



Community • Independence • Empowerment

Jeffrey W. Patton
Chief Executive Officer

www.iskzoo.org

Administrative Services
2030 Portage Street
Kalamazoo, MI 49001
(269) 553-8000

Access Center
615 East Crosstown Pkwy
Kalamazoo, MI 49001
(269) 373-6000
(888) 373-6200
MI Relay Center: 711

Integrated Health & Psychiatric Services
615 East Crosstown Pkwy
Kalamazoo, MI 49001
Adults: (269) 553-7037
Youth: (269) 553-7078

Office of Recipient Rights
2030 Portage Street
Kalamazoo, MI 49001
(269) 364-6920

Services for Adults with Mental Illness
2030 Portage Street
Kalamazoo, MI 49001
(269) 553-8000
(888) 373-6200

Services for Adults with Intellectual and Developmental Disabilities
418 West Kalamazoo Ave
Kalamazoo, MI 49007
(269) 553-8060
MI Relay Center: 711

Services for Youth and Families
418 West Kalamazoo Ave
Kalamazoo, MI 49007
(269) 553-7120

Substance Use Disorder Services
(800) 781-0353

Training
2030 Portage Street
Kalamazoo, MI 49001
(269) 364-6952

PUBLIC NOTICE

The Board of Directors of Integrated Services of Kalamazoo will hold their board meeting on the following:

Date Posted: March 13, 2023

Project Name: Integrated Services of Kalamazoo, Board of Directors, board meeting

Location: 610 S. Burdick Street, Kalamazoo, MI.,
(2nd Floor – Board Conference Room)

Date/Time: March 27, 2023 @ 4:00PM

To mitigate the spread of COVID-19 and its variants, and to protect the public health by limiting in-person contact, ISK (Integrated Services of Kalamazoo) will conduct its board meeting by offering two options: Microsoft TEAMS or in-person. By utilizing these two options to conduct this meeting, we will meet the requirements of the Open Meetings Act.

All interested persons may join the remote meeting through the following procedures:

Microsoft Teams meeting

+1 616-272-5624 United States/Conference ID: **870 664 203#**

Once you have joined the meeting, please disable your camera, and silence your microphone.

ISK welcomes and encourages persons to supply input or ask questions on any board business. To communicate with the ISK Board Members or if you have specific needs to take part in the meetings held by the Board. Please contact [Demeta J. Wallace](mailto:Demeta.J.Wallace@iskzoo.org) at least three (3) business days prior to the scheduled meeting date at Dwallace@iskzoo.org or 269-553-8000.

The ISK Board packet is posted monthly on our website @ www.iskzoo.org.



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Administrative Services

610 South Burdick Street
Kalamazoo, MI 49007
Phone: (269) 553-8000

Access Center

615 East Crosstown Parkway
Kalamazoo, MI 49001

Phone: (269) 373-6000
(888) 373-6200

Michigan Relay Center: 711

Integrated Health & Psychiatric Services

615 East Crosstown Parkway
Kalamazoo, MI 49001

Phone (Adults): (269) 553-7037

Phone (Youth): (269) 553-7078

Office of Recipient Rights

610 South Burdick Street
Kalamazoo, MI 49007

Phone: (269) 364-6920

Outpatient Services

2030 Portage Street
Kalamazoo, MI 49001

Phone: (269) 553-7132

Services for Adults with Mental Illness

2030 Portage Street
Kalamazoo, MI 49001

Phone: (269) 553-8000
(888) 373-6200

Services for Adults with Developmental Disabilities

418 West Kalamazoo Ave.
Kalamazoo, MI 49007

Phone: (269) 553-8060

Michigan Relay Center: 711

Services for Youth and Families

418 West Kalamazoo Ave.
Kalamazoo, MI 49007

Phone: (269) 553-7120

Substance Use Disorder Services

Phone: (800) 781-0353

Training

418 West Kalamazoo Ave.
Kalamazoo, MI 49007

Phone: (269) 364-6952

AGENDA

INTEGRATED Services of Kalamazoo BOARD OF DIRECTORS HAS SCHEDULED ITS MEETING FOR MONDAY, March 27, 2023, BEGINNING @ 4:00PM via Microsoft TEAMS or in person.

- I. CALL TO ORDER - CITY & COUNTY DECLARATION
- II. AGENDA
- III. CITIZEN TIME
- IV. RECIPIENT RIGHTS
 - a. Recipient Rights Monthly Reports
 - b. Reappointments to the Recipient Rights Advisory Committee/MOTION
- V. PROGRAM SERVICES REPORT
 - a. Moved to Monday, April 24, 2023
- VI. CONSENT CALENDAR/VERBAL MOTION
 - a. Minutes
 - b. Board Compensation (Policy)
 - c. Board Members' Code of Conduct (Policy)
 - d. Depreciation (Policy)
 - e. Conflict of Interest (Policy)
- VII. MONITORING REPORT
 - a. Utilization Management (Report)
- VIII. FINANCIAL REPORTS
 - a. Financial Condition Report
 - b. Utilization Report
 - c. February Disbursements/MOTION
- IX. ACTION ITEM
 - a. None
- X. CHIEF EXECUTIVE OFFICER REPORT
 - a. CEO Report
- XI. CITIZEN TIME
- XII. BOARD MEMBER TIME
 - a. SWMBH Updates/Erik Krogh
- XIII. ADJOURNMENT

IV.a.

Office of Recipient Rights
Report to the Mental Health Board
On Complaints/Allegations
Closed in: February 2023

Office of Recipient Rights Report to the Mental Health Board
Complaints/Allegations Closed in February 2023

	February 2023	FY 22-23	February 2022	FY 21-22
Total # of Complaints Closed	35	174	40	167
Total # of Allegations Closed	64	311	61	284
Total # of Allegations Substantiated	13	103	17	88

The data below represents the total number of closed allegations and substantiations for the following categories:
Consumer Safety, Dignity/Respect of Consumer, Treatment Issues, and Abuse/Neglect.

ALLEGATIONS	February 2023		February 2022	
Category	TOTAL	SUBSTANTIATED	TOTAL	SUBSTANTIATED
Consumer Safety	7	0	3	0
Dignity/Respect of Consumer	9	0	14	4
Treatment Issues/Suitable Services (Including Person Centered Planning)	10	3	10	3
Abuse I	0	0	1	0
Abuse II	5	1	3	1
Abuse III	9	0	4	1
Neglect I	0	0	1	1
Neglect II	0	0	0	0
Neglect III	9	6	7	5
	49	10	43	15

APPEALS	February 2023	FY 22-23	February 2022	FY 21-22
Uphold Investigative Findings & Plan of Action	0	0	0	0
Return Investigation to ORR; Reopen or Reinvestigate	0	0	0	0
Uphold Investigative Findings but Recommend Respondent Take Additional or Different Action to Remedy the Violation	0	0	0	0
Request an External Investigation by the State ORR	0	0	0	0

ABUSE AND NEGLECT DEFINITIONS – SUMMARIZED

Abuse Class I means serious injury to the recipient by staff. Also, sexual contact between a staff and a recipient.

Abuse Class II means non-serious injury or exploitation to the recipient by staff and includes using unreasonable force, even if no injury results.

Abuse Class III means communication by staff to a recipient that is threatening or degrading. (such as; putting down, making fun of, insulting)

Neglect Class I means a serious injury occurred because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse I or neglect I of a recipient.

Neglect Class II means a non-serious injury occurred to a recipient because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse II or neglect II of a recipient

Neglect Class III means a recipient was put at risk of physical harm or sexual abuse because a staff person DID NOT do something he or she should have done per rule or guideline. It also includes failure to report apparent or suspected abuse III or neglect III of a recipient.

ORR ADDENDUM TO MH BOARD REPORT

March 2023

Re: February 2023 Abuse/Neglect Violations

February

Abuse Violations

- There was one substantiated Abuse II violation in February 2023.
 - The remedial action for this violation was Employment Termination (1).

Neglect Violations

- There were six substantiated Neglect III violations in February 2023. Two were Failure to Report.
 - The remedial action for these violations were Employment Termination (1), Contract Action (1), Written Reprimand (3), Training (4).

2 of the 6 violations occurred at the same agency and program sites. Another 2 violations occurred at another agency and same program sites. Each of these 2 agencies had a Failure to Report.

Kalamazoo Community Mental Health and Substance Abuse Services
MOTION

Recommended Motion:

Appointments:
 “I MOVE TO RE-APPOINT THE FOLLOWING INDIVIDUALS TO THE RECIPIENT RIGHTS ADVISORY COMMITTEE (RRAC): **DIANE BORNEMAN, KAREN LONGANECKER, BECKY LOPEZ, BETSY SCHLOTT** FOR A TWO-YEAR TERM (**BEGINNING JUNE 1, 2023-JUNE 1, 2025**).”

Summary of Request

Date of Board
Consideration: MARCH 27, 2023



24 HOURS
Behavioral Health Clinic

COMING SOON

INTEGRATED Services of Kalamazoo (ISK) Board of Director's Meeting February 27, 2023 VI.a.

<u>ISK Board Member</u>	<u>Board Members PRESENT</u>	<u>Declaration of Location City/County</u>	<u>Board Members ABSENT</u>
Karen Longanecker, <i>CHAIR</i>	X	Kalamazoo/Kalamazoo	
Michael Seals, <i>VICE CHAIR</i>	X	Kalamazoo/Kalamazoo	
Nkenge Bergan	X	Kalamazoo/Kalamazoo	
Sarah Carmany	X	Kalamazoo/Kalamazoo	
Patrick Dolly	X	Kalamazoo/Kalamazoo	
Pat Guenther	X	Kalamazoo/Kalamazoo	
Michael Raphelson			X
Sharon Spears	X	Kalamazoo/Kalamazoo	
Erik Krogh			X
Melissa Woosley			X
Montez Morales, <i>COMMISSIONER</i>	X	Kalamazoo/Kalamazoo	

ISK - KCMHSAS Staff Present:

Jeff Patton, *CHIEF EXECUTIVE OFFICER*
 Roann Bonney
 Amy Rottman
 Charlotte Bowser
 Wanda Brown
 Sheila Hibbs
 Beth Ann Meints
 Kathy Lentz
 Dianne Shaffer
 Ed Sova
 Alecia Pollard
 Demeta Wallace

ISK - KCMHSAS Staff Absent:

Providers:

Dr. Shenetta Coleman
 CEO
 Residential
 Opportunities, Inc.

Tina Graham
 Executive Director
 ASK Family Services

Dan Pontius
 CEO
 MRC Industries, Inc.

Call to Order

The Board of Directors (Integrated Services of Kalamazoo) held their meeting on Monday, February 27, 2023. It began @ 4:02pm and was presided over by Chairwoman, Karen Longanecker.

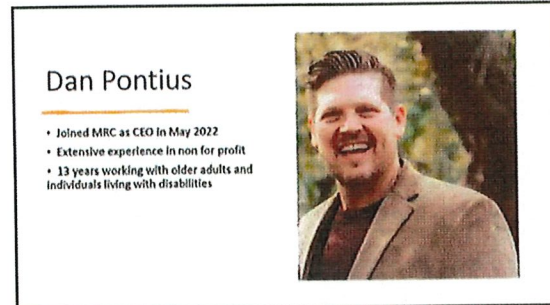


610 S. Burdick Street
 Kalamazoo, MI,
 49007-5221

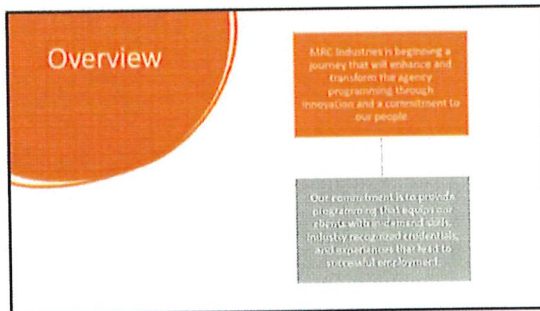
Special Presentation – Dan Pontius/CEO/MRC Industries “MRC Employment Pathway:



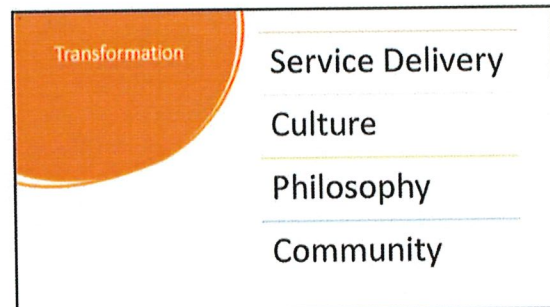
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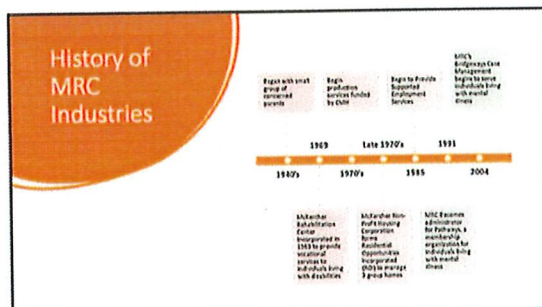
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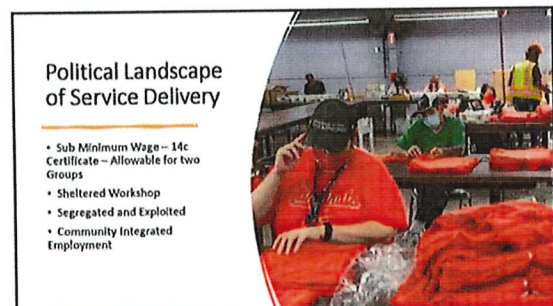
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Samuel R. Bagenstos, Principal Deputy Assistant Attorney General in the Civil Rights Division of the US Department of Justice

When individuals with disabilities spend years—indeed, decades—in congregate programs doing so-called jobs like these, yet do not learn any real vocational skills, we should not lightly conclude that it is the disability that is the problem. Rather, the programs' failure to teach any significant, job-market-relevant skills leaves their clients stuck. As a recent review of the literature concludes, "the ineffectiveness of sheltered workshops for helping individuals progress to competitive employment is well established."

7

My early Observations

- How are we evaluating and assessing skills-based training
- How can we expect individuals to know what they want to do for work when they have not had the opportunity to explore
- Quality of service and outcomes were not up to standard
- Lack of inclusivity
- Organization silos were a barrier to career pathway
- Work opportunity was not appealing and aligned with market demands
- Life certificate must go

8

New Pathway

- Service Delivery
- Culture
- Philosophy
- Community

9

Service Delivery

10

Service Delivery

11

Career Tracks

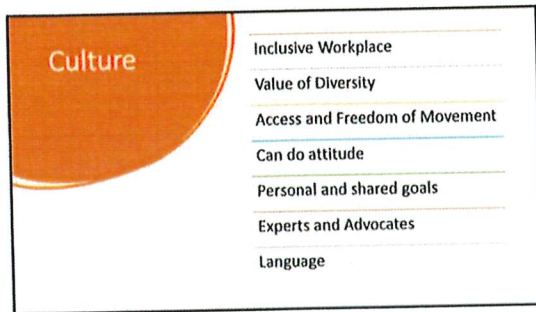
Available January 2023

- Retail
- Production/Facilities Maintenance
- Trades
- Arts

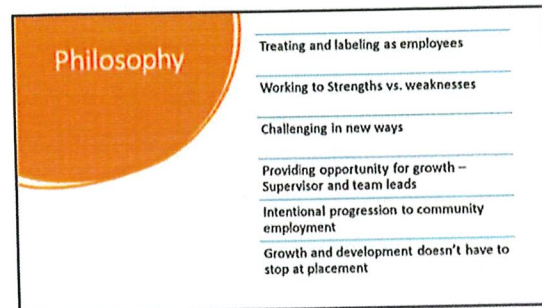
Still In Development

- Food Service
- Technology
- Grow/Green

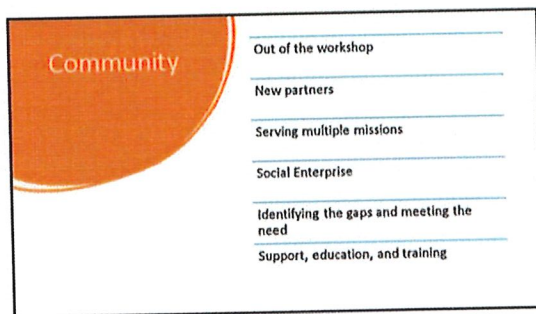
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13



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15



16

Agenda

MOTION

Member Spears moved to approve the agenda for the meeting. Supported by Member Guenther and carried without dissent.

Citizen Time: No citizens came forth.

Recipient Rights Monthly Reports:

Roann Bonney, ISK, ORR Director, presented the complaints/allegations closed in January 2023.

January

Abuse Violations

- There were three substantiated Abuse III violations in January 2023.
 - The remedial actions for these violations were Employment Termination (1), Suspension (1), Written Reprimand (2), Staff Transfer (1), and Training (1).

2 of the violations occurred at the same agency but different program sites.

Neglect Violations

- There were two substantiated Neglect II violations in January 2023. One was a Failure to Report.
 - The remedial actions for these violations were Employment Termination (2)

The two violations occurred at the same agency and program site.

- There were four substantiated Neglect III violations in January 2023.
 - The remedial actions for these violations were Employment Termination (1), Written Reprimand (4), Training (4)

The four violations occurred at the same agency and two different program sites.

All the ORR case information is sent to the ISK Population Directors monthly for any tracking/trending of the RR information in their areas of authority * (Agencies can include ISK).

Recipient Rights Annual Report:

Roann Bonney, ORR Director, ISK, presented the ORR Annual Report from October 1, 2021-September 30, 2022.

This report is a summary of the data by type or category about the rights of recipients receiving services from ISK including the number of complaints, investigations substantiated and the remedial actions. It also highlights the training provided to staff and contract providers.

To review the entire Recipient Rights Annual Report, please contact the Office of Recipient Rights @ [269-364-6920](tel:269-364-6920).

Program Services Report/VERBAL:

Wanda Brown, ISK, Senior Executive, Integrated Health Services Clinic/Psychiatric Services, presented the February 2023 Program Services Report.

The Integrated Health Services Clinic (IHSC) stays vigilant providing behavioral health services to individuals/beneficiaries of all ages. In 2022, ISK received certification from the state of Michigan as a designated Certified Community Behavioral Health Center (CCBHC), a result of the designation from the state of Michigan and SAMHSA. Along with the post COVID-19 environment and community changes, there has been an increase in the number of individuals seeking services from the IHSC. Community changes include, recent psychiatric practices closing due to physician retirement, relocation and sadly the death of a long-standing psychiatrist in the community.

The IHSC continues to undergo transitions of services. Process improvement initiatives including the implementation of the new electronic health record, which was implemented in

October 2022 (PCE/KARE), to a system that will better support care coordination. Staffing additions include two Nurse Care Managers (NCM). Currently, there are three NCM whose role is to provide care coordination, including monitoring, education and linking to services. Other staffing additions include the use of two contracted physicians and one contracted nurse practitioner. In January 2023, there was also the addition of a full-time nurse practitioner working onsite. The contracted physicians and nurse practitioner provide services via telehealth. While telehealth is an option for service delivery, it is the plan to replace vacancies with staff that will work onsite. There are collaborative agreements in place with several universities for Nurse Practitioner (NP) students who have completed their clinical training at ISK, will be offered positions to work fulltime onsite once the vacancies are filled by the contracted locum physicians and midlevel providers.






The collaborative agreement between ISK and the WMU Homer Stryker School of Medicine Department of Psychiatry continues to serve very beneficial to all. The third-year residents continue to see patients in the IHSC biweekly and are accompanied by an attending physician. Over the past year the first- and second-year residents are introduced to community mental health earlier in their program and the feedback has been overwhelmingly positive.

The collaboration between the WMU School of Medicine Psychiatry Department and ISK has afforded the Board-Certified Psychiatrist (Dr. Valrie Honablue) to continue providing evidenced based lectures and best practice peer review lectures to the ISK clinical team by serving as the Chief of Staff for 5 hours per week. Serving in this capacity she is also now co-leading evidenced based practice peer review sessions monthly for the clinical staff psychiatric physicians and mid-level providers. She also serves as the director for the Assertive Community Treatment Team (ACT).

Additionally, more transformation is underway as we begin interview process for a Practice Manager for the IHSC. The duties and responsibilities are now too much for one person to address effectively. This individual will serve in an integral role for the IHSC overseeing day to day operations and staff. We hope to have this position filled in the next weeks.

The first quarter of fiscal year 2023, a total of 6,165 services were performed and billed by Medical and Nursing Staff at 615 E. Crosstown Parkway.

Integrated Health Clinic Services for 10/1/2022-2/17/2023

-  New Patient Services billed 207
-  Established Patient Services billed 3820
-  Injection- Medication Administration within the Clinic 1795
-  Injection-Medication Administration within the Community 38
-  Injection-Medication Administration within the Individuals Served Home 305

Consent Calendar

MOTION

Chair Longanecker, "Are there any materials that the ISK Board would like to have removed from the Consent Calendar before we proceed with the verbal motion?" It was recommended that ISK Policy VI.02/INVESTMENT be removed and brought back in April 2023. This policy is being reviewed to add current language that matches current trends.

- VI.a. Minutes
- VI.b. Quality Management (Policy)
- VI.c. ~~Investment (Policy)~~
- VI.d. Board Travel (Policy)
- VI.e. Collaboration (Policy & Report)

Member Spears, "I MOVE TO ACCEPT THE CONSENT CALENDAR MONITORING REPORTS BOTH "AS-IS" OR WITH PROPOSED RECOMMENDED CHANGES." Supported by Member Guenther. MOTION PASSED.

Financial Reports/Financial Condition Reports January 31, 2023

Amy Rottman, ISK, Chief Financial Officer, presented the Financial Reports for January 31, 2023.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Net Position January 31, 2023

	January 2022 (unaudited)	January 2023
Assets		
Current assets	\$ 29,488,783	\$ 29,426,530
Cash and investments	2,044,223	5,246,659
Accounts receivable	3,414	1,795,132
Due from other governments	549,783	1,458,369
Prepaid items		
Total current assets	<u>32,086,203</u>	<u>37,926,690</u>
Non-current assets	9,248,229	10,750,331
Capital assets, net of accumulated depreciation	6,531,305	5,722,229
Net pension asset, net of deferred outflows		
Total non-current assets	<u>15,779,534</u>	<u>16,472,560</u>
Total assets	<u>47,865,737</u>	<u>54,399,250</u>
Liabilities		
Current liabilities	\$ 10,666,324	\$ 11,247,630
Accounts payable	141,436	1,258,606
Due to other governments	525,702	108,898
Due to providers	1,377,366	1,685,956
Accrued payroll and payroll taxes	371,434	182,378
Unearned revenue		
Total current liabilities	<u>13,082,262</u>	<u>14,483,468</u>
Non-current liabilities	4,617,594	-
Long-term debt		
Total liabilities	<u>17,699,856</u>	<u>14,483,468</u>
Net position	11,604,698	13,747,779
Designated	4,815,055	18,360,519
Undesignated	4,735,203	4,858,748
Investment in fixed assets	8,814,916	-
Previous year close	196,265	2,948,736
Net gain (loss) for period		
Net position	<u>\$ 30,165,881</u>	<u>\$ 39,915,783</u>

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through January 31, 2023

Percent of Year is 33.33%

	Original 2023 BUDGET	YTD Totals 1/31/23	Remaining Budget	Percent of Budget - YTD
Operating revenue				
Medicaid:				
Traditional Capitation	\$ 62,584,607	\$ 23,430,800	\$ 39,153,807	37.44%
Healthy Michigan Capitation	10,155,033	4,307,941	5,847,092	42.42%
Autism Captiation	5,722,701	1,873,056	3,849,645	32.73%
Settlement	(11,458,363)	(476,229)	(10,982,134)	0.00%
State General Fund:				
Formula Fundings	3,900,517	1,300,172	2,600,345	33.33%
PY General Fund Carryforward	-	-	-	0.00%
Settlement	-	(102,156)	102,156	0.00%
CCBHC Demonstration	33,381,000	2,502,426	30,878,574	0.00%
CCBHC Accrual	-	2,242,520	(2,242,520)	0.00%
County Allocation	1,550,400	516,800	1,033,600	33.33%
Client Fees	429,500	73,864	355,636	17.20%
SUD Block Grant	-	37,319	(37,319)	0.00%
Other grant revenue	7,133,667	3,272,667	3,861,000	45.88%
Other earned contracts	1,130,318	543,163	587,155	48.05%
COFR	-	-	-	0.00%
Interest	1,000	351	649	0.00%
Local revenue	10,000	2,050	7,950	0.00%
Total operating revenue	\$ 114,540,380	\$ 39,524,744	\$ 75,015,636	34.51%
Operating expenses				
Salaries and wages	24,113,672	7,688,677	\$ 16,424,995	31.89%
Employee benefits	8,670,498	1,918,834	6,751,664	22.13%
Staff development	223,625	54,249	169,376	24.26%
Payments to providers	68,968,243	23,260,493	45,707,750	33.73%
Administrative contracts	7,789,466	2,940,972	4,848,494	37.76%
IT software and equipment	765,010	204,593	560,417	26.74%
Client transportation	29,260	6,460	22,800	22.08%
Staff travel	310,912	68,742	242,170	22.11%
Office expenses	420,923	124,250	296,673	29.52%
Insurance expense	97,505	8,456	89,049	8.67%
Depreciation expense	560,142	176,488	383,654	31.51%
Utilities	306,573	102,827	203,746	33.54%
Facilities	124,379	20,966	103,413	16.86%
Total operating expenses	\$ 112,380,208	\$ 36,576,008	\$ 75,804,200	32.55%
Change in net position	2,160,172	2,948,736	\$ (788,564)	
Beginning net position	36,967,046	36,967,046		
Ending net position	\$ 39,127,218	\$ 39,915,783		

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INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through January 31, 2023

Percent of Year is 33.33%

	Specialty Services		Healthy Michigan		Autism		SUD Block Grant		Totals		
	Budget	YTD Totals 1/31/23	Budget	YTD Totals 1/31/23	Budget	YTD Totals 1/31/23	Budget	YTD Totals 1/31/23	YTD Budget	YTD Totals 1/31/23	Variance
Operating revenue											
Medicaid:											
Traditional Capitation	\$ 20,862,702	\$ 23,430,800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 37,319	\$ 20,862,702	\$ 23,468,119	\$ 2,605,417
Healthy Michigan Capitation	-	-	3,385,011	4,307,941	-	-	-	-	3,385,011	4,307,941	922,930
Autism Capitation	-	-	-	-	1,907,567	1,873,056	-	-	1,907,567	1,873,056	(34,511)
CCBHC Base Payment	-	(4,829,627)	-	(1,048,052)	-	-	-	-	-	(5,877,679)	(5,877,679)
Settlement Estimate	(2,169,377)	3,295,508	(1,814,681)	(1,861,362)	164,604	(1,873,056)	-	(37,319)	(3,819,454)	(476,229)	3,343,225
Client Fees	142,000	73,864	-	-	-	-	-	-	142,000	73,864	(68,136)
Total operating revenue	\$ 18,835,325	\$ 21,970,545	\$ 1,570,330	\$ 1,398,527	\$ 2,072,171	\$ -	\$ -	\$ 0	\$ 22,477,826	\$ 23,369,072	\$ 891,246
Operating expenses											
Internal services	\$ 1,032,656	\$ 1,195,046	\$ 57,621	\$ 123,299	\$ -	\$ -	\$ -	\$ -	\$ 1,090,277	\$ 1,318,345	228,068
External services	16,804,703	19,550,053	1,429,507	1,197,223	1,962,380	-	-	-	20,196,590	20,747,276	550,686
Delegated managed care	997,966	1,225,446	83,202	78,005	109,791	-	-	-	1,190,959	1,303,451	112,492
Total operating expenses	\$ 18,835,325	\$ 21,970,545	\$ 1,570,330	\$ 1,398,527	\$ 2,072,171	\$ -	\$ -	\$ -	\$ 22,477,826	\$ 23,369,072	\$ 891,246
Change in net position		0		(0)		0		0		(0)	

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INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through January 31, 2023

Percent of Year is 33.33%

	State General Fund		CCBHC		Other Funding Sources		Totals		
	YTD Budget	YTD Totals 1/31/23	YTD Budget	YTD Totals 1/31/23	YTD Budget	YTD Totals 1/31/23	YTD Budget	YTD Totals 1/31/23	Variance
Operating revenue									
General Fund	\$ 1,300,172	\$ 1,300,172	\$ -	\$ -	\$ -	\$ -	\$ 1,300,172	\$ 1,300,172	\$ (0)
Projected GF Carryforward	-	-	-	-	-	-	-	-	-
CCBHC Demonstration	-	-	11,127,000	4,744,946	-	-	11,127,000	4,744,946	(6,382,054)
Other Federal and State Grants	-	-	-	-	2,377,889	3,272,667	2,377,889	3,272,667	894,778
Earned Revenue	-	-	-	-	376,773	543,163	376,773	543,163	166,391
COFR Revenue	-	-	-	-	-	-	-	-	-
Interest	-	-	-	-	333	351	333	351	17
County Allocation	-	-	-	-	516,800	516,800	516,800	516,800	-
Local Revenue	-	-	-	-	3,333	2,050	3,333	2,050	(1,283)
Transfer from GF	-	-	-	-	753,926	583,598	753,926	583,598	(170,328)
Settlement Revenue (Expense)	-	(102,156)	-	5,877,679	-	-	-	5,775,523	5,775,523
Total operating revenue	\$ 1,300,172	\$ 1,198,016	\$ 11,127,000	\$ 10,622,625	\$ 4,029,055	\$ 4,918,629	\$ 16,456,227	\$ 16,739,270	\$ 283,043
Operating expenses									
Internal Programs	\$ -	\$ 198,756	\$ 7,632,571	\$ 5,599,907	\$ -	\$ 120,047	\$ 7,632,571	\$ 5,918,710	\$ (1,713,862)
External Programs	395,672	197,244	2,203,261	1,816,476	169,712	379,332	2,768,645	2,393,052	(375,594)
Other Federal and State Grants	-	-	-	-	2,833,387	3,654,664	2,833,387	3,654,664	821,276
HUD Grants	-	-	-	-	544,725	363,479	544,725	363,479	(181,246)
Managed Care Administration	22,137	23,392	550,296	438,097	13,044	17,388	585,476	478,878	(106,598)
Homeless Shelter	-	-	-	-	145,583	142,469	145,583	142,469	(3,114)
Transfer from GF	753,926	583,598	-	-	-	-	753,926	583,598	(170,328)
Local match expense	-	-	-	-	424,992	238,852	424,992	238,852	(186,140)
Non-DCH Activity Expenditures	-	-	-	-	46,863	16,833	46,863	16,833	(30,030)
Total operating expenses	\$ 1,171,735	\$ 1,002,990	\$ 10,386,128	\$ 7,854,480	\$ 4,178,305	\$ 4,933,064	\$ 15,736,169	\$ 13,790,534	(1,945,635)
Change in net position	128,437	195,026	740,872	2,768,145	(149,251)	(14,435)	\$ 720,058	2,948,736	2,228,678

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO**CCBHC**

October 1, 2022 through January 31, 2023

Percent of Year is 33.33%

	CCBHC Medicaid	CCBHC Healthy MI	CCBHC Non-Medicaid	CCBHC YTD Totals
Operating revenue				
Prepayment	\$ 2,502,426	\$ -	\$ -	\$ 2,502,426
CCBHC Base Payment Reclass	4,829,627	1,048,052	-	5,877,679
Remaining CCBHC revenue due	1,396,447	846,073	-	2,242,520
Total CCBHC Revenue (PPS-1 of \$375.00 x encounters)	\$ 8,728,500	\$ 1,894,125	\$ -	\$ 10,622,625
Operating expenses				
Internal services	\$ 4,603,511	\$ 998,983	\$ 435,510	\$ 6,038,004
DCO Contracts	1,384,922	300,535	131,019	1,816,476
Total operating expenses	\$ 5,988,433	\$ 1,299,518	\$ 566,529	\$ 7,854,480
Operating change in net position	2,740,067	594,607	(566,529)	2,768,145
Reclassification to cover Non-Medicaid	(566,529)	-	566,529	-
Total change in net position	2,173,538	594,607	-	2,768,145

This financial report is for internal use only. It has not been audited, and no assurance is provided.

Utilization Reports

Charlotte Bowser, ISK, Accounting Manager, presented the Utilization Report for the period ending January 31, 2023.

- MI Adult Community Inpatient Services is at (627) days and unfavorable at \$590,950
- Community Living Supports, Personal Care, and Crisis Residential is favorable at \$67,729

January Disbursements**MOTION**

Member Spears, "BASED ON THE BOARD FINANCE MEETING REVIEW, I MOVE THAT ISK APPROVE THE JANUARY 2023 VENDOR DISBURSEMENTS OF \$9,077,409.19." Supported by Member Guenther.

MOTION PASSED.

Chief Executive Officer Report:

Please take a moment to review the CCBHC 2023 Update in your packets: “CCBHC at a GLANCE”
It is a remarkable report with tremendous outcomes due to expanding access to mental health care.

Certified Community Behavioral Health Center

2023 Update: CCBHC at a Glance

Expanding Access to Mental Health Care

- Our CCBHC served **7,200 people** in 2022, including 2,050 new clients who had no services from ISK during the previous five years.
- Our **Same-Day Access** structure allowed **1,966** individuals to enter or re-enter regular services **on their schedule**: receiving a comprehensive assessment and referrals to programs the same day they walk in, no appointment required.
- Being a CCBHC also allows ISK to **serve anyone** with a mental health need — regardless of severity, insurance, or ability to pay. Last year, ISK served through our CCBHC:
 - 4,985 people with a severe and persistent mental illness, plus 2,209 with a mild to moderate level of severity
 - 6,381 Medicaid/Medicare recipients, 135 with other insurance, plus 678 who were uninsured
- ISK is **meeting people where they are**. CCBHC has let us expand and diversify our service array to better match community needs.
 - **26** Community Health Workers and Care Coordinators are employed by ISK to help connect any community member with resources for housing, food, transportation, and other **social drivers of health**.
 - Only 36% of our CCBHC service contacts took place at a clinic or office location. The remainder occurred by telehealth (20%), or in community settings like a client's home, school, or a hospital (44%).

Enhancing Our Crisis Response System

- One of the most important requirements for a CCBHC is the ability to provide robust and timely crisis response for the community. ISK has focused strongly on this, delivering **8600 crisis services** last year, with crisis contacts representing around 7% of all CCBHC services.
- CCBHC funding is also supporting ISK in constructing and launching Kalamazoo County's first and only **Behavioral Health Urgent Care and Access Center**, a new 24-hour facility that will open this July. The center will allow community members in crisis faster access to mental health professionals, while also helping divert people away from the ED when that is not the most effective option for them.

Building Strategic Community Partnerships

- To maximize customer choice, CCBHC allows for contracts with Designated Collaborating Organizations (DCOs) who can provide services on behalf of ISK and draw the same reimbursement amounts as ISK's direct-operated CCBHC services. With eight active DCOs who collectively deliver about **35%** of our CCBHC services, ISK has **one of the strongest DCO networks** in the state.
- Beyond our DCOs, ISK also maintains MOUs with over 40 local and regional organizations, helping us to coordinate care efficiently and improve the client experience across service touchpoints.

Community • Independence • Empowerment



Participating in Michigan's Statewide CCBHC Demonstration

ISK's CCBHC journey began in Fiscal Year 2019 with the launch of our first CCBHC Expansion Grant project supported by SAMHSA.

Since 2022 ISK is one of thirteen **Demonstration Sites** in Michigan. The state Demonstration allows ISK to be reimbursed by Medicaid for the full cost of CCBHC services, and offers a sustainable funding model to continue building on our original grant-funded initiatives.

With 5762 active CCBHC enrollees, and over 100,000 distinct days of CCBHC services rendered, ISK is the second-largest Michigan site by service volume and the third-largest by enrolled population.



February 2023 • www.iskzoo.org

That concludes my report.

Citizen Time:

No citizens came forth.

SWMBH (Southwest Michigan Behavioral Health) Updates/Erik Krogh:

Erik Krogh was absent from the Monday, February 27th ISK Board of Directors meeting. Therefore, no report was given.

Karen Longanecker:

I would like to take this opportunity on the behalf of the ISK Board of Directors to welcome our newest member, *Commissioner Montez Morales*. I'm really looking forward to working with you here. I believe that we can continue to make steady progress as a board working in harmony with Jeff Patton/CEO/ISK, as he leads this organization to broaden its access to mental health care and services.

Meeting ended at 6:10PM.

Demeta J. Wallace

Administrative Coordinator

INTEGRATED Services of Kalamazoo

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.07

AREA: Governance	PAGE: 1 of 2
SECTION: Board Governance Process	SUPERSEDES: 03/24/2014
SUBJECT: BOARD COMPENSATION	REVISED: 03/22/2021

PURPOSE/EXPLANATION

To establish parameters for compensation of Board members according to the Resolution adopted by the Kalamazoo County Board of Commissioners on November 4, 1997.

DEFINITIONS

Authority Board

The Integrated Services of Kalamazoo Board.

Meetings

A regular or special meeting of the Authority Board or a regular or special meeting of the Authority Board functioning as a committee of the whole, but only if a quorum of the Board or committee is present.

Per diem

Per day.

POLICY

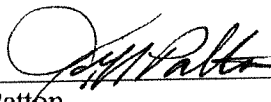
- I. Board members will be compensated for attending regular or special meetings subject to the following conditions:
 - A. If an Authority Board member desires to submit a per diem request, he/she shall submit a signed voucher detailing the meetings attended to the Finance Director within ninety (90) days of the meeting which is the subject of the per diem request.
 1. Vouchers received after ninety (90) days shall not be paid.
 2. All per diem vouchers must be approved by the Board Chair or designee prior to payment.
 3. Compensation shall be paid for both in person and virtual attendance.
 - B. The maximum compensation that Authority Board members may receive shall be \$25.00 per day and \$850.00 per year.

- C. The compensation that is authorized by the Resolution of the County Board of Commissioners does not apply to a County Commissioner who is also an Authority Board member.
- II. This policy shall remain in full force and effect until modified or terminated by an appropriate Resolution of the County Board.

EXHIBIT/REFERENCE

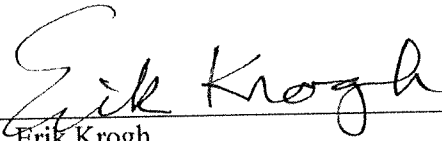
- A. Kalamazoo County Board of Commissioners "Resolution to Establish Compensation for Kalamazoo County Community Mental Health and Substance Abuse Services Authority Board Members", November 4, 1997.

CHIEF EXECUTIVE OFFICER



Jeff Patton
Chief Executive Officer

APPROVED



Erik Krogh
Board Chair

**RESOLUTION TO ESTABLISH COMPENSATION FOR KALAMAZOO COUNTY
COMMUNITY MENTAL HEALTH AUTHORITY BOARD MEMBERS**

WHEREAS, on August 6, 1996, the Kalamazoo County Board of Commissioners created the Kalamazoo County Community Mental Health Authority, with an effective date of December 31, 1996 at 12:59 p.m.; and

WHEREAS, on September 22, 1997, the Authority Board adopted a motion requesting that the County Board approve compensation for Authority Board members for attendance at the Authority's Board and committee of the whole meetings; and

WHEREAS, the County Board is willing to authorize compensation as hereinafter set forth.

NOW, THEREFORE, BE IT RESOLVED that the Kalamazoo County Board of Commissioners does hereby authorize compensation for members of the Kalamazoo County Community Mental Health Authority Board on the basis of \$25.00 per diem for attending meetings, subject to the following definitions and conditions:

1. "Per diem" means per day.
2. "Meetings" means a regular or special meeting of the Authority Board or a regular or special meeting of the Authority Board functioning as a committee of the whole, but only if a quorum of the Board or committee is present.
3. If an Authority Board member desires to submit a per diem request, he/she shall submit a signed voucher, detailing the meetings attended, to the Authority finance officer within ninety (90) days of the meeting which is the subject of the per diem request. Vouchers received after ninety (90) days shall not be paid. All per diem vouchers must be approved by the Authority Board prior to payment.
4. The maximum compensation that an Authority Board member may receive shall be \$25.00 per day and \$850.00 per year.
5. The compensation that is authorized by this Resolution shall not apply to a County Commissioner who is also an Authority Board member.

BE IT FURTHER RESOLVED that this Resolution shall be effective on January 1, 1998, and shall remain in full force and effect until modified or terminated by an appropriate Resolution of the County Board.

Robert A. Houtman, Chairman

Kalamazoo County Board of
Commissioners

STATE OF MICHIGAN)
) SS
COUNTY OF KALAMAZOO)

I, Timothy A. Snow, County Clerk/Register, do hereby certify that the foregoing is a true copy of a Resolution adopted by the Kalamazoo County Board of Commissioners at a regular session held on November 4, 1997.

Timothy A. Snow
County Clerk/Register

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.09

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 4
SUBJECT:	BOARD MEMBERS' CODE OF CONDUCT	SUPERSEDES:	03/28/2011
		REVISED:	03/25/2019

PURPOSE/EXPLANATION

The purpose of the Board Members' Code of Conduct policy is to promote the highest standards of conduct by members of the ISK Board to maintain and enhance public confidence in the integrity, independence, impartiality and effectiveness of the ISK Board.

POLICY

- A. ISK Board Members are required to comply with this Code of Conduct, as well as the same ethical standards set forth in 15.342 of Michigan Act 196 of 1973 (and as amended), and Chapter 330 of the Michigan Mental Health Code § 330.1224 for public officers and board members.
- B. The ISK Board adheres to the Carver Model of Policy Governance and its members are expected to incorporate all Ten Principles into their approach. Principles 1-3 define an organization's ownership, the board's responsibility to it, and the board's authority. Principles 4-7 specify that the board defines in writing policies identifying the benefits that should come about from the organization, how the board should conduct itself, and how staff behavior is to be proscribed. Principles 8-10 deal with the board's delegation and monitoring. In general, if a board applies ALL the principles of Policy Governance in its process and decision-making, then the board is likely practicing the model. If a board applies fewer than all the principles, it weakens or destroys the model's effectiveness as a system (The Carver Model of Policy Governance: John & Miriam Carver's guidebook #1).
- C. ISK Board members must be committed to ethical and businesslike conduct in alignment with ISK' Vision, Mission and Guiding Values.
- D. In accordance with ISK Board Policy II.11 (Conflict of Interest), board members must represent unconflicted duty of care and duty of loyalty to the interests of ISK. This accountability supersedes any conflicting loyalty such as to advocacy or interest groups and membership on other boards or staffs. It also supersedes the personal interest of any Board member acting as a person or family member to a person receiving ISK services. Members must adhere to policy II.11 (Conflict

of Interest) and complete the annual disclosure packet according to the policy.

a. *Duty of Care*

Every Board Member shall act in a reasonable and informed manner and perform his or her duties for ISK in good faith and with a degree of care that an ordinarily prudent person would exercise under similar circumstances.

b. *Duty of Loyalty*

Every Board Member owes a duty of loyalty to act always in the best interests of ISK and not in the interest of the Board member or any other Entity or Person. No board member may personally take advantage of a business opportunity that is offered to ISK unless the Board of Directors determines not to pursue that opportunity, after full disclosure and a disinterested and informed evaluation.

E. When an individual becomes a Board member, he/she must not disclose identifiable information (with or without names) about persons receiving services from ISK, regardless of where this information was obtained from, without informed consent of an authorized party. Board members must comply with all applicable Confidentiality Regulations of the Michigan Mental Health Code, HIPAA and 42 CFR Part 2.

a. All information about persons receiving mental health services through ISK is confidential whether it is written, verbal or observed and must not be disclosed without written informed consent.

b. Confidential information about recipients of ISK services must not be disclosed by a Board member, even if the information is already known to the listener.

c. Confidential information about a recipient of ISK services must not be disclosed by a Board member, even if it was disseminated by the media, and both the listener and the Board member read/heard the media account.

F. Board members will likewise exercise decorum, dignity and respect with speaking about or to employees of ISK, Provider Agencies, persons from MDHHS, other PIHPs, CMHSPs, and other constituents. While persons who are not recipients of services are not lawfully protected by HIPAA, 42 CFR Part 2 or MMHC; ISK Board members will demonstrate a conservative approach when choosing to share business or personal information to or about partners of ISK.

G. Board members may not attempt to exercise individual authority over the organization except as explicitly set forth in Board policies.

a. Members' interaction with the Chief Executive Officer or with staff, must recognize the lack of authority vested in individuals except when explicitly Board-authorized.

b. Members' interaction with public, press or other entities must recognize the same limitation and the inability of any Board member to speak for the Board.


- c. Members will not make or publish false or malicious statements about an employee, ISK, or its services or products.
 - d. Members will not engage in misconduct that renders a member's presence in ISK to be detrimental to employees, ISK operations or to others.
- H. Members are expected to vote according to the true merits of each motion, based on facts presented and applicable policy/procedure and law. Members must approach decision making with a mind that is open to persuasion by convincing evidence and argument. Members are expected to vote in the genuine best interest of ISK and the persons served by ISK without undue influence from partisan interest, public opinion, fear of criticism, or the prospect of disapproval from any person, institution or community.
- I. If a Board member has a concern with another member regarding this Code of Conduct, the issue should be directed in the following manner:
 - a. If the concern involves a member other than one of the Board Officers, the issue should be directed to the Board Officer.
 - b. If the concern involves a Board Officer, the issue should be directed to the other Board Officer.
 - c. If the concern involves both Board Officers, the Board member should select two other members and direct the issue to them for review of the concern.
- J. If all attempts at an internal resolution of the concern has failed, then either the Board Officer(s) under H.a. or H.b. or the members selected under H.c of this policy. shall refer the matter to the Kalamazoo County Board of Commissioners' Chairperson for resolution under Section 1224 of the Mental Health Code.

REFERENCES

- STANDARDS OF CONDUCT FOR PUBLIC OFFICERS AND EMPLOYEES: 15.342 of Michigan Act 196 of 1973 (and as amended): Public officer or employee; prohibited conduct
- Michigan Compiled Laws, Chapter 330. Mental Health Code § 330.1224 and as amended
- ISK Board policy I.01 (Mission/Vision/Value Statement)
- The Carver Model of Policy Governance: John & Miriam Carver's guidebook #1.
- HIPAA, 42 CFR Part 2
- 1968 PA 317, MCL 15.321 to 15.330 (contracts of public servants with public entities)

- 1978 PA 566, MCL 15.181 to 15.185 (incompatible public offices)
- 18 USC 208 (Federal Conflict of Interest Statute)
- IRS Conflict of Interest Guidelines, Policies and Pronouncements for Charitable Tax-Exempt Nonprofit Entities

CHIEF EXECUTIVE OFFICER



Jeff Patton
Chief Executive Officer

APPROVED



Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY VI.04

AREA:	Governance		
SECTION:	System Governance	PAGE:	1 of 1
SUBJECT:	DEPRECIATION	SUPERSEDES:	03/24/2014
		REVISED:	03/23/2015

PURPOSE/EXPLANATION

To establish policy and procedures to calculate and record depreciation for all depreciable capital assets.

DEFINITIONS**Capital Equipment**

A single non-disposable item costing more than \$5,000 and having a useful life greater than two years.

Depreciation

Accounting process of allocating the cost of tangible assets to expense in a systematic and rational manner to those periods expected to benefit from the use of the asset.

Depreciation Method

A systematic and rational approach to cost allocation over the estimated useful life of the asset.

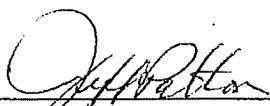
Useful Life

Period of time an asset is in service.

POLICY

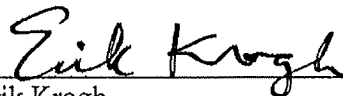
It is the policy of Integrated Services of Kalamazoo (ISK) that all capital assets will be depreciated using the "Estimated Useful Lives of Depreciable Hospital Assets (most current published version)". Assets will be depreciated using straight-line half year convention methodology to determine depreciation expense.

CHIEF EXECUTIVE OFFICER



Jeff Patton
Chief Executive Officer

APPROVED



Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.11

AREA:	Governance	PAGE:	1 of 7
SECTION:	Board Governance Process	SUPERSEDES:	02/26/2018
SUBJECT:	CONFLICT OF INTEREST	REVISED:	03/28/2022

PURPOSE/EXPLANATION

The purpose of the Conflict of Interest policy is to:

1. Protect ISK' interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of a board member,
2. Clarify the duties and obligations of Board members in the context of potential conflicts of interest and to provide board members with a method for disclosing and resolving potential conflicts of interest,
3. Supplement, but not replace, any applicable state laws governing conflicts of interest applicable to public institutions, along with nonprofit and charitable corporations.

DEFINITIONS

A. Conflict of Interest

A conflict of interest arises when a board member participates or proposes to participate in a transaction, arrangement, proceeding or other matter for ISK, in which the board member, the board member's family member or an organization in which the board member is serving as an officer, director, trustee or employee has a financial interest. Board members should avoid both the appearance of and an actual Conflict of Interest.

B. Duty of Care

Every Board Member shall act in a reasonable and informed manner and perform his or her duties for ISK in good faith and with a degree of care that an ordinarily prudent person would exercise under similar circumstances.

C. Duty of Loyalty

Every Board Member owes a duty of loyalty to act at all times in the best interests of ISK and not in the interest of the Board member or any other Entity or Person. No board member or family member as defined in this policy may personally take advantage of a business opportunity that is offered to ISK unless the Board of Directors determines not to pursue that opportunity, after full disclosure and a disinterested and informed evaluation.

D. Compensation

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature. This includes but is not limited to business, political or personal enterprises, personal fundraising, and gifts, monies or gratuities with more than a nominal value. A voting member of the Board of Directors who receives compensation, directly or indirectly, from ISK is precluded from voting on matters pertaining to such compensation arrangement.

E. Family Member

Family shall be defined to include spouse, parent, sibling (whole or half-blood), a spouse's parents, children (natural or adopted), grandchildren, great grandchildren, step family members, any person sharing the same living quarters in an intimate, personal relationship and spouses of siblings, children, grandchildren, great grandchildren, and all step family members. Relationships that create a potential conflict of interest or appearance of conflict of interest must be reported on the Conflict of Interest Disclosure Form and Acknowledgment (Exhibit A).

F. Financial Interest

A Board member has a Financial Interest if he or she has, directly or indirectly, actually or potentially, through a business, investment or through a family member:

1. An actual or potential ownership, control or investment interest in, compensation arrangement with, or serves in a governance or management capacity for, any entity or individual with which ISK currently has a transaction, arrangement, proceeding or other matter.
2. An actual or potential ownership, control or investment interest in, compensation arrangement with, or serves in a governance or management capacity for, any entity or individual with which the ISK Board is contemplating or negotiating a transaction, arrangement, proceeding or other matter.

POLICY

- I. Each ISK Board member shall act in a reasonable and informed manner and perform his or her duties for ISK in good faith and with the degree of care that an ordinarily prudent person would exercise under similar circumstances. In this regard, each Board member has a duty to disclose the existence of a Financial Interest or other actual or potential conflict of interest and all related material facts annually to the Board using the attached form (see Exhibit A).
- II. ISK will provide a means for a Board member to identify and report to the Board any direct or indirect Financial Interest and/or actual or potential conflict of interest. Based on that information, to permit the Board to review such Financial Interests and conflict of interest, ISK will provide a process for the Board to follow when managing financial interests and other actual or potential conflicts of interest, all in accordance with applicable law.

PROCEDURE

I. DUTY TO DISCLOSE

- A. Each board member shall complete and sign the annual Conflict of Interest Disclosure Form indicating that he/she agrees to abide by the terms of the Conflict of Interest policy and has disclosed the material facts of any actual, apparent or potential conflict of interest in the manner provided in this policy (see Exhibit A).
- B. Each board member has a continuing obligation to disclose (in the manner provided in this policy) the existence and nature of any actual, apparent or potential conflict of interest he/she may have. Such disclosure shall be made promptly any time an actual, apparent or potential conflict of interest arises.
- C. Conflict of Interest Disclosure Forms (Exhibit A) will be collected upon appointment of new board members and annually thereafter. Forms will be returned to the ISK Compliance Officer for review and further action as necessary, according to this policy, and kept on file. Any actual, potential or appearance of Conflict identified by the ISK Compliance Officer will be presented to the Board for further consideration.

II. ADDRESSING CONFLICTS OF INTEREST INVOLVING BOARD MEMBERS

- A. When considering a conflict of interest, the Board will consider a number of factors. In making a determination as to whether a Financial Interest is substantial enough to be likely to affect the integrity of the Board member's services to the entity, the Board shall consider, as applicable:
 - 1. Input from ISK Corporate Counsel and ISK Corporate Compliance Officer.
 - 2. The type of interest that is creating the potential conflict (e.g., stock, bonds, real estate, cash payment, job offer or enhancement of a spouse's employment).
 - 3. The identity of the person whose Financial Interest is involved, and if the interest does not belong directly to the Board member, the Board member's relationship to that person.
 - 4. The dollar value of the disqualifying Financial Interest, if known and quantifiable (e.g., amount of cash payment, salary of job to be gained or lost, change in value of securities).
 - 5. The value of the financial instrument or holding from which the disqualifying Financial Interest arises and its perceived value to the individual.
 - 6. The nature and importance of the Board member's role in the matter, including the level of discretion which the Board member may exercise in the matter.
 - 7. The sensitivity of the matter.
 - 8. The need for the Board member's services.
 - 9. Adjustments which may be made in the Board member's services as they relate to the potential conflict.

- B. The minutes of the Board and all committees with Board delegated powers shall contain:
1. The names of the persons who disclosed or otherwise were found to have a possible conflict of interest, the nature of the conflict of interest, any action taken to determine whether a conflict of interest was present and the Board/Committee's or Chief Executive Officer's decision as to whether a conflict of interest in fact existed.
 2. The names of persons who were present for discussions and votes relating to the contract, transaction or arrangement, the context of the discussion, including any alternatives to the proposed contract, transaction or arrangement, and a record of any votes taken in connection therewith.
- C. When a potential conflict arises, the Board will take the following steps:
1. The person who has information about an actual or potential conflict will present the issue to the full Board.
 2. If a majority of the ISK Board is involved in the actual or potential conflict, the matter will be submitted to the Kalamazoo County Board of Commissioners for review and decision.
 3. As necessary, the Board may request additional information from the involved Board Member, to be obtained no later than the next scheduled board meeting for vote.
 4. As necessary, the Board may request verbal input from legal counsel and the ISK Corporate Compliance Officer, to be obtained no later than the next scheduled board meeting for vote.
 5. Once all input has been obtained and presented, the Board will vote to determine whether an actual or potential conflict exists, according to this policy. The Involved Board Member(s) shall not participate in any vote on the matter.
 - a. If it is decided by majority vote of quorum that an actual or potential conflict does not in any way exist, the decision will be well-documented with supporting documentation, presented to the full board and considered resolved.
 - b. If it is decided by majority vote of quorum that a potential or actual conflict exists, the decision will be well-documented with supporting documentation, presented to the full board, and the involved Board Member will decide at that time to do one of two things:
 - i. propose an action in writing to cure the potential or actual conflict (see Step F), or
 - ii. request that the board appoint a committee to review the potential or actual conflict and make recommendations. (see Step G)
- D. If the board member chooses to propose an action to cure the potential conflict in writing he or she will present it to the full board for vote. The Board will vote to

determine whether the proposed action is sufficient as written, according to this policy and relevant law. The Involved Board Member(s) shall not participate in any vote on the matter. If it is decided by majority vote of quorum that the proposed action fully cures the potential or actual conflict as written, the proposed action will be well-documented, enacted with supporting documentation and the issue will be considered resolved. If it is decided by majority vote of quorum that the proposed action does not fully cure the potential or actual conflict, the board will appoint a committee to evaluate the potential or actual conflict and make written recommendations for final vote.

- E. If a committee is requested or required according to this policy, it will assemble before the next scheduled board meeting. The committee will consist of the ISK CEO, Board Chair, at least one other Board Member, ISK Corporate Counsel and the ISK Corporate Compliance Officer (provided that all parties are disinterested). If a committee member is unavailable to meet, she or he will produce a written opinion on the matter. The committee will form a written recommendation with supporting documentation. Upon completion of committee process, the committee will present its findings to the full board for final vote at the next scheduled board meeting (see Step H).
- F. The Board will vote to determine whether the committee's recommendation is sufficient as written, according to this policy and relevant law. The Involved Board Member(s) shall not participate in any vote on the matter. If it is decided by majority vote of quorum that the committee's recommendation is sufficient as written, the recommendation will be enacted with supporting documentation and the issue will be considered resolved.
- G. If it is decided by majority vote of quorum that the committee's recommendation is insufficient as written, the Board shall consider the following:
 - 1. Whether ISK can obtain a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest and thus avoid unnecessary risk to the organization.
 - 2. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the disinterested members of the Board shall consider granting a waiver and shall act with full knowledge and acceptance of all potential risks.
- H. Michigan law specifically provides support for granting a waiver of a Conflict of Interest arising under the following Conflict of Interest exception scenarios:
 - 1. A Community Mental Health Services Program (CMHSP) Board member may be a party to a contract with a CMHSP or administer or financially benefit from that contract, if the contract is between the CMHSP and the Regional Entity;
 - 2. A CMHSP Board member may also be a member of the Regional Entity Board, even if the Regional Entity has a contract with the CMHSP;

3. A CMHSP Board may approve a contract with the Regional Entity, if a CMHSP Board member is also an employee or independent contractor of the Regional Entity; and
 4. CMHSP public officers (e.g., Board members, officers, executives and employees) may also be Board members, officers, executives and employees of the Regional Entity, even if the Regional Entity contracts with the CMHSP, subject to any prohibition imposed by the Michigan Department of Health and Human Services in that regard.
- I. A conflict of interest waiver may be granted if the Board determines that it is not able, with reasonable efforts, to obtain a more advantageous transaction, arrangement, proceeding or other matter from another person or entity not involving the Board member, or that the actual or potential conflict is not so substantial as to be likely to affect the integrity of the services which the entity may expect from the Board Member. The Board may vote to waive the potential or actual conflict of interest and proceed with the proposed transaction, arrangement, proceeding or other matter and/or the Board member's participation in the matter. A Conflict of Interest Waiver shall be made in writing and signed by the Chairperson of the Board (or Vice Chair if the conflict involves the Chairperson) on the Conflict of Interest Waiver form (Exhibit C). The Conflict of Interest Waiver may restrict the Board member's participation in the matter, to the extent deemed necessary by the Board or the Conflict of Interest waiver may cover all matters the Board member may undertake as part of his/her official duties with the Board, without specifically enumerating such duties. All Conflict of Interest Waivers shall be issued prior to the Board member's participation in any transaction, arrangement, proceeding or other matter on behalf of ISK.

REFERENCES

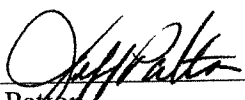
- Mental Health Code, 1974 PA 258, MCL 300.1001 to 300.2106
- 1978 PA 566, MCL 15.181 to 15.185 (incompatible public offices)
- 1968 PA 317, MCL 15.321 to 15.330 (contracts of public servants with public entities)
- 45 CFR Part 74 (Federal Procurement Regulations)
- 45 CFR Part 92 (Federal Procurement Regulations)
- 42 USC 1396a (Federal Medicaid Statute)
- Michigan Medicaid State Plan
- 18 USC 208 (Federal Conflict of Interest Statute)

- IRS Conflict of Interest Guidelines, Policies and Pronouncements for Charitable Tax-Exempt Nonprofit Entities

EXHIBITS

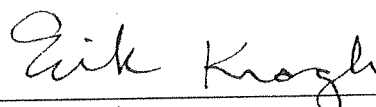
- A. Board Member Disclosure Statement
- B. Resolution of the Board
- C. Conflict of Interest Waiver

CHIEF EXECUTIVE OFFICER



Jeff Patton
Chief Executive Officer

APPROVED



Erik Krogh
Board Chair

BOARD MEMBER DISCLOSURE STATEMENT

PURPOSE

The Conflict of Interest Policy adopted by the Board of Directors of ISK requires annual disclosure of certain Interests. It is not uncommon to have these interests, but you are required to make them known to ISK.

Use this questionnaire to disclose where you or your Family Members have affiliations, interests or relationships, and/or have taken part in transactions. Your answers will be reviewed to determine whether a conflict of interest exists according to ISK Policy.

INSTRUCTIONS

1. Please read the Conflict of Interest policy and know the definitions for terms in this form.
2. Answer all questions. Please do not leave any question blank if the correct response is "no".
3. For purposes of this form, the definition of "Family Member" includes spouse, parent, sibling (whole or half-blood), a spouse's parents, children (natural or adopted), grandchildren, great grandchildren, step family members, any person sharing the same living quarters in an intimate, personal relationship and spouses of siblings, children, grandchildren, great grandchildren and all step family members.
4. Where this form refers to "you," it is also referring separately to each Family Member. Your response should indicate whether you are disclosing an interest of you or a Family Member (and, in the case of a Family Member, the nature of your relationship with that Family Member).
5. Disclose all potential Conflicts of Interest that currently exist, even if you previously reported them.
6. Complete the questionnaire, date it and sign the affirmation at the end of the document.
7. Each Board member has a duty to disclose the existence of a Financial Interest or other actual or potential conflict of interest and all related material facts annually to the Board using this form.

You must report any relationship that creates a potential Conflict of Interest that occurs between now and the completion of the next annual Conflict of Interest Annual Disclosure and Acknowledgment form completion. Any potential conflicts of interest that arise after the questionnaire has been completed should be immediately reported to the Compliance Officer.

CAUTION

May contain privileged and confidential information not subject to FOIA.

BOARD MEMBER DISCLOSURE STATEMENT

CONFLICT OF INTEREST DISCLOSURE AND ACKNOWLEDGMENT

Name: _____

I. POSITION (Board Member)

- A. I hold the following additional positions(s) and/or have the following relationship(s) with ISK:

--

II. OUTSIDE INTERESTS

- A. Do you or any Family Member hold, directly or indirectly, an ownership or investment interest in any entity that does business with ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- B. Do you or any Family Member hold, directly or indirectly, a compensation arrangement with any client, business entity, vendor, provider, contractor or consultant that does business with ISK (*examples: compensation for employment or independent contractor services, consulting fees, board stipends or fees, advisory committee fees, honoraria, etc.*)?
☐ No ☐ Yes (explain in Part VI-Page 5)
- C. Do you or any Family Member hold, directly or indirectly, a director, trustee, officer or board committee position with any other business entity that does business with ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- D. Do you or any Family Member have any personal loans, advances or other indebtedness to or from any client, business entity, vendor, provider, contractor or consultant who also does business with ISK? (*Note: you may exclude charge cards and personal or mortgage loans at market rates from financial institutions*)
☐ No ☐ Yes (explain in Part VI-Page 5)
- E. Do you or any Family Member provide managerial, consultative or other services to or on behalf of any other client, business entity, vendor, provider, contractor or consultant that does business with ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- F. Do you or any Family Member employ or otherwise retain any ISK personnel for work on non-ISK business done outside of ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- G. Have you or any Family Member been a party to any action, lawsuit or proceeding during the past five years that might be deemed material to evaluating your ability, your integrity or your interests with respect to ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- H. Do you or any Family Member know of any recent or pending actions, lawsuit or proceeding in which you have an interest adverse to the interests of, or are a party adverse to ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)

BOARD MEMBER DISCLOSURE STATEMENT

III. INSIDE ACTIVITIES

- A. Have you or any Family Member attempted to influence ISK concerning the employment or retention of any immediate family member or other individual with whom you have a business or personal relationship?
☐ No ☐ Yes (explain in Part VI-Page 5)
- B. Do you or any Family Member have any personal loans, advances or other indebtedness owed to ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)
- C. Is any ISK director, officer, employee, consultant, contractor or business associate a Family Member?
☐ No ☐ Yes
if yes, please specify name and relationship:

- D. Are you or a Family Member an employee of any ISK director, officer, employee, consultant, contractor or business associate?
☐ No ☐ Yes
if yes, please specify employer(s)

- E. Do you or a Family Member have a written contract with any ISK director, officer, employee, consultant, contractor or business associate?
☐ No ☐ Yes
if yes, please specify name and relationship:

IV. GIFTS, GRATUITIES AND ENTERTAINMENT

- A. Have you or any Family Member accepted gifts, gratuities or other favors from any client, business entity, vendor, provider or consultant under circumstances from which a reasonable person might think that such action was intended to influence you in the performance of your duties on behalf ISK? *(Note: this does not prohibit the acceptance of reasonable items of nominal value.)*
☐ No ☐ Yes (explain in Part VI-Page 5)
- B. Have you or any Family Member accepted any gifts, gratuities, favors or benefits of higher than nominal value from any client, business entity, vendor, provider or contractor, or consultants of ISK?
☐ No ☐ Yes (explain in Part VI-Page 5)

V. OTHER

Do you or a Family Member have any other interest, activities, investments or involvement that you think might be relevant for full disclosure of all actual, apparent or possible conflicts of interest?
☐ No ☐ Yes (explain in Part VI-Page 5)

BOARD MEMBER DISCLOSURE STATEMENT

VI. IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ON THE CONFLICT OF INTEREST DISCLOSURE FORM, YOU MUST COMPLETE THIS SECTION

List the question number and describe the Conflict of Interest exception(s) in detail. Explain how you intend to manage or resolve the disclosed Conflict of Interest exception(s). Attach additional pages as necessary.

VII. AFFIRMATION

I hereby state that:

1. I have read, understand and will comply with the ISK Board Conflict of Interest policy.
2. I agree to report to the Compliance Officer any change in the responses to each of the foregoing questions that may result from changes in circumstances that may develop before the completion of my next annual Conflict of Interest Disclosure form.
3. I agree to report to the Compliance Officer any further financial interest, situation, activity or conduct that may develop before completion of my next annual Conflict of Interest Disclosure form.
4. The information contained in this Conflict of Interest Disclosure form is true and accurate to the best of my knowledge and belief as of the date below.

Sign: _____ Date: _____

Print Name: _____

CONFLICT OF INTEREST

Name: _____

Position: _____

INTERNAL REVIEW (as applicable)

☐ No conflicts reported

Personal conflict: _____

Financial conflict: _____

Board review date: _____

Board review date: _____

Waiver granted by Board - ☐ Yes ☐ No

Date: _____

Corporate Counsel Signature

Date

Compliance Officer Signature

Date

Notes:

INTEGRATED SERVICES OF KALAMAZOO

RESOLUTION OF THE BOARD

Appointment to the Southwest Michigan Behavioral Health Board

WHEREAS, Integrated Services of Kalamazoo ("CMHSP") has adopted a Conflict of Interest Policy (the "Policy") requiring certain individuals to disclose Conflicts of Interest, as defined in the Policy, on the CMHSP's Conflict of Interest Policy Disclosure Statement to the CMHSP Board (the "Board");

WHEREAS, the Board has received the Conflict of Interest Policy Disclosure Statement Attached as Exhibit A, (the "Statement") in which _____ and _____ have disclosed a Conflict of Interest which requires the Board's consideration;

WHEREAS, the Board has undertaken such investigation, deliberation and discussion of the Conflict of Interest disclosed on the Statement and the potential Conflict of Interest created thereby, in accordance with the requirements of the Policy, to reach an informed decision regarding the matter; and

WHEREAS, pursuant to MCL 330.1204b, CMHSP is authorized and desires to appoint _____ to the Southwest Michigan Behavioral Health Board; and

WHEREAS, pursuant to MCL 330.1204b, CMHSP is authorized and desires to appoint _____ as an alternate member of the Southwest Michigan Behavioral Health Board to participate on that Board when _____ is unable to do so;

THEREFORE, the Board adopts the following resolutions:

1. **Due Diligence Review** – After due consideration of the factors described in the Policy, the Board has determined that it is not, with reasonable efforts, able to obtain a more advantageous arrangement from a person other than _____ and _____, and that the Conflict of Interest disclosed on the Statement is not so substantial as to be likely to affect the integrity of services which the CMHSP may expect from _____ and _____.
2. **Waiver** – In consideration of such due diligence review, the Board grants the written Conflict of Interest Waivers attached to this resolution as Exhibit B.
3. **Appointment** – The Board appoints _____ to serve on the Southwest Michigan Behavioral Health Board. Further, the Board appoints _____ to serve as an alternate member of the Southwest Michigan Behavioral Health Board, to participate on that Board when _____ is unable to do so.

Date

enter Board Members name here , Board Member

INTEGRATED SERVICES OF KALAMAZOO

CONFLICT OF INTEREST WAIVER

Review of the Disclosed Conflict of Interest

In accordance with the requirements of Integrated Services of Kalamazoo's (the "CMHSP") Conflict of Interest Policy, the CMHSP Board has undertaken appropriate due diligence review and deliberation regarding the Conflict of Interest disclosed by _____ on the Conflict of Interest Disclosure Statement (the Statement) attached as Exhibit A.

Board Resolution Granting Conflict of Interest Waiver

At the conclusion of such due diligence review and deliberation, at its meeting on _____, the Board passed the resolution attached as Exhibit B in which it determined that it is not, with reasonable efforts, able to obtain a more advantageous arrangement from a person other than _____ and the Conflict of Interest disclosed on the Statement is not so substantial as to be likely to affect the integrity of services which the CMHSP may expect from _____ and granted this Conflict of Interest Waiver under the terms described below.

Conflict of Interest Waiver Terms and Conditions

Name of Interested Person:

Description of Conflict of Interest:

_____ serves as a member of the Board for Southwest Michigan Behavioral Health and at the same time serves on the CMHSP Board.

Description of the Transaction, Arrangement, Proceeding or Matter to which the Conflict of Interest Applies:

CMHSP has contract with Southwest Michigan Behavioral Health under which the CMHSP provides, among other things, mental health services to Medicaid beneficiaries, for which the Southwest Michigan Behavioral Health compensates the CMHSP using federal and state government funds.

Interested Person's Role in the Transaction, Arrangement, Proceeding or Matter:

_____ serves as a member on the Southwest Michigan Behavioral Health Board and in this role may be directly or indirectly involved in decisions regarding the award of contracts to CMHSP and the amount of federal and/or state government funds paid to CMHSP through or by the Southwest Michigan Behavioral Health.

INTEGRATED SERVICES OF KALAMAZOO
CONFLICT OF INTEREST WAIVER

Scope of Waiver and Restrictions, if any:

This Conflict of Interest Waiver shall cover all matters _____ may undertake as part of his official duties with the CMHSP concerning any matters arising between the CMHSP and the Southwest Michigan Behavioral Health.

President/Chairperson of the Board Signature

Date

(Print Name)



Community • Independence • Empowerment

INTEGRATED SERVICES OF KALAMAZOO

**Utilization Management Plan for Individuals Enrolled in
Medicaid, Healthy Michigan Plan, SUD Community Grant,
Flint 1115 Waiver, Certified Community Behavioral Health
Clinic, Autism Benefit, SED, Child or Habilitation Supports
Waivers**

FY 23

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Introduction

Integrated Services of Kalamazoo (ISK) is a Community Mental Health Services Program providing specialty behavioral health services and performing delegated benefits management function for the individuals receiving services under the Medicaid Managed Specialty Supports and Services Demonstration 1115 Waiver, 1915 (c) (i) Program(s), the Healthy Michigan Program, the Flint 1115 Waiver, Substance Use Disorder Community Grant Programs, and Certified Community Behavioral Health Clinic for behavioral health specialty and substance use disorder services for residents of Kalamazoo County.

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

CCBHC program requirements stipulate that CCBHCs cannot refuse service to any person based on either ability to pay or residence, expanding the population eligible for the robust service array. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Additionally, CCBHCs must follow standards intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person and family-centered treatment planning and service provision.

CCBHCs must serve all individuals regardless of residency or ability to pay. CCBHCS may define service catchment areas for targeted outreach that correspond directly to the required annual needs assessment (See Program Requirements, criteria 1A. within the CCBHC Handbook). For individuals residing out of state, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services and should have protocols developed for coordinating care across state lines.

Any person with a mental health or substance use disorder (SUD) ICD-10 diagnosis code as cited in Appendix B of the CCBHC Handbook is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis. Individuals with a dual diagnosis of intellectual disability/developmental disability are eligible for CCBHC services. Eligibility review should align with assessment and diagnosis (see 13.D.4.1 of the CCBHC Handbook for more on requirements) and take place as frequently as clinically appropriate. If an individual continues to have a behavioral health diagnosis, they are eligible for all CCBHC services.

For those with Medicaid, eligible Medicaid beneficiaries include those enrolled in Medicaid (MA), Healthy Michigan Plan (MA-HMP), Freedom to Work (MA-FTW), MICHild Program (MA-MICHILD), Full Fee-for-Service Health Kids-Expansion (HK-EXP), and Integrated Care – MI Health Link (ICO-MC). Medicaid beneficiaries cannot be enrolled in the PACE or Brain Injury Services Benefit Plans concurrently with CCBHC.

Medicaid beneficiaries eligible for CCBHC are eligible for all Medicaid covered services. However, payment for duplicative services on the same day is prohibited. The CCBHC must choose which available Medicaid covered service best meets the person's needs.

Purpose

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

Essentially, the Utilization Management Program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the Utilization Management Plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools for all services and across the provider network, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Values

Integrated Services of Kalamazoo intends to operate a high-quality Utilization Management system for public behavioral health and substance use services which is responsive to community, family and individual needs. The entry process must be clear, readily available and well known to all constituents. To be effective, information, assessment, referral and linkage capacity must be readily and seamlessly available. Level of care and care management decisions must be based on medical necessity and on evidence based, wellness, recovery and best practice. ISK is committed to ensuring use of evidence-based services with individuals served, driving outcomes/results/value for taxpayer dollars and

maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, Integrated Services of Kalamazoo is committed to the identification, development, and use of innovative and less costly supportive services (e.g., Assistive Technology, Certified Peer Supports and Recovery Coaches, etc.) while meeting the service needs of individuals in the region. Integrated Services of Kalamazoo recognizes that access to physical and behavioral health services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing access to integrated service depends upon appropriate utilization throughout all aspects of the screening/assessment, level of care and care management decision making processes and care coordination and through oversight, fidelity and outcomes monitoring.

Authority and Structure

Program Oversight

The Integrated Services of Kalamazoo Utilization Management Program shall operate under the oversight of the ISK Administrator of Operations and Medical Director. Additionally, the Integrated Services of Kalamazoo Clinical Operations Committee shall serve in a critical role involving deliberation, consultation and proof of performance realms. The Administrator of Operations and Medical Director are overall accountable for management of the CMHSP's Utilization Management Program. Jointly with the Medical Director, the Administrator of Operations and Manager of Utilization Management provide clinical and operational oversight and direction to the UM program and staff and ensures that ISK has qualified staff accountable to the organization for decisions affecting persons served.

Committee

Integrated Services of Kalamazoo has an established Clinical Operations committee to review and provide input and coordination regarding utilization management policy, medical necessity criteria, clinical practice, review of service utilization, population health trends, and outlier management. The Clinical Operations committee shall serve in a support and advisory capacity to the UM Program and annually evaluate the efficiency and effectiveness of the UM Program and offer feedback related to necessary modifications. Ad hoc members will be included in the committee meetings based on need and agenda focus.

Membership

The Clinical Operations committee will consist of cross collaborative leadership representation from Integrated Services of Kalamazoo including the Administrator of Operations, Administrator of Clinical Services, Manager of Utilization Management, and Population Senior Executives. Ongoing consultation and ad hoc representation from the ISK Chief Executive Officer, Medical Director, Customer Services, Utilization Review, Finance, IT, and Provider Network staff are available to the committee. Clinical Operations committee clinical representatives are experienced administrative and clinical professionals with ad hoc specialty representation for Child and Adolescents with Serious Emotional Disturbance, Adults and Children with Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Adults and Children with Substance Use Disorders. The Clinical Operations committee typically meets on a weekly basis with dedicated time to UM plan activity review occurs at least quarterly.

Roles of the Committee

The Clinical Operations committee is charged with the following:

1. Ensure adherence to consistent application of assessment tools, level of care guidelines and medical necessity criteria. Provide recommendations for and implementation of Clinical Protocols and Clinical Practice Guidelines.

2. Review and provide input on the UM Program on an annual basis assuring adherence to and synchronization with contractual and accreditation requirements, with final approval by the Administrator of Operations and Medical Director.
3. Provide input regarding the Utilization Management Program including level of care and service utilization guidelines that may be provided without authorization, level of care and typical service utilization guidelines at the local care management level and monitor outlier levels of care and typical service utilization data.
4. Ensure that services rendered are delivered by qualified staff or contracted practitioner providers. Ensure that timely and focused utilization review (UR) is provided for delegated Utilization Management functions.
5. Develop, review and act upon service utilization and outcomes data and/or reports for purposes of demonstrating consistent Uniform Benefit (including reports of under and over utilization, length of stay, etc.).
6. Review service use and population health data that may affect policy and procedure including, but not limited to Appeal/Fair Hearing determinations, Recipient Right decisions, clinical best practices and service utilization and cost data.
7. Identify practice-based evidenced measures (i.e. clinical outcome metrics) that demonstrate the overall effectiveness and impact of clinical services being rendered.
8. Identify gaps and make recommendations for necessary clinical training to ensure delivery of quality clinical service through the use evidenced based practices that adhere to fidelity measures.
9. Assure adherence to related data and report specifications through cross collaboration with applicable ISK teams and committees.

Standards and Philosophy

Integrated Services of Kalamazoo is responsible for monitoring the provision of services to individuals enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Certified Community Behavioral Health Clinic, Autism Benefit, Habilitation Supports, SED and Child Waivers and SUD Community Grant and those receiving services under General Funds. Integrated Services of Kalamazoo ensures adherence to statutory, regulatory, and contractual obligations. Furthermore, the utilization management program is designed to be consistent with and supportive of assuring achievement of Integrated Services of Kalamazoo mission, vision and values.

The UM program document and subsequent policies provide a description of processes, procedures and criteria necessary to ensure cost-effectiveness, achieving the best individual's outcome for the resources spent. As a CMHSP with delegated managed care UM functions, Integrated Services of Kalamazoo's duty is to assure the **uniformity** of:

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

Management information system(s) adequate to support the UM Program is central. ISK currently utilizes a variety of reporting systems including reports available through SWMBH and Integrated Services of Kalamazoo PCE KARE reports to manage UM data needs. The functionalities and maintenance of such systems include, but are not limited to:

1. Utilization of electronic health information systems and incorporation/integration of behavioral health and physical health data

2. Real-time access to aggregate and case level information, which is complete, accurate, timely
3. Reporting services which are automated and routine, inclusive of rule-based alerts
4. Reporting formats which are readily available, graphically presented, easy to understand and present actionable information aligned to Board Ends and dashboard performance and clinical outcome goals
5. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provide input into severity of illness and a means to provide the data to ISK to manage over/under utilization and employ risk stratification models both in an effort to manage and impact population health.

Access to Integrated Services of Kalamazoo Behavioral Health Services

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

1. Requesting services directly from Integrated Services of Kalamazoo during business and after-hours toll-free access/crisis line.
2. Face-to-Face evaluation by Integrated Services of Kalamazoo
3. Crisis behavioral health services through the Integrated Services of Kalamazoo, inpatient hospitals, mobile crisis teams, and urgent care centers
4. Requesting substance use disorder services and depending on the level of medically necessary care and individual choice, subsequently collaborates with SWMBH and other providers for screening, service provision and/or service determination

Access Standards

Integrated Services of Kalamazoo shall comply with the MDHHS Access Standards and Michigan Mission Based Performance Indicator System (MMBPIS) per contract. These standards and expectations include:

1. The percent of all children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (Standard = 95%)
2. The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days, 10 business days, of a non-emergency request for services.
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (Standard = 95%)
4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)
5. Achieve a call abandonment rate of 5% or less.
6. Average call answer time 30 seconds or less.
7. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed three minutes without being offered an option for callback or talking with a non-professional in the interim
8. All non-emergent callbacks must occur within one business day of initial contact.
9. Adhere to MDHHS Substance Abuse Block Grant Priority Population access to service timeliness standards.

Level of Intensity of Service Determination

Level of Intensity	Definition	Regulatory Decision Response Time
Emergent - Psychiatric	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours; Prior authorization not necessary for the screening event. Disposition required for an inpatient admission within 3 hours of request

Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services is denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 days; Prior authorization required
Retrospective	Assessing appropriateness of medical necessity on a case-by-case or aggregate basis after services were provided	Within 30 calendar days of request
Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition.	Within 1 hour of request

Coordination and Continuity of Care

Integrated Services of Kalamazoo is committed to ensuring each individual served receives services designed to meet each individual special health need as identified through a population specific functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health supports and/or substance use disorder treatment services. Services and supports address integrated physical health needs and needs that may be accessed in the community such as employment, housing, financial assistance, etc. The assessment is maintained in a uniform managed care information system with collection of common data elements and contains functional assessment tool data that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the ISK direct operated and its provider network. Standardized functional assessment tools include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, PECFAS (Preschool and Early Childhood Functional Assessment Scale) and CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for adult individuals served with Intellectual/Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Functional assessments are completed by appropriate clinical professionals and according to identified timeframes/ standards or whenever there is a perceived or necessary change in level of care. Treatment plans are developed through a person-centered planning process with the individual served participation and with consultation from any specialists providing care to the individual.

Integrated Services of Kalamazoo ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.

1. Access and Eligibility: To ensure timely access to services, Integrated Services of Kalamazoo provides and monitors local access, triage, screening, and referral. Integrated Services of Kalamazoo ensures that the Access Standards are met including standards set through the Michigan Mission Based Performance Indicator System (MMBPIS).

2. Clinical Protocols: To ensure Uniform Benefit for individuals served, consistent functional assessment tools, medical necessity, level of care and clinical protocols/practices have been identified and implemented for service determination and service provision.
3. Service Authorization/Determination: Service Authorization procedures will be efficient and responsive to individuals while ensuring sound benefits management principles consistent with managed care business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness.
4. Utilization Management: Through outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process is utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit.

The Integrated Services of Kalamazoo Utilization Management plan is designed to maximize timely local access to services for individuals while providing an outlier management process to reduce over and underutilization (financial risk). The Utilization Management Plan endorses two core functions.

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

The Utilization Review process will use scheduled review of outlier management reports. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (SWMBH, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process will require that an action plan be developed to address any performance deficits.

The outlier management process and subsequent reports to manage it, including over and under-utilization and uniformity of benefit, are based on accurate and timely assessment information, level of care functional assessment tool scores and service determination criteria. Assessment data is housed in the ISK Electronic Health Record and submitted to the SWMBH data warehouse as required.

Review Activities

Utilization Management

Based on an annual review by ISK cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted with the CMHSP and provider network to assure the appropriate delivery of services. ISK has been delegated utilization management functions for mental health under their Memorandum of Understanding with SWMBH. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Detox, Residential and MAT/Methadone.

Provider Network practitioners and ISK clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, service delivery needs and workforce training. Inter-rater reliability testing is conducted annually for ISK clinical staff making medical necessity determinations.

Determination of Medical Necessity

Treatment under the individual's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for mental health, intellectual/developmental disabilities, and substance use supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. For the purposes of utilization control, ISK ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually by the Clinical Operations Committee with final approval by the ISK Medical Director.

Services selected based upon medical necessity criteria are:

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

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced

by amount, duration or scope based solely on a diagnosis, type of illness, or condition of the member.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
3. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the individual served and provider.
4. Well-publicized and readily available appeals mechanisms for both providers and individuals served exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.
7. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Use of Incentives

The use of incentives related to service determination approvals, denials or promotion of underutilization is prohibited. Service determinations are based only on medical necessity criteria and benefits coverage information. This information is provided to members, staff and providers via policy and other informational documentation such as the Customer Services handbook and the ISK Portal.

Medically necessary is determined in a manner in which it is no more restrictive than what is used in the MDHHS Medicaid program, and includes quantitative and non-quantitative treatment limits, as indicated in MDHHS statutes and regulations, the MDHHS Plan, and other MDHHS policy and procedures. The medically necessary services should address to what extent the PIHP and CMHSP is responsible for covering services that address the prevention, diagnosis, and treatment of an individual's disease, condition, and/or disorder that results in health impairments and/or disability; the ability for an individual to achieve age-appropriate growth and development; the ability for an individual to attain, maintain, or regain functional capacity; and the opportunity for a member to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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

The expectation for service provision is that intensity of service will be aligned with severity of illness. For each population served (adults with mental illness, youth with emotional disturbances, persons with intellectual and developmental disabilities, and persons with substance use disorders), SWMBH utilizes a standardized functional assessment to identify level of need at initiation of services and at established intervals throughout service provision. SWMBH and its participant CMHs have established regional Levels of Care that correspond to needs identified through the functional assessment process, which are based on severity of illness and intensity of need. Levels of Care and Core Service Menus are in place for adults with mental illness, youth with emotional disturbances, adults with intellectual and developmental disabilities, and persons with substance use disorders. The levels and service menus are reviewed and updated as necessary by SWMBH and its regional partners. The adopted core service menus are implemented and utilized consistently throughout the region.

Each Level of Care contains a Core Service Menu with suggested service types as well as expected annual amounts of services, corresponding to needs commonly presenting at each level. Services that fall within the Core Service Menu for a given Level of Care are services for which medical necessity has been established via the functional assessment, and do not require additional UM review. Services requested

that fall outside of the Core Service Menu for an individual's Level of Care may be authorized if medical necessity is established through a utilization review. These requests are referred to as Exceptions.

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

Levels of Care for Mental Health Specialty Services

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

PIHP Service Eligibility

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

Crisis Services

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

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

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

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

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

Individuals receiving services at this level of care are adults with a LOCUS score typically of 23-27 including a score of 4 on dimension II or III and who present as danger to self or others.

Treatment is typically provided in a community based free standing residential setting such as Crisis Residential and is aimed at providing reasonable protection of personal safety and property and minimizing danger to self and others.

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

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

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

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

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

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

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

Individuals receiving services at this level of care are adults with a LOCUS score typically of 10-13 with minimal impairment of functioning, minimal to no risk of harm to self or others, reside independently in the community. Minimal encouragement with linking/coordinating actively utilizing self-improvement and treatment skills acquired. May use PSR assistance with maintaining recovery. Treatment is provided in the community and is typically clinic based.

Level 0 -- Basic Services

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

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

Eligible for PIHP Medicaid Services (Severe need):

- LOCUS Recommended Disposition Level of 3, 4, 5, or 6, or

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

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

- LOCUS Recommended Disposition Level 0 or 1, or
- LOCUS Recommended Disposition Level 2 but does not meet Michigan Mental Health code definition for SMI. Considerations for determining if individuals with a recommended LOCUS Recommended Disposition Level 2 meets specialty service eligibility criteria are also outlined in the SWMBH policy 4.11.

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

Level IV -- Intense Need

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

Level III – High Need

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

Level II – Moderate Need

Individuals in this level of care are children with a CAFAS or PECFAS score of 80-110 with moderate to significant inability to function in many areas, instability in living environment, multiple service needs, family requires regular support, crisis intervention services needed. Likely at risk for out of home placement, displays disruptive behavior.

Level I – Low Need

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

Level 0 – Minimal Need

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

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

Eligible for PIHP Medicaid Services (Severe need):

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

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

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

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

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

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

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

Individuals receiving services at this level of care are adults (18 years or older) and typically demonstrate significant medical needs and/or extensive behavioral needs and require total assistance on a daily basis with 1:1 or higher level of staffing. May have potentially harmful, injurious or dangerous behaviors requiring frequent and consistent proactive interventions, and a formal behavior treatment plan. May have extensive medical/health needs, requiring daily (or more) monitoring and/or oversight and hands on assistance. Nursing services may be required to develop and train on health care protocols, if applicable.

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

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

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

Individuals receiving services at this level of care are adults (18 years or older) and typically require frequent prompts/reminders, coaching, and/or training to engage or complete activities (less than daily/more than weekly) or physical support, or some hands-on physical

support/guidance. Moderate behavioral issues may be present with or without the need for a Behavior Plan. May experience physical health issues that require increased supports. Safety risks may be present that need to be addressed or monitored; includes safety to self and safety in the community.

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

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

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

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

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

Level V – Intense Need

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

Level IV – High Need

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

Level III – Moderate Need

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

Level II – Low Need

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

Level I – Minimal Need

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

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

Level 0.5 – Early Intervention

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

Level 1.0 – Outpatient Services

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

Level OTP – Opioid Treatment Program

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

Level 2.1 – Intensive Outpatient

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

Level 2.5 – Partial Hospitalization

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

Level 3.1 – Clinically-Managed Low-Intensity Residential

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

Level 3.3 – Clinically-Managed Medium-Intensity Residential

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

Level 3.5 – Clinically Managed High Intensity Residential

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

Level 3.7 – Medically-Monitored Intensive Inpatient

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

Level 4 – Medically-Managed Intensive Inpatient

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

Level 1-WM – Ambulatory Withdrawal Management without Extended On-Site Monitoring

The patient is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 2-WM – Ambulatory Withdrawal Management with Extended On-Site Monitoring

The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 3.2-WM – Clinically Managed Residential Withdrawal Management

The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.

Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management

The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.

Level 4-WM – Medically Managed Intensive Inpatient Withdrawal Management

The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.

Review Process

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

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

Outlier Management

An integral part of Integrated Services of Kalamazoo utilization review and monitoring activities include outlier management methodologies. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focused by Integrated Services of Kalamazoo versus intensive prior authorization and utilization controls. The design encompasses a review of resource utilization of all Individuals served by

Integrated Services of Kalamazoo. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved clinicians and provider(s).

1. Outlier Definition

An "Outlier" is generally defined as significantly different from the norm. Integrated Services of Kalamazoo defines the following types of "outliers":

- Individuals who over or under-utilize services by a variety of variables including too much or too little service utilization at the individual level, by service type or by provider
- Incongruent level of care to assessed need
- Lack of contact with or by service provider
- Inpatient Recidivism
- Lengths of stay not supported by medical necessity
- Provider request to evaluate medical necessity

2. Outlier Identification

Integrated Services of Kalamazoo utilizes a variety of tools for monitoring, analyzing, and addressing outliers. ISK's Performance Indicator Reports (MDHHS required performance standards), service utilization data and reports in PCE KARE and SWMBH Tableau, and Cost Analysis Reports are available for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Additionally, at the regional level, outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the SWMBH Managed Care Information System and reviewed by the Regional Utilization Management Committee to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures

- A. As outliers are identified, analysis will occur at ISK by the Provider Network Coordinator assigned to the utilization review process to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.
- B. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the ISK staff/teams and the UM committee will ensure understanding of the utilization trends or patterns. Identified outliers are evaluated and assigned to Utilization Management and Utilization Review staff to determine whether further information is needed to understand the utilization trend pattern. If further review is warranted, active communication between the ISK Utilization Management staff and the primary case holder will ensure understanding of the utilization trends or patterns.
- C. Following the individual case review, results are forwarded to the Provider Network Coordinator assigned to the utilization review process for review analysis, clinical feedback, and entry into a tracking database. Completed reviews are then sent to the monthly Utilization Management group made up of the Manager Customer Services, the Administrator of Operations, Manager Utilization Management, and the Provider Network Coordinator assigned to the utilization review process for final review and approval of recommendations. The following recommendations may result from a review: Stay the same, Terminate a service, Terminate all services, Add a service, Increase hours/contacts/sessions, Decrease

hours/contacts/sessions, Reevaluate need (case will be marked for follow up review), and Other. Primary clinicians/supervisors are formally notified of the decision following the monthly Utilization Management group.

- D. If the utilization trends or patterns are determined to require intervention at the provider or the individual level, collaborative corrective action plans are jointly discussed with Integrated Services of Kalamazoo leadership and will include defined timelines for completion. Corrective action plans may include:
1. Brief description of the finding(s) and supporting information;
 2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps;
 3. A description of the monitoring to be performed to ensure that the steps are taken;
 4. A description of the monitoring to be performed that will reflect the resolution of the situation.
 5. Following initial review and efforts for resolution, the disposition can include either positive resolution or advance to next level of review with consultation with Leadership;
 6. Following consultation, the Administrator of Operations and/or the Medical Director will review for disposition determination, recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.
- E. The Medical Director and/or Administrator of Operations will take into consideration the outlier severity in determining recommended remedies. The following options available at this level include:
1. Acceptance of recommendations.
 2. Direction for additional action(s),
 3. Clinical Peer Review -The Peer Review consists of review, consultation, and
 4. recommendations for resolution.
 5. Render final disposition.
 6. Provide recommendations for action for remediation to the applicable Integrated Services of Kalamazoo Director
- F. The spectrum of remedies available to the Integrated Services of Kalamazoo in relation to its internal operations and provider panels stems from the authority of the Integrated Services of Kalamazoo Board and occur according to Integrated Services of Kalamazoo policy. Subject to CEO's approval, possible remedies can include but are not limited to:
1. Non-payment for case.
 2. Individual switch to a staff or new provider.
 3. Provider being put on pre-payment status.
 4. Pro-rated payback on class of cases.
 5. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
 6. Removal from provider panel.

Data Management

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

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, Individual safety, call rates, Access standards and individual quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/Central Care

Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of individual level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

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

Communication

UM Program Plan

The UM Program Plan is developed adjunct to the Quality Management Plan. The plan is reviewed by the Clinical Operations Committee and input sought from ISK teams. Providers, Individuals, and general stakeholders can access the UM plan through the Integrated Services of Kalamazoo portal and upon request. The ISK Board of Directors receives education on the Utilization Management Plan on an annual basis.

Availability of Utilization Management Staff

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

After-hours emergency services are available to Individuals and providers through a phone service which provides emergency referral and information outside of normal business hours by licensed professional staff. Individuals and providers have the ability to leave a message for UM staff through this service and also may fax information to Integrated Services of Kalamazoo after hours.

Peer Clinical Review

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

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year monitoring activity targets have been achieved and identify trends and areas for improvement. The Clinical Operations committee is responsible for implementing any improvement activities at ISK and throughout the provider network. The purpose of the annual evaluation is to identify any best practices that could be incorporated into the

UM plan as well as continue to improve the care provided to Integrated Services of Kalamazoo individuals served. Additionally, Inter-rater reliability of application of medical necessity will be evaluated annually. Oversight and monitoring of medical necessity determinations and utilization management decisions will be conducted on an ongoing basis to validate consistent application and understanding of uniform benefit, clinical protocols and medical necessity criteria.

Definitions

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

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

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

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

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

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

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

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

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

substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

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

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

Roles

Integrated Services of Kalamazoo role:

- Adhere to prescribed Assessment Tools use, frequency, and reporting to SWMBH
- Adhere to SWMBH Level of Care Guidelines.
- Report and Perform Local Care Management per the SWMBH UM Plan, Delegation Agreement and Policy.
- Report Authorizations and Encounters to SWMBH as prescribed.
- Perform delegated UM/Care Management per UM Plan and Policy.
- Oversee and monitor delegated Local Care Management per UM Plan and Policy.
- Develop, review and act upon UM analytic management reports for Integrated Services of Kalamazoo.
- Regularly identify trends and material variations.

Shared Role (Administrator of Operations, Manager of Utilization Management and UM Committee):


Regularly review UM analytic management reports. Identify trends and variations, including gaps in completeness, timeliness, and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications as necessary. Adjust business process and/or decision trees as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

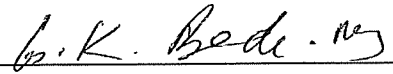
References/Additional Guiding Documents

SWMBH Level of Care Guidelines

SWMBH Regional Utilization Management Committee UM Program Plan and Work Plan/Goals

Plan Review and Approval

Administrator of Operations:  2/28/23
Signature/date of review

Medical Director:  2-28-23
Signature/date of review

INTEGRATED
SERVICES OF
KALAMAZOO



Period Ended
February 28, 2023

Monthly Finance
Report

INTEGRATED SERVICES OF KALAMAZOO

Statement of Net Position

February 28, 2023

	February 2022 (unaudited)	February 2023
Assets		
Current assets		
Cash and investments	\$ 37,610,523	\$ 30,456,944
Accounts receivable	7,523,063	3,559,192
Due from other governments	31,031	20,154
Prepaid items	859,928	1,366,564
Total current assets	<u>46,024,545</u>	<u>35,402,854</u>
Non-current assets		
Capital assets, net of accumulated depreciation	9,262,451	11,519,414
Net pension asset, net of deferred outflows	5,722,229	5,722,229
Total non-current assets	<u>14,984,680</u>	<u>17,241,643</u>
Total assets	<u>61,009,225</u>	<u>52,644,497</u>
Liabilities		
Current liabilities		
Accounts payable	\$ 9,635,522	\$ 10,936,230
Due to other governments	5,954,569	2,111,949
Due to providers	309,291	38,626
Accrued payroll and payroll taxes	1,540,643	1,649,425
Unearned revenue	192,351	163,513
Total current liabilities	<u>17,632,376</u>	<u>14,899,743</u>
Non-current liabilities		
Long-term debt	4,413,705	-
Total liabilities	<u>22,046,081</u>	<u>14,899,743</u>
Net position		
Designated	15,242,325	13,747,779
Undesignated	5,323,673	18,360,519
Investment in fixed assets	4,841,804	4,858,748
Previous year close	-	-
Net gain (loss) for period	13,555,342	777,708
Net position	<u>\$ 38,963,144</u>	<u>\$ 37,744,754</u>

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INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through February 28, 2023

Percent of Year is 41.67%

	Original 2023 BUDGET	YTD Totals 2/28/23	Remaining Budget	Percent of Budget - YTD
Operating revenue				
Medicaid:				
Traditional Capitation	\$ 62,584,607	\$ 29,309,317	\$ 33,275,290	46.83%
Healthy Michigan Capitation	10,155,033	5,406,750	4,748,283	53.24%
Autism Captiation	5,722,701	2,339,122	3,383,579	40.87%
Settlement	(11,458,363)	(2,119,315)	(9,339,048)	0.00%
State General Fund:				
Formula Fundings	3,900,517	1,625,215	2,275,302	41.67%
CCBHC Demonstration	33,381,000	3,136,827	30,244,173	0.00%
CCBHC Accrual	-	1,169,017	(1,169,017)	0.00%
County Allocation	1,550,400	646,000	904,400	41.67%
Client Fees	429,500	119,734	309,766	27.88%
SUD Block Grant	-	46,649	(46,649)	0.00%
Other grant revenue	7,133,667	3,929,702	3,203,966	55.09%
Other earned contracts	1,130,318	729,097	401,221	64.50%
COFR	-	-	-	0.00%
Interest	1,000	648	352	0.00%
Local revenue	10,000	1,100	8,900	0.00%
Total operating revenue	\$ 114,540,380	\$ 46,339,863	\$ 68,200,517	40.46%
Operating expenses				
Salaries and wages	24,113,672	9,399,856	\$ 14,713,816	38.98%
Employee benefits	8,670,498	2,505,666	6,164,832	28.90%
Staff development	223,625	79,877	143,748	35.72%
Payments to providers	68,968,243	28,943,318	40,024,925	41.97%
Administrative contracts	7,789,466	3,720,214	4,069,252	47.76%
IT software and equipment	765,010	257,387	507,623	33.64%
Client transportation	29,260	7,462	21,798	25.50%
Staff travel	310,912	90,532	220,380	29.12%
Office expenses	420,923	171,621	249,302	40.77%
Insurance expense	97,505	10,570	86,935	10.84%
Depreciation expense	560,142	211,961	348,181	37.84%
Utilities	306,573	138,058	168,515	45.03%
Facilities	124,379	25,632	98,747	20.61%
Total operating expenses	\$ 112,380,208	\$ 45,562,155	\$ 66,818,053	40.54%
Change in net position	2,160,172	777,708	\$ 1,382,464	
Beginning net position	36,967,046	36,967,046		
Ending net position	\$ 39,127,218	\$ 37,744,754		

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INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through February 28, 2023

Percent of Year is 41.67%

	Specialty Services			Healthy Michigan			Autism			SUD Block Grant			Totals		
	Budget	YTD 2/28/23	YTD Totals 2/28/23	YTD Budget	YTD 2/28/23	YTD Totals 2/28/23	YTD Budget	YTD 2/28/23	YTD Totals 2/28/23	YTD Budget	YTD 2/28/23	YTD Totals 2/28/23	YTD Budget	YTD Totals 2/28/23	Variance
Operating revenue															
Medicaid:															
Traditional Capitation	\$ 26,078,378	\$ 29,309,317	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 29,355,966	\$ 26,078,378	\$ 29,355,966	\$ 3,277,588
Healthy Michigan Capitation	-	-	-	4,231,264	5,406,750	-	-	-	-	-	-	5,406,750	4,231,264	5,406,750	1,175,487
Autism Capitation	-	-	-	-	-	-	2,384,459	2,339,122	-	-	-	2,339,122	2,384,459	2,339,122	(45,337)
CCBHC Base Payment	-	(4,968,955)	-	-	(1,096,100)	-	-	-	-	-	-	(6,065,055)	-	(6,065,055)	(6,065,055)
Settlement Estimate	(2,711,722)	2,848,631	(2,582,175)	(2,268,351)	(2,582,175)	(2,339,122)	205,755	(2,339,122)	(45,649)	(4,774,318)	(2,119,315)	(2,119,315)	(4,774,318)	(2,119,315)	2,655,003
Client Fees	177,500	119,734	-	-	-	-	-	-	-	-	-	119,734	177,500	119,734	(57,766)
Total operating revenue	\$ 23,544,156	\$ 27,308,727	\$ 1,962,913	\$ 1,962,913	\$ 1,728,475	\$ 2,590,214	\$ 2,590,214	\$ 0	\$ -	\$ -	\$ -	\$ 29,037,203	\$ 28,097,283	\$ 29,037,203	\$ 939,920
Operating expenses															
Internal services	\$ 1,290,820	\$ 1,507,880	\$ 145,340	\$ 72,027	\$ 145,340	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,653,219	\$ 1,362,847	\$ 1,653,219	290,373
External services	21,005,879	24,281,911	1,786,883	1,786,883	1,486,996	2,452,975	-	-	-	-	-	25,768,908	25,245,738	25,768,908	523,170
Delegated managed care	1,247,457	1,518,936	104,003	104,003	96,139	137,239	-	-	-	-	-	1,615,075	1,488,699	1,615,075	126,377
Total operating expenses	\$ 23,544,156	\$ 27,308,727	\$ 1,962,913	\$ 1,962,913	\$ 1,728,476	\$ 2,590,214	\$ 2,590,214	\$ -	\$ -	\$ -	\$ -	\$ 29,037,203	\$ 28,097,283	\$ 29,037,203	\$ 939,920
Change in net position	-	0	(0)	-	(0)	0	-	0	(0)	-	-	0	-	-	0

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position

October 1, 2022 through February 28, 2023

Percent of Year is 41.67%

	State General Fund			CCBHC			Other Funding Sources			Totals		
	YTD Budget	YTD Totals 2/28/23		YTD Budget	YTD Totals 2/28/23		YTD Budget	YTD Totals 2/28/23		YTD Budget	YTD Totals 2/28/23	Variance
Operating revenue												
General Fund	\$ 1,625,215	\$ 1,625,215	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,625,215	\$ 1,625,215	\$ (0)
Projected GF Carryforward	-	-	-	-	-	-	-	-	-	-	-	-
CCBHC Demonstration	-	-	13,908,750	-	10,370,899	-	-	-	-	13,908,750	10,370,899	(3,537,851)
Other Federal and State Grants	-	-	-	-	-	-	2,972,361	3,929,702	-	2,972,361	3,929,702	957,340
Earned Revenue	-	-	-	-	-	-	470,966	729,097	-	470,966	729,097	258,131
COFR Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Interest	-	-	-	-	-	-	417	648	-	417	648	232
County Allocation	-	-	-	-	-	-	646,000	646,000	-	646,000	646,000	-
Local Revenue	-	-	-	-	-	-	4,167	1,100	-	4,167	1,100	(3,067)
Transfer from GF	-	-	-	-	-	-	942,408	943,227	-	942,408	943,227	819
Settlement Revenue (Expense)	-	-	-	-	-	-	-	-	-	-	-	-
Total operating revenue	\$ 1,625,215	\$ 1,625,215	\$ 13,908,750	\$ 13,908,750	\$ 10,370,899	\$ -	\$ 5,036,318	\$ 6,249,773	\$ -	\$ 20,570,284	\$ 18,245,887	\$ (2,324,396)
Operating expenses												
Internal Programs	\$ -	\$ 262,831	\$ 9,540,714	\$ -	\$ 6,983,183	\$ -	\$ -	\$ 145,972	\$ -	\$ 9,540,714	\$ 7,391,986	\$ (2,148,728)
External Programs	494,590	244,984	2,754,077	2,754,077	2,256,133	-	212,140	343,173	-	3,460,807	2,844,290	(616,517)
Other Federal and State Grants	-	-	-	-	-	-	3,541,734	4,788,581	-	3,541,734	4,788,581	1,246,847
HUD Grants	-	-	-	-	-	-	680,906	363,479	-	680,906	363,479	(317,427)
Managed Care Administration	27,671	29,909	687,870	687,870	544,166	-	16,305	21,348	-	731,845	595,423	(136,422)
Homeless Shelter	-	-	-	-	-	-	181,979	183,705	-	181,979	183,705	1,726
Transfer from GF	942,408	943,227	-	-	-	-	-	-	-	942,408	943,227	819
Local match expense	-	-	-	-	-	-	531,240	335,500	-	531,240	335,500	(195,740)
Non-DCH Activity Expenditures	-	-	-	-	-	-	58,579	21,989	-	58,579	21,989	(36,590)
Total operating expenses	\$ 1,464,669	\$ 1,480,951	\$ 12,982,660	\$ 12,982,660	\$ 9,783,482	\$ -	\$ 5,222,882	\$ 6,203,747	\$ -	\$ 19,670,211	\$ 17,468,179	\$ (2,202,032)
Change in net position	160,546	144,265	926,090	926,090	587,417	-	(186,563)	46,026	-	900,073	777,708	(122,364)

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INTEGRATED SERVICES OF KALAMAZOO

CCBHC

October 1, 2022 through February 28, 2023
Percent of Year is 41.67%

	CCBHC Medicaid	CCBHC Healthy MI	CCBHC Non-Medicaid	CCBHC YTD Totals
Operating revenue				
Prepayment	\$ 3,136,827	\$ -	\$ -	\$ 3,136,827
CCBHC Base Payment Reclaim	4,968,955	1,096,100	-	6,065,055
Remaining CCBHC revenue due	223,674	945,343	-	1,169,017
Total CCBHC Revenue (PPS-1 of \$271.00 x encounters)	\$ 8,329,456	\$ 2,041,443	\$ -	\$ 10,370,899
Operating expenses				
Internal services	\$ 5,628,390	\$ 1,379,446	\$ 519,513	\$ 7,527,349
DCO Contracts	1,686,968	413,454	155,711	2,256,133
Total operating expenses	\$ 7,315,358	\$ 1,792,900	\$ 675,224	\$ 9,783,482
Operating change in net position	1,014,098	248,543	(675,224)	587,417
Reclassification to cover Non-Medicaid	(675,224)	-	675,224	-
Total change in net position	338,875	248,543	-	587,417

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YOUTH COMMUNITY INPATIENT SERVICES
Report Period: October 1st, 2022 through February 28th, 2023

UTILIZATION COMPARISONS FY 22/23									
MONTH	FY 21/22 Actual		FY 22/23 Budget		FY 22/23 Actual		Days Difference Favorable (Unfavorable)	Cost Difference Favorable (Unfavorable)	Cost YTD Favorable (Unfavorable)
	Days	Dollars	Days	Dollars	Days	Dollars			
OCTOBER	55	\$54,195	42	\$42,878	52	\$50,778	(10)	(\$7,900)	(\$7,900)
NOVEMBER	7	\$7,688	42	\$42,878	63	\$61,425	(21)	(\$18,547)	(\$18,547)
DECEMBER	29	\$25,836	42	\$42,878	37	\$35,968	5	\$6,910	\$6,910
JANUARY	37	\$34,540	42	\$42,878	53	\$51,685	(11)	(\$8,807)	(\$8,807)
FEBRUARY	69	\$68,647	42	\$42,878	55	\$53,801	(13)	(\$10,923)	(\$10,923)
MARCH	48	\$46,874	42	\$42,878					
APRIL	56	\$82,861	42	\$42,878					
MAY	54	\$46,668	42	\$42,878					
JUNE	74	\$67,193	42	\$42,878					
JULY	29	\$31,468	42	\$42,878					
AUGUST	26	\$27,842	42	\$42,878					
SEPTEMBER	19	\$22,420	42	\$42,878					
TOTALS	503	\$516,232	504	\$514,532	260	\$253,657	(50)	(\$39,267)	
MONTHLY AVERAGES	42		42		52				
GROSS ANNUAL COST		\$516,232		514,532		\$253,657		(\$39,267)	

Favorable/(Unfavorable):

Total: (39,267)

COMMUNITY INPATIENT SERVICES

Report Period: October 1st, 2022 through February 28th, 2023

UTILIZATION COMPARISONS FY 22/23										
MONTH	FY 21/22 Actual		FY 22/23 Budget		FY 22/23 Actual		Days Difference Favorable (Unfavorable)	Cost Difference Favorable (Unfavorable)	Cost YTD Favorable (Unfavorable)	
	Days	Dollars	Days	Dollars	Days	Dollars				
OCTOBER	389	\$379,663	487	\$497,084	609	\$634,325	(122)	(\$137,241)	(\$137,241)	
NOVEMBER	455	\$443,250	487	\$497,084	614	\$639,402	(127)	(\$142,318)	(\$142,318)	
DECEMBER	535	\$517,204	487	\$497,084	704	\$733,206	(217)	(\$236,122)	(\$236,122)	
JANUARY	540	\$522,941	487	\$497,084	670	\$695,815	(183)	(\$198,731)	(\$198,731)	
FEBRUARY	475	\$463,341	487	\$497,084	718	\$748,508	(231)	(\$251,424)	(\$251,424)	
MARCH	563	\$547,137	487	\$497,084						
APRIL	497	\$512,447	487	\$497,084						
MAY	504	\$483,973	487	\$497,084						
JUNE	597	\$575,505	487	\$497,084						
JULY	587	\$574,198	487	\$497,084						
AUGUST	522	\$510,177	487	\$497,084						
SEPTEMBER	608	\$595,064	487	\$497,084						
TOTALS	6,272	\$6,124,902	5,840	\$5,965,003	3,315	\$3,451,256	(880)	(\$965,836)		
MONTHLY AVERAGES	523		487		663					
GROSS ANNUAL COST		\$6,124,902		5,965,003		\$3,451,256		(\$965,836)		

Favorable/(Unfavorable):

Total (965,836)

COMMUNITY LIVING SUPPORTS (CLS), PERSONAL CARE (PC) & CRISIS RESIDENTIAL ALL POPULATIONS

Report Period: October 1st, 2022 through February 28th, 2023

SERVICE	FY 22/23 Budget				FY 22/23 Actual	
	Avg. Daily Rate	No. Served	Days of Service	Dollars	Dollars	Favorable / (Unfavorable)
PC/CLS	Oct	365	36,696	\$13,710,468	\$13,534,945	\$175,523
CRISIS RES.	Oct	20	413	\$391,216	\$224,614	\$166,602
CLS (SIP)	Oct	272		\$4,939,420	\$5,015,877	(\$76,457)
Annual Cost						\$265,669

Personal Care (P.C.)-hands on of daily personal activities such as laundry, feeding, bathing, etc.

Community Living Supports (CLS)-services to increase or maintain personal self -sufficiency with a goal of community inclusion, independence and productivity.

Specialized Residential (S.R.)-Licensed setting where Personal Care and Community Living Supports occur.

Supported Independent Program (SIP)-more independent setting where Personal Care and Community Living Supports occur.



Community • Independence • Empowerment

Integrated Services of Kalamazoo

MOTION

Subject:	<u>February 2023 Disbursements</u>	
Meeting Date:	March 27, 2023	Approval Date:
Prepared by:	Charlotte Bowser	<u>March 27, 2023</u>

Recommended Motion:

“Based on the Board Finance meeting review, I move that ISK approve the February 2023 vendor disbursements of \$10,191,178.13.”

Summary of Request:

As per the February 2023 Vendor Check Register Report dated 03/16/2023 that includes checks issued from 02/01/2023 to 02/28/2023.

I affirm that all payments identified in the monthly summary above are for previously appropriated amounts.

Staff: **C. Bowser, Finance Director**

Date of Board
Consideration: **March 27, 2023**