Southwest Michigan Behavioral Health Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
March 11, 2022
9:30 am to 12:00 pm
(d) means document provided
Draft: 3/3/22

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda**

   - January 14, 2022 SWMBH Board Meeting Minutes (d) pg.3

5. **Operations Committee**

   a. Operations Committee November 17, 2021 Meeting minutes (d) pg.7
   b. Operations Committee January 26, 2022 Meeting minutes (d) pg.9

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

   a. American Society of Addiction Medicine (ASAM) Continuum of Care Tool (J. Gardner) (d) pg.12
   b. Opioid Health Homes Program (J. Gardner) (d) pg.13
   c. 2021 Michigan Mission Based Performance Indicator System Results (J. Gardner) (d) pg.14

7. **Board Actions to be Considered**

   a. Fiscal Year 2022 Budget Update (T. Dawson) (d) pg.16
   b. 2022 Financial Management Plan (T. Dawson) (d) pg.17
   c. 2022 Cost Allocation Plan (T. Dawson) (d) pg.23
   d. 2022 Financial Risk Management Plan (T. Dawson) (d) pg.34
   e. Agency Counsel (B. Casemore)
   f. May Board Retreat (d) pg.37

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

   - None

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

   a. BEL-001 Budgeting (C. Naccarato) (d) pg.38
   b. BEL-003 Asset Protection (S. Barnes) (d) pg.42

10. Board Education

a. Fiscal Year 2022 Year to Date Financial Statements (T. Dawson) (d) pg.48
b. Fiscal Year 2021 Final Financial Statements (T. Dawson) (d) pg.56
c. Fiscal Year 2022 Privacy/Security Report (M. Todd) (d) pg.64
d. 2022 Utilization Management Plan (A. Wickham) (d) pg.75

11. Communication and Counsel to the Board

a. Retirement Plan Advisor Update (B. Casemore)
b. Mental Health Listening Tour Report (B. Casemore) (d) pg.98
c. April 8, 2022 Draft Board Agenda (d) pg.100
d. Board Member Attendance Roster (d) pg.102
e. April Direct Inspections-none scheduled; Election of Officers

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 Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
April 8, 2022
9:30 am - 11:00 am

Southwest Michigan
BEHAVIORAL HEALTH

Board Meeting Minutes
January 14, 2022
9:30 am-11:00 am
Draft: 1/14/22

Members Present: Edward Meny, Tom Schmelzer, Erik Krogh, Ruth Perino, Carol Naccarato

Members Absent: Marcia Starkey, Susan Barnes

Guests Present: Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance & Privacy Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance & Performance Improvement, SWMBH; Sarah Ameter, Customer Services Manager, SWMBH; Richard Thiemkey, Barry County CMH; Brad Sysol, Summit Pointe; Kris Kirsch, St. Joseph CMH; Ric Compton, Riverwood; Tim Smith, Woodlands; Jeff Patton, ISK; Carl Doerschler; Senator Sean McCann

Welcome Guests
Edward Meny called the meeting to order at 9:30 am.

Public Comment
None

Agenda Review and Adoption

Motion	Erik Krogh moved to accept the agenda as presented.
Second	Tom Schmelzer
Motion Carried	

Financial Interest Disclosure Handling
Mila Todd notified the Board that there are no financial interest disclosures for consideration this month.

Consent Agenda

Motion	Tom Schmelzer moved to approve the December 10, 2021, Board meeting minutes as presented.
Second	Ruth Perino
Motion Carried	

Special Recognition of Jonathan Gardner
Brad Casemore introduced Senator Sean McCann to the Board. Senator McCann presented Jonathan Gardner with a signed tribute from Governor Whitmer and other elected officials regarding the 2021 Nick Filonow Award of Excellence. Senator McCann gave a summary of current work going on at the State level.

Operations Committee

Operations Committee Quarterly Report

Edward Meny noted the report in the packet. No questions from the Board members were asked.

Ends Metrics

None

Board Actions to be Considered

2022 Quality Assurance and Performance Improvement Plan

Jonathan Gardner reported as documented. Discussion followed.

Motion Tom Schmelzer moved to approve the 2022 Quality Assurance and Performance Improvement Plan as presented.

Second Ruth Perino

Motion Carried

Fiscal Year 2021 Board Audit Committee

Tracy Dawson reviewed history of Board Audit Committee. Tom Schmelzer, Edward Meny and Ruth Perino volunteered to serve on the Board Audit Committee for this year's review.

Board Policy Review

BG-004 Board Ends and Accomplishments

Edward Meny reported as documented.

Motion Tom Schmelzer moved that the Board is in compliance and policy BG-004 Board Ends and Accomplishments does not need revision.

Second Carol Naccarato

Motion Carried

BG-007 Code of Conduct

Edward Meny reported as documented.

Motion Erik Krogh moved that the Board is in compliance and policy BG-007 Code of Conduct does not need revision.

Second Ruth Perino

Motion Carried

BG-001 Committee Structure

Edward Meny reported as documented.

Motion Erik Krogh moved that the Board is in compliance and policy BG-001 Committee Structure does not need revision.

Second Tom Schmelzer

Motion Carried

Executive Limitations Review

BEL-003 Asset Protection

Edward Meny asked that BEL-003 be moved to the next Board meeting due to Susan Barnes absence. Board agreed.

Board Education

Southwest Michigan Behavioral Health Retirement Plans Update

Carl Doerschler reported as documented. Discussion followed.

Fiscal Year 2021 Customer Services Report

Sarah Ameter reported as documented. Discussion followed.

Fiscal Year 2021 Year to Date Financial Statements

Tracy Dawson reported as documented. Discussion followed.

Communication and Counsel to the Board

Retirement Plan Investment Advisor Update

Brad Casemore stated that, after communication with counsel, Varnum Law, he initiated a due diligence process regarding SWMBH Retirement Plan Investment Advisor based on recent circumstances involving Carl Doerschler resignation from Rose Street Advisors.

Agency Counsel Update

Brad Casemore stated that SWMBH has identified four law firms for interviewing. Each law firm will meet with Executive leadership and deliver a presentation for consideration.

Fiscal Year 2021 Medicaid Services Verification Report

Mila Todd reported as documented.

Board Preferences for May Retreat

Brad Casemore asked the Board members to begin thinking about the May Board Retreat. What speakers, presenters and location would the Board prefer. Michelle Jacobs will send out the calendar invite next week.

February 14, 2022 SWMBH Board Agenda

Brad Casemore noted that historically the Board has cancelled their February meeting due to traveling out of State. Edward Meny and Tom Schmelzer noted that they would be out of the State in February.

Motion Erik Krogh moved to cancel the February 11, 2022 SWMBH Board meeting
Second Carol Naccarato
Motion Carried

Future SWMBH Board Meetings

Discussion to grant the Board Chair unilateral permission to cancel SWMBH Board meetings based on his judgement.

Motion Tom Schmelzer moved to grant the SWMBH Board Chair, Edward Meny, unilateral permission to cancel any future SWMBH Board meetings based on his judgement.
Second Erik Krogh

Motion Carried

Board Member Attendance Roster

Brad Casemore noted the document in the packet for the Board's review.

Public Comment

None

Adjournment

Motion	Erik Krogh moved to adjourn at 11:00 am
Second	Tom Schmelzer

Motion Carried

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: November 17, 2021 10:00am-1:00pm

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

Guests present via phone – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Moira Kean, Senior Clinical Data Analyst, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH; Sarah Green, Integrated Care Manager, SWMBH

Call to Order – Kris Kirsch began the meeting at 10:22 am.

Review and approve agenda – Agenda approved with topic additions of Beacon Services, Out of State Hospitals and Least Restrictive Setting in Hospitals.

Review and approve minutes from 10/27/21 Operations Committee Meeting – Minutes were approved by the Committee.

CMH Updates – CMHSP CEOS's shared current updates and highlighted crisis stabilization, moving building locations, new hires, lead poisoning testing, CCBHC implementation, and vaccine mandates.

Direct Care Wage Update – Tracy Dawson shared email from Behavioral Health and Developmental Disabilities Administration (BHDDA) regarding direct care wage lapse questions and due date of November 24, 2021.

Fiscal Year 2021 Year to Date Financials – Tracy Dawson stated that financials are not ready at this time due to some CMHs unable to report as a result of PCE software.

Fiscal Year 2021 Close Out – Tracy Dawson reported that close out processes are moving along as scheduled. Natalie Spivak stated that encounter submission deadline is 12/1/21 and SWMBH will submit encounters to the State on 12/15/21.

System Transformation Updates – Operations Committee discussed status of House and Senate proposals and Community Mental Health Association of Michigan's Advocacy Special Assessment.

Brabec Listening Tours – Brad Casemore stated that there is one listening tour left in Albion on November 22, 2021 and topics highlighted during the tours have been access to services, youth services, and crisis stabilization. Brad Casemore and Jeannie Goodrich are planning to attend.

Relias Population Health Overview and Demonstration – Brad Casemore stated that this topic will be moved to the January meeting as SWMBH is reviewing enhancements, conversions and analysis of quality checks.

December 15, 2021 Operations Committee Meeting – Kris Kirsch asked the group their preference for meeting on December 15th. Group agreed to cancel the 10am December 15th meeting and keep the 9am-10am meeting. Jeannie Goodrich was nominated to facilitate the January meeting. Ric Compton volunteered to facilitate the February meeting and Debbie Hess volunteered to facilitate the April meeting.

Fiscal Year 2022 Ends Metrics – Jonathan Gardner reported as documented. Brad Casemore noted the regional committees that have reviewed the fiscal year 2022 Ends Metrics. The Operations Committee unanimously endorsed the fiscal year 2022 Ends Metrics.

2022 Operations Committee Meetings – Operations Committee discussed 2022 meeting dates and approved the dates with possible revisions to July, September, and October due to meeting conflicts.

Fiscal Year 2021 Performance Bonus Incentive Program – Jonathan Gardner stated that the report was submitted to the State on November 14, thanked the CMH CEOs for their submissions and SWMBH should receive the results in mid-December.

MDHHS Waiver Corrective Action Plans (CAPS) – Jonathan Gardner stated that the State accepted the CAPS on October 5th and SWMBH needs to submit how the region will meet the CAPS to the State by 12/14/21 and asked the CMH CEOs to submit those to SWMBH by 12/2/21.

My Strength – Sarah Ameter and Sarah Green reported as documented. Discussion followed. CMHs asked for utilization reports by county and the latest upgrades to My Strength.

Building Better Lives Project – Brad Casemore stated that SWMBH has received the self-determination report from TBD Solutions. Sarah Ameter stated that SMWBH is targeting December to share the information on self-determination and person-centered planning reports with CMHs.

Out of State Hospitals – Mila Todd stated that Michigan Attorney General Certified Ohio so we can contract with/use inpatient psychiatric services there.

Beacon Services – Mila Todd stated that MDHHS request for numbers of members placed in Beacon homes, by CMH, sent to Regional PNM Committee representatives last Friday 11/12. Responses due to SWMBH 11/19 by COB. Group discussed adequate oversight, monitoring, services, deficiencies and a need for State level involvement with Beacon Services.

Lest Restrictive Environment in Hospitals – Group discussed the MDHHS communication on discharge needs from State Hospitals.

Adjourned – Meeting adjourned at 11:40am

Southwest Michigan
BEHAVIORAL HEALTH

Operations Committee Meeting Minutes
Meeting: January 26, 2022 10:00am-1:00pm

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

Guests present – Tracy Dawson, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Alena Lacey, Director of Clinical Quality, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Moira Kean, Senior Clinical Data Analyst, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH; Laura Vredeveld, TBD Solutions

Call to Order – Jeanie Goodrich began the meeting at 10:10 am.

Review and approve agenda – Agenda approved with topic additions of Beacon Services, Out of State Hospitals and Least Restrictive Setting in Hospitals.

Review and approve minutes from 11/17/21 Operations Committee Meeting – Minutes were approved by the Committee.

CMH Updates – CMHSP CEOS's shared current updates and highlighted COVID positive spikes among staff, CDC guidance changes, new hires, CCBHC implementation, grants, and Electronic Medical Records software system transitions.

Fiscal Year 2021 Year to Date Financials – Tracy Dawson reported as documented noting that the report contains some estimates due to recent Standard Cost Allocation requirements.

Fiscal Year 2021 Close Out – Tracy Dawson reported that close out processes are moving along as scheduled. Natalie Spivak stated that SWMBH is waiting on the State to pull data. Discussion followed.

Direct Care Wage Update – Tracy Dawson shared that Milliman rate changed from $2 to $2.35 and payments are expected in April.

Operating Agreement and Self-Evaluation Schedule/Approach – Brad Casemore presented dates for Operating Agreement review and Self Evaluation. The Operating Agreement will be reviewed at February's Operations Committee meeting and presented to the Board at the March meeting. The self-evaluation process will be conducted/discussed at the March and April Operations Committee meetings and presented to the Board at the May meeting.

Relias Population Health Overview and Demonstration – Moira Kean discussed recent population health statistics, new metrics and filtering capabilities. SWMBH continues to work with Relias on Certified Community Behavioral Health Clinic data and other data needs.

Beacon Services – Group discussed ongoing issues and concerns. Brad Casemore noted the longevity and magnitude of issues and a discussion of a regional collective approach to communicate to Beacon Services. CMHSPs will communicate with SWMBH Provider Network staff, Ryan King and this topic will be discussed again at February's meeting.

Regional Committee CMH Attendance, involvement, engagement – This topic will be discussed at February's meeting.

CCBHC and CCBHC/BHH/OHH expansion Counties – This topic will be discussed at February's meeting.

Upcoming Michigan BH Fee Schedule Reporting Requirements – Tracy Dawson reported as documented.

Certified Community Behavioral Health Clinics Funding – Brad Casemore reviewed a recent email from Robert Sheehan of Community Mental Health Association of Michigan. Discussion followed. This topic will be discussed further at February's meeting.

Calendar Year 2022 Operations Committee Planning-topics, deep dives, guests, etc. – Brad Casemore asked the group for ideas and feedback regarding 2022 Operations Committee planning. This topic will be discussed at February's meeting.

Clinical Quality – Alena Lacey – Brad Casemore introduced SWMBH Clinical Quality Director, Alena Lacey. Alena Lacey shared her background and education and reviewed the following areas of focus for the Clinical Quality Department: 1915i transitions, Home and Community Based Services, Supports Intensity Scale Services, Home Adult Benefit Waiver, Clinical trainings, Clinical Practices Committee, Follow up after hospitalization and recent Mental Health Block Grant submissions.

Fiscal Year 2022 CMH Site Reviews – Mila Todd noted that documents have been emailed to CMHSPs regarding the 2022 site review visits commenting that this year will be a full administrative and file review year. Document submissions are due to SWMBH by March 1, 2022. Mila Todd also noted that the seven of the eight data certifications have been received and thanked each CMHSP for their cooperation.

2022 Utilization Management Plan – Anne Wickham reported as documented.

Building Better Lives Project – Sarah Ameter and Laura Vredeveld reported as documented. Sarah Ameter asked for participation from each CMHSP as the project continues to additional domains.

Michigan Open Meetings Act – Brad Casemore reminded group of violations listed in the Michigan Open Meetings Act and will send those violations via email to the group.

Conflict Free Case Management – Group discussed several issues and concerns regarding the call today with the State on Conflict Free Case Management. This topic will be discussed further at February's meeting.

Juvenile Justice Diversion – Ric Compton asked questions regarding Juvenile Justice Diversion programs. Discussion followed.

Adjourned – Meeting adjourned at 12:00pm

Board Ends Metric (*update only – no action required*)

Implementation of the 'ASAM Continuum SUD Standardized Assessment Instrument".

PERFORMANCE METRIC DESCRIPTION	STATUS UPDATE
Implementation of the "*ASAM Continuum SUD Standardized Assessment Instrument*" for FY21 by 10/1/2021 Per MDHHS Contract. Metric Measurement Period: (9/1/20 - 10/1/21) Metric Board Report Date: February 11, 2022 Interim Report Presented to Board in September 2021. A. Training and certifying all relevant clinicians to administer the ASAM Continuum SUD Assessment (By 8/1/21). ½ point. B. Full system implementation and integration by CMHSP's and Provider sites (By 10/1/21). ½ point. C. SWMBH to implement reporting standards, validation, accuracy and targets in FY21 for FY22 metrics/targets reporting process via MDHHS calendar. ½ point. **Measurement:** Written update that SWMBH is able to implement reporting standards, validation, accuracy and targets by 10/1/2021. **Possible Points:** ½ point for each component awarded upon official Board approval. Total of 1 ½ points possible.	**Part A – Achieved (21)** **Part B – Achieved (21)** **Part C – Ongoing (22)** Metric Presentation and Approval scheduled for February Board Meeting. A. SWMBH has trained 154/166 (92.8%) clinicians to date. The trainings started the last week of July and concluded the second week of September. On-line/on-demand trainings are available for new staff. B. Streamline installed the ASAM Continuum interface into our production environment on 9/27/21. Interface is operational. C. Reporting standards have focused on assuring provider utilization of the Continuum and appropriate data transfer for level of care review. Data transfer processes continue to be evaluated and problem solved.

Opioid Health Homes Project "Retention Metric"

PERFORMANCE METRIC DESCRIPTION	STATUS
SWMBH will achieve 225 enrollees for the Opioid Health Homes Program (OHH) during year 1 of implementation. Metric Measurement Period: (1/1/21 - 12/30/21) Metric Board Report Date: February 11, 2022 A. Target: 225 total enrollees 1/1/21 – 9/30/21. 1 point B. Based on 2021 baseline enrollment data, SWMBH will establish a retention value for enrollees starting 1/1/22 who remain in OHH program for six months or more. *Note: Insufficient data to calculate for 2021 metric. ½ point was removed from denominator. Next update to be delivered Q1-22. **Possible Points:** 1 point will be awarded.	**Part A – Achieved (21)** **Part B – Ongoing (22)** Baseline Measurement Period Concludes on 9/30/21 A. 344 Enrollees in the OHH Program as of 9/17/21 B. OHH retention metric: 60% of new enrollees (enrolled after 9/30/21) will remain in "enrolled" status for at least 6 months. Metric Specifications www.michigan.gov/OHH. **Measurement Year 1**: 10/1/2020 through 9/30/2021 **Performance Year 1**: 10/1/2021 through 9/30/2022 **Performance Year 2**: 10/1/2021 through 9/30/2022

2021 MMBPIS Performance Indicator Board Ends Metric

(Motion Required)

PERFORMANCE METRIC DESCRIPTION	STATUS
24/28 or 85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 21. Metric Measurement Period: (10/1/20 - 9/30/21) Metric Board Report Date: February 11, 2022 **Measurement:** Results are verified and certified through the quarterly consultative draft report produced by MDHHS. Total number of indicators that met State Benchmark / Total number of indicators measured **Possible Points:** 1 point awarded upon official Board approval.	**Completed Successfully** **27/28 or 96.4% of Indicators met the MDHHS indicated benchmarks.** Q1: 6/7 Q2: 7/7 Q3: 7/7 Q4: 7/7 ▪ Metric Benchmarks Provided by MDHHS. 7/16 indicators currently have benchmarks. Executive Owners: Jonathan Gardner and Joel Smith

MMBPIS Indicator #	*MMBPIS Performance Indicator*	*State Standard*	Q1 2021	Q2 2021	Q3 2021	Q4 2021
1a	*Pre-Admission Screening Children*	95%	97.65%	99.17%	100.00%	100.00%
1b	*Pre-Admission Screening Adults*	95%	98.65%	98.94%	99.25%	99.45%
2a(a)	*Request to Intake MI Adults*	N/A	68.83%	56.07%	76.18%	69.56%
2a(b)	*Request to Intake MI Children*	N/A	65.64%	70.39%	68.77%	59.90%
2a(c)	*Request to Intake IDD Adults*	N/A	76.92%	77.05%	70.34%	62.83%
2a(d)	*Request to Intake IDD Children*	N/A	75.00%	60.61%	68.29%	71.79%
2e	*Request to Service SA*	N/A	383	342	325	393
3a	*First Service MI Adults*	N/A	50.73%	56.07%	59.89%	58.05%
3b	*First Service MI Children*	N/A	58.04%	62.31%	62.24%	61.33%
3c	*First Service IDD Adults*	N/A	65.00%	76.24%	75.00%	68.00%
3d	*First Service IDD Children*	N/A	69.57%	73.08%	64.71%	71.05%
4a(a)	*IP Follow Up Children*	95%	100.00%	100.00%	100.00%	97.06%
4a(b)	*IP Follow Up Adults*	95%	98.21%	98.92%	98.05%	97.72%
4b	*Detox Follow Up*	95%	93.94%	96.02%	96.33%	96.55%
10a	*IP Recidivism Children*	15%	5.00%	9.86%	3.66%	3.13%
10b	*IP Recidivism Adults*	15%	12.32%	11.00%	11.97%	10.91%
	Overall Results		6/7	7/7	7/7	7/7

*Indicators 2a, 2b, 2c, 2d, 2e, 3a, 3b, 3c & 3d currently do not allow for exceptions and exclusions *(i.e., no shows, reschedules, cancellations or refusals)* to be deducted from the numerator and denominator,

therefore providing lower values than the other indicators.

MMBPIS Indicator Descriptions

MMBPIS Indicator #	MMBPIS Performance Indicator	MMBPIS Indicator Description	State Standard
1a	Pre-Admission Screening Children	% of Medicaid adults receiving pre-admission screen for psychiatric inpatient care within 3 hrs. of disposition	95%
1b	Pre-Admission Screening Adults	% of Medicaid children receiving pre-admission screen for psychiatric inpatient care within 3 hrs. of disposition	95%
2a	Request to Intake MI Children	% of new persons (MI Children) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
2b	Request to Intake MI Adults	% of new persons (MI Adults) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
2c	Request to Intake DD Children	% of new persons (DD Children) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
2d	Request to Intake DD Adults	% of new persons (DD Adults) during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service	*
2e	Request to Intake SA	% 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.	*
3a	First Service MI Children	% of new persons (MI Children) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment	*
3b	First Service MI Adults	% of new persons (MI Adults) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment	*
3c	First Service DD Children	% of new persons (DD Children) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment	*
3d	First Service DD Adults	% of new persons (DD Adults) during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment	*
3e	First Service SA	% of new substance abuse individuals starting service within 14 calendar days after a non-emergency assessment	*
4a(a)	IP Follow Up Children	% of children who discharge from a psychiatric inpatient unit and are seen for follow-up within seven days	95%
4a(b)	IP Follow Up Adults	% of individuals who discharge from a substance abuse detox unit and are seen for follow-up within seven days	95%
4b	Detox Follow Up	% of adults who discharge from a psychiatric inpatient unit and are seen for follow-up within seven days	95%
10a	IP Recidivism Children	% of adults readmitted to a psychiatric inpatient unit within 30 days of discharge	Below 15%
10b	IP Recidivism Adults	% of children readmitted to a psychiatric inpatient unit within 30 days of discharge	Below 15%

	E	F	G	H	I	J	K	L	X
1	***Southwest Michigan Behavioral Health***								
2	For the Fiscal YTD Period Ended 9/30/2022					**FY22 Budget - DRAFT-**			
3	*(For Internal Management Purposes Only)*								
4	***INCOME STATEMENT***			**For Board Consideration**	**FY22 Budget Current Status**	**Variance**	**FY21 Budget**		
5									
6	**REVENUE**								
15	Contract Revenue			341,255,301	341,255,301	-	296,799,730		
16	DHHS Incentive Payments			624,094	624,094	-	629,741		
17	Grants and Earned Contracts			2,575,000	2,575,000	-	1,521,294		
18	Interest Income - Working Capital			11,438	11,438	-	101,227		
19	Interest Income - ISF Risk Reserve			1,082	1,082	-	5,123		
20	Local Funds Contributions			1,726,192	1,726,192	-	1,726,192		
21	Other Local Income			-	-	-	-		
22							-		
23	**TOTAL REVENUE**			**346,193,107**	**346,193,107**	**-**	**300,783,307**		
24									
25	**EXPENSE**								
26	**Healthcare Cost**								
27	Provider Claims Cost			25,276,006	25,276,006	-	22,233,468		
28	CMHP Subcontracts, net of 1st & 3rd party			246,629,278	246,629,278	-	230,237,545		
29	Insurance Provider Assessment Withhold (IPA)			3,435,307	3,435,307	-	2,894,655		
30	Medicaid Hospital Rate Adjustments			3,222,501	3,222,501	-	3,614,277		
31	MHL Cost in Excess of Medicare FFS Cost			-	-	-	-		
32				-	-	-	-		
33	**Total Healthcare Cost**			**278,563,093**	**278,563,093**	**-**	**258,979,946**		
34	**Medical Loss Ratio (HCC % of Revenue)**			**81.5%**	**81.5%**		**87.1%**		
36	**Administrative Cost**								
37	Purchased Professional Services			712,181	712,181	-	697,240		
38	Administrative and Other Cost			10,734,399	10,734,399	-	9,649,819		
39	Interest Expense			-	-	-	-		
40	Depreciation			23,911	23,911	-	89,172		
41	Functional Cost Reclassification			-	-	-	-		
42	Allocated Indirect Pooled Cost			(0)	(0)	-	-		
43	Delegated Managed Care Admin			17,784,222	17,784,222	-	15,620,489		
44	Apportioned Central Mgd Care Admin			(0)	(0)	-	0		
45									
46	**Total Administrative Cost**			**29,254,713**	**29,254,713**	**-**	**26,056,720**		
47	**Admin Cost Ratio (MCA % of Total Cost)**			**9.0%**	**9.5%**		**9.1%**		
48									
49	Local Funds Contribution			1,726,192	1,726,192	-	1,726,192		
50	PBIP Transferred to CMHPs				-				
51									
52	**TOTAL COST after apportionment**			**309,543,998**	**309,543,998**	**-**	**286,762,858**		
53									
54	**NET SURPLUS before settlement**			**36,649,109**	**36,649,109**	-	**14,020,449**		
55	**Net Surplus (Deficit) % of Revenue**			**10.6%**	**10.6%**		**4.7%**		
57	Prior Year Savings			-	-		-		
58	Change in PA2 Fund Balance			(470,752)	(470,752)	-	(245,383)		
59	ISF Risk Reserve Abatement (Funding)			(1,082)	(1,082)	-	(5,123)		
60	ISF Risk Reserve Deficit (Funding)			-	-	-	-		
61	Settlement Receivable / (Payable)			-	(8,366)	8,366	-		
62	**NET SURPLUS (DEFICIT)**			**36,177,275**	**36,168,909**	**8,366**	**13,769,943**		
63	*HMP & Autism is settled with Medicaid*								
64									
65	**SUMMARY OF NET SURPLUS (DEFICIT)**								
66	Prior Year Unspent Savings			-	-	-	-		
67	Current Year Savings			24,637,461	24,637,461	-	12,522,016		
68	Current Year Public Act 2 Fund Balance			-	-	-	-		
69	Local and Other Funds Surplus/(Deficit)			11,531,448	11,531,448	-	(2,073)		
71	**NET SURPLUS (DEFICIT)**			**36,168,909**	**36,168,909**	**-**	**12,519,943**		
72									

Southwest Michigan Behavioral Health (SWMBH) Financial Management Plan

This Financial Management Plan is prepared as an integral part of the annual operational and fiscal budget planning process. The Financial Management Plan shall be approved by SWMBH Board on an annual basis. Material revisions not directly a result of change in federal or state statute or regulation or SWMBH – Michigan Department of Health and Human Services MDHHS Contract terms shall also be approved by SWMBH Board before implementation. The Bylaws of SWMBH refer to the annual Financial Management Plan approved by SWMBH Board as the means to satisfy the legal requirements of the Michigan Mental Health Code, MCL 330.1204b.

SWMBH Financial Management Plan on a consolidated basis shall include:

- A Consolidated Executive Summary of the most significant operational proposals, changes or initiatives of SWMBH or a participating CMHSP, including the financial impacts thereof.
- A Consolidated Summary of Key Statistical Information, Projections and Assumptions.
- A Consolidated Summary Statement of Budgeted Income and Expense by payor and business segment.
- A description and *pro forma* computation of the manner for equitably providing for, obtaining, and allocating revenues between SWMBH and participating CMHSPs in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(i).
- A description and *pro forma* computation of the method or formula for equitably allocating and financing SWMBH's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(ii).
- A description and *pro forma* computation of the method for allocating any of SWMBH's other assets if applicable and in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iii).
- A description and *pro forma* computation of the manner in which, after the completion of its purpose as specified in SWMBH's bylaws, any surplus funds shall be returned to the DHHS in sufficient detail to satisfy the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(c)(iv).
- A description of the process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all SWMBH's receipts and disbursements, shall be prepared and presented. This will be in sufficient detail to satisfy

the requirements of the Michigan Mental Health Code, MCL 330.1204b(1)(e).

- A *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH Consolidated Financial Management Plan will be reviewed annually by participating CMHSPs. At the participating CMHSP level, the CMH proposed budget shall constitute a request for funding by SWMBH for its applicable allocated and apportioned cost. Each participating CMHSP submits to SWMBH a *pro forma* of the State required financial status and other mandated reports prepared with budgetary information.

SWMBH and participating CMHSPs will comply with The Mental Health Code, the MDHHS Rules, the MDHHS/PIHP Master Contracts, and applicable State and federal laws, regulations, rules, policies and procedures, including but not limited to Balanced Budget Act (BBA) of 1997 as amended and OMB Super Circular.

Financial Management Functions

SWMBH will be responsible for its own financial management functions. Financial management functions for SWMBH include at least the following:

1) Budgeting
2) General accounting
3) Financial reporting, analysis, and monitoring,
4) Financial risk management
5) Investments management
6) Supervision of external audits, internal audits, and internal controls
7) Payments for SUD, Financial Status Reports (FSR's) and invoices.
8) Cost allocation process

These functions will be performed by SWMBH finance staff under the management direction of SWMBH Chief Financial Officer.

Similar functions will continue to be performed at the participating CMHSPs because they are independent legal entities and have local responsibilities and independent contractual obligations outside of the business relationships with SWMBH.

1. Budgeting – Annual Projections of Revenues and Expenditures

The primary purpose of SWMBH is to contract with the State of Michigan and other payers for services and supports to be delivered to or arranged for covered eligible populations in the region. These services and supports for the regional service area will be provided or arranged for by SWMBH, its participating CMHSPs or others as agreed upon in writing.

Medicaid 1915 (b) / (c) Waiver

The annual budget shall be prepared and presented as an integral part of the annual financial

management plan to be reviewed and approved by SWMBH Board.

SWMBH CFO will provide revenue projections for each participating CMHSP. Assuming the Medicaid contract continues as a per eligible per month (PEPM) regional rate capitation for eligible populations (from MDHHS to SWMBH), the allocation of SWMBH capitation revenue to the CMHSP of financial responsibility will continue to use the same funding allocation methodology as its starting point for interim payments and annual net cost budget limitations.

This methodology would follow the demographic, coverage levels, rate cells and regional PEPM rates inherent in the regional capitation determination and would fluctuate from month to month based on actual and confirmed eligibility fluctuations. Since the contractual relationship would not be a risk-sharing capitation between SWMBH and CMHSP's, the need for actuarial determinations or findings of "actuarial soundness" of CMH sub-capitation style payments is not required. This funding methodology is best referred to as a sub-capitation style interim payment with an annual net cost budget limitation and net cost settlement.

Recognizing that a regional rate may not be equivalent to the true, appropriate and medically necessary cost of services and supports for the entire eligible population in a specific participating CMHSP's service area, "needs based" funding adjustments for benefit stabilization could be made in the annual prospective funding allocation developed by SWMBH and as approved by SWMBH Board.

SWMBH is the sole party at- risk with the MDHHS. SWMBH will cost settle with the MDHHS. SWMBH would retain any year end contract savings (Medicaid savings), risk reserves and other funds consistent with MDHHS/PIHP contract. For participating CMHSPs the annual net cost budget limitation will be established in the budget and financial management planning process and adjust for changes in eligible covered lives. SWMBH Board may approve prospective performance incentives and sanctions for participating CMHSPs upon SWMBH management request.

Participating CMHSPs shall provide to PIHP on a quarterly basis, the obligation for local funds as a bona fide source of match for Medicaid. The payments shall be submitted to SWMBH in accordance with the schedule established by the MDHHS. SWMBH and participating CMHSPs shall establish mechanisms to assure that the local match of each participating CMHSP is funded at the adequate level. Any participating CMHSP that projects a problem or issue with local match funding shall immediately notify SWMBH. A plan of correction must be completed and sent to SWMBH within ten (10) business days of the identification of the problem.

Capitation revenues by participating CMHSP will be used as the basis of allocation of regional cost and other regional financial considerations applicable to SWMBH expense. This percentage will be established annually during the budget setting process.

The net result would constitute the sub-contract annual net cost budget limitation amount for each participating CMHSP. This initial sub-contract amount would be a "costs not to exceed" and would be subject to cost settlement to be described in the subcontract between SWMBH and the participating CMHSP. Participating CMHSPs are required to provide all medically necessary services to Medicaid beneficiaries, subject to SWMBH utilization management, evidence-based practice guidelines and other relevant policy.

Healthy Michigan Plan

Allocation of Healthy Michigan Plan revenues to SWMBH is determined by the State based on participants in the plan in our region.

Autism is now included as part of the regions capitated funding. The PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual.

MI Health Link Duals Demonstration

Demonstration Participating CMHSPs are paid FFS for MI HealthLink participants. SWMBH and Integrated Care Organizations (ICO) according to their specific agreements pay a PEPM rate for participants enrolled in the demonstration project in our region.

MiChild

A health insurance program for uninsured children of Michigan's working families. MiChild services are provided by many HMOs and other health care plans throughout Michigan, the payment for the program is now included in the Medicaid Capitation payment amount.

Substance Abuse Prevention and Treatment Block Grant/PA2

Allocation of substance use prevention and treatment Block Grant and PA2 revenues among participating CMHSPs are determined by eligibles within the region, allocations based on the 2010 Census and regional county board request. PA2 funds and budgets are reserved to the sole authority of the Substance Use Disorder Oversight Policy Board.

Other Revenues

SWMBH Board considers recommendations for other contracts and thus revenues and expense allocation on a case by case basis. SWMBH Board may allocate other contracts and revenues among participating CMHSPs and SWMBH based on a number of beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

1. Budget Preparation

SWMBH CFO will prepare annual budget for centralized operations that include:

- An Executive Summary of significant operational proposals, changes or initiatives including the financial impacts thereof.
- A Summary of Key Statistical Information, Projections and Assumptions.
- A Summary Statement of Budgeted Income and Expense by payor and segment.

- A detail Operating Budget including revenue and expense at the account and cost center level, with a staffing table at the position and cost center level.
- A Capital Budget showing anticipated replacement or new investment in capital assets.

Annual budget for SWMBH centralized operations will be approved by SWMBH Board.

2. General Accounting

SWMBH maintains accounting and financial reporting system in accordance with Generally Accepted Accounting Principles (GAAP). The accounting procedures and internal financial controls of SWMBH shall conform to Generally Accepted Accounting Principles (GAAP) for governmental units. SWMBH shall maintain accounts and source records in which any and all revenues received and expenses incurred are ascertainable and verifiable and include date of receipt / payment and sources of funds. SWMBH shall have a certified public accounting firm perform an annual independent audit of it in substantial conformance with the American Institute of Certified Public Accountants Guide to assess compliance with the appropriate standard accounting practices and procedures and MDHHS contract requirements.

3. Financial Reporting, Analysis, and Monitoring

SWMBH shall review its Financial Management Plan not less than annually and revise the plan as necessary to maintain an adequate and acceptable level of financial management. To ensure the financial stability of SWMBH, financial activities shall be performed in accordance with applicable federal and state guidelines, rules and regulations as may apply.
Financial management reports for SWMBH and each participating CMHSP shall be prepared monthly and presented to the respective boards of directors and administrative management. SWMBH shall establish the timing and content for required submission of financial management reports and other data from participating CMHSPs.

4.Financial Risk Management: See 8.2 Financial Risk Management Plan Investment Management

It is the business practice of SWMBH to invest remaining funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds Public Act 20 of 1943 as amended. Further information is provided on investment management in the Region Entity Investment Policy and ISF policy.

5. Supervision of External Audits, Internal Audits, and Internal Controls

Independent Annual Audit - SWMBH and each participating CMHSP shall ensure the completion of an annual financial audit performed by an independent certified public accountant. A copy of the audit report, audited financial statements, footnotes and supplementary schedules, along

with the management letter and management's response to the management letter, shall be submitted to SWMBH within 5 business days of CMH Board receipt of the audit.

Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH at the close of the audit, received from the PIHP commissioned auditors within 10 business days of its completion by the audit firm.

Internal Audits – SWMBH will perform internal audits on as needed basis.

Internal Controls - SWMBH shall maintain appropriate written policies, and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

6. Claims Adjudication and Payment

For consistency of policy, process and reporting, SWMBH will utilize a regional claims processing system/process for adjudication of all provider claims and service encounters for which it is the contract holder. Participating CMHSPs may utilize this system/process to adjudicate its external provider claims as needed or the CMHSP will adopt uniform claims adjudication and payment policies that adhere to those utilized at SWMBH or prior approved by SWMBH. This process is managed and monitored by the Operations and Compliance programs of SWMBH.

7. Cost Allocation Process

With respect to the MDHHS capitated funding SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSPs. It shall be the policy of SWMBH that SWMBH will prepare a Cost Allocation Plan as an integral part of their annual budget process and is suggested that each participating CMHSP prepare the same but must adhere to GAAP and the OMB Super Circular.

SWMBH Board January 2022

Southwest Michigan Behavioral Health (SWMBH) Cost Allocation Plan for CMHSP's

POLICY

SWMBH will employ a sub capitation-style interim payment methodology with annual cost settlement to fund the services and activities of the participating CMHSP's for those funds received by the PIHP under the contract with MDHHS. It shall be the policy of SWMBH that SWMBH and each of the participating CMHSPs prepare a Cost Allocation Plan as an integral part of their annual budget process. For fiscal year 22' the Cost Allocation Plan methodology has changed for the CMH's with the development of the Standard Cost Allocation (SCA) from MDHHS. This initial year while the cost associated with the agency are relatively the same how the cost is allocated will have some differences for SCA adopted agencies and those that have not yet changed. CMHSP's that have switched over to the SCA model have specific instructions and requirements outlined by the state, CMH'S that have not changed over may have developed their cost using the state instructions and a crosswalk will be used to determine actual allowable cost subject to cost settlement between SWMBH and participating CMHSPs

The Cost Allocation Plan shall, at a minimum:

1. Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the organization.
2. Conform to the accounting principles and standards prescribed in pertinent contractual agreements, regulations and other authoritative literature (i.e., GAAP, GASB, OMB Super Circular), 2 CFR 200.
3. Contain sufficient information in such detail to permit making an informed judgment on the correctness and fairness of the procedures for identifying, measuring, and allocating all costs to each of the programs operated by the organization.

The cost allocation plan shall contain the following information:

1. An organizational chart showing the placement of each unit or program within the organization.
2. A listing of revenue and costs for all programs performed, administered, or serviced by these organizational units.
3. A description of the activities performed by each organizational unit and, where not self-explanatory an explanation of the benefits provided to other programs performed, administered, or serviced by the organization.

4. The procedures used to identify, measure, and allocate all costs to each benefiting program and activity.
5. The estimated cost impact resulting from changes to a previously approved plan.

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AUTHORITATIVE GUIDANCE

Authoritative guidance for this policy can be found in the following:

1. The Michigan Department of Community Health contract and other state and federal law, regulation and promulgation.
2. Office of Management and Budget, Super Circular, (formally OMB A-87, Cost Principles for State, Local, and Indian Tribal Governments, with particular reference to Attachment D and the referenced 45 CFR Part 95, 2 CFR 200 Subpart E.
3. Generally Accepted Accounting Principles (GAAP), with particular reference to Governmental Accounting Standards Board (GASB) Statement #34, Basic Financial

Statements and Management's Discussion and Analysis for State and Local Governments (June 1999), and GASB Statement #10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues (November 1989).

ADEQUACY OF COST INFORMATION

Cost information must be current, accurate, and in sufficient detail to support payments made for services rendered. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor timecards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made.

ADEQUATE COST DATA AND COST FINDING

PRINCIPLE

Organizations receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records, which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

DEFINITIONS

Accrual Basis of Accounting

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Allocable Costs

An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

Directly Allocable Costs

Directly allocable costs are chargeable based on actual usage (e.g., metered electricity) rather than a statistical surrogate.

Indirectly Allocable Costs

Indirectly allocable costs are not chargeable based on actual usage, and thus, must be allocated on the basis of a prospectively documented statistical surrogate (e.g., square feet).

Applicable Credits

Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs *(i.e., COBRA receipts)*.

Charges

The regular rates established by the provider for services rendered eligible individuals and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients. *(i.e., Gross Standard Charge Rate.)*

Cost Finding

Cost Finding is a determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the assignment of direct costs and the allocation of indirect costs.

Cost Center

An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications may be accumulated in separate cost centers created to accumulate these indirectly allocable costs such as depreciation, facilities, and fringe benefits. These cost centers also fall under this definition so as to facilitate cost finding and cost allocation.

General Service Costs Centers (Nonrevenue Producing)

General Service (or Nonrevenue Producing) Costs Centers are those organizational units that are operated for the benefit of the organization as a whole. Each of these may render services to other general service areas as well as to Revenue Producing Cost Centers.

For the CMHSP and PIHP environment, General Service Cost Centers can be further differentiated and grouped by function into:

- General and Board Administrative functions
- Managed Care Administrative functions
- Program Administrative functions

Revenue Producing Cost Centers

Revenue Producing Cost Centers are those that usually provide direct identifiable services to individual consumers.

For the CMHSP and PIHP environment, Revenue Producing Cost Centers can be further differentiated and grouped by similar business activity into:

- Managed Care Risk Contracts (Medicaid, , Healthy Michigan, MI Health Link)
- Service and Support Programs (direct-operated programs)
- Grants and Other Earned Contracts

Ratio of Units to total Units of Service Applied to Cost (RUUAC)

A ratio that may be expressed as follows:

- The ratio of total beneficiary units of service to total units of service applied to total costs on a departmental basis; or
- The ratio of total cost to total units of service applied to total beneficiary units of service on a departmental basis.

DETERMINATION OF COST OF SERVICES

PRINCIPLE OF COST APPORTIONMENT

Total allowable costs of an organization are apportioned between contract eligible individuals and other individuals so that the share borne by the contract is based upon actual services received by contract eligible individuals.

Departmental Method

This method of apportionment is the ratio of covered services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals, applied to the cost of the department.

COST APPORTIONMENT FOR COST-BASED CMH'S

The term apportionment, as used here, refers to the process of distributing allowable costs among various groups of cost-based eligible individuals and other non-eligible individuals.

OBJECTIVES OF APPORTIONMENT

The objectives of the apportionment process are to assure that:

- Costs of covered supports and services provided to eligible individuals under contract will not be borne by other contracts or other individuals.

- Costs of supports and services to non-contract and other non-eligible individuals will not be borne by the contract.

COST APPORTIONMENT FOR COST BASED CMH's

The total allowable cost of supports and services furnished to contract eligible individuals shall be apportioned to the contract on the basis of the ratio of covered supports and services furnished to contract eligible individuals to total supports and services furnished to all the organizations' contract and non-contract individuals. For purposes of this apportionment, the preferred methods are based on RUUAC as defined above.

The PIHP must use a method for reporting costs and statistics that results in an accurate and equitable allocation of allowable costs and is justifiable from an administrative and cost efficiency standpoint.

PROVIDER SERVICES FURNISHED UNDER ARRANGEMENTS

Costs of covered services furnished to contract eligible individuals through arrangements with non-plan providers will, in most cases, are the amount the CMH/PIHP pays the provider under its financial arrangement, to the extent it is found reasonable.

APPORTIONMENT OF ADMINISTRATIVE AND GENERAL COSTS NOT DIRECTLY ASSOCIATED WITH PROVIDING SUPPORTS AND SERVICES

Enrollment and membership costs, as well as other administrative and general costs of the CMH that benefit the total eligible population of the CMH which are not directly associated with providing supports and services, are apportioned on the basis of a ratio of contract eligible population to total PIHP eligible population. These costs are classified as Plan Administration costs. *(i.e., Managed Care Administrative Costs.)*

ALLOCATION AND DISTRIBUTION OF OTHER ADMINISTRATIVE AND GENERAL COSTS

Administrative and General (A&G) costs, other than those described immediately above, which bear a significant relationship to the services rendered are not apportioned to risk contracts directly. Instead, these costs are allocated or distributed to the components of the CMH, which, in turn, are then apportioned to risk contracts.

COST CENTER FUNCTIONAL DEFINITION

The cost allocation plan process recognizes that the organization of cost centers for internal accounting and management responsibility in the formal accounting system may not adequately segregate costs by functional activity for the purpose of reimbursable cost computation. This is particularly critical within non-revenue producing administrative and general service cost centers.

For cost allocation plan purposes, segregation of costs by functional area is required if the

costs are material, the effect of not segregating the costs is significant and if an appropriate basis for cost allocation is available. The functional areas are described below.

For example, if the above conditions are met, the cost of Billing and Accounts Receivable, and Claims and Financial Risk Management would be segregated from General Financial Management and Accounting. However, if not material, not significant or not appropriate, these would not be segregated but allocated together with General and Board Administrative Functions.

The same would apply to such functions as Quality Improvement and Recipient Rights, as similar examples.

GENERAL AND BOARD ADMINISTRATIVE FUNCTIONS

General and Board Administrative functions are those that support the entire organization and are typically allocated to all other revenue and non-revenue producing cost centers typically on the basis of accumulated cost. These costs will be allocated first.

General and Board Administrative functions typically include:

- Board and Executive Administration
- Financial Management and Accounting
- Human Resources and Employee Benefit Management
- Information Systems and Data Processing
- Other functions that benefit the entire organization as a whole

General and Board Administrative costs may also include costs that would otherwise be costs of other functional areas but where the cost of these other functions is immaterial, the effect of segregation is insignificant or an appropriate basis for separate cost finding is not available. Costs associated with other functional areas must be segregated and reclassified prior to allocation, if they are material, their effect is significant, and an appropriate basis exists.

PROGRAM ADMINISTRATIVE FUNCTIONS

Program Administrative functions are those that support the direct-operated Service and Support Programs of the organization. These are typically allocated to all Service Program revenue and non-revenue producing cost centers on the basis of accumulated cost. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Program Administrative functions typically include:

- Program Management and Supervision
- Reception and Appointment Scheduling
- Records Maintenance

- Billing and Accounts Receivable
- Quality Improvement of direct-operated programs
- Recipient Rights, as a direct-operated program
- Other functions that benefit only direct-operated programs

MANAGED CARE ADMINISTRATIVE FUNCTIONS

Managed Care Administrative functions are those that support the Pre-paid Inpatient Health Plan responsibilities under risk contracts for eligible individuals and are typically apportioned to risk contracts on the basis of eligible lives. These costs include the proportional share of General and Board Administrative costs previously allocated as discussed above.

Managed Care Administrative functions typically include the following:

- General Managed Care Administration and Governance
- Member Services, including information and referral, and eligibility maintenance, recipient rights advocacy, grievance and appeal management
- Utilization Management, including access to supports and services, provider referral and authorization, and utilization review
- Provider Network Management, including network development and provider contracting
- Claims
- Financial Risk Management
- Quality Improvement of the PIHP
- Regulatory Compliance
- Other functions that benefit the eligible population under contract

COST ALLOCATION PLAN

The Cost Allocation Plan is to be developed and review by SWMBH and the participating CMHSPs as part of the annual budget process. This planning process, in general, involves the following steps:

COST FINDING

Matching of related revenue and costs, identification of functional activities and associated costs, and, if necessary (and allowable), cost reclassifications to segregate:

- Capital-Related Cost, if not already properly assigned
- Employee Benefit Cost, if not already properly assigned
- General and Board Administrative Cost

- Program Administrative Cost
- Service Program direct and assigned indirect costs
- Grants and Earned Contract direct and assigned indirect costs
- Managed Care Administrative Cost
- Contract Provider and CMHSP Subcontract Program cost for supports and services provided to eligible individuals and segregated by risk contract responsibility.

COST ALLOCATION

Allocation of functional indirect costs to revenue/cost centers based on a priority of allocation and statistical allocation proxies.

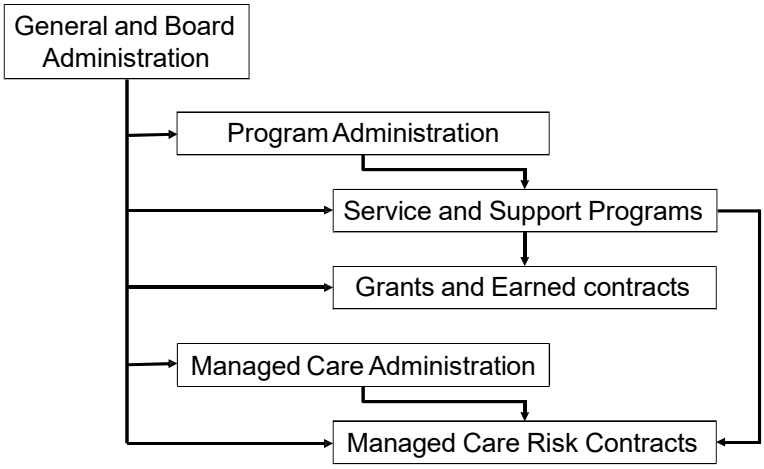
- Capital-Related Cost (depreciation and amortization, etc.) and Building Occupancy Costs, based on square feet operated for building and occupancy costs and actual depreciation for equipment and furnishings in use.
- Employee Benefit Costs, based on the dollar value of Salaries and Wages.
- General and Board Administrative Cost to all revenue / cost centers based on accumulated cost.
- Program Administrative Cost to all applicable Service Programs based on accumulated cost.

COST APPORTIONMENT to Payors

- Managed Care Administrative Costs, including previously allocated costs, apportioned to Managed Care Risk Contracts or Subcontracts based on accumulated cost.

A schematic of cost allocation process is as follows:

Cost Allocation Plan Schema



CONTRACT AND SUBCONTRACT COST SETTLEMENT

Contract and Subcontract Cost Settlement including identification of sufficient local matching fund revenues to meet matching fund requirements takes place annually.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

SWMBH February 2022

1115 Demonstration waiver, 1915 (c)/(i), Healthy Michigan Plan and Autism Program

SWMBH is solely responsible for Medicaid and Healthy Michigan Plan supports and services and any cost overruns at participating CMHSPs or in the aggregate. SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) or purchase risk reinsurance, at levels appropriate for this purpose. SWMBH will maintain a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on state maximums and allowed risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10) and the Medicaid Contract.

Beyond this and in further protection of SWMBH, participating CMHSPs will submit timely, complete and accurate financial information, results of operations and apportioned regional contract cost compared to sub-contract revenues which balance to actual confirmed claims and encounters. This shall be in a form and format determined by SWMBH.

This reporting will be inclusive of all of the activities of the CMHSP. While SWMBH has responsibility for only the regional contract activities and cost, SWMBH has to assure that it is being charged for only those costs that are ordinary and necessary, properly assigned, allocated and apportioned, for appropriate, medically necessary, covered services provided or arranged for contracted eligible beneficiaries. It is also in SWMBH's best interest to assure itself of the financial stability and viability of participating CMHSPs. Should a participating CMHSP exceed, or project to exceed, its sub-contract revenue amount, that CMHSP will be provided additional technical support and oversight from SWMBH and/or its agents. This could include:

- Enhanced management and financial review by SWMBH Chief Executive Officer, Chief Financial Officer, or their designees.
- Provision of special technical assistance off-site and on-site to the CMHSP
- Development and implementation of a Corrective Action Plan.
- Presentation to SWMBH Board for approval of the need for a sub-contract budget adjustment and funding increase.

Should SWMBH be imposed any contractual remedies, sanctions or penalties by a regulatory body or contractual payer that is a direct result of participating CMHSP failure to perform or rectify the participating CMHSP shall hold SWMBH harmless and make whole SWMBH for cost incurred or revenues lost as a result, with non-Medicaid funds.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

Healthy Michigan Plan

SWMBH is solely responsible for Healthy Michigan supports and services and any cost overruns at participating CMHSPs or in the aggregate. To this end, SWMBH will deduct and retain a portion of contract revenues to fund and maintain an Internal Service Fund (risk reserve) and/or to purchase risk reinsurance, at levels appropriate for this purpose. SWMBH maintains a funded Medicaid Internal Service Fund (ISF) Risk Reserve as its primary risk protection to assure that its risk commitment is met. This segregated risk reserve shall be funded based on actuarially determined risk reserve valuations in accordance with Governmental Accounting Standards Board Statement #10 (GASB10)

MI Health Link- Medicare Medicaid Dual Eligible (MME) Demonstration Participating CMHSPs are paid FFS for MI Link participants, CMHSP's are funded by the caption for cost above the FFS level.. There are no risk sharing arrangements with the CMHSP's. SWMBH PIHP and Integrated Care Organizations (ICO) have specific risk sharing arrangements according to their respective contracts.

Substance Abuse Prevention and Treatment Block Grant/PA2

Allocation of substance use prevention and treatment Block Grant and PA2 revenues among participating CMHSPs are determined by eligibles within the region, allocations based on the 2010 Census and regional county board request. PA2 funds and budgets are reserved to the sole authority of the Substance Use Disorder Oversight Policy Board. These are not entitled services and these services maybe reduced/suspended or terminated by SWMBH for lack of funding.

Other Revenues

SWMBH management and/or Board considers recommendations for other contracts and thus revenues and expense allocation on a case-by-case basis. SWMBH Board may allocate other contracts and revenues among participating CMHSPs and SWMBH based on several beneficiaries or other relevant statistics. SWMBH management will determine course of action for regional grants, if any, consistent with the Operating Agreement requirements.

Investment Management

It is the business practice of SWMBH to invest remaining funds in a manner which will provide the highest available investment return with reasonable and prudent security while meeting the daily cash flow objectives of the entity and conforming to all State statutes governing investment of public funds. Further information is provided on investment management in the Region Entity Investment Policy and ISF policy.

Southwest Michigan Behavioral Health (SWMBH)
Financial Risk Management Plan

Supervision of External Audits, Internal Audits, and Internal Controls

Independent Annual Audit - SWMBH and each participating CMHSP shall ensure the completion of an annual financial audit performed by an independent certified public accountant. A copy of the audit report, audited financial statements, footnotes and supplementary schedules, along with the management letter and management's response to the management letter, shall be submitted to SWMBH within five (5) business days of the presentation to the CMHSP Board.

Compliance Examination - SWMBH will commission an independent certified public accounting firm to complete the MDHHS required compliance examination for SWMBH and each participating CMHSP. The compliance examination is to assure conformity with specified contract requirements established by SWMBH, MDHHS and other payers. A copy of the participating CMHSP compliance examination report and management's response thereto shall be submitted to SWMBH within 10 days of its completion by the audit firm.

Internal Audits – SWMBH will perform internal audits on as needed basis

Internal Controls - SWMBH shall maintain appropriate written policies and shall maintain the procedures necessary to carry out those policies, that ensure adequate internal controls in accordance with regulatory and contractual requirements and generally accepted accounting principles.

Southwest Michigan Behavioral Health Board Retreat

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
May 13, 2022
10:45 am to 3:00 pm
(d) means document provided
Draft: 1/31/22

Agenda

10:45 am-11:00 am	**Board Retreat** **Welcome, Introductions, and Session Objectives (B. Casemore)**
11:00 am-12:30 pm	**Environmental Scan (B. Casemore)** **Alan Bolter, Associate Director** **Community Mental Health Association of Michigan** • **Overview of the evolving federal, state, and regional healthcare policy landscape** • **Questions and Discussion**
12:30 pm - 1:15 pm	***Lunch Break***
1:15 pm – 2:15 pm	**MDHHS Updates – Director Elizabeth Hertel**
2:15 pm - 2:45 pm	**Summary Discussion and Next Steps**
3:00 pm	**Adjourn**

Participants:

- **SWMBH Board and Board Alternates**
- **CMHSP CEOs**
- **SWMBH Chief Financial Officer, Chief Compliance & Privacy Officer, Chief Information Officer, Chief Administrative Officer, Director of Quality Assurance and Performance Improvement, Director of Clinical Quality, Director of SUD Services**
- **SWMBH Consumer Advisory Committee Chair & Vice Chair**
- **SWMBH Substance Use Disorder Oversight Policy Board Chair and Vice Chair**

Southwest Michigan Behavioral Health
Executive Limitations
Monitoring to Assure Executive Performance

March 11, 2022

Policy Number: BEL-001
Policy Name: Budgeting
Board Date: March 11, 2022
Assigned Reviewer: Carol Naccarato

Policy:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from a multi-year plan.

CEO Response: This report addresses fiscal year 2021 (October 1, 2020 to September 30, 2021) and budget process for fiscal year 2022 (October 1, 2021 to September 30, 2022). Budgeting and financial reporting have been driven by adopted Board Ends Metrics, Board-reviewed assumptions and fiscal parameters as well as Board directives from Board Planning Sessions.

Accordingly, the CEO may not allow budgeting which:

1. *Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.*

CEO Response: Fiscal year 2021 and fiscal year 2022 budgeting and financial reporting each included as much information from the state as they would provide to enable credible projection and tracking of revenues. Expense projections include appropriate categories with specificity on the multiple SWMBH contracts and business lines and across eight Participant CMHs. Capital and operational items were budgeted and reported as were cash flows.

SWMBH provided technical assistance and expectations guidance to CMHSP's throughout the FY2022 budget development process, and Medicaid and Healthy Michigan eligibles trending and projections (which drive projected Medicaid and Healthy Michigan revenues) were made for fiscal year 2021 and fiscal year 2022.

Fiscal year 2021 Medicaid revenue actual receipts to budget projections were up $ $13,056,015 (an increase of (5.4%) noting $9+ million was related to

Direct Care Wage (DCW) funding which unspent are to be returned to MDHHS. DCW funding was up $16,849,712 (7.1%) from fiscal year 2020. The increase continues to evolve due to changes in the rate setting process and changes due to the COVID environment.

Healthy Michigan Plan fiscal year 2021 revenue receipts were up $ $6,212,767 (14.9%) from budget, and up $8,720,487 (22.2%) from fiscal year 2020.

Capital and operational items are detailed consistent with GAAP. Cash flows are projected and monitored. Budget documents, financial reports and accompanying materials disclose related planning assumptions which were reviewed with the Board in June 2020 for fiscal year 2021, and in July 2021 for fiscal year 2022.

Monthly fiscal year 2021 year to date financial reports have been provided to the Board monthly. All files are maintained at SWMBH Finance Department. Participant CMH CFOs and CEOs routinely review financial projections and results, as well as budget development materials.

Significant efforts by all have occurred to assure common cost allocation per federal regulations the SWMBH Board-approved Financial Risk Management and Cost Allocation Plans and MDHHS guidance.

2. *Plans the expenditures in any fiscal year of more funds than are conservatively projected to be received in that period.*

CEO Response: SWMBH Board approved budget for fiscal year 2021 did not plan for the expenditures to be more than funds projected to be received. For fiscal year 2022 the approved budget did not plan for expenditures more than projected revenue.

3. *Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, board development, board and committee meetings, and board legal fees.*

CEO Response: The fiscal year 2021 and 2022 budget included line items and sufficient amounts for Board prerogatives including costs of financial and compliance audit, board development, board and committee meetings and board legal fees.

4. *Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve future ends.*

CEO Response: The fiscal year 2021 actual performance is expected to be improved results in part due to the regions deep dive into all areas of

appropriate cost containment. SWMBH did not ignore the building of organizational capability sufficient to achieve Ends in future years and currently expects to be able to place funds into Medicaid Savings Risk Corridor for a consecutive fiscal year. SWMBH has been active in several expense reductions, revenue maximization and funding advocacy efforts with some successes.

5. Cannot be shared with the board on a monthly basis.

CEO Response: The fiscal year 2021 and 2022 financial reports have been shared with the Board congruous with the Board's governing documents, and in format(s) approved or accepted by the Board. Throughout fiscal year 2021 and into 2022 monthly financial reports, critical assumptions, and threats to fiscal health were regularly shared with the Board.

The CEO provided this report and supporting materials to assigned Reviewer. CEO and CFO offered to meet with assigned Reviewer.

Supporting Documents

- Fiscal Year 2022 Budget Assumptions and Parameters
- Fiscal Year 2021 Board approved Budget
- Fiscal Year 2022 Board approved Budget

END

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations	Policy Number: BEL-001	Pages: 1
Subject: Budgeting	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH EO		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.2014	**Last Review Date**: 2/12/21	**Past Review Dates**: 8.8.14, 11/13/15, 1/13/17, 1/12/18,1/11/19,1/10/20

I. **PURPOSE:**

II. **POLICY:**

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

III. **STANDARDS:**

Accordingly the Executive Officer may not allow budgeting which;

1. Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.

2. Plans the expenditures in any fiscal year of more funds than are conservatively projected to be available for that period.

3. Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, Board development, Board and Committee meetings, and Board legal fees.

4. Endangers the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends.

5. Cannot be shared with the Board on a monthly basis.

Southwest Michigan
BEHAVIORAL HEALTH

Executive Limitations
Monitoring to Assure Executive Performance
Board date December 10, 2021

Policy Number: BEL-003
Policy Name: Asset Protection
Assigned Reviewer: Susan Barnes

Period under review: October 2020 – October 2021

Purpose: To establish a policy for asset protection, and financial risk management.

Policy: The Executive Officer shall not cause or allow corporate assets to be unprotected, inadequately maintained, or unnecessarily risked.

Standards: Accordingly, the EO may not;

1. Subject facilities and equipment to improper wear and tear or insufficient maintenance.

   EO Response: As evidenced by a walk-through of the agency, facilities and equipment are not subjected to improper wear and tear or insufficient maintenance. SWMBH Operations Department performs regular direct and indirect surveillance and manages maintenance needs with housekeeping contractors and landlord as needed.

2. Fail to protect intellectual property, information and files from loss or significant damage.

   EO Response: No loss of or significant damage to intellectual property, information or files has occurred. SWMBH maintains locked doors and locked cabinets for storage of key business files, and electronic filing systems are log-in and password assigned by individual and are auditable. Laptop and other devices are configured to prohibit the capture of network information onto peripheral hard drives/thumb drives. SWMBH maintains a Human Resources policy on proper use of intellectual property. Electronic files are backed up regularly and stored off-site. No loss of intellectual property, information or files has occurred as evidenced by the absence of related Incident Report, police or fire reports or related casualty-property insurance claims.

3. Fail to insure adequately against theft and casualty and against liability losses to board members, staff, and the organization itself.

   EO Response: SWMBH has a comprehensive Officers and Directors and general liability Policy with Michigan Municipal Risk Management Association. The premium has been paid and the Policy is active.

4. Compromise the independence of the board's audit or other external monitoring or advice, such as by engaging parties already chosen by the board as consultants or advisers.

   EO Response: SWMBH has not engaged any parties already chosen by the Board as consultants or advisers.

5. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission.

   EO Response: No endangerment of the organization's public image or credibility has occurred as evidenced by no negative press per media scanning and no external or internal complaints related hereto.

6. Change the organization's name or substantially alter its identity in the community.

   EO Response: SWMBH has not changed the organization's name or substantially altered the SWMBH identity in the community.

7. Allow un-bonded personnel access to material amounts of funds.

   EO Response: SWMBH staff are covered for their business activity under the MMRMA Policy. Management controls include segregation of duties. Bank accounts are reconciled by the finance department at least monthly to minimize risk of mismanagement or diversion of funds.

8. Unnecessarily expose the organization, its board, or staff to claims of liability.

   EO Response: SWMBH has not exposed the organization, the Board, or staff to claims of liability as evidenced by the absence of liability claims against the organization, Board or staff.

9. Make any purchases:

   i. Wherein normally prudent protection has not been given against conflict of interest
   ii. Inconsistent with federal and state regulations related to procurement using SWMBH funds.

iii. Of more than $100,000 without having obtained comparative prices and quality
iv. Of more than $100,000 without a stringent method of assuring the balance of long-term quality and cost.
v. Orders should not be split to avoid these criteria.

EO Response: All purchases receive prudent protection against conflict of interest by virtue of multi-party review and approvals using a detailed process. All applicable purchases are subject to review by both Operations and Program Integrity-Compliance for alignment to federal and state regulations related to procurement. No purchase above $100,000 has occurred during this time period under review. Orders have not been split to avoid these criteria. Procurement policy and administrative files are available on-site upon request.

10. Receive, process, or disburse funds under controls that are insufficient to meet the board-appointed auditor's standards.

EO Response: SWMBH does not receive, process or disburse funds under controls that are insufficient. The board-appointed auditor Roslund-Prestage had no findings in this area in its recent audit of SWMBH.

11. Invest or hold operating capital and risk reserve funds in instruments that are not complaint with the requirements of Michigan Public Act 20.

EO Response: Operating capital and risk reserve funds are held in instruments compliant with the requirements of Michigan Public Act 20 as well as the Board-approved Investment Policy.

We invited Mrs. Barnes to set a call and or meeting with the CEO and/or CFO at his discretion.

Related Documents Provided:

SWMBH Investment Policy and Investment Placements Summary
Michigan Municipal Risk Management Authority Policy

Southwest Michigan Behavioral Health
Investment Annual Report
10/01/2019 to 09/30/2020

First National Bank

ICS Account

Medicaid Savings ICS	$ 25,586,464.49
ISF	5,013,837.00
Labor Risk Reserve	284,580.91
Total Portfolio Holdings	$ 30,884,882.40

Southwest Michigan
BEHAVIORAL HEALTH

Section: Board Policy- Executive Limitation	Policy Number: BEL-003	Pages: 2
Subject: Asset Protection	**Required By**: Policy Governance	**Accountability:** SWMBH Board
Application: ☐ SWMBH Governance Board ☒ SWMBH Executive Officer (EO)		**Required Reviewer:** SWMBH Board
Effective Date: 02.14.2014	**Last Review Date**: 12.11.20	**Past Review Dates**: 11.14.14, 12.11.15, 12.9.16, 12.8.17,12.14.18, 12.13.19

I. **PURPOSE:**
To establish a policy for asset protection, and financial risk management.

II. **POLICY:**
The Executive Officer shall not cause or allow corporate assets to be unprotected, inadequately maintained, or unnecessarily risked.

III. **STANDARDS:**
Additionally, the Executive Officer shall not;

1. Subject facilities and equipment to improper wear and tear or insufficient maintenance.

2. Fail to protect intellectual property, information and files from loss or significant damage.

3. Fail to insure adequately against theft and casualty and against liability losses to Board Members, Staff, and the Organization itself.

4. Compromise the independence of the Board's audit or other external monitoring or advice, such as by engaging parties already chosen by the Board as consultants or advisers.

5. Endanger the Organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission.

6. Change the organization's name or substantially alter its identity in the community.

7. Allow un-bonded personnel access to material amounts of funds.

8. Unnecessarily expose the Organization, its Board, or Staff to claims of liability.

9. Make any purchases:
   i. Wherein normally prudent protection has not been given against conflict of interest
   ii. Inconsistent with federal and state regulations related to procurement using SWMBH funds.

iii. Of more than $100,000 without having obtained comparative prices and quality
iv. Of more than $100,000 without a stringent method of assuring the balance of long-term quality and cost.
v. Of split orders to avoid these criteria.

10. Receive, process, or disburse under controls that are insufficient to meet the Board-appointed auditor's standards.

11. Invest or hold operating capital and risk reserve funds in instruments that are not compliant with the requirements of Michigan Public Act 20.

	E	F	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 1/31/2022		**P04FYTD22**	**4**									
3	*(For Internal Management Purposes Only)*												
4	***INCOME STATEMENT***		**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**Opioid Health Home Contract**	**CCBHC**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**
5													
6													
7	**REVENUE**												
18	Contract Revenue		110,408,590	79,847,202	16,056,473	6,844,478	586,813	3,215,455	1,383,475	-	1,637,561	837,131	-
19	DHHS Incentive Payments		290,161	290,161	-	-	-	-	-	-	-	-	-
20	Grants and Earned Contracts		179,015	-	-	-	-	-	-	179,015	-	-	-
21	Interest Income - Working Capital		6,075	-	-	-	-	-	-	-	-	-	6,075
22	Interest Income - ISF Risk Reserve		358	-	-	-	-	-	-	-	-	-	358
23	Local Funds Contributions		429,784	-	-	-	-	-	-	-	-	-	429,784
24	Other Local Income		-	-	-	-	-	-	-	-	-	-	-
25													
26	**TOTAL REVENUE**		**111,313,983**	**80,137,363**	**16,056,473**	**6,844,478**	**586,813**	**3,215,455**	**1,383,475**	**179,015**	**1,637,561**	**837,131**	**436,218**
27													
28	**EXPENSE**												
29	**Healthcare Cost**												
30	Provider Claims Cost		10,294,551	1,129,078	2,585,807	-	316,491	3,097,734	1,249,499	118,186	1,469,019	328,737	-
31	CMHP Subcontracts, net of 1st & 3rd party		74,288,573	62,655,580	6,237,857	5,083,525	-	-	175,840	-	135,770	-	-
32	Insurance Provider Assessment Withhold (IPA)		1,181,818	1,003,369	178,448	-	-	-	-	-	-	-	-
33	Medicaid Hospital Rate Adjustments		-	-	-	-	-	-	-	-	-	-	-
34	MHL Cost in Excess of Medicare FFS Cost		-	112,796	-	-	-	-	(112,796)		-	-	-
35													
36	**Total Healthcare Cost**		**85,764,941**	**64,900,823**	**9,002,113**	**5,083,525**	**316,491**	**3,097,734**	**1,312,543**	**118,186**	**1,604,789**	**328,737**	**-**
37	**Medical Loss Ratio (HCC % of Revenue)**		**77.5%**	**81.0%**	**56.1%**	**74.3%**	**53.9%**	**96.3%**	**94.9%**		**98.0%**	**39.3%**	
39	**Administrative Cost**												
40	Purchased Professional Services		214,132	-	-	-	-	-	-	-	-	-	214,132
41	Administrative and Other Cost		2,998,287	-	-	-	-	-	-	60,828	6,742	-	2,930,471
42	Interest Expense		-	-	-	-	-	-	-	-	-	-	-
43	Depreciation		1,908	-	-	-	-	-	-	-	-	-	1,908
44	Functional Cost Reclassification		-	-	-	-	-	-	-	-	-	-	-
45	Allocated Indirect Pooled Cost		(0)	-	-	-	-	-	-	-	-	-	245
46	Delegated Managed Care Admin		5,602,707	4,695,316	494,460	394,679	-	-	18,252	-	-	-	-
47	Apportioned Central Mgd Care Admin		-	2,357,437	326,117	187,884	11,697	114,490	52,680	6,616	59,561	-	(3,116,481)
48													
49	**Total Administrative Cost**		**8,817,034**	**7,052,752**	**820,577**	**582,563**	**11,697**	**114,490**	**70,932**	**67,445**	**66,304**	**-**	**30,274**
50	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**9.8%**	**8.4%**	**10.3%**	**3.6%**	**3.6%**	**5.1%**		**4.0%**	**0.0%**	**3.3%**
51													
52	Local Funds Contribution		429,784	-	-	-	-	-	-	-	-	-	429,784
53	PBIP Transferred to CMHPs		-										-
54													
55	**TOTAL COST after apportionment**		**95,011,759**	**71,953,575**	**9,822,689**	**5,666,088**	**328,188**	**3,212,225**	**1,383,475**	**185,631**	**1,671,092**	**328,737**	**460,058**
56													
57	**NET SURPLUS before settlement**		**16,302,225**	**8,183,788**	**6,233,784**	**1,178,390**	**258,625**	**3,231**	**-**	**(6,616)**	**(33,531)**	**508,394**	**(23,840)**
58	**Net Surplus (Deficit) % of Revenue**		**14.6%**	**10.2%**	**38.8%**	**17.2%**	**44.1%**	**0.1%**	**0.0%**	**-3.7%**	**-2.0%**	**60.7%**	**-5.5%**
60	Prior Year Savings		-	-	-	-	-	-	-		-	-	-
61	Change in PA2 Fund Balance		(474,863)	-	-	-	-	-	-		-	(474,863)	-
62	ISF Risk Reserve Abatement (Funding)		(358)	-	-	-	-	-	-		-	-	(358)
63	ISF Risk Reserve Deficit (Funding)		-	-	-	-	-	-	-		-	-	-
64	Settlement Receivable / (Payable)		(2,613,189)	2,635,574	(3,808,518)	(1,178,390)	(258,625)	(3,231)	-	-	33,531	(33,531)	-
65	**NET SURPLUS (DEFICIT)**		**13,213,814**	**10,819,362**	**2,425,266**	**-**	**-**	**-**	**-**	**(6,616)**	**-**	**-**	**(24,199)**
66	*HMP & Autism is settled with Medicaid*												
67													
68	**SUMMARY OF NET SURPLUS (DEFICIT)**												
69	Prior Year Unspent Savings		-	-	-	-	-	-	-		-	-	-
70	Current Year Savings		12,982,773	10,557,507	2,425,266	-	-	-	-		-	-	-
71	Current Year Public Act 2 Fund Balance		-	-	-	-	-	-	-		-	-	-
72	Local and Other Funds Surplus/(Deficit)		231,041	261,856	-	-	-	-	-	(6,616)	-	-	(24,199)
74	**NET SURPLUS (DEFICIT)**		**13,213,814**	**10,819,362**	**2,425,266**	**-**	**-**	**-**	**-**	**(6,616)**	**-**	**-**	**(24,199)**
75													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*									
2	For the Fiscal YTD Period Ended 1/31/2022			4									
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	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5									P04 Estimate	P04 Estimate			
6	***Medicaid Specialty Services***			*HCC%*	81.9%	81.0%	79.0%	74.3%	76.2%	78.4%	76.7%	75.0%	82.9%
7	Subcontract Revenue		79,847,202	4,579,600	75,267,602	3,349,575	14,606,841	3,508,746	13,702,422	4,075,329	23,186,116	5,649,383	7,189,190
8	Incentive Payment Revenue		290,161	155,725	134,436	4,236	45,129	24,886	43,065	1,235	-	15,885	-
9	**Contract Revenue**		**80,137,363**	**4,735,325**	**75,402,038**	**3,353,811**	**14,651,970**	**3,533,632**	**13,745,488**	**4,076,565**	**23,186,116**	**5,665,267**	**7,189,190**
10													
11	External Provider Cost		49,100,824	1,129,078	47,971,746	1,791,580	8,701,089	2,881,536	9,321,755	2,476,864	15,478,683	3,859,824	3,460,416
12	Internal Program Cost		15,273,924	-	15,273,924	1,229,349	3,152,089	1,057,560	3,193,986	924,158	2,127,039	1,112,456	2,477,286
13	SSI Reimb, 1st/3rd Party Cost Offset		(414,250)	-	(414,250)	-	(88,740)	(8,730)	(129,375)	-	(166,304)	(6,821)	(14,279)
14	Insurance Provider Assessment Withhold (IPA)		1,003,369	1,003,369	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(81,296)	(81,296)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**64,882,571**	**2,051,150**	**62,831,420**	**3,020,929**	**11,764,437**	**3,930,366**	**12,386,366**	**3,401,022**	**17,439,418**	**4,965,459**	**5,923,423**
17	**Medical Loss Ratio (HCC % of Revenue)**		**81.0%**	**43.3%**	**83.3%**	**90.1%**	**80.3%**	**111.2%**	**90.1%**	**83.4%**	**75.2%**	**87.6%**	**82.4%**
18													
19	**Managed Care Administration**		**7,071,005**	**2,357,437**	**4,713,568**	**412,598**	**1,264,055**	**145,700**	**862,467**	**328,401**	**1,013,851**	**246,861**	**439,634**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.8%**	**3.3%**	**6.6%**	**12.0%**	**9.7%**	**3.6%**	**6.5%**	**8.8%**	**5.5%**	**4.7%**	**6.9%**
21													
22	**Contract Cost**		**71,953,575**	**4,408,587**	**67,544,988**	**3,433,527**	**13,028,492**	**4,076,066**	**13,248,834**	**3,729,423**	**18,453,269**	**5,212,320**	**6,363,057**
23	**Net before Settlement**		**8,183,788**	**326,738**	**7,857,051**	**(79,716)**	**1,623,478**	**(542,434)**	**496,654**	**347,141**	**4,732,847**	**452,947**	**826,133**
24													
25	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		2,635,574	10,492,625	(7,857,051)	79,716	(1,623,478)	542,434	(496,654)	(347,141)	(4,732,847)	(452,947)	(826,133)
28	**Net after Settlement**		**10,819,362**	**10,819,362**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		172,558	172,558	172,558	9,318	32,815	10,113	33,277	10,207	45,147	14,087	17,594
32	Revenue PMPM		$ 116.10	$ 6.86	$ 109.24	$ 89.98	$ 111.63	$ 87.35	$ 103.27	$ 99.85	$ 128.39	$ 100.54	$ 102.15
33	Expense PMPM		$ 104.25	$ 6.39	$ 97.86	$ 92.12	$ 99.26	$ 100.76	$ 99.53	$ 91.34	$ 102.18	$ 92.50	$ 90.42
34	Margin PMPM		$ 11.86	$ 0.47	$ 11.38	$ (2.14)	$ 12.37	$ (13.41)	$ 3.73	$ 8.50	$ 26.21	$ 8.04	$ 11.74
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		172,558	172,558	172,558	9,318	32,815	10,113	33,277	10,207	45,147	14,087	17,594
41	Budget		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
42	Variance - Favorable / (Unfavorable)		21,565	21,565	21,565	1,570	3,687	1,633	4,633	1,249	5,436	1,625	1,732
43	% Variance - Fav / (Unfav)		14.3%	14.3%	14.3%	20.3%	12.7%	19.3%	16.2%	13.9%	13.7%	13.0%	10.9%
44													
45	**Contract Revenue before settlement**												
46	Actual		80,137,363	4,735,325	75,402,038	3,353,811	14,651,970	3,533,632	13,745,488	4,076,565	23,186,116	5,665,267	7,189,190
47	Budget		73,422,337	4,539,883	68,882,454	2,988,096	13,576,540	3,810,638	12,556,712	3,761,413	21,048,705	4,560,132	6,580,218
48	Variance - Favorable / (Unfavorable)		6,715,026	195,442	6,519,584	365,715	1,075,430	(277,006)	1,188,776	315,152	2,137,411	1,105,135	608,972
49	% Variance - Fav / (Unfav)		9.1%	4.3%	9.5%	12.2%	7.9%	-7.3%	9.5%	8.4%	10.2%	24.2%	9.3%
50													
51	**Healthcare Cost**												
52	Actual		64,882,571	2,051,150	62,831,420	3,020,929	11,764,437	3,930,366	12,386,366	3,401,022	17,439,418	4,965,459	5,923,423
53	Budget		66,868,352	3,702,500	63,165,852	2,645,687	12,100,557	3,420,252	11,460,925	3,155,091	19,746,868	4,789,725	5,846,748
54	Variance - Favorable / (Unfavorable)		1,985,781	1,651,349	334,432	(375,242)	336,120	(510,113)	(925,442)	(245,931)	2,307,450	(175,734)	(76,676)
55	% Variance - Fav / (Unfav)		3.0%	44.6%	0.5%	-14.2%	2.8%	-14.9%	-8.1%	-7.8%	11.7%	-3.7%	-1.3%
56													
57	**Managed Care Administration**												
58	Actual		7,071,005	2,357,437	4,713,568	412,598	1,264,055	145,700	862,467	328,401	1,013,851	246,861	439,634
59	Budget		7,152,823	2,483,083	4,669,740	197,309	891,415	288,993	784,111	287,046	1,573,608	299,932	347,327
60	Variance - Favorable / (Unfavorable)		81,818	125,646	(43,828)	(215,289)	(372,640)	143,293	(78,357)	(41,356)	559,757	53,071	(92,307)
61	% Variance - Fav / (Unfav)		1.1%	5.1%	-0.9%	-109.1%	-41.8%	49.6%	-10.0%	-14.4%	35.6%	17.7%	-26.6%

	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 1/31/2022			**4**									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5									**P04 Estimate**	**P04 Estimate**			
62													
63	**Total Contract Cost**												
64	Actual		71,953,575	4,408,587	67,544,988	3,433,527	13,028,492	4,076,066	13,248,834	3,729,423	18,453,269	5,212,320	6,363,057
65	Budget		74,021,175	6,185,583	67,835,592	2,842,996	12,991,972	3,709,245	12,245,035	3,442,137	21,320,476	5,089,657	6,194,075
66	Variance - Favorable / (Unfavorable)		2,067,600	1,776,995	290,604	(590,531)	(36,520)	(366,821)	(1,003,798)	(287,287)	2,867,207	(122,663)	(168,983)
67	% Variance - Fav / (Unfav)		2.8%	28.7%	0.4%	-20.8%	-0.3%	-9.9%	-8.2%	-8.3%	13.4%	-2.4%	-2.7%
68													
69	**Net before Settlement**												
70	Actual		8,183,788	326,738	7,857,051	(79,716)	1,623,478	(542,434)	496,654	347,141	4,732,847	452,947	826,133
71	Budget		(598,838)	(1,645,699)	1,046,862	145,100	584,568	101,393	311,676	319,276	(271,770)	(529,525)	386,143
72	Variance - Favorable / (Unfavorable)		8,782,626	1,972,437	6,810,189	(224,816)	1,038,910	(643,827)	184,978	27,866	5,004,618	982,472	439,989
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 1/31/2022			4									
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	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5									P04 Estimate	P04 Estimate			
75	***Healthy Michigan Plan***			*HCC%*	8.2%	9.7%	7.4%	18.8%	13.3%	10.6%	12.5%	13.5%	6.4%
76	**Contract Revenue**		**16,056,473**	**3,123,359**	**12,933,114**	**653,638**	**2,533,678**	**610,562**	**2,387,847**	**732,196**	**3,776,589**	**1,014,762**	**1,223,842**
77													
78	External Provider Cost		5,873,508	2,585,807	3,287,701	155,254	526,228	128,089	780,269	185,863	1,143,084	259,677	109,235
79	Internal Program Cost		2,950,156	-	2,950,156	206,079	576,226	294,114	1,003,048	275,726	39,148	208,130	347,685
80	Insurance Provider Assessment Withhold (IPA)		178,448	178,448	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**9,002,113**	**2,764,256**	**6,237,857**	**361,334**	**1,102,454**	**422,204**	**1,783,318**	**461,589**	**1,182,232**	**467,807**	**456,920**
82	**Medical Loss Ratio (HCC % of Revenue)**		**56.1%**	**88.5%**	**48.2%**	**55.3%**	**43.5%**	**69.1%**	**74.7%**	**63.0%**	**31.3%**	**46.1%**	**37.3%**
83													
84	**Managed Care Administration**		**820,577**	**326,117**	**494,460**	**49,351**	**118,456**	**40,520**	**123,879**	**44,571**	**58,597**	**25,174**	**33,912**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.4%**	**3.3%**	**5.0%**	**12.0%**	**9.7%**	**8.8%**	**6.5%**	**8.8%**	**4.7%**	**5.1%**	**6.9%**
86													
87	**Contract Cost**		**9,822,689**	**3,090,372**	**6,732,317**	**410,685**	**1,220,910**	**462,724**	**1,907,197**	**506,160**	**1,240,829**	**492,981**	**490,832**
88	**Net before Settlement**		**6,233,784**	**32,987**	**6,200,797**	**242,953**	**1,312,768**	**147,838**	**480,650**	**226,036**	**2,535,760**	**521,781**	**733,010**
89													
90	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(3,808,518)	2,392,280	(6,200,797)	(242,953)	(1,312,768)	(147,838)	(480,650)	(226,036)	(2,535,760)	(521,781)	(733,010)
93	**Net after Settlement**		**2,425,266**	**2,425,266**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		73,654	73,654	73,654	3,730	14,505	3,490	13,478	4,420	21,175	5,786	7,071
97	Revenue PMPM		$ 54.50	$ 10.60	$ 43.90	$ 43.81	$ 43.67	$ 43.74	$ 44.29	$ 41.42	$ 44.59	$ 43.84	$ 43.27
98	Expense PMPM		33.34	10.49	22.85	27.52	21.04	33.15	35.38	28.63	14.65	21.30	17.35
99	Margin PMPM		$ 21.16	$ 0.11	$ 21.05	$ 16.28	$ 22.63	$ 10.59	$ 8.92	$ 12.79	$ 29.94	$ 22.54	$ 25.92
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		73,654	73,654	73,654	3,730	14,505	3,490	13,478	4,420	21,175	5,786	7,071
106	Budget		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
107	Variance - Favorable / (Unfavorable)		21,289	21,289	21,289	1,187	3,671	1,025	4,133	1,219	6,479	1,687	1,889
108	% Variance - Fav / (Unfav)		40.7%	40.7%	40.7%	46.7%	33.9%	41.6%	44.2%	38.1%	44.1%	41.1%	36.5%
109													
110	**Contract Revenue before settlement**												
111	Actual		16,056,473	3,123,359	12,933,114	653,638	2,533,678	610,562	2,387,847	732,196	3,776,589	1,014,762	1,223,842
112	Budget		13,897,971	2,614,029	11,283,942	559,990	2,267,620	542,400	2,057,012	681,146	3,219,769	876,125	1,079,880
113	Variance - Favorable / (Unfavorable)		2,158,502	509,330	1,649,172	93,648	266,058	68,162	330,835	51,049	556,820	138,637	143,963
114	% Variance - Fav / (Unfav)		15.5%	19.5%	14.6%	16.7%	11.7%	12.6%	16.1%	7.5%	17.3%	15.8%	13.3%
115													
116	**Healthcare Cost**												
117	Actual		9,002,113	2,764,256	6,237,857	361,334	1,102,454	422,204	1,783,318	461,589	1,182,232	467,807	456,920
118	Budget		9,143,318	2,062,946	7,080,371	381,130	1,185,979	351,387	1,829,003	287,830	1,860,008	464,387	720,647
119	Variance - Favorable / (Unfavorable)		141,205	(701,309)	842,514	19,796	83,525	(70,816)	45,686	(173,760)	677,776	(3,420)	263,728
120	% Variance - Fav / (Unfav)		1.5%	-34.0%	11.9%	5.2%	7.0%	-20.2%	2.5%	-60.4%	36.4%	-0.7%	36.6%
121													
122	**Managed Care Administration**												
123	Actual		820,577	326,117	494,460	49,351	118,456	40,520	123,879	44,571	58,597	25,174	33,912
124	Budget		872,564	355,650	516,914	28,424	87,368	29,690	125,133	26,186	148,222	29,080	42,810
125	Variance - Favorable / (Unfavorable)		51,987	29,534	22,453	(20,927)	(31,088)	(10,830)	1,254	(18,385)	89,625	3,906	8,898
126	% Variance - Fav / (Unfav)		6.0%	8.3%	4.3%	-73.6%	-35.6%	-36.5%	1.0%	-70.2%	60.5%	13.4%	20.8%
127													
128	**Total Contract Cost**												
129	Actual		9,822,689	3,090,372	6,732,317	410,685	1,220,910	462,724	1,907,197	506,160	1,240,829	492,981	490,832
130	Budget		10,015,881	2,418,597	7,597,285	409,553	1,273,347	381,078	1,954,136	314,016	2,008,230	493,467	763,458

	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 1/31/2022			**4**									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5									**P04 Estimate**	**P04 Estimate**			
131	Variance - Favorable / (Unfavorable)		193,192	(671,776)	864,968	(1,131)	52,438	(81,646)	46,939	(192,144)	767,401	486	272,626
132	% Variance - Fav / (Unfav)		1.9%	-27.8%	11.4%	-0.3%	4.1%	-21.4%	2.4%	-61.2%	38.2%	0.1%	35.7%
133													
134	**Net before Settlement**												
135	Actual		6,233,784	32,987	6,200,797	242,953	1,312,768	147,838	480,650	226,036	2,535,760	521,781	733,010
136	Budget		3,882,090	195,433	3,686,657	150,436	994,273	161,322	102,876	367,130	1,211,540	382,658	316,422
137	Variance - Favorable / (Unfavorable)		2,351,694	(162,446)	2,514,140	92,516	318,495	(13,484)	377,775	(141,095)	1,324,220	139,123	416,588
138													
139													

	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 1/31/2022			4									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5									**P04 Estimate**	**P04 Estimate**			
140	***Autism Specialty Services***			*HCC%*	6.6%	3.8%	9.7%	1.6%	7.1%	6.1%	6.5%	7.3%	6.2%
141	**Contract Revenue**		**6,844,478**	**(15,963)**	**6,860,441**	**360,634**	**1,245,532**	**386,169**	**1,280,168**	**392,210**	**1,973,705**	**548,584**	**673,441**
142													
143	External Provider Cost		4,424,605	-	4,424,605	-	1,442,157	7,554	612,477	263,118	1,668,351	712	430,236
144	Internal Program Cost		658,920	-	658,920	141,904	-	25,031	479,872	1,165	-	-	10,948
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**5,083,525**	**-**	**5,083,525**	**141,904**	**1,442,157**	**32,584**	**1,092,349**	**264,283**	**1,668,351**	**712**	**441,185**
147	**Medical Loss Ratio (HCC % of Revenue)**		**74.3%**	**0.0%**	**74.1%**	**39.3%**	**115.8%**	**8.4%**	**85.3%**	**67.4%**	**84.5%**	**0.1%**	**65.5%**
148													
149	**Managed Care Administration**		**582,563**	**187,884**	**394,679**	**19,381**	**154,956**	**3,449**	**75,881**	**25,519**	**82,750**	**-**	**32,745**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**10.3%**	**3.3%**	**7.0%**	**12.0%**	**9.7%**	**9.6%**	**6.5%**	**8.8%**	**4.7%**	**0.0%**	**6.9%**
151													
152	**Contract Cost**		**5,666,088**	**187,884**	**5,478,205**	**161,285**	**1,597,113**	**36,033**	**1,168,229**	**289,802**	**1,751,101**	**712**	**473,929**
153	**Net before Settlement**		**1,178,390**	**(203,847)**	**1,382,237**	**199,349**	**(351,581)**	**350,136**	**111,938**	**102,407**	**222,604**	**547,871**	**199,512**
154	Contract Settlement / Redistribution		(1,178,390)	203,847	(1,382,237)	(199,349)	351,581	(350,136)	(111,938)	(102,407)	(222,604)	(547,871)	(199,512)
155	**Net after Settlement**		**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.2%	0.6%	0.3%	1.0%	0.0%	0.4%	0.0%	0.3%	0.3%
159	**Contract Revenue**		**1,637,561**	**1,481,169**	**156,392**	**12,585**	**65,099**	**9,422**	**-**	**20,318**	**1,400**	**26,323**	**21,245**
160													
161	External Provider Cost		1,470,419	1,469,019	1,400	-	-	-	-	-	1,400	-	-
162	Internal Program Cost		134,370	-	134,370	23,669	50,134	17,759	-	19,225	-	574	23,010
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**1,604,789**	**1,469,019**	**135,770**	**23,669**	**50,134**	**17,759**	**-**	**19,225**	**1,400**	**574**	**23,010**
165	**Medical Loss Ratio (HCC % of Revenue)**		**98.0%**	**99.2%**	**86.8%**	**188.1%**	**77.0%**	**188.5%**	**0.0%**	**94.6%**	**100.0%**	**2.2%**	**108.3%**
166													
167	**Managed Care Administration**		**59,561**	**59,561**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**3.6%**	**3.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**1,664,350**	**1,528,580**	**135,770**	**23,669**	**50,134**	**17,759**	**-**	**19,225**	**1,400**	**574**	**23,010**
171	**Net before Settlement**		**(26,789)**	**(47,411)**	**20,622**	**(11,084)**	**14,965**	**(8,337)**	**-**	**1,094**	**(0)**	**25,749**	**(1,765)**
172	Contract Settlement		33,531	54,153	(20,622)	11,084	(14,965)	8,337	-	(1,094)	0	(25,749)	1,765
173	**Net after Settlement**		**6,742**	**6,742**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175													

	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 1/31/2022			4									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5									**P04 Estimate**	**P04 Estimate**			
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		104,385,715	9,168,165	95,217,550	4,376,432	18,451,149	4,514,899	17,370,437	5,220,053	28,937,810	7,239,051	9,107,718
178	Incentive Payment Revenue		290,161	155,725	134,436	4,236	45,129	24,886	43,065	1,235	-	15,885	-
179	**Contract Revenue**		**104,675,876**	**9,323,890**	**95,351,987**	**4,380,668**	**18,496,278**	**4,539,785**	**17,413,503**	**5,221,288**	**28,937,810**	**7,254,936**	**9,107,718**
180													
181	External Provider Cost		60,869,356	5,183,903	55,685,452	1,946,835	10,669,474	3,017,179	10,714,501	2,925,844	18,291,518	4,120,213	3,999,887
182	Internal Program Cost		19,017,370	-	19,017,370	1,601,001	3,778,448	1,394,464	4,676,907	1,220,275	2,166,187	1,321,160	2,858,929
183	SSI Reimb, 1st/3rd Party Cost Offset		(414,250)	-	(414,250)	-	(88,740)	(8,730)	(129,375)	-	(166,304)	(6,821)	(14,279)
184	Insurance Provider Assessment Withhold (IPA)		1,181,818	1,181,818	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(81,296)	(81,296)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**80,572,998**	**6,284,425**	**74,288,573**	**3,547,835**	**14,359,182**	**4,402,913**	**15,262,033**	**4,146,119**	**20,291,401**	**5,434,552**	**6,844,537**
187	**Medical Loss Ratio (HCC % of Revenue)**		**77.0%**	**67.4%**	**77.9%**	**81.0%**	**77.6%**	**97.0%**	**87.6%**	**79.4%**	**70.1%**	**74.9%**	**75.2%**
188													
189	**Managed Care Administration**		**8,533,705**	**2,930,998**	**5,602,707**	**481,330**	**1,537,466**	**189,669**	**1,062,227**	**398,491**	**1,155,197**	**272,035**	**506,291**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.6%**	**3.3%**	**6.3%**	**11.9%**	**9.7%**	**4.1%**	**6.5%**	**8.8%**	**5.4%**	**4.8%**	**6.9%**
191													
192	**Contract Cost**		**89,106,703**	**9,215,423**	**79,891,280**	**4,029,165**	**15,896,648**	**4,592,582**	**16,324,260**	**4,544,610**	**21,446,598**	**5,706,587**	**7,350,829**
193	**Net before Settlement**		**15,569,174**	**108,467**	**15,460,707**	**351,502**	**2,599,630**	**(52,797)**	**1,089,242**	**676,678**	**7,491,212**	**1,548,349**	**1,756,890**
194													
195	Prior Year Savings		-	-	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(2,317,802)	13,142,904	(15,460,707)	(351,502)	(2,599,630)	52,797	(1,089,242)	(676,678)	(7,491,212)	(1,548,349)	(1,756,890)
198	**Net after Settlement**		**13,251,371**	**13,251,371**	**-**	**-**	**(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 1/31/2022			4									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5									**P04 Estimate**	**P04 Estimate**			
201	***State General Fund Services***			*HCC%*	3.2%	4.9%	3.5%	4.3%	3.4%	4.4%	4.2%	4.0%	4.2%
202	**Contract Revenue**				**4,363,682**	**288,096**	**705,001**	**510,921**	**619,832**	**295,957**	**1,275,516**	**297,744**	**370,616**
203													
204	External Provider Cost				891,423	72,084	190,287	38,416	136,173	117,293	233,159	66,983	37,027
205	Internal Program Cost				1,491,916	109,570	333,552	67,271	582,661	74,309	9,741	51,053	263,760
206	SSI Reimb, 1st/3rd Party Cost Offset				-	-	-	-	-	-	-	-	-
207	**Total Healthcare Cost**				**2,383,338**	**181,655**	**523,838**	**105,687**	**718,834**	**191,601**	**242,900**	**118,036**	**300,787**
208	**Medical Loss Ratio (HCC % of Revenue)**				**54.6%**	**63.1%**	**74.3%**	**20.7%**	**116.0%**	**64.7%**	**19.0%**	**39.6%**	**81.2%**
209													
210	**Managed Care Administration**				**219,387**	**27,443**	**63,178**	**9,268**	**55,958**	**20,131**	**12,048**	**6,629**	**24,732**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**8.4%**	**13.1%**	**10.8%**	**8.1%**	**7.2%**	**9.5%**	**4.7%**	**5.3%**	**7.6%**
212													
213	**Contract Cost**				**2,602,725**	**209,097**	**587,017**	**114,955**	**774,792**	**211,732**	**254,948**	**124,665**	**325,519**
214	**Net before Settlement**				**1,760,956**	**78,999**	**117,984**	**395,965**	**(154,960)**	**84,224**	**1,020,568**	**173,079**	**45,097**
215													
216	Other Redistributions of State GF				(124,035)	-	-	-	-	-	(156,661)	32,626	-
217	Contract Settlement				(287,578)	(75,197)	(116,389)	-	-	(69,426)	-	-	(26,566)
218	**Net after Settlement**				**1,349,343**	**3,801**	**1,595**	**395,965**	**(154,960)**	**14,798**	**863,907**	**205,705**	**18,531**
219													

	E	F	G	H	J	K	L	M	N	O	P	Q	R	S	T
1	***Southwest Michigan Behavioral Health***				*Mos in Period*										
2	For the Fiscal YTD Period Ended 9/30/2021			**P12FYTD21**	**12**										
3	*(For Internal Management Purposes Only)*														
4	***INCOME STATEMENT***			**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Autism Contract**	**Opioid Health Home Contract**	**MI Health Link**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**	**Indirect Pooled Cost**	
5															
6															
7	**REVENUE**														
17	Contract Revenue			319,579,776	235,309,291	47,570,822	22,735,090	1,109,842	4,476,167	-	6,907,361	1,471,205	-	-	
18	DHHS Incentive Payments			2,847,339	654,452	-	-	-	-	-	-	-	2,192,888	-	
19	Grants and Earned Contracts			255,045	-	-	-	-	-	255,045	-	-	-	-	
20	Interest Income - Working Capital			16,147	-	-	-	-	-	-	-	-	16,147	-	
21	Interest Income - ISF Risk Reserve			1,079	-	-	-	-	-	-	-	-	1,079	-	
22	Local Funds Contributions			1,726,192	-	-	-	-	-	-	-	-	1,726,192	-	
23	Other Local Income			-	-	-	-	-	-	-	-	-	-	-	
24															
25	**TOTAL REVENUE**			**324,425,579**	**235,963,742**	**47,570,822**	**22,735,090**	**1,109,842**	**4,476,167**	**255,045**	**6,907,361**	**1,471,205**	**3,936,306**	**-**	
26															
27	**EXPENSE**														
28	**Healthcare Cost**														
29	Provider Claims Cost			23,588,952	3,335,076	7,686,020	-	776,793	4,049,320	110,124	6,160,365	1,471,254	-	-	
30	CMHP Subcontracts, net of 1st & 3rd party			238,413,280	194,300,707	23,760,835	18,428,520	-	1,475,115	-	448,103	-	-	-	
31	Insurance Provider Assessment Withhold (IPA)			2,951,950	2,212,445	739,504	-	-	-	-	-	-	-	-	
32	Medicaid Hospital Rate Adjustments			5,718,020	3,236,156	2,481,864	-	-	-	-	-	-	-	-	
33	MHL Cost in Excess of Medicare FFS Cost			-	1,347,696	-	-	-	(1,347,696)		-	-	-		
34															
35	**Total Healthcare Cost**			**270,672,201**	**204,432,082**	**34,668,223**	**18,428,520**	**776,793**	**4,176,738**	**110,124**	**6,608,468**	**1,471,254**	**-**	**-**	
36	**Medical Loss Ratio (HCC % of Revenue)**			**83.9%**	**86.6%**	**72.9%**	**81.1%**	**70.0%**	**93.3%**		**95.7%**	**100.0%**			
38	**Administrative Cost**														
39	Purchased Professional Services			453,434	-	-	-	-	-	-	-	-	453,434	-	
40	Administrative and Other Cost			8,787,668	-	-	-	-	-	191,228	168,893	-	8,427,547	0	
41	Interest Expense			-	-	-	-	-	-	-	-	-	-	-	
42	Depreciation			23,911	-	-	-	-	-	-	-	-	23,911	-	
43	Functional Cost Reclassification			-	-	-	-	-	-	-	-	-	-	-	
44	Allocated Indirect Pooled Cost			(0)	-	-	-	-	-	-	-	-	0	(0)	
45	Delegated Managed Care Admin			18,095,055	14,783,302	1,805,619	1,394,148	-	111,986	-	-	-	-	-	
46	Apportioned Central Mgd Care Admin			0	6,805,698	1,066,986	625,276	26,356	187,443	10,225	130,000	-	(8,851,983)	-	
47															
48	**Total Administrative Cost**			**27,360,067**	**21,589,000**	**2,872,604**	**2,019,424**	**26,356**	**299,429**	**201,453**	**298,892**	**-**	**52,909**	**-**	
49	**Admin Cost Ratio (MCA % of Total Cost)**			**9.7%**	**9.6%**	**7.7%**	**9.9%**	**3.3%**	**6.7%**		**4.3%**	**0.0%**	**3.0%**		
50															
51	Local Funds Contribution			1,726,192	-	-	-	-	-	-	-	-	1,726,192	-	
52	PBIP Transferred to CMHPs			1,841,326									1,841,326		
53															
54	**TOTAL COST after apportionment**			**301,599,787**	**226,021,082**	**37,540,827**	**20,447,944**	**803,149**	**4,476,167**	**311,577**	**6,907,361**	**1,471,254**	**3,620,426**	**-**	
55															
56	**NET SURPLUS before settlement**			**22,825,792**	**9,942,660**	**10,029,995**	**2,287,146**	**306,692**	**-**	**(56,531)**	**0**	**(49)**	**315,880**	**-**	
57	**Net Surplus (Deficit) % of Revenue**			**7.0%**	**4.2%**	**21.1%**	**10.1%**	**27.6%**	**0.0%**	**-22.2%**	**0.0%**	**0.0%**	**8.0%**		
59	Prior Year Savings			12,440,039	10,750,765	1,689,274	-	-	-		-	-	-		
60	Change in PA2 Fund Balance			49	-	-	-	-	-		-	49	-		
61	ISF Risk Reserve Abatement (Funding)			(1,079)	-	-	-	-	-		-	-	(1,079)		
62	ISF Risk Reserve Deficit (Funding)			-	-	-	-	-	-		-	-	-		
63	Settlement Receivable / (Payable)			(7,839,568)	3,357,659	(8,603,388)	(2,287,146)	(306,692)	-	-	(0)	-	-		
64	**NET SURPLUS (DEFICIT)**			**27,425,234**	**24,051,084**	**3,115,880**	**-**	**-**	**-**	**(56,531)**	**-**	**-**	**314,801**	**-**	
65	*HMP & Autism is settled with Medicaid*														
66															
67	**SUMMARY OF NET SURPLUS (DEFICIT)**														
68	Prior Year Unspent Savings			-	-	-	-	-	-		-	-	-		
69	Current Year Savings			20,492,815	17,376,934	3,115,880	-	-	-		-	-	-		
70	Current Year Public Act 2 Fund Balance			-	-	-	-	-	-		-	-	-		
71	Local and Other Funds Surplus/(Deficit)			6,932,419	6,674,150	-	-	-	-	(56,531)	-	-	314,801	-	
73	**NET SURPLUS (DEFICIT)**			**27,425,234**	**24,051,084**	**3,115,880**	**-**	**-**	**-**	**(56,531)**	**-**	**-**	**314,801**	**-**	
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 9/30/2021			12									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
6	***Medicaid Specialty Services***			*HCC%*	78.9%	76.4%	78.0%	79.2%	77.2%	78.1%	81.3%	77.3%	80.1%
7	Subcontract Revenue		235,309,291	9,174,820	226,134,471	9,872,426	44,570,356	12,450,893	40,874,000	12,229,536	69,521,919	15,017,184	21,598,158
8	Incentive Payment Revenue		654,452	38,653	615,799	19,062	56,126	107,487	153,552	3,706	217,092	46,595	12,178
9	**Contract Revenue**		**235,963,742**	**9,213,473**	**226,750,270**	**9,891,487**	**44,626,482**	**12,558,379**	**41,027,552**	**12,233,242**	**69,739,011**	**15,063,779**	**21,610,337**
10													
11	External Provider Cost		150,858,746	3,335,076	147,523,670	5,205,005	28,266,960	6,884,550	28,296,674	7,392,953	50,576,224	8,995,748	11,905,555
12	Internal Program Cost		49,200,451	-	49,200,451	3,322,274	10,106,924	2,844,231	8,917,382	2,770,229	8,030,346	5,299,812	7,909,256
13	SSI Reimb, 1st/3rd Party Cost Offset		(948,299)	-	(948,299)	(8,259)	(129,025)	(54,436)	(300,025)	-	(356,066)	(28,743)	(71,745)
14	Insurance Provider Assessment Withhold (IPA)		5,448,601	5,448,601	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS Cost		(239,404)	(239,404)	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		**204,320,096**	**8,544,274**	**195,775,822**	**8,519,020**	**38,244,858**	**9,674,345**	**36,914,031**	**10,163,182**	**58,250,504**	**14,266,816**	**19,743,066**
17	**Medical Loss Ratio (HCC % of Revenue)**		**86.6%**	**92.7%**	**86.3%**	**86.1%**	**85.7%**	**77.0%**	**90.0%**	**83.1%**	**83.5%**	**94.7%**	**91.4%**
18													
19	**Managed Care Administration**		**21,700,986**	**6,805,698**	**14,895,288**	**922,429**	**2,943,582**	**821,402**	**2,563,316**	**975,062**	**4,605,411**	**721,122**	**1,342,964**
20	**Admin Cost Ratio (MCA % of Total Cost)**		**9.6%**	**3.0%**	**6.6%**	**9.8%**	**7.1%**	**7.8%**	**6.5%**	**8.8%**	**7.3%**	**4.8%**	**6.4%**
21													
22	**Contract Cost**		**226,021,082**	**15,349,971**	**210,671,110**	**9,441,449**	**41,188,440**	**10,495,747**	**39,477,346**	**11,138,244**	**62,855,915**	**14,987,938**	**21,086,030**
23	**Net before Settlement**		**9,942,660**	**(6,136,499)**	**16,079,159**	**450,038**	**3,438,042**	**2,062,633**	**1,550,205**	**1,094,998**	**6,883,096**	**75,841**	**524,306**
24													
25	Prior Year Savings		10,750,765	10,750,765	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution		3,357,659	19,436,818	(16,079,159)	(450,038)	(3,438,042)	(2,062,633)	(1,550,205)	(1,094,998)	(6,883,096)	(75,841)	(524,306)
28	**Net after Settlement**		**24,051,084**	**24,051,084**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29													
30	**Eligibles and PMPM**												
31	Average Eligibles		165,454	165,454	165,454	8,845	31,742	9,555	31,474	9,876	43,261	13,618	17,083
32	Revenue PMPM		$ 118.85	$ 4.64	$ 114.21	$ 93.19	$ 117.16	$ 109.53	$ 108.63	$ 103.22	$ 134.34	$ 92.18	$ 105.42
33	Expense PMPM		$ 113.84	$ 7.73	$ 106.11	$ 88.95	$ 108.13	$ 91.54	$ 104.52	$ 93.98	$ 121.08	$ 91.72	$ 102.86
34	Margin PMPM		$ 5.01	$ (3.09)	$ 8.10	$ 4.24	$ 9.03	$ 17.99	$ 4.10	$ 9.24	$ 13.26	$ 0.46	$ 2.56
35													
36	***Medicaid Specialty Services***												
37	**Budget v Actual**												
38													
39	**Eligible Lives (Average Eligibles)**												
40	Actual		165,454	165,454	165,454	8,845	31,742	9,555	31,474	9,876	43,261	13,618	17,083
41	Budget		150,993	150,993	150,993	7,748	29,128	8,480	28,644	8,958	39,711	12,462	15,862
42	Variance - Favorable / (Unfavorable)		14,461	14,461	14,461	1,097	2,614	1,075	2,830	918	3,550	1,156	1,221
43	% Variance - Fav / (Unfav)		9.6%	9.6%	9.6%	14.2%	9.0%	12.7%	9.9%	10.2%	8.9%	9.3%	7.7%
44													
45	**Contract Revenue before settlement**												
46	Actual		235,963,742	9,213,473	226,750,270	9,891,487	44,626,482	12,558,379	41,027,552	12,233,242	69,739,011	15,063,779	21,610,337
47	Budget		220,267,012	13,619,650	206,647,362	8,964,288	40,729,621	11,431,915	37,670,135	11,284,238	63,146,116	13,680,397	19,740,654
48	Variance - Favorable / (Unfavorable)		15,696,730	(4,406,177)	20,102,907	927,200	3,896,861	1,126,465	3,357,417	949,005	6,592,895	1,383,382	1,869,682
49	% Variance - Fav / (Unfav)		7.1%	-32.4%	9.7%	10.3%	9.6%	9.9%	8.9%	8.4%	10.4%	10.1%	9.5%
50													
51	**Healthcare Cost**												
52	Actual		204,320,096	8,544,274	195,775,822	8,519,020	38,244,858	9,674,345	36,914,031	10,163,182	58,250,504	14,266,816	19,743,066
53	Budget		200,605,056	11,107,500	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
54	Variance - Favorable / (Unfavorable)		(3,715,040)	2,563,226	(6,278,266)	(581,958)	(1,943,188)	586,411	(2,531,257)	(697,909)	990,100	102,358	(2,202,824)
55	% Variance - Fav / (Unfav)		-1.9%	23.1%	-3.3%	-7.3%	-5.4%	5.7%	-7.4%	-7.4%	1.7%	0.7%	-12.6%
56													
57	**Managed Care Administration**												
58	Actual		21,700,986	6,805,698	14,895,288	922,429	2,943,582	821,402	2,563,316	975,062	4,605,411	721,122	1,342,964
59	Budget		21,458,469	7,449,248	14,009,220	591,926	2,674,245	866,979	2,352,332	861,137	4,720,823	899,797	1,041,981
60	Variance - Favorable / (Unfavorable)		(242,517)	643,551	(886,068)	(330,504)	(269,337)	45,578	(210,984)	(113,925)	115,412	178,675	(300,983)
61	% Variance - Fav / (Unfav)		-1.1%	8.6%	-6.3%	-55.8%	-10.1%	5.3%	-9.0%	-13.2%	2.4%	19.9%	-28.9%

	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 9/30/2021			**12**									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
62													
63	**Total Contract Cost**												
64	Actual		226,021,082	15,349,971	210,671,110	9,441,449	41,188,440	10,495,747	39,477,346	11,138,244	62,855,915	14,987,938	21,086,030
65	Budget		222,063,525	18,556,748	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
66	Variance - Favorable / (Unfavorable)		(3,957,557)	3,206,777	(7,164,334)	(912,462)	(2,212,525)	631,989	(2,742,241)	(811,834)	1,105,513	281,032	(2,503,806)
67	% Variance - Fav / (Unfav)		-1.8%	17.3%	-3.5%	-10.7%	-5.7%	5.7%	-7.5%	-7.9%	1.7%	1.8%	-13.5%
68													
69	**Net before Settlement**												
70	Actual		9,942,660	(6,136,499)	16,079,159	450,038	3,438,042	2,062,633	1,550,205	1,094,998	6,883,096	75,841	524,306
71	Budget		(1,796,513)	(4,937,098)	3,140,586	435,300	1,753,705	304,179	935,029	957,827	(815,311)	(1,588,574)	1,158,430
72	Variance - Favorable / (Unfavorable)		11,739,173	(1,199,400)	12,938,574	14,738	1,684,337	1,758,454	615,177	137,171	7,698,407	1,664,415	(634,124)
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 9/30/2021			12									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
75	***Healthy Michigan Plan***			*HCC%*	9.6%	14.0%	8.6%	11.2%	11.4%	10.7%	7.4%	12.3%	8.9%
76	**Contract Revenue**		**47,570,822**	**10,648,108**	**36,922,714**	**1,855,406**	**7,319,219**	**1,735,424**	**6,759,950**	**2,196,587**	**10,656,318**	**2,866,753**	**3,533,057**
77													
78	External Provider Cost		21,197,600	7,686,020	13,511,580	771,667	2,276,960	714,311	2,694,085	570,931	4,284,710	1,013,566	1,185,351
79	Internal Program Cost		10,249,254	-	10,249,254	792,625	1,939,754	651,461	2,769,690	826,444	1,004,938	1,249,467	1,014,875
80	Insurance Provider Assessment Withhold (IPA)		739,504	739,504	-	-	-	-	-	-	-	-	-
81	**Total Healthcare Cost**		**32,186,359**	**8,425,524**	**23,760,835**	**1,564,292**	**4,216,714**	**1,365,772**	**5,463,775**	**1,397,375**	**5,289,648**	**2,263,033**	**2,200,225**
82	**Medical Loss Ratio (HCC % of Revenue)**		**67.7%**	**79.1%**	**64.4%**	**84.3%**	**57.6%**	**78.7%**	**80.8%**	**63.6%**	**49.6%**	**78.9%**	**62.3%**
83													
84	**Managed Care Administration**		**2,872,604**	**1,066,986**	**1,805,619**	**169,380**	**324,547**	**115,961**	**379,405**	**134,065**	**418,211**	**114,386**	**149,664**
85	**Admin Cost Ratio (MCA % of Total Cost)**		**8.2%**	**3.0%**	**5.2%**	**9.8%**	**7.1%**	**7.8%**	**6.5%**	**8.8%**	**7.3%**	**4.8%**	**6.4%**
86													
87	**Contract Cost**		**35,058,963**	**9,492,510**	**25,566,453**	**1,733,672**	**4,541,261**	**1,481,733**	**5,843,181**	**1,531,440**	**5,707,859**	**2,377,418**	**2,349,889**
88	**Net before Settlement**		**12,511,859**	**1,155,598**	**11,356,260**	**121,734**	**2,777,958**	**253,690**	**916,769**	**665,147**	**4,948,460**	**489,334**	**1,183,168**
89													
90	Prior Year Savings		1,689,274	1,689,274	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
92	Contract Settlement / Redistribution		(8,603,388)	2,752,872	(11,356,260)	(121,734)	(2,777,958)	(253,690)	(916,769)	(665,147)	(4,948,460)	(489,334)	(1,183,168)
93	**Net after Settlement**		**5,597,744**	**5,597,744**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
94													
95	**Eligibles and PMPM**												
96	Average Eligibles		68,486	68,486	68,486	3,464	13,687	3,244	12,428	4,116	19,568	5,331	6,650
97	Revenue PMPM		$ 57.88	$ 12.96	$ 44.93	$ 44.64	$ 44.56	$ 44.58	$ 45.33	$ 44.48	$ 45.38	$ 44.82	$ 44.28
98	Expense PMPM		42.66	11.55	31.11	41.71	27.65	38.06	39.18	31.01	24.31	37.17	29.45
99	Margin PMPM		$ 15.22	$ 1.41	$ 13.82	$ 2.93	$ 16.91	$ 6.52	$ 6.15	$ 13.47	$ 21.07	$ 7.65	$ 14.83
100													
101	***Healthy Michigan Plan***												
102	**Budget v Actual**												
103													
104	**Eligible Lives (Average Eligibles)**												
105	Actual		68,486	68,486	68,486	3,464	13,687	3,244	12,428	4,116	19,568	5,331	6,650
106	Budget		52,365	52,365	52,365	2,543	10,834	2,465	9,345	3,201	14,696	4,100	5,182
107	Variance - Favorable / (Unfavorable)		16,121	16,121	16,121	921	2,853	779	3,084	915	4,871	1,231	1,468
108	% Variance - Fav / (Unfav)		30.8%	30.8%	30.8%	36.2%	26.3%	31.6%	33.0%	28.6%	33.1%	30.0%	28.3%
109													
110	**Contract Revenue before settlement**												
111	Actual		47,570,822	10,648,108	36,922,714	1,855,406	7,319,219	1,735,424	6,759,950	2,196,587	10,656,318	2,866,753	3,533,057
112	Budget		41,693,914	7,842,087	33,851,826	1,679,970	6,802,860	1,627,199	6,171,036	2,043,439	9,659,308	2,628,375	3,239,640
113	Variance - Favorable / (Unfavorable)		5,876,908	2,806,020	3,070,887	175,436	516,359	108,225	588,914	153,148	997,010	238,378	293,417
114	% Variance - Fav / (Unfav)		14.1%	35.8%	9.1%	10.4%	7.6%	6.7%	9.5%	7.5%	10.3%	9.1%	9.1%
115													
116	**Healthcare Cost**												
117	Actual		32,186,359	8,425,524	23,760,835	1,564,292	4,216,714	1,365,772	5,463,775	1,397,375	5,289,648	2,263,033	2,200,225
118	Budget		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
119	Variance - Favorable / (Unfavorable)		(4,756,406)	(2,236,686)	(2,519,720)	(420,903)	(658,777)	(311,610)	23,235	(533,886)	290,375	(869,871)	(38,283)
120	% Variance - Fav / (Unfav)		-17.3%	-36.1%	-11.9%	-36.8%	-18.5%	-29.6%	0.4%	-61.8%	5.2%	-62.4%	-1.8%
121													
122	**Managed Care Administration**												
123	Actual		2,872,604	1,066,986	1,805,619	169,380	324,547	115,961	379,405	134,065	418,211	114,386	149,664
124	Budget		2,617,692	1,066,951	1,550,741	85,271	262,104	89,071	375,399	78,559	444,666	87,240	128,431
125	Variance - Favorable / (Unfavorable)		(254,913)	(34)	(254,878)	(84,109)	(62,443)	(26,890)	(4,006)	(55,506)	26,455	(27,146)	(21,233)
126	% Variance - Fav / (Unfav)		-9.7%	0.0%	-16.4%	-98.6%	-23.8%	-30.2%	-1.1%	-70.7%	5.9%	-31.1%	-16.5%
127													
128	**Total Contract Cost**												
129	Actual		35,058,963	9,492,510	25,566,453	1,733,672	4,541,261	1,481,733	5,843,181	1,531,440	5,707,859	2,377,418	2,349,889
130	Budget		30,047,644	7,255,790	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

	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 9/30/2021			**12**									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
131	Variance - Favorable / (Unfavorable)		(5,011,319)	(2,236,720)	(2,774,599)	(505,012)	(721,220)	(338,500)	19,229	(589,392)	316,830	(897,018)	(59,516)
132	% Variance - Fav / (Unfav)		-16.7%	-30.8%	-12.2%	-41.1%	-18.9%	-29.6%	0.3%	-62.6%	5.3%	-60.6%	-2.6%
133													
134	**Net before Settlement**												
135	Actual		12,511,859	1,155,598	11,356,260	121,734	2,777,958	253,690	916,769	665,147	4,948,460	489,334	1,183,168
136	Budget		11,646,269	586,298	11,059,972	451,309	2,982,819	483,966	308,627	1,101,391	3,634,620	1,147,974	949,267
137	Variance - Favorable / (Unfavorable)		865,589	569,300	296,289	(329,576)	(204,861)	(230,275)	608,142	(436,244)	1,313,840	(658,639)	233,901
138													
139													

	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 9/30/2021			12									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
140	***Autism Specialty Services***			*HCC%*	7.4%	5.1%	10.1%	3.8%	6.6%	6.3%	7.7%	7.0%	6.7%
141	**Contract Revenue**		**22,735,090**	**-**	**22,735,090**	**1,181,963**	**4,240,127**	**1,302,810**	**4,178,215**	**1,176,989**	**6,545,875**	**1,833,563**	**2,275,547**
142													
143	External Provider Cost		16,444,866	-	16,444,866	-	4,947,582	463,497	1,837,430	813,754	5,495,501	1,268,271	1,618,832
144	Internal Program Cost		1,983,654	-	1,983,654	571,548	1,226	4,310	1,336,133	3,493	-	22,475	44,468
145	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
146	**Total Healthcare Cost**		**18,428,520**	**-**	**18,428,520**	**571,548**	**4,948,808**	**467,807**	**3,173,563**	**817,247**	**5,495,501**	**1,290,747**	**1,663,300**
147	**Medical Loss Ratio (HCC % of Revenue)**		**81.1%**	**0.0%**	**81.1%**	**48.4%**	**116.7%**	**35.9%**	**76.0%**	**69.4%**	**84.0%**	**70.4%**	**73.1%**
148													
149	**Managed Care Administration**		**2,019,424**	**625,276**	**1,394,148**	**61,887**	**380,894**	**39,719**	**220,373**	**78,407**	**434,486**	**65,241**	**113,141**
150	**Admin Cost Ratio (MCA % of Total Cost)**		**9.9%**	**3.1%**	**6.8%**	**9.8%**	**7.1%**	**7.8%**	**6.5%**	**8.8%**	**7.3%**	**4.8%**	**6.4%**
151													
152	**Contract Cost**		**20,447,944**	**625,276**	**19,822,668**	**633,435**	**5,329,702**	**507,526**	**3,393,936**	**895,654**	**5,929,987**	**1,355,988**	**1,776,441**
153	**Net before Settlement**		**2,287,146**	**(625,276)**	**2,912,422**	**548,529**	**(1,089,575)**	**795,284**	**784,279**	**281,335**	**615,889**	**477,576**	**499,107**
154	Contract Settlement / Redistribution		(2,287,146)	625,276	(2,912,422)	(548,529)	1,089,575	(795,284)	(784,279)	(281,335)	(615,889)	(477,576)	(499,107)
155	**Net after Settlement**		**0**	**0**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
156													
157													
158	***SUD Block Grant Treatment***			*HCC%*	0.2%	0.7%	0.3%	0.2%	0.0%	0.4%	0.0%	0.2%	0.4%
159	**Contract Revenue**		**6,907,361**	**6,330,426**	**576,935**	**37,755**	**195,296**	**28,267**	**-**	**60,955**	**111,957**	**78,969**	**63,736**
160													
161	External Provider Cost		6,160,545	6,160,365	180	180	-	-	-	-	-	-	-
162	Internal Program Cost		447,923	-	447,923	77,023	144,796	19,791	-	57,517	1,636	40,467	106,694
163	Insurance Provider Assessment Withhold (IPA)		-	-	-	-	-	-	-	-	-	-	-
164	**Total Healthcare Cost**		**6,608,468**	**6,160,365**	**448,103**	**77,203**	**144,796**	**19,791**	**-**	**57,517**	**1,636**	**40,467**	**106,694**
165	**Medical Loss Ratio (HCC % of Revenue)**		**95.7%**	**97.3%**	**77.7%**	**204.5%**	**74.1%**	**70.0%**	**0.0%**	**94.4%**	**1.5%**	**51.2%**	**167.4%**
166													
167	**Managed Care Administration**		**130,000**	**130,000**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
168	**Admin Cost Ratio (MCA % of Total Cost)**		**1.9%**	**1.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
169													
170	**Contract Cost**		**6,738,468**	**6,290,365**	**448,103**	**77,203**	**144,796**	**19,791**	**-**	**57,517**	**1,636**	**40,467**	**106,694**
171	**Net before Settlement**		**168,893**	**40,061**	**128,832**	**(39,448)**	**50,500**	**8,475**	**-**	**3,438**	**110,322**	**38,502**	**(42,958)**
172	Contract Settlement		(0)	128,831	(128,832)	39,448	(50,500)	(8,475)	-	(3,438)	(110,322)	(38,502)	42,958
173	**Net after Settlement**		**168,893**	**168,893**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
174													
175													

	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 9/30/2021			12									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		312,522,563	26,153,354	286,369,209	12,947,550	56,324,998	15,517,393	51,812,164	15,664,067	86,836,070	19,796,469	27,470,498
178	Incentive Payment Revenue		654,452	38,653	615,799	19,062	56,126	107,487	153,552	3,706	217,092	46,595	12,178
179	**Contract Revenue**		**313,177,014**	**26,192,006**	**286,985,008**	**12,966,612**	**56,381,125**	**15,624,880**	**51,965,716**	**15,667,773**	**87,053,162**	**19,843,064**	**27,482,677**
180													
181	External Provider Cost		194,661,758	17,181,461	177,480,296	5,976,852	35,491,501	8,062,359	32,828,189	8,777,638	60,356,434	11,277,585	14,709,738
182	Internal Program Cost		61,881,283	-	61,881,283	4,763,470	12,192,700	3,519,793	13,023,205	3,657,683	9,036,920	6,612,220	9,075,292
183	SSI Reimb, 1st/3rd Party Cost Offset		(948,299)	-	(948,299)	(8,259)	(129,025)	(54,436)	(300,025)	-	(356,066)	(28,743)	(71,745)
184	Insurance Provider Assessment Withhold (IPA)		6,188,106	6,188,106	-	-	-	-	-	-	-	-	-
185	MHL Cost in Excess of Medicare FFS Cost		(239,404)	(239,404)	-	-	-	-	-	-	-	-	-
186	**Total Healthcare Cost**		**261,543,443**	**23,130,163**	**238,413,280**	**10,732,064**	**47,555,176**	**11,527,715**	**45,551,369**	**12,435,321**	**69,037,288**	**17,861,062**	**23,713,285**
187	**Medical Loss Ratio (HCC % of Revenue)**		**83.5%**	**88.3%**	**83.1%**	**82.8%**	**84.3%**	**73.8%**	**87.7%**	**79.4%**	**79.3%**	**90.0%**	**86.3%**
188													
189	**Managed Care Administration**		**26,723,014**	**8,627,959**	**18,095,055**	**1,153,696**	**3,649,023**	**977,082**	**3,163,094**	**1,187,534**	**5,458,108**	**900,749**	**1,605,769**
190	**Admin Cost Ratio (MCA % of Total Cost)**		**9.3%**	**3.0%**	**6.3%**	**9.7%**	**7.1%**	**7.8%**	**6.5%**	**8.7%**	**7.3%**	**4.8%**	**6.3%**
191													
192	**Contract Cost**		**288,266,457**	**31,758,122**	**256,508,335**	**11,885,759**	**51,204,199**	**12,504,797**	**48,714,463**	**13,622,855**	**74,495,396**	**18,761,811**	**25,319,054**
193	**Net before Settlement**		**24,910,558**	**(5,566,116)**	**30,476,673**	**1,080,853**	**5,176,926**	**3,120,083**	**3,251,253**	**2,044,918**	**12,557,766**	**1,081,252**	**2,163,622**
194													
195	Prior Year Savings		12,440,039	12,440,039	-	-	-	-	-	-	-	-	-
196	Internal Service Fund Risk Reserve		-	-	-	-	-	-	-	-	-	-	-
197	Contract Settlement		(7,532,876)	22,943,797	(30,476,673)	(1,080,853)	(5,176,926)	(3,120,083)	(3,251,253)	(2,044,918)	(12,557,766)	(1,081,252)	(2,163,622)
198	**Net after Settlement**		**29,817,721**	**29,817,721**	**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 9/30/2021			12									
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**	**Integrated Services of Kalamazoo**	**St Joseph CMHA**	**Van Buren MHA**
5													
201	***State General Fund Services***			*HCC%*	3.9%	3.7%	3.0%	5.6%	4.7%	4.4%	3.7%	3.3%	3.8%
202	**Contract Revenue**				**12,101,147**	**793,253**	**2,019,282**	**751,543**	**2,070,022**	**887,870**	**3,652,587**	**743,903**	**1,182,687**
203													
204	External Provider Cost				2,311,269	160,526	324,249	140,494	243,909	349,612	823,116	198,764	70,599
205	Internal Program Cost				7,370,478	254,633	1,132,543	543,690	1,996,644	223,008	1,955,251	404,395	860,314
206	SSI Reimb, 1st/3rd Party Cost Offset				(141,582)	-	-	-	-	-	(141,582)	-	-
207	**Total Healthcare Cost**				**9,540,165**	**415,159**	**1,456,792**	**684,184**	**2,240,554**	**572,620**	**2,636,785**	**603,159**	**930,912**
208	**Medical Loss Ratio (HCC % of Revenue)**				**78.8%**	**52.3%**	**72.1%**	**91.0%**	**108.2%**	**64.5%**	**72.2%**	**81.1%**	**78.7%**
209													
210	**Managed Care Administration**				**810,822**	**49,607**	**125,528**	**65,160**	**174,262**	**59,766**	**231,890**	**34,066**	**70,543**
211	**Admin Cost Ratio (MCA % of Total Cost)**				**7.8%**	**10.7%**	**7.9%**	**8.7%**	**7.2%**	**9.5%**	**8.1%**	**5.3%**	**7.0%**
212													
213	**Contract Cost**				**10,350,987**	**464,767**	**1,582,320**	**749,344**	**2,414,816**	**632,386**	**2,868,675**	**637,225**	**1,001,455**
214	**Net before Settlement**				**1,750,160**	**328,486**	**436,962**	**2,199**	**(344,794)**	**255,484**	**783,912**	**106,678**	**181,232**
215													
216	Other Redistributions of State GF				-	-	-	-	-	-	-	-	-
217	Contract Settlement				(1,939,876)	(320,634)	(420,085)	-	-	(211,090)	(775,214)	(90,754)	(122,098)
218	**Net after Settlement**				**(189,716)**	**7,852**	**16,877**	**2,199**	**(344,794)**	**44,394**	**8,698**	**15,924**	**59,134**
219													

Fiscal Year 2021 Privacy & Security Update

Mila C. Todd, Chief Compliance & Privacy Officer
Natalie Spivak, Chief Information & Security Officer

March 11, 2022

Privacy Officer Overview

Promote and ensure compliance with HIPAA, 42 CFR Part 2, and MI Mental Health Code including:

- **Monitoring legal updates;**
- **Policies & Procedures;**
- **Staff trainings;**
- **Business processes surrounding PHI sharing (MIHIN, Standard Consent Form, ICT meeting communications, Record Requests, texting/emailing with members, etc.);**
- **Business Associate Agreements and/or Qualified Service Organization Agreements;**
- **Responding to subpoenas for records and/or for staff to testify;**
- **Breach Risk Team Chair**

Ensure compliance with other applicable laws that effect privacy (HIV, other communicable disease information, etc.)

Security Officer Overview

- **Develop, enforce and maintain SWMBH's Information Security policies, procedures and standards. Conduct annual review of required HIPAA regulations and reports.**
- **Maintain appropriate security measures and mechanisms to guard against unauthorized access to electronically stored and /or transmitted PHI and protect against reasonably anticipated threats and hazards.**
- **Oversee and/or assist in performing on-going security monitoring, and recommend new information security technologies and counter-measures against threats to information or privacy.**
- **Ensure compliance through adequate training programs and periodic security audits (*see associated IT/QAPI Audit/Review Schedule*).**

Network Penetration Testing

Penetration testing* is the practice of testing a computer system, to find security vulnerabilities that an attacker could exploit.

Solid Firewall protection

Vulnerability Index = 0.000 – Very Low Risk

Physical Security – Low Risk

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

100% of reviewed workstations & servers are running supported Operating System versions

Final Security Rating 8.0/10 = Secure & Protected

Rated Above average compared to similar organizations

Regular Audits done to keep security practices up-to-date

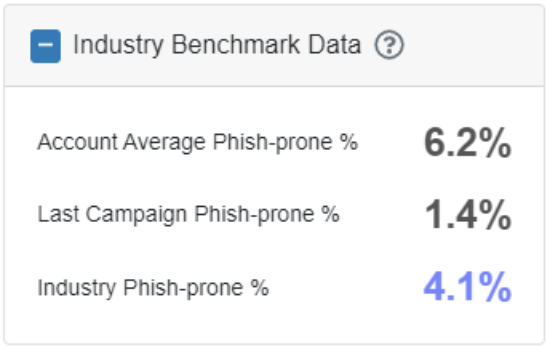
*Testing performed by OST – Grand Rapids June 2021

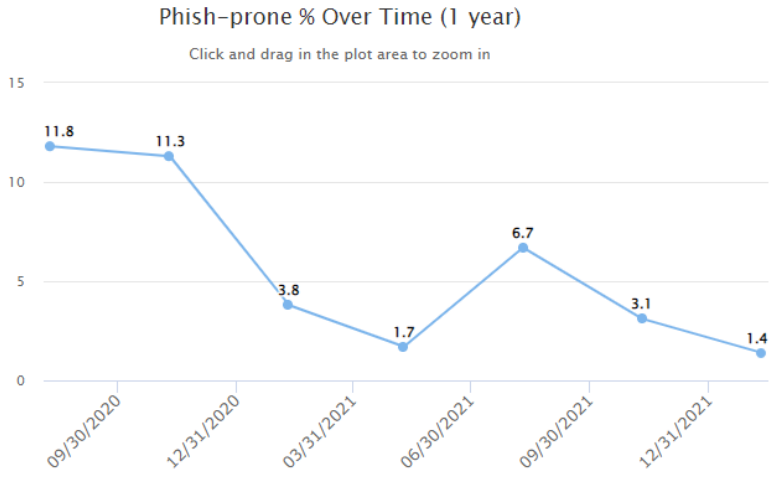
Phishing Education

Phishing – is the fraudulent practice of sending e-mails purporting to be from reputable people/companies in order to induce individuals respond and reveal personal information such as passwords, and credit card numbers.

Education – 100% participation

- Your Role: Internet Security & You
- Social Engineering Red Flags
- Common Threats





68

Data Loss Prevention

Software process that detects potential data breaches by catching unencrypted sensitive information going out through e-mail.

- Very low instance of PHI sent unencrypted
  - For the month of February found an employee's drivers license in unencrypted email

Monthly Vulnerability Scans

New

- Contract with OST, outside agency, to check for electronic vulnerabilities
- Began in November 2021
- 113 network devices scanned
- Able to crack 6 portal user passwords in February 2022
- One vulnerability found on server operating system
- All SWMBH virtual servers moved to an updated environment

Privacy Program

Prospective

- Business Associate and/or Qualified Service Organization Agreement execution and tracking
- Data Use Agreement execution and tracking
- Committee Confidentiality Statements
- MDHHS Standard Consent Form
- Training – at hire, annually electronically, annually in-person
  - What is PHI?
  - What are the governing regulations?
  - What is minimum necessary?
  - Where to direct questions/concerns?
- Role-based Training

Retrospective

- Breach Risk Team
- Business Associate Agreement Audit

Breach Risk Team

Responsibilities

- Investigate unauthorized uses/disclosures of PHI as reported/discovered;
- Meet monthly to review and complete a Risk Assessment to assess probability of compromise; and
- Determine if notification is necessary and if so, what kind(s).

Risk Assessment Standard

- 45 CFR 164.402(2) – "Except as provided in paragraph (1) of this definition, an acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment…"

- SWMBH Breach Risk Assessment Tool utilized to assess all reported incidences
  - Tool contains all the assessment factors articulated in 45 CFR 164.402

Breach Risk Team: Standards

Notification Requirements

- Following a breach of unsecured PHI, covered entities must provide notification of the breach to the affected individuals, the Secretary, and, in certain circumstances, to the media.
  - Time constraints depend on the number of individuals affected by the breach;
  - Notification to the Secretary (OCR) is required for all breaches, however, it can be done annually if a breach affects less than 500 individuals.
- Business associates must notify the covered entity if a breach occurs at or by the business associate.
  - SWMBH Business Associate Agreements include provisions requiring Business Associates to promptly report breaches of PHI

Breach Risk Team: FY 2021 Summary

64 Incidents reported for Breach Risk Team review

The Breach Team reviewed each incident and evaluated whether an exception applies under the law, and the probability of compromise to the Protected Health Information used or disclosed. Of the sixty-four (64) incidents reviewed, NONE were determined to be reportable.

Southwest Michigan Behavioral Health

Utilization Management Program for Members Enrolled in Medicaid, Healthy Michigan Plan, SUD Community Grant, Flint 1115 Waiver, Autism Benefit, SED, Child or Habilitation Supports Waivers

FY 2022 (October 1, 2021 – September 30, 2022)

Table of Contents

Introduction

Southwest Michigan Behavioral Health is the Regional Entity designated to function as the Prepaid Inpatient Health Plan performing the benefits management function for members receiving services under the Medicaid Managed Specialty Supports and Services Demonstration 1115 Waiver, 1915 (c) (i) Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs for behavioral health specialty and substance use disorder services for the eight county region of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St Joseph and Van Buren counties. The specialty mental health services are provided by eight Community Mental Health Services Programs (CMHSP's: Barry County Community Mental Health and Substance Abuse Services, Community Mental Health and Substance Abuse Services of St. Joseph County, Kalamazoo Community Mental Health and Substance Abuse Services, Pines Behavioral Health, Riverwood Center, Summit Pointe, Van Buren Community Mental Health, Woodlands Behavioral Health Network) and their provider networks. The substance use disorder services are managed and/or provided by a combination of various CMHSP's and the SWMBH provider network. SWMBH is also designated as a duals demonstration pilot region for persons enrolled in the MI Health Link plan (MHL).

These various funding source/programs managed by SWMBH possess different definitions, criteria and benefits. The Medicaid Managed Specialty Supports and Services program is available to both children and adults and is funded under Medicaid which is a Federal and state entitlement program that provides physical and behavioral health benefits to low-income individuals who have no insurance. Criteria for Medicaid varies based among other indicators including on disability type, physical health status, age and income. Healthy Michigan Plan provides comprehensive health care coverage for a category of eligibility for individuals who are 19-64 years of age; have income at or below 133% of the federal poverty level; do not qualify for or are not enrolled in Medicare; do not qualify for or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State of Michigan. The Flint 1115 Waiver a program available under Medicaid. Eligibility for coverage includes children up to the age of 21 who are or were being served by Flint's water system between April 2014 and a future date when the water system is deemed safe. Pregnant women and their children also will be made eligible. Substance Use Disorder Community Block Grant is a Federal program that provides substance use disorder benefits to low-income individuals who have no insurance.

Purpose

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources

for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Values

SWMBH intends to operate a high-quality utilization management system for public behavioral health and substance abuse services which is responsive to community, family and individual needs. The entry process must be clear, readily available and well known to all constituents. To be effective, information, assessment, referral and linkage capacity must be readily and seamlessly available. Level of care and care management decisions must be based on medical necessity and on evidenced based, wellness, recovery and best practice. SWMBH is committed to ensuring use of evidence-based services with member matching that drive outcomes/results/value for taxpayer dollar and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, SWMBH is committed to the identification, development and use of innovative and less costly supportive services (e.g., Assistive Technology, Certified Peer Supports and Recovery Coaches, etc.) while meeting the service needs of members in the region. SWMBH recognizes that access to physical and behavioral health services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing access to integrated service depends upon appropriate utilization throughout all aspects of the screening, assessment, level of care and care management decision making processes and care coordination and through oversight, fidelity and outcomes monitoring.

Authority and Structure

Program Oversight

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director. Additionally, the Regional Utilization Management Committee shall serve in a critical role involving deliberation, consultation and proof of performance realms. The SWMBH Medical Officer is accountable for management of the PIHP's Utilization Management Program. Jointly with the board-certified Medical Officer, the Chief Administrative Officer and Manager of UM and Call Center provides clinical and operational oversight and direction to the UM program and staff and ensures that SWMBH has qualified staff accountable to the organization for decisions affecting customers.

Committee

SWMBH has established the Regional Utilization Management Committee (RUM) to review and provide input on monitoring and ensuring the uniformity and consistent application of standardized screening and assessment tools and level of care, service determination and eligibility criteria at a local care management level. Using level of care and utilization data to track service provision to customers and to the implementation of level of care and care management practices. Further, the committee is responsible for identifying service gaps and training needs for regional utilization management activities.

Staffing

The RUM is a PIHP Committee consisting of cross collaborative leadership representation from SWMBH including the Chief Administrative Officer and the Director of Clinical Quality and each of the eight Community Mental Health Service Programs. At a minimum collaboration occurs with the Quality Management Committee (QMC) on an annual basis. Ongoing consultation and ad hoc representation from the SWMBH Medical Director, Customer Services, QMC, Finance, IT, Provider Network and Outcomes is available to the committee. RUM clinical representatives are experienced clinical

professionals with specialty representation for Child and Adolescent Serious Emotional Disturbance, Adults and Children with Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Adults and Children with Substance Use Disorders. The committee members are designated by the CEOs and empowered to make policy decisions for their CMHSP's as required by the scope of the committee in the area of Utilization Management. Furthermore, members ensure that pertinent information from the committee is shared with their respective CMHSP. The RUM committee meets at a minimum 10 times per year.

Roles of the Committee

The RUM is charged with the following

1. Ensure adherence to consistent and application of assessment tools, level of care guidelines and medical necessity criteria at the Local Care Management Level and development of recommendations for UM level of care guidelines.
2. Review and provide input on the UM Program on an annual basis assuring adherence to and synchronization with Operating Agreement sections and RUM Charter, with final approval by the PIHP Chief Administrative Officer, the Director of Clinical Quality and the Medical Director.
3. Provide input regarding the outlier management program including level of care and service utilization guidelines that may be provided without authorization, level of care and typical service utilization guidelines reviewed at the local care management level and outlier levels of care and typical service utilization data reviewed by the PIHP. This information is reviewed by the Operating Committee.
4. Ensure that services rendered are delivered by qualified staff or contracted practitioner providers. Ensure that timely and focused utilization review (UR) is provided for delegated Utilization Management functions.
5. Develop, review and act upon service utilization and outcomes data and/or reports for purposes of demonstrating consistent Uniform Benefit (including reports of under and over utilization).
6. Review service use and population health data that may affect policy and procedure including, but not limited to Appeal/Fair Hearing determinations, Recipient Right decisions, clinical best practices and service utilization and cost data.
7. Assures adherence to related data and report specification's through cross collaboration with other applicable regional committees including the Regional Quality Management, Regional Clinical Practices and Regional Customer Services Committees.

Standards and Philosophy

SWMBH is responsible for monitoring the provision of services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH ensures adherence to statutory, regulatory, and contractual obligations. Furthermore, the utilization management program is designed to be consistent with and supportive of assuring achievement of SWMBH's Board focus and guiding principles

The UM program document and subsequent policies provide a description of processes, procedures and criteria necessary to ensure cost-effectiveness, achieving the best customer outcome for the resources spent. As a Regional Entity, SWMBH's duty is to assure region-wide **uniformity** of:

1. Benefit
2. Adequate timely access
3. Application of functional assessment tools, evidenced based practices and medical necessity criteria
4. UM decision-making including application of eligibility criteria and level of care guidelines

Management information system(s) adequate to support the UM Program is central, as SWMBH, the participant CMHSP's and the SWMBH provider network rely on SWMBH IT IS, QAPI and PNM for reports. The functionalities and maintenance of such systems include, but are not limited to:

1. Utilization of electronic health information systems and incorporation/integration of behavioral health and physical health data
2. Real-time access to aggregate and case level information, which is complete, accurate, timely
3. Reporting services which are automated and routine, inclusive of rule-based alerts
4. Reporting formats which are readily available, graphically presented, easy to understand and present actionable information aligned to SWMBH Ends and goals
5. Utilization of a managed care information system that meets meaningful use standards
6. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provide input into severity of illness and a means to provide the data to SWMBH to manage over/under utilization and employ risk stratification models both in an effort to manage and impact population health.

Access to SWMBH Behavioral Health Services

A beneficiary may access the system through any of the following avenues:

1. Requesting services directly from SWMBH during business and after-hours toll-free access/crisis line.
2. Telephonic screening or face-to-face assessment by the local CMHSP
3. Crisis behavioral health services through the local CMHSP, inpatient hospitals, mobile crisis teams, and urgent care centers
4. Requesting services from a local substance use disorder provider or CMHSP who, depending on the level of medically necessary care, subsequently collaborates with SWMBH UM for screening and authorization.

Access Standards

1. The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
2. The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services. F
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)

4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
4b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)
5. Achieve a call abandonment rate of 5% or less.
6. Average call answer time 30 seconds or less.

Level of Intensity of Service Determination

Level of Intensity	Definition	Expected Decision/Response Time
Emergent - Psychiatric	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request
Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services are denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 days; Prior authorization required
Retrospective	Accessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided	Within 30 calendar days of request
Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition	Within 1 hour of request

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of

common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.

1. Access and Eligibility: To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see Policy Access Management). SWMBH ensures that the Access Standards are met including MMBPIS.
2. Clinical Protocols: To ensure Uniform Benefit for Customers, consistent functional assessment tools, medical necessity, level of care and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
3. Service Authorization: Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness
4. Utilization Management: Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH Utilization Management plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization Management Plan endorses two core functions.

1. Outlier Management of identified high cost, high risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The

model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions. The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, EQRO, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including Over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Review Activities

Utilization Management

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding and some CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone. Based upon the UM Program review, annual audits and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers or SWMBH departments.

Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs and workforce training. Each CMHSP is required to have their own utilization management/review process. The Medical Director and a Physician specializing in Addictionology meets weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director who holds an unrestricted license is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. For the purposes of utilization control, SWMBH ensures all services furnished can

reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the customer;
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided);
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience;
5. Provided in a sufficient amount, duration and scope to reasonably achieve their purpose – in other words, are adequate and essential; and
6. Provided with consideration for and attention to integration of physical and behavioral health needs.

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the member.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
3. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
4. Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
7. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Use of Incentives

The use of incentives related to service determination approvals, denials or promotion of underutilization is prohibited. Service determinations are based only on medical necessity criteria and

benefits coverage information. This information is provided to members, staff and providers via policy and other informational documentation such as the member handbook and the SWMBH website.

Intensity of Service and Severity of Illness (Levels of Care)

The expectation for service provision is that intensity of service will be aligned with severity of illness. For each population served (adults with mental illness, youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders), SWMBH utilizes a standardized functional assessment to identify level of need at initiation of services and at established intervals throughout service provision. SWMBH and its participant CMHs have established regional Levels of Care that correspond to needs identified through the functional assessment process, which are based on severity of illness and intensity of need. Levels of Care and Core Service Menus are in place for adults with mental illness, youth with emotional disturbances, adults with intellectual and developmental disabilities, and persons with substance use disorders. The levels and service menus that were developed in 2016 are being used for those population areas until the updates are complete.

Each Level of Care contains a Core Service Menu with suggested service types as well as expected annual amounts of services, corresponding to needs commonly presenting at each level. Services that fall within the Core Service Menu for a given Level of Care are services for which medical necessity has been established via the functional assessment, and do not require additional UM review. Services requested that fall outside of the Core Service Menu for an individual's Level of Care may be authorized if medical necessity is established through a utilization review. These requests are referred to as Exceptions.

Most services designated as Exceptions are authorized through Local Care Management via a delegation to the CMHSPs. CMHSPs are delegated Healthy Michigan Plan and Medicaid authorization/UM functions for behavioral health community-based supports and services. For those CMHSPs which are delegated authorization/UM functions for substance use services, CMHSPs authorize and provide medically necessary services according to the SWMBH Levels of Care for SUD. For authorization of any Exception, a utilization management professional will review the request to determine if medical necessity has been established for the service, including the amount, scope, and duration of the service being requested. Exception approvals always clearly document medical necessity, and how the intensity of the service is indicated by the individual's level of need.

Levels of Care for Mental Health Specialty Services

Levels of Care for each of the SWMBH population areas are described below. Core Service Menus with recommended authorization thresholds for all levels of care (except for children with intellectual and developmental disabilities) have been developed and are attached to SWMBH Regional Policy 4.10 Levels of Care.

PIHP Service Eligibility

Not all Medicaid-eligible persons with mental illness or emotional disturbances are eligible for PIHP services. For adults with mental illness and youth with emotional disturbance, thresholds for meeting eligibility for PIHP services are denoted below Level of Care descriptions that follow. Behavioral health services for persons with mild to moderate mental illness or emotional disturbances are provided through Medicaid health plans. All Medicaid behavioral health services for persons with substance use disorders and intellectual and developmental disabilities are provided through the PIHP.

Crisis Services

Crisis services are considered a benefit for any SWMBH customer or anyone who is physically in a county of the SWMBH region who needs urgent intervention. Crisis services are not considered a Level of Care and do not require prior authorization. Appropriately trained and qualified CMHSP behavioral health practitioners with sufficient clinical experience who meet the qualifications for a preadmission unit pursuant to Michigan Mental Health Code 330.1409 Sec 409 provide prescreening services and authorization of 1-3 days of psychiatric inpatient or crisis residential, and any appropriate diversion and/or second opinion services.

Levels of Care for Adults (18 years or older) with Serious Mental Illness or Co-occurring MI and Substance Use Disorders. Level of Care Utilization System (LOCUS) The LOCUS is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level VI- Intensive High Need/Acute (Medically Managed Residential)

Customers receiving services at this level of care are adults with a LOCUS score typically of 28 or higher including a score of 4 on dimension I and who present as a persistent danger to self or others. Treatment is typically provided in an inpatient setting and is aimed at ensuring safety and minimizing danger to self and others and alleviating the acute psychiatric crisis.

Level V – Intense Need/Acute (Medically Monitored Residential)

Customers receiving services at this level of care are adults with a LOCUS score typically of 23-27 including a score of 4 on dimension II or III and who present as danger to self or others. Treatment is typically provided in a community based free standing residential setting such as Crisis Residential and is aimed at providing reasonable protection of personal safety and property and minimizing danger to self and others.

Level IV – High Need (Medically Monitored Non- Residential Services)

Customers receiving services at this level of care are adults with a LOCUS score typically of 20-22 including a score of 4 on dimension IV or V and who present with a significant impairment of functioning in most areas, moderate to significant risk of harm to self or others, with significant supported needed to function independently in the community. May be engaging in high-risk behaviors and be involved in the criminal justice system. Treatment typically is provided in the community and include services such as Assertive Community Treatment and Partial Hospitalization

Level III – Moderate Need (High Intensity Community Based Services)

Customers receiving services at this level of care are adults with a LOCUS score typically of 17-19 including a sum score of 5 or less on dimension IV A & B and who present with intensive support and treatment needs however demonstrate low to moderate risk of harm to self or others, require minimal support to reside independently in the community. Occasional risk activities. Needs regular assistance with linking/coordinating and developing skills and self-advocacy. Treatment is typically provided in the community and include such services as targeted case management and supports coordination

Level II – Low Need (Low Intensity Community Based Need)

Customers receiving services at this level of care are adults with a LOCUS score typically of 14-16 who present with ongoing treatment needs however have a low impairment of functioning in most areas, low to minimal risk of harm to self or others, able to reside independently in the community. Minimal assistance with linking/coordinating actively utilizing self-improvement and treatment skills acquired. Treatment is provided in the community and is typically clinic based.

Level I – Minimal Need (Recovery Maintenance and health Management)

Customers receiving services at this level of care are adults with a LOCUS score typically of 10-13 with minimal impairment of functioning, minimal to no risk of harm to self or others, reside independently in the community. Minimal encouragement with linking/coordinating actively

utilizing self-improvement and treatment skills acquired. May use PSR assistance with maintaining recovery. Treatment is provided in the community and is typically clinic based.

Level 0 -- Basic Services

Basic services are those services that should be available to all members of a community. They are services designed to prevent illness or to limit morbidity. They often have a special focus on children and are provided primarily in community settings but also in primary care settings. There is clinical capability for emergency care, evaluations, brief interventions, and outreach to various portions of the population. This would include outreach to special populations, victim debriefing, high-risk screening, educational programs, mutual support networks, and day care programs. There are a variety of services available to provide support, address crisis situations and offer prevention services.

Thresholds for PIHP Service Eligibility for Adults with Mental Illness (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- LOCUS Recommended Disposition Level of 3, 4, 5, or 6, or
- LOCUS Recommended Disposition Level of 2 with need for specialty behavioral supports and services as evidenced by meeting Michigan Mental Health code definition for SMI

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- LOCUS Recommended Disposition Level 0 or 1, or
- LOCUS Recommended Disposition Level of 2 but does not meet Michigan Mental Health code definition for SMI.

Levels of Care for Children (ages 4 – 18) with Serious Emotional Disturbance (SED) or Co-occurring SED and Substance Use Disorders. The Child and Adolescent Functional Assessment Scale (CAFAS) is utilized for ages 7-18, and the Pre-school and Early Childhood Functional Assessment Scale (CAFAS) is utilized for ages 4-6, to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level IV -- Intense Need

Customers in this level of care are children with a CAFAS or PECFAS score of 160 or higher who require total assistance and present with inability to function in most areas, persistent danger to self and others, at significant risk of institutionalization or placement out of the home, involved in numerous provider systems (criminal justice, mental health, department of human services, school). High risk difficulties in school/day care setting or substance use dominates life or is out of control.

Level III – High Need

Customers in this level of care are children with a CAFAS or PECFAS score of 120-150 with inability to function in most areas, persistent danger to self and others, at moderate to significant risk of institutionalization or placement out of the home, likely involved in numerous provider systems (criminal justice, mental health, department of human services, school). Significant difficulties in school/day care setting. Treatment needs likely beyond home based services.

Level II – Moderate Need

Customers in this level of care are children with a CAFAS or PECFAS score of 80-110 with moderate to significant inability to function in many areas, instability in living environment,

multiple service needs, family requires regular support, crisis intervention services needed. Likely at risk for out of home placement, displays disruptive behavior.

Level I – Low Need

Customers in this level of care are children with a CAFAS or PECFAS score of 50-70 with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention not needed or infrequently need.

Level 0 – Minimal Need

Customers in this level of care are children with a CAFAS or PECFAS score of 40 and below with minimal inability to function in some areas, overall stable living environment, service needs focus on building resiliency and other protective factors in child/family, crisis intervention services not needed or needed infrequently. Children ages Infant-7 are typically placed in the Level I category for utilization management purposes with needed services authorized based upon medical necessity.

Thresholds for PIHP Service Eligibility for Youth with Emotional Disturbance, ages 7-17 (subject to confirmation from biopsychosocial assessment):

Eligible for PIHP Medicaid Services (Severe need):

- CAFAS total score of 50 or greater (using the eight subscale scores), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Not Eligible for PIHP Medicaid Services (Mild/Moderate need):

- CAFAS total score of less than 50 (using the eight subscale scores), and
- No more than one 20 on any of the first eight subscales of the CAFAS, and
- No 30 on any subscale of the CAFAS, except for substance abuse only.

Levels of Care for Adults (ages 18 and older) Intellectual and Developmental Disabilities. The Supports Intensity Scale (SIS) is utilized to identify level of support needs for adults with intellectual and developmental disabilities. The SIS ABE score (the composite score of SIS Part A: Home Living Activities; Part B: Community Living Activities; and Part E: Health and Safety Activities), and the Medical and Behavioral Needs scales, are used to determine recommended level of care.

Level VI- Acute (Any functional support needs, extraordinary medical and/or behavioral support needs). ABE - Any Score. Medical 10+ OR Behavior 10+

Customers receiving services at this level of care are adults (18 years or older) and demonstrate extraordinary behavioral and/or medical needs typically provided in an acute care setting or a nursing home. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring monitoring and/or oversight multiple times during the day. Nursing services typically required to develop and train on health care protocols, if applicable.

Level V – Intense Need (Any functional support needs, high medical and/or behavioral support needs). ABE - Any Score. Medical 7-9 OR Behavior 7-9

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate significant medical needs and/or extensive behavioral needs and require total assistance on a daily basis with 1:1 or higher level of staffing. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring

daily (or more) monitoring and/or oversight and hands-on assistance. Nursing services may be required to develop and train on health care protocols, if applicable.

Level IV – High Need (Any functional support needs, moderate medical and/or behavioral support needs). ABE - Any Score. Medical 4-6 OR Behavior 4-6

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate substantial behavioral needs and/moderate physical healthcare needs due to medical conditions. Safety risks exist to self or others, potentially with need for environmental accommodations. May have harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have medical/health needs requiring weekly (or more) monitoring and/or oversight and assistance.

Level III – Moderate Need (High functional support needs, low medical and behavioral support needs). ABE Score 28+, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require frequent prompts/reminders, coaching, and/or training to engage or complete activities (less than daily/more than weekly) or physical support, or some hands-on physical support/guidance. Moderate behavioral issues may be present with or without the need for a Behavior Plan. May experience physical health issues that require increased supports.

Safety risks may be present that need to be addressed or monitored; includes safety to self and safety in the community.

Level II – Low Need (Moderate functional support needs, low medical and behavioral support needs. ABE Score 23-27, and Medical Score 0-3, and Behavior 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require occasional verbal prompts/reminders, coaching, and/or training to engage or complete activities (weekly or less) and monitoring of support needs with changes as situation dictates. May require a behavior support plan to ensure consistency and proactive approaches.

Level I – Minimal Need (Low functional support needs, low medical and behavioral support needs). ABE Score 0-22, and Medical Score 0-3, and Behavior Score 0-3

Customers receiving services at this level of care are adults (18 years or older) and typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion. May require a behavior support plan to ensure consistency and proactive approaches.

Levels of Care for Children Developmental Disabilities (infants through age 17) (Functional Assessment Tool TBD)

Level V – Intense Need

Customers receiving services at this level of care are children and typically require total assistance on a daily basis including enriched staffing (24 hours per day, 2:1, or 1:1 staffing during awake hours).

Level IV – High Need

Customers receiving services at this level of care are children who typically require daily reminders to engage or complete activities and personal support which may include enhanced staffing (24 hours per day, 1:2 or 1:1 staffing while awake) has an active Behavior Management Plan and or specialty professional staff (OT, PT, etc.).

Level III – Moderate Need

Customers receiving services at this level of care are children who typically require frequent prompts/reminders to engage or complete activities (less than daily/more than weekly) or physical support. Moderate behavioral issues may be present with or without the need for a Behavior Plan.

Level II – Low Need

Customers receiving services at this level of care are children who typically require occasional prompts/reminders to engage or complete activities (weekly or less) to insure maintenance of skills or physical support. Mild/moderate behavioral issues without the need for a Behavior Management Plan.

Level I – Minimal Need

Customers receiving services at this level of care are children who typically require minimal prompts to engage or complete activities, monitoring of support needs with changes as situation dictates. Support may be needed for community inclusion.

Levels of Care for Substance Use Treatment Services for Adults and Adolescents. The American Society of Addiction Medicine - Patient Placement Criteria (ASAM) are utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level 0.5 – Early Intervention

Services include assessment and education for those who are at risk, but do not currently meet the diagnostic criteria for a substance-related disorder. Customers who are determined to have this level of need are typically referred to available community resources including support groups and prevention activities. Customer is screened for co-occurring mental health issues and referred to appropriate levels of care to meet identified needs. Per definition, early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

Level 1.0 – Outpatient Services

Community-based substance use outpatient treatment of less than 9 hours per week for adults and less than 6 hours per week for youth. Treatment is directed at recovery, motivational enhancement therapy and strategies to reduce or eliminate substance use and improve ability to cope with situations without substance use.

Level 2.1 – Intensive Outpatient

Community-based substance use outpatient treatment of greater than 9 hours per week for adults and greater than 6 hours per week for youth. Treatment is directed to treat multidimensional instability. This level of care may be authorized as a step-down from a higher level of care or in situations in which a higher level of care would otherwise be warranted, but is not an appropriate option (either due to inability to participate in a residential treatment program or motivational issues).

Level 2.5 – Partial Hospitalization

Partial Hospitalization treatment is a structured treatment similar to the treatment available in a residential setting, however, is directed toward customers who require greater than 20 hours per week of treatment for multidimensional stability, but not requiring 24-hour care.

Level 3.1 – Clinically-Managed Low-Intensity Residential

Clinically managed low-intensity residential treatment includes a 24-hour setting with available trained staff and at minimum 5 hours of clinical treatment services per week.

Level 3.3 – Clinically-Managed Medium-Intensity Residential

Clinically managed medium-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger.

Level 3.5 – Clinically Managed High Intensity Residential

Clinically managed high-intensity residential treatment includes a 24-hour setting with staff who are trained to treat multidimensional needs and address risk/imminent danger and prepare for outpatient step-down. Member must be able to tolerate and use full active milieu available.

Level 3.7 – Medically-Monitored Intensive Inpatient

Medically-Monitored Intensive Inpatient – Nursing care with physician availability 24-hours per day for significant problems that arise in Dimensions 1, 2, or 3. Counselor is available 16 hours per day.

Level 4 – Medically-Managed Intensive Inpatient

Medically-Managed Intensive Inpatient – Nursing care and daily physician care 24-hours per day for severe, unstable problems that arise in Dimensions 1, 2, or 3. Counselor is available to engage the member in treatment.

Level I-D – Detoxification

Detoxification – Nursing care with services provided by a licensed hospital 24-hours per day only to address medical or psychiatric needs.

Level OMT – Opioid Maintenance Therapy

Opioid medication and counseling available daily or several times per week to maintain multidimensional stability for those with opioid dependence. Opioid maintenance therapy is considered to be an appropriate and effective treatment for opiate addiction for some customers, particularly customers who have completed other treatment modalities without success and are motivated to actively engage in the treatment necessary in OMT.

Review Process

A Prospective Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service delivery. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

UM staff obtain review information from any reasonably reliable source. The purpose of review is to obtain the most current, accurate, and complete clinical presentation of the customer's needs and whether the services requested are appropriate, sufficient, and cost-effective to achieve positive clinical outcomes. Only information necessary to make the authorization admission, services, length of stay, frequency and duration is requested.

Outlier Management

An integral part of SWMBH's Performance Improvement Based Utilization Management Program is continued development and implementation of its outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focus by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan customers covered by the PIHP. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP(s).

1. Outlier Definition
   "Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:
   - A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.
2. Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures

A. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.

B. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.

C. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion. Corrective action plans might include:

1. Brief description of the finding(s) and supporting information;
2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps;
3. A description of the monitoring to be performed to ensure that the steps are taken;
4. A description of the monitoring to be performed that will reflect the resolution of the situation.
5. Following initial review and efforts for resolution at a desk audit level, the disposition can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;
6. Following consultation, recommendations are reviewed by the Director of Clinical Quality and/or the Medical Director for disposition determination. The MD and/or Director of Clinical Quality will review the recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.

D. The MD and Director of Clinical Quality will take into consideration the outlier severity in determining recommended remedies. The following options available at this level include:

1. Acceptance of PIHP recommendations.
2. Direction for additional PIHP staff and provider action(s),
3. Clinical Peer Review -The Peer Review consists of review, consultation, and recommendations for resolution.
4. Render final disposition.
5. Provide recommendations for action for remediation to the SWMBH CEO

E. If the utilization trends or patterns are determined to be systemic or regional in nature, collaborative corrective action is jointly discussed at the regional committee level with defined timelines for completion. Corrective action includes:
   1. Brief description of the finding(s) and supporting information;
   2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps at the PIHP and CMHSP/Provider level;
   3. A description of the monitoring to be performed to ensure that the steps are taken;
   4. A description of the monitoring to be performed that will reflect the resolution of the situation.
   5. Following initial review and efforts for resolution, the review findings can include either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;

F. The spectrum of remedies available to the PIHP in relation to its provider panels stems from the authority of the PIHP Board. Subject to PIHP CEO's approval, possible remedies can include but are not limited to:
   1. Non-payment for case.
   2. Plan member switch to new provider.
   3. Provider loss of "Delegated Benefit Management" status.
   4. Loss of credential for specified service(s).
   5. Pro-rata payback on class of cases.
   6. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
   7. Removal from provider panel.

Data Management

Data management and standardized functional assessment tools and subsequent reporting tools are an integral piece to utilization management and application of uniform benefit. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, patient safety, call rates, Access standards and customer quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/Central Care Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of customer level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for customers can be assigned. This work allows for people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It is a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

Communication

UM Program Plan

The UM Program Plan is developed as part of the Quality Assurance Improvement Plan and formally approved and distributed as part of it. The UM plan is reviewed by and input sought from various committees including RUM, Quality Improvement and the Customer Advisory Council. The UM plan is

distributed to providers according to the SWMBH distribution policy. Providers, customers and general stakeholders can access the UM plan through the SWMBH website. The SWMBH Board receives UM education annually.

Availability of Utilization Management Staff

SWMBH UM staff are available by telephone (toll free) from 8:00 a.m. to 5:00 p.m. Monday through Friday of each normal business day. Utilization Review staff respond to email and telephonic communications within one business day during provider's normal business hours. UM staff identify themselves by name, title and organization during correspondence. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, SWMBH provides the opportunity for the requesting customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

After-hours emergency services are available to customers and providers through a phone service which provides emergency referral and information outside of normal business hours by licensed professional staff. Additionally, UM staff are available to providers after hours, weekends and holidays to make determinations for a limited set of acute services. Customers and providers have the ability to leave a message for UM staff through this service and also may fax information to SWMBH after hours. Each CMHSP with UM Medicaid/HMP delegated functions manages the UM process based on local policy and procedure that adheres to regional contractual and statutory requirements.

Peer Clinical Review

Utilization Management staff are available to discuss authorization decisions with the requesting customer, provider and attending physician (if applicable). The Utilization Management staff assist with physician-to-physician communication with the Medical Director and assist in obtaining relevant clinical information and documentation for review. When a decision is made to deny an authorization request, UM staff provides within one business day, upon request, the opportunity to discuss the determination with the UM Peer Reviewer who made the determination, or another Peer Clinical Reviewer if the original reviewer cannot be available within one business day. If this Peer communication does not result in an authorization, the provider is given information regarding how to appeal the determination and any applicable timelines. Upon request, UM will provide specific clinical rationale on which the decision to deny the authorization was made.

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year goals have been achieved and identify trends and areas for improvement. While the Regional Quality Management Committee manages the evaluation, the RUM is involved with this review and responsible for implementing any improvement activities at the CMHSP and throughout their provider network. The purpose of the annual evaluation is to identify any best practices that could be incorporated into the UM plan as well as continue to improve on the care provided to SWMBH customers. Additionally, Inter-rater reliability of application of medical necessity will be evaluated annually. Oversight and monitoring of medical necessity determinations and utilization management decisions will be conducted annually to validate consistent application and understanding of uniform benefit, clinical protocols and medical necessity criteria.

Definitions

Authorization: An authorization is an approval of service(s) by an insurance company.

Core Service Menu: The services which are available with defined Recommended Thresholds for an identified population at a given Level of Care.

Exception: Service(s) that fall above the Recommended Threshold or outside of the Core Service Menu for a given Level of Care.

Level of Care: Refers to the intensity of services (setting, frequency and mode) an individual will receive during a specific stage of treatment.

Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. (Medicaid Provider Manual)

Medical Necessity Criteria: Guidelines that direct the most appropriate service or level of care which can reasonably be expected to improve symptoms associated with the customer's diagnosis and is consistent with generally accepted standards of practice.

Outlier: A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

Person-Centered Planning: *Person-centered planning means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities.* MCL 330.1700(g)

Serious Emotional Disturbance: As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

1) A substance use disorder
2) A developmental disorder
3) A "V" code in the diagnostic and statistical manual of mental disorders

Serious Mental Illness: As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the

American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Uniform Benefit/Uniformity of Benefit: Consistent application of and criteria for benefit eligibility, level of care determination and service provision regardless of various demographics including geographic location, **based upon the clinical and functional presentation of the person served, over time.**

Utilization Review: The process of monitoring, evaluating medical necessity, use, delivery, cost effectiveness, appropriateness, and the efficient use of health care services provided by health care professionals on a prospective, concurrent or retrospective basis. Utilization review activities include monitoring of individual consumer records, specific provider practices and system trends. to determine appropriate application of Guidelines and Criteria in the following areas: level of care determination, Application of Service Selection Criteria, Application of Best Practice Guidelines, Consumer outcomes, Over-Utilization/under Utilization, and Review of clinical or resource utilization Outliers.

Utilization Management: A set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the applicat of written policies and procedures, Utilization Management is designed to ensure that only eligible beneficiaries receive specialty plan benefits; that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires; and that beneficiaries are linked to other Medicaid Health Plan or other services when necessary. Utilization Management functions include: Access and eligibility determination, level of care assessment and service selection, Authorization processes, utilization review, and care management activities.

Roles

CMH Role: Adhere to prescribed Assessment Tools use, frequency and reporting to SWMBH. Adhere to Level of Care Guidelines. Report and Perform Local Care Management per UM Plan, Delegation Agreement and Policy. Report Authorizations, Assessment and Encounter data to SWMBH as prescribed.

SWMBH Role: Perform Central Care Management per UM Plan and Policy. Oversee and monitor delegated Local Care Management per UM Plan and Policy. Provide regular UM analytic management reports for SWMBH and CMHs. Regularly identify trends and material variations.

Shared Role (Director of Clinical Quality, Local Care Manager designees and RUM Committee): Regularly review UM analytic management reports. Identify trends and variations, including gaps in completeness, timeliness and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications, as necessary. Adjust business process and/or decision trees, as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

References/Additional Guiding Document

SWMBH UM Policy Manual Section 4 and Attachments
SWMBH Level of Care Guidelines

Plan Review and Approval

Medical Director: _____
Signature/date of review

Chief Administrative Officer: _____
Signature/date of review

: _____
Signature/date of review

ENHANCING OUR **Community Mental Health** SYSTEM

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Overview

Between September and December 2021, Michigan House Democrats held over 15 Mental Health Listening Tour stops throughout Michigan. The goal of these tours was to facilitate a guided discussion among local mental health practitioners, consumers, and their families on the current state of our Community Mental Health (CMH) system in Michigan. The tour was meant to ensure that any changes to our CMH system were consumer-centered. Consumers and families need to be actively involved in the planning and delivery of services at all levels of the system.

Through these listening tours, we were able to learn about the great work being done locally throughout our CMH system as well as identify areas for improvement. Issues such as access, workforce recruitment and retention, and funding were all common challenges across the state. Michiganders deserve and expect a strong public mental health system. By implementing key policy changes and making targeted investments, Michigan can continue to enhance the system it has built over the past 50 years and create a system that is accessible, person-centered, and community-driven.

Key Takeaways

1. **Keeping Community Mental Health in the Community:** Consumers and mental health practitioners alike support a community-based approach. Most people do not want to see services and decision-making taken out of the local setting. There are countless local partnerships that are working well and should not be disrupted. In fact, many argued that it is through local partnerships that consumers are able to get appropriate services.

2. **Elevating the CCBHC Model:** Certified Community Behavioral Health Clinics (CCBHCs) are a new provider type in Medicaid that must directly provide (or contract to provide) nine types of services. They emphasize 24-hour crisis care and integration with physical health care. CCBHCs are available to any individual in need of care, which is crucial in helping improve access to care for our mild-to-moderate population. Supporting the implementation of CCBHCs in the initial pilot sites (there are currently 36 sites in Michigan) and continuing to scale up statewide is imperative in improving access to care for all Michiganders.

3. **Constant Efforts to Restructure Creates Instability Within the System:** There have been numerous proposals over the years that would drastically alter how behavioral health care is delivered in Michigan. From drastic funding cuts to complete system overhauls, each measure (real or perceived) destabilizes the system and directly impacts consumers, their families, and workforce recruitment and retention.

Albion
Ann Arbor
Battle Creek
Detroit
Grand Rapids
Kalamazoo
Lansing
Livonia
Marquette
Novi
Saginaw
Traverse City (2)
Troy
Warren

15 Listening Tour Sessions

88 Panelists

30+ Hours Spent Listening

38 Survey Responses

450 Attendees

Report prepared by
State Representative Felicia Brabec
101st Legislature • December 2021

Key Takeaways (continued)

4. **Improving Workforce Recruitment and Retention:** The pandemic has only exacerbated already existing workforce issues. Across the state, we are seeing challenges in recruiting and maintaining a qualified workforce. Commonly cited challenges include low wages and benefits, overly burdensome documentation, increased workload, need for child care, lack of training reciprocity, and lack of professionalization of career paths – particularly for our direct care workers.

5. **Adopting a New Funding Strategy:** Over the years, a number of financing decisions have systematically restricted the ability of Michigan's public mental health system to meet the needs of Michiganders. Funding is far below what is needed to meet growing demand. General Fund cuts, the inability of the public system to retain savings, and insufficient Medicaid reimbursement rates are all issues that need to be addressed.

6. **Relieving Administrative Burdens:** In the behavioral health system, there is a tremendous amount of duplication and redundancy in the way the state reviews and audits. There needs to be oversight of the system, but we need to eliminate the duplication and non-value added requirements. These administrative burdens often take away time from helping consumers, and can create significant hurdles for those seeking care.

7. **Addressing Barriers to Access:** There are still barriers to access for consumers for a multitude of reasons. We need to continue to support the work of the system in coordinating the network of services necessary to address the range of social determinants of health: housing, employment, food access, transportation, family support, child care, etc. The shortage of acute and residential psychiatric beds and broadband capacity to access telehealth are also key to addressing access.

8. **Improving Stigma and Public Awareness:** Many people stressed the importance of destigmatization, education, and outreach. More needs to be done to lessen the impact stigma can have on seeking care. Similarly, there needs to be greater clarity in describing available services so that people know where the "front door" is.

MENTAL HEALTH LISTENING TOUR
MICHIGAN HOUSE DEMOCRATS

Conclusion

There are many aspects of the Community Mental Health system that are working well for consumers and should be celebrated. The system has demonstrated strong performance in providing a wide range of services to multiple populations in the community setting. Much of these successes can be attributed to local partnerships, a person-centered approach to care, and the system's proven ability to control costs.

These successes prove the system is working. However, it is equally important for us to recognize areas in which the system can be enhanced. Through thoughtful, responsive legislation, we can work to address barriers to access, issues with workforce recruitment and retention, better address social determinants of health, and improve funding. We can also work to revise departmental policies to reduce duplication and redundancy within the system. There is much work to be done, but we are committed to offering changes in a way that actively involves consumers and their families.

Southwest Michigan Behavioral Health Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
April 8, 2022
9:30 am to 11:00 am
(d) means document provided
Draft: 2/2/22

1. **Welcome Guests/Public Comment**

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

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

   - None Scheduled

4. **Consent Agenda**

   - March 11, 2022 SWMBH Board Meeting Minutes (d)

5. **Operations Committee**

   a. Operations Committee February 23, 2022 Meeting minutes (d)
   b. Operations Committee Quarterly Report (d. Hess) (d)

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

   - Annual Consumer Satisfaction Survey Results (J. Gardner) (d)

7. **Board Actions to be Considered**

   a. Election of Officers
   b. Operating Agreement Review (D. Hess) (d)

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

   a. BG-006 Annual Board Planning (d)
   b. BG-010 Board Committee Principles (d)

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

   - None

10. Board Education

a. Fiscal Year 2022 Year to Date Financial Statements (T. Dawson) (d)
b. Fiscal Year 2021 External Auditor Report (T. Dawson) (d)
c. Fiscal Year 2021 Performance Bonus Incentive Program Results (J. Gardner) (d)

11. Communication and Counsel to the Board

a. Retirement Plan Advisor Selection (B. Casemore)
b. Michigan Consortium for Healthcare Excellence Update (B. Casemore) (d)
c. MI Health Link & National Council on Quality Assurance (NCQA) (B. Casemore)
d. Building Better Lives Project Update (S. Ameter) (d)
e. May 13, 2022 Board Agenda (d)
f. Board Member Attendance Roster (d)
g. May Direct Inspection Reports-none scheduled

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 Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001
May 13, 2022
9:30 am - 10:30 am

Board Retreat
May 13, 2022
10:45am – 3:00pm

2022 SWMBH Board Member & Board Alternate Attendance												
Name:	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Members:												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Marcia Starkey (Calhoun)												
Vacant (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarto (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Randy Hyrns (Berrien)												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Vacant (Cass)												
Patricia Guenther (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 1/14/22

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