000	N/A	N/A
2	Personal Property in Transit	2,000,000	N/A	N/A	N/A
3	Unreported Property	5,000,000	N/A	N/A	N/A
4	Member's Newly Acquired or Constructed Property	10,000,000	N/A	N/A	N/A
5	Fine Arts	2,000,000	N/A	N/A	N/A
6	Debris Removal (25% of Insured direct loss plus)	25,000	N/A	N/A	N/A
7	Money and Securities	1,000,000	N/A	N/A	N/A
8	Accounts Receivable	2,000,000	N/A	N/A	N/A
9	Fire Protection Vehicles, Emergency Vehicles, and Mobile Equipment (Per Unit)	5,000,000	10,000,000	N/A	N/A
10	Fire and Emergency Vehicle Rental (12 week limit)	1,000 per week	N/A	N/A	N/A
11	Structures Other Than a Building	15,000,000	N/A	N/A	N/A
12	Storm or Sanitary Sewer Back-Up	1,000,000	N/A	N/A	N/A
13	Marine Property	1,000,000	N/A	N/A	N/A
14	Other Covered Property	10,000	N/A	N/A	N/A
15	Income and Extra Expense	5,000,000	N/A	N/A	N/A
16	Blanket Employee Fidelity	1,000,000	N/A	N/A	N/A
17	Faithful Performance	Per Statute	N/A	N/A	N/A
18	Earthquake	5,000,000	N/A	5,000,000	100,000,000
19	Flood	5,000,000	N/A	5,000,000	100,000,000
20	Terrorism	50,000,000	50,000,000	N/A	N/A

Table III

Network and Information Security Liability, Media Injury Liability, Network Security Loss, Breach Mitigation Expense, PCI Assessments, Social Engineering Loss, Reward Coverage, Telecommunications Fraud Reimbursement.				
	Limits of Coverage Per Occurrence/Claim	**Deductible Per Occurrence/Claim**		**Retroactive Date**
	$5,000,000			
Coverage A Nework and Information Security Liability: Regulatory Fines:	Each Claim Included in limit above Each Claim Included in limit above	$25,000	Each Claim	10/1/2013
Coverage B Media Injury Liability	Each Claim Included in limit above	$25,000	Each Claim	10/1/2013
Coverage C Network Security Loss Network Security Business Interruption Loss:	Each Unauthorized Access Included in limit above Each Business Interruption Loss Included in limit above	$25,000	Each Unauthorized Access Retention Period of 72 hours of Business Interruptoin Loss	Occurrence
Coverage D Breach Mitigation Expense:	Each Unintentional Data Compromise Included in limit above	$25,000	Each Unintentional Data Compromise	Occurrence
Coverage E PCI Assessments:	Each Payment Card Breach $1,000,000 Occ./$1,000,000 Agg. Included in limit above	$25,000	Each Payment Card Breach	Occurrence
Coverage F Social Engineering Loss:	Each Social Engineering Incident $100,000 Occ./$100,000 Agg Included in limit above	$25,000	Each Social Engineering Incident	Occurrence
Coverage G Reward Coverage	Maximum of 50% of the Covered Claim or Loss; up to $25,000 Included in Limit above		Not Applicable	Occurrence
Coverage H Telecommunications Fraud Reimbursement	$25,000 Included in limit above		Not Applicable	Occurrence

Annual Aggregate Limit of Liability

Member Aggregate	**All Members Aggregate**
$5,000,000	$25,000,000

The total liability of MMRMA shall not exceed $5,000,000 per Member Aggregate Limit of Liability for coverages A, B, C, D, E, F, G, and H, in any Coverage Period.

The total Liability of MMRMA and MCCRMA shall not exceed $25,000,000 for All Members Combined Aggregate Limit of Liability for coverages A, B, C, D, E, F, G, and H, in any Coverage Period.

It is the intent of MMRMA that the coverage afforded under the Subjects of Coverage be mutually exclusive. If however, it is determined that more than one Subject of Coverage applies to one coverage event ensuing from a common nexus of fact, circumstance, situation, event, transaction, or cause, then the largest of the applicable Deductibles for the Subjects of Coverage will apply.

Table IV

Specialized Emergency Response Expense Recovery Coverage

Limits of Coverage

Specialized Emergency Response Expense Recovery	Limits of Coverage per Occurrence		Annual Aggregate	
	Member	All Members	Member	All Members
	N/A	N/A	N/A	N/A

Table V

Specialized Emergency Response Expense Recovery Coverage

Deductibles

Specialized Emergency Response Expense Recovery	Deductible per Occurrence
	Member
	N/A

D. Contribution for MMRMA Participation

South West Michigan Behavioral Health

Period: October 01, 2020 To October 01, 2021

Coverages per Member Coverage Overview:	$46,624
TOTAL ANNUAL CONTRIBUTIONS:	$46,624

E. List of Addenda

Consensus Revenue Estimating Conference (CREC)

On 8/24 the third Consensus Revenue Estimating Conference (CREC) of the year was held to reevaluate revenue estimates for Fiscal Years (FY) 2019-20, FY 2020-21, and FY 2021-22 due to the COVID-19 pandemic. While the entire country has been upended because of the pandemic, Michigan was hit particularly hard during the spring. As such, projections in May were grim.

Yesterday's conference however, provided some welcome news with projections revised upward from May. Federal stimulus dollars received through the CARES Act and unemployment assistance have helped cushion the blow to the economy. Estimates from Treasury and the House and Senate Fiscal Agencies today indicate the state has received $43.3 billion in federal assistance during the COVID-19 pandemic. Unpacking that number reflects $16 billion in Paycheck Protection Program loans to Michigan businesses; $8.3 billion in economic impact payments and $13.4 billion (federal) in unemployment insurance compensation.

For combined General Fund/General Purpose (GF/GP) and School Aid Fund (SAF) revenue for FY 2019-20, projections are up $2.3 billion from the May CREC, but are still down $926.4 million from the January CREC. For FY 2020-21, combined revenues are up $579 million from the May CREC, but still down $2.47 billion from January's CREC. For FY 2021-22, combined revenues are up $376 million from the May CREC, but still down $1.7 billion from January's estimates.

According to the economists, the improvement in outlook can be attributed to the following:

- Delayed tax filing deadline until July yielded higher payments than expected
- Manufacturing and automotive production recovered more rapidly than expected (it was observed that, overall, higher-wage industries are recovering more quickly than lower-wage industries)
- CARES Act impact on revenue was underestimated, specifically the impact of the Paycheck Protection Program, Economic Impact Payments and Pandemic Unemployment Insurance Compensation
- Consumer spending is higher than expected, shifting to home improvement projects, consumer goods, etc.

While economists noted the upward revisions were indeed positive developments they were careful to frame these developments cautiously. They acknowledged that widespread uncertainty still exists regarding the path of the pandemic, further federal stimulus spending, and how consumers will react, among other variables.

As these forecasts provide the foundation for the construction of the upcoming (Fiscal Year 2020-2021) budget, we can now expect the budget discussions to kick into high gear in the coming weeks.

You can access the presentations and materials from the CREC at the Senate Fiscal Agency website here or the House Fiscal Agency website here.

2020-2023 Strategic Business Planning Meeting Schedule

Date	Time	Speaker	Facilitator
Friday, October 9, 2020	11:15 am - 1:15 pm	Liz Hertel, MDHHS	Scott Dzurka, Public Sector Consultants
Friday, November 13, 2020	11:15 am - 1:15 pm	Brian Thiel, Capitoline Alan Bolter, CMHAM	Scott Dzurka, Public Sector Consultants
Friday, December 11, 2020	No meeting		
Friday, January 8, 2021	11:15 am - 1:15 pm	TBD	Scott Dzurka, Public Sector Consultants

Notes
Invitees: SWMBH Board,
SMWBH Board Alternates,
CMH CEOs,
SUD OPB Chair & Vice Chair,
NAMI Representatives,
CAC Representatives,
SWMBH SLs,
Kevin Brozovich

8/25/2020
mab

Southwest Michigan
BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health Board Meeting

HOW TO PARTICIPATE

For webinar and video please join the meeting from your computer, tablet or smartphone at:
https://global.gotomeeting.com/join/515345453
For call in only, please dial:
1-571-317-3122
access code: 515 345 453
To request accommodation under ADA please call Anne Wickham at 269-488-6982
October 9, 2020
9:30 am to 11:00 am
Draft: 8/31/20

1. **Welcome Guests/Public Comment**

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

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

4. **Consent Agenda**

   - September 11, 2020 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   a. Operations Committee Minutes August 26, 2020 (d)
   b. Operations Committee Quarterly Report (d)

6. **Ends Metrics Updates**
   Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

   a. * Behavioral Health (BH) Treatment Episode Data Set (TEDS) (J. Gardner) (d)
   b. Habilitation Supports Waiver (d) (R. Freitag)
   c. Medicaid Health Plans and SWMBH Joint Endeavors (d) (J. Gardner)

7. **Board Actions to be Considered**

   - Fiscal Year 2021 Program Integrity Compliance Plan (d) (M. Todd)

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

   - EO-003 Emergency Executive Officer Succession (d)

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

   - BEL-008 Communication and Counsel (d) (T. Schmelzer)

10. Board Education

a. Fiscal Year 2020 Year to Date Financial Statements (d) (T. Dawson)
b. Executive Officer Performance Review (documents to Committee for November Board Report) (B. Casemore)
c. CMH Review Results (d) (M. Todd)
d. SWMBH 2020 Penetration Testing Results (d) (N. Spivak)
e. Integrated Care (M. Kean) (d)

11. Communication and Counsel to the Board

a. Michigan Consortium for Healthcare Excellence Update (d) (B. Casemore)
b. Michigan Health Endowment Fund Grant Update (d) (M. Kean)
c. November 13, 2020 Board Agenda (d)
d. Board Member Attendance Roster (d)
e. November Board Policies: BEL-010 Regional Entity 501 (c) (3) Representation (J. Bermingham); EO-002 Monitoring Executive Performance

12. Public Comment

13. Adjournment

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

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

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

Next SWMBH Board Meeting
November 13, 2020
9:30 am - 11:00 am

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

as of 8/14/20

Moses Walker (Kalamazoo)												
Nancy Johnson (Berrien)												

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