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

June 14, 2024
9:30 am to 11:30 am
(d) means document provided
Draft: 6/5/24

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. May 10, 2024 SWMBH Board Meeting Minutes (d) pg.3
   b. April 24, May 8. And May 29, 2024 Operations Committee Meeting Minutes (d) pg.6

5. **Fiscal Year 2023 External Audit (Christina Schaub of Roslund Prestage) (15 minutes) (d) pg.10**

6. **Required Approvals (0 minutes)**

   a. Operating Agreement Review (request to defer)
   b. Operations Committee Self Evaluation (request to defer)

7. **Ends Metrics Updates *(*Requires motion) (2 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.

   - None scheduled

8. **Board Actions to be Considered (40 minutes)**

   a. Community Mental Health Board inputs to SWMBH Ends (S. Radwan) (d) pg.19
   b. Draft Ends (S. Radwan) (d) pg.32
   c. Debrief May 10 Board Planning Session (d) pg.34

9. **Board Policy Review (0 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 scheduled

10. Executive Limitations Review (0 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 scheduled

11. Board Education (20 minutes)

a. Fiscal Year 2024 Year to Date Financial Statements and 2023 SWMBH Cash Settlement (G. Guidry) (d) pg.38
b. 2024 Mid-Year Administrative Services Contracts (G. Guidry) (d) pg.47
c. Conflict Free Access and Planning (A. Lacey)
d. 2023 Michigan Mission Based Performance Indicator 3 Regional Details (A. Lacey) (d) pg.50
e. Fiscal Year 2023 Customer Satisfaction Survey Results follow up (A. Lacey) (d) pg.51
f. Community Mental Health and Prepaid Inpatient Health Plan Board's Opposition Resolutions on Conflict Free Access and Planning (B. Casemore) (d) pg.99
g. Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) (B. Casemore) (d) pg.101
h. Key Informant Interviews Update (E. Philander) (d) pg.110

12. Communication and Counsel to the Board (5 minutes)

a. Michigan Advocacy Organizations Letter to Center for Medicaid Services (d) pg.114
b. Region 4 - 2024 State Opioid Response Site Review Letter (d) pg.119
c. Michigan Opioids Task Force Appointment (d) pg.121
d. July Board Draft Agenda and Board Policy Direct Inspection – BEL-009 Global Executive Constraints (d) pg.122

13. Public Comment

14. 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
July 12, 2024
9:30 am - 11:30 am
Air Zoo Aerospace & Science Museum
6151 Portage Rd, Portage, MI 49002

Board Meeting Minutes
May 10, 2024
Bay Pointe Inn, 11456 Marsh Rd. Shelbyville, MI 49344
9:30 am-11:30 am
Draft: 5/15/24

Members Present: Edward Meny, Tom Schmelzer, Louie Csokasy, Carol Naccarato, Sherii Sherban, Tina Leary, Lorriane Lindsey, Erik Krogh

Members Absent: Mark Doster

Guests Present: Brad Casemore, Chief Executive Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Ella Philander, Executive Project Manager, SWMBH; Cameron Bullock, Pivotal; Cathi Abbs, Pivotal Board Alternate, Mandi Quigley, Summit Pointe, Ric Compton, Riverwood; John Ruddell, Woodlands; Sue Germann, Pines BH; Jon Houtz, Pines Board Alternate; Jeff Patton, ISK; Debbie Hess, Van Buren CMH; Scott Dzurka, Public Sector Consultants

Welcome Guests
Sherii Sherban called the meeting to order at 9:31 am and introductions were made.

Public Comment
None

Agenda Review and Adoption

Motion: Erik Krogh moved to approve the agenda with the addition of Fiscal Year 2024 what ? added to 7d.
Second: Edward Meny
Motion Carried

Financial Interest Disclosure (FID) Handling
Mila Todd reviewed Lorraine Lindsey completed conflict of interest form. Lorraine Lindsey introduced and shared a little bit about herself. Discussion of conflict of interest followed.

Motion: Edward Meny moved that a conflict exists and that:

1) The Board is not able to obtain a more advantageous arrangement with someone other than Lorraine Lindsey;
2) The Financial Interests disclosed by Lorraine Lindsey are not so substantial as to be likely to affect the integrity of the services that SWMBH may expect to receive; and
3) A Conflict of Interest Waiver should be granted.

Second: Tom Schmelzer
Motion Carried

Consent Agenda

Motion	Carol Naccarato moved to approve the April 12, 2024 Board minutes as presented.
Second	Tom Schmelzer
Motion Carried

March 27, 2024 Operations Committee Meeting Minutes

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

Ends Metrics

None

Board Actions to be Considered

Board Regulatory Compliance Committee

Mila Todd reviewed history and need for Board Regulatory Compliance Committee. Discussion followed.

Motion	Erk Krogh moved to approve the SWMBH Board Regulatory Compliance Committee Charter. Board members for this committee are Sherii Sherban, Louie Csokasy and Edward Meny. Mila will arrange a Committee Meeting.
Second	Carol Naccarato
Motion Carried

BG-001 Committee Structure

Brad Casemore noted policy in the Board packet for reference regarding the Board Regulatory Compliance Committee.

BG-010 Board Committee Principles

Brad Casemore noted policy in the Board packet for reference regarding the Board Regulatory Compliance Committee.

Fiscal Year 2023 and Fiscal Year 2024 Performance Bonus Incentive Program Distribution

Brad Casemore and Garyl Guidry presented as documented, reviewing history, funding, formulas, contractual obligations and Regional Operations Committee approval. Discussion followed.

Motion	Louie Csokasy moved that the Board approve as not precedent setting the distribution of the Fiscal Year 2023 and Fiscal Year 2024 Performance Bonus Incentive Program earnings as outlined in this report, and as unanimously agreed to between Southwest Michigan Behavioral Health and the participant Community Mental Health Service Provider Chief Executive Officers.
Second	Tom Schmelzer
Motion Carried

Board Policy Review

BG-011 Governing Style

Sherii Sherban reported as documented.

Motion Tom Schmelzer moved The Board accepts the interpretation of Policy BG-011 Governing Style as meeting the test of any reasonable interpretation and the data shows compliance with the interpretation.

Second Erik Krogh

Motion Carried

Executive Limitations Review

None

Board Education

Fiscal Year 2024 Year to Date Financial Statements

Garyl Guidry reported as documented noting actual financial statements from seven Community Mental Health Service Providers (CMHSP) and one estimate from Summit Pointe. Garyl Guidry reviewed revenue, expenses and projected deficits and noted that the mid-year favorable rate adjustment from the State will not be enough to cover expenses as projected. Discussion followed.

Fiscal Year 2023 Michigan Mission Based Performance Indicator System Results

The Board agreed to move this topic to the June Board meeting.

Fiscal Year 2023 Customer Satisfaction Survey Results

The Board agreed to move this topic to the June Board meeting.

Communication and Counsel to the Board

June Board Policy Direct Inspection

None scheduled

June Draft Board Agenda

June draft Board agenda included in the packet.

Community Mental Health Association of Michigan (CMHAM)

Brad Casemore noted the June CMHAM Summer Conference. Details will be emailed to the Board.

Public Comment

None

Adjournment

Motion Erik Krogh moved to adjourn.

Second Edward Meny

Motion Carried

Meeting adjourned at 10:30am

OPS Comm meeting 5-8-24 @ 9am

Minutes by John Ruddell

Attendance: Sue German, Deb Hess, Rich Thiemkey, John Ruddell, Cameron Bullock, Ric Compton, Brad Casemore, Mila Todd, Garyl Guidry

Absent: Jeff Patton, Jeannie Goodrich

- Agenda – discussed, added EDV, Beacon letter, grad student presence, minute approval wait for quorum.
- SWMBH intern update (Morgan Osaer) – any volunteers to host intern for meet & greet, if yes please let Brad know.
- Beacon letter discussion – Beacon will discontinue case management and other services due to CFAP.
- Minutes – discussed/reviewed and approved.
- CFAP – discussion, centered around lack of direction from State of Mich and SWMBH request for individual CMH meeting for "fact finding".
- Geographic Factors – Garyl presented information and updated dashboard creation progress, discussion ensued.
- FY24 YTD financials – Garyl presented information (approx. $10.5 deficit through 6 months), will improve with rate amendment but still trending towards a FY24 deficit.
- FY25 financial projections – Garyl had a brief update into FY25, also trending towards a deficit.
- EDV encounter evaluation – Mila updated on new HSAG activity, similar to a Medicaid services audit, most data will be due by June 7th.
- Operating agreement review and Ops comm self-evaluation delayed until summer (June/July)
- Ops comm operating process and procedure – Brad suggested updating these to reflect current format.

Adjourn @ 10:20am

Agenda topics May 29th:

- TBD solutions for MCIS/Data project
- Ella to present Strategic Imperative drafts and key informative information
- CFAP (Conflict Free Access & Planning)
- EDV (Encounter Data Verification)
- Geographic factors (State invited)

Ops Comm Meeting 4-24-24

Minutes by Cameron Bullock

Attendance: Debra Hess, Ric Compton, John Ruddell, Rich Thiemkey, Sue German, Jeannie Goodrich, Cameron Bullock, Brad Casemore, Mila Todd, Garyl Guidry.

Absent: Jeff Patton

Minutes: Changes discussed, and then approved unanimously for Minutes from the April 11th, 2024 meeting. Response to MHA on prescreens: SWMBH paused submission until 4-30-24, any feedback to Beth before that date.

PBIP: The FY 2023 updated number given is the SUD providers' number, which was finalized at 170,762.05. The distribution to CMH/SWMBH is $2,226,318.88, split 90/10 between CMH's $2,003,686.99 and SWMBH's $222,631.89. The remaining $1,000,000 will be added and divided via Medicaid eligibles by county. Subject to Board approval in May. CMH SUD PBIP Gainshare for FY 2024 is still to be determined.

The PBIP proposal for FY 24:

FY 24 PBIP will be distributed as such subject to Board approval:

- Total amount earned - SUD Provider Promised amount = Total distribution available.
- From that total distribution available, it will be split 90 (CMH)/10(SWMBH) by Medicaid eligibles.
- This offer does not include the $1 million as in FY 23.

This will be presented at the board meeting in May. 8 CMH CEOs are in agreement.

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CFAP: Much discussion ensued. No update. The PIHP/MDHHS meeting is on May 21st for 1 hour.

Rates, including Geographic Factor:

Garyl Presented updated Revenue Rates for FY 24.

- BHTEDs influence on rates presented
- Milliman Geo Rate Factor Analysis presented- Tableau reports will be made available to CEOs when complete and ready to go – Garyl will ensure with IT what access is needed for CEOs.

Environmental Scan and Strategic Initiatives. These are still under development and will be used at the May board planning meeting. The Strategic Plan goes to the board in July. Feedback to Brad and Ella.

Operating Agreement Review: Due to board June 14th – Brad will propose to the Board to defer until the Board meeting August 9th,

OC Self Evaluation. Brad will propose to the Board to defer until the Board meeting August 9th,

HCBS update – Mila provided an HCBS update from the state/CMS. Quick turn around time for information needed.

Agenda Topics May 8th:

- CFAP
- Geographic Factors and Rates
- Financial Initiatives- CMH trends (tour) YTD financials and Projections
- Financials

May 29th

- TBDS to OC for MCID/Data exchange project report.
- Ella to review Environmental Scan, Key Informant Interviews and Strategic Imperatives drafts.
- CFAP
- Geographic Factors

SWMBH Operations Meeting – May 29, 2024

Present: Sue G, facilitator, Deb H., Rich T., Ric C., Jeff P., Jeannie G., Cameron B., John R.

Staff: Mila T. Garyl G., Brad C.

Guests: TBD: Jason, Brent

Minutes from last meeting: Minutes approved as originally submitted, without the red line suggestions. Operations Committee agreed.

TBD Solution Report: TBD Solutions staff, Jason and Brent, reviewed the report that was provided in the packet. Discussion from Operations on the report and the next steps. Brad provided information on what he believes SWMBH next steps would be moving forward which include assessment of the procurement process, engagement with TBD for MCIS Specs functional needs. The CEOs discussed the next steps with Brad relative to continued engagement with TBD considering this may be a duplication with PCE. The topic will remain on the agenda for further discussion. No further timeline was provided.

CFAP: Discussion about status of CFAP and questions posed by SWMBH to the State. CMHs discussed the resolution, most are either approved or on the agenda for their Board. SWMBH Board has it in the packet for review. Cameron and Ric shared both the Mid State resolution that has been shared through CMHA and what they have provided their Board for CEO review. Discussion about last MDHHS meeting relative to FAQs that SWMBH is waiting for from that meeting.

EVV: Mila provided an update on the EVV request and appreciated the quick turn around from the CMHs.

Financials: Garyl presented the information YTD for the region. Mila provided information on the psych inpatient rates that need to change in July. Tableau report link will be provided by Garyl. CMHs identified some variances on data (inpatient, autism, specialized residential). SWMBH financials project spending beyond the ISF into the risk corridor. This will be on the agenda for further discussion at Operations.

Next Agenda: Considered same items from today's discussion for next week.

Respectfully submitted, Jeannie G.

Southwest Michigan Behavioral Health

Financial Statements
September 30, 2023

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

Independent Auditor's Report

To the Members of the Board
Southwest Michigan Behavioral Health
Portage, Michigan

Report on the Audit of the Financial Statements

Opinions

We have audited the accompanying financial statements of the business-type activities, each major fund, and the aggregate remaining fund information of Southwest Michigan Behavioral Health (the PIHP), as of and for the year ended September 30, 2023, and the related notes to the financial statements, which collectively comprise the PIHP's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities, each major fund, and the aggregate remaining fund information of the PIHP, as of September 30, 2023, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the PIHP and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the PIHP's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions.

Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

ROSLUND, PRESTAGE & COMPANY, P.C.
525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN

Southwest Michigan Behavioral Health
Statement of Net Position
September 30, 2023

	Enterprise Fund	Internal Service	
	Mental Health Operating	Medicaid Risk Reserve	Total Proprietary Funds
Current assets			
Cash and cash equivalents - unrestricted	$ 38,512,457	$ -	$ 38,512,457
Cash and cash equivalents - restricted	355,940	22,021,566	22,377,506
Accounts receivable	761,664	-	761,664
Due from other governmental units (Note 4)	28,161,136	-	28,161,136
Due from other funds	-	472,344	472,344
Prepaid expenses	121,354	-	121,354
Total current assets	67,912,551	22,493,910	90,406,461
Noncurrent assets			
Capital assets being depreciated, net	190,330	-	190,330
Total assets	68,102,881	22,493,910	90,596,791
PY Total assets			99,781,995
Current liabilities			
Accounts payable	565,630	-	565,630
Accrued payroll and benefits	261,059	-	261,059
Due to other governmental units (Note 7)	38,242,400	-	38,242,400
Due to other funds	472,344	-	472,344
Unearned revenue	5,772,759	-	5,772,759
Compensated absences, due within one year	53,391	-	53,391
Direct borrowing, due within one year	168,865	-	168,865
Total current liabilities	45,536,448	-	45,536,448
Noncurrent liabilities			
Compensated absences, due beyond one year	302,549	-	302,549
Total noncurrent liabilities	302,549	-	302,549
Total liabilities	45,838,997	-	45,838,997
PY Total liabilities			48,436,707
Net position			
Net investment in capital assets	21,465	-	21,465
Restricted for Medicaid risk management	-	18,527,804	18,527,804
Restricted for Healthy Michigan risk management	-	3,966,106	3,966,106
Restricted for Healthy Michigan Savings	3,552,313	-	3,552,313
Restricted for Performance Bonus Incentive Pool	4,876,091	-	4,876,091
Unrestricted	13,814,015	-	13,814,015
Total net position	$ 22,263,884	$ 22,493,910	$ 44,757,794
PY Net position	27,964,367	23,380,921	51,345,288

The notes to the financial statements are an integral part of this statement.

Southwest Michigan Behavioral Health
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2023

	Enterprise Fund Mental Health Operating	Internal Service Medicaid Risk Reserve	Total Proprietary Funds
Operating revenues			
State and federal funding			
Medicaid	$ 270,810,614	$ -	$ 270,810,614
Healthy Michigan	57,443,546	-	57,443,546
CCBHC	11,627,683	-	11,627,683
Incentive payments	2,782,944	-	2,782,944
Medicare-Medicaid capitated revenue	1,647,180	-	1,647,180
State and federal grant revenue	9,842,780	-	9,842,780
Total State and Federal funding	354,154,747	-	354,154,747
Local funding			
Public Act 2 funding	1,699,624	-	1,699,624
Local match drawdown	852,520	-	852,520
Total local funding	2,552,144	-	2,552,144
Other operating revenues	3,194	-	3,194
Total operating revenues	356,710,085	-	356,710,085
	PY Operating revenues		343,068,875
Operating expenses			
Funding for affiliate partners			
Barry County Community Mental Health	13,336,705	-	13,336,705
Kalamazoo Community Mental Health	97,768,334	-	97,768,334
Pines Behavioral Health	15,453,930	-	15,453,930
Riverwood Center	59,285,967	-	59,285,967
St. Joseph Community Mental Health	24,867,281	-	24,867,281
Summit Pointe	60,621,180	-	60,621,180
Van Buren Community Mental Health	31,606,708	-	31,606,708
Woodlands Behavioral Healthcare Network	20,836,703	-	20,836,703
PBIP funding for affiliate partners	1,591,261	-	1,591,261
CCBHC funding for affiliate partners	2,112,880	-	2,112,880
Total funding for affiliate partners	327,480,949	-	327,480,949
	PY Funding for affiliate partners		287,540,925
Contract expenditures			
Contractual services	29,337,959	-	29,337,959
IPA and HRA taxes	9,869,592	-	9,869,592
Local match drawdown	852,520	-	852,520
Total contract expenditures	40,060,071	-	40,060,071
	PY Contract expenditures		35,191,556
Administrative expenses			
Salaries and contracted personnel	5,965,205	-	5,965,205
Fringe benefits	1,986,782	-	1,986,782
Board expenses	18,109	-	18,109
Community education	107,549	-	107,549
Depreciation expense	164,139	-	164,139
Furniture and small equipment	451,358	-	451,358
Insurance	10,959	-	10,959
IT and Consulting services	655,437	-	655,437
Lease expense	21,421	-	21,421
Legal and professional	237,173	-	237,173

The notes to the financial statements are an integral part of this statement.

Southwest Michigan Behavioral Health
Statement of Revenues, Expenses, and Changes in Net Position
For the Year Ended September 30, 2023

	Enterprise Fund Mental Health Operating	Internal Service Medicaid Risk Reserve	Total Proprietary Funds
Maintenance and custodial	$ 21,950	$ -	$ 21,950
Meeting and training expense	121,496	-	121,496
Membership and dues	51,925	-	51,925
Other operating expenses	(45,690)	-	(45,690)
Staff development and travel	80,809	-	80,809
Supplies	46,700	-	46,700
Utilities	70,029	-	70,029
Total administrative expenses	9,965,351	-	9,965,351
		PY Administrative expenses	10,367,577
Total operating expenses	377,506,371	-	377,506,371
Operating income (loss)	(20,796,286)	-	(20,796,286)
Non-operating revenues (expenses)			
Investment income	634,413	245,562	879,975
Interest expense	(15,288)	-	(15,288)
Non-operating local expense	(115,225)	-	(115,225)
Gain on sale of capital assets	16,118	-	16,118
Total non-operating revenues (expenses)	520,018	245,562	765,580
Transfers			
Transfer in (out)	396,553	(396,553)	-
Total transfer in (out)	396,553	(396,553)	-
Change in net position	(19,879,715)	(150,991)	(20,030,706)
PY Change in net position	8,296,621	1,604,917	9,901,538
Net position, beginning of year	27,964,367	23,380,921	51,345,288
Prior period adjustment	14,179,232	(736,020)	13,443,212
Net position, end of year	$ 22,263,884	$ 22,493,910	$ 44,757,794

The notes to the financial statements are an integral part of this statement.

NOTE 2 – CASH, CASH EQUIVALENTS AND INVESTMENTS

The PIHP utilizes a pooled cash concept for its funds, to maximize its investment program. Investment income from this internal pooling is allocated to the respective funds based upon the sources of funds invested.

Cash and Cash Equivalents
Michigan's statutory authority allows governmental entities to invest in the following investments:
- Bonds, securities, other obligations and repurchase agreements of the United States, or an agency or instrumentality of the United States.
- Certificates of deposit, savings accounts, deposit accounts or depository receipts of a qualified institution.
- Commercial paper rated at the time of purchase within the 2 highest classifications established by not less than 2 standard rating services and that matures not more than 270 days after the date of purchase.
- Bankers' acceptances of United States banks.
- Obligations of the State of Michigan and its political subdivisions that, at the time of purchase are rated as investment grade by at least one standard rating service.
- Mutual funds registered under the Investments Company Act of 1940 with the authority to purchase only investment vehicles that are legal for direct investment by a public corporation.
- External investment pools as authorized by Public Act 20 as amended through December 31, 1997.

A reconciliation of carrying amounts to the basic financial statements follows:

Description	Amount
Cash and cash equivalents - unrestricted	38,512,457
Cash and cash equivalents - restricted	22,377,506
Total cash and cash equivalents	60,889,963

Cash and Cash Equivalents - Restricted
The PIHP has charged to MDHHS for the vested portion of compensated absences as of September 30th. The PIHP holds, in a separate bank account, funds restricted for the payment of the compensated absences as they come due.

Cash and cash equivalents have been restricted in the Internal Service Fund for the expected future risk corridor requirements of the MDHHS contract.

Description	Amount
Restricted for compensated absences	355,940
Restricted for Internal Service Fund	22,021,566
Total	22,377,506

Custodial Credit Risk
In the case of deposits, this is the risk that, in the event of a bank's failure, the PIHP's deposits may not be returned to it. The PIHP evaluates each financial institution with which it deposits funds and assesses the level of risk of each institution. Only those institutions with an acceptable estimated risk level are used as depositories. The PIHP bank balance was $78,994,731 and $995,690 of that amount was exposed to custodial credit risk because it was uninsured by FDIC.

NOTE 3 – ACCOUNTS RECEIVABLE

The PIHP believes that the accounts receivable will be collected in full and therefore the receivable balance has not been offset by an allowance for doubtful accounts.

NOTE 4 - DUE FROM OTHER GOVERNMENTAL UNITS

Due from other governmental units as of September 30th consists of the following:

Description	Amount
MDHHS	8,135,076
Barry County CMH	456,173
Pines Behavioral Health	643,581
Integrated Services of Kalamazoo	18,926,306
Total	28,161,136

NOTE 5 - INTERFUND RECEIVABLES AND PAYABLES

The amounts of interfund receivable and payable shown on the fund financial statements as of September 30th, are as follows:

Description	Due from Other Funds	Due to Other Funds
Mental health operating fund	-	472,344
Medicaid risk reserve fund	472,344	-
Total	472,344	472,344

The outstanding balances between funds result mainly from the time lag between the dates that 1) interfund goods and services are provided or reimbursable expenditures occur, 2) transactions are recorded in the accounting system and 3) payments between funds are made.

NOTE 6 - CAPITAL ASSETS

A summary of changes in capital assets is as follows:

	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets being depreciated/amortized					
Computers and software	796,755	-	-	-	796,755
Vehicles	28,613	36,313	(28,613)	-	36,314
Right to use - building	472,940	-	-	-	472,940
Total capital assets being depreciated/amortized	1,298,308	36,313	(28,613)	-	1,306,009
Accumulated depreciation/amortization					
Computers and software	(796,755)	-	-	-	(796,755)
Vehicles	(23,844)	(6,493)	26,706	-	(3,631)
Right to use - building	(157,647)	(157,647)	-	-	(315,294)
Total accumulated depreciation/amortization	(978,246)	(164,139)	26,706	-	(1,115,680)
Capital assets being depreciated/amortized, net	320,062	(127,826)	(1,907)	-	190,330

NOTE 7 - DUE TO OTHER GOVERNMENTAL UNITS

Due to other governmental units as of September 30th consists of the following:

Description	Amount
Riverwood Center	1,920,308
Summit Pointe	5,906,707
Woodlands Behavioral Healthcare Network	1,642,388
St. Joseph County CMH	1,826,751
Van Buren County CMH	2,681,717
MDHHS	11,548,684
IPA Assessment	917,411
Other	11,798,434
Total	38,242,400

NOTE 8 - UNEARNED REVENUE

The amount reported as unearned revenue represents revenues received in advance of the period earned as follows:

Description	Amount
PA2 revenues	5,772,759

NOTE 9 - LONG-TERM LIABILITIES

Direct Borrowings

Description	Original Borrowing	Interest Rates	Final Maturity	Outstanding at Year-end
Hinman building lease	472,940	6.00%	2024	168,865

The CMHSP's outstanding loans from direct borrowings and direct placements related to mental health operations contain provisions that in an event of default, either by (1) unable to make principal or interest payments (2) false or misrepresentation is made to the lender (3) become insolvent or make an assignment for the benefit of its creditors (4) if the lender at any time in good faith believes that the prospect of payment of any indebtedness is impaired. Upon the occurrence of any default event, the outstanding amounts, including accrued interest become immediately due and payable.

Summary of Long-Term Debt
The changes in long-term debt during the fiscal year are as follows:

	Beginning Balance	Additions	(Deletions)	Ending Balance	Due within one year
Compensated absences	321,853	82,365	(48,278)	355,940	53,391
Direct borrowings	325,485	-	(156,620)	168,865	168,865
Total	647,338	82,365	(204,898)	524,805	222,256

NOTE 16 – PRIOR PERIOD ADJUSTMENT

The prior period adjustment in Mental Health Operating fund consists of the following items:

Description	Amount
Compliance audit adjustments resulting in changes to HMP Savings	480
Compliance audit adjustments resulting in changes to Medicaid savings	1,153,524
Compliance audit adjustments resulting in changes to interfund transfers	736,020
CCBHC Supplemental payment	12,716,571
Record adjustment to unearned revenue for PA2	(424,452)
Other	(2,911)
Total	14,179,232

The prior period adjustment in Medicaid Risk Reserve fund consists of the following items:

Description	Amount
Compliance audit adjustments resulting in changes to interfund transfers	(736,020)

NOTE 17 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No. 100*, Accounting Changes and Error Corrections*, was issued by the GASB in June 2022 and will be effective for the PIHP's fiscal year September 30, 2024. The primary objective of this Statement is to enhance accounting and financial reporting requirements for accounting changes and error corrections to provide more understandable, reliable, relevant, consistent, and comparable information for making decisions or assessing accountability.

This Statement prescribes the accounting and financial reporting for 1) each type of accounting change and 2) error corrections. This Statement requires that (a) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (b) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (c) changes in accounting estimates be reported prospectively by recognizing the change in the current period.

GASB Statement No. 101*, Compensated Absences*, was issued by the GASB in June 2022 and will be effective for the PIHP's fiscal year September 30, 2025. The objective of this Statement is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. That objective is achieved by aligning the recognition and measurement guidance under a unified model and by amending certain previously required disclosures.

This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This Statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This Statement also establishes guidance for measuring a liability for leave that has not been used, generally using an employee's pay rate as of the date of the financial statements.

Proposed Ends based on Feedback From Ownership Linkage Activity

This document presentation is intended to facilitate discussion regarding the document "SWMBH Proposed Ends" version 5.31.2024 included in this packet.

Susan Radwan, Policy Governance Consultant

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

Version June 5, 2024

Why we are here

The original Ends were written as though SWMBH was a direct provider, rather than a health benefits manager.

1. Quality of Life: Persons with intellectual & developmental disabilities, serious emotional disturbance, autism spectrum disorders, serious mental illness, and substance use disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery, and family preservation

2. Exceptional Care: Persons and families served are highly satisfied with the services they receive.

3. Improved Health

4. Mission and Value Driven

5. Quality and Efficiency

Ends & Ownership Linkage Definition

Ends are policies that 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.

There is a broad global End which is an umbrella to lower level ends, these further define impacts contained in the global End language.

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.

Process of Ownership Linkage

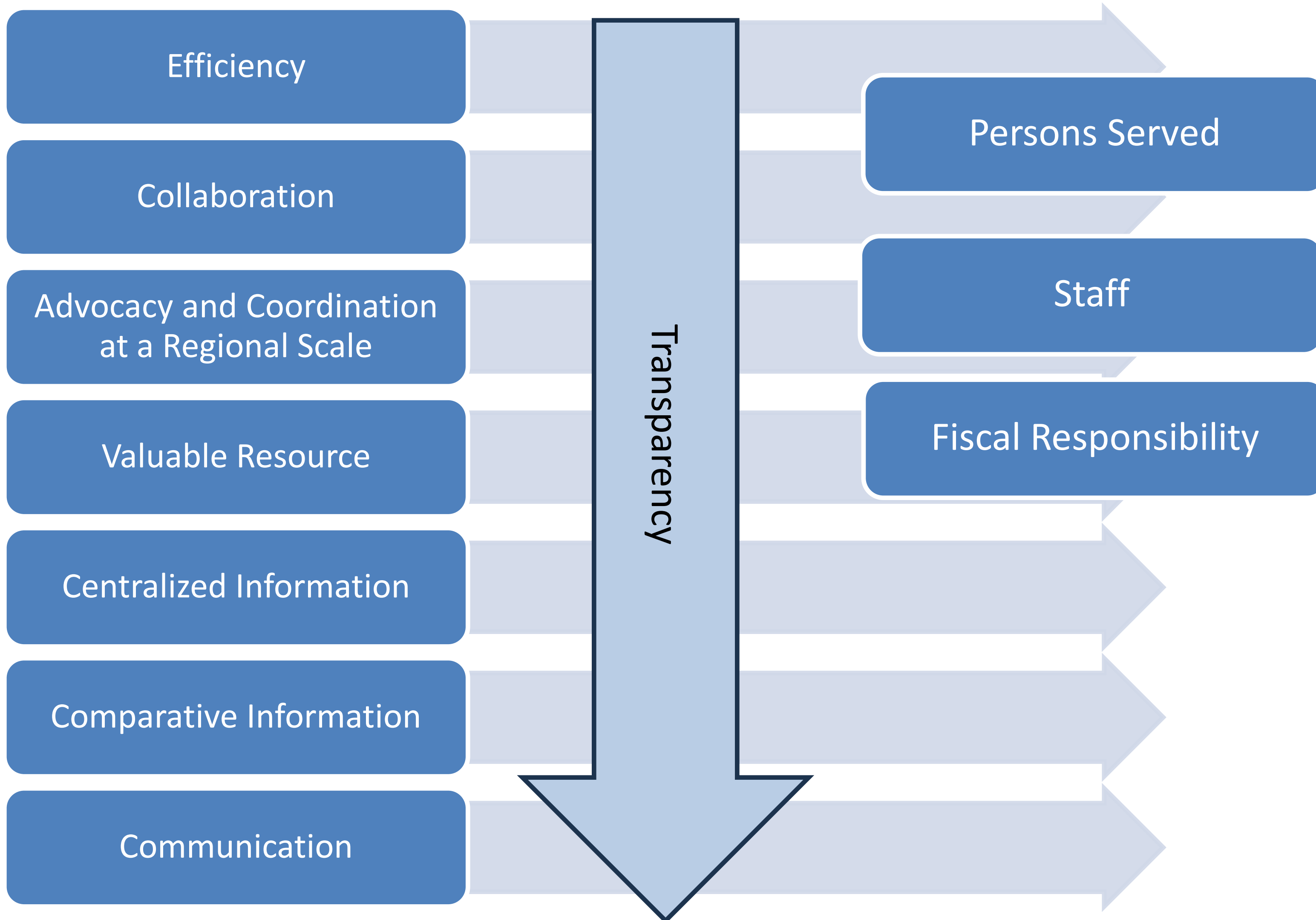
Each of the Boards has a unique culture and unique communication style.

Some Boards provided written responses: ISK, Barry, Van Buren, and Riverwood.

Susan Radwan facilitated live discussions with CMH Boards

- Pivotal Board Meeting October 16, 2023
- Cass Woodlands Board Meeting October 24, 2023
- ISK Board Meeting January 29, 2024
- Barry Board Meeting cancelled due to weather
- Van Buren Board Meeting February 12, 2024
- Pines Board Meeting February 27, 2024
- Summit Pointe Board Meeting May 7, 2024
- Riverwood Board Meeting May 15, 2024

Themes Developed in the Linkage Activity



Each CMH is unique with its own culture, needs, and strengths.

Proposed Global End

What Good, For Whom, At what cost/worth

As a benefits manager of state and federal funds, SWMBH exists to assure that member agenciesand 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.*

Efficiency

Valuable Resource

Fiscal Responsibility

Persons Served

Communication

Proposed Lower Level Ends

1. Member CMHs benefit from SWMBH's regional and statewide regulatory and public relations advocacy.
   a. Member CMH boards are aware of environmental disruptors and trends impacting the Mental Health Community.

2. Member CMHs identify the resources needed to address their communities' individualized needs and successfully access appropriate resources.
   a. Member CMHs and other providers use SWMBH resources to expand services and qualify for participation in demonstrations and pilot projects.

3. Member CMHs and other providers assure and monitor ready access to appropriate programs and services for their consumers.
   a. Member CMHs and other providers contribute accurate data to create aggregated, comprehensive, and comparative regional results.
   b. Member CMHs perform managed care functions within contractual parameters.

4. The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.

5. Member CMHs' boards, EOs, and staff value SWMBH as a partner, and experience the relationship as collaborative, transparent, and responsive.

Member CMHs benefit from SWMBH's regional and statewide regulatory and public relations advocacy.

Member CMH boards are aware of environmental disruptors and trends impacting the Mental Health Community.

Coordination and Regional Scale

Comparative Information

Collaboration

Valuable Resource

Communication

8

Member CMHs identify the resources needed to address their communities' individualized needs and successfully access appropriate resources.

Member CMHs and other providers use SWMBH resources to expand services and qualify for participation in demonstrations and pilot projects.

- Efficiency
- Collaboration
- Valuable Resource
- Centralized Information
- Coordination and Regional Scale

Member CMHs and other providers assure and monitor ready access to appropriate programs and services for their consumers.

Member CMHs and other providers contribute accurate data to create aggregated, comprehensive, and comparative regional results.

Member CMHs perform managed care functions within contractual parameters.

Valuable Resource

Comparative Information

Collaboration

Centralized Information

The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.

- Collaboration
- Valuable Resource
- Comparative Information
- Communication
- Efficiency
- Coordination and Regional Scale
- Centralized Information

Member CMHs' boards, EOs, and staff value SWMBH as a partner, and experience the relationship as collaborative, transparent, and responsive.

- Collaboration
- Valuable Resource
- Comparative Information
- Communication
- Efficiency
- Coordination and Regional Scale
- Centralized Information

Complete Set of Ends Proposed

Global: *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.*

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4. The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.
5. Member CMHs' boards, EOs, and staff value SWMBH as a partner, and experience the relationship as collaborative, transparent, and responsive.

In 2013, The state of Michigan changed the structure of the public behavioral health system by decreasing the number of PIHPs from 18 to 10. At that time, Southwest Michigan Behavioral Health was created *under Section 1204b of the Mental Health Code as a new legal entity jointly "owned" and governed by the sponsoring CMHSPs*.

Per the SWMBH Operating Agreement, SWMBH was formed for the purposes of:

- managing the business lines for which SWMBH is the contractor to Michigan Department of Health and Human Services (MDHHS);
- ensuring a comprehensive array of services and supports as provided in the contracts with MDHHS;
- performing all the duties and responsibilities contained in the Department/Regional Entity Contract;
- Substance Abuse Coordinating Agency (CA) required functions for its service area,
- exercising the powers and authority set forth by the Bylaws and governed by the SWMBH Board.

Per the Bylaws, SWMBH has the following powers:

2.2.3 The power to contract with a state, federal, local, and/or commercial organization(s).

2.2.4 The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the State or a State department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the Regional Entity, and from a private, or civic source.

2.2.5 The power to enter into a contract with a Participant for any service to be performed for, by, or from the Participant; and 2.2.6 The power to create a risk pool and take other actions as necessary to reduce the risk that the Participants otherwise bear individually.

2.2.7 The power to calculate, assess, and collect from the Participant payments attributable to their designated share of the Regional Entity's costs and expenses.

2.2.8 Other powers granted by the Regional Entity Board that the Participants share in common and may exercise separately under the Mental Health Code.

BOARD DISCUSSION DRAFT

Over the past decade SWMBH has progressed through the startup, growth, and maturity stages of business, and as it enters its second decade of existence, SWMBH enters a different stage of business growth, review and renew. As a part of this stage, we are asking the SWMBH Board to renew its Boards Ends.

Boards Ends are policies that define the intended impacts on the beneficiaries of the organization. Ends are about the impact to the beneficiaries of the organization, NOT about the organization itself. They answer three questions:

1. What good do we exist to create?
2. For whom?
3. At what worth to the organization?

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

There is a broad global End which is an umbrella to lower-level ends, these further define impacts contained in the global End language.

Proposed Ends – What good, for whom, at what worth (willing to invest/cost)

Global: *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 CMHs benefit from SWMBH's regional and statewide regulatory and public relations advocacy.
    a. Member CMH boards are aware of environmental disruptors and trends impacting the Mental Health Community.
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4. The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.
5. Member CMHs' boards, EOs, and staff value SWMBH as a partner, and experience the relationship as collaborative, transparent, and responsive.

BOARD DISCUSSION DRAFT

May 10, 2024 SWMBH Board Planning Session Notes
Bay Pointe Inn 11456 Marsh Road, Shelbyville, MI 49344
Draft: 5/15/24

Attendees: Edward Meny, Tom Schmelzer, Louie Csokasy, Carol Naccarato, Sherii Sherban, Tina Leary, Lorriane Lindsey, Erik Krogh, Mark Doster, Brad Casemore, Chief Executive Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Ella Philander, Executive Project Manager, SWMBH; Cameron Bullock, Pivotal; Cathi Abbs, Pivotal Board Alternate, Mandi Quigley, Summit Pointe, Ric Compton, Riverwood; John Ruddell, Woodlands; Sue Germann, Pines BH; Jon Houtz, Pines Board Alternate; Jeff Patton, ISK; Debbie Hess, Van Buren CMH; Scott Dzurka, Public Sector Consultants

Meeting purpose, objectives and Board Member Statements
Scott Dzurka reviewed history, purpose and accomplishment hopes. Discussion and input from attendees.

Environmental Scan and Key Informant Interviews
Ella Philander reported as documented, reviewing 2023 environmental scan and 2024 key informant interviews. Discussion and input from attendees.

Strategic Imperatives
Attendees participated in developing strategic imperative priorities. Scott Dzurka captured group themes and areas of importance. Discussion and input from attendees.

Summary and Next Steps for June and July
Scott Dzurka will draft a document reflecting attendees' inputs and responses for review at the June Board. Susan Radwan will present consolidated CMH Ends feedback and revised Ends draft, and the Board will review key informant interview content.
At the July Board meeting Susan Radwan will present the revised Board Ends with CMH Board input incorporated and Board will review draft Strategic Plan.

Adjourn 3:00pm

SWMBH Retreat Notes 5-10-24

The following are the recorded high level discussion points from the facilitator flip charts. Note that an asterisk (*) denotes a similar comment from another participant. Bolded areas were selected by the groups as important or themes. Numbers noted in parenthesis () indicate alignment with a strategic imperative.

What do we hope to get out of today?

- Learn/gain knowledge*
- Listen
- How can we benefit community/consumer
- Define lanes/solutions
- Children's needs
- CCBHC, Medicaid re-determination
- 5-7 quantifiable goals*
- Rate of change
- Roadmap for region
- Serving clients
- Common goals
- Collaboration
- Improve communication
- Develop relationships
- Discuss threats
- Common goals/outcomes
- Understanding perspectives of PIHP/CMHSP
- Roadmap – our <u>own</u> roadmap
- Successful direction

Environmental Scan

Headlines

- Legislature needs to understand CMH*
- Public needs more understanding
- Let us do our job
- Behavioral health moving toward integration
- Simplify the process to get into healthcare
- Healthcare offers 2 for 1 sale
- CMH offers holistic care**
- CCBHC puts us under water
- Continued access improving
- System changes end user effect
- Changes on the horizon
- Follow the money
- Improvement for client should be focus
- CMH continues to be public safety net for behavioral health services
- CCBHCs redefine health care
- Public behavioral health needs better offense
- State needs to work on building roads/not roadblocks for behavioral health
- Mental health system needs to stay in contact with all of community
- We need to know what they want
- Ownership needs to remain with community
- 2027 – 8 county CMHs in SW MI show best outcomes

Most concerning/apprehension

- Money
- Lack of understanding by decision makers*
- Competition
- Lack of vision @ department
- Lack of alignment between CMHSP/PIHP
- Cognitive – care or crash?
- Flexibility
- Public/private system – a joint system
- Gaps in coverage
- It's about the care/access

What action ideas has this triggered?

- Decrease administrative burden (not focused on quality of care
- Over-regulation
- State's lack of a roadmap
- Collective voice with uniqueness
- What CCBHCs are and are not
- We're not that much different than education system
- Finance and understanding goals go hand in hand

Strategic Imperatives Feedback

Biggest Challenge to Implement

- **Not in agreement with each other**
  - **Two different playing fields**
  - **Being regulated to provider status only (CMHs)**
- **Effective communication and collaboration**
- Vision of SWMBH to be a benefits manager/insurance company/corp. (#3)
- Bureaucracy
- Changes – constant
- Reducing health disparities as populations grow
- Bridge differences between CMHs with 1 size fits all policies and regulations
- Having power to influence
- Staff education on their impact on policy revenue and expenses

Easiest to achieve

THEME: MEASUREMENT

- **Be realistic about goals**
  - **Is pre-eminent in bureaucracy what we really want?**
  - **Is 80% good enough**
  - **-Aim higher where there's real quality of care**
  - **-Build on strengths**
- **Progress, not perfection**
- **Make measurable/smart goals (#4)**
- **System uniformity with respect to individual needs of CMHs**

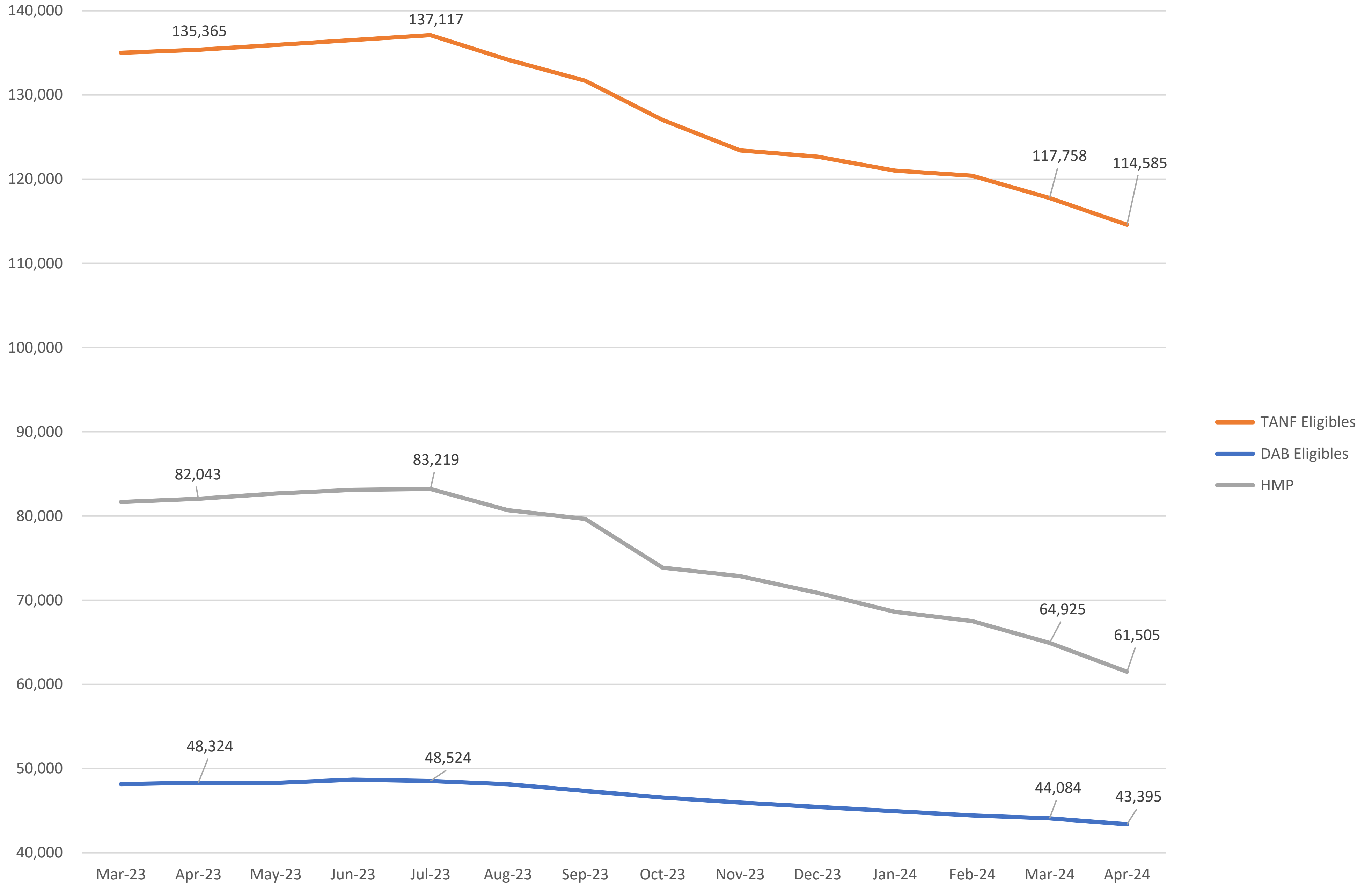
- Let's not be concerned about what's "easy", but what's worthwhile for the end user/consumer
- All CMHs be(come) CCBHCs
- Should be easier if on same EMR systems (?)

What's missing?

- **Workforce shortage – there are no specific strategies as to what to do; need to add quality/competency of staff; address regional strategies (#1)**
- **Missing how all 4 strategies are benefitting the end user/consumer/CMHs**
- **There is no mention of IT system barriers across the system (PCE); creates administrative burden**
- Lacks emphasis on children/adolescents & I/DD
- Missing comfort and satisfaction in providing quality of services even if not "best in class"
- Specifics/actions/measuring
- Robust financial reporting
- Focus on services to consumer/outcomes – support CMHs in serving community
- CCBHC model/operations/understanding
- Non-medicaid funding/flow through
- Accurate Milliman forecasting

Needs more focus

- **Strategy #4 needs more work regarding legislation/legislators/public officials/decision makers**
- **Do something about administrative burden**
- **Data integration; simplify by being on same platform (PCE)**
- **Regional Collaboration**
- Collaboration with respect for individual county/CMH differences
- Make time for CMHs to collaborative with each other; working meetings; facilitate sharing and understanding; can SWMBH commons be used for ease of sharing information?
- Transparency about money; start with balance statement
- Are we appropriately scaled? Administrative %
- Communication/collaboration


Southwest Michigan Behavioral Health
Total Eligibles Mar '23-Apr '24
May 6th 2024
140,000
130,000
120,000
110,000
100,000
90,000
80,000
70,000
60,000
50,000
40,000
135,365
137,117
117,758
114,585
82,043
83,219
64,925
61,505
48,324
48,524
44,084
43,395
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
TANF Eligibles
DAB Eligibles
HMP

		FY23 Due to CMH (SWMBH)
Barry	$	(465,488.29)
Berrien	$	1,946,168.78
Branch	$	(290,729.88)
Calhoun	$	6,481,004.86
Cass	$	3,395,372.12
Kalamazoo	$	204,425.85
St Joseph	$	3,642,674.80
Van Buren	$	3,349,771.15
	$	**18,263,199.39**

Version date: ***5/22/2024***

	E	F	I	J	K	L
1	***Southwest Michigan Behavioral Health***					
2	For the Fiscal YTD Period Ended 9/30/2024			**FY24 Projection Medicaid and Healthy Michigan**		
3	*(For Internal Management Purposes Only)*			***Revised - FY24 Rate Amendment***		
4			**FY24 Budget**	**FY24 Actual as P07**	**FY 24 Projection**	**Change FY24B v FY24P Fav/(Unfav)**
6	**REVENUE**					
7	**Contract Revenue**					
8	Medicaid Capitation		211,146,980	132,395,890	226,964,384	15,817,404
9	Healthy Michigan Plan Capitation		48,606,904	18,123,578	31,068,991	(17,537,913)
10	Autism Services Capitation		19,546,840	11,781,724	20,197,240	650,400
14	Medicaid Hospital Rate Adjustments		5,963,797	3,119,330	5,347,423	(616,374)
19	DHHS Incentive Payments		501,957	209,679	359,449	(142,508)
25						
26	**TOTAL REVENUE**		**285,766,479**	**165,630,201**	**283,937,487**	**(1,828,992)**
27						
28	**EXPENSE**					
29	**Healthcare Cost**					
30	Provider Claims Cost		15,193,598	7,013,018	12,022,317	(3,171,281)
31	CMHP Subcontracts, net of 1st & 3rd party		232,978,523	148,614,683	254,768,027	21,789,504
32	Insurance Provider Assessment Withhold (IPA		3,790,852	1,970,184	3,377,458	(413,394)
33	Medicaid Hospital Rate Adjustments		5,963,797	3,119,330	5,347,423	(616,374)
35						
36	**Total Healthcare Cost**		**257,926,770**	**160,717,215**	**275,515,226**	**17,588,455**
37	**Medical Loss Ratio (HCC % of Revenue)**		**90.4%**	**97.2%**	**97.2%**	
38						
39	**Administrative Cost**					
41	Administrative and Other Cost		11,033,143	5,211,499	8,933,998	(2,099,145)
46	Delegated Managed Care Admin		22,429,220	14,631,724	25,082,956	2,653,735
47	Apportioned Central Mgd Care Admin		(0)	-	-	0
48						
49	**Total Administrative Cost**		**33,462,363**	**19,843,223**	**34,016,953**	**554,590**
50	**Admin Cost Ratio (MCA % of Total Cost)**		**11.5%**	**11.0%**	**11.0%**	
54						
55	**TOTAL COST after apportionment**		**291,389,134**	**180,560,438**	**309,532,179**	**18,143,045**
56						
57	**NET SURPLUS before settlement**		**(5,622,655)**	**(14,930,237)**	**(25,594,692)**	**(19,972,037)**
58	**Net Surplus (Deficit) % of Revenue**		**-2.0%**	**-9.0%**	**-9.0%**	
59						
60	Prior Year Savings Utilization		9,769,410	3,552,313	-	(9,769,410)
63	ISF Risk Reserve Utilization		-	4,573,791	22,966,024	22,966,024
66	**NET SURPLUS (DEFICIT)**		**4,146,755**	**(6,804,132)**	**(2,628,668)**	**(6,775,423)**
67	*HMP & Autism is settled with Medicaid*					
68						
69	*Notes:*					
70	*The revenue projections are a rough estimates due to rate cell level information not yet available from MDHHS.*					

Southwest Michigan Behavioral Health

MEDICAID Summary Income Statement

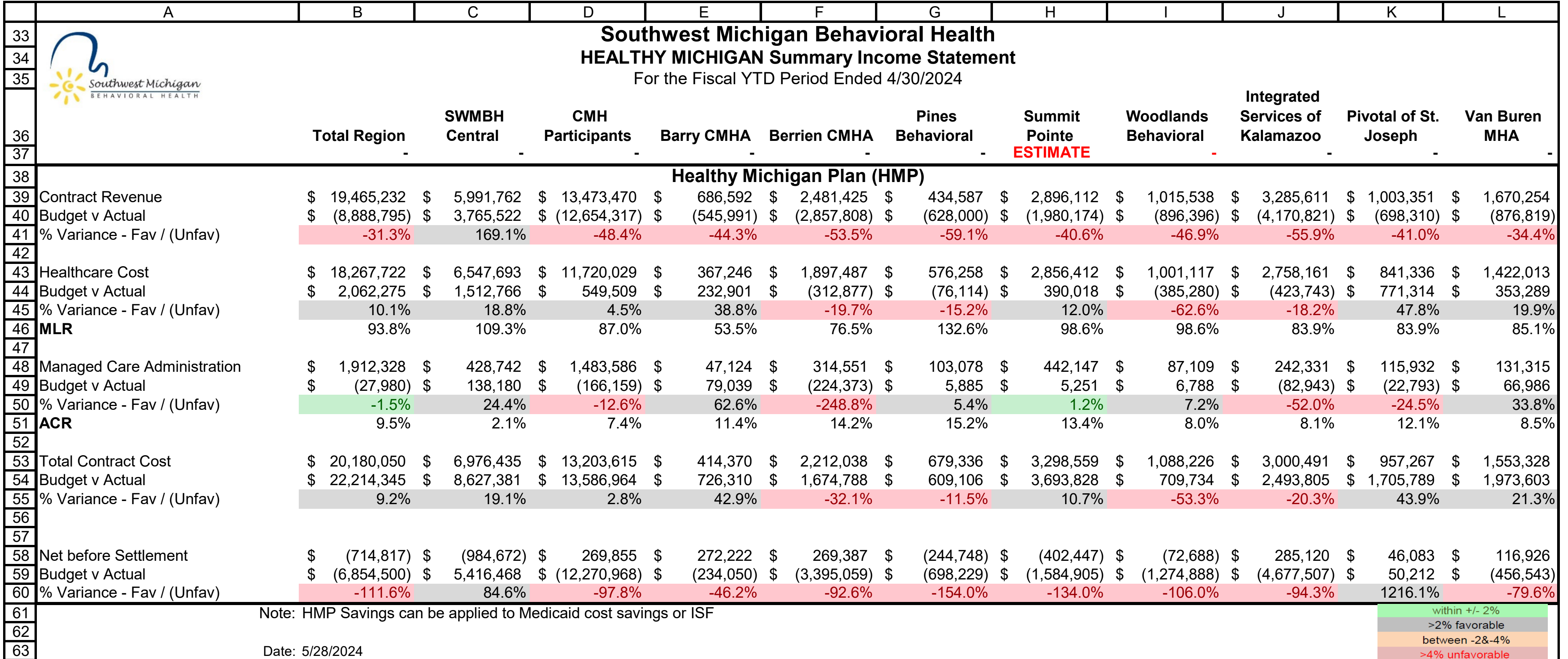
For the Fiscal YTD Period Ended 4/30/2024

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe ESTIMATE	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
Medicaid Specialty Services											
Contract Revenue	$ 146,164,969	$ 9,995,106	$ 136,169,862	$ 6,322,113	$ 26,156,756	$ 7,127,944	$ 25,395,161	$ 8,863,692	$ 39,054,722	$ 8,883,395	$ 14,366,079
Budget v Actual	$ 7,821,883	$ (5,800,324)	$ 13,622,207	$ 1,317,029	$ 2,186,392	$ 1,023,186	$ 3,455,238	$ 582,166	$ 3,405,797	$ 1,391,805	$ 260,596
% Variance - Fav / (Unfav)	5.7%	-36.7%	11.1%	26.3%	9.1%	16.8%	15.7%	7.0%	9.6%	18.6%	1.8%
Healthcare Cost	$ 142,449,493	$ 5,554,839	$ 136,894,654	$ 4,593,230	$ 24,899,716	$ 6,268,428	$ 24,671,304	$ 10,573,521	$ 40,504,672	$ 10,486,722	$ 14,897,062
Budget v Actual	$ (12,322,207)	$ 937,846	$ (13,260,053)	$ (832,172)	$ (594,822)	$ (303,967)	$ (6,191,100)	$ (639,369)	$ (725,169)	$ (3,143,029)	$ (830,426)
% Variance - Fav / (Unfav)	-9.5%	14.4%	-10.7%	-22.1%	-2.4%	-5.1%	-33.5%	-6.4%	-1.8%	-42.8%	-5.9%
MLR	97.5%	55.6%	100.5%	72.7%	95.2%	87.9%	97.1%	119.3%	103.7%	118.0%	103.7%
Managed Care Administration	$ 16,793,962	$ 3,645,824	$ 13,148,138	$ 589,395	$ 2,504,929	$ 692,675	$ 2,795,381	$ 826,768	$ 3,558,908	$ 925,042	$ 1,255,040
Budget v Actual	$ (1,085,709)	$ 296,144	$ (1,381,853)	$ 145,468	$ (514,438)	$ (10,232)	$ 28,986	$ (27,524)	$ (842,874)	$ (393,880)	$ 232,640
% Variance - Fav / (Unfav)	-6.9%	7.5%	-11.7%	19.8%	-25.8%	-1.5%	1.0%	-3.4%	-31.0%	-74.2%	15.6%
ACR	10.5%	2.3%	8.3%	11.4%	9.1%	10.0%	10.2%	7.3%	8.1%	8.1%	7.8%
Total Contract Cost	$ 159,243,455	$ 9,200,663	$ 150,042,792	$ 5,182,625	$ 27,404,645	$ 6,961,103	$ 27,466,684	$ 11,400,289	$ 44,063,580	$ 11,411,764	$ 16,152,102
Budget v Actual	$ (13,407,916)	$ 1,233,989	$ (14,641,906)	$ (686,704)	$ (1,109,260)	$ (314,199)	$ (6,162,114)	$ (666,892)	$ (1,568,043)	$ (3,536,909)	$ (597,786)
Variance - Favorable / (Unfavorable)	-9.2%	11.8%	-10.8%	-15.3%	-4.2%	-4.7%	-28.9%	-6.2%	-3.7%	-44.9%	-3.8%
Net before Settlement	$ (13,078,487)	$ 794,443	$ (13,872,930)	$ 1,139,488	$ (1,247,889)	$ 166,842	$ (2,071,523)	$ (2,536,597)	$ (5,008,858)	$ (2,528,369)	$ (1,786,023)
Budget v Actual	$ (5,586,033)	$ (4,566,334)	$ (1,019,698)	$ 630,325	$ 1,077,132	$ 708,987	$ (2,706,876)	$ (84,727)	$ 1,837,754	$ (2,145,104)	$ (337,190)
Variance - Favorable / (Unfavorable)	-74.6%	-85.2%	-7.9%	123.8%	46.3%	130.8%	-426.0%	-3.5%	26.8%	-559.7%	-23.3%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 5/28/2024

within +/- 2%
>2% favorable
between -2&-4%
>4% unfavorable



Southwest Michigan Behavioral Health

HEALTHY MICHIGAN Summary Income Statement

For the Fiscal YTD Period Ended 4/30/2024

	Total Region	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	Pivotal of St. Joseph	Van Buren MHA
	-	-	-	-	-	-	ESTIMATE	-	-	-	-
Healthy Michigan Plan (HMP)											
Contract Revenue	$ 19,465,232	$ 5,991,762	$ 13,473,470	$ 686,592	$ 2,481,425	$ 434,587	$ 2,896,112	$ 1,015,538	$ 3,285,611	$ 1,003,351	$ 1,670,254
Budget v Actual	$ (8,888,795)	$ 3,765,522	$ (12,654,317)	$ (545,991)	$ (2,857,808)	$ (628,000)	$ (1,980,174)	$ (896,396)	$ (4,170,821)	$ (698,310)	$ (876,819)
% Variance - Fav / (Unfav)	-31.3%	169.1%	-48.4%	-44.3%	-53.5%	-59.1%	-40.6%	-46.9%	-55.9%	-41.0%	-34.4%
Healthcare Cost	$ 18,267,722	$ 6,547,693	$ 11,720,029	$ 367,246	$ 1,897,487	$ 576,258	$ 2,856,412	$ 1,001,117	$ 2,758,161	$ 841,336	$ 1,422,013
Budget v Actual	$ 2,062,275	$ 1,512,766	$ 549,509	$ 232,901	$ (312,877)	$ (76,114)	$ 390,018	$ (385,280)	$ (423,743)	$ 771,314	$ 353,289
% Variance - Fav / (Unfav)	10.1%	18.8%	4.5%	38.8%	-19.7%	-15.2%	12.0%	-62.6%	-18.2%	47.8%	19.9%
MLR	93.8%	109.3%	87.0%	53.5%	76.5%	132.6%	98.6%	98.6%	83.9%	83.9%	85.1%
Managed Care Administration	$ 1,912,328	$ 428,742	$ 1,483,586	$ 47,124	$ 314,551	$ 103,078	$ 442,147	$ 87,109	$ 242,331	$ 115,932	$ 131,315
Budget v Actual	$ (27,980)	$ 138,180	$ (166,159)	$ 79,039	$ (224,373)	$ 5,885	$ 5,251	$ 6,788	$ (82,943)	$ (22,793)	$ 66,986
% Variance - Fav / (Unfav)	-1.5%	24.4%	-12.6%	62.6%	-248.8%	5.4%	1.2%	7.2%	-52.0%	-24.5%	33.8%
ACR	9.5%	2.1%	7.4%	11.4%	14.2%	15.2%	13.4%	8.0%	8.1%	12.1%	8.5%
Total Contract Cost	$ 20,180,050	$ 6,976,435	$ 13,203,615	$ 414,370	$ 2,212,038	$ 679,336	$ 3,298,559	$ 1,088,226	$ 3,000,491	$ 957,267	$ 1,553,328
Budget v Actual	$ 22,214,345	$ 8,627,381	$ 13,586,964	$ 726,310	$ 1,674,788	$ 609,106	$ 3,693,828	$ 709,734	$ 2,493,805	$ 1,705,789	$ 1,973,603
% Variance - Fav / (Unfav)	9.2%	19.1%	2.8%	42.9%	-32.1%	-11.5%	10.7%	-53.3%	-20.3%	43.9%	21.3%
Net before Settlement	$ (714,817)	$ (984,672)	$ 269,855	$ 272,222	$ 269,387	$ (244,748)	$ (402,447)	$ (72,688)	$ 285,120	$ 46,083	$ 116,926
Budget v Actual	$ (6,854,500)	$ 5,416,468	$ (12,270,968)	$ (234,050)	$ (3,395,059)	$ (698,229)	$ (1,584,905)	$ (1,274,888)	$ (4,677,507)	$ 50,212	$ (456,543)
% Variance - Fav / (Unfav)	-111.6%	84.6%	-97.8%	-46.2%	-92.6%	-154.0%	-134.0%	-106.0%	-94.3%	1216.1%	-79.6%

Note: HMP Savings can be applied to Medicaid cost savings or ISF

Date: 5/28/2024

Legend
within +/- 2%
>2% favorable
between -2&-4%
>4% unfavorable

	E	H	J	K	M	N	P	Q	R	S
1	***Southwest Michigan Behavioral Health***		*Mos in Period*							
2	For the Fiscal YTD Period Ended 4/30/2024	**P07FYTD24**	**7**							
3	*(For Internal Management Purposes Only)*									
4	***INCOME STATEMENT***	**TOTAL**	**Medicaid Contract**	**Healthy Michigan Contract**	**Opioid Health Home Contract**	**CCBHC**	**MH Block Grant Contracts**	**SA Block Grant Contract**	**SA PA2 Funds Contract**	**SWMBH Central**
5										
18	Contract Revenue	210,239,624	145,955,290	19,465,232	953,844	37,819,049	409,379	4,405,453	1,231,376	-
19	DHHS Incentive Payments	209,679	209,679	-	-	-	-	-	-	-
21	Interest Income - Working Capital	642,667	-	-	-	-	-	-	-	642,667
22	Interest Income - ISF Risk Reserve	187,322	-	-	-	-	-	-	-	187,322
23	Local Funds Contributions	519,946	-	-	-	-	-	-	-	519,946
24	Other Local Income	-	-	-	-	-	-	-	-	-
25										
26	**TOTAL REVENUE**	**211,799,238**	**146,164,969**	**19,465,232**	**953,844**	**37,819,049**	**409,379**	**4,405,453**	**1,231,376**	**1,349,935**
27										
28	**EXPENSE**									
29	**Healthcare Cost**									
30	Provider Claims Cost	12,550,590	2,383,161	4,629,858	617,235	-	137,990	3,853,105	928,235	-
31	CMHP Subcontracts, net of 1st & 3rd party	187,141,465	136,894,654	11,720,029	-	38,152,004	-	374,779	-	-
32	Insurance Provider Assessment Withhold (IPA)	1,970,184	1,394,003	576,181	-	-	-	-	-	-
33	Medicaid Hospital Rate Adjustments	3,119,330	1,777,676	1,341,654	-	-	-	-	-	-
34	MHL Cost in Excess of Medicare FFS Cost	-	1,032	-	-	-		-	-	-
35										
36	**Total Healthcare Cost**	**204,781,569**	**142,450,526**	**18,267,722**	**617,235**	**38,152,004**	**137,990**	**4,227,883**	**928,235**	**-**
37	**Medical Loss Ratio (HCC % of Revenue)**	**97.3%**	**97.5%**	**93.8%**	**64.7%**	**100.9%**		**96.0%**	**75.4%**	
38										
40	Purchased Professional Services	203,738	-	-	-	-	-	-	-	203,738
41	Administrative and Other Cost	5,412,967	-	-	-	-	271,389	59,929	-	5,083,040
43	Depreciation	4,237	-	-	-	-	-	-	-	4,237
44	Functional Cost Reclassification	-	-	-	-	-	-	-	-	-
45	Allocated Indirect Pooled Cost	0	-	-	-	-	-	-	-	(1,391)
46	Delegated Managed Care Admin	14,631,724	13,148,138	1,483,586	-	-	-	-	-	-
47	Apportioned Central Mgd Care Admin	0	3,645,824	428,742	16,186	991,125	10,735	118,887	-	(5,211,525)
48										
49	**Total Administrative Cost**	**20,252,666**	**16,793,962**	**1,912,328**	**16,186**	**991,125**	**282,124**	**178,816.56**	**-**	**78,098**
50	**Admin Cost Ratio (MCA % of Total Cost)**	**9.0%**	**10.5%**	**9.5%**	**2.6%**	**2.5%**		**4.1%**	**0.0%**	**2.3%**
51										
52	Local Funds Contribution	519,946	-	-	-	-	-	-	-	519,946
54										
55	**TOTAL COST after apportionment**	**225,554,181**	**159,244,487**	**20,180,050**	**633,421**	**39,143,129**	**420,114**	**4,406,700**	**928,235**	**598,045**
56										
57	**NET SURPLUS before settlement**	**(13,754,943)**	**(13,079,519)**	**(714,817)**	**320,423**	**(1,324,079)**	**(10,735)**	**(1,247)**	**303,141**	**751,890**
58	**Net Surplus (Deficit) % of Revenue**	**-6.5%**	**-8.9%**	**-3.7%**	**33.6%**	**-3.5%**	**-2.6%**	**0.0%**	**24.6%**	**55.7%**
60	Prior Year Savings	-	-	-	-	-		-	-	-
61	Change in PA2 Fund Balance	(301,894)	-	-	-	-		-	(301,894)	-
62										
63	ISF Risk Reserve Abatement (Funding)	(187,322)	-	-	-	-		-	-	(187,322)
64	ISF Risk Reserve Deficit (Funding)	13,794,336	13,794,336	-	-	-		-	-	-
65	CCBHC Supplemental Reciveable (Payable)	751,951				751,951				
66	Settlement Receivable / (Payable)	0	(966,523)	714,817	(320,423)	572,128	-	1,247	(1,247)	-
67	**NET SURPLUS (DEFICIT)**	**302,128**	**(251,705)**	**-**	**-**	**-**	**(10,735)**	**-**	**-**	**564,568**
68	*HMP & Autism is settled with Medicaid*									
69										
70	**SUMMARY OF NET SURPLUS (DEFICIT)**									
71	Prior Year Unspent Savings	-	-	-	-	-		-	-	-
72	Current Year Savings	-	-	-	-	-		-	-	-
73	Current Year Public Act 2 Fund Balance	-	-	-	-	-		-	-	-
74	Local and Other Funds Surplus/(Deficit)	302,128	(251,705)	-	-	-	(10,735)	-	-	564,568
75										
76	**NET SURPLUS (DEFICIT)**	**302,128**	**(251,705)**	**-**	**-**	**-**	**(10,735)**	**-**	**-**	**564,568**

	F	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***		*Mos in Period*									
2	For the Fiscal YTD Period Ended 4/30/2024		7									
3	*(For Internal Management Purposes Only)*		*ok*					ESTIMATE				
4	***INCOME STATEMENT***	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5												
6	***Medicaid Specialty Services***		*HCC%*		54.7%	73.2%	60.7%	66.7%	84.5%	86.5%	83.6%	84.7%
7	Subcontract Revenue	145,955,290	9,796,018	136,159,272	6,311,524	26,156,756	7,127,944	25,395,161	8,863,692	39,054,722	8,883,395	14,366,079
8	Incentive Payment Revenue	209,679	199,089	10,590	10,590	-	-	-	-	-	-	-
9	**Contract Revenue**	**146,164,969**	**9,995,106**	**136,169,862**	**6,322,113**	**26,156,756**	**7,127,944**	**25,395,161**	**8,863,692**	**39,054,722**	**8,883,395**	**14,366,079**
10												
11	External Provider Cost	125,420,226	2,383,161	123,037,066	3,469,414	23,489,086	5,986,391	22,880,385	7,679,900	39,356,193	9,987,523	10,188,174
12	Internal Program Cost	14,453,645	-	14,453,645	1,128,316	1,926,236	282,037	1,790,919	2,893,621	1,150,638	499,199	4,782,680
13	SSI Reimb, 1st/3rd Party Cost Offset	(596,057)	-	(596,057)	(4,500)	(515,606)	-	-	-	(2,159)	-	(73,792)
14	Insurance Provider Assessment Withhold (IPA)	3,171,679	3,171,679	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**	**142,449,493**	**5,554,839**	**136,894,654**	**4,593,230**	**24,899,716**	**6,268,428**	**24,671,304**	**10,573,521**	**40,504,672**	**10,486,722**	**14,897,062**
17	**Medical Loss Ratio (HCC % of Revenue)**	**97.5%**	**55.6%**	**100.5%**	**72.7%**	**95.2%**	**87.9%**	**97.1%**	**119.3%**	**103.7%**	**118.0%**	**103.7%**
18												
19	**Managed Care Administration**	**16,793,962**	**3,645,824**	**13,148,138**	**589,395**	**2,504,929**	**692,675**	**2,795,381**	**826,768**	**3,558,908**	**925,042**	**1,255,040**
20	**Admin Cost Ratio (MCA % of Total Cost)**	**10.5%**	**2.3%**	**8.3%**	**11.4%**	**9.1%**	**10.0%**	**10.2%**	**7.3%**	**8.1%**	**8.1%**	**7.8%**
21												
22	**Contract Cost**	**159,243,455**	**9,200,663**	**150,042,792**	**5,182,625**	**27,404,645**	**6,961,103**	**27,466,684**	**11,400,289**	**44,063,580**	**11,411,764**	**16,152,102**
23	**Net before Settlement**	**(13,078,487)**	**794,443**	**(13,872,930)**	**1,139,488**	**(1,247,889)**	**166,842**	**(2,071,523)**	**(2,536,597)**	**(5,008,858)**	**(2,528,369)**	**(1,786,023)**
24												
25	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
27	Contract Settlement / Redistribution	(966,523)	(14,839,453)	13,872,930	(1,139,488)	1,247,889	(166,842)	2,071,523	2,536,597	5,008,858	2,528,369	1,786,023
28	**Net after Settlement**	**(14,045,009)**	**(14,045,009)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
29												
30	**Eligibles and PMPM**											
31	Average Eligibles	165,953	165,953	165,953	9,094	31,232	9,797	32,305	9,653	43,818	13,480	16,574
32	Revenue PMPM	$ 125.82	$ 8.60	$ 117.22	$ 99.31	$ 119.64	$ 103.94	$ 112.30	$ 131.18	$ 127.33	$ 94.14	$ 123.83
33	Expense PMPM	$ 137.08	$ 7.92	$ 129.16	$ 81.41	$ 125.35	$ 101.50	$ 121.46	$ 168.72	$ 143.66	$ 120.94	$ 139.22
34	Margin PMPM	$ (11.26)	$ 0.68	$ (11.94)	$ 17.90	$ (5.71)	$ 2.43	$ (9.16)	$ (37.54)	$ (16.33)	$ (26.79)	$ (15.39)
35												
36	***Medicaid Specialty Services***											
37	**Budget v Actual**											
38												
39	**Eligible Lives (Average Eligibles)**											
40	Actual	165,953	165,953	165,953	9,094	31,232	9,797	32,305	9,653	43,818	13,480	16,574
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)	(16,402)	(16,402)	(16,402)	(997)	(3,066)	(961)	(3,090)	(1,017)	(3,911)	(1,550)	(1,810)
43	% Variance - Fav / (Unfav)	-9.0%	-9.0%	-9.0%	-9.9%	-8.9%	-8.9%	-8.7%	-9.5%	-8.2%	-10.3%	-9.8%
44												
45	**Contract Revenue before settlement**											
46	Actual	146,164,969	9,995,106	136,169,862	6,322,113	26,156,756	7,127,944	25,395,161	8,863,692	39,054,722	8,883,395	14,366,079
47	Budget	138,343,085	15,795,430	122,547,655	5,005,085	23,970,364	6,104,758	21,939,924	8,281,527	35,648,925	7,491,590	14,105,483
48	Variance - Favorable / (Unfavorable)	7,821,883	(5,800,324)	13,622,207	1,317,029	2,186,392	1,023,186	3,455,238	582,166	3,405,797	1,391,805	260,596
49	% Variance - Fav / (Unfav)	5.7%	-36.7%	11.1%	26.3%	9.1%	16.8%	15.7%	7.0%	9.6%	18.6%	1.8%
50												
51	**Healthcare Cost**											
52	Actual	142,449,493	5,554,839	136,894,654	4,593,230	24,899,716	6,268,428	24,671,304	10,573,521	40,504,672	10,486,722	14,897,062
53	Budget	130,127,286	6,492,685	123,634,601	3,761,058	24,304,894	5,964,461	18,480,204	9,934,152	39,779,503	7,343,693	14,066,637
54	Variance - Favorable / (Unfavorable)	(12,322,207)	937,846	(13,260,053)	(832,172)	(594,822)	(303,967)	(6,191,100)	(639,369)	(725,169)	(3,143,029)	(830,426)
55	% Variance - Fav / (Unfav)	-9.5%	14.4%	-10.7%	-22.1%	-2.4%	-5.1%	-33.5%	-6.4%	-1.8%	-42.8%	-5.9%
56												
57	**Managed Care Administration**											
58	Actual	16,793,962	3,645,824	13,148,138	589,395	2,504,929	692,675	2,795,381	826,768	3,558,908	925,042	1,255,040
59	Budget	15,708,253	3,941,968	11,766,285	734,864	1,990,491	682,443	2,824,367	799,244	2,716,034	531,162	1,487,680
60	Variance - Favorable / (Unfavorable)	(1,085,709)	296,144	(1,381,853)	145,468	(514,438)	(10,232)	28,986	(27,524)	(842,874)	(393,880)	232,640
61	% Variance - Fav / (Unfav)	-6.9%	7.5%	-11.7%	19.8%	-25.8%	-1.5%	1.0%	-3.4%	-31.0%	-74.2%	15.6%
62												
63												
64	**Total Contract Cost**											
65	Actual	159,243,455	9,200,663	150,042,792	5,182,625	27,404,645	6,961,103	27,466,684	11,400,289	44,063,580	11,411,764	16,152,102
66	Budget	145,835,539	10,434,653	135,400,886	4,495,922	26,295,385	6,646,904	21,304,571	10,733,396	42,495,537	7,874,855	15,554,317
67	Variance - Favorable / (Unfavorable)	(13,407,916)	1,233,989	(14,641,906)	(686,704)	(1,109,260)	(314,199)	(6,162,114)	(666,892)	(1,568,043)	(3,536,909)	(597,786)
68	% Variance - Fav / (Unfav)	-9.2%	11.8%	-10.8%	-15.3%	-4.2%	-4.7%	-28.9%	-6.2%	-3.7%	-44.9%	-3.8%
69												
70	**Net before Settlement**											
71	Actual	(13,078,487)	794,443	(13,872,930)	1,139,488	(1,247,889)	166,842	(2,071,523)	(2,536,597)	(5,008,858)	(2,528,369)	(1,786,023)
72	Budget	(7,492,454)	5,360,778	(12,853,231)	509,163	(2,325,022)	(542,146)	635,353	(2,451,870)	(6,846,612)	(383,265)	(1,448,833)
73	Variance - Favorable / (Unfavorable)	(5,586,033)	(4,566,334)	(1,019,698)	630,325	1,077,132	708,987	(2,706,876)	(84,727)	1,837,754	(2,145,104)	(337,190)
74		-74.6%	-85.2%	-7.9%	123.8%	46.3%	130.8%	-426.0%	-3.5%	26.8%	-559.7%	-23.3%
75												

	F	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***		*Mos in Period*									
2	For the Fiscal YTD Period Ended 4/30/2024		7									
3	*(For Internal Management Purposes Only)*		*ok*					ESTIMATE				
4	***INCOME STATEMENT***	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5												
76	***Healthy Michigan Plan***		*HCC%*		4.4%	5.5%	5.6%	7.7%	8.0%	10.0%	9.8%	8.0%
78								ESTIMATE				
79	External Provider Cost	14,196,292	4,629,858	9,566,435	333,863	1,596,741	540,038	2,692,117	283,369	2,701,315	800,805	618,187
80	Internal Program Cost	2,153,594	-	2,153,594	33,383	300,746	36,219	164,296	717,748	56,846	40,531	803,826
81	SSI Reimb, 1st/3rd Party Cost Offset	-	-	-	-	-	-	-	-	-	-	-
82	Insurance Provider Assessment Withhold (IPA)	1,917,835	1,917,835	-	-	-	-	-	-	-	-	-
83	**Total Healthcare Cost**	**18,267,722**	**6,547,693**	**11,720,029**	**367,246**	**1,897,487**	**576,258**	**2,856,412**	**1,001,117**	**2,758,161**	**841,336**	**1,422,013**
84	**Medical Loss Ratio (HCC % of Revenue)**	**93.8%**	**109.3%**	**87.0%**	**53.5%**	**76.5%**	**132.6%**	**98.6%**	**98.6%**	**83.9%**	**83.9%**	**85.1%**
85												
86	**Managed Care Administration**	**1,912,328**	**428,742**	**1,483,586**	**47,124**	**314,551**	**103,078**	**442,147**	**87,109**	**242,331**	**115,932**	**131,315**
87	**Admin Cost Ratio (MCA % of Total Cost)**	**9.5%**	**2.1%**	**7.4%**	**11.4%**	**14.2%**	**15.2%**	**13.4%**	**8.0%**	**8.1%**	**12.1%**	**8.5%**
88												
89	**Contract Cost**	**20,180,050**	**6,976,435**	**13,203,615**	**414,370**	**2,212,038**	**679,336**	**3,298,559**	**1,088,226**	**3,000,491**	**957,267**	**1,553,328**
90	**Net before Settlement**	**(714,817)**	**(984,672)**	**269,855**	**272,222**	**269,387**	**(244,748)**	**(402,447)**	**(72,688)**	**285,120**	**46,083**	**116,926**
91												
92	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-
93	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
94	Contract Settlement / Redistribution	714,817	984,672	(269,855)	(272,222)	(269,387)	244,748	402,447	72,688	(285,120)	(46,083)	(116,926)
95	**Net after Settlement**	**(0)**	**(0)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
96												
97	**Eligibles and PMPM**											
98	Average Eligibles	68,593	68,593	68,593	3,579	13,649	3,304	12,603	3,994	19,730	5,207	6,527
99	Revenue PMPM	$ 40.54	$ 12.48	$ 28.06	$ 27.40	$ 25.97	$ 18.79	$ 32.83	$ 36.33	$ 23.79	$ 27.53	$ 36.56
100	Expense PMPM	42.03	14.53	27.50	16.54	23.15	29.37	37.39	38.93	21.73	26.26	34.00
101	Margin PMPM	$ (1.49)	$ (2.05)	$ 0.56	$ 10.87	$ 2.82	$ (10.58)	$ (4.56)	$ (2.60)	$ 2.06	$ 1.26	$ 2.56
102												
103	***Healthy Michigan Plan***											
104	**Budget v Actual**											
105												
106	**Eligible Lives (Average Eligibles)**											
107	Actual	68,593	68,593	68,593	3,579	13,649	3,304	12,603	3,994	19,730	5,207	6,527
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)	(12,306)	(12,306)	(12,306)	(556)	(2,128)	(549)	(2,197)	(929)	(3,716)	(1,018)	(1,213)
110	% Variance - Fav / (Unfav)	-15.2%	-15.2%	-15.2%	-13.4%	-13.5%	-14.3%	-14.8%	-18.9%	-15.9%	-16.4%	-15.7%
111												
112	**Contract Revenue before settlement**											
113	Actual	19,465,232	5,991,762	13,473,470	686,592	2,481,425	434,587	2,896,112	1,015,538	3,285,611	1,003,351	1,670,254
114	Budget	28,354,027	2,226,241	26,127,787	1,232,583	5,339,233	1,062,587	4,876,285	1,911,933	7,456,432	1,701,660	2,547,073
115	Variance - Favorable / (Unfavorable)	(8,888,795)	3,765,522	(12,654,317)	(545,991)	(2,857,808)	(628,000)	(1,980,174)	(896,396)	(4,170,821)	(698,310)	(876,819)
116	% Variance - Fav / (Unfav)	-31.3%	169.1%	-48.4%	-44.3%	-53.5%	-59.1%	-40.6%	-46.9%	-55.9%	-41.0%	-34.4%
117												
118	**Healthcare Cost**											
119	Actual	18,267,722	6,547,693	11,720,029	367,246	1,897,487	576,258	2,856,412	1,001,117	2,758,161	841,336	1,422,013
120	Budget	20,329,997	8,060,459	12,269,537	600,147	1,584,610	500,144	3,246,431	615,837	2,334,418	1,612,650	1,775,302
121	Variance - Favorable / (Unfavorable)	2,062,275	1,512,766	549,509	232,901	(312,877)	(76,114)	390,018	(385,280)	(423,743)	771,314	353,289
122	% Variance - Fav / (Unfav)	10.1%	18.8%	4.5%	38.8%	-19.7%	-15.2%	12.0%	-62.6%	-18.2%	47.8%	19.9%
123												
124	**Managed Care Administration**											
125	Actual	1,912,328	428,742	1,483,586	47,124	314,551	103,078	442,147	87,109	242,331	115,932	131,315
126	Budget	1,884,348	566,922	1,317,427	126,164	90,178	108,963	447,398	93,897	159,388	93,139	198,301
127	Variance - Favorable / (Unfavorable)	(27,980)	138,180	(166,159)	79,039	(224,373)	5,885	5,251	6,788	(82,943)	(22,793)	66,986
128	% Variance - Fav / (Unfav)	-1.5%	24.4%	-12.6%	62.6%	-248.8%	5.4%	1.2%	7.2%	-52.0%	-24.5%	33.8%
129												
130	**Total Contract Cost**											
131	Actual	20,180,050	6,976,435	13,203,615	414,370	2,212,038	679,336	3,298,559	1,088,226	3,000,491	957,267	1,553,328
132	Budget	22,214,345	8,627,381	13,586,964	726,310	1,674,788	609,106	3,693,828	709,734	2,493,805	1,705,789	1,973,603
133	Variance - Favorable / (Unfavorable)	2,034,295	1,650,946	383,349	311,940	(537,250)	(70,230)	395,269	(378,492)	(506,686)	748,522	420,276
134	% Variance - Fav / (Unfav)	9.2%	19.1%	2.8%	42.9%	-32.1%	-11.5%	10.7%	-53.3%	-20.3%	43.9%	21.3%
135												
136	**Net before Settlement**											
137	Actual	(714,817)	(984,672)	269,855	272,222	269,387	(244,748)	(402,447)	(72,688)	285,120	46,083	116,926
138	Budget	6,139,682	(6,401,140)	12,540,823	506,272	3,664,445	453,481	1,182,457	1,202,200	4,962,627	(4,129)	573,470
139	Variance - Favorable / (Unfavorable)	(6,854,500)	5,416,468	(12,270,968)	(234,050)	(3,395,059)	(698,229)	(1,584,905)	(1,274,888)	(4,677,507)	50,212	(456,543)
140		-111.6%	84.6%	-97.8%	-46.2%	-92.6%	-154.0%	-134.0%	-106.0%	-94.3%	1216.1%	-79.6%

	F	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***		*Mos in Period*									
2	For the Fiscal YTD Period Ended 4/30/2024		7									
3	*(For Internal Management Purposes Only)*		*ok*					ESTIMATE				
4	***INCOME STATEMENT***	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5												
160												
161	***Certified Community Behavioral Health Clin***		*HCC%*		0.0%	0.0%	0.0%	0.0%	0.0%	26.0%	21.9%	0.0%
162	**Contract Revenue**	**37,819,049**	**(399,433)**	**38,218,482**	**2,039,958**	**7,281,151**	**2,551,869**	**6,935,612**	**-**	**15,778,146**	**3,631,746**	**-**
163								ESTIMATE				
164	External Provider Cost	3,457,110	-	3,457,110	-	-	-	-	-	3,457,110	-	-
165	Internal Program Cost	34,688,584	-	34,688,584	2,773,477	5,967,308	2,781,308	7,238,367	-	12,466,810	3,461,314	-
166	SSI Reimb, 1st/3rd Party Cost Offset	(349,578)	-	(349,578)	-	-	-	-	-	(272,160)	(77,418)	-
168	**Total Healthcare Cost**	**38,152,004**	**-**	**38,152,004**	**3,129,365**	**5,967,308**	**2,781,308**	**7,238,367**	**-**	**15,651,760**	**3,383,896**	**-**
169	**Medical Loss Ratio (HCC % of Revenue)**	**100.9%**	**0.0%**	**99.8%**	**153.4%**	**82.0%**	**109.0%**	**104.4%**	**0.0%**	**99.2%**	**93.2%**	**0.0%**
170												
171	**Managed Care Administration**	**991,125**	**991,125**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
172	**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%**
173												
174	**Contract Cost**	**39,143,129**	**991,125**	**38,152,004**	**3,129,365**	**5,967,308**	**2,781,308**	**7,238,367**	**-**	**15,651,760**	**3,383,896**	**-**
175	**Net before Settlement**	**(1,324,079)**	**(1,390,558)**	**66,478**	**(1,089,407)**	**1,313,843**	**(229,438)**	**(302,755)**	**-**	**126,385**	**247,850**	**-**
176	PPS-1 Supplemental Payment Difference	-	4,228,007	(4,228,007)	(1,185,067)	(851,215)	(865,214)	(574,561)	-	241,745	(993,696)	-
177	Contract Settlement / Redistribution	-	(4,294,486)	4,294,486	95,660	2,165,058	635,775	271,806	-	(115,360)	1,241,546	-
178	**Net after Settlement**	**-**	**(4,294,486)**	**4,294,486**	**95,660**	**2,165,058**	**635,775**	**271,806**	**-**	**(115,360)**	**1,241,546**	**-**
179												
180												
199	***SWMBH CMHP Subcontracts***							ESTIMATE				
200	Subcontract Revenue	203,239,572	15,388,347	187,851,224	9,038,074	35,919,332	10,114,401	35,226,885	9,879,230	58,118,479	13,518,491	16,036,333
201	Incentive Payment Revenue	209,679	199,089	10,590	10,590	-	-	-	-	-	-	-
202	**Contract Revenue**	**203,449,250**	**15,587,436**	**187,861,814**	**9,048,664**	**35,919,332**	**10,114,401**	**35,226,885**	**9,879,230**	**58,118,479**	**13,518,491**	**16,036,333**
203												
204	External Provider Cost	143,073,629	7,013,018	136,146,944	3,803,277	25,085,827	6,526,429	25,572,501	8,049,601	45,514,618	10,788,328	10,806,361
205	Internal Program Cost	51,295,823	-	51,295,823	3,935,176	8,194,290	3,099,563	9,193,582	3,611,369	13,674,294	4,001,043	5,586,506
206	SSI Reimb, 1st/3rd Party Cost Offset	(596,057)	-	(596,057)	(4,500)	(515,606)	-	-	-	(274,319)	(77,418)	(73,792)
207	Insurance Provider Assessment Withhold (IPA)	5,089,514	5,089,514	-	-	-	-	-	-	-	-	-
209	**Total Healthcare Cost**	**198,862,909**	**12,102,532**	**186,846,710**	**7,733,953**	**32,764,511**	**9,625,993**	**34,766,084**	**11,660,970**	**58,914,593**	**14,711,953**	**16,319,075**
210	**Medical Loss Ratio (HCC % of Revenue)**	**97.7%**	**77.6%**	**99.5%**	**85.5%**	**91.2%**	**95.2%**	**98.7%**	**118.0%**	**101.4%**	**108.8%**	**101.8%**
211												
212	**Managed Care Administration**	**19,697,415**	**5,065,691**	**14,631,724**	**636,519**	**2,819,480**	**795,753**	**3,237,527**	**913,877**	**3,801,239**	**1,040,973**	**1,386,355**
213	**Admin Cost Ratio (MCA % of Total Cost)**	**9.0%**	**2.3%**	**6.7%**	**7.6%**	**7.9%**	**7.6%**	**8.5%**	**7.3%**	**6.1%**	**6.6%**	**7.8%**
214												
215	**Contract Cost**	**218,560,324**	**17,168,223**	**201,478,434**	**8,370,472**	**35,583,991**	**10,421,746**	**38,003,611**	**12,574,847**	**62,715,832**	**15,752,926**	**17,705,430**
216	**Net before Settlement**	**(15,111,073)**	**(1,580,787)**	**(13,616,620)**	**678,191**	**335,341**	**(307,345)**	**(2,776,726)**	**(2,695,618)**	**(4,597,353)**	**(2,234,436)**	**(1,669,097)**
217												
218	Prior Year Savings	-	-	-	-	-	-	-	-	-	-	-
219	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-
220	Contract Settlement	(251,705)	(18,169,120)	17,917,415	(226,644)	1,829,717	943,121	3,048,531	2,695,618	4,481,993	3,475,982	1,669,097
221	**Net after Settlement**	**(15,362,779)**	**(19,749,907)**	**4,300,795**	**451,548**	**2,165,058**	**635,775**	**271,806**	**-**	**(115,360)**	**1,241,546**	**-**
222												

SWMBH SERVICES ADMINISTRATIVE CONTRACTS

(October 2023-March 2024)

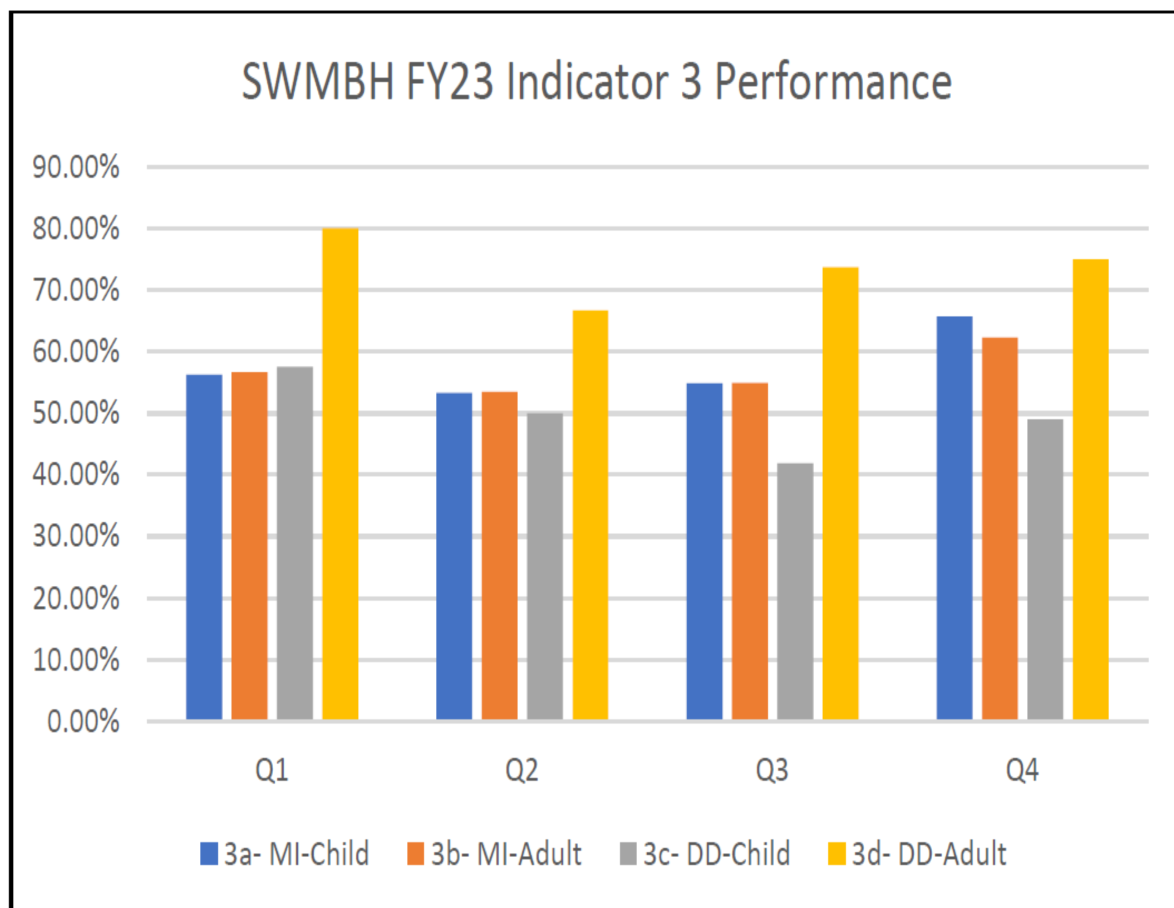
	AUNALYTICS
Deliverables/Services	• Provides Data Center & Storage Services • Web Hosting • Cloud Computing Services • Network Infrastructure • VOIP • Wireless Communications • Hardware and Software Needs (with Helpdesk Support) • Related Project Management
	FY24 Expenditure: $171,024 (FY23 Expenditure: $199,420)
	BAUCKHAM, SPARKS, THALL, SEEBER & KAUFMAN P.C.
Deliverables/Services	• Medicaid fair hearing counsel: Act as legal representation on behalf of SWMBH and participant CMHSP's for the Fair Hearing process • Perform tasks related to Fair Hearing preparation process: Record review, witness preparation and interviews • Hearing Summary preparation • Legal consultation related to Fair Hearing process
	FY24 Expenditure: $3,437 (FY23 Expenditure: $0)
	BLUE FIRE MEDIA, INC
Deliverables/Services	• Supports the SWMBH public website
	FY24 Expenditure: $890 (FY23 Expenditure: $1,030)
	CAPITOLINE CONSULTING
Deliverables/Services	• Consultation service on federal policy, regulations & funding opportunities • Secure materials and prepare briefs summarizing attended events
	FY24 Expenditure: $6,500 (FY23 Expenditure: $6,000)
	CONTRACT PHYSICIANS
Deliverables/Services	• Program policy issue consultation • Service guideline consultation and review • Medical policy review and approval • SWMBH credentialing panel participant • Consultation provided to Member Services and Contractor Network Management as necessary • On-call Medical decisions with Utilization Management during non-business hours

	• BH Human Resource Management Committee consultant
	FY24 Expenditure: $26,671 (FY23 Expenditure: $25,444)
	DOERSCHLER & ASSOCIATES
Deliverables/Services	• Fiduciary Advisors for retirement plans
	FY24 Expenditure: $12,591 (FY23 Expenditure: $11,280)
	HEALTH MANAGEMENT ASSOCIATES
Deliverables/Services	• Technical assistance on emerging regulatory initiatives regarding population health management, duals, opioid health homes and data analytics
	FY24 Expenditure: $8,763 (FY23 Expenditure: $6,233)
	LEADING EDGE MENTORING
Deliverables/Services	• Performs a preliminary assessment of SWMBH Board and management implementation.
	FY24 Expenditure: $3,437 (FY23 Expenditure: $5,012)
	MORC, INC
Deliverables/Services	• Support intensity scale assessment training
	FY24 Expenditure: $1,800 (FY23 Expenditure: $1,920)
	PHD CONSULTANTS/LIGHTHOUSE BEHAVIORAL HEALTH
Deliverables/Services	• Mental Health Parity project • Clinical consultation and project management
	FY24 Expenditure: $1,875 (FY23 Expenditure: $1,875)
	PREST AND ASSOCIATES
Deliverables/Services	• Health Plan professional independent review and consulting service • Utilization reviews concerning medical necessity and/or medical appropriateness of treatment
	FY24 Expenditure: $1,412 (FY23 Expenditure: $1,154)
	GRYPHON
Deliverables/Services	• After hours phone ansering serived for SUD phone lines
	FY24 Expenditure: $80,957 (FY23 Expenditure: $80,997)
	QUEST ANALYTICS, LLC
Deliverables/Services	• Annual Software licensing cost • To Provide Network Adequacy analysis
	FY24 Expenditure: $8,545 (FY23 Expenditure: $8,545)

	RELIAS POPULATION HEALTH (FORMERLY CARE MANAGEMENT TECHNOLOGIES, INC)
Deliverables/Services	• Licensed proprietary healthcare data analytics solution • Analyze data in order to determine opportunities for improving care and decreasing costs for SWMBH and CMHSPs • Install and manage population health and case level user application
	FY24 Expenditure: $87,569 (FY23 Expenditure: $92,550)
	ROSE ST ADVISORS/HRM INNOVATIONS, INC
Deliverables/Services	Provides support, direction and consultation in the area of Human Resources ensuring federal and state regulations and standards are met. Tasks include, but not limited to: • Cultural Insights Surveys • Strategic leadership planning • Human Resource Consulting • Recruiting
	FY24 Expenditure: $34,675 (FY23 Expenditure: $28,600)
	ROSLUND PRESTAGE & COMPANY, P.C
Deliverables/Services	• Financial, Compliance, and Single audit
	FY24 Expenditure: $73,300 (FY23 Expenditure: $46,150)
	STREAMLINE HEALTHCARE SOLUTIONS
Deliverables/Services	• Streamline Care Management System is a desktop application used to manage and pay external providers
	FY24 Expenditure: $128,706 (FY23 Expenditure: $134,128)
	TBD SOLUTIONS LLC
	• Level of Care Data Analytics and Guidelines project • Strategic Planning Support • Internal Functional assessment of UM Call Center and Provider Network
	FY24 Expenditure: $30,402 (FY23 Expenditure: $25,091)
	VARNUM LLP
Deliverables/Services	• General Counel. Retirement plans and labor law legal consultation
	FY24 Expenditure: $25,586 (FY23 Expenditure: $45,828)
	VOICES FOR HEALTH
Deliverables/Services	• Translation and Interpretation services
	FY24 Expenditure: $4,919 (FY23 Expenditure: $1,480)

Contract Services (through March 31, 2024)
FY 2024 Actual: $715,057
FY 2023 Actual: $722,737
Delta $: -7,680
Delta %: -1.06

MDHHS MMBPIS Indicator #3: *Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (by four subpopulations: MI-adults, MI-children, I/DD-adults, and I/DD-children)*



FY23 aggregate results: 56.78%

SWMBH has identified MMBPIS Indicator 3 as a region-wide performance improvement project (PIP) as outlined in the FY24 SWMBH Quality Assurance and Performance Improvement Program (QAPIP) plan. The goal of this PIP is to improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children.

The identified steps for this project include:

1. Data gathering survey completed by the CMHSPs.
2. Causal barrier analysis completed by SWMBH.
3. Data-driven development of interventions.
4. Ongoing cross-functional regional discussions.
5. Continued monitoring of the performance indicator status, using the already established practices.

2023 Consumer Satisfaction Survey Final Analysis & Recommendations

Feb. 2024

Prepared by: Kiaer Research

Prepared for: Southwest Michigan Behavioral Health

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(clickable)

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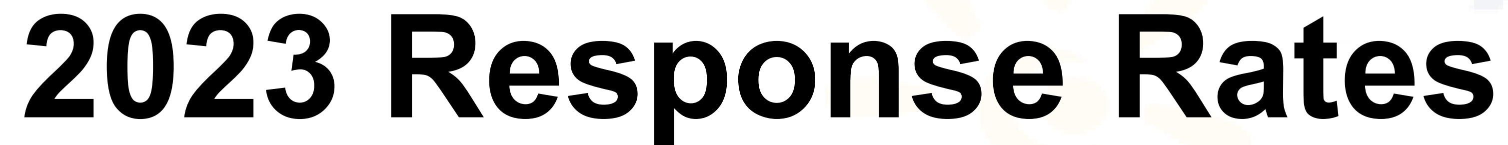
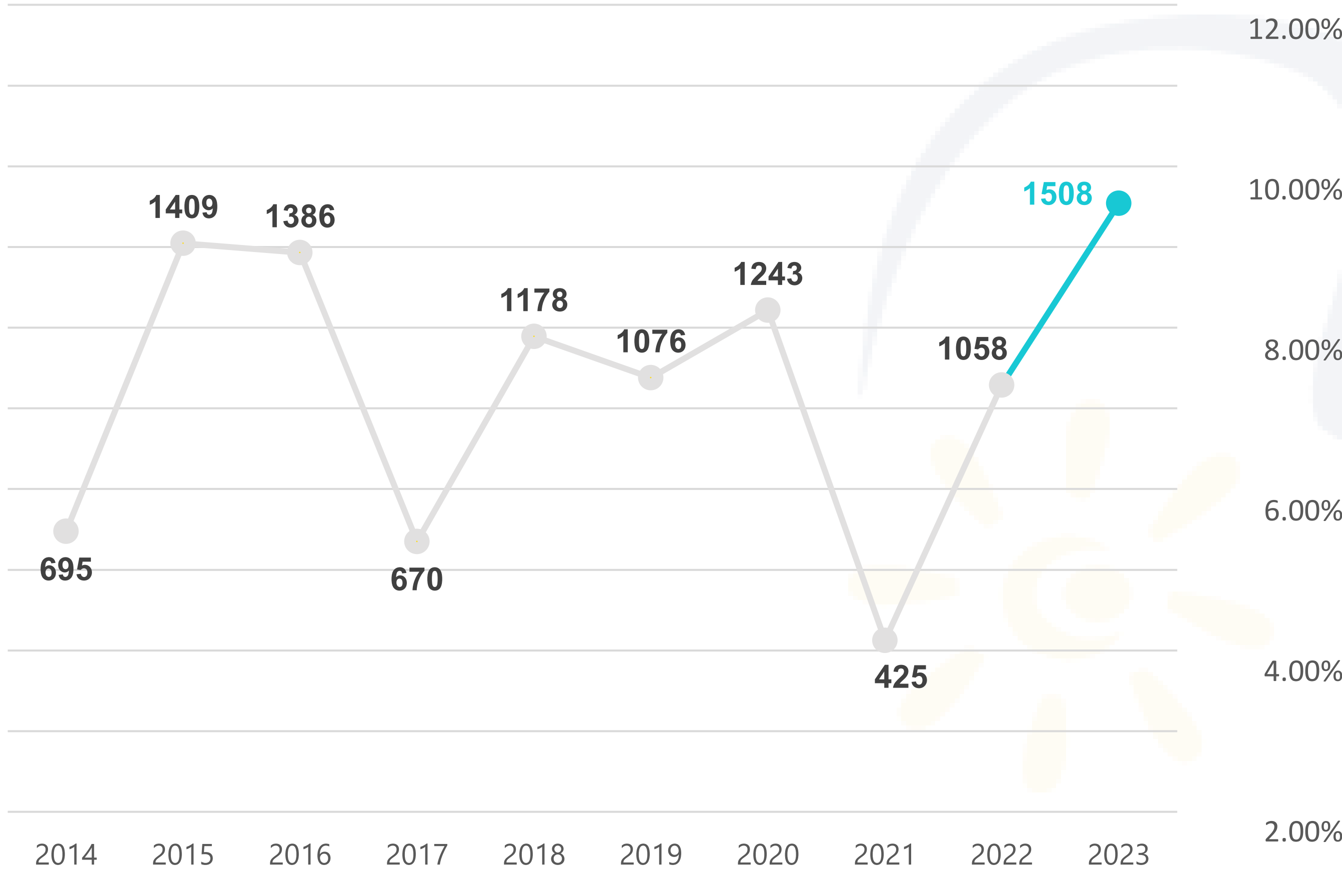


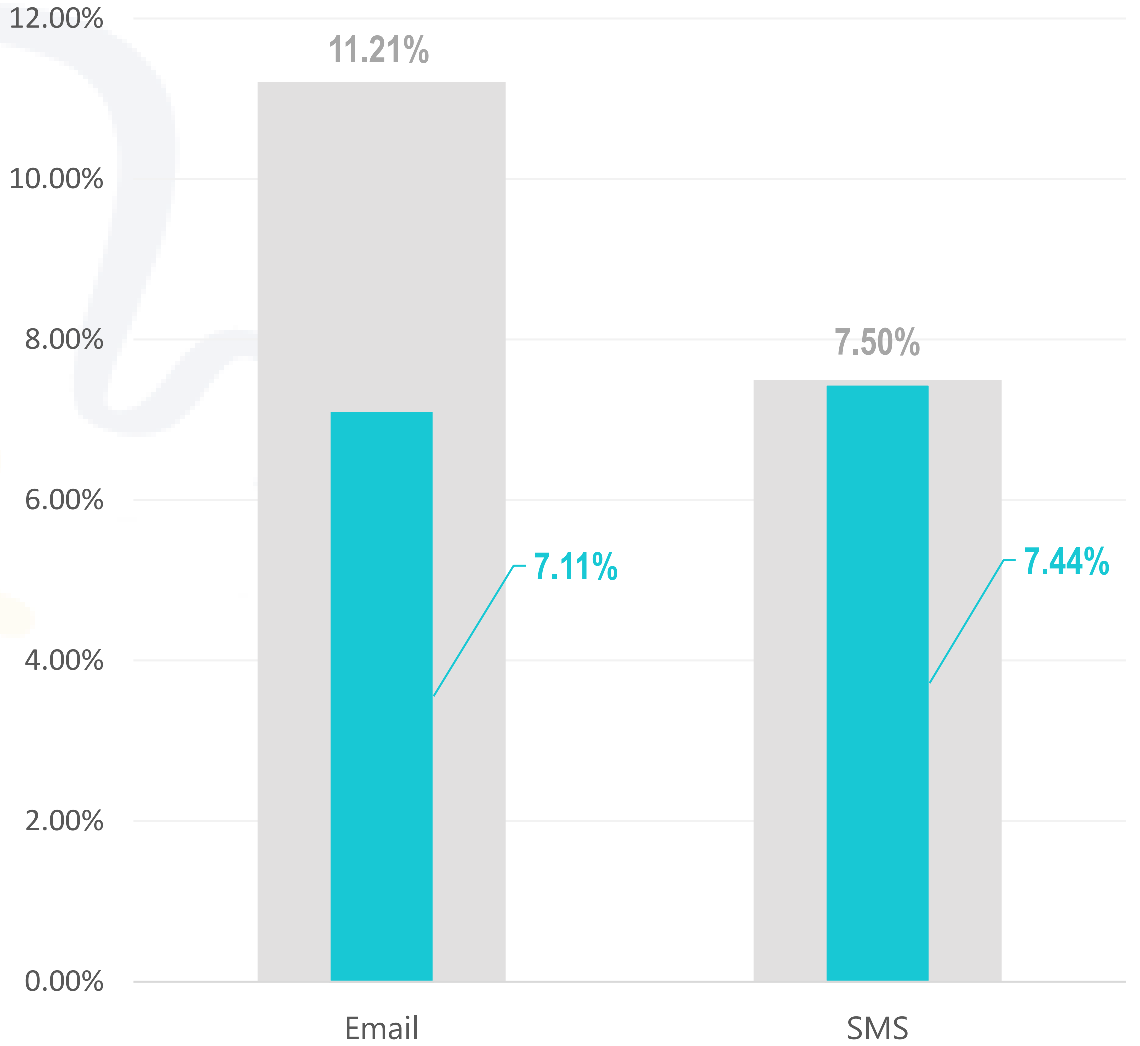
2023 Response Rates

Full methods breakdown available at end of report

Highest number of responses ever recorded for 2023 MHSIP

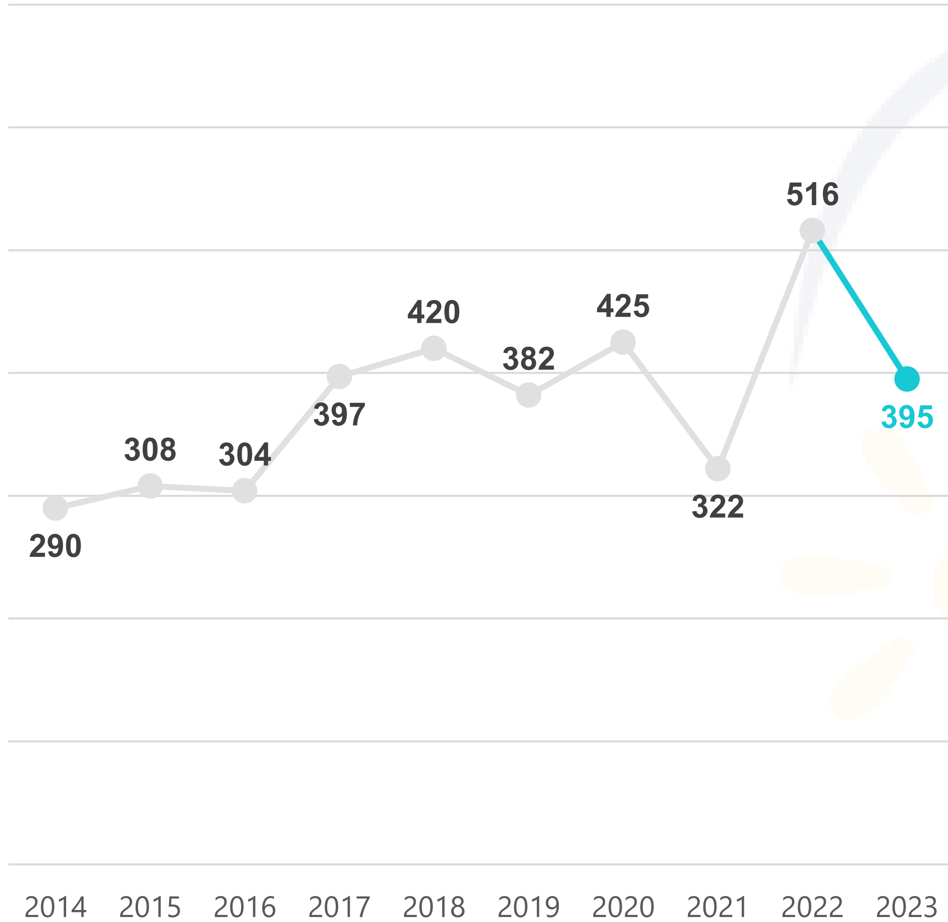
In-office responses (via QR code or paper survey) accounted for 292 (19.3%) of MHSIP responses

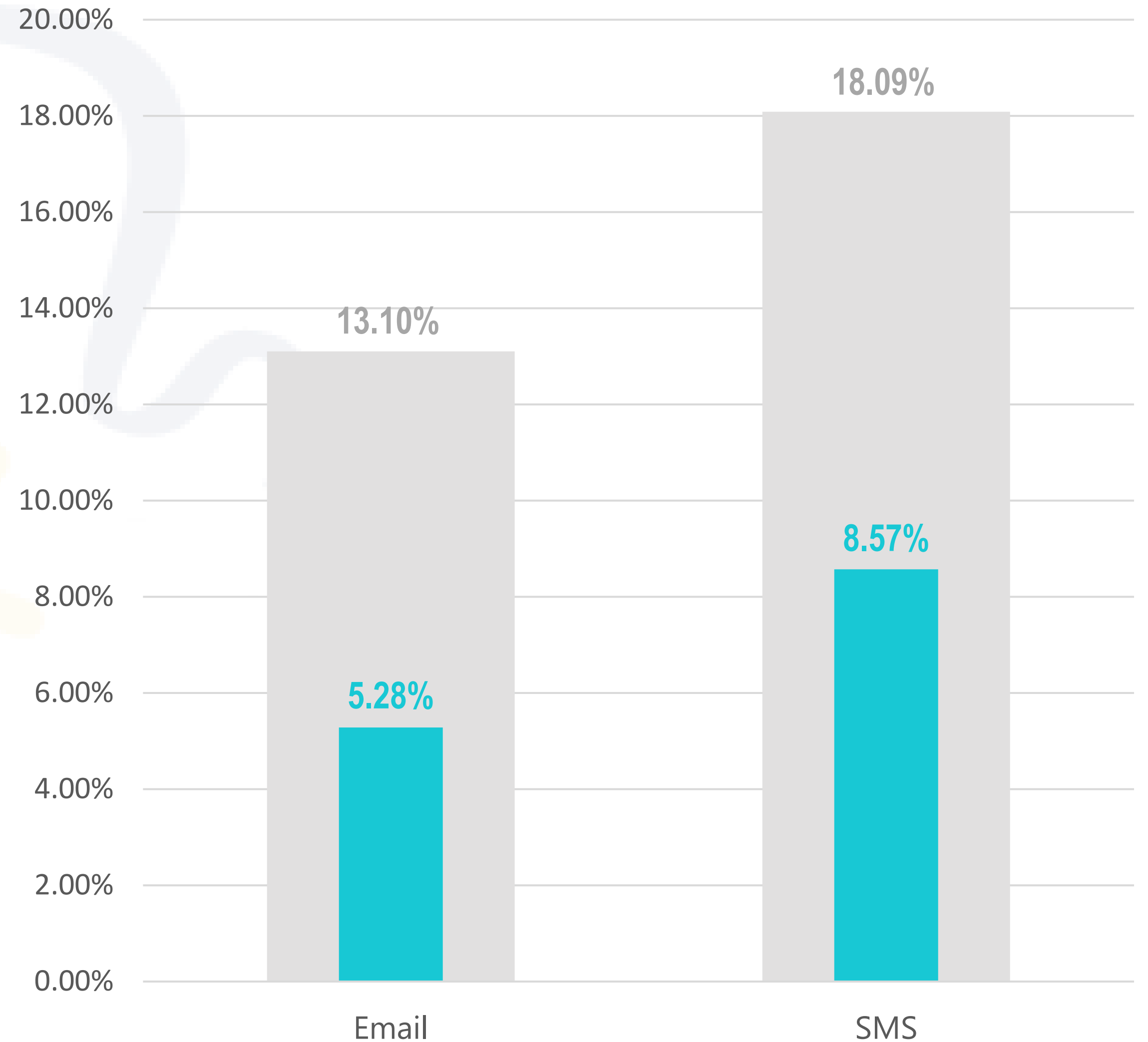




YSS total responses and response rates dipped in 2023

In-office responses (via QR code or paper survey) accounted for 73 (18.5%) of YSS responses





Changes to the 2023 Survey

Improving readability and adding demographic questions

Changes were made on 10/31/2023 at 5pm, with some responses already recorded

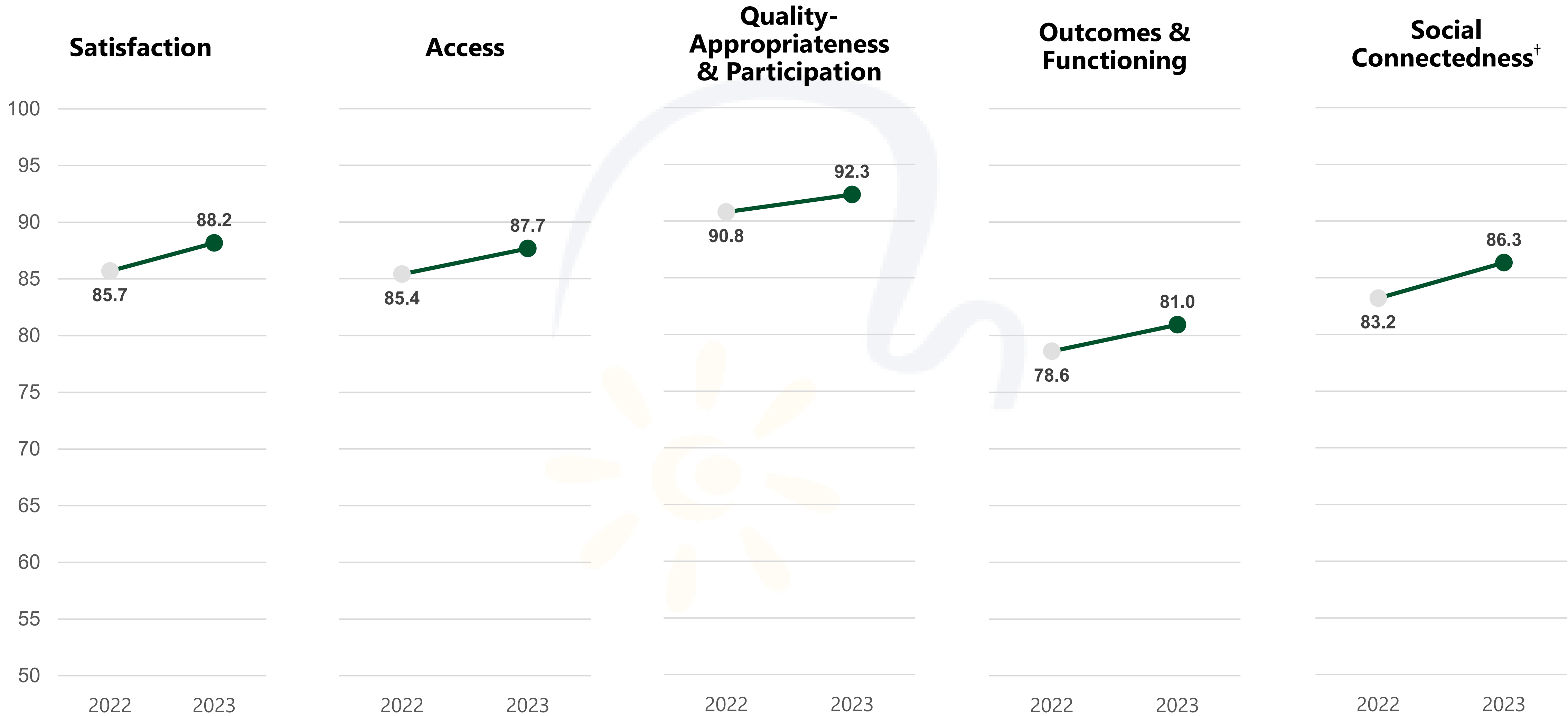
- After receiving feedback that the survey's reading level was too high, revisions were made to make questions simpler
  - Target for the survey: 6th grade reading level (Flesch-Kincaid)
  - Most revisions were not for the items themselves, but for the descriptive text before items
  - E.g.: *"Please indicate your agreement or disagreement with each of the following statements"* changed to *"Please tell us whether you agree or disagree"*
- Some items were revised to be more useful and reflective of reality
  - *"I was able to get urgent treatment as soon as I needed to"* was revised to *"…get urgent support within 3 hours"* – this reflects a more realistic type of response from CMHs
  - *"I was able to get every type of service that my provider recommended"* was revised to *"…every service that my provider and I decided I should get"* to reflect the co-construction of treatment
- Further demographic questions were added
  - Asking more specifically where consumers received services for certain CMHs
  - Asking about primary living arrangement

Mental Health Statistics Improvement Plan (MHSIP) Revised Tool: 2023 Results

Sample size: 1508

Overall, adults' social connectedness improved from 2022-2023

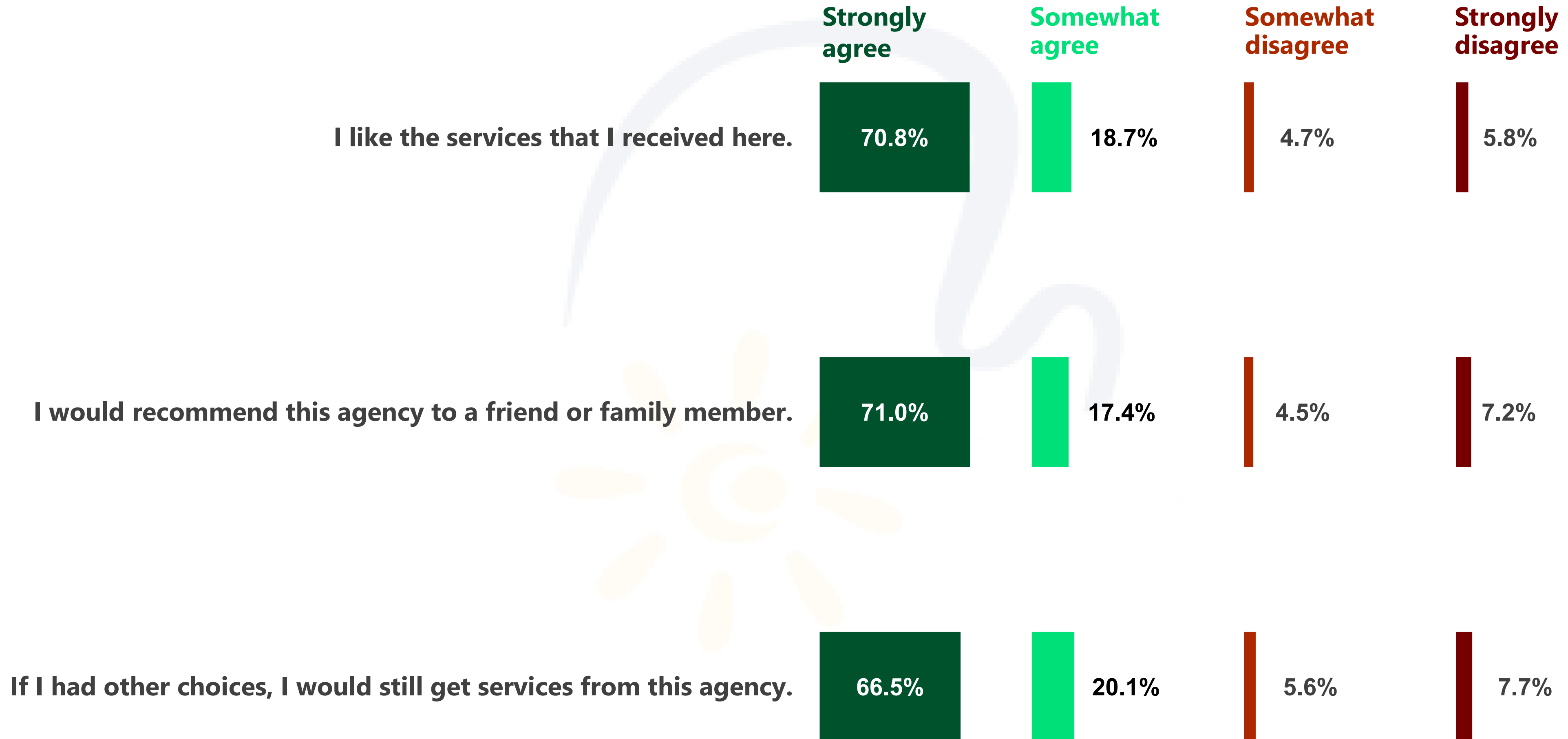
MHSIP scores by construct for previous 2 years, further past years incomparable due to survey changes. Difference in other constructs not statistically significant at 95% confidence.



† significant difference (p < .05) between this county and others for construct

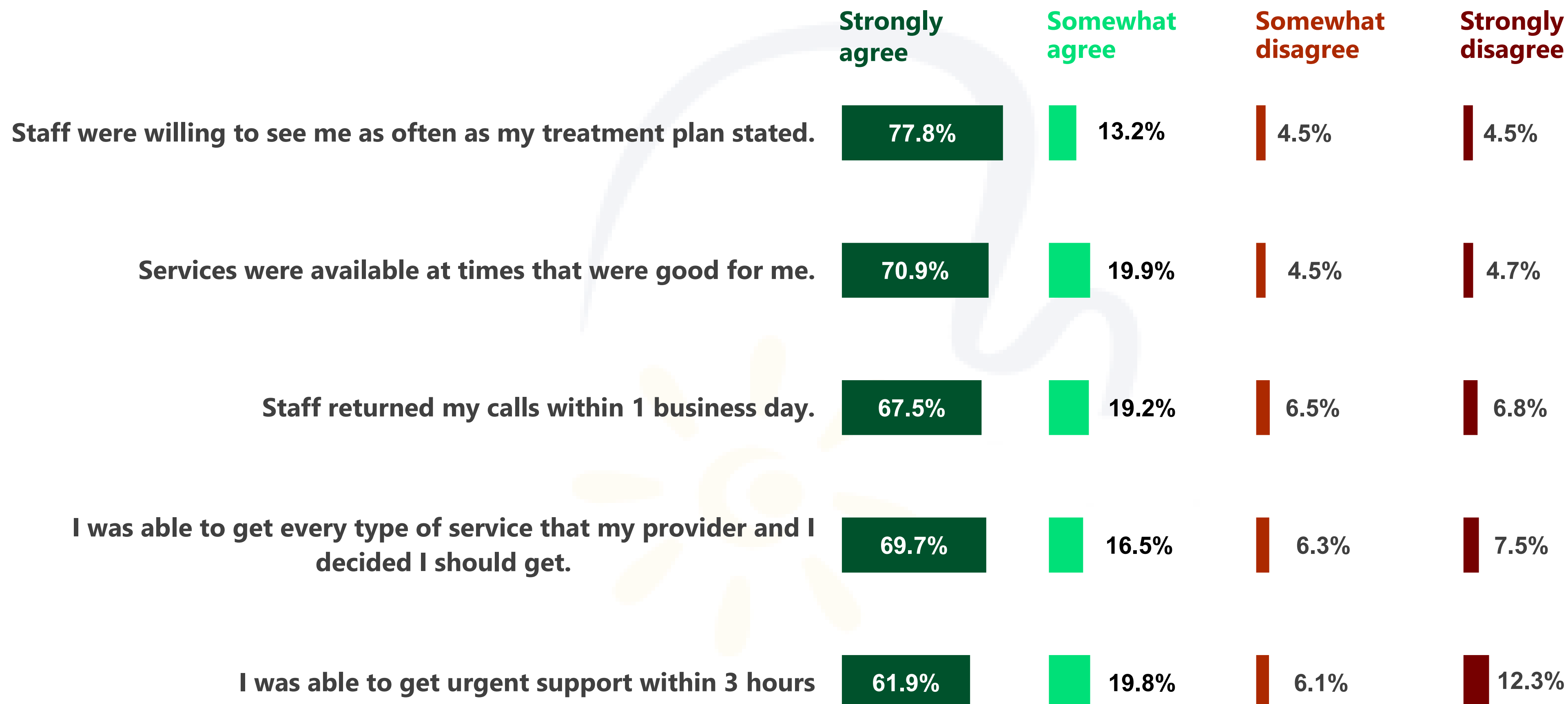
General CMHSP satisfaction was consistent across all items

And positive – a majority of MHSIP respondents **strongly agreed** with each item measuring satisfaction



Majority of consumers had good access to services

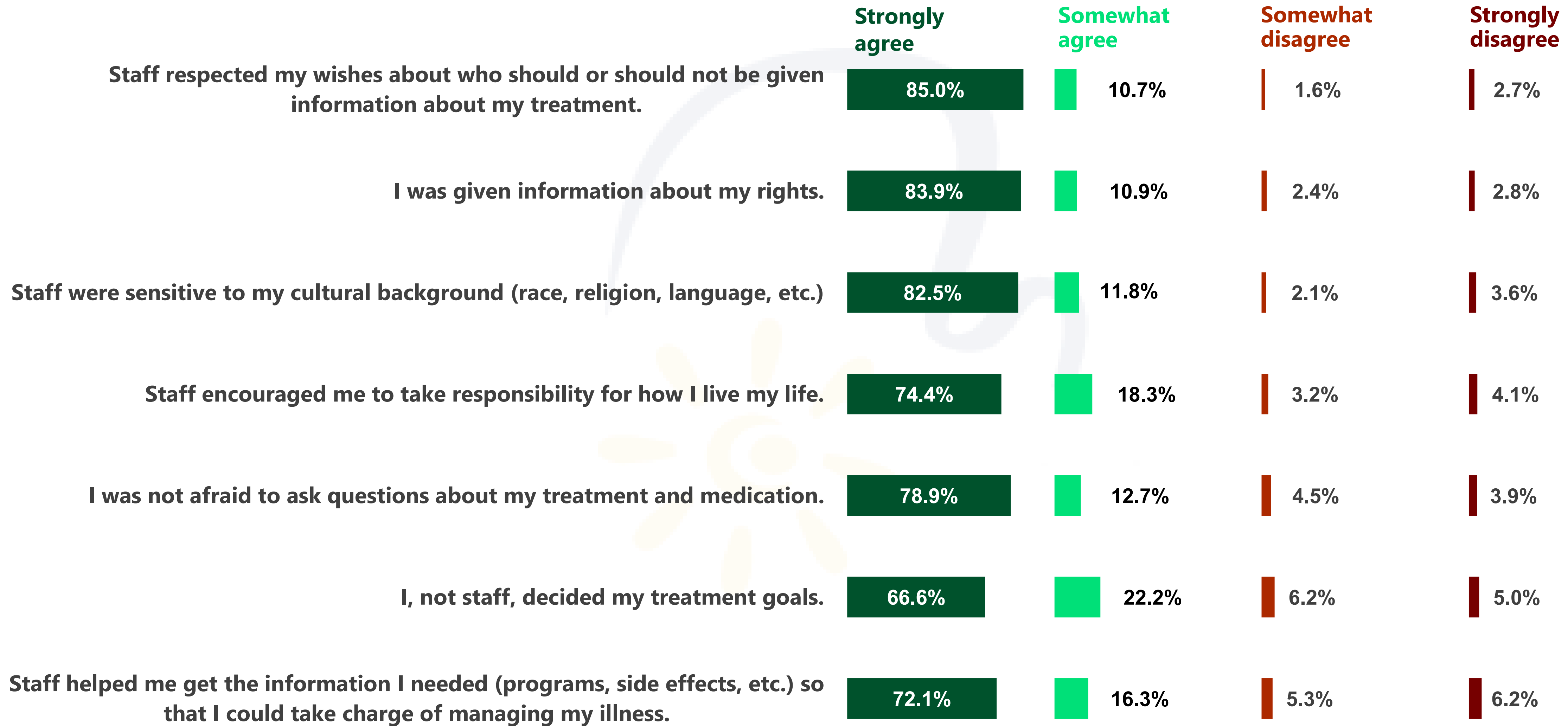
Treatment plan adherence and the timing of services were the most approved items.



	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
Staff were willing to see me as often as my treatment plan stated.	77.8%	13.2%	4.5%	4.5%
Services were available at times that were good for me.	70.9%	19.9%	4.5%	4.7%
Staff returned my calls within 1 business day.	67.5%	19.2%	6.5%	6.8%
I was able to get every type of service that my provider and I decided I should get.	69.7%	16.5%	6.3%	7.5%
I was able to get urgent support within 3 hours	61.9%	19.8%	6.1%	12.3%

Similar to 2022, lack of information provided biggest detractor from quality-appropriateness and participation

Still only just over 1 in 10 reported not having adequate information about their treatment

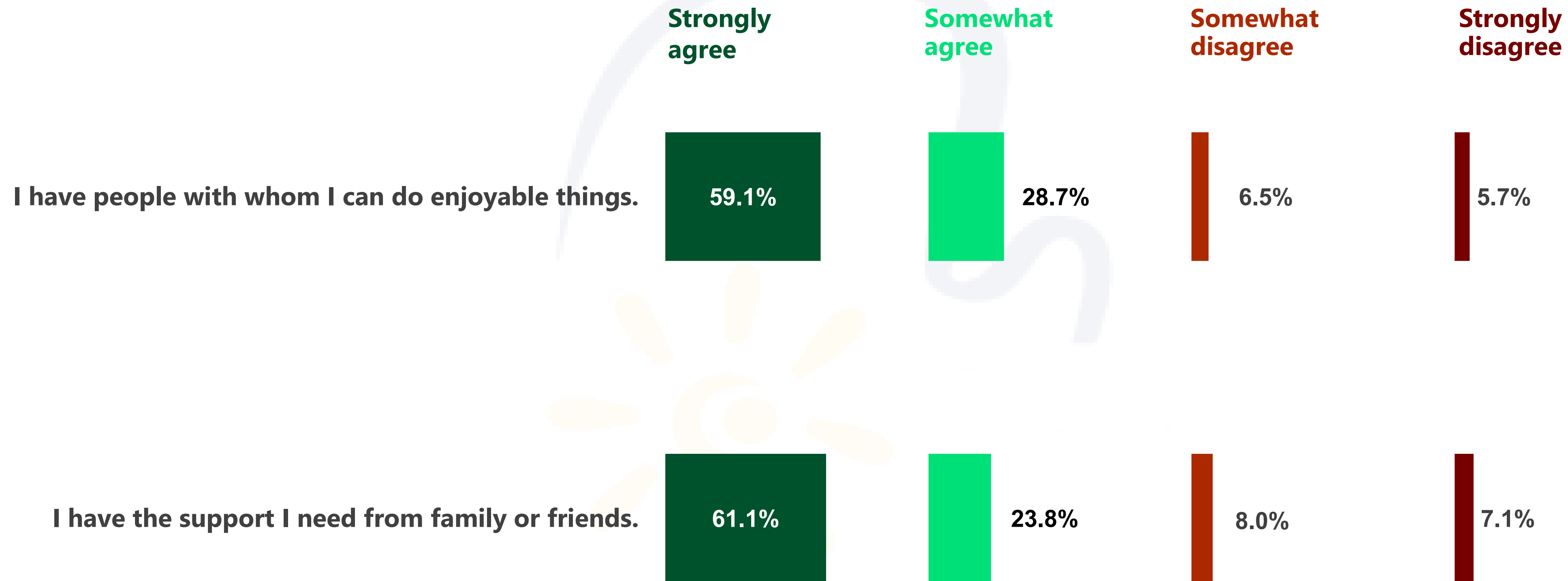


Consumer outcomes & functioning relatively consistent across all items

Nearly one in four **disagreed** that their "symptoms [were] not bothering me as much" – highest on all O&F items.

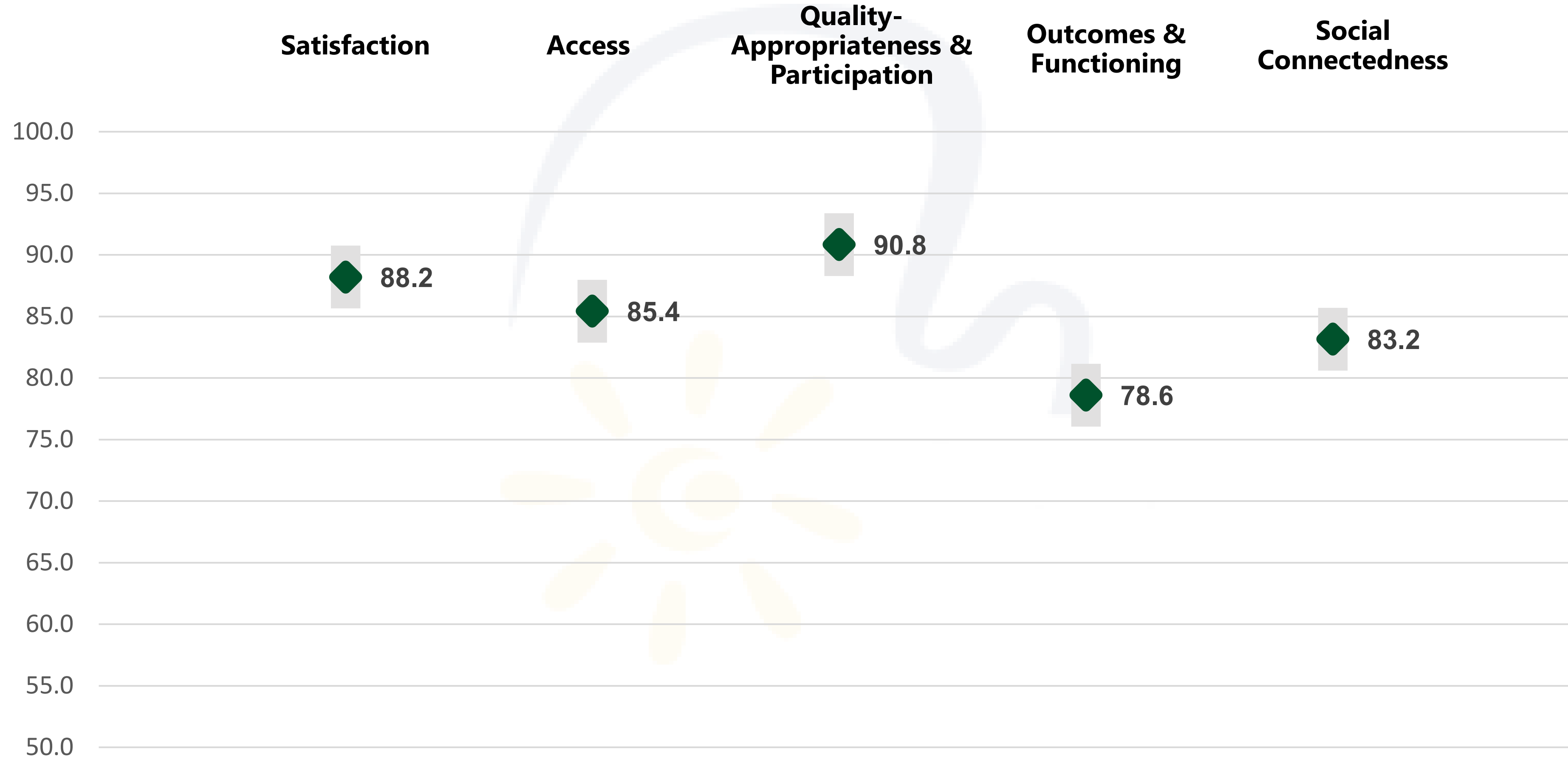
Strong majority of consumers have adequate social supports

Over 80% of consumers rated that they had social support in each item.



All SWMBH CMHSPs: 2023 MHSIP scores by construct

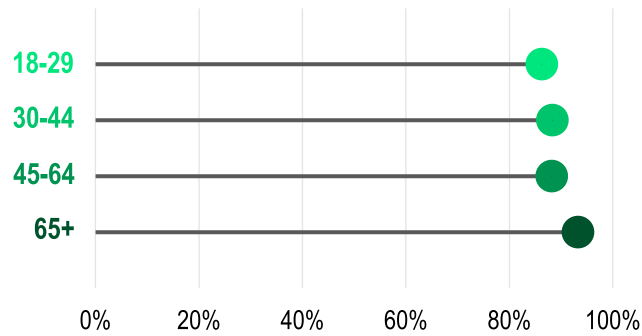
Dark green denotes the percentage in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all SWMBH consumers might lie (i.e., margin of error*)



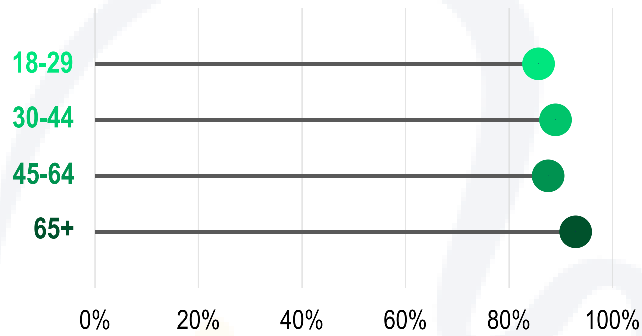
95% margin of error for all CMHSPs: ±2.6 pts
n = 1508

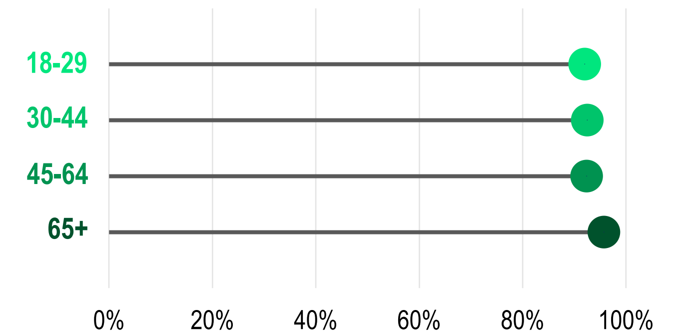
Age: Those 65 and up had higher ratings than other age groups

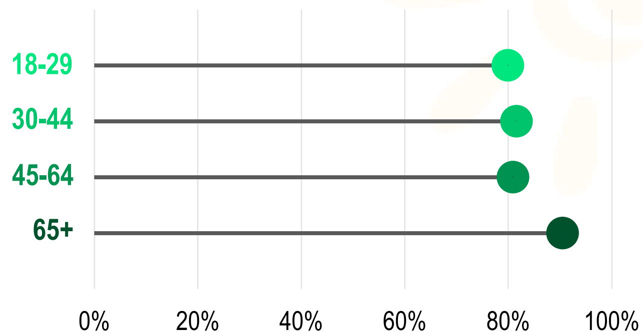
Although, construct ratings were generally similar between groups.

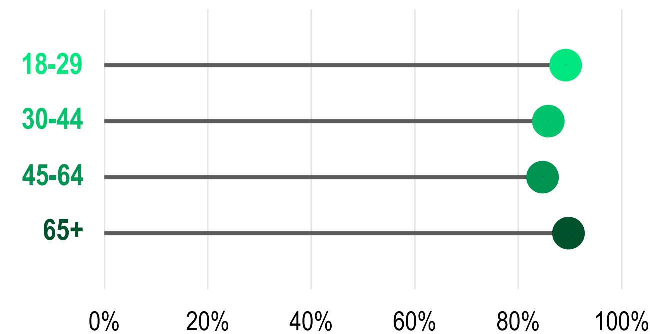


% stating "agree"







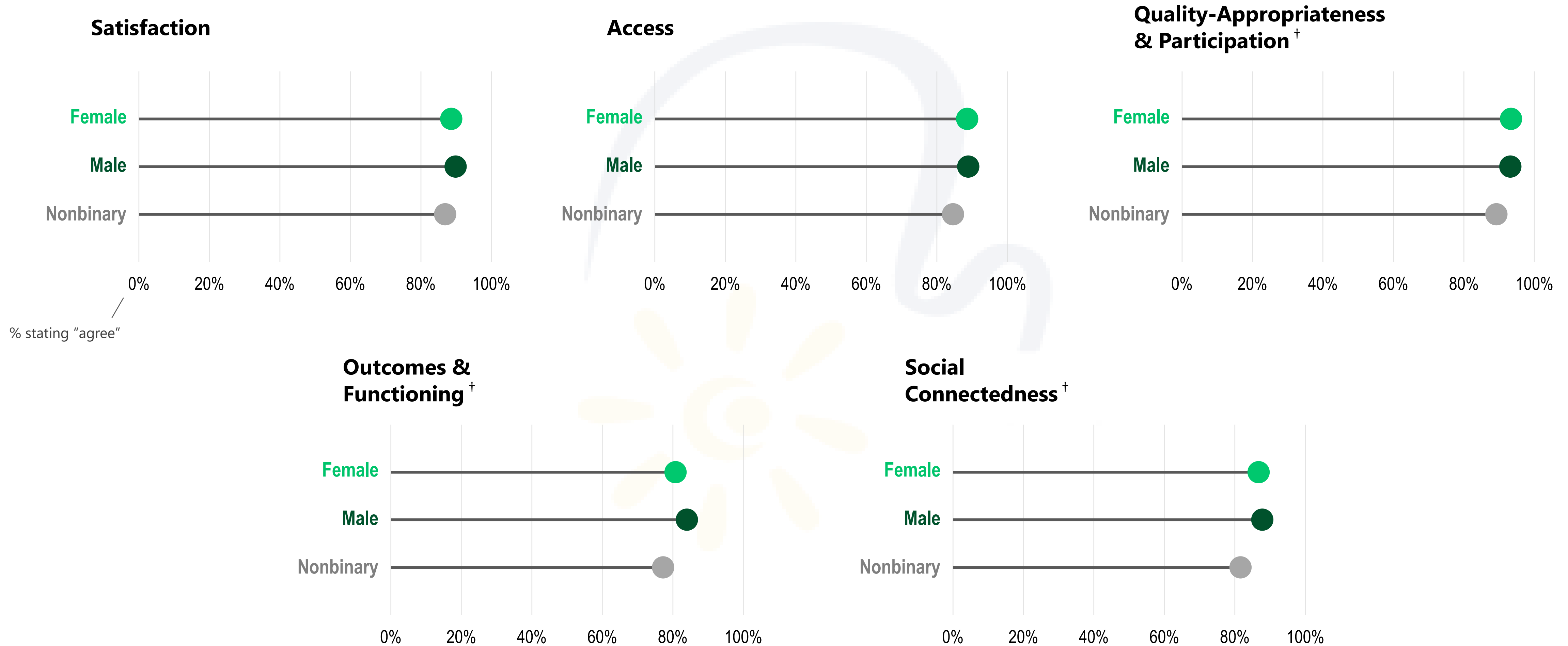


† statistically significant difference ($p < .05$) found between groups

18-29 n = 321
45-64 n = 563
30-44 n = 432
65+ n = 123

Gender: Nonbinary consumers reported lower quality-appropriateness & participation, outcomes, and social connectedness

Meanwhile, male consumers rated both outcomes and social connectedness slightly higher than female consumers.
The next page documents qualitative data from LGBTQIA+ consumers.

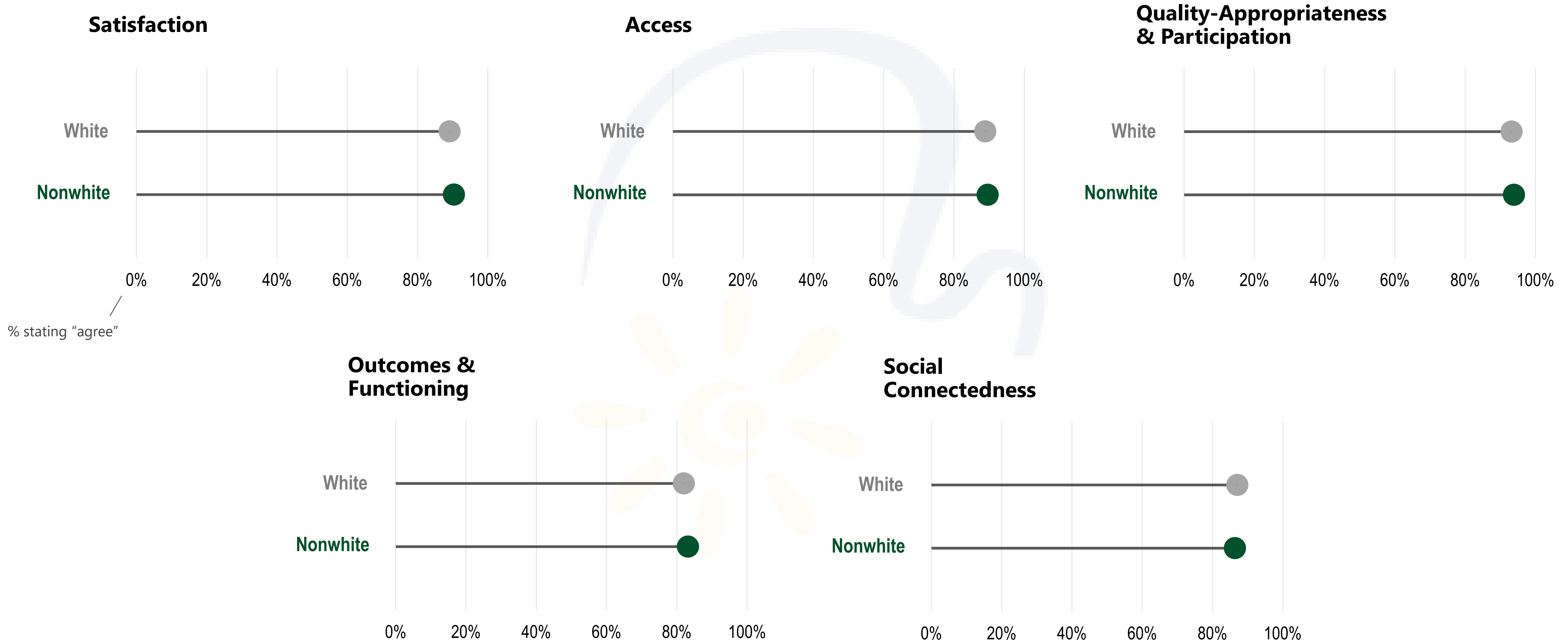


† statistically significant difference ($p < .05$) found between groups

Female n = 846
Male n = 511
Nonbinary n = 49

Race: Not much difference in ratings by race

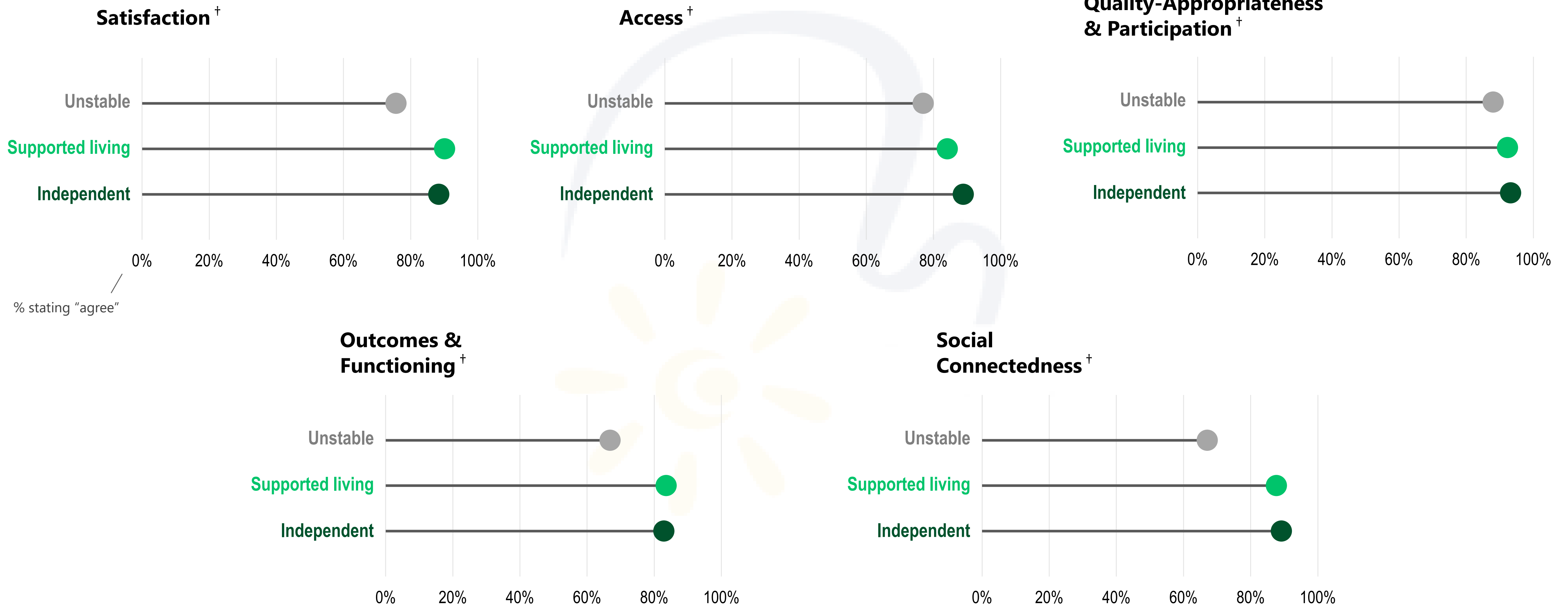
"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races. This aggregation was done mostly due to small sample sizes.



White n = 1,108
Nonwhite n = 245

Living situation: Those with unstable housing had lower ratings, especially in access, outcomes & functioning, & social connectedness

Those in supported living had worse access ratings than those living independently ($p < .05$). "Unstable" was indicated if the respondent reported living in a shelter, motel/hotel, vehicle, etc. "Supported living" included AFC, a group home, or other supported independent living. "Independent" included all other living situations.

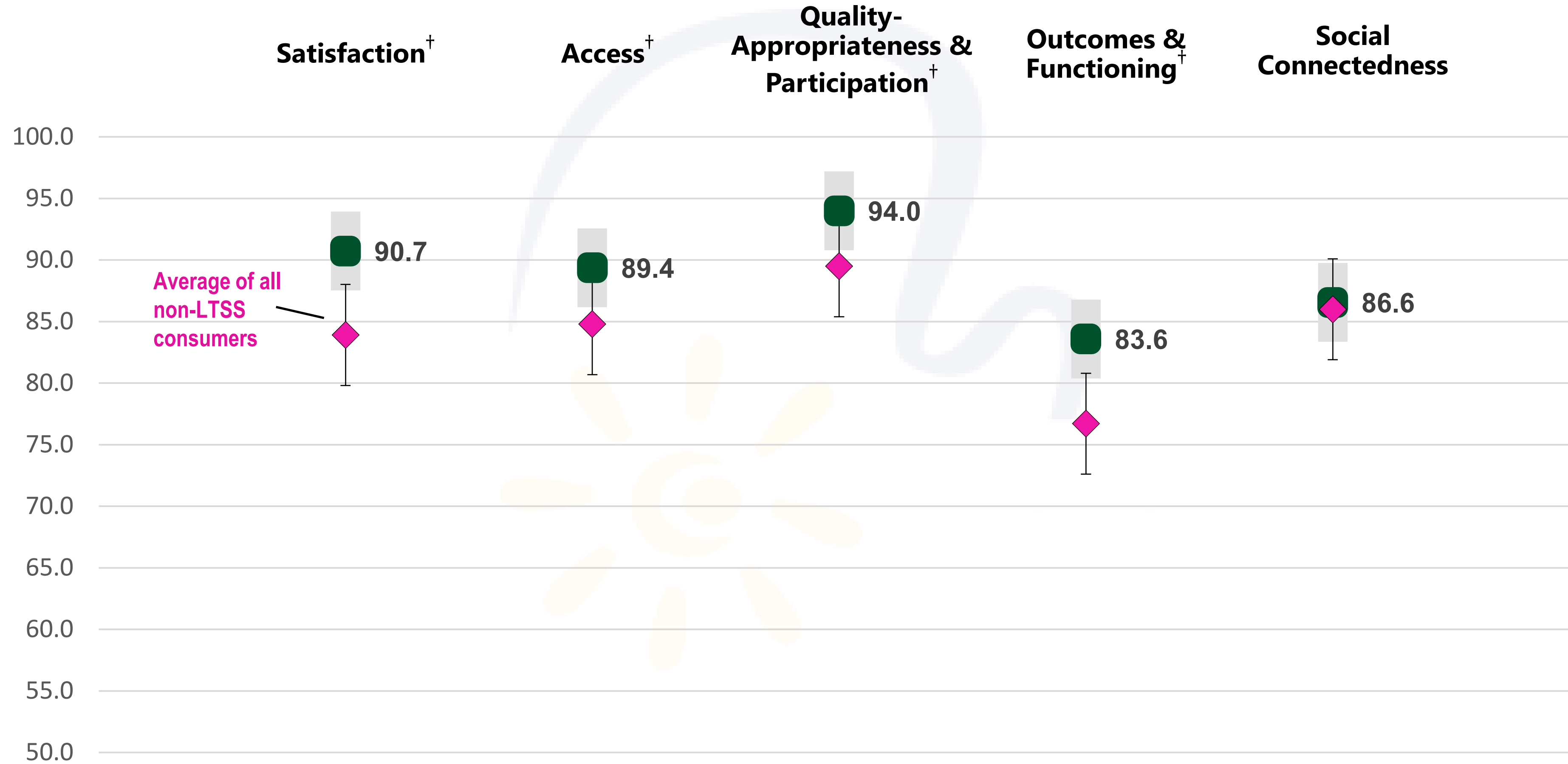


† statistically significant difference ($p < .05$) found between groups

Unstable n = 80
Supported living n = 150
Independent n = 867

Adult LTSS consumers reported better scores than non-LTSS adults in all constructs except social connectedness

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)

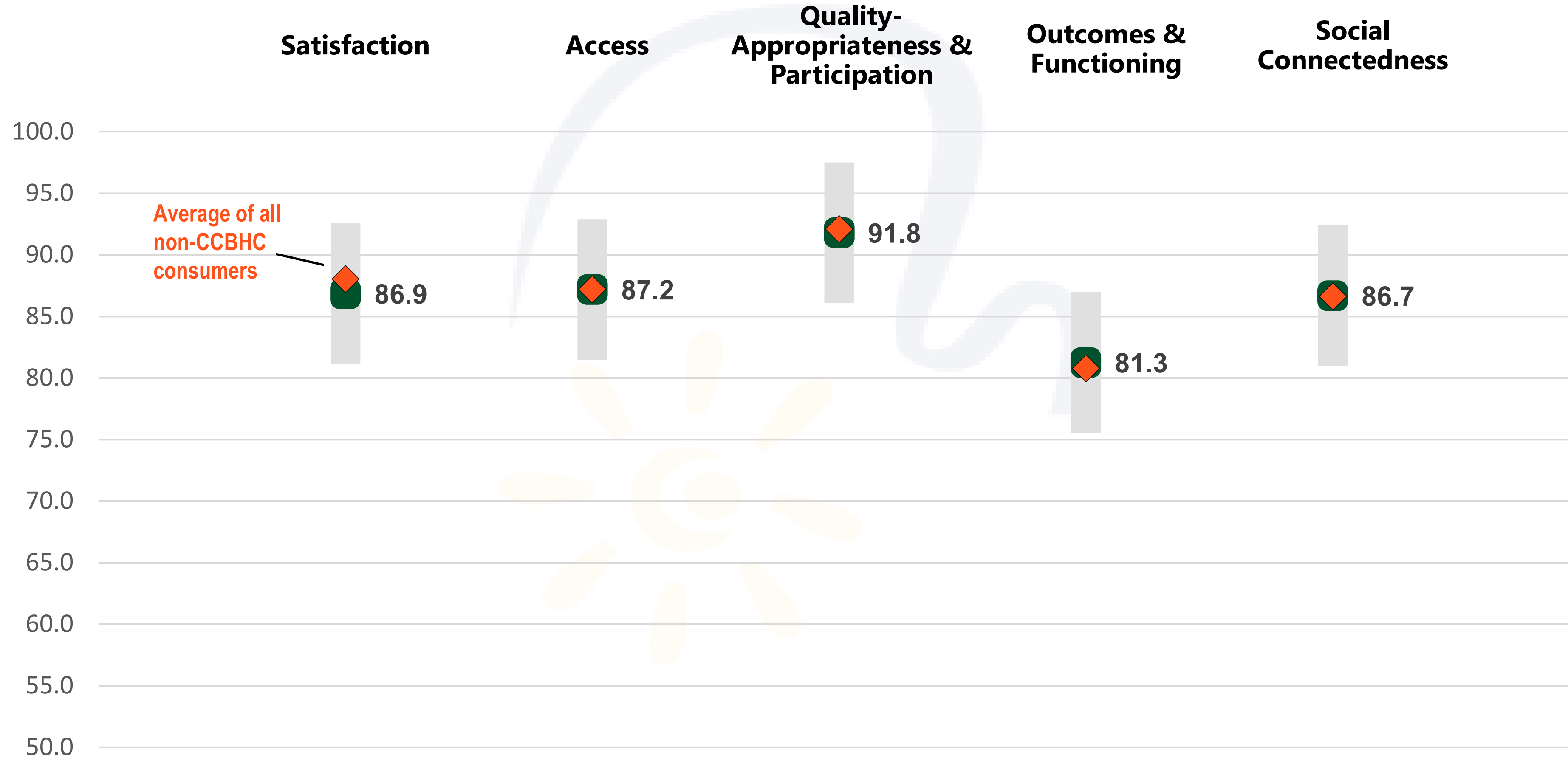


† significant difference ($p < .05$) between LTSS and non-LTSS for construct

*margin of error for **LTSS** adults: ±3.2 pts (n = 930)
margin of error for **non-LTSS** adults: ±4.1 pts (n = 578)

Adult CCBHC consumers reported similar scores to non-CCBHC adults

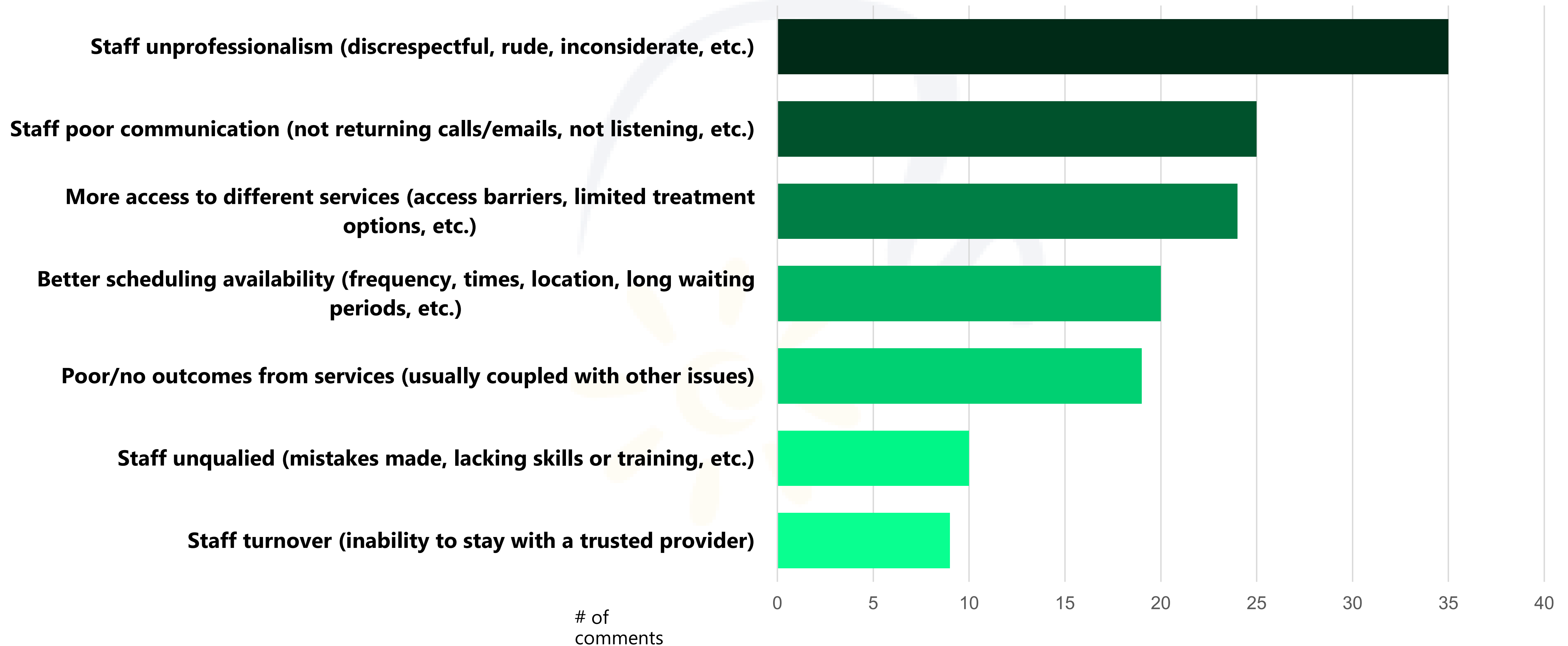
Dark green denotes the percentage of CCBHC (certified community behavioral health clinic) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



*margin of error for **CCBHC** adults: ±5.7 pts (n = 294)
margin of error for **non-CCBHC** adults: ±3.0 pts (n = 1,071)

Opportunities for improvement in staff conduct, more access

Of respondents to the MHSIP who were *dissatisfied* with services, staff conduct was cited most frequently. Respondents also desired better access and availability of services.

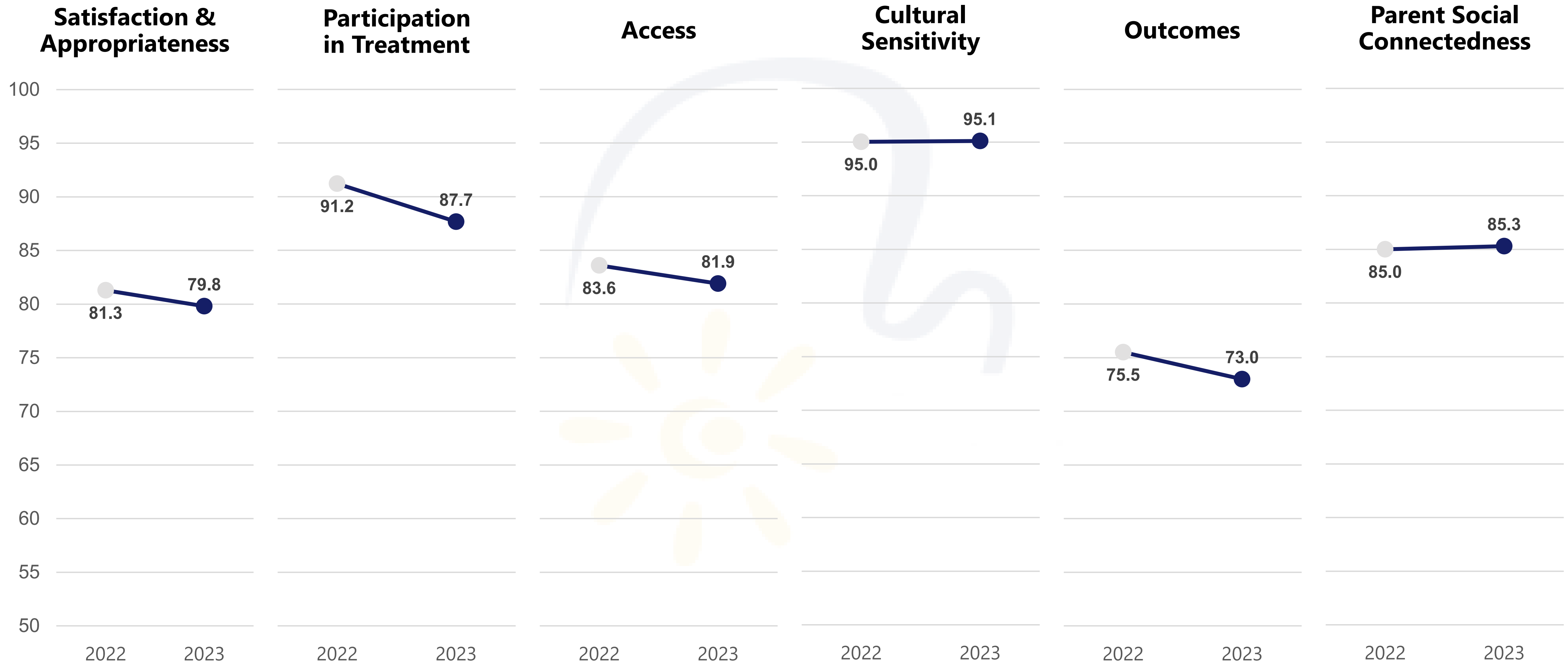


Youth Services Survey for Families (YSS) Revised Tool: 2023 Results

Sample size: 395

Overall, YSS saw similar ratings from 2022-2023 (no statistical difference)

YSS scores by construct for previous 2 years, further past years incomparable due to survey changes. Differences in constructs are not statistically significant.



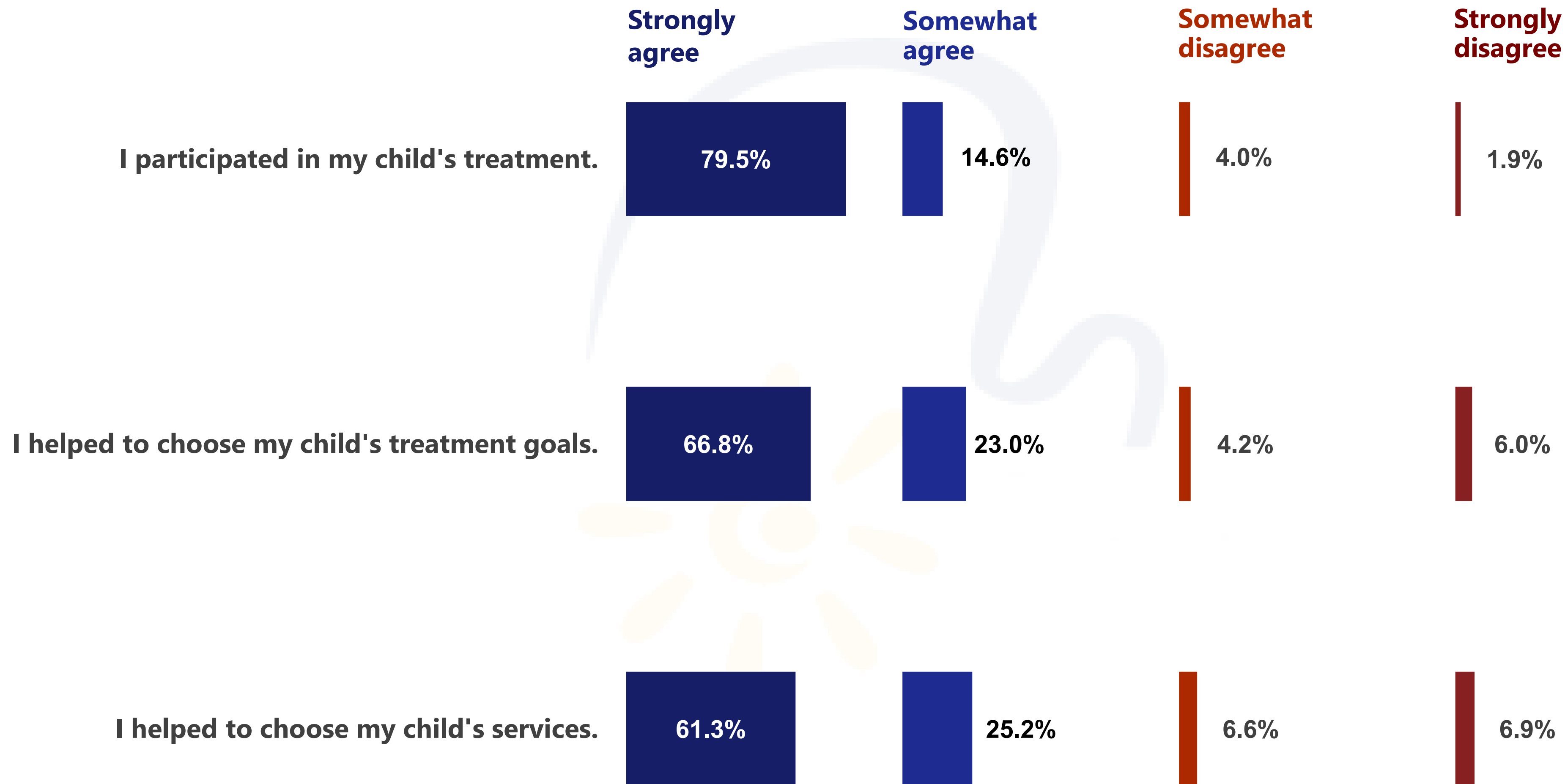
CMHSP satisfaction & appropriateness hindered by access to services

YSS item related to amount of help received got lowest **strongly agree** ratings for the second year straight

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
The people helping my child stuck with us no matter what.	63.8%	19.9%	5.9%	10.4%
Overall, I am satisfied with the services my child received.	57.4%	23.7%	10.3%	8.7%
The services my child and/or family received were right for us.	56.0%	24.2%	10.4%	9.4%
I felt my child had someone to talk with when they were troubled.	59.6%	20.5%	8.2%	11.7%
[My family got as much help as we needed for my child.	49.6%	24.3%	10.7%	15.4%]

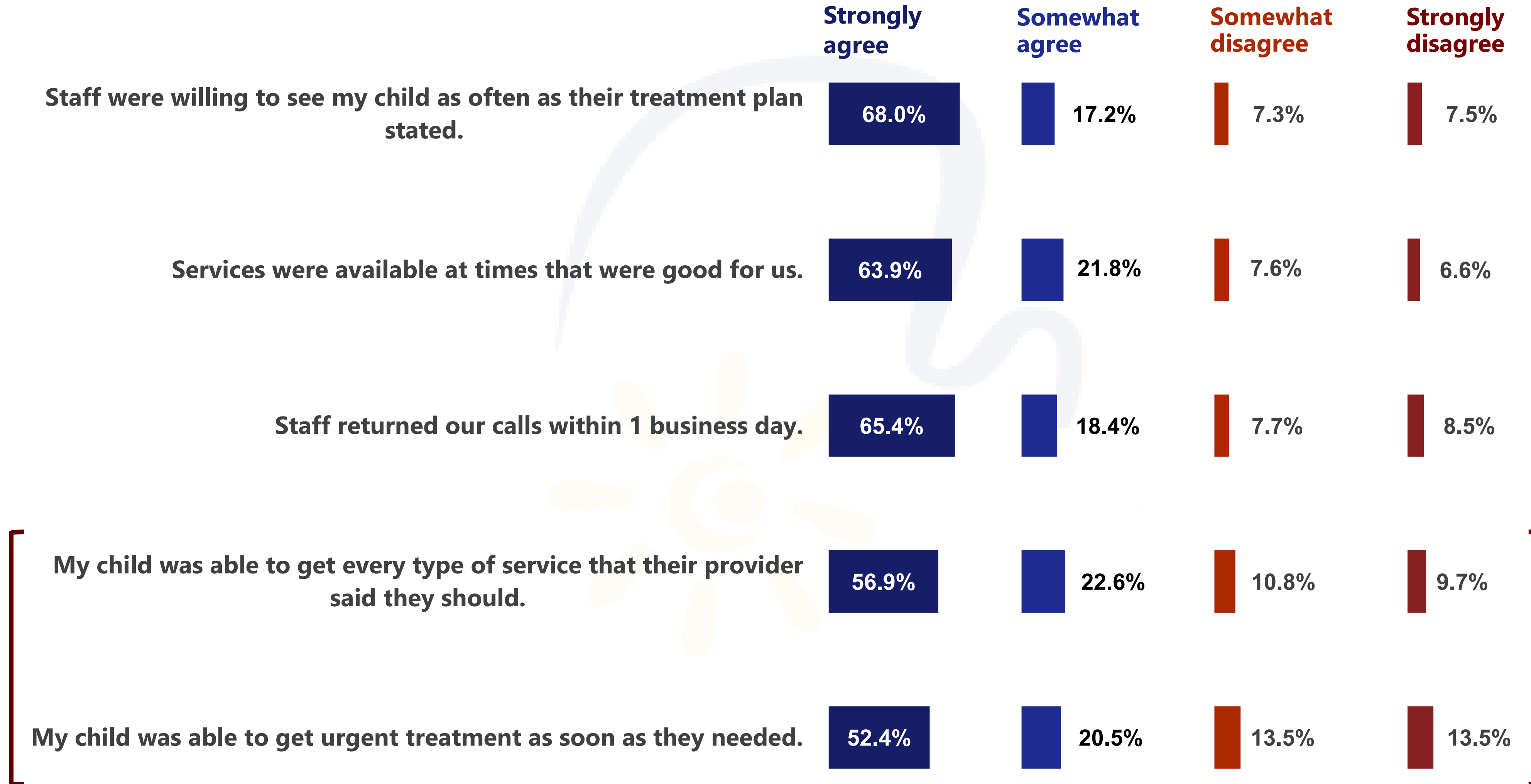
Parents overall felt very involved with their child's services

YSS items measuring parental involvement in childrens' services received very low **disagreement** ratings



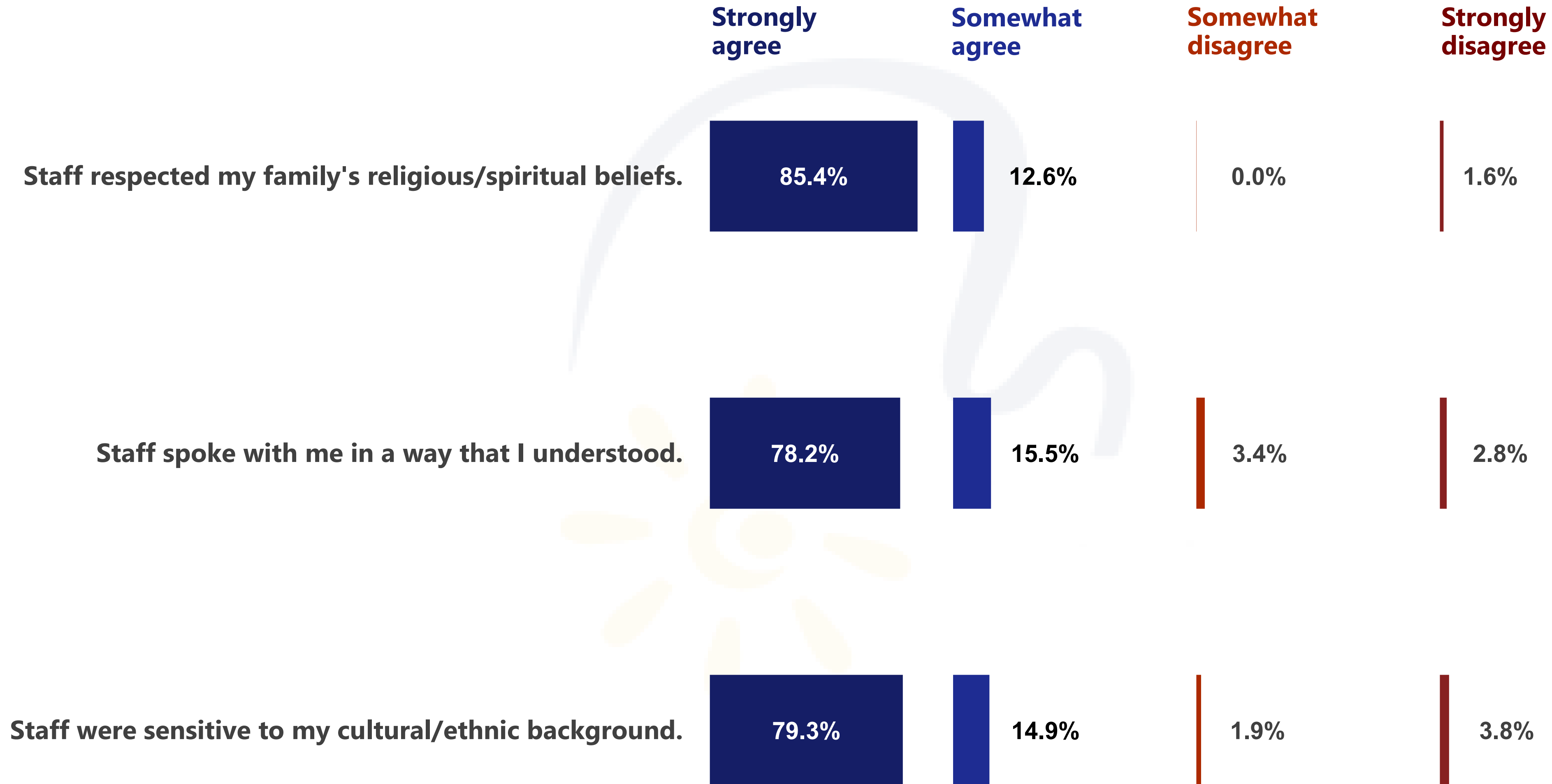
Most access ratings were strong, some weaker

Less **agreement** with items related to receiving different types of services and urgent treatment.



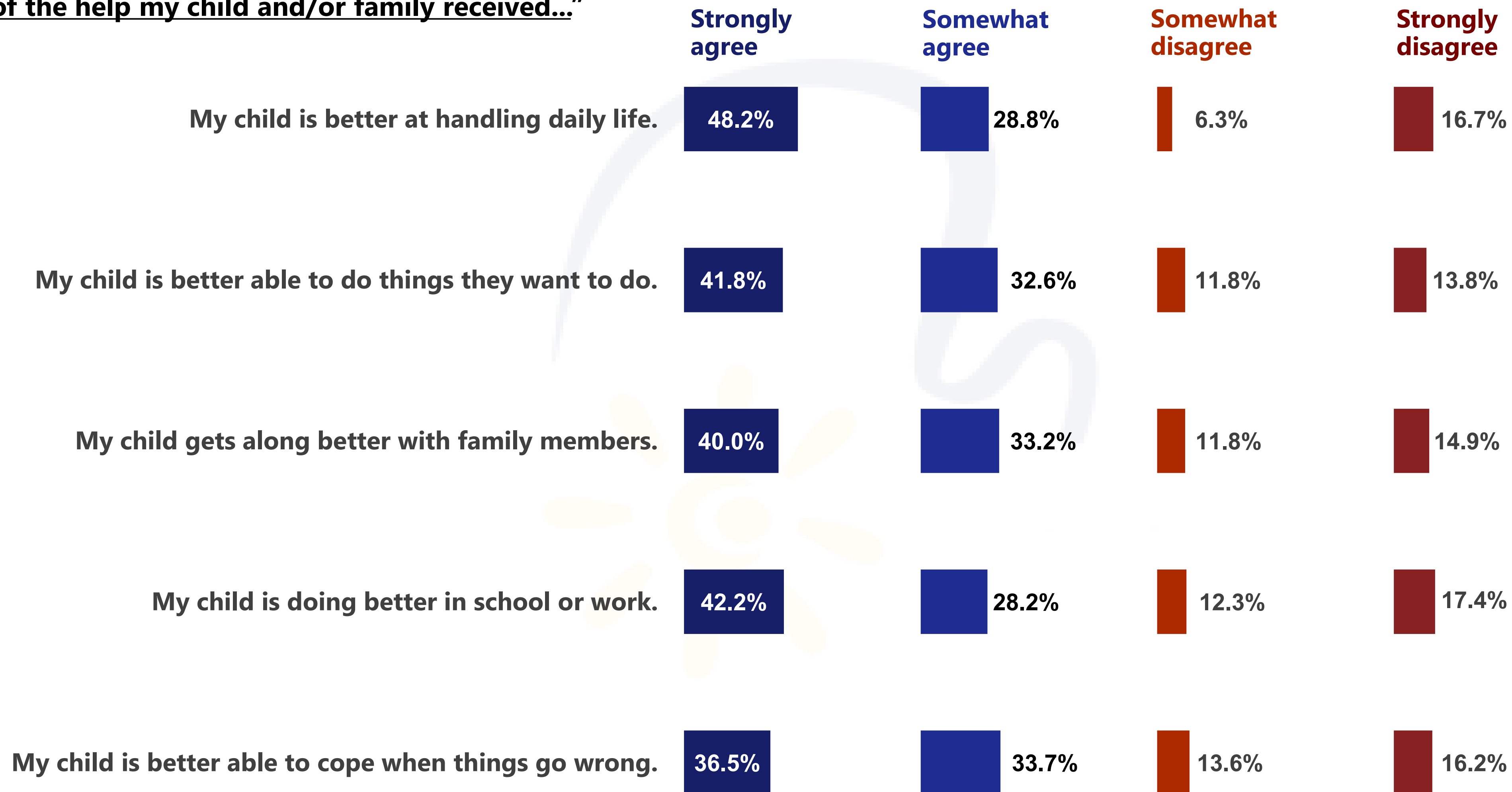
CMHSP cultural sensitivity received near perfect ratings

A majority of YSS respondents gave the cultural sensitivity items **strongly agree** ratings



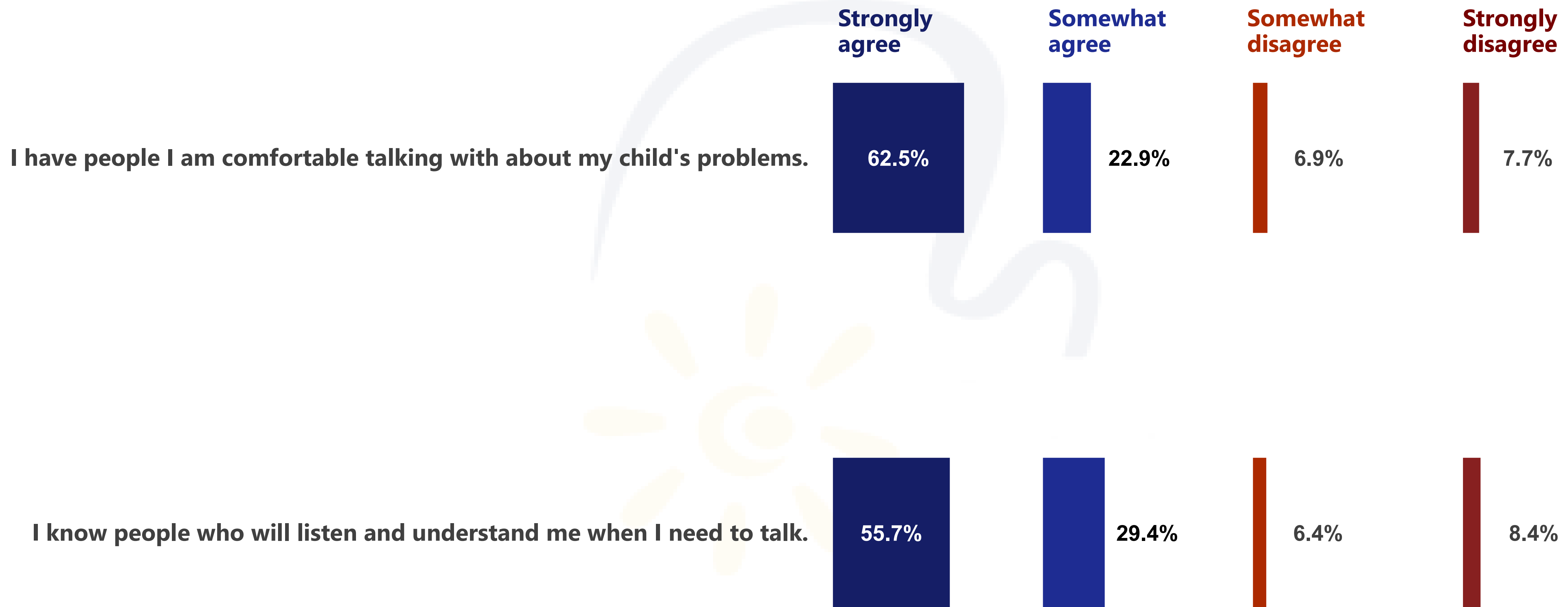
Outcomes for youth consistent, but not stellar

For close to 1 in 4 respondents, their child saw no improvement across the different outcome measures



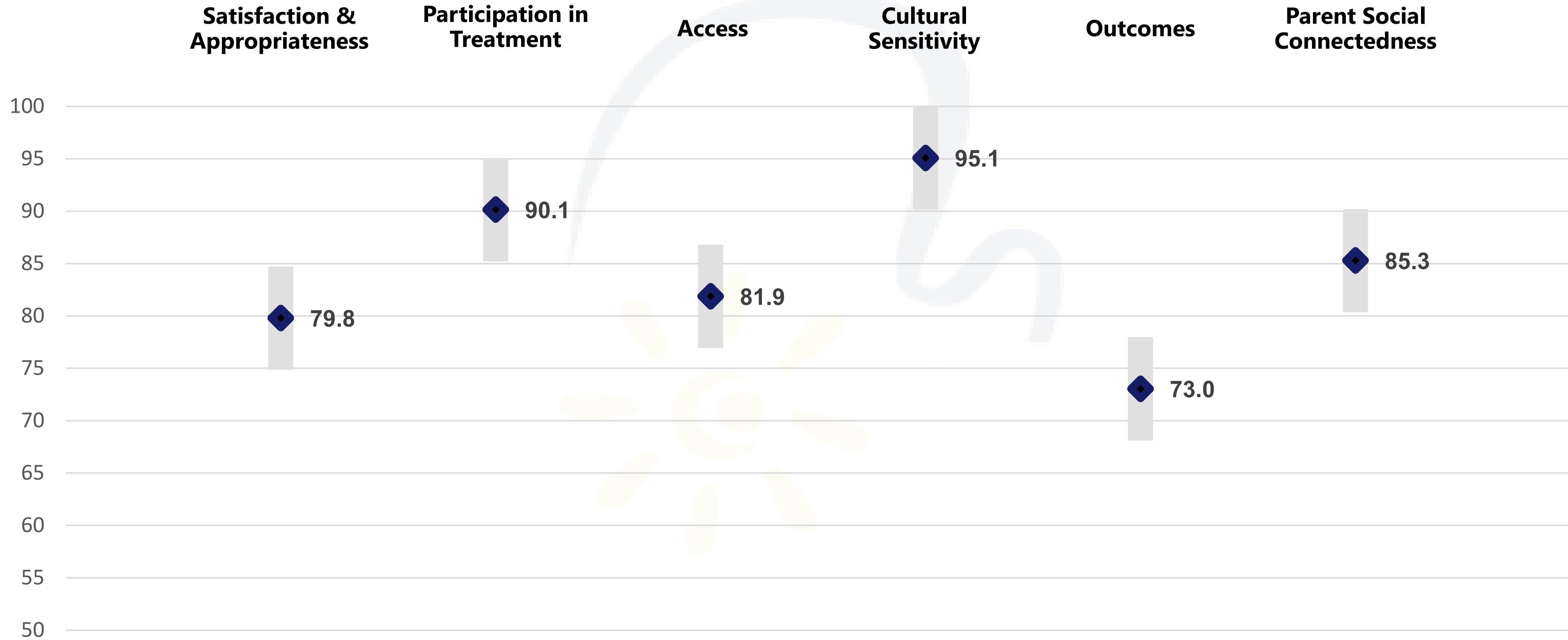
Parents' social connectedness rated as mostly positive

A majority of YSS respondents gave the social connectedness items **agree** ratings



All SWMBH CMHSPs: 2023 YSS scores by construct

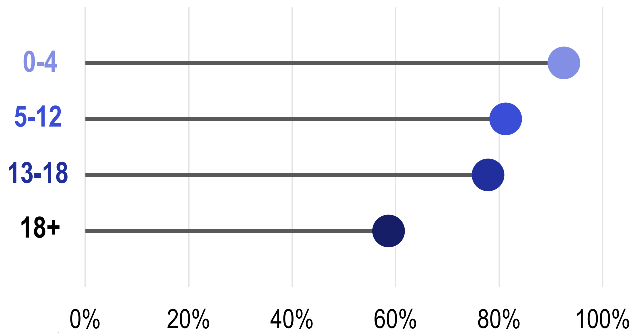
Dark blue denotes the percentage in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all SWMBH consumers might lie (i.e., margin of error*)

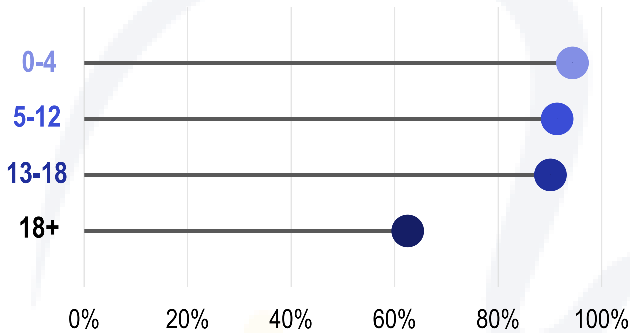


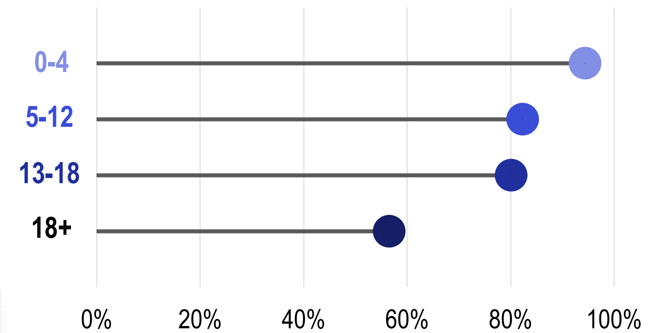
*margin of error for all CMHSPs: ±4.9 pts
n = 395

Generally, the older the youth, the lower the survey scores

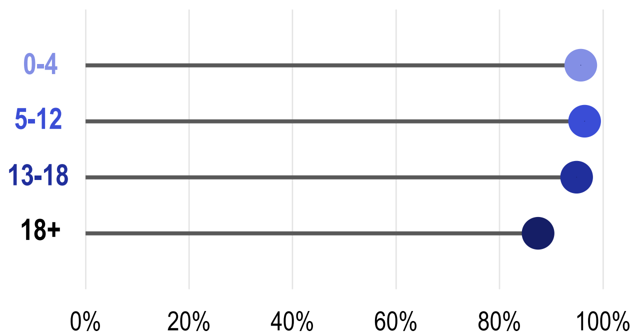
YSS survey completers with children **over 18** (n = 6) reported lower scores because the child was no longer in their care.

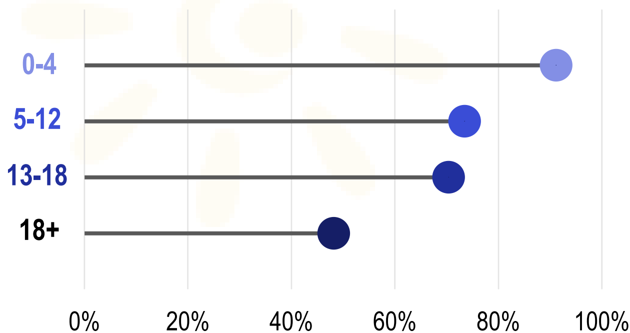


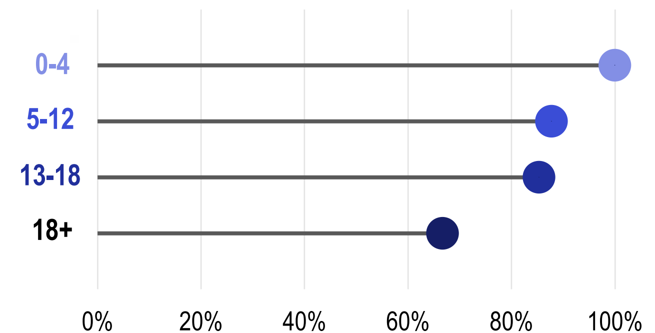




% stating "agree"





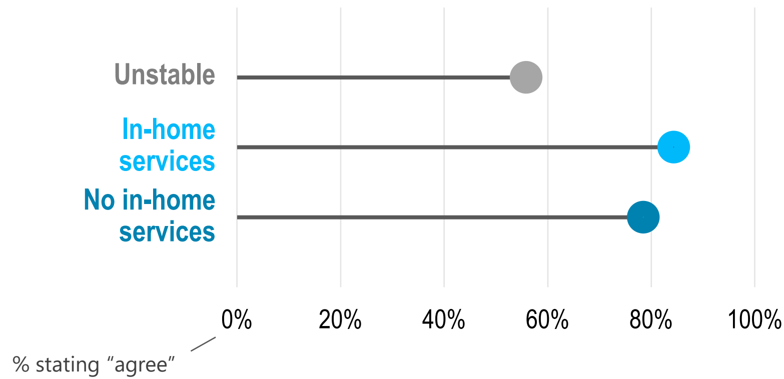


† statistically significant difference ($p < .05$) found between groups

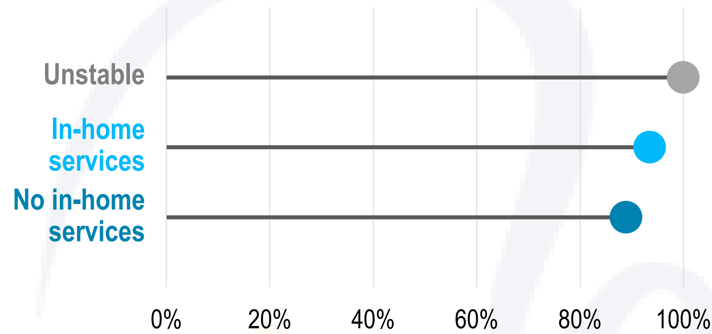
0-4 n = 44
13-18 n = 153
5-12 n = 174
18+ n = 6

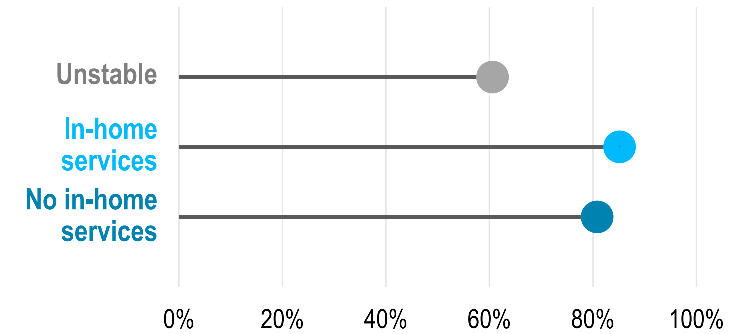
Youth receiving in-home services tended to have higher ratings

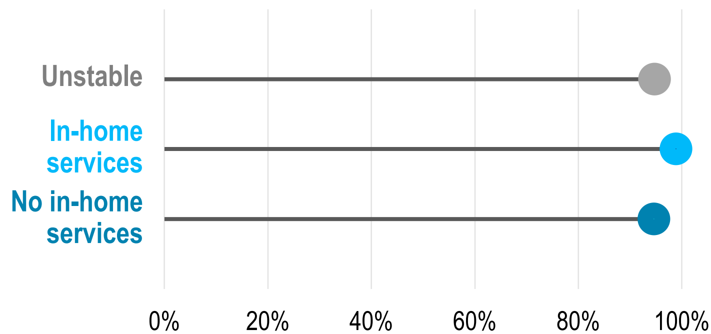
Youth with unstable housing were rare; in-home services included foster care, group homes, residential care, or other in-home services. Youth's living situation did not show statistical differences in parent's social connectedness.

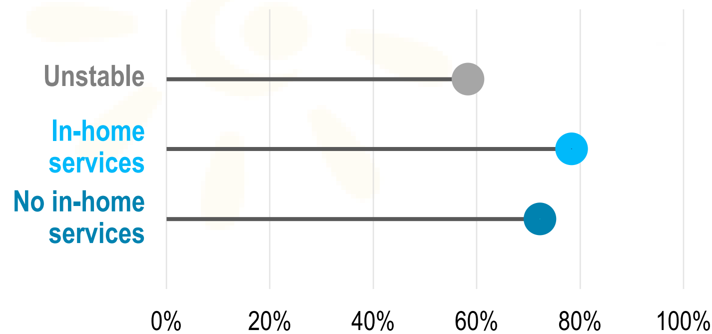


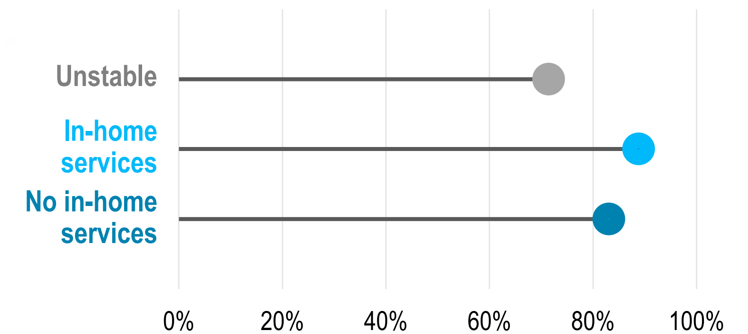
% stating "agree"









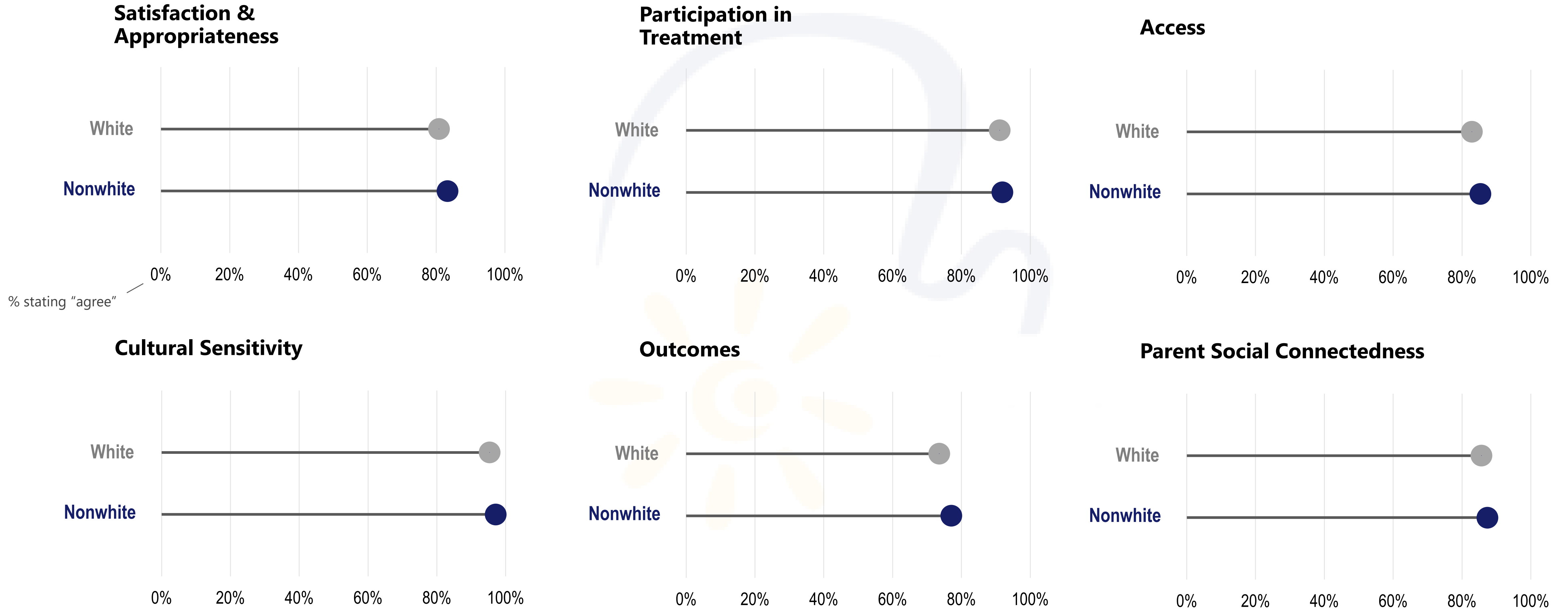


† statistically significant difference ($p < .05$) found between groups

Unstable n = 8
In-home services n = 83
No in-home services n = 198

Youth scores similar for each race in 2023 YSS

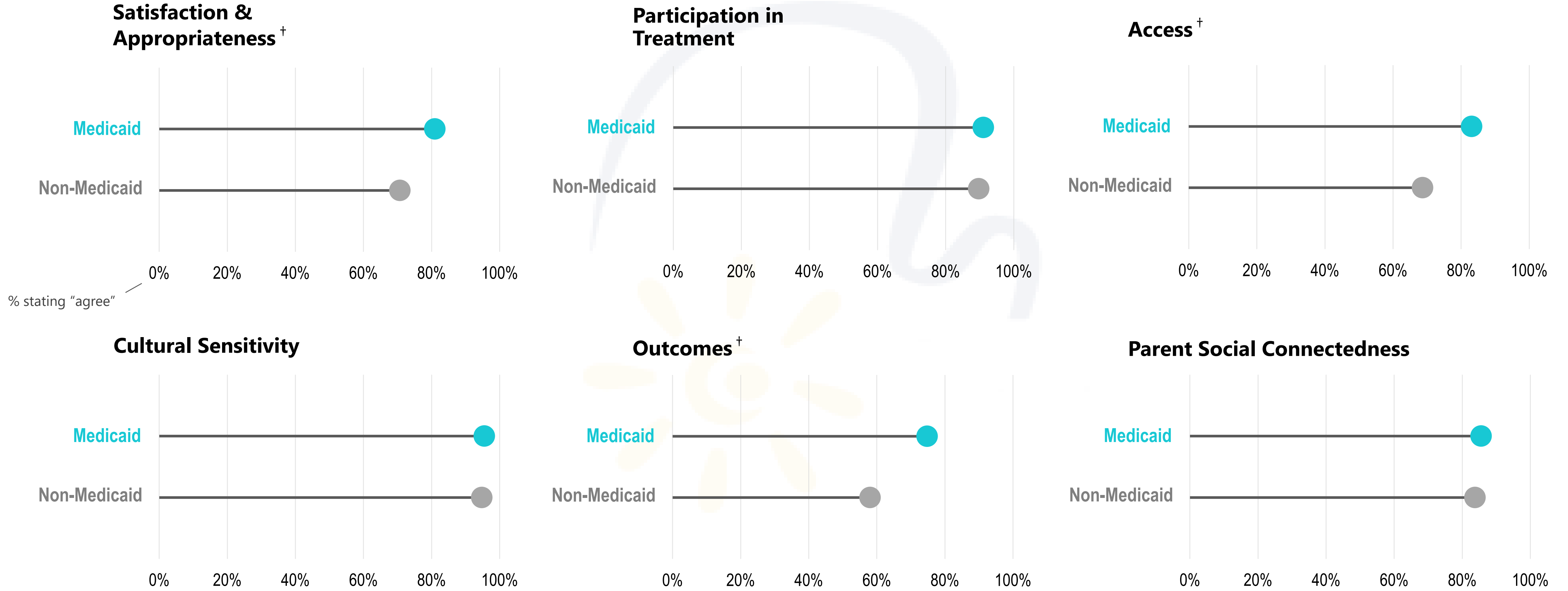
"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races.



White n = 245
Nonwhite n = 111

Youth not using Medicaid reported less access, lower satisfaction, and poorer outcomes

Non-Medicaid families mentioned staff "not knowing how to help them," being told "we can only help people with Medicaid," and being "on a waiting list for a Medicaid waiver."

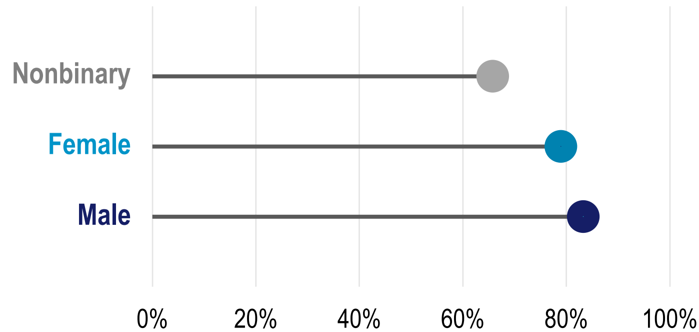


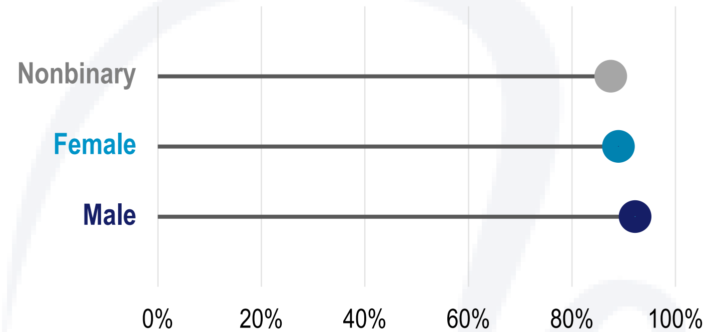
† statistically significant difference ($p < .05$) found between groups

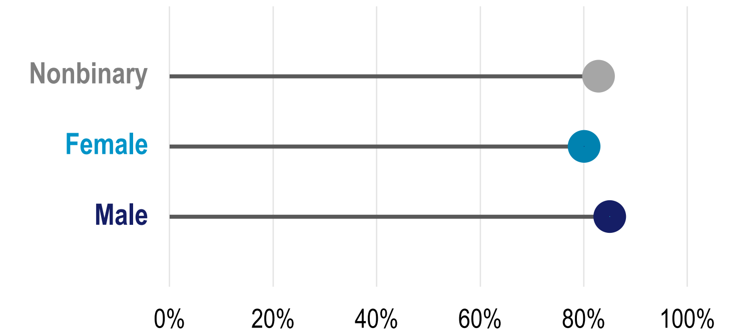
Medicaid n = 347
Non-Medicaid n = 25

Generally, male youth had slightly higher reported ratings

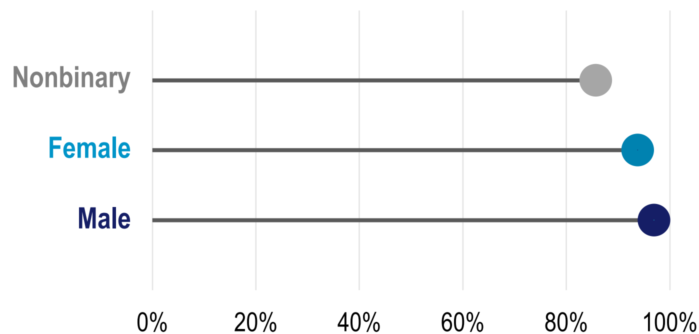
Nonbinary youth, despite only 8 reporting, had statistically worse reported outcomes and satisfaction than both male and female youth ($p < .05$).

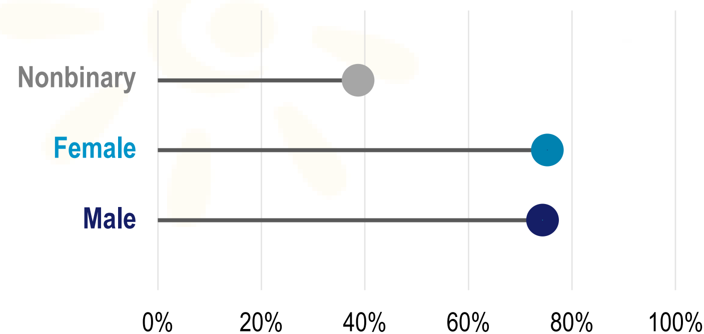


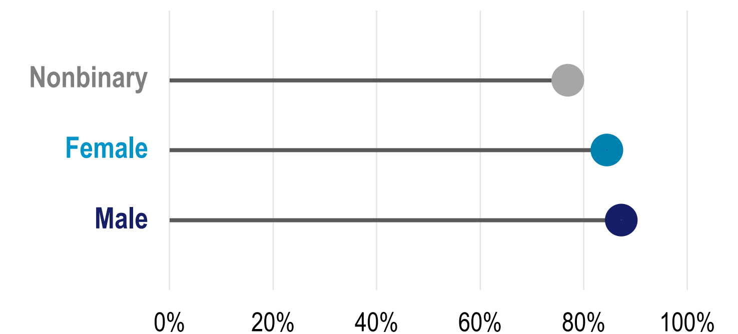




% stating "agree"





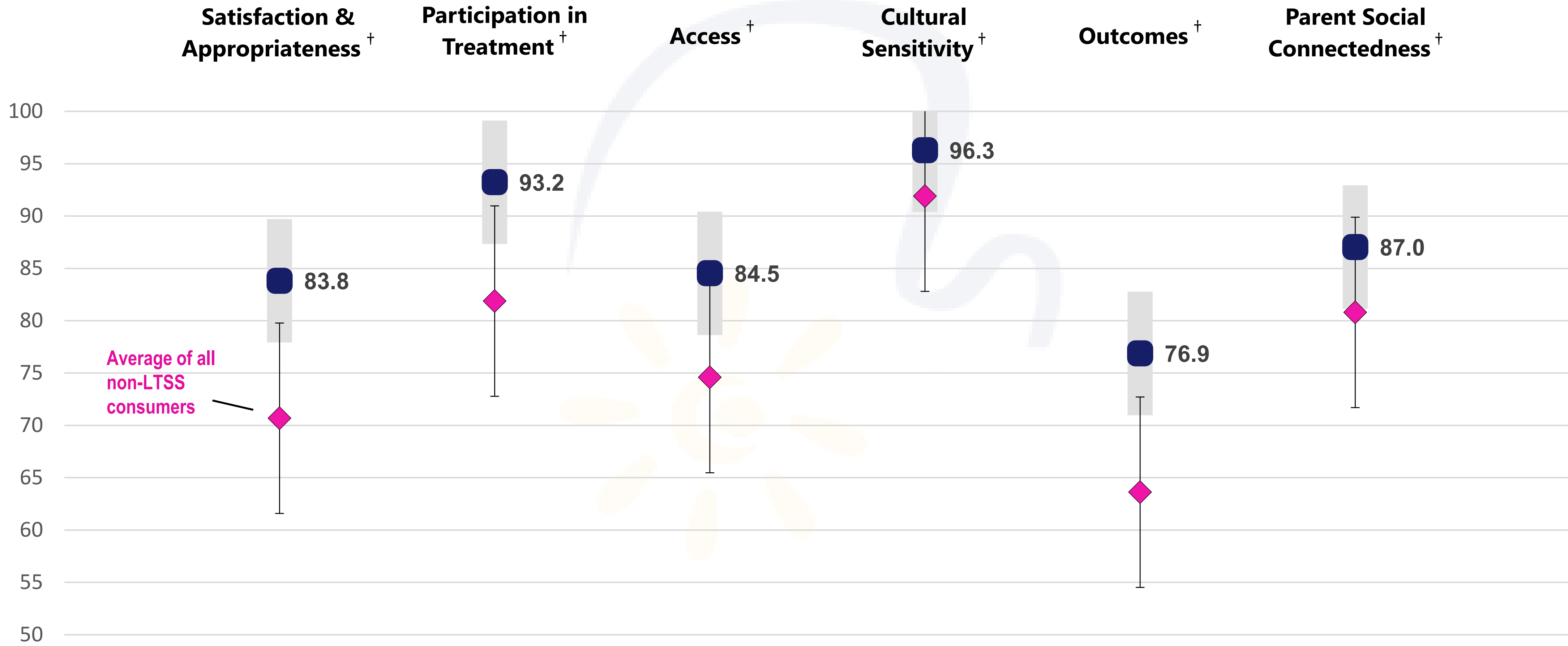


† statistically significant difference ($p < .05$) found between groups

Nonbinary n = 8
Female n = 138
Male n = 218

Youth LTSS families report better satisfaction, participation, access, and outcomes for the 2023 YSS

Dark blue denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)

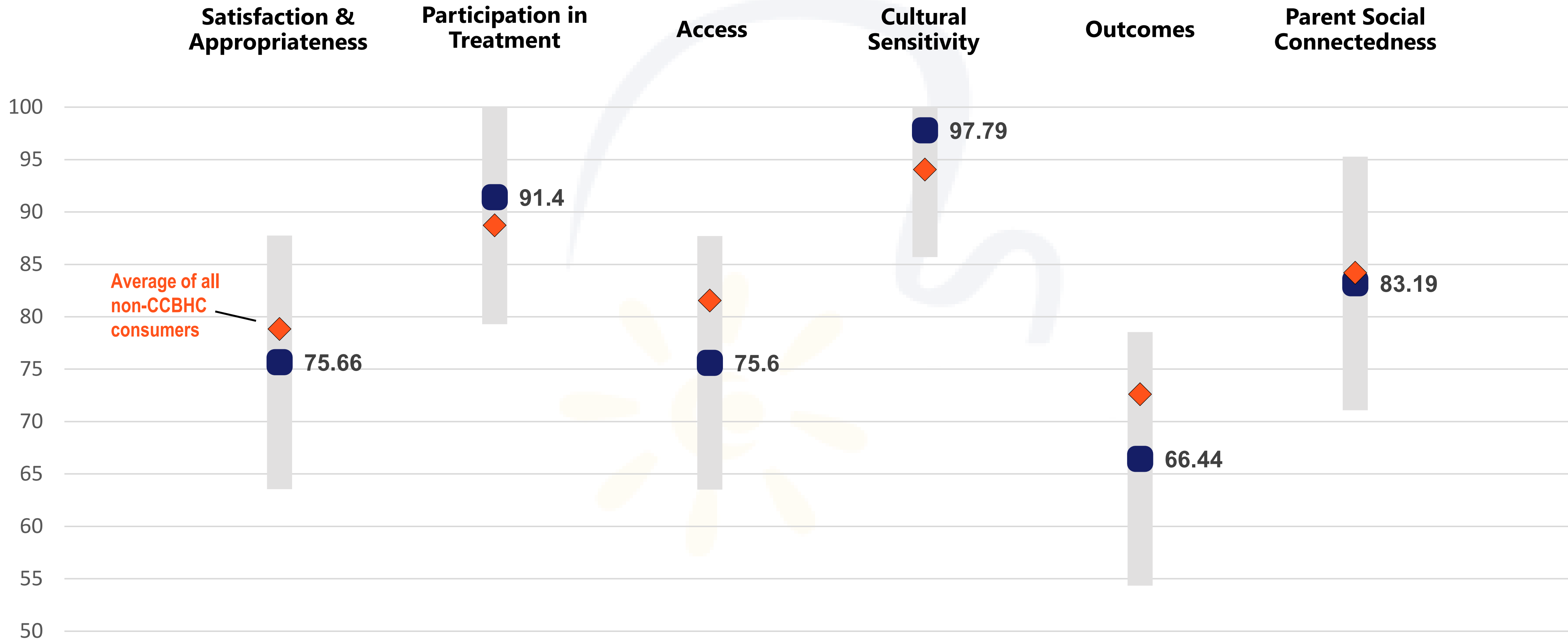


† statistically significant difference ($p < .05$) between this county and others for construct

*margin of error for **LTSS** youth: ±5.9 pts (n = 280)
margin of error for **non-LTSS** youth: ±9.1 pts (n = 115)

Youth CCBHC families report similar scores to non-CCBHC consumers

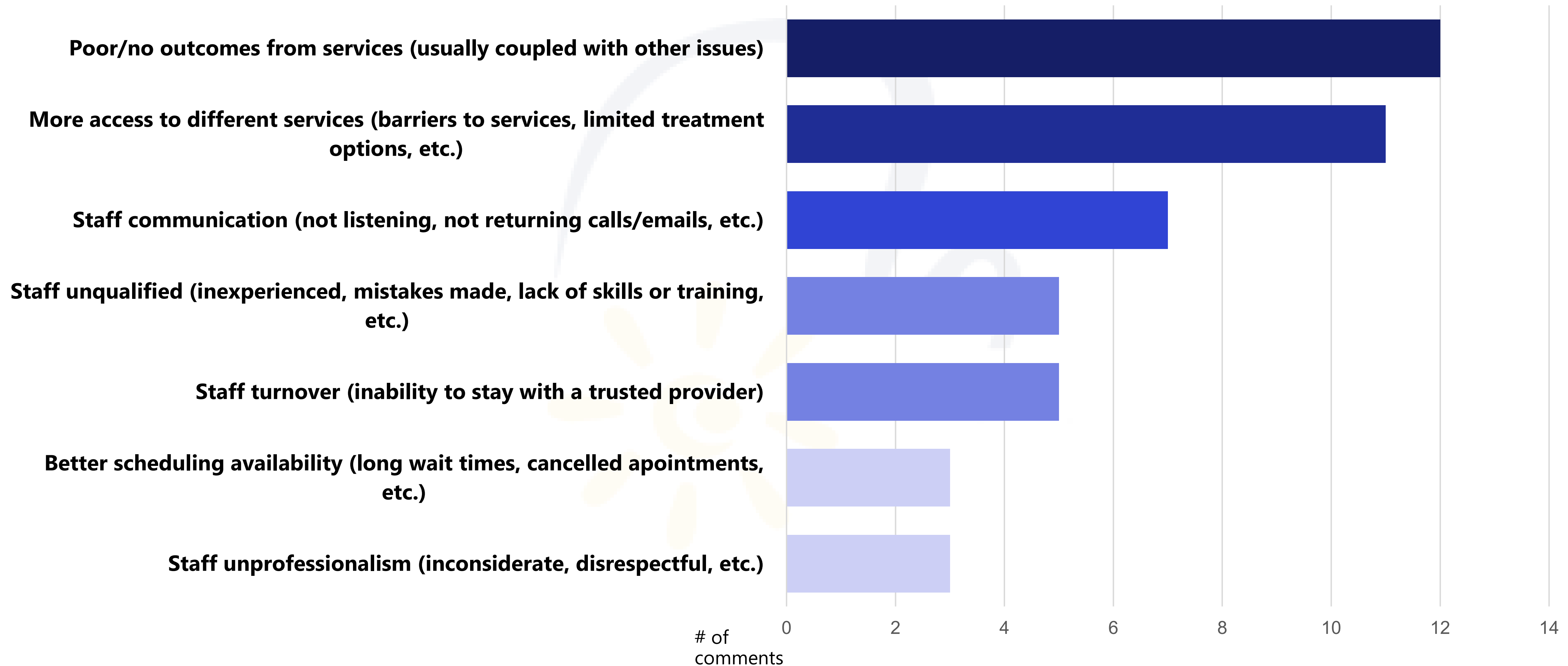
Dark blue denotes the percentage of CCBHC (certified community behavioral health clinic) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all CCBHC consumers might lie (i.e., margin of error*)



*margin of error for **CCBHC** youth: ±12.1 pts (n = 66)
margin of error for **non-CCBHC** youth: ±5.8 pts (n = 287)

Opportunities for improvement in granting more access to services

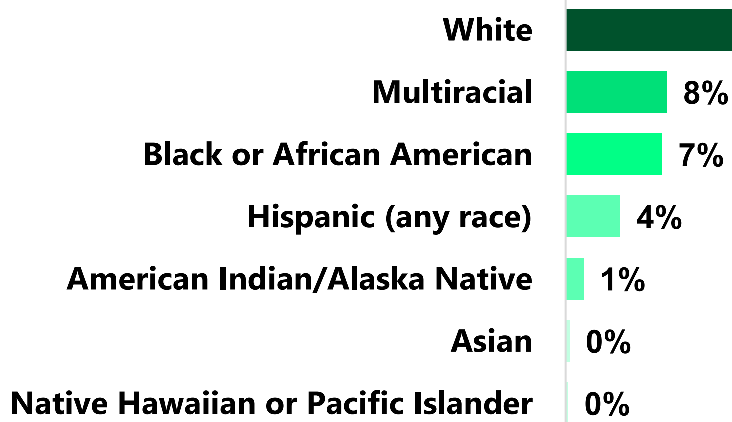
Comments emphasized the inability for their children to receive services as a driver of poor outcomes.

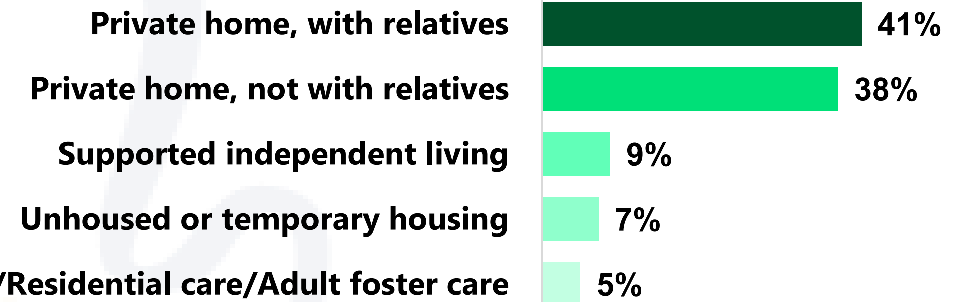


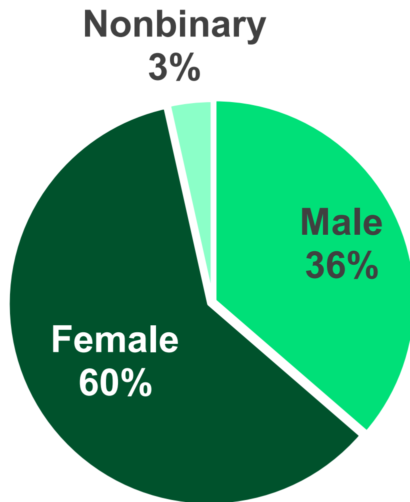
Survey Diagnostics, Methods & Recommendations

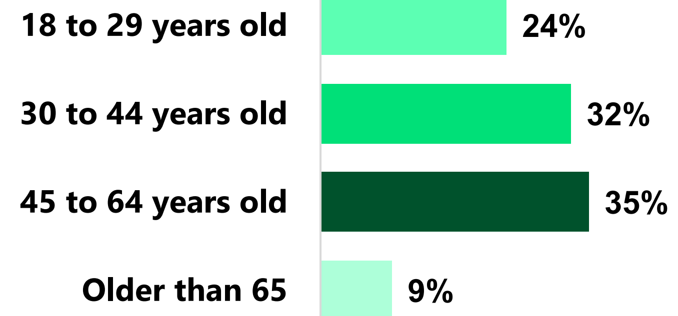
MHSIP 2023 respondents similar in makeup to prior years

In 2023, a new question about living situation was asked, though it may be tweaked in future surveys.



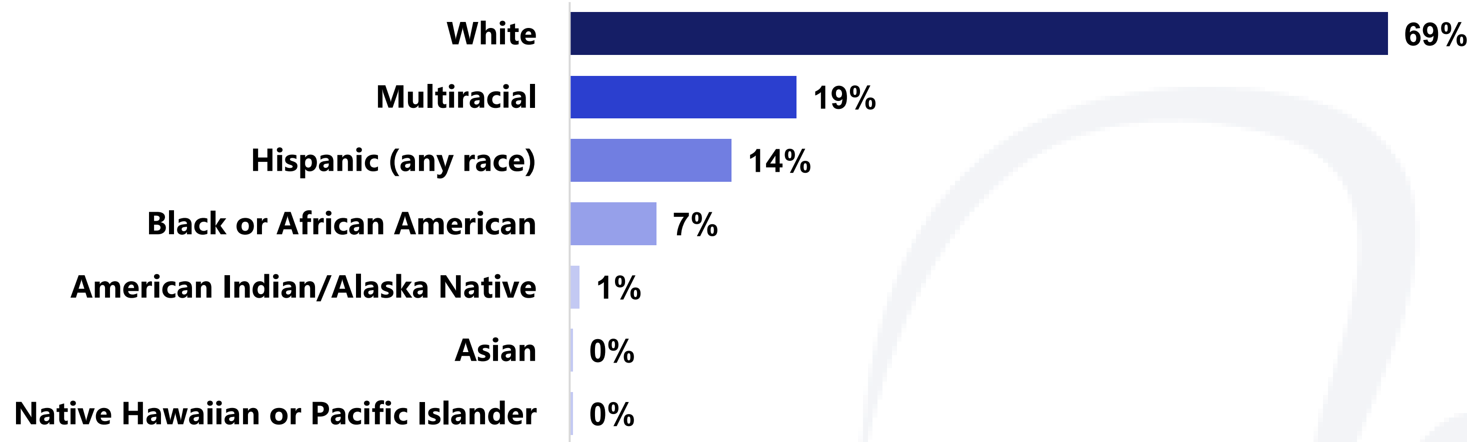


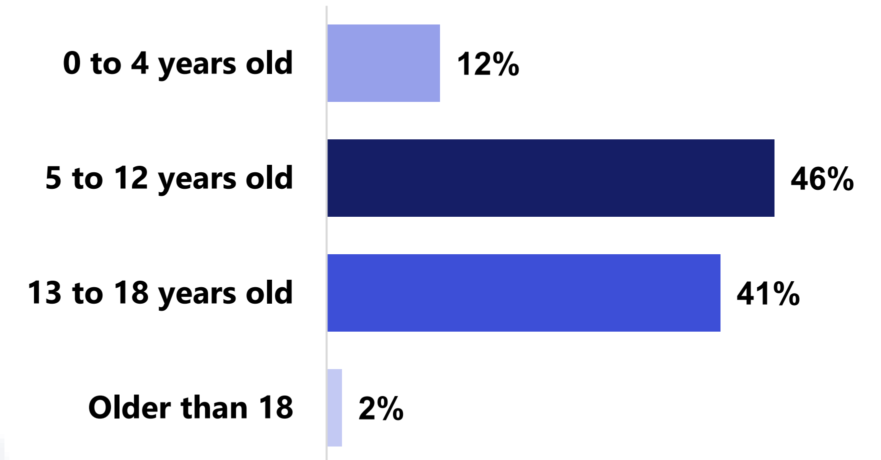


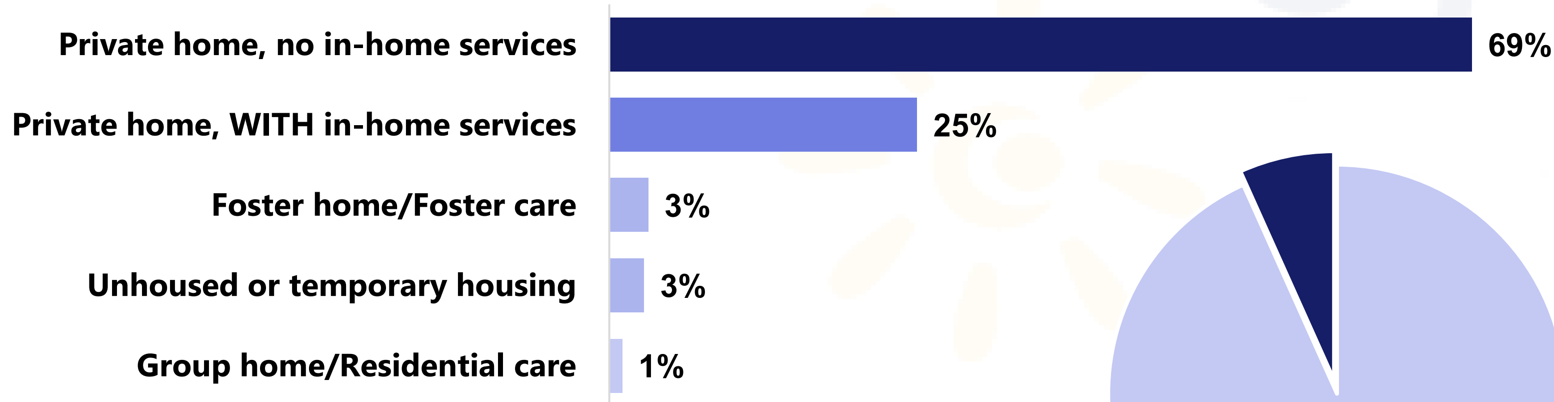


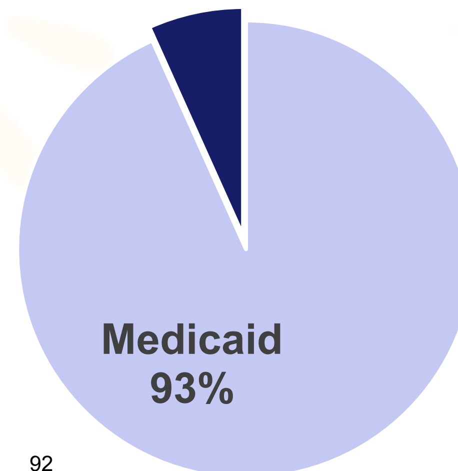
YSS 2023 youth represented were more diverse than in 2022

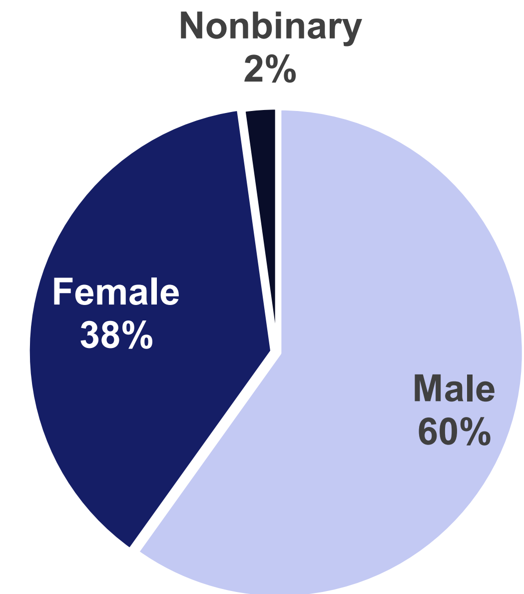
More Hispanic youth were represented and more non-Medicaid youth were represented.





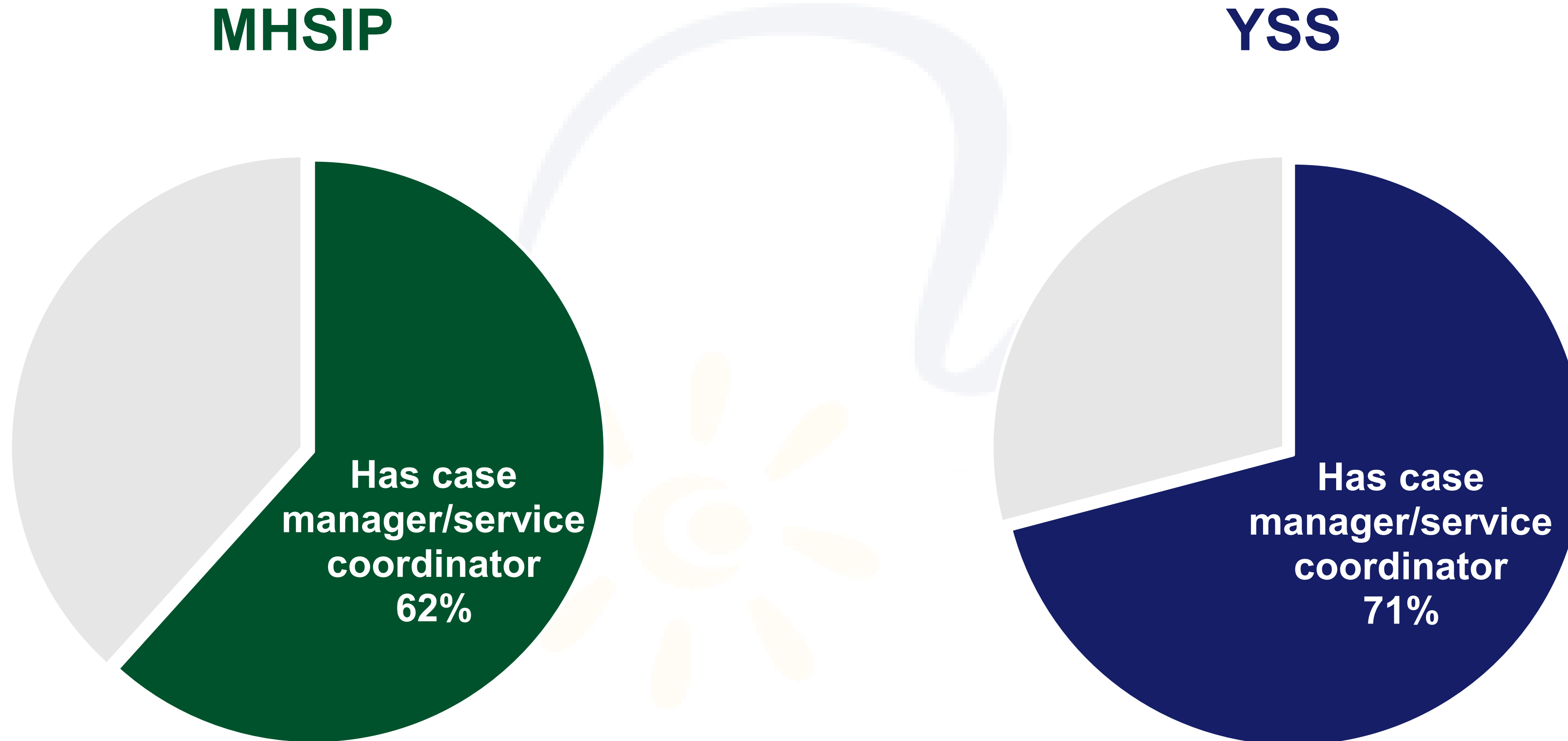






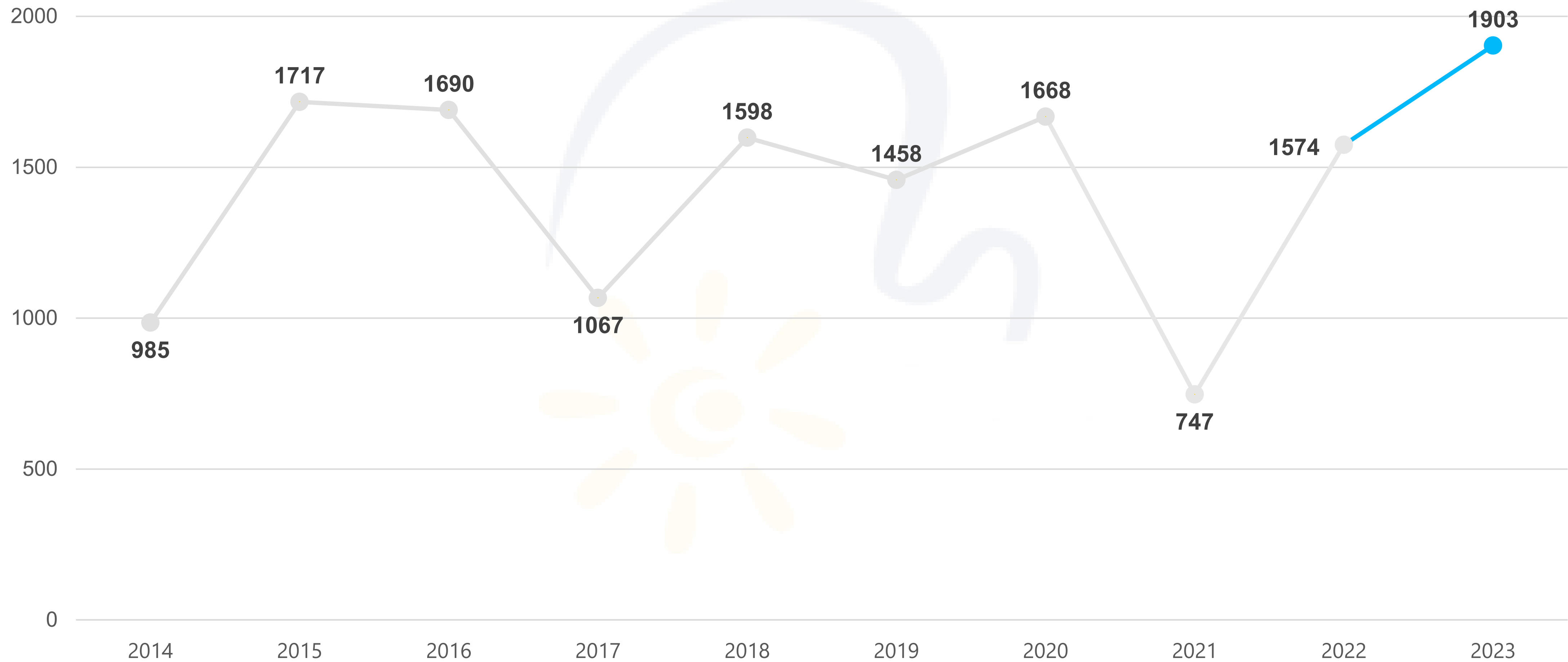
More youth than adults reported having a case manager or service coordinator

Presence of case manager or service coordinator indicates consumer is receiving long term support services (LTSS)



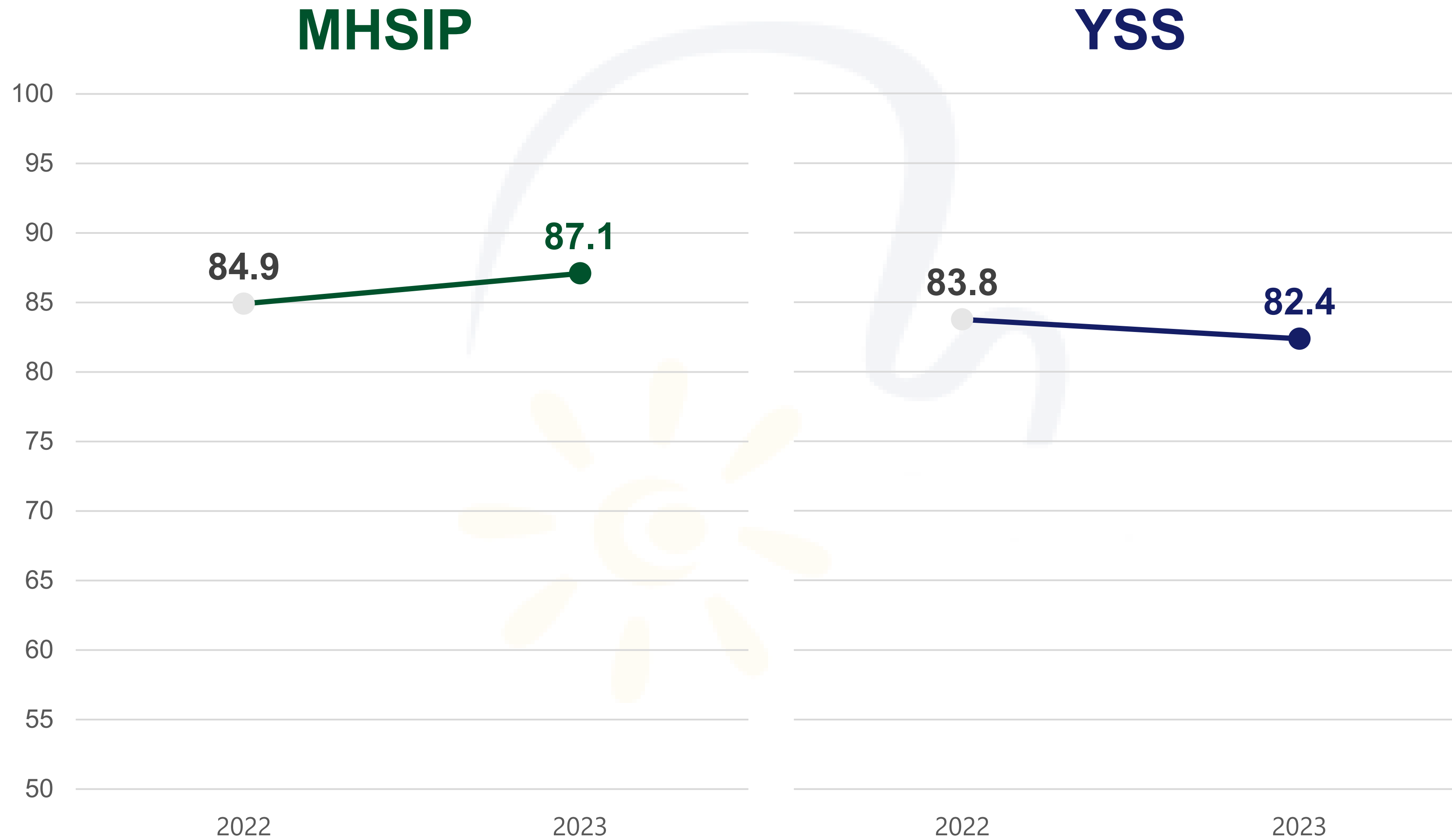
Total cumulative completions reached highest point in 2023

This year, YSS responses dipped while MHSIP responses soared – opportunity for improvement for YSS



Total aggregate average score dipped for YSS, lifted for MHSIP in 2023

While 2022 had similar scores for MHSIP and YSS, 2023 has a nearly 5-pt difference between the two



Survey methods employed in 2023

- Survey invitations were first sent by email (if available) then by SMS (if possible)
- Some CMHs also printed out QR code flyers and paper surveys, the paper surveys being entered into Alchemer by CMH staff as completed
- Several survey revisions took place as mentioned in the second section of this report. Some 2023 respondents took the previous version of the survey, but the data was compiled altogether.
  - The revisions went live on 10-31-23, before survey invitations went out
- reCAPTCHA was employed due to many fake responses in 2022 – this succeeded at keeping bots out of the survey

Analytical methods employed in 2023

- Results were disaggregated by more demographic variables than in the past
  - Including new questions such as living situation and previous ones like race and age
- Statistical tests between a county and the group of other counties were conducted using Pearson's chi-squared test due to the data not following a normal distribution
- Statistical tests between demographic groups either used Kruskal-Wallis tests (if more than two groups needed to be compared) or Pearson's chi-squared tests (if only two groups needed to be compared)
  - Each of these were used due to the data not following a normal distribution
- In comparisons between counties where statistically significant differences were found, margins of error were also displayed for the comparison group

"My child is thriving, successful in every aspect of life…I am so extremely happy with services. Thank you!"

- YSS respondent

Nathan Browning
Principal Consultant

nathan@kiaerresearch.com
(734) 308-6744 (call/text)
https://kiaerresearch.com

Kiaer Research

MSHN
Mid-State Health Network

Community Mental Health Member Authorities

Bay-Arenac Behavioral Health

CMH of Clinton.Eaton.Ingham Counties

CMH for Central Michigan

Gratiot Integrated Health Network

Huron Behavioral Health

The Right Door for Hope, Recovery & Wellness (Ionia County)

LifeWays

Montcalm Care Network

Newaygo County Mental Health Center

Saginaw County CMH

Shiawassee Health & Wellness

Tuscola Behavioral Health Systems

Board Officers

Edward Woods
Chairperson

Irene O'Boyle
Vice-Chairperson

Deb McPeek-McFadden
Secretary

RESOLUTION OF THE MID-STATE HEALTH NETWORK BOARD OF DIRECTORS OPPOSING MDHHS DECISIONS TO IMPLEMENT CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN

WHEREAS the Mid-State Health Network (MSHN) is a regional entity created in 2014 by the twelve Community Mental Health Services Programs (CMHSPs) listed at left and functions as a Pre-Paid Inpatient Health Plan (PIHP) for twenty-one mid-Michigan counties under a master Medicaid specialty supports and services contract with the Michigan Department of Health and Human Services (MDHHS). The MSHN Board of Directors is comprised of two appointees from each of the CMH Participants in the MSHN region, half of which are primary or secondary consumers of public behavioral health services.

WHEREAS in May 2023, the MSHN Board passed a resolution opposing all four models proposed by MDHHS, and the recent decisions announced by MDHHS in March and April 2024 are not substantially different from those models opposed by the MSHN Board at that time.

WHEREAS MDHHS has announced its decision to require CMHSPs to separate service assessment and planning from service delivery, requiring beneficiaries to receive the assessment and planning services from one entity and ongoing direct services from another, separate entity by October 1, 2024.

WHEREAS after careful review and in addition to the conclusions presented in our May 2023 Resolution, the conclusions of the MSHN Board are that the current decision:

- Is in conflict with the statutory responsibilities of CMHSPs under Michigan law;
- Erroneously implies profit driven or undue enrichment motives on the part of governmental entities (CMHSPs and PIHPs) instead of recognizing what is actually a formal transfer of governmental responsibility from the State to the Counties for the delivery of public behavioral health services;
- Ignores the capitation-based financing of the Michigan public behavioral health system, which is constant and does not vary by volume of individuals served negating any conflicts of interest in service planning and service delivery;
- Ignores Michigan's current shared risk (with MDHHS) financing system which already mitigates against conflict and self-interest.
- Is in conflict with the Certified Community Behavioral Health Clinic (CCBHC) model currently being implemented and expanded in Michigan;
- Ignores, at best, and disregards, at worst, input from persons with lived experience that have consistently stated that the available procedural safeguards are preferable to systemic/structural upheaval inherent in MDHHS announced decisions;

THEREFORE, BE IT UNANIMOUSLY RESOLVED THAT, **in the strongest possible terms**, and for the reasons noted herein, the MSHN Board of Directors **opposes the MDHHS announced structural strategies** for compliance with the federal Conflict Free Access and Planning Rules.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the Mid-State Health Network Board of Directors requests MDHHS reconsideration of its current decisions and to honor CMS waiver approval of procedural mitigation of conflict, and to pursue CMS approval of strengthened procedural safeguards against conflict of interest in Michigan.

ON BEHALF OF THE MID-STATE HEALTH NETWORK BOARD OF DIRECTORS BY ITS OFFICERS

Ed Woods, Chairperson
(LifeWays)

Irene O'Boyle, Vice Chairperson
(Gratiot Integrated Health Network)

Deb McPeek-McFadden, Secretary
(The Right Door for Hope, Recovery, and Wellness)

Unanimously Adopted May 7, 2024

530 W. Ionia Street, Suite F | Lansing, MI 48933 | P: 517.253.7525 | www.midstatehealthnetwork.org

RESOLUTION OF THE
BERRIEN MENTAL HEALTH AUTHORITY (BMHA) d/b/a RIVERWOOD CENTER
BOARD OF DIRECTORS
OPPOSING MDHHS DECISIONS TO IMPLEMENT
CONFLICT FREE ACCESS AND PLANNING IN MICHIGAN

WHEREAS (BMHA) is an affiliate of the Southwest Michigan Behavioral Health (SWMBH) PIHP comprised of eight counties;

WHEREAS MDHHS has announced its decision to require CMHSPs to separate service assessment and planning from service delivery, requiring beneficiaries to receive the assessment and planning services from one entity and ongoing direct services from another, separate entity by October 1, 2024;

WHEREAS BMHA d/b/a Riverwood Center provided services to over 5,000 people/consumers in 2023, and many of the consumers are the most vulnerable in our society - including people with intellectual and developmental disabilities and children with emotional disturbance. The interruption or loss of BMHA services to people served under the MDHHS decision would be disastrous to many individuals that currently receive service assessments, planning, and service delivery from BMHA.

WHEREAS after careful review the conclusions of the BMHA Board are that the current decision:

- Is in conflict with the statutory responsibilities of CMHSPs under Michigan law;
- Erroneously implies profit driven or undue enrichment motives on the part of governmental entities (CMHSPs and PIHPs) instead of recognizing what is actually a formal transfer of governmental responsibility from the State to the Counties for the delivery of public behavioral health services;
- Ignores the capitation-based financing of the Michigan public behavioral health system, which is constant and does not vary by volume of individuals served negating any conflicts of interest in service planning and service delivery;
- Ignores Michigan's current shared risk (with MDHHS) financing system which already mitigates against conflict and self-interest.
- Is in conflict with the Certified Community Behavioral Health Clinic (CCBHC) model currently being implemented and expanded in Michigan;
- Ignores, at best, and disregards, at worst, input from persons with lived experience that have consistently stated that the available procedural safeguards are preferable to systemic/structural upheaval inherent in MDHHS announced decisions;

THEREFORE, BE IT UNANIMOUSLY RESOLVED THAT, **in the strongest possible terms**, and for the reasons noted herein, the BMHA Board of Directors **opposes the MDHHS announced structural strategies** for compliance with the federal Conflict Free Access and Planning Rules.

BE IT FURTHER UNANIMOUSLY RESOLVED THAT, the BMHA Board of Directors requests MDHHS reconsideration of its current decisions and to honor CMS waiver approval of procedural mitigation of conflict, and to pursue CMS approval of strengthened procedural safeguards against conflict of interest in Michigan.

ON BEHALF OF THE BERRIEN MENTAL HEALTH AUTHORITY
d/b/a RIVERWOOD CENTER BOARD OF DIRECTORS

Marian Tripplett, Board Chairperson

Shannon Trecartin, Board Secretary

Approved 5/15/2024

HIDE-SNP

Highly Integrated Dual Special Needs Plan

Should we participate?

June 5, 2024

1

MI Health Link is a D-SNP

Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.

HIDE-SNP is coming January 2026

A managed care organization (MCO) plan that combines Medicare and Medicaid benefits into a single care plan.

They offer a higher level of integration than D-SNPs, they **include behavioral health and Managed Long-Term Services and Supports (LTSS) benefits**.

MDHHS: This is permanent and there will be statewide expansion.

Benefits to Persons Served

- Consolidated and aligned Member Services, Utilization Management, and other Plan Member benefits management functions
- Friendly supportive CMH and SWMBH support for primary care, whole health, social determinants of health, and medical-surgical services advocacy
- Aligned physical and behavioral health Plans driving improved overall care
- HIDE-SNP compared to MI Health Link:
  - Better care coordination
  - Access to a broader package of health care benefits
  - Improved communication and materials.

Should we Participate?

- Maximize influence of D-SNP system for the benefit of persons served and the region
- Integrated Care Organizations through its MI Health Link Demonstration participation
- Easier alignment for Healthcare Information Exchange and healthcare data analytics
- Environmental Scan indicates integration of physical and behavioral health are coming ~ this allows our region to be a front leader

Regional Benefits

- Potential start-up expense coverage from D-SNPs for CMHs and SWMBH
- Enhanced likelihood of earning Medicaid contingent revenue
- Incremental service, administrative and gain sharing revenue to CMHs, other providers, and SWMBH
- Regional local funds generation

If the SWMBH region does not actively participate, we will not be able to influence D-SNPs and/or another agency may be selected to manage their behavioral health benefits.

Benefits for CMHs

- Be an active partner stakeholder influencer with D-SNPs and MDHHS
- Improved outcomes for persons served
- Potential shared savings gain sharing
- Guaranteed option to provide Medicaid mild to moderate and Medicare behavioral health services
- Potential start-up expense coverage from D-SNPs

Roles for CMHs

- Active care coordination participants with direct access to Integrated Care Teams for persons served
- Optional providers of Medicaid mild to moderate and Medicare behavioral health services ~ CCBHC is already requiring this

Benefits for Behavioral Health Providers
(including Substance Use Disorder Treatment Providers)

- Guaranteed access to Medicaid mild to moderate and Medicare behavioral health treatment contract, provider panel, contract, service expansion and incremental revenue

- Consolidated and aligned plan/provider contracting, credentialing, claims submission, data exchange, and other Provider benefits management functions

Benefits to SWMBH

- SWMBH as an active partner, stakeholder, and influencer with D-SNPs and MDHHS
- Partial revenue coverage of fixed costs
- Full revenue coverage of incremental costs
- Potential start-up expense coverage from D-SNPs

SWMBH Strengths

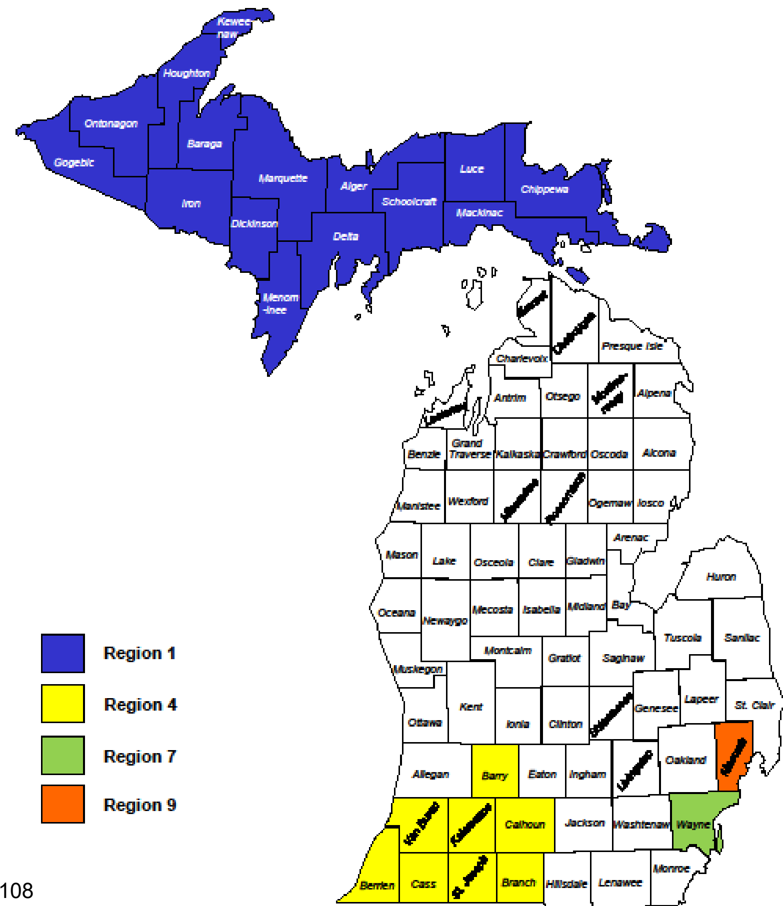
- SWMBH successfully achieved and maintained NCQA Managed Behavioral Health Organization Accreditation
- SWMBH has years of successful experience managing dual eligible benefits with MDHHS and indirectly with CMS

Timeline

May 2024 – Request for Proposal expected to be Released
October 1, 2024 – Contract Awarded
January 1, 2026 – Start Date

Implementation

MDHHS is considering proceeding with procurement for Prosperity Regions that are a part of MI Health Link: 1 (The Upper Peninsula) Region 10 (Wayne, Macomb and Oakland counties) and Region 8 (SW Michigan + Barry County) first, with the intent to expand statewide in the future.



Characteristics of HIDE-SNP Model

- MDHHS intends to prioritize integration moving forward.
  - Directly contracting with D-SNPs vs contracting with an MHP.
  - Capitated compensation to participating plans.
  - Limitations on enrollment eligibility
  - Maintain the current MI Health Link benefit package, including some type of Home and Community Based Services (HCBS) waiver.
  - A robust quality oversight program
  - Integrated materials, including appeals and grievance

June 5, 2024

Summary of Key Informant Interviews completed as of May 31, 2024 to inform 2024-2027 SWMBH Strategic Plan

Key Informant Interviews (KII): Methodology

All interviews are being conducted by the same SWMBH staff. They are all via TEAMs or Zoom and are scheduled for one hour. The interviews are conducted in an open manner resembling a conversation between acquaintances, allowing for a free flow of ideas and information.

Comments are not attributed to specific organizations at the request of some individuals. Concepts that were shared by a single organization are noted as such.

The interviewer framed questions and probed for additional information as the conversations progressed. Specific topics that were introduced if they did not naturally arise include: Data Driven Decision-Making; Intensity of Service / Severity of Illness Criteria; Opioid settlement dollars; Value based payments, Proof of clinical program performance, and predictive modeling.

SWMBH region CMH CEOs feedback is not incorporated at this time given that they are in progress.

Opportunities Identified

Marketing: Ensure the public knows who we are, what we do, and the changes we make in individuals lives.

Identify and address data needs: Publish data on people's lives have been improved. Develop metrics with entities that have not historically been funded such as peers and community health workers.

Enhance relationships with organizations to better serve individuals:

- FQHC
- Coroners Offices
- Foster Care Local Departments
- Jails and Prisons
- Other Michigan PIHPs

Develop a regional system to complete immediate in-take for children entering foster care and individuals being released from institutional correction facilities.

Key Informant Interview Participants

Advanced Care, Grant Brown

Autism Alliance, Colleen Allen

Health Management Associations, David Schneider

Mental Health Association of Michigan, Marianne Huff

Michigan Association of Counties (Opioid Funds), Amy Dolinky

Michigan Association of Health Plans, Dominick Pallone

Michigan Health Information Network, Tim Pletcher

Michigan Hospital Association, Lauren LaPine

National Alliance on Mental Illness, Kevin Fischer

TBD Solutions, Laura Vredeveld and Jason Radamacher

In progress: SWMBH Region CMH CEOs

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KII: Threat of Privatization of the Public Behavioral Health System

Many individuals interviewed shared the view that the threat of privatization lingers. There was support amongst some that the CMHA system is the better of the two options, and advice on what is needed to keep the threat minimal was shared.

- Acknowledge that while the public health system isn't broken, it needs to be improved.
- Demonstrate that we are providing better outcomes.
- Be innovative, reduce duplication of effort.
- Focus on economies of scale.
- Be a great partner to all agencies working with our persons served.

And while the private system has the ability to operate efficiently, their downfall is greed. We can learn from their efficiencies however. Afterall, they don't understand the mental health needs of our people. They don't understand self determination and that quality of life is more than just doctor appointments.

"At the Federal Level, the CCBHC 51% rule is known as the Michigan Rule."

Advocates feel Individuals with newly Identified Needs don't know about the Public Health System

Multiple advocate agencies stated individuals who are recently diagnosed are not aware of who to call and how to get services. Further, coverage in the media has focused on what we don't have available.

The belief is that this is a systemic problem. The public health system is good at talking to each other, but people who are not in the system need more information.

Suggestions included pamphlets available at primary care locations and truly "meeting people where they are." Keeping in mind that underserved populations do not mean just racial groups. We need to reach out to various age groups; go into middle schools and homes for the elderly. And remember that not all first responders are the same; firefighters require a different approach than police officers.

Value Based Payments: This requires realistic expectations. Health Plans are required to have these in place with their providers. The goals placed on the Health Plans are changed with every contract, the expectation is individualized based on previous performance and holding them to a higher standard every year. BCBS is attempting to create these for Autism services.

Data-Driven decision making: There is an intentional move towards this on the part of agencies. A "word of Caution, data is widely important but you can get paralyzed waiting for more data – you still need to move forward and make decisions." Agencies are using data to inform policy and make legislative recommendations.

New Settings for Providing Care

There are new settings for providing care, but we have not figured out how these are going to integrate into the larger behavioral health system.

- Psychiatric Residential Treatment Facilities
- Crisis Stabilization Units
- Certified Community Behavioral Health Clinics (CCBHC)

More on CCBHC

One advocate believes this is the bottom of integrated care, and there is concern from the Michigan Association of Health Plans when the concept of CCBHC is touted to be integrated care given that the Health Plans have not been involved at all.

CCBHC—Changes Coming in 2025

The 2025 Michigan handbook has increased direction for PIHP roles in monitoring.

There is a new "rule" that 51% of daily encounters must be provided by the CCBHC, not a Designated Collaborating Organization (DCO).

"At the federal level, the intent is to have CCBHCs be a primary provider, but many Michigan CCBHCs are trying to function as managed care entities."

Integrated Care

Within the current state system there is a push to breakdown silos of care. The upcoming conversion to a HIDE-SNP will further integrate care for individuals served by both Medicare and Medicaid. There is additional focus on juvenile and justice involved individuals and it is beyond physical and mental health. There is also a push to look at housing and food needs.

This is a federal initiative and it will pivot back to the public system. SWMBH should consider formal relationships with agencies, departments, and units which work with our population of persons served.

HIDE-SNP is Coming . . . What is the role of the PIHP?

Opioid Settlement Funds

PIHPs have an opportunity to be trusted advisors for local funds. We need to be more vocal about how we can help in determining use of funds that will make a difference.

At a federal level there is a focus on lowering the barriers to access to care. One way is through more grass roots and mutual aid organizations which have proven to provide the lowest barrier support.

What is needed is meaningful reporting requirements for these grass roots organizations. Metrics need to be developed for providers who have not been funded historically such as peers and community health workers.

Warnings: Traditional Concepts are being co-opted such as harm reduction. Entities are providing a perverted version of harm reduction which indirectly leads to criminalization of opioid use. This is not the purposeful intention, but some approaches being seen across Michigan will lead to criminalization. Large agencies are trying to "cash in" and become subject matter experts with no previous experience in the field.

Artificial Intelligence, Predictive Modeling, and Chat GPT

"This is the future."

Recommendations include developing a region-wide policy.

It is believed clinical documentation may be the first area impacted.

And while multiple agencies interviewed are using Chat-GPT in some capacity already, it is believed the state may be the slower to use the technology.

Psychiatric Beds

Michigan Hospital Association shared that while some Michigan partners want to decrease psychiatric beds, it is notable that across the country there is more availability in other states.

While it is good that Michigan has moved from long-term psychiatric care unnecessarily, there are certain individuals who still need the long-term care.

Michigan still needs facilities and long-term spaces.

Legislation that is trying to be Introduced

Full Financial and Clinical Integration of Behavioral and Physical Health Care (MHP)

Change the structure of the PIHPs to decrease CMH control hence allowing the PIHPs to truly function as an insurance company (3 advocacy groups).

Workforce Shortage

The health plans acknowledge they do not have enough providers; miscommunication on the part of provider availability is a communication breakdown. Providers are expected to notify MHPs when they are no longer accepting new patients but this does not happen. Legislation is out requiring they accept to panel any willing provider, they do this currently.

Autism services are expanding to include older individuals. The concern is practitioners lack of experience with adults as well as a willingness to work more physically challenging clients. There are also not enough diagnosticians.

Expect an increase in demand for peer coaches and specialists as well as community health workers.

The rate of pay for direct care workers is approaching that of clinicians new to the field; rate of pay increases are needed for clinicians as well.

Integrated Care: "We need a common statewide definition and leadership over the movement. How we define it and execute it is the question."

There are 3 buckets: Financial, Operational, and clinical. Most agree clinical integration is good. For example, having dental, SW, GP, specialists, ABA all under one roof. At minimum a team assigned to the individual. Operationally technology is part of the solution.

Some (MHP) believe in order for clinical to occur, the other 2 buckets need to occur too.

Michigan Association of Health Plans reports there is a movement across the country to integrate all three buckets. Integration on the commercial side has been pushed forward faster with parity a beginning step.

Arizona and Washington are the furthest along with Arizona fully integrating Autism, IDD, and LTC. Managed care seems to be the more common than FFS approach. Florida, North Caroline, Arkansas, and Iowa are examples.

Most interviewed believe some collaboration between private and public is inevitable.

Collaborative Care Model

Many interviewees believe this is an extension of Integrated Care. A difficulty in using this model is the current staffing shortage across the state.

Henry Ford is one hospital with a behavioral health primary care collaborative model in which they are using data to track outcomes.

Michigan Hospital Association supports building collaborative relationships between CMHs and hospitals. While SWMBH does a good job at this, other PIHPs do not. They would like to see "best practices" developed to help roll this out in other regions.

An individual advocate stated Michigan has a nationwide reputation that this is difficult to achieve due to our systems not getting along (education and mental health).

It is believed there may be a future requirement for CMHs to contract with medical providers.

March 5, 2024

Centers for Medicare and Medicaid Services
ATTN: Keri Toback, CMS
keri.toback@cms.hhs.gov.

RE: Concerns about the proliferation of conflict of interest in the Michigan Community Mental Health System

Dear Ms. Toback:

We represent three of Michigan's oldest, statewide disability rights organizations and we write to share our concerns regarding the conflict of interest that is present in the public mental health system in our state. The Arc Michigan, Disability Rights Michigan and the Mental Health Association in Michigan have over 160 years of combined experience advocating for individuals with developmental and intellectual disabilities; mental health and substance use disorders and children with serious emotional disturbance. In our work with persons who receive services from the community mental health system in Michigan, we are uniquely positioned to observe the problems that have been created by the lack of accountability and oversight that is endemic in our state mental health system.

The main driver behind the lack of accountability and oversight is the blatant conflict of interest that is woven into the governance boards of the managed care organizations or Prepaid Inpatient Health Plans (PIHPS). We have been perplexed and confused by the way in which the PIHP boards have been allowed to be structured and cannot understand it. We have wondered if it is allowed under Federal rules for a managed care organization's board to be populated with the entities that contract with it, thus allowing the contracted entities to control the managed care organization. This seems, at least to us, to be problematic, particularly if the MCO is charged with monitoring the members of its provider network.

As advocates, we listen to beneficiaries, to beneficiaries' families and to those who support beneficiaries as they explain their frustrations trying to access specialty supports and services from community mental health services providers or CMHSPs. We and our staff provide direct advocacy assistance to beneficiaries and have witnessed the challenges that they experience. Problems include:

- Being told that home and community-based services and supports are not available due to a lack of providers
- That there is not enough money to pay for supports and services that are needed
- That the beneficiary does not meet "medical necessity criteria" but the rationale for making the determination lacks specificity.
- The failure to provide beneficiaries with notice of their rights to due process when there is an adverse benefit determination is an ongoing problem.

Person-centered planning is virtually non-existent, and beneficiaries are rarely offered the opportunity to have an independent facilitator during the planning process. Adults with serious mental illness and children with serious emotional disturbance (SED) are rarely offered the chance to participate in a self-determination arrangement. These are only a few of the problems that are ongoing in our state. At the same time, one of the solutions that MDHHS proposes to eliminate the conflict of interest is to have independent facilitation and self-determination available.

We have made concerted efforts to meet with leadership from the Michigan Department of Health and Human Services (MDHHS) to voice our concerns about the conflicts of interest and how that conflict of interest interferes with the ability of persons served to access and select Medicaid-covered services and support, but our concerns have gone unanswered. Additionally, we have met with MDHHS leadership on three separate occasions: August 7, 2023; October 31, 2023, and December 19, 2023. Despite these conversations, our statement of concerns which includes not only the conflict of interest on the PIHP boards but also the fact that the MDHHS is not following its own 2019 1915(i) waiver application with respect to addressing the conflict free access and planning that is required by the revisions to the HCBS rules that occurred in 2014. Therefore, we have decided to bring our concerns to you, the Centers for Medicare and Medicaid (CMS), with the hope that you will actively address the problems that we will outline in this correspondence with the state of Michigan.

We were also told by officials in MDHHS that there is "no way to hold the PIHPs/CMHSPs accountable." In light of the conversations that we had with state officials, we believe that the only way to address these ongoing systemic failures is to seek your help. Unfortunately, despite the multiple meetings with the state, the most outstanding obstacle in the system has gone unaddressed: the lack of accountability and oversight by the PIHPs and the MDHHS.

As it stands right now, the CMHSPs have absolute control of the boards of directors of the PIHPs and yet, the CMHSPS also contract with those same PIHPS. We cannot understand how this arrangement was allowed in light of the role of the PIHP. The PIHP has two functions: 1. To write the check to the CMHSPs for Medicaid and 2. To hold the CMHSPs accountable under myriad federal and state statutes, rules, and regulations for public dollars. When the state decided to reduce the number of PIHPS from 18 to 10 in 2014, the CMHSPs became owners/members of the PIHPs. [i] For example, the Application for Participation (AFP) that was issues by the state of Michigan Behavioral Health and Developmental Disabilities Administration on February 6, 2013, provided this guidance regarding the governance of the PIHPs:

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed

by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

The boards of directors of the PIHPs became populated with and controlled by the board members from the CMHSPs boards of directors. It is not possible for the board member of a CMHSP to sit on the board of a PIHP and remain fully objective and unbiased regarding the activities of its own CMHSP. As advocates, we have plenty of anecdotal evidence to support our knowledge of the fact that the PIHPs are ineffective in ensuring that the CMHSPs are following the terms of the master PIHP/CMHSP contract. We believe that most of the difficulties that beneficiaries and their families and those who love/support them experience are related to the inability of the PIHPs to ensure that the CMHSPs are abiding by their contractual obligations.

The 2013 Application for Participation that was issued by the state made it clear that the CMHSPs are to be part of the governance structure of the PIHPs.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized, and designated as the PIHP (for a region consisting of more than one CMHSP).[ii]

Additionally, we are bringing to the attention of CMS the problems created by the governance structure of the PIHPs in light of the MDHHS' efforts to implement conflict free access and planning in accordance with its 2019 1915(i)spa application. In its 1915(i)-spa waiver application, the MDHHS gave assurances to CMS that the MDHHS will "maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state HCBS benefit." MDHHS/BHDDA contracts with regional managed care Pre-Paid Inpatient Health Plans (PIHP) as the other contracted entity, to assist in monitoring functions of the HCBS benefit." [iii] We believe that the MDHHS and the PIHPs have been unable to keep this commitment to CMS.

The MDHHS assured CMS that certain safeguards would be implemented to allow beneficiaries to have freedom of access to home and community-based services through the elimination of conflict of interest. The state responded***, "MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities.***" [iv] Our concern is that, as long as the CMHSPs control the governing boards of the PIHPs, then it is not possible for the PIHPs to effectively monitor the implementation of the 1915(i) SPA services. In our state, CMHSPs have functioned as both payer and provider for years. If Michigan is going to address the structural conflict of interest in the system, then changes

must be made to the board governance of the PIHPS. Despite the ongoing work that was undertaken by a workgroup convened by the MDHHS to address conflict free access and planning, Michigan still has not met the requirements as dictated by the changes in the HCBS rules in 2014.

On Pages 3-4 of the 1915 (1) waiver application that was submitted by the state of Michigan in 2019, Michigan made certain assertions that it was going to assure that certain administrative functions are carried out by either the state Medicaid Agency or by the contracted entities or PIHPs. The waiver application alleges that the state or the PIHPs will carry out the review of participant plans of service; prior authorization of State Plan HCBS; Utilization Management; Qualified provider enrollment and execution of the Medicaid provider agreements. Unfortunately, we can provide the CMS with information that demonstrates that the PIHPs DO NOT monitor the person-centered services plans of beneficiaries and that the PIHPs DO NOT implement utilization management. We believe that this information should be of concern to the federal government.

In accordance with the language from the 2019 waiver application, Michigan checked the box and made these assurances (see below) on page 2:

(By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

We request the opportunity to meet with CMS at its earliest convenience so that we can discuss our concerns and provide representatives with anecdotal evidence that supports the concerns that have been raised in this correspondence. We are also asking that CMS inquire with the state of Michigan about the conflict of interest that has been identified in this correspondence. We remain baffled by the understanding that the current structure of the PIHP system in Michigan has been allowed under the Federal rules. We quite simply don't understand how it was or has been approved. We are seeking not only verification of the fact that such an arrangement has been undertaken with the full knowledge of the Centers for Medicare and Medicaid Services, but we would like to have a greater understanding of why this has been allowed.

Finally, we would like to include some persons served and their families in a meeting with representatives from CMS. We believe that you would benefit from hearing directly from those

who have found it necessary to fight the system in order to get what is needed for themselves and/or their loved ones. Given the fact that the community mental health system has had three federal lawsuits filed against it with and on behalf of individuals served by the system—with one filed against the MDHHS and two against CMHSPS—we believe that CMS might be interested in hearing more about "how" Michigan is underperforming in the public mental health arena.

Thank you for your attention and assistance. We look forward to hearing from you. Our contact information is: Sherri Boyd, Executive Director, Arc Michigan (sherri@arcmi.org and (517) 487-5426); Michelle Roberts, Executive Director, Disability Rights Michigan (mroberts@drm.org and (517) 487-1755); Marianne Huff, Executive Director, Mental Health Association in Michigan (mhuff@mha-mi.com and (517) 898-3907).

Sincerely,

Sherri Boyd

Michelle Roberts

Marianne Huff

Cc: Meghan Groen, Kristin Jordan, Erin Emerson, Belinda Hawks, Jackie Sproat

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[i] On 2/6/13, the Michigan Department of Health and Human Services issued the Application for Participation for Specialty Prepaid Inpatient Health Plans which describes the process that those entities desiring to become or remain PIHPS must follow. Application for Participation for Specialty Prepaid Inpatient Health Plans.

[ii] IBID. Page 4.

[iii]C: MI 1915i for Behavioral Health State Plan Amendment (SPA) #: 19-0006. "Contracted Entity: MDHHS/BHDDA, as the Medicaid State Agency, will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state plan HCBS benefit. MDHHS local field offices establish Medicaid eligibility (function 2) as the other state agency and MDHHS/BHDDA contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the other contracted entity, to assist in monitoring functions of the HCBS benefit (functions 1, 3, 4, 5, 6, 7, and 10). MDHHS/BHDDA, the PIHP, an EQR Vendor, and local nonstate entities/Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities (function 10).

[iv] MI 1915i for Behavioral Health State Plan Amendment (SPA) #: 19-0006. State's response to section 5/conflict of interest.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

May 22, 2024

Mr. Bradley Casemore, Executive Officer
Southwest Michigan Behavioral Health
5250 Lovers Lane, Suite 200
Portage, MI 49002

Dear Mr. Casemore,

Thank you for the cooperation extended to the Behavioral and Physical Health and Aging Services Administration staff during the May 8, 2024, State Opioid Response (SOR) virtual site visit.

PRESENT AT THE SITE VISIT

Southwest Michigan Behavioral Health:	Joel Smith, SUD Prevention and Treatment Director Garyl Guidry, Chief Financial Officer Tiffany Jackson, Financial Analyst Amy St. Peter, SUD Grant Specialist Erin Hetrick, SUD Treatment Specialist
Behavioral and Physical Health and Aging Services Administration:	Angie Smith-Butterwick, Substance Use, Gambling & Epidemiology Manager Choua Gonzalez-Medina, State Opioid Coordinator – SOR 3 Foua Hang, Project Assistant – SOR 3 Danyle Stacks, Opioid Care Liaison – SOR 3
Wayne State University:	Danielle Hicks, Evaluation Project Manager

The purpose of the Grant Year Two Site Visit was to verify that Southwest Michigan Behavioral Health's State Opioid Response (SOR) grant activities and services for opioid use disorder (OUD) are following federal and state requirements to support prevention, treatment, and recovery activities.

SOR REQUIREMENTS

Prepaid Inpatient Health Plans (PIHP) must utilize funds within programs for individuals with opioid use disorders to fulfill federal and state funding requirements. SOR funds are distributed to increase the availability of prevention, treatment and recovery services designed for individuals with an OUD.

SITE VISIT FINDINGS

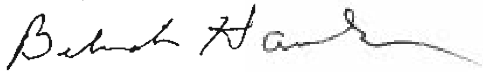
After careful consideration and review of the requirements and documentation submitted, we have determined that Southwest Michigan Behavioral Health is in compliance with the Substance Abuse and Mental Health Services Administration's Funding Opportunity Announcements and the Michigan Department of Health and Human Services Contract.

Currently, Southwest Michigan Behavioral Health has all the necessary tools in place to manage, maintain and report on the SOR activities and data from their provider network. Their providers will screen individuals to assess their needs and provide or make referrals for interventions as needed for individuals with an OUD.

We greatly appreciate Southwest Michigan Behavioral Health's preparation for the site visit and their commitment to provide our staff with the necessary documentation.

If you have any further questions, please contact Angie Smith-Butterwick at SmithA8@michigan.gov or Logan O'Neil at ONeilL@michigan.gov.

Sincerely,



Belinda Hawks, MPA
Director
Division of Adult Home and Community Based Services
Behavioral and Physical Health and Aging Services Administration

BH/ds

Enclosure (if applicable)

c: Angie Smith-Butterwick, Substance Use, Gambling & Epidemiology Manager
Logan O'Neil, Project Director – SOR 3
Joel Smith, SUD Prevention and Treatment Director

Governor Gretchen Whitmer announced the appointment of Bradley Casemore to the *Michigan Opioids Task Force*.

Bradley Casemore, of Battle Creek, is the Chief Executive Officer of Southwest Michigan Behavioral Health. He is a Fellow of the American College of Healthcare Executives, and a former member of the Opioid Advisory Commission. Casemore received a Bachelor of Arts in psychology and sociology, a Master of Social Work in administration, and a Master of Health Services Administration from the University of Michigan. Bradley Casemore is reappointed to represent PIHP Region 4 for a term commencing June 15, 2024, and expiring June 14, 2028. This appointment is not subject to the advice and consent of the Senate.

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

July 12, 2024
9:30 am to 11:30 am
(d) means document provided
Draft: 5/28/24

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. June 14, 2024 SWMBH Board Meeting Minutes (d) pg.
   b. May 8 and 29, 2024 Operations Committee Meeting Minutes (d) pg.

5. **Required Approvals (10 minutes)**

   - None scheduled

6. **Ends Metrics Updates *(*Requires motion)***
   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.

   - CCBHC Consumer Satisfaction Survey Results (A. Lacey) (d) pg.

7. **Board Actions to be Considered (10 minutes)**

   a. Ends Revisions (S. Radwan) (d) pg.
   b. Strategic Plan Draft (E. Philander) (d) pg.

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-002 Management Delegation (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.

   - BEL-009 Global Executive Constraints (d) pg.

10. **Board Education (25 minutes)**

    a. Fiscal Year 2024 Year to Date Financial Statements (G. Guidry) (d) pg.
    b. Board Monitoring of Ends Achievement (S. Radwan) (d) pg.
    c. Open Meetings Act Overview (M. Todd) (d) pg.
    d. Conflict Free Access and Planning (A. Lacey)
    e. Fiscal Year 2024 Regional Population Health Report (A. Lacey; M. Kean) (d) pg.
    f. Fiscal Year 2023 Health Services Advisory Group Report (M. Todd; A. Lacey) (d) pg.
    g. Information Technology Update (N. Spivak)

11. **Communication and Counsel to the Board**

    - August Board Policy Direct Inspection – BEL-004 Treatment of Staff (M. Doster); BEL-006 Investments (S. Sherban); BEL-007 Compensation and Benefits (T. Leary)

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
August 9, 2024
9:30 am - 11:30 am
Air Zoo Aerospace & Science Museum
6151 Portage Rd, Portage, MI 49002