SALISH BEHAVIORAL HEALTH ORGANIZATION
Utilization Management Plan
FY 2018-2019

The Salish Behavioral Health Organization (SBHO) Utilization Management (UM) Plan summarizes the processes, procedures, standards and monitoring mechanisms that govern the utilization management program. The SBHO UM functions attempt to strike a balance between promoting a recovery based service delivery system and effectively managing resources.

The SBHO UM Plan is designed to comply with the contractual requirements outlined in the Agreement with Washington State.

SBHO Mission

The Salish Behavioral Health Organization (SBHO) is dedicated to ensuring and continually improving the delivery of quality behavioral health care so that the individuals we serve may better manage their illness, achieve their personal goals, and live, work and participate in their community.

The SBHO is committed to creating and supporting a behavioral health treatment system that focuses on supporting individuals and encouraging recovery and resiliency. We understand and promote the understanding that behavioral health is an essential element of overall health. Physical illness, mental illness, and substance use disorders are conditions from which people can and do recover.

The SBHO UM program strives to assist every individual in receiving quality care through utilization of adequate resources in the most cost effective manner. The SBHO believes a managed care structure allows for the delivery of the highest possible quality care, in a coordinated and cost effective manner.

Introduction

The SBHO provides a full range of behavioral health services to individuals within the service delivery geographical area, providing the required covered services for the Medicaid and state only revenue contracts. The SBHO provides comprehensive and medically necessary services in a variety of settings including, but not limited to outpatient, inpatient, residential, and intensive outpatient programs. The SBHO delivers timely, appropriate, and quality behavioral health services through an effective and carefully monitored network of behavioral health providers. All services requested, authorized, and provided for individuals using SBHO funding are subject to utilization review.

- *State funded services are provided according to the state defined priority services and additional outpatient services are provided based upon available resources.*

Service Delivery Structure: The SBHO has an extensive and fully licensed network of behavioral health providers that delivers comprehensive, quality care. The SBHO sub-capitates the Medicaid service funding with the core network providers, thereby ensuring full participation in implementing cost effective utilization management strategies.

Standard Authorization Structure: The SBHO has contracted with Community Network for Behavioral Healthcare, Inc. (CommCare) to authorize SBHO services requests from the provider network. CommCare is accredited by the Utilization Review Accreditation Commission (URAC) and is required to maintain the accreditation per contract. CommCare is responsible for providing service authorization determinations for services the SBHO has identified as requiring prior authorization, on behalf of the SBHO, for Medicaid and non-Medicaid individuals seeking behavioral health services.

SBHO Oversight Committee: The SBHO operates a UM committee to provide network oversight of the UM Plan activities, identify UM program and plan improvements, and review the Plan at least annually. The SBHO UM committee is responsible for prioritizing the UM Plan activities, targeting areas needing improvement, identifying benchmarks, and maintaining threshold capacity. The UM Committee members are listed in attachment 1.

Utilization Program Goals

The goal of the SBHO UM program is to provide a process that systematically monitors and evaluates service delivery to ensure individuals have access and are receiving timely and appropriate behavioral health services to meet their needs. In addition, the UM activities provide a continuous framework for network evaluation of the appropriate use and amount of current resources within the network. The process focuses on monitoring contract requirements and developing cost-effective strategies within the service delivery structure.

Utilization Management Program Objectives

The SBHO UM program strives to ensure easy and timely access to medically necessary treatment; work collaboratively with each network provider in delivering quality care; address the needs of special populations; and make appropriate clinical decisions at the level closest to the individual. The UM program attempts to integrate with the network providers UM activities and internal quality management strategies where possible. The SBHO UM program emphasizes the principles of recovery, reintegration, rehabilitation, and resiliency which include involvement of individuals, and their families, in the direction of their treatment.

Utilization Management Program Structure

The UM program operates in a clearly defined organizational structure (see attachment 1). The SBHO UM program is supported by adequate clinical staff from multiple levels within the service structure, including staff from CommCare, the SBHO staff, and the network provider’s senior management and clinical staff. The SBHO Quality Improvement Committee (QUIC) is responsible for the overarching oversight of the UM program, prioritizing monitoring activities and reviewing UM committee functions.

CommCare, the SBHO utilization management contractor, is required to adhere to Utilization Review Accreditation Commission (URAC) standards. CommCare is contracted to review authorization requests for outpatient, inpatient, and residential care.

CommCare’s utilization management system improves the functioning and quality of life of individual served by the SBHO by applying a clinically sound, individual-oriented, and cost-effective authorization process to the regional system of care.

CommCare's Care Managers are behavioral health clinicians who are trained to address not only the psychological needs of the individual and their families, but also their medical, substance use disorder, and social needs. Each member of the clinical staff averages over four (4) years of experience in the case management of Medicaid populations. The CommCare Medical Director is a board- certified psychiatrist who oversees all of CommCare's clinical activities. (see attachment 2)

The SBHO Administrator, Utilization and Integration Manager, Compliance Officer, Adult Services Manager, Quality Assurance Manager, Children's Services Manager, Substance Use Disorder Manager, and Residential and Long-Term Care Manager participate in the SBHO UM program. The SBHO Utilization and Integration Manager is responsible for this plan and activities monitoring for network sufficiency, facilitates the quarterly UM meetings, and maintains the SBHO Level of Care criteria. The Adult Services Manager facilities the SBHO network Clinical Directors meetings. The Service Managers conduct clinical chart review, monitors internal network adherence to authorized care, and participate in the network Clinical Directors meetings. The SBHO Quality Assurance Manager is responsible for providing the linkages between the UM Plan to the SBHO Quality Management (QA) Plan, including plan activities and committees. The SBHO Children's Services Manager is responsible for oversight of the continuum of care for Children's services. The Substance Use Disorder Manager conducts agency clinical reviews and monitors contract and policy adherence. The Residential and Long Term Care Manager participates in clinical reviews and provides support to residential and inpatient settings in mental health.

The Utilization Management Committee (UMC) reports to the QUIC that is compiled of SBHO staff, network provider senior clinical management staff, advisory board members and clients/ client advocates. The network agency representatives have been oriented and trained on SBHO clinical criteria, case management philosophy and procedures, and treatment resources available. Each network agency provides at least one representative that routinely attends the UMC quarterly face to face meetings.

The UMC is responsible for:

- Monitoring of the service authorization process; ensuring access to care standards are being met.
- Establishing and reviewing application of the SBHO criteria for each level of care.
- Monitoring of authorizations across all levels of care.
- Monitoring the process of re-authorizing or extended service outpatient authorization.
- Tracking inpatient service denials (including the process of appeal).
- Monitoring inpatient utilization trends.
- Established regional benchmarks and thresholds of authorization procedures.
- Evaluating current network sufficiency and recommending changes to the governing boards and other SBHO committees, as necessary.
- Recommends Corrective Action Plans for concerning trends, such as late PRAT requests.
- Assists in the development of UM Policies and Procedures (including Levels of Care criteria), and annually reviews UM Plan.

- Reviews and makes recommendations for updates to the authorization forms (PRAT for outpatient services, PARS for residential services, certification/authorization for inpatient services, and other relevant authorization documents).
- Operationalizes state-directed inpatient authorization requirements/ modifications, such as the Community Psychiatric Instructions and Parent Initiated Treatment.

The SBHO ensures that utilization management activities are not structured in such a way as to provide incentives to any individual or entity to deny, limit, or discontinue medically necessary behavioral health services to any enrollee as evidenced in the SBHO policy: Authorization of Services: Independence from Financial Incentives.

Service Authorization for Routine Care, Medicaid and non-Medicaid

The SBHO utilization management contractor, CommCare, uses the medical necessity criteria, Levels of Care standards, and resources available when making authorization determinations. The SBHO requires prior authorization for all routine outpatient service levels. These standards are reviewed at least annually (through chart reviews and data reports) to incorporate the evidence based and best practice industry standards in the behavioral health field.

The SBHO adopts Levels of Care Standards that:

a. Include the State's Access to Care Standards.
b. Promote individual progress towards the highest possible level of health and self-sufficiency.
c. Can be reasonably expected to benefit the individual's behavioral health.
d. Are medically necessary and appropriate to the individual's condition.
e. Are designed to assist individuals in managing their illness to the greatest extent possible in order to live, learn, and work in their own communities.
f. *For non-Medicaid services, are provided based upon available resources.*

Service Authorization Principles

1. The service authorization process is intended to meet all applicable requirements of the Centers for Medicare and Medicaid Services (CMS) and Washington State.

2. The service authorization process is designed to allow for rapid approval, with a minimum of steps to promote timely access to services. All service authorizations provide an expedited review process for urgent and emergent situations, as well as a standard review process.

    - Corrective Action plans will be required for late PRATs, exceeding 15% of the monthly total.

3. Medicaid recipients/enrollees will be authorized and receive all medically necessary behavioral health services defined in the Medicaid state plan.

4. Individuals not enrolled in Medicaid will be authorized and receive medically necessary outpatient behavioral health services subject to availability of resources.

5. All individuals residing within the SBHO have access to state funded crisis services.

6. Family member involvement is valued by the SBHO. Families will be encouraged to be involved in the assessment, service planning and treatment process whenever possible. Family non-involvement will not result in denial of service.

7. Authorized services will be provided in the most clinically effective, cost effective and least restrictive setting.

Outpatient Service Authorization Process

1. Following the Intake Assessment, service admission authorization requests typically are made by the SBHO network provider behavioral health professional that conducted the intake assessment. Requests are made using one of the following methods: (1) the Peninsula Regional Assessment Tool (PRAT) and submitted electronically to CommCare via ProFiler. ProFiler is the regional Electronic Medical Record (EMR). (2) the Substance Use Disorder Outpatient Authorization Tool and is submitted via secured email or fax to Commcare.

2. The admission PRAT for outpatient services requires the following information:
    - Medicaid recipient/enrollee or Non-Medicaid assigned funding.
    - DSM-5 Diagnosis
    - Access to Care standards, including medical necessity criteria questions.
    - Requested Level of Care (Mental Health refer to Mental Health Level of Care Policy, 7.03 and Substance Use Disorders refer to Substance Use Disorder Level of Care Guidelines Policy, 7.08).
        - Mental Health: For Level 2 services, additional risk assessment criteria.
    - For admission authorization beyond 14 days from the intake or assessment, a request for an extension is required.
    - For Substance Use Disorder Outpatient Authorizations: Releases for both CommCare and SBHO are completed and sent with completed authorization.
    - For Substance Use Disorder Outpatient Authorizations: Priority is given to the following: pregnant women who use IV drugs, pregnant women, others who use IV drugs, post-partum women (up to one year). Other prioritized groups that are considered: Parents/legal guardians involved with Child Protective Services, parenting adults, and youth.
    - (optional) If entrance criteria is not met, referral provided.
    - (optional) There is a text box that allows for additional information to be provided by the requestor.

4. CommCare may review additional documentation, such as the Intake or Assessment and other relevant information available in the electronic medical record in making an authorization determination according to the SBHO standards.

5. CommCare will make an authorization determination within 14 days. CommCare will document the determination either on the PRAT and transmit an on-line authorization determination back to the network provider or complete their portion of the Substance Use Disorder Outpatient Authorization Request Tool (indicating the appropriate level of care and authorization dates) and return it to the agency via secure email or fax. Authorization determinations will be placed in client's chart.
   - The SBHO directly notifies individuals in writing when outpatient services are authorized. The SBHO Handbook accompanies the notification letter.
   - When requested services are denied authorization, CommCare mails a letter of adverse benefit determination to Medicaid individuals and a notice of determination to non-Medicaid individuals.

6. If the requested service is denied, individuals are found to not qualify for outpatient services, or there are not sufficient resources to provide services, CommCare will issue a Notice of Adverse Benefit Determination letter, on behalf of the SBHO, to the Medicaid individuals and a Notice of Determination to non-Medicaid individuals.
   - The notification letter is mailed directly to the individual and a copy is mailed to the SBHO office.
   - CommCare will conduct the Adverse Benefit Determination Appeals for authorization decisions and service denials they issue for Medicaid individuals. (Reference SBHO policy: 6.05 Adverse Benefit Determination Requirements).

7. Authorization termination applies to Outpatient SUD services for an individual who has left services within an authorized benefit period. These can occur at any point during an authorized period benefit, but the providing agency must notify CommCare within 24 hours of the individual change of circumstances. Authorization termination instructions are available in SBHO policy 7.09.

8. The SBHO staff conduct retrospective reviews of a sample of authorized charts, as a part of the quality management plan and annual chart reviews of network contractors and subcontractors.

   The individual service plan (ISP)/treatment planning process is reviewed as a part of the retrospective reviews to ensure it:
   - Meets the needs of the individual.
   - Is consistent with the requested LOC and, if applicable, adopted SBHO Clinical Practice guidelines.
   - Includes individual participation in the treatment planning process.
   - Involved family members, when appropriate, in the evaluation and service planning processes.
   - Includes input from other formal service systems and is consistent with privacy requirements.

9. The SBHO staff conduct targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been a concerning adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

10. If a network provider performs below expected standards during any of the reviews, listed above, a Corrective Action will be required for SBHO approval.

Authorization for Inpatient Services, Medicaid and Non-Medicaid

The SBHO utilization management contractor, CommCare, uses the Statewide Community Psychiatric Inpatient Instructions Per Diem (implemented August 1, 2007), medical necessity criteria and SBHO Levels of Care standards for Mental Health when making inpatient authorization determinations. The SBHO requires prior authorization for all inpatient services. The SBHO provides an expedited review process for urgent and emergent inpatient authorizations.

All service denials of requested inpatient care are made by CommCare's board certified psychiatrist or consulting physician.

A. Service Authorization Process for Inpatient

The SBHO inpatient authorization process follows the Community Hospital Billing Instructions.

1. The request for inpatient services is verbally requested and followed-up with an electronically submitted request to CommCare to authorize. CommCare is required to use the medical necessity and SBHO Levels of Care for authorization determination.

2. CommCare is required to provide an authorization determination (certification) to the requesting entity. This may be an initial verbal determination via phone; followed by confirmation entered into ProFiler, Provider 1 database, and/or secure email. CommCare provides written certification to the facility or individual. For voluntary retro reviews, CommCare will provide written certification to the facility and individual.

3. A SBHO Designated Crisis Responder (DCR) conducts a crisis face to face evaluation within 2 hours of a request and determine the level of acuity. For out of region requests, the request is verbally assessed by CommCare within 2 hours of the request.

4. The SBHO DCR submits the request for inpatient services, providing the necessary documentation, to make an inpatient authorization determination.

    - Mental Health/DCR: The determination to authorize inpatient care shall be completed within 12 (twelve) hours from the initial request for authorization. The determination is entered into Provider 1 by the next business day for community inpatient facilities and ProFiler. Determinations for requests at the local Evaluation and Treatment Centers are entered into ProFiler by the next business day.

5. If the requested service is denied, CommCare will notify provider via ProFiler and/or secure email. For individuals without Medicaid coverage, a notice of adverse benefit determination (NOABD) letter will be sent and include how to request a second opinion.

6. The SBHO staff conducts retrospective reviews of a sample of inpatient authorized charts, as a part of the quality management plan, annual E&T administrative reviews, and chart reviews of network contractors and subcontractors.

7. The SBHO staff conducts targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

8. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.

9. The inpatient facility is responsible for requesting extension/continuing stay requests and retro-certifications, 24 (twenty-four) hours (Mental Health, Inpatient) prior to the expiration of an episode.
    - Extension/continuing stay authorization requests are reviewed by a mental health professional (for mental health services).
    - CommCare makes authorization determinations for extension, continuing stay requests and retro-certifications

B. Discharge Planning for voluntary hospitalizations

The SBHO expects the network provider to coordinate the discharge planning for individuals voluntarily hospitalized

The discharge planning process must begin within 3 days of admission and include:
- Purposeful use of the individual's/family's strengths
- Identification of what caused the individual to need hospital or out of home placement
- What the individual and his/her family need to be successful in the community
- Identified solutions to getting those needs met
- Offered Outpatient appointment (within 7 days of inpatient discharge)

A follow-up outpatient appointment must be offered within 7 (seven) days of discharge. These discharge coordination dates are tracked using monthly UM reports.

An individual, and their family, must be an integral part of the treatment and discharge planning, with a voice in the discharge placement decisions. Discharge planning is integral to the authorization, retrospective certifications, and re-authorization process.

<u>Authorization for Substance Use Disorder and Mental Health Residential Services, Medicaid and Non-Medicaid</u>

The SBHO utilization management contractor, CommCare, uses the medical necessity criteria and SUD or Mental Health Levels of Care standards developed and adopted by the SBHO when making residential service authorization determinations. The SBHO requires prior authorization for SUD residential service and is based upon ASAM criteria. *Authorization of residential services for non-Medicaid individuals will be based upon available resources.*

For Substance Use Disorders, State prioritizes the following for state-funded treatment, including inpatient treatment: pregnant women who use IV drugs, pregnant women, others who use IV drugs, post-partum women (up to one year). Other prioritized groups that are considered: Parents/legal guardians involved with Child Protective Services, parenting adults, and youth.

A. Service Authorization Process for SUD Residential (Inpatient) Services

1. The SBHO network Outpatient provider completes an assessment and obtains signed ROI's for both CommCare and SBHO. If the individual meets medical necessity for residential services, the SBHO network provider locates a suitable residential provider and obtains a bed date Whereas for Substance Use Disorder or CD Involuntary Treatment Activity (CD-ITA) a CD-ITA specialist conducts an assessment utilizing the LOC Guidelines and ASAM criteria to determine if the individual meets medical necessity for CD-ITA services.

2. The SBHO network provider submits a Substance Use Disorder Residential Authorization Request Tool with completed CommCare and SBHO ROI's via ProFiler, secure email and/or fax. CommCare may review additional documentation, such as the Assessment, ASAM criteria, and other relevant information in making an authorization determination according to the SBHO standards.

3. CommCare will document an authorization determination within the Substance Use Disorder Residential Authorization Request Tool and return via ProFiler and/or secure email within 3 days of initial request. The network provider is responsible for providing and verbally notifying individuals of their authorized residential services.

4. If the requested service is denied, CommCare will notify provider via ProFiler and/or secure email. For individuals without Medicaid coverage, a notice of adverse benefit determination (NOABD) letter will be sent and include how to request a second opinion.

5. The inpatient facility is responsible for requesting extension/continuing stay requests and retro-certifications, 24 (twenty-four) hours (Mental Health, Inpatient) or at least 5 days (Substance Use Disorder, residential), prior to the expiration of an episode.

6. The SBHO staff conduct retrospective reviews of a sample of charts authorized for residential services, as a part of the quality management plan and annual Residential Reviews of network contractors and subcontractors.

7. The SBHO staff conduct targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative

media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

8. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.

B. Service Authorization Process for Mental Health Intensive Residential Services

1. The SBHO network provider submits an electronic Peninsula Assessment for Residential Services (PARS) request (for intensive residential services authorization) service authorization to CommCare via Profiler. CommCare may review additional documentation, such as the Intake Assessment, Crisis Prevention Plan, Individual Service Plan (ISP)/treatment plan and other relevant information in making an authorization determination according to the SBHO standards.

1. CommCare will make an authorization determination; document the determination on the PARS form and transmits an on-line authorization determination back to the network provider. The network provider is responsible for providing and verbally notifying individuals of their authorized residential services.

2. If the requested service is denied, CommCare will issue a service denial notification, on behalf of the SBHO, to the Medicaid and Non-Medicaid individual.

4. The SBHO staff conduct retrospective reviews of a sample of charts authorized for residential services, as a part of the quality management plan and annual Residential Reviews of network contractors and subcontractors.

5. The SBHO staff conduct targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

5. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.

<u>Notice of Adverse Benefit Determination (NOABD)</u>

If Access to Care Standards are not met for any level of service, including outpatient, intensive outpatient, residential, and/or inpatient, a Notice of Adverse Benefit Determination (NOABD) is sent to individual and provider (via Profiler and/or secure email). Individuals without Medicaid coverage will be sent a Notice of Determination (NOD) letter and how to request a second opinion.

<u>Continuing Stay and Service Re-Authorization</u>

The SBHO network providers use the Levels of Care (LOC), Mental Health and/or Substance Use Disorder, developed and adopted by the SBHO when making re-authorization determinations.

- The SBHO requires prior re-authorization for *all* continuing stay inpatient services.
- The SBHO requires re-authorization for outpatient service episodes within 30 days of a previously authorized benefit period expiring.
- The SBHO requires reauthorization for SUD residential treatment service episodes at least 5 days in advance.
- The SBHO does not require a re-authorization within a current authorized benefit period. The SBHO network providers may close and re-open a clinical episode within an authorized administrative benefit period.

The SBHO LOC for outpatient and inpatient care outline the re-authorization criteria must be met, documentation provided to support criteria, and information reviewed when re-authorizing a service episode.

Service re-authorizations for Non-Medicaid individuals must meet the LOC additional requirements to serve the individuals. *There must be available resources to provide the services.*

The SBHO may request a review of the individual service plan (ISP) as part of the continuing stay service authorization process to ensure it:

- Meets the needs of the individual.
- Is consistent with the requested LOC and, if applicable, adopted SBHO Clinical Practice guidelines.
- Includes individual participation in the treatment planning process.
- Involved family members, when appropriate, in the evaluation and service planning processes.
- Includes input from other formal service systems and is consistent with privacy requirements.

Consistency of Authorization Determination and Service Requests

The SBHO has formally adopted the *Authorization of Outpatient Services Based on Medical Necessity* policy and Levels of Care protocols to ensure the SBHO, network providers, and CommCare share a common definition and standardized process to determine the medical necessity of requested and authorized behavioral health services provided by the SBHO.

The SBHO expects the utilization management contractor, CommCare, to consistently apply and authorize the most appropriate Level of Care and service modalities, based upon the request and clinical documentation provided for determining medical necessity.

The SBHO expects the network providers to provide clear and consistent assessments, request clinically appropriate services, and adhere and deliver services within the scope of authorized behavioral health services.

Limitations on the Provision of Covered Services, Medicaid and Non-Medicaid

The SBHO contracts with CommCare to make all the service authorization decisions on behalf of the SBHO.

A. There are several ways that CommCare can limit the provision of Medicaid covered services. These include:
   - Determining that an enrollee does not meet Access to Care standards.
   - Denying authorization for a requested covered service: Denials of a requested service will be addressed through the SBHO service denial and notification policy and procedures.
   - Determining to reduce, suspend or terminate a previously authorized service.
   - Pend an authorization request, awaiting additional information

B. There are several ways that CommCare can limit the provision of services to Non-Medicaid individuals. These include all the above, a reduction of resources, as well as the additional criteria for Non-Medicaid individuals.

C. When one of the above actions occurs, CommCare through the notification process informs an individual in writing. Medicaid recipients receive an Adverse Benefit Determination for all actions and Non-Medicaid individuals receive a Notice of Determination.

   When services are reduced as a result of reduced state funding, a notification letter is mailed to the individual with a copy sent to the SBHO.
   - CommCare will conduct the NOA appeal, if requested.
   - SBHO will conduct a Grievance investigation, if requested.
   - DSHS will conduct a Fair Hearing, if requested.

Ensuring Client Rights Are Provided

The SBHO places a high priority on informing individuals seeking services of their rights. The SBHO ensures individuals are provided this information through the State booklet, the SBHO Handbook and brochures, and reviews the provision of information through monthly on-site chart reviews, and annual Administrative Reviews. A clinical chart must evidence that individuals were given the client rights information prior to the completion of the intake assessment. The SBHO developed and distributes the informational SBHO Handbook and brochures, and a standardized outpatient client rights form to network providers to be given to each individual seeking services. The SBHO also distributes the informational material to subcontractors, such as the local Ombuds office, BRIDGES to Parent Voice program, and NAMI advocacy groups.

Individuals with sensory impairments, or who speak a language other than English, are provided equal access to this information through:
- Provision of material in Braille.
- Use of a State TDD language or TTY line.
- Access to certified sign and language interpreters.
- SBHO contracted hearing impaired consultant.
- Client rights are posted in common areas of the network agencies in the twelve State identified languages.

Clients are informed that behavioral health professional and primary behavioral health care providers, acting within the lawful scope of behavioral health practice, are not prohibited or restricted from advising or advocating on behalf of them with respect to their behavioral health

status. Reference the SBHO policies: General Information and Requirements, Enrollee Rights, and Behavioral Health Care Professional Advocacy policies.

Clients are informed of their second opinion rights, how and when to request a second opinion, and payment of costs associated with providing a second opinion in the published and distributed documents, as well as on the Notice Adverse Benefit Determination and Notice of Determination letters.

SBHO Oversight and Sampling Methodology

The SBHO utilizes random sampling to select charts for clinical and targeted reviews. The SBHO conducts a minimum of 500 chart reviews annually, sufficient to meet CMS and the Department requirements for reviews. Additional reviews may occur to address performance issues, concerning trends, or to accomplish utilization management or quality management activities.

The SBHO conducts annual Administrative Reviews of each network provider, the ASO, and the local Ombuds office.

Over and Under Utilization Project

The SBHO monitors and detects for consistent application of requested, authorized, and provided services through an over and under utilization project that meets federal requirements. Both of these projects are monitored through regional quality assurance activities. Both projects are explained in the SBHO Quality Management Plan.

High Utilizers: The SBHO monitors for high inpatient utilization through chart reviews, with a targeted data pull and with specific items on the crisis chart review tool.

Under Utilizers: The SBHO monitors for outpatient under utilization through a data report and/or chart reviews.

Examination of Network Sufficiency

The SBHO UM program uses a variety of measures as indicators of network sufficiency and resources sufficiency. These indicators include:

- Historical use of resources.
- Current use of resources.
- Projections for future use and need of resources.
- Funding shifts- expenses and revenue reports.
- Quarterly Provider Performance Reports
- Census information for Medicaid and general population growth, by age, ethnicity, and gender.
- Monitoring of outpatient and inpatient utilization through the Authorization and Utilization Management Reports reviewed monthly by the UMC.

The SBHO has policies and procedures for collecting the service data, demographic, and census data, as evidenced in the Using the Information System for Utilization and Resource Management policy.

Integration of Utilization Management Data

Utilization management data is an integral part of the SBHO overall quality improvement strategy. The SBHO UM Plan defines areas of focus, establishes thresholds and benchmarks against which performance is measured, and defines special utilization management studies to be conducted.

The SBHO utilizes a regional and statewide database system to collect the required service data for individuals receiving SBHO funded services:

- Client Demographic Information.
- Social Security Number.
- Health Insurance Information (plan, group number, subscriber name).
- Attending Physician/Practitioner Information/Primary Behavioral Health Care Provider assigned.
- Client Diagnosis/Treatment Information.
- Inpatient/Residential Facility Information.

Unique situations may require for additional information prior to making an authorization determination. Clinical and demographic information may be shared within the SBHO service network to avoid multiple requests for information from patients and providers.

Information from utilization management activities is aggregated, trended and analyzed to establish validity for completeness, accuracy, and timeliness. The SBHO staff and UMC evaluate the data using comparative statistical methods to identify variance from expected performance and reviews progress over time for trends or patterns. They report their findings to the SBHO QUIC.

The SBHO staff, UMC, and QUIC monitor performance against the benchmarks established in the Quality Management Plan. Should required activities not result in attainment of established benchmarks, the QUIC can impose corrective actions or implement concurrent reviews, as required to achieve benchmarks.

When analysis of available data suggests a deficiency in the sufficiency of the network, the UMC and/or the QUIC presents the issue for discussion and decision making to the SBHO governing boards.

Annual Evaluation of the SBHO UM Program

The SBHO Utilization Management Program is reviewed, evaluated and revised annually. The plan evaluation includes an assessment of the UM plan activities, and the extent to which compliance was achieved with the specified performance standards and outcomes.

The plan evaluation includes:

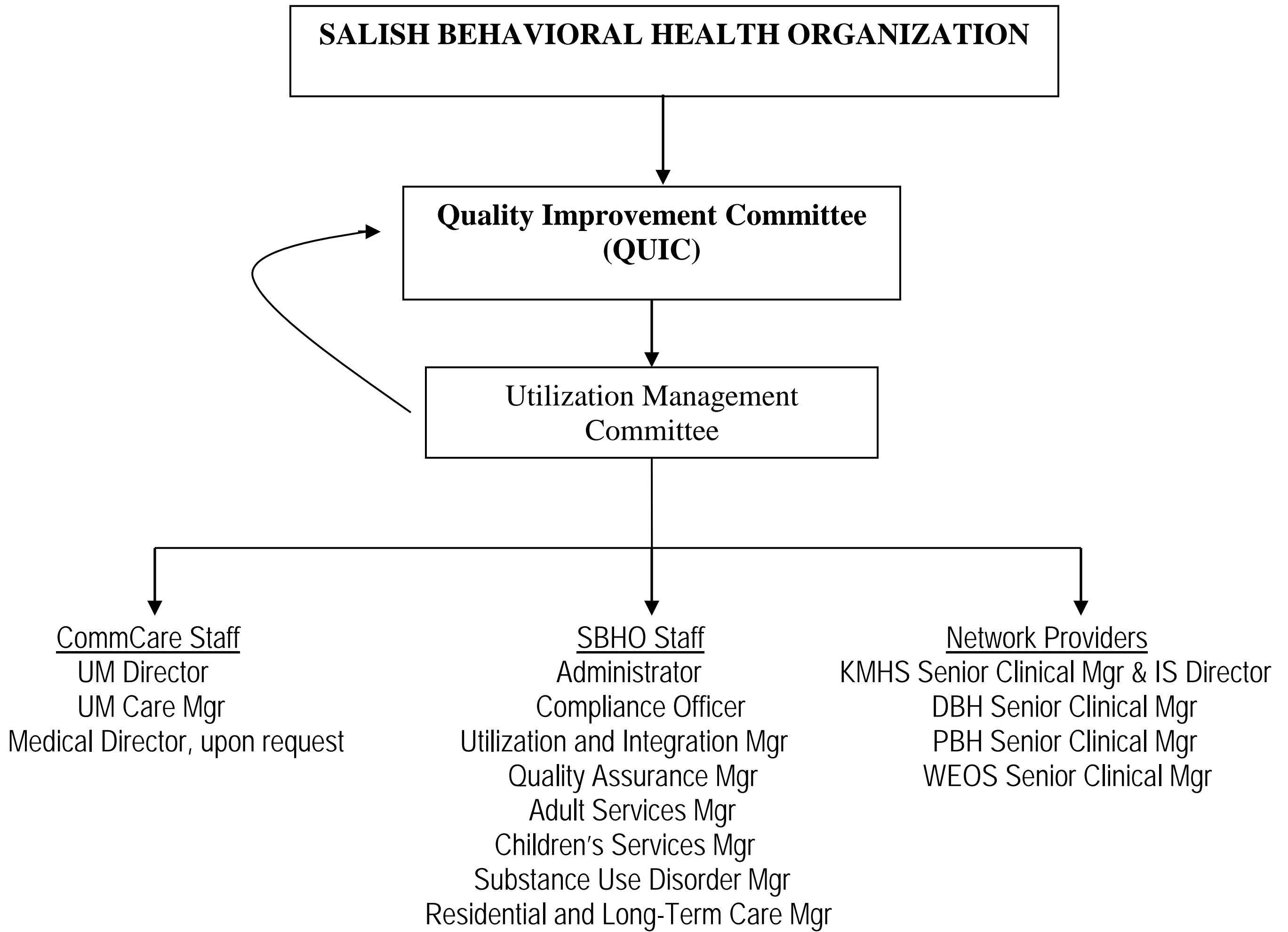
1. Identification of activities to be included in the subsequent year's Utilization Management Program.
2. Identification of any barriers to implementing the Utilization Management Program.
3. Recommended changes in the SBHO infrastructure, as needed, to accomplish the goals of the UM Plan.
4. Identification of opportunities for improvement through the provision of on-site technical assistance or training.
5. Updating information within the UM Plan that accurately reflects the monitoring and oversight activities.
6. Recommended changes or additions to the criteria for monitoring over or underutilization project.

The written summary of the evaluation is prepared by the SBHO staff, in conjunction with UM Committee, and presented to the QUIC.

The annual UM Program evaluation is the basis for the development and focus of the upcoming fiscal year's established priorities.

Attachment 1

SBHO
Utilization Management & Clinical Directors Committee
Organizational Chart



Attachment 2

SALISH BEHAVIORAL HEALTH ORGANIZATION
Contracted Authorization and Utilization Management
CommCare Organizational Chart

Organizational Chart