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 24

Table of Contents

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), Health 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. Additional established and integrated assurances exist within the Utilization Management Program and Utilization Management department to ensure distinct separation between service determination, authorization, and direct service delivery to mitigate against risks of conflict of interest.

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, Corporate Compliance, Quality Management, and each population's Senior Executives and Managers. 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 bi-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' 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 and Power BI 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	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

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, 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 as adopted by SWMBH. Authorization/service determination functions are dictated by policies and practices to ensure that appropriate staff with roles separate from providing ongoing direct service delivery are responsible for the review and authorization of medically necessary services.
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 (Functional Assessment Tool TBD)

MDHHS chose not to renew the contract for use of the SIS (Supports Intensity Scale) and has not determined another standardized Level of Care tool to date. Biopsychosocial and other applicable needs assessments will be utilized, and medical necessity criteria will document the individual's needs based on the person-centered planning process. At the time MDHHS selects a standardized assessment tool, policies and plans will be updated to reflect the new contractual standards.

Level VI- Acute (Any functional support needs, extraordinary medical and/or behavioral support needs).

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).

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).

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).

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.

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).

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, ISK Power BI reports, 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 Utilization Management 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, Manger Utilization Management, and the Utilization Management 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: _____ 3/1/2024

Signature/date of review

Medical Director: _____

Signature/date of review