



**Air Zoo Aerospace & Science Museum 6151 Portage Road  
October 11, 2024 9:30 am to 11:30 am  
(d) means document provided  
Version 10/2/24**

- 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 (2 minutes)**
  - a. September 13, 2024 SWMBH Board Meeting Minutes (d) pg.3
  - b. August 28 and September 11, 2024 Operations Committee Meeting Minutes (d) pg.8
- 5. Required Approvals (5 minutes)**
  - a. Fiscal Year 2025 Program Integrity Compliance Plan (M. Todd) (d) pg.17
  - b. Credentialing of Behavioral Health Practitioners (M. Todd) (d) pg.51
  - c. Credentialing of Organizational Providers (M. Todd) (d) pg.61
- 6. Ends Metrics (\*Requires motion) (5 minutes)**

*Proposed Motion: The Board accepts the interpretation of Ends Metrics as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

  - \* Health Services Advisory Group Performance Measure Validation Audit (N. Spivak) (d) pg.69
- 7. Board Actions to be Considered (60 minutes)**
  - a. Fiscal Year 2025 Budget (G. Guidry) (to be displayed)
  - b. SWMBH Board Ends (S. Radwan) (d) pg.72
  - c. Michigan Consortium for Healthcare Excellence Membership (B. Casemore) (d) pg.79
  - d. Charge Executive Officer Evaluation Committee (Chair) (d) pg.80

**8. Board Policy Review (5 minutes)**

*Proposed Motion: The Board accepts the interpretation of Policy \_\_\_\_\_ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

- BG-001 Committee Structure (d) pg.82

**9. Executive Limitations Review (10 minutes)**

*Proposed Motion: The Board accepts the interpretation of Policy \_\_\_\_\_ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

- a. BEL-002 Financial Conditions (L. Csokasy) (d) pg.83
- b. EO-003 Emergency Executive Officer Succession (B. Casemore) (d) pg.88
- c. BEL-010 RE 501 (C) (3) (S. Sherban) (d) pg.90

**10. Board Education (10 minutes)**

- a. Fiscal Year 2024 Year to Date Financial Statements (G. Guidry) (d) pg.93
- b. Michigan Consortium for Healthcare Excellence (B. Casemore) (d) pg.100

**11. Communication and Counsel to the Board (10 minutes)**

- a. Board Regulatory Compliance Committee (E. Meny) (d) pg.103
- b. Board Education Planning 2025 (B. Casemore)
- c. Debrief October 4 Health Policy Forum (B. Casemore)
- d. Draft November Board Agenda (d) pg.104

**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  
November 8, 2024  
9:30 am - 11:30 am**



**Board Meeting Minutes**

**September 13, 2024**

**Air Zoo Aerospace & Science Museum, 6151 Portage Rd, Portage, MI 49002**

**9:30 am-11:30 am**

**Draft: 9/17/24**

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**Members Present:** Sherii Sherban, Tom Schmelzer, Louie Csokasy, Edward Meny, Erik Krogh, Carol Naccarato, Lorraine Lindsey

**Members Absent:** Tina Leary

**Guests Present:** Brad Casemore, Chief Executive Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Sarah Ameter, Manager of Customer Services, SWMBH; Jeannette Bayyapuneedi, Behavioral Health & Integrated Care Manager, SWMBH; Cameron Bullock, Pivotal; Mandi Quigley, Summit Pointe; John Ruddell, Woodlands; Sue Germann, Pines BH; Debbie Hess, Van Buren County CMH; Richard Thiemkey, Barry County CMH; Ric Compton, Riverwood; Jon Houtz, Pines BH Board Alternate

**Welcome Guests**

Sherii Sherban called the meeting to order at 9:34 am.

**Public Comment**

None

**Agenda Review and Adoption**

Motion Louie Csokasy moved to approve the agenda as presented.  
Second Carol Naccarato  
Motion Carried

**Financial Interest Disclosure (FID) Handling**

Mila Todd stated that Barry County CMH has appointed a new Board Alternate to the SWMBH Board; Bob Becker. Mr. Becker was not present at the meeting.

Motion Tom Schmelzer moved that The Board, with reasonable efforts, is not able to obtain a more advantageous transaction or arrangement with someone other than Mr. Becker, the conflict is not so substantial as to be likely to affect the integrity of the services the Board can expect to receive from Mr. Becker, and a conflict of interest waiver should be granted.

Second Edward Meny  
Motion Carried

**Consent Agenda**

Motion Lorraine Lindsey moved to approve the August 9, 2024 Board minutes as presented.  
Second Tom Schmelzer  
Motion Carried

**July 31, August 14, 2024 Operations Committee Meeting Minutes**

Minutes were included in the packet for the Board’s information.

Motion Lorraine Lindsey moved to approve the July 31, and August 14, 2024 Board minutes as presented.  
Second Tom Schmelzer  
Motion Carried

**Required Approvals**

**Operating Agreement**

Brad Casemore noted one revision to the Operating Agreement of removing the line related to MI Health Link as SWMBH is no longer participating in the MI Health Link demonstration. Discussion followed with Sherii Sherban recommending the Board focus on scope and authority at the next review.

Motion Edward Meny moved to approve the Operating Agreement as presented.  
Second Tom Schmelzer  
Motion Carried

**Ends Metrics Updates**

None scheduled

**Board Actions to be Considered**

**Financial Risk Management Plan**

Garyl Guidry presented one proposed revision, as supported by SWMBH’s Audit Firm, to the SWMBH Financial Management Plan. The proposed revision is removing the line: “As a financial risk management strategy, SWMBH maintains \$3 million in reserved local funds as a regional fund for possible use in the event of an entry into the state share of the Medicaid Risk Corridor.” Brad Casemore added that using \$3 million in reserved local funds for legitimate Medicaid expenses artificially reduces Medicaid expense and future capitation rates. Discussion followed.

Motion Lorraine Lindsey moved to approve the SWMBH Financial Risk Management Plan revision as presented.

Second Erik Krogh

Roll Call Vote

- Sherii Sherban yes
- Tom Schmelzer yes
- Carol Naccarato yes
- Edward Meny yes
- Erik Krogh yes
- Louie Csokasy yes
- Lorraine Lindsey yes

Motion Carried

**Board Finance Committee**

Tom Schmelzer summarized the August 8, 2024 Board Finance Committee meeting and presented the Board Finance Committee Charter for Board approval. Tom also noted that another Board member needs to be appointed to the committee considering Mark Doster’s resignation. Sherii Sherban nominated Carol Naccarato in addition to Tom Schmelzer and Louie Csokasy to serve on the Board Finance Committee and that the Board Finance Committee review the Financial Risk Management Plan and Investment portfolio prior to Board future review and approval. Discussion followed.

Motion Erik Krogh moved to approve the nomination of Carol Naccarato, Tom Schmelzer and Louie Csokasy to the Board Finance Committee  
Seconded Lorraine Lindsey  
Motion Carried

Motion Tom Schmelzer moved to approve the SWMBH Board Finance Committee Charter as presented.  
Second Carol Naccarato  
Motion Carried

**Holiday Luncheon**

Brad Casemore reviewed history of Board holiday luncheons for the Board’s consideration and the topic will be added to the October Board agenda for discussion/decision. Initial view is January after that Board meeting.

**Board Policy Review**

**BG-008 Board Member Job Description**

Sherii Sherban reported as documented.

Motion Lorraine Lindsey moved that the Board is in compliance with BG-008 Board Member Job Description and the policy does not need revision.  
Second Louie Csokasy  
Motion Carried

**EO-001 Executive Role & Job Description**

Sherii Sherban reported as documented.

Motion Tom Schmelzer moved that the Board accepts the interpretation of Policy EO-001 Executive Role & Job Description as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation. And that the Policy does not need revision.  
Second Carol Naccarato  
Motion Carried

## **Executive Limitations Review**

### **BEL-005 Treatment of Plan Members**

Louie Csokasy reported that he reviewed materials provided by Sara Ameter and commented materials were overwhelmingly positive and SWMBH is going in the right direction. Discussion followed.

Motion Louie Csokasy moved that the Board accepts the interpretation of Policy BEL-005 Treatment of Plan Members as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation. And that the Policy does not need revision.

Second Carol Naccarato

Motion Carried

### **BEL-008 Communication and Counsel**

Tom Schmelzer reported as documented.

Motion Tom Schmelzer moved that the Board accepts the interpretation of Policy BEL-008 Communication and Counsel as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation. And that the Policy does not need revision.

Second Lorraine Lindsey

Motion Carried

## **Board Education**

### **Fiscal Year 2024 Year to Date Financial Statements**

Garyl Guidry reported as documented noting revenue, expenses and projected deficits. Garyl noted that the Region, for period 10, has a \$24.3 million dollar deficit and is projected to use all of its Internal Service Funds and enter the State's risk corridor for eight million dollars. Brad Casemore noted that it is doubtful to expect the State to adjust fiscal year 2024 Medicaid rates. Discussion followed.

### **Preview Fiscal Year 2025 Budget**

Garyl Guidry reported as documented highlighting projected revenues and expenses noting SWMBH will enter fiscal year 2025 with no Internal Service Funds and no Medicaid savings. Final revenue rate information will be known on Monday, September 16<sup>th</sup> per MDHHS and a revised Fiscal Year 2025 Budget will be brought to the October Board for approval. Discussion followed. Discussion ensued around Board Policies on Financial Conditions and Budgeting and the Financial Risk Management Plan.

### **Compliance Role & Function**

Mila Todd reported as documented.

### **Integrated Care**

Jeanette Bayyapuneedi reported as documented. Discussion followed.

## **Communication and Counsel to the Board**

### **October Board Direct Inspections**

Brad Casemore noted the draft October Board agenda and October Policy direct inspections of: BEL-002 Financial Conditions (L. Csokasy); and Executive Officer Evaluation Committee establishment.

### **Investments Update**

Garyl Guidry stated that SWMBH is meeting with Investments Advisors and will continue to keep the Board updated. This will become a standing item on Board Finance Committee agenda.

### **October 4, 2024 9<sup>th</sup> Annual Regional Healthcare Policy Forum**

Brad Casemore reminded the Board of the upcoming event as documented in the packet and encouraged the Board to attend and to circulate the announcement and registration information.

## **Public Comment**

Cameron Bullock and Rich Thiemkey shared their opinions of Fiscal Year 2025 contracts and budgeting. Ric Compton added that PIHP revenues need to be actuarially sound.

## **Adjournment**

Motion Louie Csokasy moved to adjourn at 12:22 pm.  
Second Tom Schmelzer  
Motion Carried

Date:	08/28/2024
Time:	9:00a-11:00a
Facilitator:	Rich Thiemkey
Minute Taker:	Cameron
Meeting Location:	SWMBH Moses L. Walker Room <a href="#">Click here to join the meeting</a>

- Present:**  Rich Thiemkey (Barry)       John Ruddell (Woodlands)       Brad Casemore (SWMBH)  
 Ric Compton (Riverwood)       Jeff Patton (ISK)       Mila Todd (SWMBH)  
 Sue Germann (Pines BHS)       Cameron Bullock (Pivotal)       Garyl Guidry (SWMBH)  
 Jeannie Goodrich (Summit)       Debbie Hess (Van Buren)  
 Guest(s): Eleos Team

Version: 8/22/24

Agenda Topics:	Discussion Points:	Minutes:
<b>1. Agenda Review &amp; Adoption – determine today’s facilitator (All) (d)</b>		<ul style="list-style-type: none"> <li>Rich Volunteered to Facilitate</li> <li>Added Financial Plan Management revision</li> <li></li> </ul>
<b>2. Prior Minutes (All) (d)</b>		<ul style="list-style-type: none"> <li>All present in favor, no changes</li> </ul>
<b>3. FY25 Budget (Garyl) (d)</b>		<ul style="list-style-type: none"> <li>Revenue projection: 396.073 Million – rates are based off of late June Rate setting. Next scheduled meeting will be September 6<sup>th</sup>, 2024. Information will be disseminated once received, and will need to be walked to the board.</li> <li>Expense projection: \$416.527 Million</li> <li>Projected Deficit: \$20.454 Million</li> <li>No savings, no ISF going into FY 25.</li> <li>What happens if there is no funds available? – Not going to be able to cash advance settlements as in years past</li> <li>Where does the 7.5% cash come from to cover SWMBH costs of state share – no additional cash available. PIHP responsible for that portion. CMH's book</li> </ul>



		a receivable, cash flow becomes a potential issue. CMH's will need to figure out how to deal with potential cash flow issues.
<b>4. YTD Financials (Garyl) (d)</b>		<ul style="list-style-type: none"> <li>• P10 was not better , projected expenses of 313.5 million dollars, deficit will be 31+ million, fully expend ISF, risk corridor, we are in 3<sup>rd</sup> corridor risk corridor, with is 100% covered by department (\$7.5 million amount)</li> </ul>
<b>5. Prep for Kristen Jordan meeting</b>		<ul style="list-style-type: none"> <li>• 9/11 meeting @ 930a-10a</li> <li>• Previous Milliman meeting has not received any responses</li> <li>• No communication between PIHPs/State</li> <li>• Plan First cost and issues</li> <li>• PIHP CFO update hopefully be shared</li> <li>• Any internal reviews be shared with SWMBH for help.</li> <li>• State hospital cost shift</li> </ul>
<b>6. Operating Agreement review for September Board (All)</b>		<ul style="list-style-type: none"> <li>• Remove mihealth link references</li> <li>• Ops Comm review of all Grants is questioned – For grants that are other than Block Grant</li> <li>•</li> </ul>
<b>7. CMH CEO Planning Inputs review (d) (Brad)</b>		<ul style="list-style-type: none"> <li>• Moved to September 11<sup>th</sup></li> </ul>
<b>8. Delegation Grid (Mila) (d)</b>		<ul style="list-style-type: none"> <li>• Summit Point, Pivotal and Cass have officially requested Inpatient Authorizations.</li> <li>• Pivotal has stated that GF is not under the prevue of SWMBH and should not be delegated at this point as well.</li> </ul>
<b>9. Ops Comm Self-Evaluation (d)</b>		<ul style="list-style-type: none"> <li>• Moved to September 11<sup>th</sup></li> </ul>
<b>10. Service Use Analysis, ASD CLS Spec Res CLS (d)</b>		
<b>11. Joint approaches with Providers</b>		<ul style="list-style-type: none"> <li>• Divided regional approach</li> </ul>

<p><b>12. AI <a href="http://www.elios.com">www.elios.com</a> (d)</b></p>		<ul style="list-style-type: none"> <li>• Presentation was had on what Eleos is and what a cost sharing agreement arrangement could be arranged.</li> <li>• Ops Comm can review the information sent via Cameron to be able to see if Eleos is right for their organization.</li> <li>• Possible 8 CMH's interested, 3 are currently utilizing.</li> <li>• SWMBH will review and meet with Eleos and do some initial review</li> <li>• CMH's to send initial ballpark on possible users per CMH</li> </ul>
<p><b>13. CMHAM views on FY 2025 PIHP Agreement (All)</b></p>		
<p><b>14. Financial Risk Management Plan Revisions</b></p>		<ul style="list-style-type: none"> <li>• Discussed FY 24/25</li> <li>• Changes needed to plan discussed.</li> </ul>
<p><b>15. WASKFUL Settlement</b></p>		<ul style="list-style-type: none"> <li>• Concerns raised on signing contract without knowing the impacts to the SWMBH region</li> <li>• Concerns about not signing a contract, and the state withholding funds from SWMBH region</li> <li>• ISF language seems ambiguous and needs to be revised to be more actuarially sound measures. 7.5% is an arbitrary number that has no statistical significance.</li> <li>• Jeff suggests getting with legal council to attach a letter to emphasize the unfunded mandate and the inability to pay for lawsuit.</li> </ul>
<p><b>15. Confirm 2024 OC dates</b></p>		<ul style="list-style-type: none"> <li>• Brad to update and send out for confirmation.</li> </ul>
<p><b>16. Confirm Next Meeting</b></p>	<p>September 11, 2024 9a-11a Facilitator: Jeannie</p>	
<p><b>17. Next Meeting Agenda Items</b></p>		<ul style="list-style-type: none"> <li>• ELEOS</li> <li>• Budget – Garyl</li> <li>• Kristen Jordan - 930a - 10a</li> <li>• CMH CEO Input- Brad</li> <li>• Ops Comm Self- Eval- Brad</li> </ul>



Date:	09/11/2024
Time:	9:00a-11:00a
Facilitator:	Jeannie
Minute Taker:	Cameron
Meeting Location:	<b>SWMBH Moses L. Walker Room</b> <a href="#">Click here to join the meeting</a>

- Present:**  Rich Thiemkey (Barry)       John Ruddell (Woodlands)       Brad Casemore (SWMBH)  
 Ric Compton (Riverwood)       Jeff Patton (ISK)       Mila Todd (SWMBH)  
 Sue Germann (Pines BHS)       Cameron Bullock (Pivotal)       Garyl Guidry (SWMBH)  
 Jeannie Goodrich (Summit)       Debbie Hess (Van Buren)  
 Guest(s):

Version: 9/5/24 Annotated by BC and JG

Agenda Topics:	Discussion Points:	Minutes:
<b>1. Agenda Review &amp; Adoption (All) (d)</b>		<ul style="list-style-type: none"> <li>• Approved</li> </ul>
<b>2. Prior Minutes (All) (d)</b>		<ul style="list-style-type: none"> <li>• Cameron will send out individually as the regional email group isn't apparently working.</li> <li>• All approved, no changes.</li> </ul>
<b>3. FY25 Budget and Medicaid Rates (Garyl) (d) to be provided &amp; displayed based on 9/6 rate setting information</b>		<ul style="list-style-type: none"> <li>• Milliman and MDHHS sharing two different expectations. KJ says we will get a rate adjustment, Milliman says that it's still be assessed.</li> <li>• Region 4 Geographical score did increase by 1.1% HAB waiver slots did increase by 10.</li> <li>• HRA rate increase by 6.9%. Speculative, awaiting final confirmation.</li> <li>• CCBHC rates changed based on internal projections from Pivotal and ISK.</li> <li>• Still projecting a \$9.2 deficit for FY 25, which comes out to \$3.6 once risk sharing has been completed. Jeannie and Cameron made concerns known regarding the withholding of revenue at the SWMBH level, and</li> </ul>

		credibility for our boards and our staffing.
<p><b>4. Kristen Jordan 9:30-10:00 remote</b></p>	<p>List provided to KJ</p> <ul style="list-style-type: none"> <li>• Medicaid Redeterminations / Plan First / Loss of DABs</li> <li>• SWMBH and overall PIHP financial jeopardy</li> <li>• ISF policy and practices</li> <li>• GF pressures on CMH due to losses of Medicaid eligibility and reduced/no state psych beds</li> <li>• Waskul settlement</li> </ul>	<ul style="list-style-type: none"> <li>• FY 24 Financial Situation <ul style="list-style-type: none"> <li>○ \$ 31 million dollar deficit as a region, \$8 million coming from the state, fully depleting current ISF and taking nothing into FY 25.</li> <li>○ SWMBH has not heard much back from Milliman.</li> <li>○ Jeff stated that the region experienced a downturn in revenues prior to the pandemic; during the pandemic, there was very little utilization of services. Which allowed SWMBH to add to ISF. Services post-pandemic, specifically Autism, Inpatient, and Specialized Residential, have increased both in cost and utilization.</li> <li>○ Hospital waiting lists for state hospitals have increased. State hospitals cannot be funded with Medicaid, but only Local averages of \$90 a day. Comparatively, inpatient rates have a Medicaid average of \$1100 per day.</li> <li>○ Rates are starting to get out of control, and not sure there is an accurate understanding of what is occurring.</li> <li>○ Workforce shortages are also causing an increase in expenses.</li> <li>○ Brad added that in previous versions of rate setting, that Milliman was going to use a \$750 per diem for Psych rates, when actuality is very different. Hospitals are getting increases in HRAs and Medicaid payments.</li> <li>○ Amy added that Spec Res Providers can be choosy on who they take, and the expenses that they expect.</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>○ Group consensus is that the acuity and length of stay for higher acuity are becoming the same as or very close to hospital costs.</li> <li>● ISF Language <ul style="list-style-type: none"> <li>○ Kristen to explore what ISF is sufficient and determine those nuances moving forward very quickly.</li> </ul> </li> <li>● Waskul <ul style="list-style-type: none"> <li>○ Language has been modified.</li> <li>○ Settlement is likely to happen this year.</li> <li>○ Rate adjustments should occur with amendments</li> </ul> </li> <li>● FY 25 Deficits <ul style="list-style-type: none"> <li>○ Kristen states that if there is sufficient data to support increases in rates, there will be changes.</li> </ul> </li> </ul>
<p><b>5. YTD Financials (Garyl) (d)</b></p>		<ul style="list-style-type: none"> <li>● \$31 million deficit projection</li> <li>● Currently at \$24.4 Million</li> <li>● \$8 Million dollar risk corridor portion</li> </ul>
<p><b>6. OC Alternates (Mila) refresher on how to name an optional CMH Alternate to Ops Comm</b></p>		<ul style="list-style-type: none"> <li>● Can appoint alternates- notify Mila, don't have to have a formally designated alternate. If not approved officially via SWMBH cannot vote.</li> <li>● Mila to send out an approved list of alternatives.</li> <li>● Ric brings up the rarity in which we do Operation Committee Agreements and votes. Instead of the current process, which is SWMBH-driven.</li> <li>● Jeannie and Cameron disagree that the current process for Conflict of Interest disclosure should be done when we don't have to separate ourselves from CMHs.</li> <li>● Cameron states that we need to be sure that Ops Agreement and SMWBH policy do not contradict each other. Mila agreed that we should not have policies that conflict with Ops Comm.</li> </ul>

		<ul style="list-style-type: none"> <li>• May need to review the Conflict of Interest disclosure at the board level policy- Reach out to council?</li> </ul>
<b>7. Facilitator meeting prep role (Brad)</b> Discuss and clarify role of the facilitator in OC meeting planning		<ul style="list-style-type: none"> <li>• Moved to next meeting</li> </ul>
<b>8. OC meeting logistics (Brad) discuss and clarify generally preferred methods of OC planning and document control</b>		<ul style="list-style-type: none"> <li>• Moved to next meeting</li> </ul>
<b>9. CMH CEO Planning Inputs review (d) (Brad) see document attached to OC calendar invite</b>		<ul style="list-style-type: none"> <li>• Moved to next meeting</li> </ul>
<b>10. Ops Comm Self-Evaluation (d) Discussion</b>		<ul style="list-style-type: none"> <li>• Moved to next meeting</li> </ul>
<b>11. Service Use Analysis, ASD CLS Spec Res (d) follow up from prior conversation</b>		<ul style="list-style-type: none"> <li>• Work has begun on this but is not yet available to everyone. Working to compare our region, to state data.</li> <li>• Let Garyl know if you want to see comparisons to similar CMH's</li> </ul>
<b>12. PIHP Contract '25 (Mila and Brad) developments on FY 2025 PIHP DHHS Contract (email/letter from Brad)</b>		<ul style="list-style-type: none"> <li>• Full and Final FY 25 contract has not been received.</li> <li>• Email from Kristen Jordan to be sent to Ops Comm</li> <li>• At least one PIHP intends to do an electronic strike-out</li> <li>• SWMBH has reached out to their Counsel.</li> <li>• MDHHS will release 9/16/24 Cell rates which is required for contract to be signed.</li> <li>• Jeannie was a bit shocked about the CCBHC-specific language. Brad noted the PIHP concerns about unclear and contradictory language between PIHP DHHS Agreement and CCBHC Handbook which informed the basis for language reconciliation.</li> </ul>
<b>13. PCE Update (Brad)</b>		<ul style="list-style-type: none"> <li>• SWMBH meeting with PCE third week of October.</li> <li>• Information-only exchange process</li> </ul>
<b>14. Update on Delegated Function Request/Process (Mila)</b>		<ul style="list-style-type: none"> <li>• Waiting for Brad to send an email on what is needed for Summit Point, Woodlands, and Pivotal to have inpatient continued stays at the CMH's.</li> </ul>

<p><b>15. Confirm Next Meeting Review Revised 2024 OC Meeting dates and absences</b></p>	<p>September 25, 2024 9a-11a Facilitator: Jeannie</p>	<ul style="list-style-type: none"> <li>• Deb Hess will be absent, are unable to send an alternative.</li> </ul>
<p><b>16. Next Meeting Agenda</b></p>		<ul style="list-style-type: none"> <li>• Facilitator meeting prep role- Brad</li> <li>• OC meeting Logistics- Brad</li> <li>• CMH CEO Planning Inputs Review- Brad</li> <li>• Ops Comm Self-Evaluation- Brad</li> <li>• Delegated Functions – Mila/Brad</li> <li>• Finance - Garyl</li> </ul>



# **Southwest Michigan Behavioral Health CORPORATE COMPLIANCE PLAN**

Approved by SWMBH Board of Directors  
10/11/2024~~10/12/2023~~

**Mila C. Todd**  
**SWMBH Chief Compliance Officer**

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## ORGANIZATIONAL STRUCTURE

Southwest Michigan Behavioral Health (SWMBH) serves as both the Medicaid Prepaid Inpatient Health Plan (PIHP) and Coordinating Agency (effective no later than 10/1/14) for the following eight county region:

Barry County:	Barry County Community Mental Health Authority;
Berrien County:	Berrien Mental Health Authority d/b/a Riverwood Center;
Branch County:	Branch County Community Mental Health Authority, d/b/a Pines Behavioral Health Services;
Calhoun County:	Calhoun County Community Mental Health Authority, d/b/a Summit Pointe;
Cass County:	Cass County Community Mental Health Authority d/b/a Woodlands Behavioral Healthcare Network;
Kalamazoo County:	Kalamazoo County Community Mental Health Authority d/b/a Integrated Services of Kalamazoo;
St. Joseph County:	St. Joseph County Community Mental Health Authority d/b/a Pivotal;
Van Buren County:	Van Buren Community Mental Health Authority

The Participant community mental health authorities have elected to configure SWMBH under the Michigan Mental Health Code Section 3301.1204b. ~~It is also a selected participant Region for the Medicare-Medicaid Eligibles (MME) Demonstration effective July 1, 2014.~~

- **SWMBH as the PIHP**

SWMBH serves as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the region with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory and contractual obligations related to the applicable waiver(s) and MDHHS contract(s). The role of SWMBH as the PIHP is defined in federal statute, specifically 42 CFR 438 and the MDHHS/PIHP Contract.

SWMBH is the contracting entity for Medicaid contracts with MDHHS ~~and Medicare behavioral health contracts with the Integrated Care Organizations (ICO), Aetna-Better Health of Michigan and Meridian Health Plan.~~ Contracts include Medicaid 1115 Demonstration Waiver, 1915(c)/(i) Specialty Supports and Services, the Healthy Michigan Program, the Flint 1115 Waiver, Substance Use Disorder Community Grant Programs, and/or other(s).

- **SWMBH as the Coordinating Agency**

Beyond a Medicaid role, SWMBH also serves as the Coordinating Agency (CA) for member counties with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory and contractual obligations related to that role and its contracts. SWMBH, as a designated CA, manages SAPT Block Grant funds, other federal/state non-Medicaid SUD funds, and PA2 liquor tax funds.

## **SWMBH: MISSION, VISION AND VALUES**

### **Philosophy:**

*“Excellence through Partnership.”*

### **Mission:**

*“SWMBH strives to be Michigan’s pre-eminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success.”*

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

### **Vision:**

*“An optimal quality of life in the community for everyone.”*

The Vision of SWMBH is to ensure persons with specialty care needs reside in their own community, have a quality and healthy lifestyle, and are fully accepted.

### **Values:**

- Customer Driven
- Person-Centered
- Recovery Oriented
- Evidenced-Based
- Integrated Care
- Trust
- Integrity
- Transparency
- Inclusive
- Accessibility
- Acceptability
- Impact
- Value
- Culturally Competent & Diverse Workforce
- High Quality Services
- Regulatory Compliance

## OVERVIEW

This Corporate Compliance Plan documents SWMBH's approach to assuring that federal and state regulatory and contractual obligations related to compliance of the Prepaid Inpatient Health Plan (PIHP) are fulfilled.

The SWMBH Corporate Compliance Plan addresses SWMBH's regulatory compliance obligations as a Prepaid Inpatient Health Plan (PIHP) and how, where it has obligations, it will oversee the PIHP functions it delegates to the Participant Community Mental Health Service Providers (CMHSP). SWMBH's Corporate Compliance Program is designed to further SWMBH's commitment to comply with applicable laws, promote quality performance throughout the SWMBH region, and maintain a working environment for all SWMBH personnel that promotes honesty, integrity and high ethical standards. SWMBH's Corporate Compliance Program is an integral part of SWMBH's mission, and all SWMBH personnel, Participant CMHSPs and contracted and sub- contracted Providers are expected to support the Corporate Compliance Program. SWMBH's Compliance Plan is comprised of the following principal elements as outlined in the Federal Sentencing Guidelines:

- 1) The development and distribution of written standards of conduct, as well as written policies and procedures, that promote SWMBH's commitment to compliance and that address specific areas of potential fraud;
- 2) The designation of a Chief Compliance Officer and other appropriate bodies, (e.g., a Corporate Compliance Committee), charged with the responsibility and authority of operating and monitoring the compliance program;
- 3) The development and implementation of regular, effective education and training programs for all affected employees;
- 4) The development of effective lines of communication between the Chief Compliance Officer and all employees, including a hotline to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect callers from retaliation;
- 5) The use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas within delivered services, claims processing and managed care functions;
- 6) The development of disciplinary mechanisms to consistently enforce standards and the development of policies addressing dealings with sanctioned and other specified individuals; and
- 7) The development of policies to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to Government authorities when appropriate.

SWMBH's Corporate Compliance Program is committed to the following:

- Minimizing organizational risk and improving compliance with the service provision, documentation, and billing requirements of Medicaid and other SWMBH-managed funding streams-Medicare;

- Maintaining adequate internal controls throughout the region and provider network;
- Encouraging the highest level of ethical and legal behavior from all employees and providers;
- Educating employees, contract providers, board members, and stakeholders on their responsibilities and obligations to comply with applicable local, state, and federal laws; and
- Providing oversight and monitoring functions.

There are numerous laws that affect the regulatory compliance of SWMBH and its provider network; however, in formalizing the PIHP's compliance program, the legal basis of the SWMBH compliance program centers around four key laws and statutes:

- **The Affordable Care Act (2010)** This Act requires the PIHP to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste and abuse across the PIHP's provider network. All programs funded by the PIHP including CMHSPs, sub-contracted provider organizations and practitioners, board members and others involved in rendering PIHP covered services fall under the purview and scope of SWMBH's compliance program.
- **The Federal False Claims Act** This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; conspires with others to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal government (or its designated entity).
- **The Michigan False Claims Act** This Act prohibits fraud in the obtaining of benefits or payments in conjunction with the MI Medical assistance program; prohibits kickbacks or bribes in connection with the program; prohibits conspiracies in obtaining benefits or payments; and authorizes the MI Attorney General to investigate alleged violations of this Act.
- **The Anti-Kickback Statute** This Act prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the Federal government or for any good or service paid for in connection with consumer service delivery.

There are numerous Federal and State regulations that affect the SWMBH compliance program. Some of these laws not referenced above include but are not limited to:

- The Medicaid Managed Care Final Rules (42 CFR Part 438)
- The Deficit Reduction Act of 2005
- Social Security Act of 1964 (Medicare & Medicaid)

- Privacy and Security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)
- 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records
- Code of Federal Regulations
- Letters to State Medicaid Directors
- The MI Medicaid False Claims Act (Current through amendments made by Public Act 421 of 2008, effective 1/6/2009)
- Michigan Whistleblowers Act, Act 469 of 1980
- Michigan Mental Health Code and Administrative Rules
- Medical Services Administration (MSA) Policy Bulletins
- State Operations Manual
- State of Michigan PIHP contract provisions
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- Michigan State Licensing requirements
- Michigan Medical Records Act
- Civil Monetary Penalty Law of 1981
- American with Disabilities Act of 1990

The SWMBH Compliance Plan is subject to the following conditions:

- A. SWMBH's Chief Compliance Officer (CCO) may recommend modifications, amendments or alterations to the written Corporate Compliance Plan as necessary and will communicate any changes promptly to all personnel and to the Board of Directors.
- B. This document is not intended to, nor should be construed as, a contract or agreement and does not grant any individual or entity employment or contract rights.

## **APPLICATION OF COMPLIANCE PLAN**

SWMBH is a regional PIHP and as such, this Plan is intended to address SWMBH's function as a PIHP. It is the intent of SWMBH that the scope of all its compliance policies and procedures should promote integrity, support objectivity and foster trust throughout the service region. This Plan applies to all SWMBH operational activities and administrative actions, and includes those activities that come within federal and state regulations relating to PIHPs. SWMBH personnel are subject to the requirements of this plan as a condition of employment. All SWMBH personnel are required to fulfill their duties in accordance with SWMBH's Compliance Plan, human resource and operational policies, and to promote and protect the integrity of SWMBH. Failure to do so by SWMBH personnel will result in discipline, up to and including termination of employment depending on the egregiousness of the offense. Disciplinary action may also be taken against a supervisory employee who directs or approves an employee's improper conduct, is aware of the improper conduct and does not act appropriately to correct it, or who fails to properly exercise appropriate supervision over an employee.

SWMBH directly and indirectly, through its Participant CMHSPs, contracts services for adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders within its eight counties (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren counties).

The PIHP Compliance Plan applies to all contracted and subcontracted providers receiving payment through SWMBH and/or through the PIHP managed care functions. All Participant CMHSPs and contracted and subcontracted providers, including their officers, employees, servants and agents, are subject to the requirements of this Plan as applicable to them and as stated within the applicable contracts. Failure to follow the SWMBH Compliance Plan and cooperate with the compliance program will result in remediation effort attempts and/or contract action, if needed. SWMBH has the responsibility of regulating, overseeing and monitoring ~~the Medicare funds it receives specific to its participation in the dual eligibles demonstration project, and~~ the Medicaid processes of business conducted throughout its service area. SWMBH also has the responsibility to support business practices conducted with integrity and in compliance with the requirements of applicable laws and sound business practices.

The SWMBH Corporate Compliance Plan standards and policies included or referenced herein are not exhaustive or all inclusive. All SWMBH personnel, Participant CMHSPs and providers are required to comply with all applicable laws, rules and regulations including those that are not specifically addressed in the Corporate Compliance Plan.

#### **DEFINITIONS AND TERMS**

- Compliance investigation: the observation or study of suspected fraud, abuse, waste, or reported violations of applicable laws and regulations for all SWMBH-administered funding streams by close examination and systematic inquiry.
- Abuse: means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)
- Fraud (Federal False Claims Act): means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2)
- Fraud (MI Medicaid False Claims Act): Michigan law permits a finding of Medicaid fraud based upon “constructive knowledge.” This means that if the course of conduct reflects a systematic or persistent tendency to cause inaccuracies” then it may be fraud, rather than simply a good faith error or mistake. (Public Act 421 of 2008, effective 1/6/2009)
- Waste: means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.



- Participant CMHSPs: Participant CMHSPs hold a subcontract with SWMBH to provide supports and services to adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders to Plan Members and to perform various delegated managed care functions consistent with SWMBH policy. “Participant CMHSPs” includes the agency itself as well as those acting on its behalf, regardless of the employment or contractual relationship.
- Contracted Providers: substance abuse, ~~MI Health Link~~ and other Providers throughout the SWMBH region with which SWMBH directly holds a contract to provide Medicaid covered mental health and substance abuse services.
- Subcontracted Providers: various Providers throughout the SWMBH region that contract directly with one or more of the Participant CMHSPs to provide covered mental health and substance abuse services.
- ~~Medicare Funds: when Medicare or Medicare funds are referenced in this Compliance Plan, the related activities are limited to services covered by SWMBH Medicare funds received due to its participation in the dual eligibles demonstration project.~~

## SECTION I - CODE OF CONDUCT

- SWMBH Personnel and Board of Directors Code of Conduct  
In order to safeguard the ethical and legal standards of conduct, SWMBH will enforce policies and procedures that address behaviors and activities within the work setting, including but not limited to the following:
  - 1) Confidentiality: SWMBH is committed to protecting the privacy of its consumers. Board members and SWMBH personnel are to comply with the Michigan Mental Health Code, Section 330.1748, 42 CFR Part 2 relative to substance abuse services, and all other privacy laws as specified under the Confidentiality section of this document.
  - 2) Harassment: SWMBH is committed to an environment free of harassment for Board members and SWMBH personnel. SWMBH will not tolerate harassment based on sex, race, color, religion, national origin, citizenship, chronological age, sexual orientation, or any other condition, which adversely affects their work environment. SWMBH has a strict non-retaliation policy prohibiting retaliation against anyone reporting suspected or known compliance violations.
  - 3) Conflict of Interest: SWMBH Board members and personnel will avoid any action that conflicts with the interest of the organization. All Board members and personnel must disclose any potential conflict of interest situations that may arise or exist. SWMBH will maintain standards establishing a clear separation of any supplemental employment in terms of private practice and outside employment from activities performed for SWMBH.
  - 4) Reporting Suspected Fraud: SWMBH Board members and personnel must report any suspected or actual “fraud, abuse or waste” (consistent with the

definitions as set forth in this Plan) of any SWMBH funds to the organization.

- 5) Culture: SWMBH Board members, Executive Officer and management personnel will establish at SWMBH, and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations. SWMBH will assist Participant CMHSPs, contracted and subcontracted providers in adopting practices that promote compliance with ~~Medicare and Medicaid~~ fraud, abuse and waste program requirements. The SWMBH Compliance Plan and program will be enforced consistently.
- 6) Delegation of Authority: SWMBH Board members, Executive Officer and management personnel will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.
- 7) Excluded Individuals: SWMBH will perform or cause to be performed criminal records checks on potential SWMBH personnel, and shall avoid placing untrustworthy or unreliable employees in key positions. In addition, SWMBH will consult the OIG Cumulative Sanctions List, the System for Award Management, and the Michigan Department of Health and Human Services List of Sanctioned Providers to determine whether any current or prospective SWMBH Board members or personnel have been excluded from participation in federal health care programs.
- 8) SWMBH Board members and SWMBH personnel are expected to participate in compliance training and education programs.
- 9) SWMBH Board members and SWMBH personnel are expected to cooperate fully in any investigation.
- 10) Reporting: All SWMBH Board members and SWMBH personnel have the responsibility of ensuring the effectiveness of the organization's Compliance Program efforts by actively participating in the reporting of suspected violations of the Compliance Plan or policies, and the standards stated in this Code of Conduct.
- 11) Gifts From Consumers/Members: SWMBH personnel are prohibited from soliciting tips, personal gratuities or gifts from members or member families. Additionally, SWMBH personnel are prohibited from accepting gifts or gratuities of more than nominal value. SWMBH generally defines "nominal" value as \$25.00 per gift or less. If a member or other individual wishes to present a monetary gift of more than nominal value, he or she should be referred to the Executive Officer.
- 12) Gifts Influencing Decision-Making: SWMBH personnel will not accept from anyone gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting SWMBH might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, customer/member, government official or other person by any SWMBH personnel or

SWMBH is absolutely prohibited. Any such conduct should be reported immediately to the CCO, or through the SWMBH corporate compliance hotline at (800) 783-0914.

- 13) Gifts from Existing Vendors: SWMBH personnel may accept gifts from vendors, suppliers, contractors or other persons that have nominal values as defined in SWMBH financial and compliance policies. SWMBH expects SWMBH personnel to exercise good judgment and discretion in accepting gifts. If any SWMBH personnel have any concerns regarding whether a gift should be accepted, the person should consult with his or her supervisor. SWMBH personnel will not accept excessive gifts, meals, expensive entertainment or other offers of goods or services, which has a more than a nominal value as defined in SWMBH financial and compliance policies.
- 14) Vendor Sponsored Entertainment: At a vendor's invitation, SWMBH personnel may accept meals or refreshments of nominal value at the vendor's expense. Occasional attendance at local theater or sporting events, or similar activity at a vendor's expense may also be accepted provided that, a business representative of the vendor attends with SWMBH personnel. Such activities are to be reported to the Chief Compliance Officer by SWMBH personnel.
- 15) Purchasing and Supplies: It is the policy of SWMBH to ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

All subcontractor and supplier arrangements will be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors will be selected based on objective criteria including quality, technical excellence, price, delivery, and adherence to schedules, services and maintenance of adequate sources of supply. Purchasing decisions will be made on the supplier's ability to meet needs and not on personal relationships or friendships. SWMBH will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of purchasing activities.

- 16) Marketing: Marketing and advertising practices are defined as those activities used by SWMBH to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. SWMBH will present only truthful, fully informative and non-deceptive information in any materials or announcements. All marketing materials will reflect available services.

The federal Anti-kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay,

solicit, or receive “remuneration” as an inducement to generate business compensated by Medicare and Medicaid programs. Therefore, all direct- to-consumer marketing activities require advance review by the Compliance Committee or designee if the activity involves giving anything of value directly to a consumer.

- 17) Financial Reporting: SWMBH shall ensure integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law, and shall be recorded in conformity with generally accepted accounting principles or any other applicable criteria.

All financial reports, accounting records, research reports, expense accounts, time sheets and other documents will accurately and clearly represent the relevant facts or the true nature of a transaction. No undisclosed or unrecorded funds or assets will be established for any purpose.

SWMBH will not tolerate improper or fraudulent accounting, documentation, or financial reporting. SWMBH personnel have a duty to make reasonable inquiry into the validity of financial information reporting. In addition to employee discipline and termination, SWMBH may terminate the contractual arrangement involving any contracted provider due to fraudulent accounting, documentation, or financial reporting.

SWMBH shall develop internal controls and obtain an annual independent audit of financial records; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete documentation; and shall maintain accountability of assets.

- 18) Third Party Billing and Governmental Payers: SWMBH is committed to truthful billing that is supported by complete and accurate documentation. SWMBH personnel may not misrepresent charges to, or on behalf of, a consumer or payer.

SWMBH must comply with all payment requirements for government-sponsored programs. All SWMBH personnel must exercise care in any written or oral statement made to any government agency. *SWMBH will not tolerate false statements by SWMBH personnel to a governmental agency.* Deliberate misstatements to governmental agencies or to other payers will expose the individual to potential criminal penalties and termination.

- 19) Responding to Government Investigations: SWMBH will fully comply with the law and cooperate with any reasonable demand made in a governmental investigation as outlined and specified in the SWMBH Compliance and Program Integrity Operating Policy 19.9, *Response To Government Investigations*. SWMBH personnel may not conceal, destroy,

or alter any documents, lie or make misleading statements to governmental representatives. SWMBH personnel may not aid in any attempt to provide inaccurate or misleading information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of the law.

It is crucial that the legal rights of SWMBH personnel and SWMBH are protected. If any SWMBH personnel receives an inquiry, a subpoena, or other legal documents requiring information about SWMBH business or operation, whether at home or in the workplace, from any government agency, SWMBH requests that the person notify SWMBH's Executive Officer or the Chief Compliance Officer immediately.

SWMBH will distribute the Code of Conduct to all SWMBH personnel upon hire who shall certify in writing that they have received, read, and will abide by the organization's Code of Conduct. In addition to the Code of Conduct, all SWMBH personnel will be familiar with and agree to abide by all SWMBH operational and human resources policies and procedures as well as the employee handbook. All operational and human resources policies and procedures and the employee handbook are available to SWMBH personnel through the SWMBH intranet and the shared drive.

- **Participant CMHSP and Contracted and Subcontracted Provider Relationships**  
It is the policy of SWMBH to ensure that all direct and subcontracted provider contractual arrangements are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers we serve. In order to ethically and legally meet all standards, SWMBH will strictly adhere to the following:
  - 1) SWMBH does not receive or provide any inducement for referrals. Consumer referrals and intakes will be accepted based on the consumer's needs, eligibility, and SWMBH's ability to provide the services needed.
  - 2) No employee, Participant CMHSP, or contracted or subcontracted provider, or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers.
  - 3) SWMBH does not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician's ability to provide services to state and federal health care program beneficiaries.
  - 4) SWMBH does not enter into contractual relationships with individuals or agents/agencies that have been convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal health care programs. Reasonable and prudent background investigations will be completed prior to entering into contractual relationships with all individuals and agents/agencies. SWMBH will consult the National Practitioner Data

Bank and the OIG Cumulative Sanctions List to determine whether any current or prospective Participant CMHSPs or contracted or subcontracted Providers have been excluded from participation in federal health care programs.

- 5) All Participant CMHSP, contracted and subcontracted provider personnel have the responsibility of ensuring the effectiveness of SWMBH's Compliance Program efforts by actively participating in the reporting of suspected violations of the Compliance Plan or policies, and the standards stated in this Code of Conduct consistent with SWMBH compliance policies.

Participant CMHSPs and contracted and subcontracted providers will be required to comply with the SWMBH Code of Conduct or provide evidence of a sufficient Code of Conduct of their own. If complying with the SWMBH Code of Conduct, Participant CMHSPs and contractual providers will receive a copy of the Code of Conduct at the time of the initial contract and will be required to certify in writing that they have received, read, and will abide by SWMBH's Code of Conduct for inclusion in the contractor file. Participant CMHSPs and contracted or subcontracted providers having developed their own Code of Conduct will be required to provide evidence of such for inclusion in the contractor file. Participant CMHSPs and contracted and subcontracted providers will be familiar with and agree to abide by the SWMBH Compliance Plan and all applicable policies and procedures as incorporated into relevant contracts. All policies and procedures are available to the Participant CMHSPs, contracted, and subcontracted providers via the SWMBH Internet Website at [www.swmbh.org](http://www.swmbh.org). Participant CMHSPs and contracted and subcontracted providers are responsible for monitoring and staying informed of regulatory developments independent of SWMBH Compliance Program efforts.

- All SWMBH personnel, Participant CMHSPs, contracted and subcontracted providers will refrain from conduct that may violate the Medicare and Medicaid anti-kickback, false claims or physician self-referral laws and regulations. A false claim includes the following: billing for services not rendered; misrepresenting services actually rendered; falsely certifying that certain services were medically necessary; or submitting a claim for payment that is inconsistent with or contrary to Medicaid payment requirements. In general, these laws prohibit:
  - Submission of false, fraudulent or misleading claims for payment, the knowing use of a false record or statement to obtain payment on false or fraudulent claims paid by the United States government, or the conspiracy to defraud the United States government by getting a false or fraudulent claim allowed or paid. If the claims submitted are knowingly false or fraudulent then the False Claims Act has been violated;
  - Knowingly and willfully making false representation to any person or entity in order to gain or retain participation in the Medicaid program or to obtain payment for any service from the United States government;

- A physician (or immediate family member of the physician) who has a financial relationship with an entity from referring a Medicaid patient to the entity for the provision of certain “designated health services” unless an exception applies; or an entity from billing an individual, third party payer, or other entity for any designated health services provided pursuant to a prohibited referral; and
- Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application (claim) for benefits or payments under a Federal health care program.

## **SECTION II - CHIEF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE**

SWMBH EO will designate a Chief Compliance Officer (CCO) who reports directly to the SWMBH EO and has direct access to the SWMBH Board of Directors, and who will be given sufficient authority to oversee and monitor the Compliance Plan, including but not limited to the following:

- Recommending revisions/updates to the Compliance Plan, policies, and procedures to reflect organizational, regulatory, contractual and statutory changes.
- Reporting on a regular basis the status of the implementation of the Compliance Plan and related compliance activities.
- Assuring and/or coordinating compliance training and education efforts for SWMBH personnel, Participant CMHSPs and contracted and subcontracted providers.
- Assuring continuing analysis, technical expertise and knowledge transmission of corporate compliance requirements and prepaid health plan performance in keeping with evolving federal requirements and MDHHS contractual obligations and standards.
- Coordinating internal audits and monitoring activities outlined in the compliance work plan.
- Performing or causing to be performed risk assessments, verification audits, and on-site monitoring consistent with the approved annual PIHP compliance work plan(s) intended to reduce the risk of criminal conduct at SWMBH, Participant CMHSPs, contracted and subcontracted providers.
- Ensure coordinating efforts with Human Resources, Provider Network Management, and other relevant departments regarding employee certifications/licensures, background checks, and privileging and credentialing.
- Developing and modifying policy and programs that encourage the reporting of suspected fraud and other potential problems without fear of retaliation.
- Independently investigating and acting on matters related to compliance.
- Drafting and maintaining SWMBH Board and executive reports including annual Compliance Program Evaluation and bi-annual Board compliance reports.

The authority given the CCO will include the ability to review all SWMBH, Participant CMHSP, contracted and subcontracted provider ~~Medicare (specific to the Medicare funds received for participation in the dual eligible demonstration project)~~, Medicaid and

| ~~ABW~~any other SWMBH-managed funding streams



documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records and contracts and obligations of SWMBH, consistent with applicable contract provisions.

SWMBH maintains and charters a Corporate Compliance Committee that oversees the implementation and operation of the SWMBH Compliance Plan. The Corporate Compliance Committee reviews reports and recommendations made by the SWMBH CCO regarding compliance activities. This includes data regarding compliance generated through audits, monitoring, and individual reporting. Based on these reports, the Chief Compliance Officer will make recommendations to the Executive Officer regarding the efficiency of the SWMBH Compliance Plan and program. The Corporate Compliance Committee will be chaired by the CCO and will consist of members appointed by the EO of SWMBH, which can include:

- Executive Officer (EO) of SWMBH or his/her designee;
- Chief Compliance Officer/Privacy Officer;
- Chief Information Officer;
- Member Services Coordinator;
- Director of Performance Improvement Program;
- Directors of Clinical functional areas;
- Chief Administrative Officer;
- Provider Network Manager;
- Chief Financial Officer; and
- Participant CMHSP CEO

**Specific responsibilities of the Corporate Compliance Committee include:**

- Regularly reviewing compliance program policies to ensure they adequately address legal requirements and address identified risk areas;
- Assisting the CCO with developing standards of conduct and policies and procedures to promote compliance with the Compliance Plan;
- Analyzing the effectiveness of compliance education and training programs;
- Reviewing the compliance log for adequate and timely resolution of issues and/or inquiries;
- Assisting the CCO in identifying potential risk areas, advising and assisting the CCO with compliance initiatives, identifying areas of potential violations, and recommending periodic monitoring/audit programs ;
- Assisting in the development of policies to address the remediation of identified problems;
- Receiving, interpreting, and acting upon reports and recommendations from the CCO;
- Evaluating the overall performance of the Compliance Program and making recommendations accordingly; and
- Providing a forum for the discussion of ethical issues related to entity business functions.

### SECTION III - COMPLIANCE TRAINING AND EDUCATION

Proper and continuous training and education of SWMBH personnel at all levels is a significant element of an effective compliance program. Therefore, SWMBH will establish a regular training program consistent with applicable compliance policies that covers the provisions of the Code of Conduct, as well as the processes for obtaining advice and reporting misconduct. Training is provided upon hire for new employees; annual and periodic retraining is provided to existing SWMBH personnel and, as applicable, independent contractors.

SWMBH Board members and personnel will be scheduled to receive SWMBH's compliance program training on the Compliance Plan and Code of Conduct at orientation or within thirty (30) days of employment. Tailored training may be required for employees involved in specific areas of risk and the CCO will coordinate and schedule this as needed and will supplement with training and/or newsletters, e-mails and in-services. Records will be maintained on all formal training and educational activities. Training is considered a condition of employment and failure to comply will result in appropriate disciplinary action.

Upon employment, all SWMBH personnel will be provided a written copy of the Plan; staff signature (Compliance Certification Form Attachment A) acknowledges that the staff received:

- Corporate Compliance Orientation
- A copy of the Code of Conduct
- A copy of the SWMBH Corporate Compliance Plan

The Compliance Certification Forms will be maintained in the Program Integrity and Compliance Office. Modifications to the Plan will be distributed to all personnel after revisions have been approved by the SWMBH Compliance Committee and accepted by the Board of Directors.

A copy of the Plan will be kept on file by the CCO and maintained at SWMBH's corporate office. The SWMBH Corporate Compliance Plan can also be accessed on the shared drive of SWMBH's network, and on the SWMBH Internet Website at [www.swmbh.org](http://www.swmbh.org).

- Initial training: The Chief Compliance Officer shall ensure the scheduling and documentation of initial trainings for all SWMBH personnel regarding SWMBH's Corporate Compliance Plan. Training sessions may include, but are not limited to face-to-face educational presentations or videotapes. Subsequent compliance instruction will occur annually.
- Continuing Education: The CCO shall review and circulate periodic information to the Corporate Compliance Committee regarding any health care fraud issues as received from the Office of Inspector General (OIG), the Department of Health and Human Services (DHHS), and other updated compliance materials. The CCO shall ensure current mandates are instituted in both initial and refresher

education/training that will assist in answering personnel questions related to modifications in either federal or state edicts. Continued compliance training will be documented in electronic format. These training sessions are obligatory, personnel initiated, or instituted upon request of the supervisor. Failure to participate in mandatory training session(s) will result in verbal/written reprimand, suspension, or termination of employment as deemed appropriate by SWMBH's EO. The CCO will be available to all personnel to answer questions regarding modifications of governmental guidelines.

- Regulations: It is the responsibility of SWMBH personnel to maintain job specific certifications and/or licensing requirements, proficiencies, and competencies set forth by the State of Michigan licensing body.

Training and educational opportunities related to compliance may be made available by SWMBH to Participant CMHSPs, contracted and subcontracted provider staff, as well as consumers and others as appropriate. Participant CMHSPs, contracted and subcontracted providers are expected to provide the following minimum compliance training annually to all staff and agents working on their behalf:

- Establish and review policies and procedures that provide detailed information about the Federal False Claims Act;
- Establish and review policies and procedures that provide detailed information about the MI State False Claims Act;
- Review administrative, civil and criminal remedies for false claims and statements under both the Federal and State False Claims Act;
- Establish and review agency policies/procedures relating to prevention of fraud, waste and abuse; and
- Establish and review agency policies and procedures relating to whistleblower provisions and non-retaliation protections.

SWMBH reserves the right to review all compliance related training materials used by Participant CMHSPs covering the elements noted above in order to ensure compliance with contractual requirements.

## SECTION IV - COMPLIANCE REPORTING AND ONGOING COMMUNICATION

All SWMBH Board members and personnel must be familiar with applicable federal and state laws and regulations as well as SWMBH policies and procedures. Any SWMBH Board member and personnel that know, or has reason to believe, that an employee of, or independent professional providing services to, SWMBH is not acting in compliance with federal and state laws and regulations should report such matters to the CCO consistent with the applicable compliance policy. Reporting of suspected violations may be accomplished through a verbal, written, or anonymous report using the following mechanisms:

- SWMBH Telephone Hot Line – Suspected compliance violations or questions can be made to a toll-free hot line. The number is (800) 783-0914 and includes confidential voice mail.
- SWMBH Electronic Mail (E-Mail) – Suspected compliance violations or questions can be sent electronically via e-mail to the [mila.todd@swmbh.org](mailto:mila.todd@swmbh.org) or [swmbhcompliance@swmbh.org](mailto:swmbhcompliance@swmbh.org).
- Mail Delivery – Suspected compliance violations or questions can be mailed to:  
Southwest Michigan Behavioral Health  
Attn: Chief Compliance Officer  
5250 Lovers Lane, Suite 200  
Portage, MI 49002
- In Person - Suspected compliance violations or questions can be made in person to SWMBH's CCO at the above address.

### Whistleblower Protections for SWMBH Personnel

**Employees who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, as more fully described below.**

Under the *Federal False Claims Act* and the *Michigan Medicaid False Claims Act*, employees who report violations in good faith are entitled to protection from disciplinary actions taken by their employer.

The *Federal False Claims Act*, 31 USC §§3729 through 3731, provides for administrative remedies, encourages enactment of parallel State laws pertaining to civil and criminal penalties for false claims and statements, and provides “whistle-blower” protection for those making good faith reports of statutory violations.

Under the *Michigan Medicaid False Claims Act*, an employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding or court action under this act or because the employee cooperates with or assists in an investigation under this act. This prohibition does not apply to an employment action against an employee who the court finds: (i) brought a frivolous claim, as defined in section 2591 of the revised judicature act of 1961, 1961 PA 236, MCL §600.2591; or, (ii) planned, initiated, or participated in the conduct upon

which the action is brought; or, (iii) is convicted of criminal conduct arising from a violation of that act.

An employer who takes action against an employee in violation of the *Michigan Medicaid False Claims Act* is liable to the employee for all of the following:

1. Reinstatement to the employee's position without loss of seniority;
2. Two times the amount of lost back pay;
3. Interest on the back pay;
4. Compensation for any special damages; and,
5. Any other relief necessary to make the employee whole.

Under the *Federal False Claims Act*, any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

Partly because of their status as primary contracted agents performing delegated managed care functions and in order to minimize regional risk and harm, Participant CMHSPs will report suspected compliance issues within three business days or less to the SWMBH Chief Compliance Officer when one or more of the following criteria are met:

- 1) During an inquiry by the Participant CMHSP compliance officer there is determined to be (reasonable person standard) ~~Medicare (for a Duals Demonstration beneficiary) or~~ Medicaid fraud, abuse, or waste as defined by federal statute, CMS, HHS OIG and applicable Michigan statute or regulation; or
- 2) Prior to any self-disclosure to any federal or state of Michigan ~~Medicare (for a Duals Demonstration beneficiary) or~~ Medicaid authority. In no way is this intended to nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations; or
- 3) When a Participant CMHSP knows or (reasonable person standard) suspects that an action or failure to take action in the organization or its contractors would result in the improper application or improper retention of Medicaid funds.

Participant CMHSPs shall undertake fraud, waste and abuse prevention, detection, and surveillance measures per contractual obligations and industry standards.

They are encouraged to independently assure that claims, encounters, other data and financial submissions to SWMBH are complete, accurate and timely on an ongoing basis. They are encouraged to update financial reports and encounter submissions consistent with this approach.

## **SECTION V - COMPLIANCE AUDITING, MONITORING AND RISK EVALUATION**

The SWMBH CCO is responsible for monitoring compliance activities and operations within SWMBH. The CCO must then report any determinations of noncompliance to the Executive Officer, the Corporate Compliance Committee, and SWMBH's Board of Directors. The CCO will identify, interpret and determine standards of compliance through internal audit and monitoring functions and external audits. The CCO shall prepare an Annual Auditing and Monitoring Plan for EO and Corporate Compliance Committee review and input.

Monitoring and Auditing: SWMBH believes that a thorough and ongoing evaluation of the various aspects of SWMBH's Compliance Plan is crucial to its success. In order to evaluate the effectiveness of the Plan, SWMBH will employ a variety of monitoring and auditing techniques, including but not limited to, the following:

- Periodic interviews with personnel within SWMBH, Participant CMHSPs, and contracted and subcontracted providers regarding their perceived levels of compliance within their departments or areas of responsibilities;
- Questionnaires developed to poll personnel within SWMBH, Participant CMHSPs, contracted and subcontracted providers regarding compliance matters including the effectiveness of training/education;
- Information gained from written reports from SWMBH compliance staff utilizing audit and assessment tools developed to track all areas of compliance;
- Audits, both planned and unplanned, designed and performed by internal and/or external auditors utilizing specific compliance guidelines;
- Data mining activities based on identified risk areas, that review data for potential deficiencies;
- Investigations of alleged noncompliance reports as described in SWMBH Compliance Operating Policy 10.8 – *Compliance Reviews—and Investigations for Reporting Responsibilities and Operating Procedure 10.08.02 Compliance Investigations*; and
- Exit interviews with departing SWMBH employees.
- Participant CMHSPs, contracted and subcontracted providers are encouraged to perform auditing and monitoring functions involving ~~Medicare and~~ Medicaid covered services through their own compliance program efforts.

The SWMBH CCO, legal counsel, Corporate Compliance Committee, and as appropriate, other SWMBH personnel will take actions to ensure the following:

- Access to and familiarity with the latest HHS OIG compliance guidelines and

current enforcement priorities; and

- Assessment of the baseline risk of any significant issues regarding non-compliance with laws or regulations in accordance with SWMBH's Compliance Plan.

The CCO is also responsible to ensure a risk assessment is performed annually with the results integrated into the daily operations of the organization.

**SECTION VI - ENFORCEMENT OF COMPLIANCE POLICIES AND STANDARDS**

Corrective action shall be imposed as a means of facilitating the overall SWMBH Compliance Plan goal of full compliance. Corrective action plans should assist SWMBH personnel, Participant CMHSPs, contracted and subcontracted providers to understand specific issues and reduce the likelihood of future noncompliance. Corrective action, however, shall be sufficient to address the particular instance of noncompliance and should reflect the severity of the noncompliance. The following Corrective Action Plan Guidelines are to be used with SWMBH Personnel, Participant CMHSPs, contracted and subcontracted providers:

<u>Violation</u>	<u>Possible Disciplinary Action</u>
Knowingly and willfully committing fraud and/or violation of a federal or state billing or documentation practice(s). Knowingly and willfully providing false or misleading information in a compliance context to SWMBH, governmental agency, consumer or MDHHS. [E.g. billing for services not performed, forging documentation or signatures, upcoding, kickbacks, bribes]	<p>First Offense for SWMBH Personnel: Immediate termination of employment.</p> <p>First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Termination of subcontract or provider contract. All related remuneration and/or funds will be recouped by SWMBH.</p>
Unknowingly violating federal or state billing or documentation practice(s).	<p>First Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon CCO/human resources judgment up to and including: written reprimand for personnel file, mandatory compliance refresher training, individual counseling with manager and Chief Compliance Officer, probation, etc.</p> <p>Second Offense for SWMBH Personnel: Possible/potential disciplinary action as warranted and based upon EO.</p> <p>First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Written notice of noncompliance for contract file, mandatory compliance</p>



	<p>training approved by SWMBH Corporate Compliance Committee or provided by SWMBH CCO, Corrective Action Plan to be submitted to the SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from <del>Medicare—and Medicaid</del>/<u>SWMBH-administered funding streams</u> service provision or administrative activity. All related remuneration and/or funds will be recouped by SWMBH.</p> <p>Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.</p>
<p>Knowingly violating policies and/or procedures as set forth in the Compliance Plan.</p>	<p>First Offense for SWMBH Personnel: Written reprimand for personnel file, individual counseling with manager and Chief Compliance Officer, and placed on 60-day probation.</p> <p>Second Offense for SWMBH Personnel: Unpaid suspension and possible termination.</p> <p>First Offense for Participant CMHSP, Contracted and Subcontracted Providers: Written notice of noncompliance for contract file, Corrective Action Plan to be submitted to SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from <del>Medicare—and Medicaid</del>/<u>SWMBH-administered funding streams</u> service provision or administrative activity.</p> <p>Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.</p>
<p>Detection of, but, failure to report or failure to detect substantive violations of federal and state mandates in duties where a</p>	<p>First Offense for SWMBH Personnel: Written reprimand for personnel file, mandatory compliance refresher training,</p>

<p>reasonable person could be expected to detect violation(s).</p>	<p>individual counseling with manager and Chief Compliance Officer, and placed on 60-day probation.</p> <p>Second Offense for SWMBH Personnel: Suspension and possible termination.</p> <p>First Offense for Participant CMHSP, Contracted or Subcontracted Provider: Written notice of noncompliance for contract file, mandatory compliance training approved by SWMBH Corporate Compliance Committee or provided by SWMBH CCO, Corrective Action Plan to be submitted to SWMBH Corporate Compliance Committee, may be placed on probationary period. Related individual(s) may be barred from <del>Medicare—and Medicaid/SWMBH-administered funding stream</del> service provision or administrative activity.</p> <p>Second Offense for Participant CMHSP, Contracted or Subcontracted Provider: Possible termination of subcontract or contract.</p>
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Basis for Participant CMHSP, Contracted or Subcontracted Provider Corrective Action: Monitoring and auditing, and reports of questionable practices may form the basis for imposing corrective action.

Elements of a Participant CMHSP, Contracted or Subcontracted Provider Corrective Action Plan: As appropriate given the nature of the noncompliance, a corrective action plan submitted to SWMBH for approval shall include:

- A description of how the issue(s) identified was immediately corrected OR the reason the issue(s) cannot be immediately corrected (i.e. the consumer has been discharged).
- A description of the steps to be put into place to prevent the issue(s), or a similar issue(s), from occurring again (i.e. staff training, process redesign, etc.)
- A description of the quality assurance program put into place for monitoring purposes to ensure the corrective action plan is effective and/or similar issues do not occur.

## **SECTION VII - CONFIDENTIALITY AND PRIVACY**

SWMBH is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in the current published Privacy Notice. Any Board member, SWMBH personnel, or contracted or subcontracted provider who engages in unauthorized disclosure of consumer information is subject to disciplinary action which may result in removal from the Board, termination of employment, or termination of the contract.

To ensure that all consumer information remains confidential, SWMBH personnel and contracted and subcontracted providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA privacy regulations outlined below:

- Privacy Notice - SWMBH will have a Notice of Privacy Practices to be given to each consumer at intake and to be further available upon request.
- Consent - Prior to treatment, Participant CMHSPs and contracted and subcontracted providers will obtain a signed consumer consent for permission to treat, bill for and carry out health care operations described in the Privacy Notice.
- Authorization - If consumer Protected Health Information is disclosed to an individual or entity outside of SWMBH, a signed authorization will be obtained from the consumer consistent with the HIPAA Privacy Rule, MI Mental Health Code, and 42 CFR Part 2 requirements.
- Business Associate Agreement – SWMBH will obtain assurances with all Business Associates that protected health care information shared with them, will be protected and appropriately safeguarded consistent with all applicable State and Federal laws and requirements..
- SWMBH shall investigate any reports of suspected violations and respond to findings of the investigations in compliance with the HIPAA Privacy and Security regulations.
- SWMBH will perform any necessary risk analyses or assessments to ensure compliance.

All SWMBH Board members, SWMBH personnel, Participant CMHSPs, and contracted and subcontracted providers must conduct themselves in accord with the principle of maintaining the confidentiality of consumers' information in accordance with all applicable laws and regulations, including but not limited to the Michigan Mental Health Code, the Privacy and Security Regulations issued pursuant to HIPAA and recent updated HITECH revisions, and 42 CFR Part 2 as it relates to substance abuse records. All will refrain from disclosing any personal or confidential information concerning members unless authorized by laws relating to confidentiality of records and protected health information. If specific questions arise regarding the obligation to maintain the confidentiality of information or the appropriateness of releasing information, SWMBH Board members, SWMBH personnel, and Participant CMHSPs should seek guidance from the Chief Compliance Officer/Chief Privacy Officer (the Chief Compliance Officer also fulfills the role of Chief Privacy Officer), or anonymously through the SWMBH corporate compliance hotline at (800) 783-0914.

**SWMBH PERSONNEL COMPLIANCE CERTIFICATION FORM**

- 1) I have received, read and understand the SWMBH Compliance Plan, Code of Conduct, and related policies and procedures.
- 2) I pledge to act in compliance with and abide by the Code of Conduct and SWMBH Compliance Plan during the entire term of my employment and/or contract.
- 3) I acknowledge that I have a duty to report to the Chief Compliance Officer any alleged or suspected violation of the Code of Conduct, agency policy, or applicable laws and regulations.
- 4) I will seek advice from my supervisor or the Chief Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct or Compliance Plan.
- 5) I understand that failure to comply with this certification or failure to report any alleged or suspected violation of the Code of Conduct or Compliance Plan may result in disciplinary action up to and including termination of employment or contract.
- 6) I agree to participate in any future compliance trainings as required and acknowledge my attendance at such trainings as a condition of my continued employment/contract.
- 7) I agree to disclose the existence and nature of any actual or potential conflict of interest to the Chief Compliance Officer. Further, I certify that I am not aware of any current, undisclosed conflicts of interest.

\_\_\_\_\_  
Employee/Provider/Contractor Signature

\_\_\_\_\_  
Date

**SWMBH BOARD OF DIRECTORS COMPLIANCE CERTIFICATION FORM**

- 1) I have received, read and understand the SWMBH Compliance Plan and Code of Conduct.
- 2) I pledge to act in compliance with and abide by the Code of Conduct and SWMBH Compliance Plan during the entire term of my Board service.
- 3) I acknowledge that I have a duty to report to the SWMBH Chief Compliance Officer any alleged or suspected violation of the Code of Conduct or related laws and regulations by myself, another Board Member or any other person.
- 4) I will seek advice from the SWMBH Board Chairman or the SWMBH Chief Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct or Compliance Plan.
- 5) I understand that failure to comply with any part of this certification may result in my removal from the Board of Directors.
- 6) I agree to participate in future Board compliance trainings as required
- 7) I agree to disclose the existence and nature of any actual or potential conflict of interest to the Board Chairman and Chief Compliance Officer. Further, I certify that I am not aware of any current, undisclosed conflicts of interest.

Board Member Signature \_\_\_\_\_

Date \_\_\_\_\_

**SWMBH FY2025 Payment Integrity and Clinical Quality Audit and Monitoring Plan**  
**October 1, 2024 - September 30, 2025**

The SWMBH FY2025 Payment Integrity Auditing and monitoring plan, monitors services delivered by CMHSPs as well as contracted service providers to assess compliance with applicable Federal and State billing rules, applicable contracts, and SWMBH policies and procedures. The reviews are also designed to monitor and detect deficiencies in business processes used for coverage determinations and claims adjudication. The Audit and Monitoring Plan focuses on review of services that fall under the following business lines: Medicaid, Healthy Michigan, SED Waiver, SAPT Block Grant and P.A.2 funds both in Fee-for-Service claims and net cost contract formats.

	<b>Audit Topic</b>	<b>Audit Mechanism</b>	<b>Known Risks and/or Purpose of Audit</b>	<b>Frequency of Audits</b>	<b>Responsibility</b>
<b>1</b>	<p><b>Medicaid Services Verification Claims Review</b>  <b>CONTRACT REQUIREMENT:</b> FY25 Section C.4 Medicaid Services Verification</p>	<p>Review Medicaid covered services using the Medicaid Services Verification Review Tool. Tool will identify those items for which scores will be reported to the State. Reviews CMHSP provided services, CMHSP subcontracted provider services, and SUD services paid for utilizing Medicaid funds, for documentation and claims/payment accuracy.</p>	<p>1) Required through PIHP/MDHHS contract; 2) Procedures prescribed by MDHHS Technical Advisory; and 3) Additional elements added to address known risk areas (overlapping billing, IOP, etc.).</p>	<p>Quarterly audit (based on Fiscal Year Quarters) consisting of a sample for CMHSPs of 15 internal services and 15 external services. CMHSP sampling universes will be stratified to remove the top external providers and top hospital providers that will be independently audited. Audit will consist of a sample of 30 dates of service from SUD providers collectively (stratified to remove any SUD provider that is also a top external provider and to include only 10 methadone dosing claims), 15 dates of service for each of the top three hospital providers (by dollar figure), 30 dates of service for each of the top three external providers (by dollar figure), 30 dates of service for the top SWMBH-contracted fee-for-service SUD provider, and a 60 date of service sample for the remaining providers in the region. Samples pulled utilizing sampling specifications consistent with the OIG Self Reporting Protocol.</p>	<p>SWMBH Program Integrity &amp; Compliance</p>
<b>2</b>	<p><b>Block Grant FFS Claims</b></p>	<p>Review of Block Grant Fee-for-Service claims including ATP process.</p>	<p>1) SWMBH Organizational Risk Assessment identified very minimal oversight of Block Grant funding stream; 2) Past findings concerning ATP process.</p>	<p>Quarterly sample of 60 DOS for SUD services paid via Block Grant funds. Audit will ensure: Customer eligibility, Block Grant used as last resort, ATP completed, client Medicaid application, Collection of ATP prior to billing SWMBH, valid Treatment plan, and service documentation.</p>	<p>SWMBH Program Integrity &amp; Compliance</p>

**SWMBH FY2025 Payment Integrity and Clinical Quality Audit and Monitoring Plan**  
**October 1, 2024 - September 30, 2025**

	<b>Audit Topic</b>	<b>Audit Mechanism</b>	<b>Known Risks and/or Purpose of Audit</b>	<b>Frequency of Audits</b>	<b>Responsibility</b>
3	<b>Block Grant Captitated CMH</b>	Review of Block Grant Captitated CMH claims including ATP process.	1) SWMBH Organizational Risk Assessment identified very minimal oversight of Block Grant funding stream; 2) Past findings concerning ATP process; 3) Captitated CMHs' have not been audited on their Block Grant/ATP process	Quarterly sample of 30 DOS for SUD services paid via Block Grant funds. Audit will ensure: Customer eligibility, Block Grant used as last resort, ATP completed, client Medicaid application, Collection of ATP prior to billing SWMBH, valid Treatment plan, and service documentation.	SWMBH Program Integrity & Compliance
4	<b>Net cost Contract Review</b>	Review of SUD Net Cost Contracts - review to include FSR (financial status reports) and Data Template review, SWMBH work plan included with contracts, and supporting documentation from Provider as necessary.	1) Previous SWMBH Organizational Risk Assessment identified need for Funding Stream Oversight; 2) Financial audit requirements	Quarterly monitoring of •Staffing Costs •Supplied and Materials •Sub-Contracts •Documentation for invoicing/payments •Data Reporting	SWMBH Program Integrity & Compliance & SWMBH Finance
5	<b>Coordination of Benefits audit</b>	Audit of SUD providers to ensure that Coordination of Benefits occurs when a client has both commercial and Medicaid insurance.	Required to ensure that SWMBH is the payor of last resort when a client has commercial insurance.	Quarterly review of 30 claims to ensure Medicaid is the payor of last resort. Ensure EOB is accurate and the Medicaid payment is secondary to the primary insurance payment.	SWMBH Program Integrity & Compliance
6	<b>CCBHC Monitoring</b>	tbd	tbd		SWMBH Program Integrity & Compliance
7	<b>SUD Health Home (SUDHH) Monitoring (formerly Opioid Health Home)</b>	Audit of SUDHH (S0280) payable claims to ensure SUDHH requirements are being met and business processes followed.	New program not currently monitored for compliance with authorization, service documentation and claim submission processes.	Quarterly audit (based on Fiscal Year Quarters) consisting of a sample of payable S0280 (SUDHH) claims. Ensure appropriate authorization is in place, review Care Plan and service documentation to ensure SUDHH requirements are met. Tool in development (9.5.24)	SWMBH Program Integrity & Compliance

The SWMBH FY2025 Payment Integrity Data Mining Plan, monitors services delivered by CMHSPs as well as contracted service providers to assess compliance with applicable Federal and State billing rules, applicable contracts, and SWMBH policies and procedures. The data-mining scenarios reviewed and described below are developed to address known risks or deficiencies as identified by routine audits and monitoring, investigations, OIG referrals and OIG workplans.

	<b>Audit Topic</b>	<b>Audit Mechanism</b>	<b>Known Risks and/or Purpose of Audit</b>	<b>Frequency of Audits</b>	<b>Responsibility</b>
1	<b>Potential Duplicate Claims</b>	Review of Tableau Report which pulls data if all of the following are the same: Medicaid ID, Date of Service, Provider Name, Code+Modifier(s), Place of Service Code & Units	To ensure claims are not inappropriately or inadvertently duplicated. To ensure that per diem/day codes are reported only once/day. To ensure codes with DT limits are not over-reported. Also informs if Providers are utilizing inappropriate codes for reporting encounters.	Quarterly reports are run to review any risk that has occurred within the areas of identified concern. Claim corrections, recoupments and/or CAPs can be requested when issues are discovered.	SWMBH Program Integrity & Compliance
2	<b>Day of Discharge Billing</b>	Review of Tableau Report which pulls data if a H0018, H0010 or H0019 claim has the same date as the BHTeds Discharge for that customer and provider.	The Day of Discharge is not billable for SUD Residential/Detox providers.	Quarterly reports are run to review any risk that has occurred within the areas of identified concern. Claim corrections, recoupments and/or CAPs can be requested when issues are discovered.	SWMBH Program Integrity & Compliance
3	<b>Inappropriate Overlapping Claims</b>	Review of Tableau Report which pulls data if the same Medicaid ID receives a per diem or bundled service and a disallowed overlapping service on the same date, regardless of provider.	Per MDHHS: The per diem and bundled codes used by the CMH system and SUD residential services are inclusive of all the services in the service code description. Additional services provided must not replace those services that are part of the bundle/code.	Quarterly reports are run to review any risk that has occurred within the areas of identified concern. Claim corrections, recoupments and/or CAPs can be requested when issues are discovered.	SWMBH Program Integrity & Compliance



4	<b>Services After Death</b>	Review of Tableau Report which pulls: data from a customer's BHTeds "Discharge Date" when the discharge reason is "death"; "Death Date" as reported by the CMH when there are services/encounters reported after the Death Date. Report will show the first service date after death and how many services have been reported.	To ensure customer death data is accurate and no services are being paid/reported for dates after the reported death date.	In development	SWMBH Program Integrity & Compliance
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The SWMBH FY2025 Clinical Quality Audit and Monitoring Plan reviews services delivered by CMHSPs as well as contracted service providers to assess compliance with applicable Federal and State billing and licensing rules, applicable contracts, and SWMBH policies and procedures. The reviews are also designed to monitor and detect deficiencies in business processes, documentation, and scope of care.

	Audit Topic	Audit Mechanism	Known Risks and/or Purpose of Audit	Frequency of Audits	Responsibility
1	<b>SUD Site Review (Administrative &amp; Clinical)</b>	Annual review of SUD Providers, including CMHSP SUD Providers, including an administrative review and a clinical file review of services paid for utilizing Medicaid, Healthy Michigan Plan (HMP), and Block Grant funds.	1) Past audit findings through SWMBH.	Sample size is 5% with a minimum of 8 files and a maximum of 20 records. If multiple sites, files to be reviewed from each site. SUD clinical to determine focus population(s) and review entire scope of care (not DOS specific).	SWMBH Provider Network and SWMBH Clinical Quality/SUD Department
2	<b>Inpatient Psychiatric Hospital Services Review (Administrative &amp; Clinical)</b>	Administrative and Clinical review of inpatient psychiatric services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds.	1) Services have been subject to minimal review in the past and are a high cost service; 2) Review pursuant to the PIHP Statewide Provider Monitoring - Inpatient Protocol under the Statewide Reciprocity Agreement; 3) Claims/coding/payment/COB accuracy due to past audit findings regarding coding accuracy & documentation sufficiency.	SWMBH Clinical Quality working with Statewide Reciprocity Workgroup re: Inpatient Review methodology, and working with CMHSP PNM/RR officers re: responsibility for auditing inpatient providers physically located within Region 4. Review will utilize approved Inpatient Protocol.	Coordinated by SWMBH Provider Network/Clinical Quality for entire Region pursuant to the PIHP Statewide Inpatient Reciprocity protocol
3	<b>Crisis Residential Services Review (Administrative &amp; Clinical)</b>	Administrative and Clinical review of crisis residential services paid for utilizing Medicaid and Healthy Michigan Plan (HMP) funds.	1. Administrative oversight and monitoring as well as Clinical quality and adherence to the standards outlined in the Medicaid Provider Manual.	Annual sample size of 5% of staff for each provider with a minimum of 8 clinical files. Clinical sample size is 5% or no less than 8 files, staff file sample size is 5% or no less than 5 files. If multiple sites, files to be reviewed from each site. Provider Network with stratify within Universe to determine focus areas. Not DOS specific, rather review will focus on entire scope of care.	SWMBH Provider Network Management & SWMBH Clinical Quality
4	<b>Annual CMHSP Site Review (Administrative &amp; Clinical)</b>	Administrative and Clinical review of functions delegated to participant CMHSP related to Medicaid and Healthy Michigan Plan (HMP) funds.	1) Title 42: Public Health PART 438—MANAGED CARE Subpart D—MCO, PIHP and PAHP Standards  \$438.230 Sub contractual relationships and delegation	Sample size is 5% with a minimum of 8 files and a maximum of 20 records. If multiple sites, files to be reviewed from each site. Clinical Quality/SUD determine focus population and review entire scope of care (not DOS specific).	SWMBH Provider Network, SWMBH Clinical Quality, and SWMBH SUD Departments
5	<b>Autism Provider Reviews (Administrative &amp; Clinical)</b>	Annual review of ABA Providers, including an administrative review and brief clinical review for State of Michigan quality metrics.	1. Administrative oversight and monitoring as well as Clinical quality and adherence to the standards outlined in the Medicaid Provider Manual.	Minimum of 8 files. Clinical Quality to determine necessity if additional files are needed. If multiple sites, files to be reviewed from each site. Provider Network will stratify within Universe to determine focus areas. Not DOS specific, rather review will focus on entire scope of care.	SWMBH Provider Network Management & SWMBH Clinical Quality
6	<b>Fiscal Management Services Administrative Review</b>	Annual administrative review of regional FMA providers utilizing Medicaid and Healthy Michigan Plan (HMP) funds.	1. Administrative oversight and monitoring including training and HR functions for Self-D staff.	Minimum of one sampled Self-D consumer and one sampled Self-D staff for each contracting CMH.	SWMBH Provider Network Management



Section: <b>Provider Network Management</b>	Policy Name: <b>Credentialing &amp; Re-Credentialing: Behavioral Health Practitioners</b>	Policy Number: <b>02.02</b>
Owner: <b>Chief Compliance &amp; Privacy Officer</b>	Reviewed By: <b>Mila Todd</b>	Total Pages: <b>10</b>
Required By: <input checked="" type="checkbox"/> <b>BBA</b> <input checked="" type="checkbox"/> <b>MDHHS</b> <input type="checkbox"/> <b>Other (please specify):</b> _____	Final Approval By:  <b>Approved by SWMBH Board</b>	Date Approved:
Application: <input checked="" type="checkbox"/> <b>SWMBH Staff/Ops</b> <input checked="" type="checkbox"/> <b>Participant CMHSPs</b> <input checked="" type="checkbox"/> <b>SUD Providers</b> <input checked="" type="checkbox"/> <b>MH/IDD Providers</b> <input type="checkbox"/> <b>Other (please specify):</b> _____	Line of Business: <input checked="" type="checkbox"/> <b>Medicaid</b> <input type="checkbox"/> <b>Other (please specify):</b> _____ <input checked="" type="checkbox"/> <b>Healthy Michigan</b> <input checked="" type="checkbox"/> <b>SUD Block Grant</b> <input checked="" type="checkbox"/> <b>SUD Medicaid</b> <input checked="" type="checkbox"/> <b>MI Health Link</b>	Effective Date: <b>1/1/14</b>

**Policy:** Southwest Michigan Behavioral Health (SWMBH), its participant Community Mental Health Service Providers (CMHSP), and network organizational providers with contractual credentialing responsibilities will ensure the credentialing and re-credentialing of behavioral health practitioners whom they employ, contract with, and who fall within their scope of authority. The credentialing process will be completed in compliance 42 CFR 422.204 and MDHHS Credentialing and Recredentialing standards. Practitioners may not provide care for SWMBH members until they have been credentialed in accordance with this policy.

SWMBH and its participant CMHSPs will not discriminate against any provider solely on the basis of race, ethnic/national identity, gender, age, sexual orientation, licensure, registration or certification. SWMBH and its participant CMHSPs will not discriminate against health care professionals who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

**Purpose:** To ensure that all customers receiving services within the SWMBH Region receive care from practitioners who are properly credentialed, licensed and/or qualified.

**Scope:** SWMBH Provider Network  
Management Participant CMHSPs  
Network Providers

**Responsibilities:** SWMBH Provider Network Management, Participant CMHSPs, and network providers must follow the below requirements as it relates to practitioner credentialing activities.



## **Definitions:**

- A. **Practitioner:** A professional who provides health care services within the scope of practice that he/she is legally authorized to do so by the State in which he or she delivers the services.

## **Standards and Guidelines:**

### **A. Practitioner Types Requiring Credentialing**

1. Credentialing will be completed for all practitioners as required by this policy and all applicable Michigan and Federal laws. Specifically, the following types of practitioners will be credentialed:
  - a. Physicians (M.D.s or D.O.s)
  - b. Physician Assistants
  - c. Psychologists (Licensed, Limited License, and Temporary License),
  - d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
  - e. Licensed Professional Counselors
  - f. Board Certified Behavior Analysts
  - g. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
  - h. Occupational Therapists and Occupational Therapist Assistants
  - i. Physical Therapists and Physical Therapist Assistants
  - j. Speech Pathologists
  - k. Licensed Marriage and Family Therapists
  - l. Other behavioral healthcare specialists licensed, certified, or registered by the State

### **B. Timeframes for Credentialing and Re-Credentialing Individual Practitioners**

1. Initial credentialing of individual practitioners applying for inclusion in the SWMBH network must be completed within 90 calendar days.
  - a. The 90-day timeframe starts when SWMBH or the participant CMHSP has received a completed, signed and dated credentialing application from the individual practitioner.
  - b. The completion time is the date written communication is sent to the individual practitioner notifying them of SWMBH or the participant CMHSP's decision.
  - c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. Re-credentialing shall occur at least every two (2) years.

### **C. Initial Credentialing Process**

1. Practitioners requesting inclusion in the SWMBH provider network will complete the current SWMBH Individual Practitioner Credentialing Application, with signed and dated attestations regarding:
  - a. lack of present illegal drug use;
  - b. history of loss of license, registration, certification, and/or any felony convictions;
  - c. any history of loss or limitation of privileges or disciplinary action;
  - d. accuracy and completeness of information in the application;
  - e. ability to perform the essential functions of the position with or without accommodation; and



f. consent allowing verification of license, education, competence and any other related information.

2. Credentialing staff will verify information obtained in the credentialing application as described below. Copies of verification sources will be maintained in the practitioner credentialing file. When source documentation is not electronically dated, staff will initial and date with the current date.

3. Credentialing criteria for physicians and practitioners, and verification methods, are as follows:

Credentialing Criteria	Verification Method(s)
Current valid and unrestricted license to practice in the state in which the practitioner practices	<ul style="list-style-type: none"> <li>• Verification of the license will be made directly with state licensing agency internet web site (LARA website for the state of Michigan <a href="http://w3.lara.state.mi.us/free/">http://w3.lara.state.mi.us/free/</a>)</li> </ul>
A valid and unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) for those practitioners who prescribe medication.	<ul style="list-style-type: none"> <li>• A DEA or CDS may be verified by a copy of the DEA or CDS certificate provided by the practitioner, with the state licensing agency via internet website, or the National Information Service (NTIS) database.</li> </ul>
(If a practitioner's DEA certificate is pending, the practitioner may make arrangements with a participating practitioner to write all prescriptions requiring a DEA number until the practitioner has a valid DEA certificate and the practitioner will provide documentation of such arrangement in writing.)	
Work history for the past five years, with each gap in work history of six (6) months or more clarified in writing from the practitioner.	<ul style="list-style-type: none"> <li>• Work history is verified through practitioner's credentialing application.</li> <li>• Gaps in work history of six (6) months or more must be explained in writing.</li> </ul>

<p>Board certification, or education appropriate to license and area of practice.</p>	<ul style="list-style-type: none"> <li>• Verification of education shall be completed through primary source verification to the educational institution or certification board. Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education. If a practitioner is not board certified, verification of the medical education at the highest level is verified.</li> <li>• The American Medical Association (AMA) or American Osteopathic Association (AOA) Master Files may be used as the source for education verification for physicians.</li> <li>• The Educational Commission for Foreign Medical Graduates (ECFMG) may be used to verify education of foreign physicians educated after 1986 (for practitioners who are not board certified and verification of completion of a residency program or graduation from a foreign medical school are not verifiable with the primary source).</li> <li>• LARA license may be used in lieu of official transcript of graduation form an accredited school.</li> </ul>
<p>Current professional liability insurance meeting the standards defined by contract.</p>	<ul style="list-style-type: none"> <li>• Copy of current certificate of insurance.</li> </ul>

Credentialing Criteria	Verification Method(s)
No malpractice lawsuits and/or judgments or settlements from within the last five (5) years.	<ul style="list-style-type: none"> <li>• A query to the National Practitioner Data Bank (NPDB) will be completed via web-based access to the NPDB site for each practitioner. The NPDB query contains malpractice history which was reported by malpractice carriers to the NPDB.</li> <li>• A written description of any malpractice lawsuits and/or judgments from the last five (5) years will be provided either by the practitioner or their malpractice carrier.</li> </ul>
The practitioner must not be excluded from participation in Medicare, Medicaid, or other federal contracts, and is not excluded from participation through the MDHHS Sanctioned Provider list.	<ul style="list-style-type: none"> <li>• Queries will be made to the System for Award Management (SAM), the Office of Inspector General (OIG), and the MDHHS Sanctioned Provider list to ensure that practitioners have not been suspended or debarred from participation with Medicare, Medicaid or other Federal contracts (initial credentialing).</li> <li>• Queries will be made monthly thereafter as part of on-going monitoring and for re-credentialing purposes.</li> </ul>
No state sanctions or restrictions on licensure in the past ten (10) years.	<ul style="list-style-type: none"> <li>• Verification of the license will be made directly with state licensing agency internet web site (LARA website for the state of Michigan <a href="http://w3.lara.state.mi.us/free/">http://w3.lara.state.mi.us/free/</a>)</li> </ul>

**D. Re-credentialing Process.**

1. Re-credentialing will be completed at least every two (2) years. The Credentialing Committee may recommend re-credentialing for a lesser period of time.
2. Every practitioner will complete or update the current SWMBH Practitioner Credentialing Application and related materials required for the re-credentialing process. Additionally, the practitioner will provide the relative information supporting any changes in their credentials. The application will be processed by the credentialing staff.
3. Re-credentialing criteria and application processing includes review of the re-credentialing application for completeness and accuracy. Primary source verification and re-credentialing criteria for physicians and practitioners is as previously outlined in Section C.3. above, with the exception of the following:
  - a. Education, Training and Work History: Education and Training are considered ‘static’ and no re-verification is conducted during re-credentialing. However, work history may change and will be re-verified.
  - b. Board Certification will be re-verified.
  - c. The practitioner is required to sign and date the attestation statement attesting to the



- correctness and completeness of the application. The practitioner is required to sign any relevant addenda concerning the following:
- i. the reasons for inability to perform essential functions,
  - ii. lack of present illegal drug use,
  - iii. history of loss of license,
  - iv. history of loss or limitation of privileges,
  - v. current malpractice coverage that was not provided with the re-credentialing application and signed attestation.
- d. Quality information and member complaint data will be considered at re-credentialing. This includes but is not limited to grievances and appeals, recipient rights complaints, customer services complaints, and compliance-related issues including fraud/waste/abuse.
- e. To ensure quality and safety of care between credentialing cycles, SWMBH performs on-going monitoring of the following, in accordance with SWMBH Policy 2.18:
- i. Member complaints, adverse events, and information from quality improvement activities related to identified instances of poor quality,
  - ii. Any incidences of Medicaid and Medicare sanctions and,
  - iii. Restrictions and/or sanctions on licensure and/or certification.

#### **E. Temporary/Provisional Credentialing Process**

1. Temporary or provisional status can be granted one time to practitioners until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.

#### **2. Timeframes.**

- a. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below.
- b. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.
- c. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.

#### **3. Requirements.**

- a. Providers seeking temporary or provisional status must complete and sign the current approved SWMBH Practitioner Credentialing Application, including attestations regarding:
  - i. Lack of present illegal drug use;
  - ii. History of loss of license, registration, certification, and/or felony convictions;
  - iii. Any history of loss or limitation of privileges or disciplinary action;
  - iv. The accuracy and completeness of the application.
- b. SWMBH and/or participant CMHSPs shall perform verification from primary sources of:
  - i. Current valid license or certification, in good standing.
  - ii. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
  - iii. Official transcript of graduation from an accredited school and/or LARA license.





- iv. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
    - a. Minimum five (5) year history of professional liability claims resulting in a judgment of settlement;
    - b. Disciplinary status with regulatory board or agency; and
    - c. Medicare/Medicaid sanctions and exclusions.
  - v. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.
- c. SWMBH/Participant CMHSPs shall evaluate the individual practitioner's work history for the prior five (5) years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
4. SWMBH/Participant CMHSPs shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

**F. Credentialing Reciprocity (Deemed Status).**

1. **Out of Region.** SWMBH and its participant CMHSPs may accept credentialing activities conducted by any other Region in lieu of completing its own credentialing activities. If SWMBH chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the SWMBH/Participant CMHSP credentialing file.
2. **In Region.** SWMBH and its participant CMHSPs shall work collaboratively to reduce the burden on shared network providers (providers that contract with two or more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/recredentialing through a single participant CMHSP or SWMBH, and that those credentialing/recredentialing results are shared with the Region.
3. **Reciprocity Procedure.** When accepting credentialing activities performed by another Region or another in-Region entity, SWMBH and its participant CMHSPs shall follow the SWMBH Procedure 02.03.01 – Credentialing Reciprocity.



### **G. Practitioner Right for Request for Review**

1. The Applicants Rights for Credentialing and Re-credentialing will be included in the initial credentialing packet sent to Applicants applying to be providers in the SWMBH provider network.
2. Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact the credentialing staff via telephone, in writing or email as to the status of their application.
3. Applicants have the right to review the information submitted in support of their credentialing application. This review is at the applicant's request. The following information is excluded from a request to review information:
  - a. Southwest Michigan Behavioral Health is not required to provide the applicant with information that is peer-review protected.
  - b. Information reported to the National Practitioner Data Bank (NPDB).
  - c. Criminal background check data.
4. Should the information provided by the applicant on their application vary substantially from the information obtained and/or provided to SWMBH/participant CMHSPs by other individuals or organizations contacted as part of the credentialing and/or re-credentialing process, credentialing staff will contact the applicant within 180 days from the date of the signed attestation and authorization statement to advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is erroneous.
5. The applicant will submit any corrections in writing within fourteen (14) calendar days to the credentialing staff. Any additional documentation will be date stamped and kept as part of the applicant's credentialing file.

### **H. Credentialing Decisions**

1. Credentialing decisions shall be made in accordance with SWMBH policies 02.02 (Clean Credentialing & Re-Credentialing Files) and 02.05 (Credentialing Committee, Confidentiality of Credentialing Records, & Provider Nondiscrimination). Practitioners not selected for inclusion in the network will be given written notice of the reason for the decision.
2. SWMBH and/or participant CMHSPs shall notify an individual practitioner that is denied credentialing or re-credentialing of the reason(s) for the adverse credentialing decision in writing within thirty (30) days of the decision. This written adverse credentialing decision notification must include information on the appeal process available to the practitioner, in accordance with SWMBH Policy 2.14.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

### **I. Reporting Requirements.**

#### **1. Routine.**

- a. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.



b. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS-PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.

**2. Ad hoc.**

a. Participant CMHSPs shall promptly report to SWMBH's Director of Provider Network information about an organizational provider which could result in suspension or termination from the SWMBH network, including but not limited to:

- i. Known improper conduct (e.g. fraud, threats to member health and safety, etc.);
- ii. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13;
- iii. Any other information that may affect the practitioner's status as a SWMBH network provider.

b. SWMBH shall report any known improper conduct of an individual practitioner which could result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, AG, provider's governing board, etc.).

**Procedures:** 02.03.01 Credentialing Reciprocity

**Effectiveness Criteria:** N/A

**References:** 42 CFR § 438.214 (a-e)

MDHHS-PIHP Contract Schedule A, Section 1(N)(1)

MDHHS BPHASA Credentialing and Recredentialing Processes

Public Act 218 as amended by Act 59 section 400.734b

42 FR 422.204

SWMBH Policy 2.18

SWMBH Policy 10.13

**Attachments:** 02.02A Applicant Credentialing Rights



**Revision History**

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	5/10/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
5	01/10/20	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
6	09/28/21	Paragraph G	Added Reporting Requirements	Mila Todd
7	11/12/21	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board
8	02/14/23	Multiple	Revised entire policy to be consistent with updated MDHHS Credentialing Process.	Mila Todd
9	03/17/23	N/A	Reviewed by Regional PNM Committee.	Mila Todd
10	10/13/23	N/A	Annual Board approval as required per MDHHS contract	Mila Todd & SWMBH Board



Section: <b>Provider Network Management</b>	Policy Name: <b>Credentialing &amp; Re-Credentialing: Organizational Providers</b>	Policy Number: <b>02.03</b>
Owner: <b>Director of Provider Network Management</b>	Reviewed By: <b>Mila Todd</b>	Total Pages: <b>8</b>
Required By: <input checked="" type="checkbox"/> <b>BBA</b> <input checked="" type="checkbox"/> <b>MDHHS</b> <input type="checkbox"/> <b>Other (please specify):</b> _____	Final Approval By:  <b>Approved by SWMBH Board</b>	Date Approved:
Application: <input checked="" type="checkbox"/> <b>SWMBH Staff/Ops</b> <input checked="" type="checkbox"/> <b>Participant CMHSPs</b> <input checked="" type="checkbox"/> <b>SUD Providers</b> <input checked="" type="checkbox"/> <b>MH/IDD Providers</b> <input type="checkbox"/> <b>Other (please specify):</b> _____	Line of Business: <input checked="" type="checkbox"/> <b>Medicaid</b> <input type="checkbox"/> <b>Other (please specify):</b> <input checked="" type="checkbox"/> <b>Healthy Michigan</b> _____ <input checked="" type="checkbox"/> <b>SUD Block Grant</b> <input checked="" type="checkbox"/> <b>SUD Medicaid</b> <input checked="" type="checkbox"/> <b>MI Health Link</b>	Effective Date: <b>1/1/14</b>

**Policy:** Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (CMHSPs) will credential and re-credential behavioral health organizational providers with whom they contract and that fall within their scope of authority and action. Neither SWMBH nor its participant CMHSPs will discriminate against any provider solely on the basis of licensure, registration or certification. Neither SWMBH nor its participant CMHSPs will discriminate against health care professionals or organizations who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

**Purpose:** To ensure that all customers served receive care from organizational providers that are properly credentialed, licensed and/or qualified.

**Scope:** SWMBH Provider Network Management  
Participant CMHSPs  
Network Providers

**Responsibilities:** SWMBH Provider Network Management, participant CMHSPs, and network providers will follow the requirements listed herein as it relates to credentialing.

**Definitions:** Organizational provider: An entity that directly employs and/or contracts with individuals to provide health care services. Examples of organizational providers include, but are not limited to, community mental health services programs (CMHSPs); hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance use disorder programs; and home health agencies



## **Standards and Guidelines:**

### **A. Process for Credentialing and Re-Credentialing Organizational Providers**

1. Initial credentialing of all organizational providers applying for inclusion in the SWMBH network must be completed within 90 calendar days.
  - a. The 90-day time frame starts when SWMBH or the participant CMHSP has received a completed, signed and dated credentialing application from the organizational provider.
  - b. The completion time is the date when written communication is sent to the organizational provider notifying them of SWMBH or the participant CMHSP's decision.
  - c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. During initial credentialing and at re-credentialing, SWMBH or participant CMHSPs will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding the inclusion on the SWMBH Provider Network. Packets will be reviewed for completeness prior to committee meeting. If files meet clean file criteria in every category listed, the medical director or designee may sign off to approve the provider, in lieu of taking to Credentialing Committee.
3. During initial credentialing and at re-credentialing, SWMBH and its participant CMHSPs will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision, the organizational provider will be notified of the reason(s) in writing and of their right to and process for appealing/disputing the decision in accordance with SWMBH Policy 2.14.

### **B. Organizational Provider Assignments**

1. SWMBH is responsible for credentialing/recredentialing the following organizational provider types, on behalf of the Region:
  - a. Substance Use Disorder
  - b. Psychiatric Inpatient
  - c. Crisis Residential
  - d. Autism Services
  - e. Financial Management Services
  - f. Specific Specialized Residential service providers as determined by the Regional Provider Network Management Committee
2. Participant CMHSPs are responsible for credentialing/recredentialing all other organizational provider types for inclusion in each participant CMHSP subcontracted network of providers.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

### **C. Requirements for Credentialing and Re-Credentialing Organizational Providers**

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require organizational providers wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application.
2. The application will contain the following:



- a. A signed and dated statement from an authorized representative.
- b. Documentation collected and verified for organizational providers will include (as applicable), but are not limited to, the following information:

Documentation Requirement	Clean File Criteria
Complete application with a signed and dated statement from an authorized representative of the organizational provider attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization for SWMBH or CMHSP to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure or certification information. License/certification status and any violations or special investigations thereof incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license/certification violations and no special state investigations in timeframe (in past five years for initial credentialing and past two years for re-credentialing).
Accreditation by a national accrediting body (if such accreditation has been obtained). Substance abuse treatment providers are required to be accredited. If an organization is not accredited, an on-site quality review will occur by SWMBH or CMHSP provider network staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction for an on-site pre-credentialing site review. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, NCQA, CHAPS, COA, and AOA.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgments from within the last five (5) years.
Verification that the organization and any individuals listed as a "Screened Person" under SWMBH Policy 10.13 have not been excluded from participation in Medicare, Medicaid, or other Federal contracts, and are not excluded from participation through the MDHHS Sanctioned Provider list.	<p>Organization and its "Screened Persons" are not listed as sanctioned and/or excluded by the OIG, the System for Award Management (SAM), or the Michigan Sanctioned Provider list (for initial credentialing).</p> <p>Queries will be made monthly thereafter as part of on-going</p>



	monitoring and for re-credentialing. Provider and its Screened Persons must not have been listed as excluded during any month since the prior credentialing activity (re-credentialing).
A copy of the organization’s liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.
Any other information necessary to determine if the organization meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of organization.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals, recipient rights, and customer services complaints are within the expected threshold given the provider size; there are no substantiated fraud; MMBPIS and other performance indicators substantially meet set standards (if applicable).

**D. Temporary/Provisional Credentialing Process**

- a. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.
- b. **Timeframes.**
  - i. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below.
  - ii. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.
  - iii. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.
- c. **Requirements.**
  - i. Providers seeking temporary or provisional status must complete the current approved SWMBH Organizational Credentialing Application, signed and dated by an authorized representative.
  - ii. SWMBH and/or Participant CMHSPs shall perform verification from primary sources of:
    - 1. Current valid license or certification and in good standing as necessary to operate in the State of





Michigan.

2. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following:
  - a. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement; and
  - b. Disciplinary status with regulatory board or agency.
3. Medicare/Medicaid sanctions (OIG, SAM, and Michigan Sanctioned Provider lists)
- iii. SWMBH and/or Participant CMHSPs shall evaluate the organizational provider's continuing operation as a provider for the prior five (5) years. Gaps in operation of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
- d. SWMBH/Participant CMHSPs shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

**E. Credentialing Reciprocity (Deemed Status).**

- a. **Out of Region.** SWMBH and its participant CMHSPs may accept credentialing activities conducted by any other Region in lieu of completing its own credentialing activities. If SWMBH chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the SWMBH/Participant CMHSP credentialing file.
- b. **In Region.** SWMBH and its participant CMHSPs shall work collaboratively to reduce the burden on shared network providers (providers that contract with two or more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/recredentialing through a single participant CMHSP or SWMBH, and that those credentialing/recredentialing results are shared with the Region.
- c. **Reciprocity Procedure.** When accepting credentialing activities performed by another Region or another in-Region entity, SWMBH and its participant CMHSPs shall follow the SWMBH Procedure 02.03.01 – Credentialing Reciprocity.

**F. Site Reviews and Quality Assessments**

- a. Initial Credentialing.
  - i. On-site reviews must be performed prior to initial credentialing/contracting for the following:
    1. Non-accredited organizational providers that are not solely community-based; and
    2. Specialized Residential sites (homes).
      - a. The Specialized Residential parent organization's accreditation does not eliminate the requirement for an on-site review of each specialized residential site (home).
  - ii. For solely community-based providers (e.g. ABA or CLS in private residences), an on-site review is not required. An alternative quality assessment shall be performed in lieu of an on-site review. The alternative quality assessment shall be performed prior to initial credentialing/contracting.
  - iii. SWMBH and its participant CMHSPs may accept on-site reviews performed by another Region as part of Credentialing Reciprocity.
- b. Re-credentialing



- i. The most recent annual site review/monitoring results shall be reviewed during the re-credentialing process.
- ii. The following information will be reviewed as part of the Quality checks during recredentialing:
  1. Grievances and appeals;
  2. Recipient Rights complaints;
  3. Customer Services complaints;
  4. Compliance-related issues including fraud/waste/abuse;
  5. If applicable, status of MMBPIS and other performance indicators.
- iii. SWMBH and its participant CMHSPs will perform on-going monitoring of network providers in accordance with SWMBH Policy 2.18 – Ongoing Monitoring of Network Practitioners and Organizations.

**G. Organizational Provider credentialing of its direct employees and contractors.**

- a. Organizational providers may be held responsible for credentialing and re-credentialing their direct employees and subcontracted professional service providers per SWMBH or SWMBH participant CMHSP contractual requirements.
- b. Organizational providers shall maintain written credentialing/re-credentialing policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements.
- c. Organizational providers shall perform credentialing/re-credentialing activities in accordance with applicable contractual requirements, SWMBH policies and procedures, MDHHS policies and procedures, and any other applicable requirements.
- d. SWMBH or a participant CMHSP shall verify through annual on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

**H. Reporting Requirements.**

- a. **Routine.**
  - i. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.
  - ii. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS-PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.
- b. **Ad hoc.**
  - i. Participant CMHSPs shall promptly report to SWMBH's Director of Provider Network information about an organizational provider which could result in suspension or termination from the SWMBH network, including but not limited to:
    1. known improper conduct (e.g. fraud, threats to member health and safety, etc.);
    2. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13;
    3. Any other information that may affect the organizational provider's status as a SWMBH network provider.
  - ii. SWMBH shall report any known improper conduct of an organizational provider which could



result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, MI AG, provider's governing board, etc.).

**Procedures:** SWMBH Operating Procedure 2.03.01 Credentialing Reciprocity

**Effectiveness Criteria:** N/A

**References:**

MDHHS-PIHP Contract Schedule A, Section 1(N)(1)  
MDHHS BPHASA Credentialing and Re-Credentialing Processes  
BBA § 438.214  
SWMBH Policy 2.18

**Attachments:**

2.03A SWMBH Organizational Credentialing Application  
2.03B SWMBH Organizational Credentialing Checklist



**Revision History**

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	12/1/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
5	01/10/20	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
6	09/28/21	Paragraph E	Added Reporting Requirements	Mila Todd
7	11/12/21	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
8	02/10/23	Multiple	Revised entire policy to ensure alignment with revised MDHHS Credentialing Policy, and to add specificity around Quality checks and Reciprocity process.	Mila Todd
9	03/17/23	N/A	Reviewed by Regional PNM Committee	Mila Todd
10	10/13/23	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board



## Summary of State Fiscal Year 2024 – HSAG Validation of Performance Measures for Region 4

**Result – Very favorable outcome achieved. All items were marked met and reportable. Items identified from previous year’s audit have been corrected. Small number of new items to work on were recommended along with the two strengths of collaboration and process improvement across all of the CMHSPs and continued improvement in data quality.**

**Purpose** - The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements.

### Methods of Data Collection and Analysis

1. Information Systems Capabilities Assessment Tool (ISCAT)
2. Source code (programming language) for performance indicators
3. Performance indicator reports
4. Supporting documentation

### Rating of Acceptable for:

1. Data Integration – the steps used to combine data sources such as claims, encounters, eligibility and administrative data
2. Data Control – Sound quality assurance practices and backup procedures
3. Performance Indicator Documentation - ISCAT, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance indicator calculations, and other related documentation

### Indicator-Specific Review Findings and Designations for SWMBH

Based on all validation activities, HSAG determined results for each performance indicator was Reportable meaning indicator was compliant with the State’s specifications and the rate can be reported.

1. Data Integration and Control Findings
2. Accuracy of data transfers to assigned performance indicator data repository
3. Accuracy of file consolidations, extracts, and derivations
4. If the PIHP uses a performance indicator data repository, its structure and format facilitate any required programming necessary to calculate and report required performance indicators.
5. Assurance of effective management of report production and of the reporting software.
6. Denominator Validation Findings for SWMBH
7. Numerator Validation Findings for SWMBH

### Strengths, Opportunities for Improvement, and Recommendations

**Strength #1: SWMBH** continued to demonstrate strength in its collaboration and process improvements across all of the CMHSPs. Through committee meetings, process improvement trainings, and Power Business Intelligence dashboard checks and balances, **SWMBH** has continued its efforts to ensure

standardization of CMHSP data entry that supports accurate performance indicator reporting while providing the PIHP with the ability to readily monitor CMHSP performance. [Quality, Timeliness, and Access]

**Strength #2: SWMBH** continues to see an improvement in data quality as all delegated CMHSPs work in the same PCE-based EHR system, which includes extensive data controls and validation steps. [Quality]

**Weakness #1:** During PSV, multiple CMHSPs' indicator #2e cases were identified as erroneously reported as an expired requests, including one Barry case, one Berrien case, one **SWMBH** SUD case, and three Pines cases. [Quality]

**Weakness #2:** During PSV, HSAG identified one Berrien indicator #10 case that was incorrectly reported as an exception because the provided documentation did not support the case being considered an exception. [Quality]

**Weakness #3:** During HSAG's review of member-level data, HSAG identified a misalignment between the member-level detail data counts and Michigan's Mission-Based Performance Indicator System (MMBPIS) reporting to MDHHS as follows:

- Indicators #2a and #2 total—The member-level data count was 405 for the number of new persons completing the biopsychosocial assessment within 14 calendar days or at first request for service but the final report count was 404, which impacted the total count in the final report.
- Indicator #4a adults—The member-level data count for the number of discharges that were exceptions was 210, that number of net discharges was 326, and the number of discharges followed up by the CMHSP/PIHP within seven days was 315. The final report count was 211, 325, and 314, respectively.

[Quality]

**Weakness #4:** During PSV, HSAG identified that one indicator #4b case was incorrectly reported as compliant when in fact the case should have been reported as an exception, because the member left the facility against medical advice (AMA). [Quality]

**Weakness #5: SWMBH's** indicator #3 total rate fell below the 50th percentile benchmark. [Quality and Timeliness]

**Assessment of Network Adequacy Data,  
Methods and Results**

**Findings For: Region 4: Southwest Michigan Behavioral Health (SWMBH)  
Reporting Year: 2024**

<b>Standard Type</b>	<b>Total "Met" elements</b>	<b>Total "Not Met" elements</b>	<b>Score</b>	<b>Validation Rating</b>
PIHP-Time and Distance-Behavioral Health	19	0	100	High confidence

# Ends Development Process and Result

Presented by Sue Radwan  
Policy Governance Consultant  
October 11, 2024



# Board Ends Define a Value System and Guide Operational Choices

The Board's role in policy making is to be *the informed voice and agent of the ownership*.

- The Board has engaged in ownership linkage to better understand the values held by the ownership entities AND integrate those values into policy.
- Ends policies should be a result of discerning those values expressed.

**Ends policies define the intended impacts on the beneficiaries of the organization.**

- Ends answer the questions of (1) What good do we exist to create? (2) For whom? (3) At what worth to the organization?
- Ends are NEVER about the organization itself . . . They are about the impact to the beneficiaries of the organization.

The broad global End is an umbrella to lower level ends which further define impacts contained in the global End language.

# The Role of Ends

- **Ends direct the operational organization from a “mission” perspective. The Board holds the CEO accountable to achieve a reasonable interpretation of Ends and comply with a reasonable interpretation of Executive Limitations.**
- Policy EO-002 Monitoring the Executive Officer Performance  
The Executive Committee, (Chair, Vice Chair, and Secretary), will take data and information from the bulleted documents below upon which the annual performance of the EO will be evaluated. **The overall evaluation consists of compliance with Executive Limitations Policies, Ends Interpretation and Ends Monitoring reports and supporting documentation...**

# Recap of the Ends Development Process

- May 2023 - Collective Ownership by 8 CMH Boards and SWMBH
- July 2023 – Audit of Policy Manual
- August 2023 – Ownership Linkage and Ends Development
- September 2023 – Ownership Linkage Process and Questions for individual CMH “focus groups”
- October 2023-May 2024 – Ownership Linkage Information Gathering
- June 2024 – Draft 1 of Revised Ends Presented
- June- September 2024 Ownership Comment Period on Revised Ends
- October 2024-Proposed Final Draft of Ends for Board Consideration and Approval

# Proposed Final Draft of SWMBH Ends Revision

Global End: As a benefits manager of state and federal funds, SWMBH exists to assure that member agencies and providers create sustainable programs and provide specialty services so that persons in the SWMBH region have access to appropriate resources and experience improvements in their health status and quality of life, optimizing self-sufficiency, recovery, and family preservation. Quality services are provided while minimizing costs through efficient stewardship of human, financial, and technology resources available and use of shared knowledge.

1. Member CMH boards, EOs, and staff value the partnership with SWMBH, and experience the relationship as collaborative, transparent, responsive, **and reciprocal**.
2. Member CMHs are aware of environmental disruptors and trends and benefit from SWMBH's regional and statewide regulatory and public relations advocacy impacting the Mental Health Community.
3. Member CMHs have the resources needed to address their communities' individualized needs, successfully access appropriate resources and successfully meet contractual obligations (*including managed care functions*).
4. Member CMHs and other providers assure and monitor ready access to appropriate programs and services for their consumers and contribute accurate data so SWMBH can create aggregated, comprehensive, and comparative regional results which supports access to maximum funding available.
5. The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.

## **SWMBH Proposed Boards Ends revised based on CMH Boards Recommendations**

**Susan Radwan, Policy Governance Consultant**

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## **SWMBH Proposed Boards Ends revised based on CMH Boards Recommendations**

### **SWMBH bylaws**

Purpose: The Regional Entity is formed for the purpose of carrying out the provisions of the Mental Health Code in the Service Area as they relate to: serving as a prepaid inpatient health plan, as defined in 42 CFR 438.2 (“PIHP”), to manage the Medicaid Specialty Support and Services Concurrent 1915(b)/(c) Waiver Programs (“Medicaid”) and the Michigan ABW NON-Pregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration program (“ABW”); ensuring a comprehensive array of services and supports as provided in the PIHIP Medicaid and ABW contracts with MDCH; and exercising the powers and authority set forth in these Bylaws. Additional purposes may be added by the Regional Entity Board.

### **Process**

September 2023: Board Ends Development Plan presented to SWMBH Board

October 2023 – May 2024: Ownership linkage activities including written communication from CMH Boards and Susan Radwan facilitating discussion with CMH Boards.

June 2024: Proposed Boards Ends presented to SWMBH Board and subsequently sent to CMH Boards for feedback.

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**SOUTHWEST MICHIGAN BEHAVIORAL HEALTH**

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**TO: BOARD**  
**FROM: BRAD**  
**SUBJECT: MCHE**  
**DATE: 10/11/24**

Regarding SWMBH's membership in Michigan Consortium for Healthcare Excellence

Request & Proposed Motion

*To continue SWMBH membership in MCHE through November 2025.*

MCHE is a Michigan non-profit membership corporation of/for PIHPs transitioned from Michigan Association of Coordinating Agencies (CAs) in 2014/2015 when CAs were ceased by DHHS and the statutory CA roles given to PIHPs. Since its founding MCHE has served as vehicle for favorable pricing group purchasing most recently contracting with Wakely an actuarial firm, for MCG utilization management criteria guidelines and TBD Solutions contracting for quality assurance management reporting technical assistance. MCHE carries an active agency and Officers & Directors insurance policy. There are no dues imposed on members by MCHE. The MCHE Bylaws, semi-annual EO Report on MCHE and Board Policy BEL-010 Report are also included in this month's Board packet.

# *Southwest Michigan*

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## B E H A V I O R A L H E A L T H

<b>Section:</b> Board Policy – Executive Limitations		<b>Policy Number:</b> EO-002	<b>Pages:</b> 2
<b>Subject:</b> Monitoring of Executive Officer Performance		<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH EO			<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 03.14.14	<b>Last Review Date:</b> 11.10.23	<b>Past Review Dates:</b> 07.11.2014, 03.13.15, 05.13.16 11.11.16, 11.10.17, 11.9.18, 10.11.19, 11.13.20, 11.12.21, 11.11.22	

**I. PURPOSE:**

To ensure Executive Officer performance is monitored and evaluated.

**II. POLICY:**

Monitoring Executive Officer, EO, performance is synonymous with monitoring organizational performance against Board policies on Ends and on Executive Limitations. Any evaluation of EO performance, formal or informal, may be derived from these monitoring data.

**III. STANDARDS:**

Accordingly,

1. The purpose of monitoring is to determine the degree to which Board policies are being fulfilled. Information that does not do this will not be considered to be monitoring.
2. A given policy may be monitored in one or more of three ways; with a balance of using all of the three types of monitoring:
  - a. Internal report: Disclosure of compliance information to the Board from the Executive Officer.
  - b. External report: Discovery of compliance information by a disinterested, external auditor, inspector or judge who is selected by and reports directly to the Board. Such reports must assess Executive Officer performance only against policies of the Board, not those of the external party unless the Board has previously indicated that party’s opinion to be the standard.
  - c. Direct Board inspection: Discovery of compliance information by a Board Member, a Committee or the Board as a whole. This is a Board inspection of documents, activities or circumstances directed by the Board which allows a “prudent person” test of policy compliance.
3. Upon the choice of the Board, any policy can be monitored by any method at any time. For regular monitoring, however, each Ends and Executive Limitations policy will be classified by the Board according to frequency and method.
  - a. Internal



- b. External
  - c. Direct Inspection
4. Each November the Board will have a formal evaluation of the EO. This evaluation will consider monitoring data as defined here and as it has appeared over the calendar year.
  5. The Executive Committee, (Chair, Vice Chair, and Secretary), will take data and information from the bulleted documents below upon which the annual performance of the EO will be evaluated. The overall evaluation consists of compliance with Executive Limitations Policies, Ends Interpretation and Ends Monitoring reports and supporting documentation, (as per the Board developed schedule), and follow through on Board requests, (what we ask for in subsequent meetings and what we want to see on the agendas). For the performance review the following should be documents given the Executive Committee at least one month prior, (October), to the Board EO evaluation, (November).
    - Minutes of all meetings
    - Ends Monitoring reports for the past year along with the Ends Interpretation for each Ends Monitoring report
    - Any supporting Ends documentation
    - Ends Monitoring Calendar
    - Other policies monitoring calendar

# *Southwest Michigan*

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## BEHAVIORAL HEALTH

<b>Section:</b> Board Policy – Governance		<b>Policy Number:</b> BG-001	<b>Pages:</b> 1
<b>Subject:</b> Committee Structure		<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input checked="" type="checkbox"/> SWMBH Governance Board <span style="margin-left: 150px;"><input type="checkbox"/> SWMBH EO</span>			<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 03.14.2014	<b>Last Review Date:</b> 5/10/24	<b>Past Review Dates:</b> 3.13.15, 3/11/16, 3/10/17, 3/9/18, 1/11/19, 1/10/20, 1/8/21, 1/14/22, 4/14/23	

I. **PURPOSE:**

To define a SWMBH Board Committee.

II. **POLICY:**

A committee is a Board Committee only if its existence and charge come from the Board, regardless whether Board Members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

III. **STANDARDS:**

1. The Board will charge the committee formed.

**Executive Limitations  
Monitoring to Assure Executive Performance  
Board Meeting October 11, 2024**

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**Policy Number: BEL-002**  
**Policy Name: Financial Conditions**  
**Assigned Reviewer: Louie Csokasy**

**Purpose:** The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the Board's Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

**Policy:** With respect to the actual, ongoing condition of the organization's financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from Board priorities established in policies.

EO Response: This report addresses fiscal year 2023, October 1, 2022 to September 30, 2023. As expected, any material exceptions noted after September 30, 2023 to close of current year would be provided to the Board regardless of the reporting period.

**Standards: Accordingly, the EO may not;**

1. Expend more funds than have been received in the fiscal year to date, (including carry forward funds from prior year), unless the Board's debt guideline is met.

EO Response: *SWMBH has not expended more funds than have been received for the reviewed fiscal year.*

*In fiscal year 2023, October 1, 2022 to September 30, 2023, SWMBH received gross revenues, (all types), of \$378,937,003 million. Expenses during the period, (all types), were \$377,506,371 million and a favorable difference of \$1,430,632 million.*

*Please see 2023 Financial Audit as presented to the Board in June for a detailed breakdown by contract/business line/funding streams. Recall that Medicaid and Medicaid-Healthy Michigan are entitlements with cost settled risk contracts with MDHHS. Substance Abuse Prevention, Treatment Block Grant and PA2 are not entitlements and are funded on a reimbursement basis and do-not-exceed grant contract from MDHHS.*

2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.

EO Response: *SWMBH has incurred no debt obligations.*

3. Use any designated reserves other than for established purposes.

EO Response: *No designated reserve funds, (Internal Service Fund), have been used for any purpose other than that mentioned above. SWMBH has no other contractual or Board-designated reserves.*

4. Conduct interfund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.

EO Response: *No interfund shifting has occurred outside these parameters.*

5. Fail to settle payroll and debts in a timely manner.

EO Response: *Payroll has been paid in a timely manner as evidenced by payroll run reports and absence of staff complaints related thereto. Accounts Payable payment policy is 30 days. All invoices received and deemed accurate for payment were paid within this period, on average 2,200 invoices a year.*

6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.

EO Response: *Tax payments and other government-ordered payments tax returns have been timely and accurately filed. Tax filings are available upon request.*

7. Fail to adhere to applicable Generally Acceptable Accounting standards.

EO Response: *Per CFO all monthly financial statements were prepared and presented in accordance with accepted accounting principles. This was verified by external auditors via their clean opinion.*

8. Make a single purchase or commitment of greater than \$100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.

EO Response: *No single purchase or commitment of greater than \$100,000 has occurred between October 1, 2022 and September 30,*

*2023. The EO interprets “purchase or commitment” as acquisition of a product or service which excludes a termination clause.*

9. Purchase or sell real estate in any amount absent Board authorization.

*EO Response: No real estate has been purchased. No real estate is owned.*

10. Fail to aggressively pursue receivables after a reasonable grace period.

*EO Response: Receivables include payments from MDHHS which are routine transmissions to us on a regular MDHHS-defined schedule. Immaterial receivables stem from contracts with other agencies who are invoiced promptly and pay promptly.*

Materials available for Review: Fiscal Year 2023 External Audit and Financial Statements (provided at the September 13, 2024 Board meeting).

Mr. Csokasy was invited to contact the CEO and/or CFO, to request additional materials, or set a phone or live meeting to discuss.

Enclosures:

- 2023 Audited Financial Statements
- July 31, 2024 Financials

# Southwest Michigan

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## BEHAVIORAL HEALTH

<b>Section:</b> Board Policy – Executive Limitation		<b>Policy Number:</b> BEL-002	<b>Pages:</b> 2
<b>Subject:</b> Financial Conditions		<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH Executive Officer (EO)			<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 02.14.14	<b>Last Review Date:</b> 10.13.23	<b>Past Review Dates:</b> 10.12.14, 02.13.15, 5.13.16, 5.12.17, 6.8.18; 6.14.19, 06.12.20, 7.9.21, 11.11.22	

**I. PURPOSE:**

The Executive Officer shall not cause or allow financial planning for any fiscal year or the remaining part of any fiscal year to deviate materially from the board’s Ends priorities, risk financial jeopardy, or fail to be derived from a budget plan.

**II. POLICY:**

With respect to the actual, ongoing condition of the organization’s financial health, the Executive Officer may not cause or allow the development of fiscal jeopardy or the material negative deviation of actual expenditures from board priorities established in policies and inclusive of annual budget.

**III. STANDARDS:**

Accordingly, the Executive Officer may not:

1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year).
2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with Board approved schedule.
3. Use any designated reserves other than for established purposes.
4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.
5. Fail to settle payroll and debts in a timely manner.
6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.
7. Fail to adhere to applicable generally acceptable accounting standards.

8. Make a single purchase or commitment of greater than \$100,000 in a fiscal year, except for participant CMH contracts and Region 4 Clinical Service Providers. Splitting orders to avoid this limit is not acceptable.
9. Purchase or sell real estate in any amount absent Board authorization.
10. Fail to aggressively pursue receivables after a reasonable grace period.

# *Southwest Michigan*

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## B E H A V I O R A L H E A L T H

<b>Section:</b> Board Policy		<b>Policy Number:</b> EO-003	<b>Pages:</b> 1
<b>Subject:</b> Emergency EO Succession		<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input checked="" type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH EO			<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 06.13.2014	<b>Last Review Date:</b> 10.13.23	<b>Past Review Dates:</b> 11.14.14, 9.11.15, 9.9.16, 11.11.16, 11.10.17, 10.12.18, 11.8.19, 11.13.20, 10.8.21, 8.12.22	

I. **PURPOSE:**

In order to protect the Board from sudden loss of Executive Officer services.

II. **POLICY:**

In order to protect the Board from sudden loss of the Executive Officer services, the Executive Officer will have no less than two executives identified to the Board sufficiently familiar with Board and Executive Officer issues and processes to enable them to take over with reasonable proficiency as an interim Executive Officer if called upon by the Board.



**Board Policy review for compliance  
10/11/24**

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**Policy Number: EO-003**

**Policy Name: Emergency Executive Officer Succession**

**Policy Purpose:** In order to protect the Board from sudden loss of the Executive Officer services, the Executive Officer will have no less than two executives identified to the Board sufficiently familiar with Board and Executive Officer issues and processes to enable them to take over with reasonable proficiency as an interim Executive Officer if called upon by the Board.

EO Response

I have previously named and hereby rename Mila Todd Chief Compliance Officer & Provider Network Director and Anne Wickham Chief Administrative Officer as two persons sufficiently familiar with Board and Executive Officer issues and processes to enable them to take over with reasonable proficiency as an interim Executive Officer if called upon by the Board.

Mila regularly attends the Board and Operations Committee. Both Mila and Anne are deeply and broadly familiar with Board and Executive Officer issues and processes. I meet regularly with them together and separately and involve them early and deeply in emerging strategy and issues.

**SWMBH Board  
Executive Limitations  
Monitoring to Assure Executive Performance  
Board Date October 11, 2024  
V 10/2/24**

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**Policy Number: BEL-010**

**Policy Name: Regional Entity 501 (c) 3 Representation**

**Review Period November 2023 September 2024**

**Assigned Reviewer: Sherii Sherban**

**PURPOSE**

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership.

**II. POLICY**

1. The SWMBH Board has approved SWMBH becoming a Member of MCHE; and
2. The EO of SWMBH is hereby authorized to serve as SWMBH's representative and a Director of the MCHE Board, the latter being subject to the approval of the Members of MCHE in accordance with its Bylaws; and
3. The EO is hereby authorized and directed to execute and deliver any and all instruments, certificates, agreements, and other documents necessary for SWMBH to hold a membership interest in MCHE; and
4. The SWMBH Board will evaluate on at least an annual basis in October of each year whether SWMBH will continue to hold a membership interest in MCHE or withdraw from such membership. **<See Board Agenda item 7.c.>**

**III. STANDARDS**

Accordingly, the Executive Officer as SWMBH representative to MCHE shall:

1. Provide semi-annual written MCHE status reports to the SWMBH Board in April and October.

EO Response: The EO presented written MCHE reports to the Board in April and October of 2024.

2. Provide verbal reports to the SWMBH Board if there are items of importance which in the Executive Officer's judgment materially affect favorably or unfavorably SWMBH's core roles, strategy, or finances.

EO Response: There were no items of these types during this Policy review period.

- Present MCHE Articles of Incorporation revisions to the Board prior to voting on them.

EO Response: There were no MCHE Articles of Incorporation revisions during this Policy review period.

- Present MCHE Bylaws revisions to the Board prior to voting on them and after the adoption of them by MCHE Board.

EO Response: There were no MCHE Bylaws revisions during this Policy review period.

- Assure that total direct annual costs payable to MCHE shall not exceed \$5,000 absent prior official approval of the Board except for group purchases which in the EO's judgement are required and have more favorable terms though MCHE than an independent purchase by SWMBH.

EO Response: The costs payable to MCHE were within the above Policy parameters i.e., all were group purchases with more favorable terms than an independent purchase by SWMBH; see detail below prepared by SWMBH finance team.

<u>5/24/2023</u>	<u>MCHE Wakely</u>	<u>8,290.64</u>
<u>8/25/2023</u>	<u>MCHE MCG</u>	<u>47,580.12</u>
<u>7/25/2023</u>	<u>MCHE Insurance</u>	<u>175.30</u>
1/23/2024	MCHE TBD Solutions	8,878.67
<u>9/30/2024</u>	<u>MCHE MCG</u>	<u>41,485.21</u>
<u>9/30/2024</u>	<u>MCHE Insurance</u>	<u>172.11</u>
	Total	\$106,582.05

**Motion Requested: The Executive Officer is in compliance with this Policy and no revisions to the Policy are necessary.**

Materials Provided to Ms. Sherban

April 2024 MCHE Update  
November 2023 MCHE Member Annual Report  
MCHE Bylaws

# Southwest Michigan

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## B E H A V I O R A L H E A L T H

<b>Section:</b> Board Policy – Executive Limitations		<b>Policy Number:</b> BEL-010	<b>Pages:</b> 1
<b>Subject:</b> Regional Entity 501 (c)(3) Representation		<b>Required By:</b> Policy Governance	<b>Accountability:</b> SWMBH Board
<b>Application:</b> <input checked="" type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH EO			<b>Required Reviewer:</b> SWMBH Board
<b>Effective Date:</b> 02.13.2015	<b>Last Review Date:</b> 11/10/23	<b>Past Review Dates:</b> 2.13.15, 3.11.16, 10.14.16, 10.13.17, 10.12.18, 11.8.19, 12.11.20, 11/12/21, 11/11/22	

**I. PURPOSE:**

To define the SWMBH Executive Officer role and responsibilities in conjunction with SWMBH MCHE membership.

**II. POLICY:**

1. The SWMBH Board has approved SWMBH becoming a member of MCHE; and
2. the EO of SWMBH is hereby authorized to serve as SWMBH’s representative and a Director of the MCHE Board, the latter being subject to the approval of the Board Members of MCHE in accordance with its Bylaws; and
3. the EO is hereby authorized and directed to execute and deliver any and all instruments, certificates, agreements, and other documents necessary for SWMBH to hold a membership interest in MCHE; and
4. the SWMBH Board will evaluate on at least an annual basis in October of each year whether SWMBH will continue to hold a membership interest in MCHE or withdraw from such membership.

**III. STANDARDS:**

Accordingly, the Executive Officer as SWMBH representative to MCHE shall:

1. Provide semi-annual written MCHE status reports to the SWMBH Board in April and October; and
2. Provide verbal reports to the SWMBH Board if there are MCHE related items of importance which in the Executive Officer’s judgment materially affect favorably or unfavorably SWMBH’s core roles, strategy, or finances; and
3. Present MCHE Articles of Incorporation revisions to the Board prior to voting on them; and
4. Present MCHE Bylaws revisions to the Board prior to voting on them and also after the adoption of them by MCHE Board; and
5. Assure that total direct fiscal year annual costs payable to MCHE shall not exceed \$5,000, absent prior official approval of the Board except for group purchases which in the EO’s judgement are required and have more favorable terms through MCHE than an independent purchase by SWMBH. In the event of an urgent payment required, EO shall contact SWMBH Board Chair for guidance.

	A	B	C	D	E	F	G	H	I	J	K	L
1	<b>Southwest Michigan Behavioral Health</b>											
2	<b>MEDICAID Summary Income Statement</b>											
3	For the Fiscal YTD Period Ended 8/30/2024											
4		<b>Total Region</b>	<b>SWMBH Central</b>	<b>CMH Participants</b>	<b>Barry CMHA</b>	<b>Berrien CMHA</b>	<b>Pines Behavioral</b>	<b>Summit Pointe</b>	<b>Woodlands Behavioral</b>	<b>Integrated Services of Kalamazoo</b>	<b>Pivotal of St. Joseph</b>	<b>Van Buren MHA</b>
5												
6		<b>Medicaid Specialty Services</b>										
7	Contract Revenue	\$ 234,932,864	\$ 22,327,176	\$ 212,605,688	\$ 9,685,212	\$ 40,870,559	\$ 11,601,066	\$ 39,006,147	\$ 13,943,198	\$ 61,006,608	\$ 13,918,164	\$ 22,574,734
8	Budget v Actual	\$ 17,536,587	\$ (2,494,215)	\$ 20,030,802	\$ 1,820,079	\$ 3,202,845	\$ 2,007,875	\$ 4,529,125	\$ 929,370	\$ 4,986,868	\$ 2,145,665	\$ 408,975
9	% Variance - Fav / (Unfav)	8.1%	-10.0%	10.4%	23.1%	8.5%	20.9%	13.1%	7.1%	8.9%	18.2%	1.8%
10												
11	Healthcare Cost	\$ 229,866,539	\$ 11,062,141	\$ 218,804,398	\$ 7,389,503	\$ 40,729,692	\$ 11,613,864	\$ 37,724,628	\$ 16,051,282	\$ 64,716,697	\$ 15,778,622	\$ 24,800,110
12	Budget v Actual	\$ (25,380,804)	\$ (859,351)	\$ (24,521,454)	\$ (1,479,269)	\$ (2,536,287)	\$ (2,241,140)	\$ (8,684,308)	\$ (440,471)	\$ (2,206,050)	\$ (4,238,533)	\$ (2,695,396)
13	% Variance - Fav / (Unfav)	-12.4%	-8.4%	-12.6%	-25.0%	-6.6%	-23.9%	-29.9%	-2.8%	-3.5%	-36.7%	-12.2%
14	<b>MLR</b>	97.8%	49.5%	102.9%	76.3%	99.7%	100.1%	96.7%	115.1%	106.1%	113.4%	109.9%
15												
16	Managed Care Administration	\$ 25,619,046	\$ 5,765,098	\$ 19,853,948	\$ 622,661	\$ 4,061,530	\$ 742,200	\$ 4,174,030	\$ 1,267,143	\$ 5,488,797	\$ 1,454,382	\$ 2,043,204
17	Budget v Actual	\$ (934,649)	\$ 429,422	\$ (1,364,071)	\$ 532,124	\$ (933,616)	\$ 330,211	\$ 264,261	\$ (11,187)	\$ (1,220,743)	\$ (619,699)	\$ 294,579
18	% Variance - Fav / (Unfav)	-3.8%	6.9%	-7.4%	46.1%	-29.8%	30.8%	6.0%	-0.9%	-28.6%	-74.2%	12.6%
19	<b>ACR</b>	10.0%	2.3%	7.8%	7.8%	9.1%	6.0%	10.0%	7.3%	7.8%	8.4%	7.6%
20												
21	Total Contract Cost	\$ 255,485,585	\$ 16,827,240	\$ 238,658,346	\$ 8,012,164	\$ 44,791,222	\$ 12,356,064	\$ 41,898,658	\$ 17,318,425	\$ 70,205,494	\$ 17,233,004	\$ 26,843,315
22	Budget v Actual	\$ (26,315,453)	\$ (429,928)	\$ (25,885,525)	\$ (947,145)	\$ (3,469,903)	\$ (1,910,929)	\$ (8,420,047)	\$ (451,659)	\$ (3,426,793)	\$ (4,858,232)	\$ (2,400,817)
23	Variance - Favorable / (Unfavorable)	-11.5%	-2.6%	-12.2%	-13.4%	-8.4%	-18.3%	-25.2%	-2.7%	-5.1%	-39.3%	-9.8%
24												
25												
26	Net before Settlement	\$ (20,552,722)	\$ 5,499,936	\$ (26,052,658)	\$ 1,673,048	\$ (3,920,663)	\$ (754,998)	\$ (2,892,511)	\$ (3,375,227)	\$ (9,198,886)	\$ (3,314,840)	\$ (4,268,581)
27	Budget v Actual	\$ (8,778,866)	\$ (2,924,143)	\$ (5,854,723)	\$ 872,935	\$ (267,058)	\$ 96,945	\$ (3,890,922)	\$ 477,711	\$ 1,560,075	\$ (2,712,567)	\$ (1,991,843)
28	Variance - Favorable / (Unfavorable)	-74.6%	-34.7%	-29.0%	109.1%	-7.3%	11.4%	-389.7%	12.4%	14.5%	-450.4%	-87.5%
29	Note: HMP Savings can be applied to Medicaid cost savings or ISF											within +/- 2%
30	Date: 9/27/2024											>2% favorable
31												between -2&-4%
32												>4% unfavorable

	A	B	C	D	E	F	G	H	I	J	K	L
33	<b>Southwest Michigan Behavioral Health</b>											
34	<b>HEALTHY MICHIGAN Summary Income Statement</b>											
35	For the Fiscal YTD Period Ended 8/30/2024											
36		<b>SWMBH</b>	<b>CMH</b>							<b>Integrated</b>		
37	<b>Total Region</b>	<b>Central</b>	<b>Participants</b>	<b>Barry CMHA</b>	<b>Berrien CMHA</b>	<b>Pines Behavioral</b>	<b>Summit Pointe</b>	<b>Woodlands Behavioral</b>	<b>Services of Kalamazoo</b>	<b>Pivotal of St. Joseph</b>	<b>Van Buren MHA</b>	
38	<b>Healthy Michigan Plan (HMP)</b>											
39	Contract Revenue	\$ 31,536,448	\$ 11,620,210	\$ 19,916,238	\$ 972,085	\$ 3,778,216	\$ 847,263	\$ 4,114,816	\$ 1,533,313	\$ 4,695,447	\$ 1,505,454	\$ 2,469,644
40	Budget v Actual	\$ (13,019,880)	\$ 8,121,832	\$ (21,141,713)	\$ (964,831)	\$ (4,612,008)	\$ (822,517)	\$ (3,547,918)	\$ (1,471,153)	\$ (7,021,803)	\$ (1,168,583)	\$ (1,532,899)
41	% Variance - Fav / (Unfav)	-29.2%	232.2%	-51.5%	-49.8%	-55.0%	-49.3%	-46.3%	-49.0%	-59.9%	-43.7%	-38.3%
42												
43	Healthcare Cost	\$ 32,244,173	\$ 12,090,074	\$ 20,154,099	\$ 721,581	\$ 3,018,608	\$ 969,873	\$ 5,305,506	\$ 1,868,866	\$ 4,245,590	\$ 1,502,844	\$ 2,521,231
44	Budget v Actual	\$ (297,035)	\$ 576,362	\$ (873,397)	\$ 221,506	\$ (528,507)	\$ (183,933)	\$ (203,972)	\$ (901,122)	\$ (577,219)	\$ 1,031,320	\$ 268,529
45	% Variance - Fav / (Unfav)	-0.9%	4.6%	-4.5%	23.5%	-21.2%	-23.4%	-4.0%	-93.1%	-15.7%	40.7%	9.6%
46	<b>MLR</b>	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
47												
48	Managed Care Administration	\$ 3,015,077	\$ 717,646	\$ 2,297,431	\$ 60,803	\$ 464,158	\$ 110,968	\$ 720,683	\$ 154,635	\$ 360,075	\$ 197,939	\$ 228,170
49	Budget v Actual	\$ (53,958)	\$ 173,231	\$ (227,189)	\$ 137,454	\$ (322,450)	\$ 60,259	\$ (17,630)	\$ (7,083)	\$ (109,609)	\$ (51,578)	\$ 83,446
50	% Variance - Fav / (Unfav)	-1.8%	19.4%	-11.0%	69.3%	-227.5%	35.2%	-2.5%	-4.8%	-43.8%	-35.2%	26.8%
51	<b>ACR</b>	8.6%	2.0%	6.5%	7.8%	13.3%	10.3%	12.0%	7.6%	7.8%	11.6%	8.3%
52												
53	Total Contract Cost	\$ 35,259,249	\$ 12,807,720	\$ 22,451,530	\$ 782,384	\$ 3,482,766	\$ 1,080,841	\$ 6,026,189	\$ 2,023,501	\$ 4,605,665	\$ 1,700,783	\$ 2,749,401
54	Budget v Actual	\$ 34,908,256	\$ 13,557,313	\$ 21,350,944	\$ 1,141,345	\$ 2,631,810	\$ 957,167	\$ 5,804,587	\$ 1,115,296	\$ 3,918,837	\$ 2,680,526	\$ 3,101,377
55	% Variance - Fav / (Unfav)	-1.0%	5.5%	-5.2%	31.5%	-32.3%	-12.9%	-3.8%	-81.4%	-17.5%	36.6%	11.3%
56												
57												
58	Net before Settlement	\$ (3,722,801)	\$ (1,187,509)	\$ (2,535,292)	\$ 189,701	\$ 295,450	\$ (233,578)	\$ (1,911,373)	\$ (490,188)	\$ 89,783	\$ (195,329)	\$ (279,758)
59	Budget v Actual	\$ (13,370,873)	\$ 8,871,426	\$ (22,242,299)	\$ (605,870)	\$ (5,462,964)	\$ (946,191)	\$ (3,769,520)	\$ (2,379,359)	\$ (7,708,631)	\$ (188,840)	\$ (1,180,924)
60	% Variance - Fav / (Unfav)	-138.6%	88.2%	-112.9%	-76.2%	-94.9%	-132.8%	-202.9%	-125.9%	-98.8%	-2910.4%	-131.0%
61	Note: HMP Savings can be applied to Medicaid cost savings or ISF											within +/- 2%
62												>2% favorable
63	Date: 9/27/2024											between -2&-4%
												>4% unfavorable

	E	F	H	J	K	M	N	P	Q	R	S
1	<b>Southwest Michigan Behavioral Health</b>			<i>Mos in Period</i>							
2	For the Fiscal YTD Period Ended 8/30/2024		<b>P11FYTD24</b>	<b>11</b>							
3	<i>(For Internal Management Purposes Only)</i>										
4	<b>INCOME STATEMENT</b>										
5		<b>TOTAL</b>	<b>Medicaid Contract</b>	<b>Healthy Michigan Contract</b>	<b>Opioid Health Home Contract</b>	<b>CCBHC</b>	<b>MH Block Grant Contracts</b>	<b>SA Block Grant Contract</b>	<b>SA PA2 Funds Contract</b>	<b>SWMBH Central</b>	
6	<b>REVENUE</b>										
18	Contract Revenue	340,149,944	234,622,052	31,536,448	1,457,556	62,209,088	641,399	7,748,380	1,935,020	-	
19	DHHS Incentive Payments	310,811	310,811	-	-	-	-	-	-	-	
21	Interest Income - Working Capital	1,133,677	-	-	-	-	-	-	-	-	1,133,677
22	Interest Income - ISF Risk Reserve	273,512	-	-	-	-	-	-	-	-	273,512
23	Local Funds Contributions	786,005	-	-	-	-	-	-	-	-	786,005
24	Other Local Income	-	-	-	-	-	-	-	-	-	-
25											
26	<b>TOTAL REVENUE</b>	<b>342,653,950</b>	<b>234,932,864</b>	<b>31,536,448</b>	<b>1,457,556</b>	<b>62,209,088</b>	<b>641,399</b>	<b>7,748,380</b>	<b>1,935,020</b>	<b>2,193,195</b>	
27											
28	<b>EXPENSE</b>										
29	<b>Healthcare Cost</b>										
30	Provider Claims Cost	20,775,745	3,722,570	7,496,832	1,043,079	-	196,365	6,873,086	1,442,546	-	
31	CMHP Subcontracts, net of 1st & 3rd party	301,337,456	218,804,398	20,154,099	-	61,831,449	-	547,509	-	-	
32	Insurance Provider Assessment Withhold (IPA)	2,964,817	2,119,747	845,070	-	-	-	-	-	-	
33	Medicaid Hospital Rate Adjustments	8,967,996	5,219,824	3,748,172	-	-	-	-	-	-	
34	MHL Cost in Excess of Medicare FFS Cost	-	1,300	-	-	-	-	-	-	-	
35											
36	<b>Total Healthcare Cost</b>	<b>334,046,014</b>	<b>229,867,840</b>	<b>32,244,173</b>	<b>1,043,079</b>	<b>61,831,449</b>	<b>196,365</b>	<b>7,420,596</b>	<b>1,442,546</b>	<b>-</b>	
37	Medical Loss Ratio (HCC % of Revenue)	98.1%	97.8%	102.2%	71.6%	99.4%	-	95.8%	74.5%	-	
38											
40	Purchased Professional Services	294,721	-	-	-	-	-	-	-	-	294,721
41	Administrative and Other Cost	8,725,333	-	-	-	-	445,034	121,493	-	-	8,160,637
43	Depreciation	6,658	-	-	-	-	-	-	-	-	6,658
44	Functional Cost Reclassification	-	-	-	-	-	-	-	-	-	-
45	Allocated Indirect Pooled Cost	0	-	-	-	-	-	-	-	-	(1,831)
46	Delegated Managed Care Admin	22,151,379	19,853,948	2,297,431	-	-	-	-	-	-	-
47	Apportioned Central Mgd Care Admin	0	5,765,098	717,646	27,072	1,604,759	16,647	206,061	-	-	(8,337,316)
48											
49	<b>Total Administrative Cost</b>	<b>31,178,090</b>	<b>25,619,046</b>	<b>3,015,077</b>	<b>27,072</b>	<b>1,604,759</b>	<b>461,680</b>	<b>327,554.43</b>	<b>-</b>	<b>122,869</b>	
50	Admin Cost Ratio (MCA % of Total Cost)	8.5%	10.0%	8.6%	2.5%	2.5%	-	4.2%	0.0%	2.3%	
51											
52	Local Funds Contribution	786,005	-	-	-	-	-	-	-	-	786,005
54											
55	<b>TOTAL COST after apportionment</b>	<b>366,010,109</b>	<b>255,486,886</b>	<b>35,259,249</b>	<b>1,070,150</b>	<b>63,436,208</b>	<b>658,046</b>	<b>7,748,150</b>	<b>1,442,546</b>	<b>908,874</b>	
56											
57	<b>NET SURPLUS before settlement</b>	<b>(23,356,159)</b>	<b>(20,554,022)</b>	<b>(3,722,801)</b>	<b>387,405</b>	<b>(1,227,120)</b>	<b>(16,647)</b>	<b>230</b>	<b>492,474</b>	<b>1,284,321</b>	
58	Net Surplus (Deficit) % of Revenue	-6.8%	-8.7%	-11.8%	26.6%	-2.0%	-2.6%	0.0%	25.5%	58.6%	
60	Prior Year Savings	-	-	-	-	-	-	-	-	-	
61	Change in PA2 Fund Balance	(492,474)	-	-	-	-	-	-	(492,474)	-	
62											
63	ISF Risk Reserve Abatement (Funding)	(273,512)	-	-	-	-	-	-	-	-	(273,512)
64	ISF Risk Reserve Deficit (Funding)	19,201,901	19,201,901	-	-	-	-	-	-	-	-
65	CCBHC Supplemental Receivable (Payable)	7,725,657	-	-	-	7,725,657	-	-	-	-	-
66	Settlement Receivable / (Payable)	5,074,692	8,238,063	3,722,801	(387,405)	(6,498,537)	-	(230)	-	-	-
67	<b>NET SURPLUS (DEFICIT)</b>	<b>7,880,104</b>	<b>6,885,942</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(16,647)</b>	<b>-</b>	<b>-</b>	<b>1,010,809</b>	
68	<i>HMP &amp; Autism is settled with Medicaid</i>										
69											
70	<b>SUMMARY OF NET SURPLUS (DEFICIT)</b>										
71	Prior Year Unspent Savings	-	-	-	-	-	-	-	-	-	-
72	Current Year Savings	-	-	-	-	-	-	-	-	-	-
73	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-	-	-
74	Local and Other Funds Surplus/(Deficit)	7,880,104	6,885,942	-	-	-	(16,647)	-	-	-	1,010,809
75											
76	<b>NET SURPLUS (DEFICIT)</b>	<b>7,880,104</b>	<b>6,885,942</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(16,647)</b>	<b>-</b>	<b>-</b>	<b>1,010,809</b>	

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	<b>Southwest Michigan Behavioral Health</b>			<i>Mos in Period</i>										
2	For the Fiscal YTD Period Ended 8/30/2024			11										
3	(For Internal Management Purposes Only)			ok										
4	<b>INCOME STATEMENT</b>			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	<b>Medicaid Specialty Services</b>			<i>HCC %</i>										
7	Subcontract Revenue	234,622,052	22,016,365	212,605,688	9,685,212	40,870,559	11,601,066	39,006,147	13,943,198	61,006,608	13,918,164	22,574,734		
8	Incentive Payment Revenue	310,811	310,811	-	-	-	-	-	-	-	-	-	-	
9	<b>Contract Revenue</b>	<b>234,932,864</b>	<b>22,327,176</b>	<b>212,605,688</b>	<b>9,685,212</b>	<b>40,870,559</b>	<b>11,601,066</b>	<b>39,006,147</b>	<b>13,943,198</b>	<b>61,006,608</b>	<b>13,918,164</b>	<b>22,574,734</b>		
10														
11	External Provider Cost	201,101,983	3,722,570	197,379,413	5,508,870	38,720,618	11,183,500	34,897,344	11,774,874	62,920,794	15,058,700	17,314,713		
12	Internal Program Cost	22,055,343	-	22,055,343	1,886,429	2,406,580	430,364	2,924,872	4,276,408	1,798,870	719,922	7,611,898		
13	SSI Reimb, 1st/3rd Party Cost Offset	(630,358)	-	(630,358)	(5,796)	(397,506)	-	(97,588)	-	(2,968)	-	(126,500)		
14	Insurance Provider Assessment Withhold (IPA)	7,339,571	7,339,571	-	-	-	-	-	-	-	-	-		
16	<b>Total Healthcare Cost</b>	<b>229,866,539</b>	<b>11,062,141</b>	<b>218,804,398</b>	<b>7,389,503</b>	<b>40,729,692</b>	<b>11,613,864</b>	<b>37,724,628</b>	<b>16,051,282</b>	<b>64,716,697</b>	<b>15,778,622</b>	<b>24,800,110</b>		
17	Medical Loss Ratio (HCC % of Revenue)	97.8%	49.8%	102.9%	76.3%	99.7%	100.1%	96.7%	118.1%	106.1%	113.4%	109.9%		
18														
19	<b>Managed Care Administration</b>	<b>25,619,046</b>	<b>5,765,098</b>	<b>19,853,948</b>	<b>622,661</b>	<b>4,061,530</b>	<b>742,200</b>	<b>4,174,030</b>	<b>1,267,143</b>	<b>5,488,797</b>	<b>1,454,382</b>	<b>2,043,204</b>		
20	Admin Cost Ratio (MCA % of Total Cost)	10.0%	2.3%	7.8%	7.8%	9.1%	6.0%	10.0%	7.3%	7.8%	8.4%	7.6%		
21														
22	<b>Contract Cost</b>	<b>255,485,585</b>	<b>16,827,240</b>	<b>238,658,346</b>	<b>8,012,164</b>	<b>44,791,222</b>	<b>12,356,064</b>	<b>41,898,658</b>	<b>17,318,425</b>	<b>70,205,494</b>	<b>17,233,004</b>	<b>26,843,315</b>		
23	<b>Net before Settlement</b>	<b>(20,552,722)</b>	<b>5,499,936</b>	<b>(26,052,658)</b>	<b>1,673,048</b>	<b>(3,920,663)</b>	<b>(754,998)</b>	<b>(2,892,511)</b>	<b>(3,375,227)</b>	<b>(9,198,886)</b>	<b>(3,314,840)</b>	<b>(4,268,581)</b>		
24														
25	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-		
26	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-		
27	Contract Settlement / Redistribution	8,238,063	(17,814,595)	26,052,658	(1,673,048)	3,920,663	754,998	2,892,511	3,375,227	9,198,886	3,314,840	4,268,581		
28	<b>Net after Settlement</b>	<b>(12,314,658)</b>	<b>(12,314,658)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>		
29														
30	<b>Eligibles and PMPM</b>													
31	Average Eligibles	160,587	160,587	160,587	8,659	30,260	9,466	31,351	9,330	42,508	12,970	16,043		
32	Revenue PMPM	\$ 133.00	\$ 12.64	\$ 120.36	\$ 101.68	\$ 122.79	\$ 111.41	\$ 135.86	\$ 130.47	\$ 97.55	\$ 127.92			
33	Expense PMPM	\$ 144.63	\$ 9.53	\$ 135.11	\$ 84.12	\$ 134.56	\$ 118.66	\$ 121.49	\$ 168.75	\$ 150.14	\$ 120.79	\$ 152.11		
34	Margin PMPM	\$ (11.63)	\$ 3.11	\$ (14.75)	\$ 17.56	\$ (11.78)	\$ (7.25)	\$ (8.39)	\$ (32.89)	\$ (19.67)	\$ (23.23)	\$ (24.19)		
35														
36	<b>Medicaid Specialty Services</b>													
37	<b>Budget v Actual</b>													
38														
39	<b>Eligible Lives (Average Eligibles)</b>													
40	Actual	160,587	160,587	160,587	8,659	30,260	9,466	31,351	9,330	42,508	12,970	16,043		
41	Budget	182,355	182,355	182,355	10,091	34,298	10,758	35,395	10,670	47,729	15,030	18,384		
42	Variance - Favorable / (Unfavorable)	(21,768)	(21,768)	(21,768)	(1,432)	(4,038)	(1,292)	(4,044)	(1,340)	(5,221)	(2,060)	(2,341)		
43	% Variance - Fav / (Unfav)	-11.9%	-11.9%	-11.9%	-14.2%	-11.8%	-12.0%	-11.4%	-12.6%	-10.9%	-13.7%	-12.7%		
44														
45	<b>Contract Revenue before settlement</b>													
46	Actual	234,932,864	22,327,176	212,605,688	9,685,212	40,870,559	11,601,066	39,006,147	13,943,198	61,006,608	13,918,164	22,574,734		
47	Budget	217,396,277	24,821,391	192,574,886	7,865,133	37,667,714	9,593,192	34,477,023	13,013,827	56,019,739	11,772,498	22,165,760		
48	Variance - Favorable / (Unfavorable)	17,536,587	(2,494,215)	20,030,802	1,820,079	3,202,845	2,007,875	4,529,125	929,370	4,986,868	2,145,665	408,975		
49	% Variance - Fav / (Unfav)	8.1%	-10.0%	10.4%	23.1%	8.5%	20.9%	13.1%	7.1%	8.9%	18.2%	1.8%		
50														
51	<b>Healthcare Cost</b>													
52	Actual	229,866,539	11,062,141	218,804,398	7,389,503	40,729,692	11,613,864	37,724,628	16,051,282	64,716,697	15,778,622	24,800,110		
53	Budget	204,485,735	10,202,791	194,282,944	5,910,234	38,193,405	9,372,724	29,040,320	15,610,810	62,510,647	11,540,089	22,104,715		
54	Variance - Favorable / (Unfavorable)	(25,380,804)	(859,351)	(24,521,454)	(1,479,269)	(2,536,287)	(2,241,140)	(8,684,308)	(440,471)	(2,206,050)	(4,238,533)	(2,695,396)		
55	% Variance - Fav / (Unfav)	-12.4%	-8.4%	-12.6%	-25.0%	-6.6%	-23.9%	-29.9%	-2.8%	-3.5%	-36.7%	-12.2%		
56														
57	<b>Managed Care Administration</b>													
58	Actual	25,619,046	5,765,098	19,853,948	622,661	4,061,530	742,200	4,174,030	1,267,143	5,488,797	1,454,382	2,043,204		
59	Budget	24,684,397	6,194,520	18,489,877	1,154,786	3,127,914	1,072,411	4,438,291	1,255,955	4,268,054	834,683	2,337,783		
60	Variance - Favorable / (Unfavorable)	(934,649)	(429,422)	(1,364,071)	532,124	(933,616)	330,211	(264,261)	(11,187)	(1,220,743)	(619,699)	294,579		
61	% Variance - Fav / (Unfav)	-3.8%	6.9%	-7.4%	46.1%	-29.8%	30.8%	6.0%	-0.9%	-28.6%	-74.2%	12.6%		
62														
63														
64	<b>Total Contract Cost</b>													
65	Actual	255,485,585	16,827,240	238,658,346	8,012,164	44,791,222	12,356,064	41,898,658	17,318,425	70,205,494	17,233,004	26,843,315		
66	Budget	229,170,132	16,397,311	212,772,821	7,065,020	41,321,319	10,445,135	33,478,611	16,866,766	66,778,701	12,374,772	24,442,498		
67	Variance - Favorable / (Unfavorable)	(26,315,453)	(429,928)	(25,885,525)	(947,145)	(3,469,903)	(1,910,929)	(8,420,047)	(451,659)	(3,426,793)	(4,858,232)	(2,400,817)		
68	% Variance - Fav / (Unfav)	-11.5%	-2.6%	-12.2%	-13.4%	-8.4%	-18.3%	-25.2%	-2.7%	-5.1%	-39.3%	-9.8%		
69														
70	<b>Net before Settlement</b>													
71	Actual	(20,552,722)	5,499,936	(26,052,658)	1,673,048	(3,920,663)	(754,998)	(2,892,511)	(3,375,227)	(9,198,886)	(3,314,840)	(4,268,581)		
72	Budget	(11,773,856)	8,424,079	(20,197,935)	800,113	(3,653,605)	(851,943)	998,412	(3,852,938)	(10,758,962)	(602,273)	(2,276,738)		
73	Variance - Favorable / (Unfavorable)	(8,778,866)	(2,924,143)	(5,854,723)	872,935	(267,058)	96,945	(3,890,922)	477,711	1,560,075	(2,712,567)	(1,991,843)		
74	% Variance - Fav / (Unfav)	-74.6%	-34.7%	-29.0%	109.1%	-7.3%	11.4%	-389.7%	12.4%	14.5%	-450.4%	-87.5%		
75														



	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	<b>Southwest Michigan Behavioral Health</b>			<i>Mos in Period</i>									
2	For the Fiscal YTD Period Ended 8/30/2024			11									
3	(For Internal Management Purposes Only)			ok									
4	<b>INCOME STATEMENT</b>												
5		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	
76	<b>Healthy Michigan Plan</b>												
77	Contract Revenue	31,536,448	11,620,210	19,916,238	972,085	3,778,216	847,263	4,114,816	1,533,313	4,695,447	1,505,454	2,469,644	
78													
79	External Provider Cost	23,640,526	7,496,832	16,143,694	648,396	2,533,943	905,046	4,726,456	466,732	4,230,642	1,438,413	1,194,066	
80	Internal Program Cost	4,010,546	-	4,010,546	73,185	484,665	64,827	579,050	1,402,134	15,089	64,431	1,327,165	
81	SSI Reimb., 1st/3rd Party Cost Offset	(142)	-	(142)	-	-	-	-	-	(142)	-	-	
82	Insurance Provider Assessment Withhold (IPA)	4,593,242	4,593,242	-	-	-	-	-	-	-	-	-	
83	<b>Total Healthcare Cost</b>	<b>32,244,173</b>	<b>12,090,074</b>	<b>20,154,099</b>	<b>721,581</b>	<b>3,018,608</b>	<b>969,873</b>	<b>5,305,506</b>	<b>1,868,866</b>	<b>4,245,590</b>	<b>1,502,844</b>	<b>2,521,231</b>	
84	Medical Loss Ratio (HCC % of Revenue)												
85													
86	<b>Managed Care Administration</b>	<b>3,015,077</b>	<b>717,646</b>	<b>2,297,431</b>	<b>60,803</b>	<b>464,158</b>	<b>110,968</b>	<b>720,683</b>	<b>154,635</b>	<b>360,075</b>	<b>197,939</b>	<b>228,170</b>	
87	Admin Cost Ratio (MCA % of Total Cost)	8.6%	2.0%	6.5%	7.8%	13.3%	10.3%	12.0%	7.6%	7.8%	11.6%	8.3%	
88													
89	<b>Contract Cost</b>	<b>35,259,249</b>	<b>12,807,720</b>	<b>22,451,530</b>	<b>782,384</b>	<b>3,482,766</b>	<b>1,080,841</b>	<b>6,026,189</b>	<b>2,023,501</b>	<b>4,605,665</b>	<b>1,700,783</b>	<b>2,749,401</b>	
90	<b>Net before Settlement</b>	<b>(3,722,801)</b>	<b>(1,187,509)</b>	<b>(2,535,292)</b>	<b>189,701</b>	<b>295,450</b>	<b>(233,578)</b>	<b>(1,911,373)</b>	<b>(490,188)</b>	<b>89,783</b>	<b>(195,329)</b>	<b>(279,758)</b>	
91													
92	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-	
93	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-	
94	Contract Settlement / Redistribution	3,722,801	1,187,509	2,535,292	(189,701)	(295,450)	233,578	1,911,373	490,188	(89,783)	195,329	279,758	
95	<b>Net after Settlement</b>	<b>(0)</b>	<b>(0)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	
96													
97	<b>Eligibles and PMPM</b>												
98	Average Eligibles	64,020	64,020	64,020	3,266	12,907	3,104	11,825	3,733	18,304	4,876	6,005	
99	Revenue PMPM	\$ 44.78	\$ 16.50	\$ 28.28	\$ 27.06	\$ 26.61	\$ 24.81	\$ 31.63	\$ 37.34	\$ 23.32	\$ 28.07	\$ 37.39	
100	Expense PMPM	50.07	18.19	31.88	21.78	24.53	31.65	46.33	49.28	22.87	31.71	41.62	
101	Margin PMPM	\$ (5.29)	\$ (1.69)	\$ (3.60)	\$ 5.28	\$ 2.08	\$ (6.84)	\$ (14.69)	\$ (11.94)	\$ 0.45	\$ (3.64)	\$ (4.24)	
102													
103	<b>Healthy Michigan Plan</b>												
104	<b>Budget v Actual</b>												
105													
106	<b>Eligible Lives (Average Eligibles)</b>												
107	Actual	64,020	64,020	64,020	3,266	12,907	3,104	11,825	3,733	18,304	4,876	6,005	
108	Budget	80,899	80,899	80,899	4,135	15,777	3,853	14,800	4,923	23,446	6,225	7,740	
109	Variance - Favorable / (Unfavorable)	(16,879)	(16,879)	(16,879)	(869)	(2,870)	(749)	(2,975)	(1,189)	(5,143)	(1,350)	(1,735)	
110	% Variance - Fav / (Unfav)	-20.9%	-20.9%	-20.9%	-21.0%	-18.2%	-19.4%	-20.1%	-24.2%	-21.9%	-21.7%	-22.4%	
111													
112	<b>Contract Revenue before settlement</b>												
113	Actual	31,536,448	11,620,210	19,916,238	972,085	3,778,216	847,263	4,114,816	1,533,313	4,695,447	1,505,454	2,469,644	
114	Budget	44,556,329	3,498,378	41,057,951	1,936,916	8,390,224	1,669,780	7,662,734	3,004,466	11,717,250	2,674,037	4,002,543	
115	Variance - Favorable / (Unfavorable)	(13,019,880)	8,121,832	(21,141,713)	(964,831)	(4,612,008)	(822,517)	(3,547,918)	(1,471,153)	(7,021,803)	(1,168,583)	(1,532,899)	
116	% Variance - Fav / (Unfav)	-29.2%	232.2%	-51.5%	-49.8%	-55.0%	-49.3%	-46.3%	-49.0%	-59.9%	-43.7%	-38.3%	
117													
118	<b>Healthcare Cost</b>												
119	Actual	32,244,173	12,090,074	20,154,099	721,581	3,018,608	969,873	5,305,506	1,868,866	4,245,590	1,502,844	2,521,231	
120	Budget	31,947,138	12,666,436	19,280,702	943,088	2,490,101	785,940	5,101,534	967,743	3,668,371	2,534,164	2,789,760	
121	Variance - Favorable / (Unfavorable)	(297,035)	576,362	(873,397)	221,506	(528,507)	(183,933)	(203,972)	(901,122)	(577,219)	1,031,320	268,529	
122	% Variance - Fav / (Unfav)	-0.9%	4.6%	-4.5%	23.5%	-21.2%	-23.4%	-4.0%	-93.1%	-15.7%	40.7%	9.6%	
123													
124	<b>Managed Care Administration</b>												
125	Actual	3,015,077	717,646	2,297,431	60,803	464,158	110,968	720,683	154,635	360,075	197,939	228,170	
126	Budget	2,961,119	890,877	2,070,242	198,257	141,708	171,227	703,053	147,552	250,466	146,361	311,616	
127	Variance - Favorable / (Unfavorable)	(53,958)	173,231	(227,189)	137,454	(322,450)	60,259	(17,630)	(7,083)	(109,609)	(51,578)	83,446	
128	% Variance - Fav / (Unfav)	-1.8%	19.4%	-11.0%	69.3%	-227.5%	35.2%	-2.5%	-4.8%	-43.8%	-35.2%	26.8%	
129													
130	<b>Total Contract Cost</b>												
131	Actual	35,259,249	12,807,720	22,451,530	782,384	3,482,766	1,080,841	6,026,189	2,023,501	4,605,665	1,700,783	2,749,401	
132	Budget	34,908,256	13,557,313	21,350,944	1,141,345	2,631,810	957,167	5,804,587	1,115,296	3,918,837	2,680,526	3,101,377	
133	Variance - Favorable / (Unfavorable)	(350,993)	749,593	(1,100,586)	358,961	(850,956)	(123,674)	(221,602)	(908,205)	(686,828)	979,742	351,975	
134	% Variance - Fav / (Unfav)	-1.0%	5.5%	-5.2%	31.5%	-32.3%	-12.9%	-3.8%	-81.4%	-17.5%	36.6%	11.3%	
135													
136	<b>Net before Settlement</b>												
137	Actual	(3,722,801)	(1,187,509)	(2,535,292)	189,701	295,450	(233,578)	(1,911,373)	(490,188)	89,783	(195,329)	(279,758)	
138	Budget	9,648,072	(10,058,935)	19,707,007	795,571	5,758,414	712,613	1,858,147	1,889,171	7,798,413	(6,488)	901,166	
139	Variance - Favorable / (Unfavorable)	(13,370,873)	8,871,426	(22,242,299)	(605,870)	(5,462,964)	(946,191)	(3,769,520)	(2,379,359)	(7,708,631)	(188,840)	(1,180,924)	
140	% Variance - Fav / (Unfav)	-138.6%	88.2%	-112.9%	-76.2%	-94.9%	-132.8%	-202.9%	-125.9%	-98.8%	-2910.4%	-131.0%	

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	<b>Southwest Michigan Behavioral Health</b>			<i>Mos in Period</i>									
2	For the Fiscal YTD Period Ended 8/30/2024			11									
3	(For Internal Management Purposes Only)			ok									
4	<b>INCOME STATEMENT</b>												
5		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	
160	<b>Certified Community Behavioral Health Clin</b>												
161			HCC%		0.0%	0.0%	0.0%	0.0%	0.0%	25.7%	21.8%	0.0%	
162	Contract Revenue	62,209,088	790,773	61,418,315	3,248,396	11,966,525	3,668,084	11,560,321	-	25,283,841	5,691,148	-	
163	External Provider Cost	5,558,617	-	5,558,617	-	-	-	-	-	5,558,617	-	-	
165	Internal Program Cost	55,937,307	-	55,937,307	4,854,581	9,710,527	4,839,629	11,604,031	-	19,590,381	5,338,158	-	
166	CCBHC General Fund Pass-through	984,369	984,369	-	-	-	-	-	-	-	-	-	
167	SSI Reimb, 1st/3rd Party Cost Offset	(648,843)	-	(648,843)	-	-	(120,056)	-	-	(403,335)	(125,452)	-	
169	<b>Total Healthcare Cost</b>	<b>61,831,449</b>	<b>984,369</b>	<b>60,847,080</b>	<b>4,854,581</b>	<b>9,710,527</b>	<b>4,719,572</b>	<b>11,604,031</b>	<b>-</b>	<b>24,745,663</b>	<b>5,212,706</b>	<b>-</b>	
170	Medical Loss Ratio (HCC % of Revenue)	99.4%	124.5%	99.1%	149.4%	81.1%	128.7%	100.4%	0.0%	97.9%	91.6%	0.0%	
171	<b>Managed Care Administration</b>	<b>1,604,759</b>	<b>1,604,759</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	
173	Admin Cost Ratio (MCA % of Total Cost)	2.5%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
174	<b>Contract Cost</b>	<b>63,436,208</b>	<b>2,589,128</b>	<b>60,847,080</b>	<b>4,854,581</b>	<b>9,710,527</b>	<b>4,719,572</b>	<b>11,604,031</b>	<b>-</b>	<b>24,745,663</b>	<b>5,212,706</b>	<b>-</b>	
176	<b>Net before Settlement</b>	<b>(1,227,120)</b>	<b>(1,798,355)</b>	<b>571,235</b>	<b>(1,606,185)</b>	<b>2,255,998</b>	<b>(1,051,488)</b>	<b>(43,711)</b>	<b>-</b>	<b>538,178</b>	<b>478,442</b>	<b>-</b>	
177	PPS-1 Supplemental Payment Difference	-	7,725,657	(7,725,657)	(1,881,097)	(1,508,905)	(1,646,480)	(1,632,916)	-	392,043	(1,448,302)	-	
178	Contract Settlement / Redistribution	-	(8,296,892)	8,296,892	274,912	3,764,903	594,992	1,589,205	-	146,135	1,926,744	-	
179	<b>Net after Settlement</b>	<b>-</b>	<b>(8,296,892)</b>	<b>8,296,892</b>	<b>274,912</b>	<b>3,764,903</b>	<b>594,992</b>	<b>1,589,205</b>	<b>-</b>	<b>146,135</b>	<b>1,926,744</b>	<b>-</b>	
180	<b>SWMBH CMHP Subcontracts</b>												
200	Subcontract Revenue	328,367,589	34,427,348	293,940,241	13,905,693	56,615,300	16,116,414	54,681,284	15,476,511	90,985,896	21,114,766	25,044,378	
202	Incentive Payment Revenue	310,811	310,811	-	-	-	-	-	-	-	-	-	
203	<b>Contract Revenue</b>	<b>328,678,401</b>	<b>34,738,160</b>	<b>293,940,241</b>	<b>13,905,693</b>	<b>56,615,300</b>	<b>16,116,414</b>	<b>54,681,284</b>	<b>15,476,511</b>	<b>90,985,896</b>	<b>21,114,766</b>	<b>25,044,378</b>	
204	External Provider Cost	230,301,125	11,219,402	219,081,724	6,157,267	41,254,561	12,088,546	39,623,800	12,241,606	72,710,053	16,497,113	18,508,779	
206	Internal Program Cost	82,003,197	-	82,003,197	6,814,195	12,601,772	5,334,819	15,107,953	5,678,542	21,404,341	6,122,511	8,939,063	
207	CCBHC General Fund Pass-through	984,369	984,369	-	-	-	-	-	-	-	-	-	
208	SSI Reimb, 1st/3rd Party Cost Offset	(1,279,343)	-	(630,358)	(5,796)	(397,506)	(120,056)	(97,588)	-	(406,303)	(125,452)	(126,500)	
209	Insurance Provider Assessment Withhold (IPA)	11,932,813	11,932,813	-	-	-	-	-	-	-	-	-	
211	<b>Total Healthcare Cost</b>	<b>323,942,161</b>	<b>23,152,215</b>	<b>300,454,562</b>	<b>12,965,665</b>	<b>53,458,827</b>	<b>17,303,309</b>	<b>54,634,165</b>	<b>17,920,148</b>	<b>93,708,091</b>	<b>22,494,173</b>	<b>27,321,342</b>	
212	Medical Loss Ratio (HCC % of Revenue)	98.6%	66.6%	102.2%	93.2%	94.4%	107.4%	99.9%	115.8%	103.0%	106.5%	109.1%	
213	<b>Managed Care Administration</b>	<b>30,238,882</b>	<b>8,087,503</b>	<b>22,151,379</b>	<b>683,464</b>	<b>4,525,688</b>	<b>853,168</b>	<b>4,894,713</b>	<b>1,421,778</b>	<b>5,848,873</b>	<b>1,652,320</b>	<b>2,271,374</b>	
215	Admin Cost Ratio (MCA % of Total Cost)	8.5%	2.3%	6.3%	5.0%	7.8%	4.7%	8.2%	7.4%	5.9%	6.8%	7.7%	
216	<b>Contract Cost</b>	<b>354,181,043</b>	<b>31,239,718</b>	<b>322,605,941</b>	<b>13,649,129</b>	<b>57,984,515</b>	<b>18,156,477</b>	<b>59,528,878</b>	<b>19,341,925</b>	<b>99,556,963</b>	<b>24,146,493</b>	<b>29,592,716</b>	
217	<b>Net before Settlement</b>	<b>(25,502,643)</b>	<b>3,498,441</b>	<b>(28,665,700)</b>	<b>256,564</b>	<b>(1,369,215)</b>	<b>(2,040,064)</b>	<b>(4,847,595)</b>	<b>(3,865,415)</b>	<b>(8,571,067)</b>	<b>(3,031,727)</b>	<b>(4,548,338)</b>	
219	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-	
221	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-	
222	Contract Settlement	11,960,864	(24,352,743)	36,313,607	18,348	5,134,118	2,635,056	6,436,800	3,865,415	8,717,061	4,958,471	4,548,338	
223	<b>Net after Settlement</b>	<b>(13,541,778)</b>	<b>(20,854,302)</b>	<b>7,647,907</b>	<b>274,912</b>	<b>3,764,903</b>	<b>594,992</b>	<b>1,589,205</b>	<b>-</b>	<b>145,994</b>	<b>1,926,744</b>	<b>-</b>	
224													

	E	F	I	J	K
1	<b>Southwest Michigan Behavioral Health</b>				
2	For the Fiscal YTD Period Ended 9/30/2024		<b>FY24 Projection Medicaid and Healthy Michigan</b>		
3	(For Internal Management Purposes Only)		<i>Revised - FY24 Rate Amendment</i>		
4					
4					
6	<b>REVENUE</b>				
7	<b>Contract Revenue</b>				
8					
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28	<b>EXPENSE</b>				
29	<b>Healthcare Cost</b>				
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39	<b>Administrative Cost</b>				
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## **Michigan Consortium for Healthcare Excellence**

### **Chief Executive Officer Board Report April 12, 2024**

# Ongoing Efforts

- Joint contracting with TBD Solutions for a catalogue of known national, statewide and regional public behavioral health system performance measures and sources for purposes of enhancing PIHP collection and reporting of credible system performance reports.
- Joint contracting with Wakely a Health Management Associates Actuarial firm for purposes of performing an objective review of MDHHS and Milliman Medicaid rate setting practices.
- Joint renegotiation with MCG regarding Utilization Management Criteria

# Why Collaborate?

- **Enhance public policy influence via collective consensus views and advocacy with executive and legislative branches**
- **Enhance collective and individual relations with Advocacy groups and leaders**
- **Share scarce resources and technical assistance**
- **Share operational and performance information for quality improvement and benchmarking**
- **Reduce provider burdens and provider administrative costs**
- **Reduce PIHP administrative costs**
- **Identify and pursue system joint purchasing opportunities**

# Southwest Michigan

## BEHAVIORAL HEALTH

### Board Regulatory Compliance Committee Meeting draft minutes

Members: Sherii Sherban, Louie Csokasy, Edward Meny

SWMBH Staff: Mila Todd, Michelle Jacobs

September 13, 2024

12:30 p.m. – 1:15 p.m. (or immediately following the SWMBH Board Meeting)

Air Zoo Aerospace & Science Museum

Draft: 9/17/24

#### 1. Review Agenda

Agenda approved.

#### 2. Central Topics

- a. Board Regulatory Compliance Committee Members – reviewed members and determined that Sherii Sherban is an ad hoc member, and another member would be needed. This was determined at the Board meeting and Sherii Sherban appointed Lorraine Lindsey.
- b. Review Board Regulatory Compliance Committee Charter – Committee approved charter with no revisions.
- c. Fiscal Year 2025 Compliance activities update – Mila Todd stated she would bring the Fiscal Year 2025 Compliance Plan and Monitoring Plan to the next meeting for the Committee's review.

#### 3. Planning

- a. Updates to SWMBH Board – as needed and include brief minutes
- b. Next meeting – Committee requested to meet monthly for 30 minutes immediately following the Board meeting

**Next Meeting: October 11, 2024**



**Southwest Michigan Behavioral Health Board Meeting  
Air Zoo Aerospace & Science Museum  
6151 Portage Rd, Portage, MI 49002**

**November 8, 2024  
9:30 am to 11:30 am  
(d) means document provided  
Draft: 9/17/24**

- 1. Welcome Guests/Public Comment**
- 2. Agenda Review and Adoption (d) pg.**
- 3. Financial Interest Disclosure Handling (M. Todd)**
  - None Scheduled
- 4. Consent Agenda (2 minutes)**
  - a. October 11, 2024 SWMBH Board Meeting Minutes (d) pg.
  - b. September 25, 2024 Operations Committee Meeting Minutes (d) pg.
- 5. Required Approvals (10 minutes)**
  - Calendar Year 2025 Board Calendars (d) pg.
- 6. Ends Metrics Updates (\*Requires motion) (15 minutes)**

*Proposed Motion: The Board accepts the interpretation of Ends Metrics as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

  - a. Fiscal Year 2024 Health Services Advisory Group External Quality Review (A. Lacey) (d). pg.
  - b. Initiation and Engagement Metric (A. Lacey) (d). pg.
  - c. CCBHC Quality Bonus Metric (E. Philander) (d). pg.
- 7. Board Actions to be Considered (10 minutes)**
  - a. Executive Officer Evaluation (S. Sherban)
  - b. Board Finance Committee (T. Schmelzer)
  - c. Holiday Luncheon
- 8. Board Policy Review (5 minutes)**

*Proposed Motion: The Board accepts the interpretation of Policy \_\_\_\_\_ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

  - EO-002 Monitoring Executive Officer Performance (E. Meny) (d) pg.



**9. Executive Limitations Review (10 minutes)**

*Proposed Motion: The Board accepts the interpretation of Policy \_\_\_\_\_ as meeting the test of ANY reasonable interpretation and the data shows compliance with the interpretation.*

- None

**10. Board Education (15 minutes)**

- a. Fiscal Year 2024 Year to Date Financial Statements (G. Guidry) (d) pg.
- b. Investments (Mercer) (d) pg.
- c. Fiscal Year 2024 Community Mental Health Services Program Site Review Results (M. Todd) (d) pg.

**11. Communication and Counsel to the Board (2 minutes)**

- a. Board Finance Committee
- b. Board Regulatory Compliance Committee (d) pg.
- c. December Draft Board Agenda and December Board Policy Direct Inspection – BEL-003 Asset Protection (E. Krogh)

**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  
December 13, 2024  
9:30 am - 11:30 am**