



UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Behavioral Healthcare, Inc. (BHI) maintains a comprehensive and effective Utilization Management (UM) Program to monitor access to the outcomes, appropriate utilization, level and intensity of covered behavioral health services. BHI utilization review comprises a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, efficacy and efficiency of health care services, referrals, procedures and settings. BHI reviews the appropriateness of members' use, consumption, level and intensity of care in a fair, impartial and consistent manner. The UM Program supports BHI client recovery by ensuring consistent access to the most effective and least restrictive medically necessary behavioral health services. UM functions are designed to never impede timely access to behavioral health services.

Utilization management at BHI is under the direction of Jennifer Conrad, MSW, LCSW. The UM Director works in collaboration with the BHI UM Committee, the BHI Quality Improvement (QI) Department and all providers within the BHI Provider Network. This interdisciplinary group of staff members and providers plays a major role in formulating the priorities of the BHI UM Program including development and dissemination of BHI Medical Necessity Criteria; standardization of UM and clinical decision-making processes; identification and analysis of over/under-utilization of services at all levels of care; development of access to care standards; and development and monitoring of performance measures.

All of the requirements and supporting documentation of BHI's UM Policies and Procedures Recommended Minimum Set comply with CMS Regulations at 42 CFR Section 438 *et seq*, the National Commission on Quality Assurance (NCQA) UM Standards and Guidelines for the Accreditation of Managed Behavioral Health Organizations (MBHOs), and the Mercer Audit Recommendations. The elements of the UM Program described in the remainder of this section are addressed through BHI policies and procedures, clinical documentation, committee meeting minutes, annual UM Program descriptions and evaluations, provider and facility contracts, delegation oversight agreements, key UM staff job descriptions, training of BHI staff and contracted providers and the BHI Provider Manual and utilization review (UR) notes. These required activities and documentation are in place at BHI.

Key UM Staff

BHI UM functions and goals are overseen by the BHI UM Department and include activities performed by the BHI UM staff, the BHI Chief Medical Officer (CMO) and all other entities that perform delegated UM functions. The UM Department has sufficient qualified staff members to review and authorize health care, prior authorizations, concurrent and retrospective reviews and to coordinate inpatient certification and recertification of need. The BHI UM Department operates under the leadership of the UM Director, Jennifer Conrad, MSW, LCSW, who works in consultation with the BHI Chief Medical Officer (CMO), Eve Wood, MD, and the BHI Chief Executive Officer (CEO), Roger Gunter.

Utilization Management Director

The UM Director maintains responsibility for the direction and leadership of all BHI UM functions including supervision of UM staff, program direction and oversight, policy development, data gathering and reporting. The UM Director establishes, updates and disseminates, monitors and ensures compliance with UM Department policies and procedures; promotes collaboration and consistency in UM processes throughout the BHI system; identifies, reports and analyzes key UM performance indicators; monitors over- and under-utilization; issues Actions related to discontinuation of inpatient hospitalization; conducts and oversees all delegated UM functions; provides training to BHI providers and staff and policy clarification and assistance to all delegates; and evaluates the BHI UM program annually.

Chief Medical Officer

The position of BHI Chief Medical Officer (CMO) is a Colorado-licensed, board-certified psychiatrist who has responsibility for the effective implementation of clinical/medical programs and quality management and utilization management programs in compliance with federal and state laws and the requirements of the RFP. The Chief Medical Officer (CMO) is involved in key aspects of the UM program including but not limited to Notice of Action and appeal decisions, medical necessity criteria development, development, review, dissemination and training of clinical practice guidelines, new technology reviews, reviewing inpatient reviews for medical necessity, doctor-to-doctor consultations with attending physicians to determine appropriate level of care, oversight of denied claims, identifying barriers to admission, discharge, and disposition, and oversight of clinical decision making.

Utilization Review (UR) Manager

The BHI UR Manager provides utilization review, is responsible for the appeals process, prior service authorization, participates in inter-agency meetings and complex case reviews, tracking, monitoring and oversight of behavioral health services for the BHI Contracted Provider Network, including specialty services and the out-of-area Medicaid client population from throughout Colorado served by BHI. The UR Manager provides back-up responsibilities for the UM Director as needed.

UR Coordinator

The BHI UR Coordinator provides utilization review (UR), is responsible for the preauthorization and reauthorization for inpatient and other acute levels of care, participates in inter-agency meetings and complex case reviews, tracking, monitoring and oversight of behavioral health services for the BHI Contracted Provider Network. The UR Coordinator provides back-up responsibilities for the UM Director as needed.

UM Criteria

BHI has established UM criteria for all of its providers that serve as the basis for consistent and clinically appropriate service authorization decisions for all levels of mental health and co-

occurring mental health and substance abuse care. The UM criteria consistently support BHI adopted clinical practice guidelines, and serve as a tool to promote sound and efficient utilization of available resources. BHI UM criteria are consistent with the UM criteria defined by HCPF Medicaid Managed Care Rules and Regulations. Medical necessity is determined through the evaluation of a number of factors that include:

- Client and family/guardian identification of preferences and goals for recovery;
- Ongoing consultation with the provider throughout the episode of care to determine the medical necessity of needed services as determined by changes in the client's condition and treatment needs; and
- Consultation with the client, family, informal supports and/or person with legal custody about the treatment history, which identifies unique or special client needs, including cultural considerations, communications needs and special clinical circumstances that may necessitate a unique approach to treatment, based on Clinical Practice Guidelines as applicable.
- All consultation with requesting providers, Members, guardians, family or designated client representatives will be documented.

The BHI UM Criteria are a synthesis of scientific research, professional literature review, accepted evidence-based practices, industry standards from the American Psychiatric Association (APA) and NCQA and best practice outcome data. The UM criteria take into account individual needs and the local delivery system. They were developed by a multi-disciplinary committee and are informed by input from BHI clinicians, psychiatrists and clients.

A multidisciplinary committee of mental health professionals is responsible for periodically reviewing and updating UM criteria.

BHI UM criteria do not supplant provider judgment. A medical review is recommended in any circumstance that is unusual or not specifically addressed by the UM criteria. The UM criteria are disseminated to all providers upon acceptance into the network and at the time of criteria revision through the BHI Provider Manual, the BHI provider contract and through the BHI website. The UM criteria also are available to any interested party, including clients, family members and advocates, through the BHI website or in hardcopy upon request.

Monitoring Over- & Under-Utilization

Key quantitative measures of over- and under-utilization include penetration rates by age, ethnicity, and geographic area; inpatient recidivism at seven, 30 and 90 days; inpatient length of stay by age group and geographic area, and inpatient admissions and days per 1,000 consumers by age group and geography. The aggregate data that is analyzed for over- and under utilization includes quarterly performance data on key indicators of BHI enrollment, penetration rates, client satisfaction, resolution of client grievances and appeals, peer review of treatment records,

outcome measures, and utilization of crisis, inpatient, emergency department and outpatient services.

Performance data is analyzed and trended to identify normal and special cause variation such as outliers, and provide detailed comparative data against local and national benchmarks. Previous and overall BHI performance data is used in this analysis and problem identification. Aggregate provider performance is evaluated by client age group, ethnicity and Medicaid aid category. Report cards provide management and staff with the ability to quickly analyze information at the program level. BHI benchmark data allows for comparison of BHI performance to other Behavioral Health Organizations (BHOs) across age groups, level of care, ethnicity and other domains.

The BHI UM Department identifies and examines utilization patterns outside of established criteria ranges through examination of individual and aggregate grievances and appeal data; peer review of Quality of Care Concerns (QOCC) related to UM, such as receiving service authorizations outside of required timelines; participation by a member of the BHI UM Department in hospital review meetings, interagency staffing and difficult or complex case reviews; and UM Department participation at meetings of the Risk and Resource committees, Provider Advisory Council and UM Committee.

In each of these venues, details regarding individual clinical cases are discussed, allowing case-by-case identification of access issues, barriers to discharge from higher levels of care, over- and under- utilization of services, provider-specific UM issues and gaps in the BHI service continuum. This process can uncover barriers to appropriate service utilization that may not be reflected in aggregate data and provides case examples that may be useful in explaining identified trends. Collected data is reviewed and analyzed by the UM Committee. The committee develops corrective action plans for areas of concern identified in the UM Program. The UM Committee is responsible for oversight of any corrective action plans (CAPs) that are implemented.

Additional activities to identify and address under-utilization include the identification of BHI clients who discontinue care prematurely. It is BHI's policy to take appropriate and timely steps to contact clients to promote the continuation of needed behavioral health services while addressing any identified barriers to care at the same time. BHI evaluates the specific circumstances of each client who no-shows or unexpectedly cancels an appointment in order to perform outreach, determine the status of the client's treatment needs and identify any barriers and a plan to overcome them.

Utilization Review (UR) Decisions

Prior authorization is required for services through BHI, with the exception of emergency and post-stabilization services, and client-run alternative services, including drop-in centers, clubhouse and peer specialist services, and prevention and early intervention services. Prior service authorization is conducted for specifically identified intensive levels of care. BHI works to reduce and simplify the steps that a client or provider must take to receive prior authorization

for services within required timeframes because minimizing administrative barriers improves access to mental health and substance abuse care. BHI sets appropriate limits on a service:

- On the basis of criteria applied under the State Plan, to include medical necessity;
- For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in 42 C.F.R. Section 438.210(a)(3)(i);
- Consistent with BHI's published practice guidelines; and
- If established on the basis of HCPF's established utilization requirements or utilization review standards.

BHI responds to service authorization requests on the basis of medical necessity. Utilization review decisions accommodate the clinical urgency of the request. BHI consults with the requesting provider for any additional information needed which is relevant to making a utilization decision. All consultations with providers are clearly documented. Similarly, all BHI UM decisions and related notifications accommodate the clinical urgency of the request and comply with the timelines set forth by Medicaid and other relevant regulations. Prior service authorization decisions are communicated to clients and providers in compliance with Medicaid regulations regarding timelines and notice content. Prior service authorization decisions take into account both administrative and clinical factors, including:

- Determination that the individual for whom service is requested is a BHI Medicaid member for the relevant date of service;
- Determination that the service requested is covered under the Medicaid capitation program;
- Verification that the service request is reviewed through BHI's clinical technology review process in cases where the service requested includes a non-covered new technology or a new application of existing technology;
- Confirmation of benefit availability;
- Special regulatory circumstances, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Senate Bill (SB) 230; and
- Determination that the requested service is medically necessary as defined by BHI's medical necessity and UM criteria.

Prior service authorizations are based on necessary supporting documentation and a thorough review of complete and current clinical information. If the documentation is incomplete, BHI UM staff members follow up with a verbal request to the provider for the missing clinical information.

For outpatient services, documentation includes a Colorado Client Assessment Record (CCAR), Initial Assessment, Individualized Service Plan and admission form, progress notes, specialty evaluations or consultations, or equivalent information. For inpatient services, documentation includes a Census Tracking and Authorization (CT&A) form, inpatient psychiatric and medical evaluations, assessments, progress notes, and specialty evaluations and/or consultations.

All covered behavioral health services are authorized in sufficient amount, duration and scope to achieve the identified treatment objectives. All prior service authorization decisions are made in compliance with regulatory and contractually required timelines and documentation standards. Required services are not arbitrarily denied or reduced in amount, duration or scope, because of diagnosis, type of illness or condition of the client. All prior service authorization decisions are based solely on the appropriateness of care for the individual client's needs while taking into account the local delivery system. BHI does not offer incentives of any kind for individuals or entities to limit, discontinue, or deny medically necessary services to any member.

Consistency & Timeliness in Decision-Making

Policies and procedures are in place to ensure BHI UM Criteria are consistently applied across all levels of care. Periodic evaluations and reviews of service authorizations and inter-rater reliability studies are conducted by BHI and its subcontracted providers are overseen by the delegation oversight process.

BHI monitors the timeliness of UM decision-making by tracking the date services are initially requested, the date on which the authorization decision is made and whether this timeframe is within authorization response time requirements. BHI takes action to improve performance if authorization response standards are not met. BHI also conducts annual audits of UM timelines for service authorizations and denials. Policies and procedures require adherence to the timeframes for which prior service authorization, concurrent and retrospective UR decisions are made. Standard service authorization decisions are made and communicated to the client and provider within 7 calendar days following the receipt of the request; this may be extended up to 14 calendar days if the client or provider requests an extension. BHI may request additional information to justify that the requested extension is in the client's best interest. An expedited UR process is used when BHI determines that the standard authorization timeline could seriously jeopardize the client's life, health or ability to attain, maintain or regain maximum function. These UR decisions are made and communicated to the client and provider as expeditiously as the client's condition requires and no later than 3 working days after the receipt of the request for service authorization. The BHI UM Director, or his/her designee, will review all utilization determination documentation related to denial decisions. The BHI UM Director will review denial or documentation trends with the UM Committee on a quarterly basis.

Access & Availability

BHI centralizes triage and referral services for mental health and substance abuse services. Policies and procedures are in place to ensure that these services are appropriately implemented, monitored and professionally managed 24 hours a day, seven days a week. Access and availability of medically necessary covered services are determined according to the level of care

that is needed for routine, urgent or emergent situations. All behavioral healthcare providers are expected to offer face-to-face appointments to Medicaid members within specified timeframes, according to the level of request. Providers must offer appointments within seven working days from the request for routine care and within 24 hours of a request for urgent care. Providers must provide face-to-face evaluations within one hour of being notified of medical clearance by emergency department staff.

The BHI UM Director and BHI Director of the Office of Member and Family Affairs (OMFA), or their designee, will investigate any grievances or complaints regarding continuity of care, track this information in the existing grievance database and use this information to address training needs.

BHI conducts an annual audit of active credentialed independent providers to determine adherence to access standards. If a provider does not meet required access standards, the provider is re-educated regarding those requirements. A follow-up audit is then conducted. If the follow-up audit shows continued non-compliance, a corrective action plan (CAP) is required and monitored as a condition for continued referrals. BHI gathers and analyzes access to care data from network providers according to the State Operational Guidelines for Measuring Access Times. BHI adheres to the following standards established by HCPF:

- Routine appointments are available in seven days 100% of the time.
- Urgent appointments are available in 24 hours 100% of the time.
- Emergency services are available by phone within 15 minutes of the initial contact and in person within 60 minutes of the initial contact 100% of the time.

BHI reports Provider Access data quarterly to HCPF. The information also is analyzed in the quarterly Quality Improvement Performance Report Card for review by the BHI Provider Advisory Council, Board of Directors, the Client Quality Advisory Committee and the Program Evaluation Committee.

If a community mental health center provider falls below the benchmark for any Access Standard, a follow-up Corrective Action Plan (CAP) is submitted to BHI within one month. If a community mental health center falls below 90% of standard, a monthly corrective action report is required until the performance reaches 100%. At that point, quarterly corrective action reports are required until 100% performance is sustained for a minimum of 12 months.

Delegated UM Functions

BHI remains accountable for any functions and responsibilities that it delegates to any subcontractor. BHI has appropriate structures and mechanisms in place to oversee delegated UM/UR activities, including a written delegation agreement. BHI evaluates a prospective subcontractor's ability to perform the activities to be delegated. A written agreement specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. BHI

monitors the sub-contractor's performance no less than annually and subjects it to formal periodic review, consistent with industry standards, the Colorado Medicaid contract and Colorado laws and regulations.

The delegate submits a copy of its UM program descriptions (including information on access, triage and service authorization procedures) annually to BHI. The delegate agrees to provide complete requested information or records regarding UM issues to BHI for review within 48 hours of notice during audits, site visits and/or the delegation oversight process by State or Federal regulatory bodies for BHI's covered population. The delegate agrees to comply with BHI recommendations and keeps all information relating to BHI and its UM activities confidential except as required by law. BHI provides the delegate with all policies, procedures, protocols and guidelines necessary to ensure compliance and notifies the delegate of any changes to BHI or contract-specific policies and procedures at least 10 business days prior to the changes being implemented.

If BHI identifies deficiencies or areas for improvement, BHI and the sub-contractor take corrective action to develop a written action plan within 15 business days. The delegate provides monthly status reports to BHI on implementation of corrective action plans.

BHI Oversight of Delegated Functions

BHI conducts an annual delegation oversight evaluation process to review policies and procedures related to sub-contracted functions; the qualifications of staff responsible for conducting, supervising and reviewing delegated activities; member and provider satisfaction; and compliance with established standards. BHI performs a desktop review of sub-contractors' policies, procedures, program descriptions and related material for referral and triage, UM/UR, client rights, Notices of Action processing, appeals and fair hearing notices and QI program information. Additionally, BHI requires evidence of sub-contractors' implementation and monitoring of its own performance of the delegated functions. Effective oversight of delegated functions is assured by annual audits, site visits, documentation reviews and/or committee meetings. The BHI Delegation Oversight Committee is composed of the BHI CEO, UM Director, QI Director, Director of the Office of Member and Family Affairs (OMFA), and Director of Provider Relations. The BHI Delegation Oversight Committee reviews the delegation audit findings, makes recommendations for improvements, reviews all action plans and follow-up activities, and determines delegation status and agreements, including termination if CAPs do not result in the improvement of performance or compliance with BHI, State Medicaid Contract or other required policies and procedures according to specified timelines.