Pines Behavioral Health Utilization Management Program

FY 2022 (October 1st 2022- September 30th 2023)

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Introduction

Pines Behavioral Health is the Branch County Community Mental Health designated by the Michigan's Mental Health Code to provide mental health services to persons those most in need with the priority to those with a serious mental illness, intellectual/developmental disability, severe emotional disturbance, and/or substance use disorders. Other than persons who are uninsured, the funding for the persons served is managed by Southwest Michigan Behavioral Health (SWMBH), the Prepaid Inpatient Health Plan. SWMBH performs the benefits management function for members receiving "specialty services" under the Medicaid Managed Specialty Supports and Services Demonstration 115 Waiver, 1915(c) (i) Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs for behavioral health specialty and substance use disorder services for not only Branch County, but also Barry, Berrien, Calhoun, Cass, Kalamazoo, St Joseph and Van Buren counties. The specialty mental health services include a comprehensive set of services designed to meet the need for serious behavioral health conditions, whereas mild/moderate conditions are served by providers contracted by Medicaid Health Plans.

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

Purpose

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the dollars spent on services. Pines has accepted a

delegated UM function under the guidelines set by SWMBH. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, Flint 115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

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, 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

Pines intends to operate a high quality utilization management system for public behavioral health and substance abuse services which is responsive to community, family and individual needs. The entry process must be clear, readily available and well known to all constituents. To be effective, information, assessment, referral and linkage capacity must be readily and seamlessly available. Level of care and care management decisions must be based on medical necessity and on evidenced based, wellness, recovery and best practice. Pines is committed to ensuring use of evidence-based services with member matching that drive outcomes/results/value for taxpayer dollar and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, Pines is committed to the identification, development and use of innovative and less costly supportive services (e.g. Assistive Technology, Certified Peer Supports and Recovery Coaches, etc.) while meeting the service needs of members in this region. Pines 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 Pines Utilization Management Program shall operate under the oversight of the Medical Director. Additionally, participation on SWMBH's Regional Utilization Management (RUM) Committee shall serve in a critical role involving deliberation, consultation and proof of performance realms. The Medical Director is accountable for management of the Utilization Management Program. Jointly with the Medical Director, and the Utilization Committee provide, clinical and operational oversight and direction to the UM program and staff to ensure that Pines has qualified staff accountable to the organization for decisions affecting customers.

Committee

SWMBH has established the Regional Utilization Management (RUM) to review and provide input and coordination regarding utilization management policy, medical necessity criteria, and clinical practice, review service use, population health and satisfaction data and annually evaluate the efficiency and effectiveness of the UM Program and offer feedback related to necessary modifications. RUM's policies, procedures, and criteria are used by Pines to support the delegated function at Pines. Locally, Pines has a UM Director who reviews unexpected service requests according to established trends for medical necessity. These outliers and high cost cases are reviewed by the utilization management committee to assure compliance with regional processes and policies and to assure efficient and effective resources across all populations served.

Staffing

The local Utilization Management system consists of a Utilization Management Director who is a licensed mental health professional as well as a Certified Advanced Addiction Counselor. This individual has several years' experience working with all populations, services, and levels of care including inpatient. The UM Director works closely with the Director of Outpatient Services to assure appropriate eligibility standards are followed and oversees adjunct grant programs which are not affiliated with the Medicaid funding. At any time that the UM Director is involved in recommending a level of care or services, is involved in authorizing services, or the service requested is outside of the UM Director's scope, an alternative qualified professional who was not involved will instead provide the utilization review within their scope of practice. The alternative could be a supervisor within a different department, the CEO, a specialty behavioral health clinician, or the Medical Director. The Medical Director is the sole individual involved in hearing an appeal for a hospitalization denial, and if the initial denial were by him/her, a second psychiatrist on staff would hear the appeal in his/her stead. Requested services/units that are within the appropriate level of care for that individual, according to SWMBH's level of care guidelines, will be automatically approved.

Role of Utilization Management Staff

1. Ensure adherence to consistent and application of assessment tools, level of care guidelines and medical necessity criteria at the Local Care Management Level, recommendation for and implementation of Clinical Protocols and Clinical Practice Guidelines, and development of recommendations for UM level of care guidelines.
2. Review and provide input on the UM Program on an annual basis assuring adherence to the UM Plan.
3. Provide input regarding the outlier management program including level of care and service utilization guidelines that may be provided without authorization, level of care and typical service utilization guidelines reviewed at the local care management level and outlier levels of care and typical service utilization data reviewed by the PIHP.
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 Utilization Management functions.
5. Develop, review and act upon service utilization and outcomes data and/or reports for purposes of demonstrating consistent Uniform Benefit (including reports of under and over utilization).
6. Review and provide input regarding appropriate care delivery to members who present with high risk, catastrophic, high volume, complex or chronic conditions.
7. 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.
8. Identify practice-based evidenced measures (i.e. clinical outcome metrics) that demonstrate the overall effectiveness and impact of clinical services being rendered.
9. 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.
10. Assure adherence to related data and report specifications through cross collaboration with other applicable regional committees including the Quality Management and Customer Services.

Standards and Philosophy

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

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

An effective Management Information System(s) adequate to support the UM Program is essential to implement this UM Program as written. 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 with both Pines and SWMBH goals
5. Utilization of a managed care information system that meets meaningful use standards
6. Collection of uniform behavioral health and physical health data elements and utilization of functional assessment tools that provide input into severity of illness and a means to provide the data to SWMBH to manage over/under utilization and employ risk stratification models both in an effort to manage and impact population health.

Eligibility for Services

Customers who are diagnosed with a serious mental illness, intellectual/developmental disability, serious emotional disturbance, and have current needs based on functional impairment and level of intensity and duration of symptoms are eligible for specialty services. Customers with a substance use disorder are eligible for services if they reside within the 8 county region.

Developmental Disability: Means either of the following: 1. If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements: A. Is attributable to a mental or physical impairment or a combination of mental and physical impairments B. Is manifested before the individual is 22 years old. C. Is likely to continue indefinitely. D. Results in substantial functional limitations in three or more of the following areas of major life activities: 1. self-care; 2. receptive and expressive language; 3. learning, mobility; 4. self-direction; 5. capacity for independent living; 6. economic self-sufficiency. E. Reflects the individual's need for a combination and sequence of special, inter-disciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. 2. If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item 1 if services are not provided

Serious Emotional Disturbance: 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: 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. The following disorders are included only if they occur in conjunction with another diagnosable serious mental illness: 1. A substance use disorder 2. A developmental disorder 3. A "V" code in the diagnostic and statistical manual of mental disorders.

Substance Use Disorder (SUD): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Access to Pines Behavioral Health Services

A beneficiary may access the system for mental health and/or substance use services through any of the following avenues:

1. Requesting services directly from Pines during business and after hours' toll-free access/crisis line.
2. Face-to-Face evaluation by Pines
3. Telephonic Screening evaluation by Pines
4. Crisis behavioral health services through Pines, the prescreening unit, or the youth mobile crisis team.
5. Contacting SWMBH during business hours or through their toll-free after hours' line.

Access Standards

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

4a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard = 95%)

4b. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days. (Standard = 95%)

6. Achieve a call abandonment rate of 5% or less.
7. Average call answer time 30 seconds or less.

Admission Preference

Mental Health:

- Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.
- Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations

Substance Use:

The Code of Federal Regulations and the Michigan Public Health Code define priority population clients. The priority populations are identified as follows and in the order of importance:

a. Pregnant injecting drug user;

b. Pregnant;

c. Injecting drug user;

d. Parent at risk of losing their child(ren) due to substance use; and

e. All others.

SUD Access Timeliness Standards

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are in italics: Admission Priority Requirements.

Population	**Admission Requirement**	**Interim Service Requirement**
Pregnant Injecting Drug User	1)Screened & referred w/in 24 hrs. 2)Detox, Meth. or Residential – Offer Admission w/in 24 business hrs. Other Levels of Care – Offer Admission w/in 48 Business hrs.	**Begin w/in 48 hrs.:** Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care Early Intervention Clinical Svc

Pregnant Substance User	1) Screened & referred w/in 24 hrs. 2) Detox, Meth or Residential Offer admission w/in 24 business hrs. Other Levels of Care – Offer Admission w/in 48 Business hrs.	**Begin w/in 48 hrs.** 1. Counseling & education on: A. HIV & TB B. Risks of transmission to sexual partners & infants C. Effects of alcohol & drug use on the fetus 2. Referral for pre-natal care 3. Early Intervention Clinical Svc
Injecting Drug User	Screened & Referred w/in 24 hrs.; Offer Admission w/in 14 days	**Begin w/in 48 hrs. –** **maximum waiting time** **120 days** 1. Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants 2. Early Intervention Clinical Svc
Parent at Risk of Losing Children	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	**Begin w/in 48 business hrs.** Early Intervention Clinical Services
All Others	Screened & referred w/in seven calendar days. Capacity to offer Admission w/in 14 days	**Not Required**

Level of Intensity of Service Determination

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

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

Coordination and Continuity of Care

Pines is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance use treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed in a uniform electronic medical record with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH 8-county region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/Developmental Disabilities, and the ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical

professionals. Treatment plans are developed during through person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

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

1. Access and Eligibility: Timely access to services including proper adherence to eligibility standards, and meeting access standards.
2. Clinical Protocols: To ensure Uniform Benefit for Customers, consistent use of functional assessment tools, medical necessity, level of care and regional clinical protocols
3. Service Authorization: Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness

The Pines Utilization Management plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and under-utilization across populations. The Utilization Management Plan endorses two core functions.

1. Outlier Management of identified high cost, high risk service outliers or those with need displaying an under-utilization of services.
2. The Outlier Management process provides service authorization determinations and applicable appeal determinations as requested. Service authorization determinations are delivered via an electronic medical record with embedded level of care tools and guidelines. Outlier Management and level of care guideline methodology is based upon service utilization across the region, with set ranges adopted for each CMH as a result of that overall utilization. The model is flexible and consistent based upon utilization and funding methodology.
   The Utilization Review process uses reports generated by SWMBH to ensure intensity of service matching level of care with services and typical service utilization. Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted by the department in question to address any performance deficits. Quality Management/Compliance staff monitor the implementation of the Corrective Action Plans.

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 data and scores and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Review Activities

Utilization Management

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

Determination of Medical Necessity

Treatment under the customer's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, intellectual/developmental disabilities, and substance abuse supports and services and provider qualifications are found in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. For the purposes of utilization control, Pines 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. The same criteria are applied to persons served that are non-Medicaid. Levels of Care, service utilization expectations, changes (if any) in MDHHS Medicaid criteria or professional qualifications requirements, and utilization management standards are reviewed annually in conjunction with the SWMBH RUM Committee with final approval by the SWMBH Medical Director for Medicaid and Pines Medical Director for non-Medicaid.

Services selected based upon medical necessity criteria are:

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

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the member.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate
3. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the customer and provider.
4. Well-publicized and readily available appeals mechanisms for both providers and members exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction or other appropriate measures.

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 SWMBH and Pines member handbooks and websites.

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), Pines 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. The Levels of Care and Core Service Menus for adults with mental illness, youth with emotional disturbances, adults with intellectual and developmental disabilities, and persons with substance use disorders. The levels and service menus that were developed in 2016, updated in 2020 and 2022.

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.

Pines authorizes and provides medically necessary services according to the ASAM Levels of Care for SUD. For authorization of any Exception, the UM Director 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 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 can be provided upon request.

Not all Medicaid-eligible persons with mental illness or emotional disturbances are eligible for Specialty Behavioral Health 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 CCBHC services or Medicaid health plans, if they have Medicaid. Non-Medicaid persons with mild to moderate symptoms are offered groups through CCBHC (Branches) and/or referred to other resources including private mental health agencies. All persons with substance use disorders and intellectual and developmental disabilities are provided by Pines.

Crisis Services

Crisis services are considered a benefit for anyone who is physically in our county 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)

Consumers 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)

Consumers 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)

Consumers 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)

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

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

Consumers 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 through the CCBHC Branches program or may be provided in the community.

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

Consumers 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. Treatment is generally provided through the CCHBC Branches program or in the community.

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. CCBHC Branches services are available at this level if desired. 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 Specialty Behavioral Health 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, unless approved by SWMBH,

or

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

Levels of Care for Children (Infant – 18) with Serious Emotional Disturbance or Co-occurring SED and Substance Use Disorders

Level V Acute Need

Customers in this level of care are Children (8-18) with a CAFAS score of 140 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 IV – High Need

Customers in this level of care are Children (8-18) with a CAFAS score of 140 or higher 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 Ill — Moderate Need

Customers in this level of care are Children (8-18) with a CAFAS score of 100-139 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 Il — Low Need

Customers in this level of care are Children (8-18) with a CAFAS score of 60-99 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 infrequent need.

Level I — Minimal Need

Customers in this level of care are Children (Infant-18 with a CAFAS score of 59 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. It is anticipated that the PECFAS and potentially the DECA will be incorporated into the EMR at a future date to provide for the ability to determine levels for children younger than 8.

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.

Once meeting the thresholds for SED eligibility, below are the typical levels of care:

Levels of Care for Children (ages 7 – 17) with Serious Emotional Disturbance or Co-occurring SED and Substance Use Disorders. The Child and Adolescent Functional Assessment Scale (CAFAS) is utilized to identify level of care needs for the purpose of assessment and treatment referral and service provision.

Level V - Acute Need

Youth in this level of care are children (7-17) with a CAFAS score of 140 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 IV – High Need

Youth in this level of care are children (7-17) with a CAFAS score of 140 or higher 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 III – Moderate Need

Youth in this level of care are children (7-17) with a CAFAS score of 100-139 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 II – Low Need

Youth in this level of care are children (7-17) with a CAFAS score of 60-99 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 I – Minimal Need

Youth in this level of care are children (7-17) with a CAFAS score of 59 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. It is anticipated that the PECFAS and potentially the DECA will be incorporated into the EMR at a future date to provide for the ability to determine levels for children younger than 7.

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. Levels of care for adults with I/DD yet to be determined)

Level VI- Acute

Customers receiving services at this level of care are adults (18 years or older) and demonstrate extraordinary behavioral need typically provided in an acute care setting or a nursing home

Level V – Intense Need

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate extraordinary medical needs and/or extensive behavioral needs and require total assistance on a daily basis may require 1:1 or higher level of staffing
Poorly managed, volatile; needs support, frequent interventions/monitoring necessary

Low impulse control, active safety risk to self or others

Level IV – High Need

Customers receiving services at this level of care are adults (18 years or older) and typically demonstrate substantial behavioral needs and require multiple daily reminders to engage or complete activities and personal support which may include enhanced staffing (up to & including physical assistance); frequent hands-on assistance. Safety risks to self or others and/or need for environmental accommodations

Level III – Moderate Need

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

Level II – Low Need

Customers receiving services at this level of care are adults (18 years or older) and typically require occasional verbal prompts/reminders, coaching, and/or training to engage or complete activities (weekly or less) and monitoring of support needs with changes as situation dictates. Mild/moderate behavioral issues without the need for a Behavior Management Plan. Minimal safety risk

Level I – Minimal Need

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

Levels of Care for Children Developmental Disabilities (infants-18) (Tool TBD)

Level V – Intense Need

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

Level IV – High Need

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

Level III – Moderate Need

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

Level II – Low Need

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

Level I – Minimal Need

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

Levels of Care for Substance Use Treatment Services for Adults and Adolescents

Level 0.5 – Early Intervention

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

Level 1.0 – Outpatient Services

Community-based substance use outpatient treatment of less than 9 hours per week for adults and less than 6 hours per week for youth. Treatment is directed at recovery, motivational enhancement therapy and strategies to reduce or eliminate substance use and

improve ability to cope with situations without substance use.

Level 2.1 – Intensive Outpatient

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

Level 2.5 – Partial Hospitalization

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

Level 3.1 – Clinically-Managed Low-Intensity Residential

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

Level 3.3 – Clinically-Managed Medium-Intensity Residential

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

Level 3.5 – Clinically Managed High Intensity Residential

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

Level 3.7 – Medically-Monitored Intensive Inpatient

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

Level 4 – Medically-Managed Intensive Inpatient

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

Level I-D – Detoxification

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

Level OMT – Opioid Maintenance Therapy

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

Review Process

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

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

Outlier Management

An integral part of the Utilization Management Program is continued development and implementation of its outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focus versus intensive and costly utilization controls. The design encompasses review of resource utilization of all customers. 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 provider(s) and customers.

1. Outlier Definition
   An "Outlier" is generally defined as significantly different from the norm. Pines defines the following types of "outliers":
   - Customers 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
2. Outlier Identification
   Multiple tools are available for monitoring, analyzing and addressing outliers. Performance Indicator Reports (MDHHS required performance standards), service utilization data, and Cost Analysis Reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and available on the SWMBH portal and reviewed by Pines and RUM Committee to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3. Outlier Management Procedures

A. As outliers are identified, protocol driven analysis will occur 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 by the Pines UM Committee to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between staff and the UM Committee and/or the customer or the provider as needed, to ensure understanding of the utilization trends or patterns.

C. If the utilization trends or patterns are determined to require intervention at the provider or the individual level, collaborative corrective action plans are discussed with the staff and/or provider. Corrective action plans include:

   1. Brief description of the finding(s) and supporting information;

   2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps;

   3. A description of the monitoring to be performed to ensure that the steps are taken;

4. A description of the monitoring to be performed that will reflect the resolution of the situation.

5. Following initial review and efforts for resolution at a desk audit level, the disposition can include either positive resolution or advance to next level of review;

6. Following consultation, recommendations are reviewed with the UM Committee and the Medical Director for disposition determination. The MD and/or UM Committee will review the recommendations, corrective action plans and processes undertaken to resolve the outlier event(s) and render final disposition.

D. The MD and UM Committee 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 staff and provider action(s),

3. Clinical Peer Review -The Peer Review consists of review, consultation, and recommendations for resolution.

4. Render final disposition.

5. Provide recommendations for action for remediation to the SWMBH CEO

E. If the utilization trends or patterns are determined to be systemic in nature, collaborative corrective action is jointly discussed at the regional committee level for input/guidance. Corrective action includes:

1. Brief description of the finding(s) and supporting information;

2. Specific steps to be taken to correct the situation and a timetable for performance of specified corrective action steps at the PIHP and CMHSP/Provider level;

3. A description of the monitoring to be performed to ensure that the steps are taken;

4. A description of the monitoring to be performed that will reflect the resolution of the situation.

5. Following initial review and efforts for resolution, the review findings can include

either positive resolution or advance to next level of review with consultation with the provider conducted by assigned PIHP staff;

F. If the utilization trends or patterns are deemed by SWMBH as needing a PIHP level remedy, the following possibility may ensue:

1. Non-payment for case.
2. Plan member switch to new provider.
3. Provider loss of "Delegated Benefit Management" status.
4. Loss of credential for specified service(s).
5. Pro-rata payback on class of cases.
6. Contract Amendment (modification of performance expectations, compensation, or range of services purchased).
7. Removal from provider panel.

Data Management

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

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

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for customers can be assigned. This work allows for people to be assigned categories of expected services and addresses a uniform benefit throughout the region. It'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 as part of the Quality Improvement Program and is referenced in the QI Program Plan. Providers, customers and general stakeholders can access the UM plan through

the Pines website.

Availability of Utilization Management Staff

Pines staff responsible for making service related decisions are available from 8:00 a.m. to 5:00 p.m. Monday through Friday of each normal business day. Staff generally respond to email and telephonic communications within one business day during normal business hours. UM requirements and procedures are made available upon request as well as contained in the provider manual and in the customer handbook. When a denial determination occurs, Pines provides the opportunity for the requesting customer or provider to discuss the determination with either the reviewer making the determination or, if not available within one business day, a different clinical peer reviewer.

After-hours emergency services are available to customers telephonically and face to face 24 hours a day, 7 days a week. Voicemail is available for customers and providers wishing to leave a general message regarding routine service concerns.

Peer Clinical Review

Pines staff involved in making service decisions are available to discuss authorization decisions with the requesting customer, provider and attending physician (if applicable). The Utilization Management staff assist with physician to physician communication with the Medical Director and assist in obtaining relevant clinical information and documentation for review. When a decision is made to deny an authorization request, UM staff provides within one business day, upon request, the opportunity to discuss the determination with the UM Peer Reviewer who made the determination, or another Peer Clinical Reviewer of same professional stature if the original reviewer cannot be available, within one business day. If this peer review 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 quarterly by the UM Committee to determine trends and identify areas of improvement. The purpose of this evaluation is to improve the care provided to PBHS consumers. This committee serves as an oversight to the UM Department to assure consistency and understanding of a 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, freque4ncy and mode) an individual will receive during a specific stage of treatment.

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

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

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

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

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

1) A substance use disorder

2) A developmental disorder

3) A "V" code in the diagnostic and statistical manual of mental disorders

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

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

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

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

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

Roles

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

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

Shared Role (Director of Clinical Quality, Local Care Manager designees and RUM Committee): Regularly review UM analytic management reports. Identify trends and variations, including gaps in

completeness, timeliness and accuracy of applicable Data. Annual statistical analysis of LOC Guidelines with modifications as necessary. Adjust business process and/or decision trees as necessary. Sample and discuss aggregate service type anomalies. Sample and discuss case outliers.

References/Additional Guiding Documents

SWMBH Level of Care Guidelines date 10.01.19-09.30.20

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Revised: 03/12/2020
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Revised: 05/02/2022
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