MSHN
Mid-State Health Network

# POLICIES AND PROCEDURE MANUAL

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| **Chapter:** | **Utilization Management** | | |
| **Title:** | **Utilization Management Procedure** | | |
| **Policy:** ☐<br>**Procedure:**☒<br>**Page:** 1 of 8 | **Review Cycle:** Biennial<br>**Author: Chief Population Health Officer**<br>and UM Committee | **Adopted Date: 04.2022**<br>**Review Date: 05.07.2024** | **Related Policies:**<br>Utilization Mgmt: Access Policy<br>Utilization Mgmt: UM Policy<br>Service Delivery System: Service Philosophy;<br>Level of Care System (LOC) for Parity |

## Purpose

To establish consistent standards for all aspects of the Mid-State Health Network (MSHN) regional utilization management program, including those functions which are retained by MSHN and those which are delegated to its Community Mental Health Service Program (CMHSP) Participants.

## Procedure

The Utilization Management (UM) Committee is the primary body responsible for evaluating the utilization of MSHN provider network services and making recommendations to the MSHN Chief Executive Officer (CEO), Deputy Director and the Operations Council (OC). The UM Committee is responsible for reviewing aggregated and trend data related to the implementation and effectiveness of the UM plan.

- Utilization Management Committee: The UM Committee is comprised of the MSHN Chief Population Health Officer, MSHN Utilization Management Administrator, and the CMHSP Participants' Utilization Management staff appointed by the respective CMHSP Participant CEO/Executive Director (ED). All CMHSP Participants shall have equal representation on this committee. Retained and delegated UM functions are outlined in the MSHN Utilization Management Delegation Grid (Attachment A).
- Operations Council: The Operations Council reviews reports concerning utilization and quality improvement matters as identified by the Quality Improvement Council (QIC) and UM Committee and makes recommendations for regional planning and improvement to the MSHN CEO. The Operations Council shall be comprised of the CEO/ED of each CMHSP Participant.

Utilization Management Plan

MSHN shall create, implement and maintain a region-wide UM Plan that complies with applicable federal and state statutes, laws and regulations. The MSHN UM Plan shall adhere to regulations established by governing bodies including the Michigan Department Health & Human Services (MDHHS), Medicaid Services Administration, Centers for Medicaid and Medicare, and relevant accrediting bodies. Annually, MSHN and the UM Committee shall conduct a review of the UM Plan and its stated priorities to assure program effectiveness.

A. The MSHN UM Plan shall be implemented in a manner which remains true to MSHN Service Philosophies, particularly person/family centeredness, self-determination, cultural sensitivity, trauma informed/sensitive, and responsiveness to co-occurring (dual-diagnoses) conditions.
B. All CMHSP Participants/Provider Network shall create policies and procedures necessary to fulfill all aspects of the MSHN UM Plan that include criteria for evaluating medical necessity and processes for reviewing and approving the provision of services.
C. MSHN will monitor CMHSP Participant/Provider Network follow-through, specifically evidence of local monitoring for over/under utilization, consistent and responsive to regionally identified patterns and trends.

D. All CMHSP Participants/Provider Network shall establish procedures for prospective (preauthorization), concurrent, and retrospective authorizations. Procedures shall ensure that:
    1. Any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested are made by a health care professional who has appropriate clinical licensure and expertise in treating the beneficiary's condition.
    2. Efforts are engaged to obtain all necessary information, including pertinent clinical data and consultation with the treating physician or prescriber as appropriate for decision making.
    3. Reasons for decisions are clearly documented and readily available to service recipients.
    4. Appeals mechanisms for both providers and service recipients are well-publicized and readily available. Notification of denial decisions shall include a description of how to file an appeal and shall be provided to both the beneficiary and the provider.
    5. Decisions and appeals are conducted in a timely manner as required by the exigencies of the situation.
    6. Mechanisms are implemented to evaluate the effects of the program using data related to consumer satisfaction, provider satisfaction, or other appropriate measures.
    7. Mechanisms are in place to ensure the consistent application of review criteria for authorization decisions. Each CMHSP Participant has a standardized interrater reliability process that includes elements such as but not limited to: use of test case scenarios, reviewing the performance of each authorization decision-maker, taking corrective action when appropriate, and using the overall interrater reliability results to conduct targeted training and update policies and processes, as necessary, to improve consistency in authorization decision-making. For small CMHSPs that may only have one or two UM staff members, a peer review process may be used instead to ensure consistent understanding and application of medical necessity criteria to authorization decision-making.

<u>Eligibility Determination:</u>
The determination of eligibility will be based upon the target populations as provided in the MDHHS/Pre-paid Inpatient Health Plan (PIHP) Medicaid Managed Specialty Supports and Services Contract, and the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter of the Medicaid Provider Manual (MPM) if the individual is a Medicaid beneficiary. Eligibility determinations and verification of medical necessity will be performed by CMHSP Participants for mental health services, and by Substance Use Disorder (SUD) service providers for substance use disorder services.

Eligibility determinations occur at initial entry into an episode of care, and on an ongoing basis during an episode of care. Initial eligibility is determined through the access screening process to determine the likelihood of a mental illness, serious emotional disturbance, substance use disorder, or intellectual/developmental disability. Ongoing eligibility is determined by provider clinical reviews and/or UM continued stay reviews. Ongoing eligibility reviews shall be used to ensure that the individual continues to qualify for ongoing services.

Certain Medicaid services have additional requirements for service eligibility or medical necessity, including enrollment/certification and/or specialized testing/evaluation, which are outlined in the MSHN UM Plan. This includes persons who may be eligible for the Habilitation Supports Waiver (HSW) and/or the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit that further delineates eligibility for autism services (also referred to as the expanded Autism Benefit). The HSW and EPSDT policies are referenced in the subsequent References/Legal Authority Section of this Policy.

<u>Medical Necessity</u>
The MSHN region will operate within a common definition of medical necessity for services, which must be consistently applied region-wide according to the Medicaid Provider Manual. The following medical necessity criteria apply to the MSHN Medicaid behavioral health and substance use disorder supports and services.

- Necessary for screening and assessing the presence of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Required to identify and evaluate a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, serious emotional disturbance, intellectual/developmental disability, or substance use disorder and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or intellectual/developmental disabilities, based on person-centered planning, and for beneficiaries with substance disorders, individualized treatment planning that directs the provision of supports and services to be provided; and
- Made by appropriately licensed and trained mental health, intellectual/developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Based on documented evidenced-based criteria for determination of scope, duration and intensity; and
- Documented in the individual plan of service.

Supports, Services and Treatment Authorized by the PIHP (through the CMHSP Participant) must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

Using criteria for medical necessity, a PIHP (through its Provider Network) may deny services that are:

- Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- Experimental or investigational in nature;
- For which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

Authorization for Treatment & Support Services:
Initial and ongoing approval or denial of requested services is delegated to the local CMHSP Participants. This approval or denial includes the screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community mental health services. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals shall be provided in accordance with the Medicaid Managed Specialty Supports and Services contract with the MDHHS. The reasons for treatment decisions shall be clearly documented and available to Medicaid beneficiaries. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. MSHN shall monitor affiliate authorization, second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

1. Utilization reviews are conducted using medical necessity criteria adopted or developed specifically to guide the level of care and appropriate care planning (Medicaid Provider Manual). This may include, but is not limited to, appropriate length of stay for each level of care according to identified needs of the beneficiary in order for payment to be authorized.
2. The responsibility for managing the utilization of clinical care resources is delegated to the MSHN provider network/professional staff members who assess the needs of and authorize care for beneficiaries receiving services funded by the PIHP.
3. Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:
    a. Accurate and consistent with medical necessity criteria;
    b. Consistent with Medicaid eligibility, entry, continuing stays and discharge criteria as applicable;
    c. Consistent with formal assessments of need and beneficiary desired outcomes;
    d. Consistent with established guidelines (Medicaid Provider Manual);
    e. Adjusted appropriately as beneficiary needs, status, and/or service requests change;
    f. Timely;
    g. Provided to the consumer in writing as to the specific nature of the decision and its reasons;
    h. As applicable, shared with affected service providers verbally or in writing as to the specific nature of the decision and its reasons if there are any concerns with decisions made;
    i. clearly documented as to the specific nature of the services authorized or denied and the reasons for denial; and
    j. Accompanied by the appropriate notice to consumers regarding their appeal rights with a copy of the notice placed in the consumer's clinical case record.
4. Timeliness of authorization decisions and issuing of appropriate notice to consumers:
    a. For a service authorization decision that denies or limits services, notice must be provided to the member within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision.
    b. For service authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, this constitutes a denial and thus the member must receive notice of Adverse Benefit Determination (ABD) on the date that the timeframe expires or a standardized 14-day extension notification letter.
    c. The CMHSP (by delegated function of the PIHP) may extend the standard or expedited service authorization timeframe in certain circumstances for up to an additional 14 calendar days. Circumstances in which an extension may be acceptable include: the consumer requests the extension; awaiting the results of assessment/testing that will inform service level recommendations; additional information is needed from the service provider that submitted the authorization request on behalf of the consumer in order to determine medical necessity of the services being requested; other reasons if the extension is in the best interest of the consumer. If so, the CMHSP must:

i. Provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if s/he disagrees with that decision; and
ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d. Each CMHSP participant must ensure that it has an established policy/procedure identifying the responsible staff and the method for tracking the timeframe for issuing of an Adverse Benefit Determination (ABD) or the issuing of a standardized 14-day extension notification letter.

5. MSHN CMHSP Participants shall not deny the use of a covered service based on preset limits of units or cost, amount, scope, and duration of service; but instead reviews the continued medical necessity on an individualized basis.

6. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

7. Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 Code of Federal Regulations (CFR) 438.208(c)(4). This standard does not apply to SUD Community Grant services.

<u>Eligibility and Authorization for 1915(i) Services and Supports</u>
Additional services and supports are available to Medicaid beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability through the §1915(i) State Plan Amendment (SPA) for home and community-based services in accordance with §1915(i)(7) of the Social Security Act. The intent of the §1915(i) SPA is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. Service settings must meet the home and community-based setting requirements as specified in the SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

All CMHSP Participants shall verify the following eligibility criteria are met for individuals receiving 1915(i) services and supports:

- The individual has at least 1 (one) functional impairment in the areas below:
  - Self-Care
  - Mobility
  - Economic self-sufficiency
  - Communication
  - Self-Direction
  - Learning
  - Capacity for independent living
- AND; Without 1915(i) services the individual is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, or community inclusion and participation.

The authorization and use of Medicaid funds for any of the §1915(i) SPA supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the Michigan Medicaid Provider Manual

- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary
- 1915(i) eligibility of enrolled individuals is reevaluated at least annually
- The service(s) being expected to achieve one or more of the following home and community-based goals as identified in the beneficiary's plan of service:
    - Community Inclusion and Participation
    - Independence
    - Productivity

**Applies to:**

☒ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☒ Other: Sub-contract Providers

**Definitions/:**

ABD: Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services

Appeal: A review at the local level by a PIHP or CMHSP or an Adverse Benefit Determination, as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery

CEO: Chief Executive Officer

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program (inclusive of Substance Use Service Provision, coordination and administrative oversight)

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Contractual Provider: refers to an individual or organization under contract with MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP Participants who hold retained functions contracts

ED: Executive Director

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

Employee: refers to an individual who is employed by the MSHN PIHP

Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision

HSW: Habilitation Supports Waiver

MDHHS: Michigan Department of Health and Human Services

MPM: Medicaid Provider Manual

MSHN: Mid-State Health Network

OC: Operations Council

PIHP: Pre-paid Inpatient Health Plan

Provider Network: refers to MSHN CMHSP Participants and SUD providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements

QIC: Quality Improvement Council

SPA: State Plan Amendment

Staff: refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD providers

Subcontractors: refers to an individual or organization that is directly under contract with CMHSP and/or MSHN to provide behavioral health services and/or supports.
SUD: Substance Use Disorder
UM: Utilization Management

**Related Materials:**
MSHN Utilization Management Plan

**References/Legal Authority:**
1. Appeal and Grievance Resolution Processes Technical Requirement: MDHHS, revised July 29, 2020
2. Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans: MDHHS, Current Year
3. Michigan Mission-Based Performance Indicator System, Version 6.0 for PIHPs, Current Year
4. MDHHS Medicaid Providers Manual, Current Edition
5. MSA Bulletin: Mental Health/Substance Abuse 04-03 (Prepaid Inpatient Health Plans)
6. 42 CRF 438.210(b)(1-2); 42 CFR 438.404c(5)(6)

**Change Log**:

| Date of Change | Description of Change | Responsible Party |
|---|---|---|
| 04/01/2022 | New Procedure | Director of Utilization & Care Management |
| 02.22.2024 | Biennial Review – added language regarding the need for standardized interrater reliability process | UMC |

**Attachment A**
**MSHN Utilization Management Delegation Grid**

| **PIHP Delegated Activity** | **Retained or Delegated?** | **If Retained:** Conducted internally by MSHN or contracted? |
|---|---|---|
| Prospective approval or denial of requested service as guided by the regional Level of Care System (LOC) for parity:<br>- Initial assessment for and authorization of psychiatric inpatient services;<br>- Initial assessment for and authorization of psychiatric partial hospitalization services;<br>- Initial and ongoing authorization of services to individuals receiving community-based services;<br>- Grievance and Appeals, Second Opinion management, coordination and notification;<br>- Communication with consumers regarding UM decisions, including adequate and advanced notice, right to second opinion and grievance and appeal | ___ Retained by MSHN<br><br>☑ Delegated to local CMHs<br><br>*This topic has been marked as an implementation issue requiring the development of a specific policy or procedure at the MSHN level. | ☐Conducted by MSHN<br><br>☐Contracted |
| Local-level Concurrent and Retrospective Reviews of affiliate Authorization and Utilization Management decisions/activities to internally monitor authorization decisions and congruencies regarding level of need with level of service, consistent with PIHP policy, standards and protocols. | ___ Retained by MSHN<br><br>☑ Delegated to local CMHs | ☐Conducted by MSHN<br><br>☐Contracted |
| Persons who are enrolled on a habilitation supports waiver must be certified as current enrollees and be re-certified annually. A copy of the certification form must be in the individual's file and signed by the local CMHSP representative. | *This will be a **local responsibility** that is **prompted centrally by MSHN**. It will be a central responsibility to manage the resource of waiver slots and provide oversight. | ☒Conducted by MSHN<br><br>☐ Contracted |
| Development, adoption and dissemination of Practice Guidelines (PGs), Medical Necessity Criteria, and other Standards to be used by the local CMHSP. 42 CFR: 438.236: Practice Guidelines | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |
| Development, modification and monitoring of related PIHP UM Policy, Procedures and Annual Plan as part of the Affiliation QI Plan. | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |
| Review and Analysis of the CMHSP's quarterly utilization activity and reporting of services. Annual review of each CMHSP's and the PIHP's overall Utilization Activities. | ☑ Retained by MSHN<br><br>___Delegated to local CMHs | ☒Conducted by MSHN<br><br>☐Contracted |