Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

FULL BOARD
Wednesday, June 15, 2022
Hotel St. Regis – 1st Floor
3071 W. Grand Blvd. Detroit, Michigan 48202
1:00 P.M
AGENDA

I. CALL TO ORDER

II. ROLL CALL

III. APPROVAL OF THE AGENDA

IV. MOMENT OF SILENCE

V. APPROVAL OF BOARD MINUTES – Full Board Meeting – May 18, 2022

VI. RECEIVE AND FILE – Approved Finance Committee Minutes – May 4, 2022
Approved Program Compliance Committee Minutes **–** May 11, 2022

VII. ANNOUNCEMENTS
A) Network Announcements
B) Board Member Announcements

VIII. BOARD COMMITTEE REPORTS
A) Board Chair Report
1) Update Chamber of Commerce Policy Conference - May 31 – June 3, 2022 Mackinac Island, Michigan
2) Update Community Mental Health Association of Michigan (CMHAM) Conference and Metro Region Officer Vacancy (June 6-8 2022)
3) Board Conflict of Interest Statement

B) Executive Committee
1) Board Self-Assessment
2) Update New Board Member Virtual Orientation – May 19, 2022
3) Board Study Session
4) Update Budget Hearing (Joint Finance and Program Compliance Meeting – August 3, 2022)
5) Update Metro Region Virtual Meeting – DWIHN Host (June 9, 2022)
6) Update Annual Virtual Meeting –July 20, 2022 (Full Board In Person Meeting 11:00 a.m.)

C) Finance Committee
D) Program Compliance Committee
E) Recipient Rights Advisory Committee

IX. SUBSTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD REPORT

X. AD HOC COMMITTEE REPORTS

A) Policy/Bylaw Committee

XI. UTILIZATION MANAGEMENT PROGRAM DESCRIPTION FY 2021-2024

XII. UTILIZATION MANAGEMENT PROGRAM EVALUATION FY 2021

XIII. PRESIDENT AND CEO MONTHLY REPORT

XIV. UNFINISHED BUSINESS

Staff Recommendations:

A. BA #21-72 (Revised) Annual Financial Statement Audits – Plante & Moran *(Finance)*
B. BA #22-12 (Revision 5) Detroit Wayne Integrated Health Network (DWIHN) FY 2021/2022 Operating Budget *(Finance)*
C. BA #22-22 (Revised) – FY '21/22 Provider Network System

XV. NEW BUSINESS

Staff Recommendations:

A. BA #22-63 – Detroit Wayne Integrated Health Network (DWIHN) Mobile Application for Community Engagement – AgreeYa Solutions, Inc. *(Finance)*

XVI. PROVIDER PRESENTATION – SOBRIETY HOUSE

XVII. REVIEW OF ACTION ITEMS

XVIII. GOOD & WELFARE/PUBLIC COMMENT/ANNOUNCEMENTS

Members of the public are welcome to address the Board during this time for no more than two minutes. (The Board Liaison will notify the Chair when the time limit has been met.) Individuals are encouraged to identify themselves and fill out a comment card to leave with the Board Liaison; however, those individuals that do not want to identify themselves may still address the Board. Issues raised during Good and Welfare/Public Comment that are of concern to the general public and may initiate an inquiry and follow-up will be responded to and may be posted to the website. Feedback will be posted within a reasonable timeframe (information that is HIPAA related or of a confidential nature will not be posted but rather responded to on an individual basis).

XIX. ADJOURNMENT

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FULL BOARD MEETING
Meeting Minutes
Wednesday, May 18, 2022
1:00 pm.

BOARD MEMBERS PRESENT

Angelo Glenn, Chairperson	Eva Garza Dewaelsche
Kenya Ruth, Vice Chair	Michelle Jawad
Dora Brown, Treasurer	Jonathan C. Kinloch
Dorothy Burrell	Bernard Parker
Lynne F. Carter, M.D.	William Phillips

BOARD MEMBERS EXCUSED: Dr. Cynthia Taueg; Board Secretary and Mr. Kevin McNamara

BOARD MEMBERS ATTENDING VIRTUALLY: None

GUEST(S): None

CALL TO ORDER
The meeting was called to order at 1:06 p.m. by Mr. Angelo Glenn, Chairperson

ROLL CALL
Roll call was taken by the Board Liaison Ms. Lillian M. Blackshire and a quorum was present.

APPROVAL OF THE AGENDA
Mr. Glenn, Chairperson welcomed everyone to the meeting and called for a motion on the agenda.

It was moved by Ms. Ruth and supported by Mr. Phillips approval of the agenda as presented. There was no further discussion. Motion carried unanimously.

MOMENT OF SILENCE
The Chairperson called for a moment of silence. Moment of Silence taken.

APPROVAL OF BOARD MINUTES
The Chair called for a motion on the Board minutes from the Full Board meeting of April 20, 2022. **It was moved by Mr. Parker and supported by Ms. Jawad to accept the Full Board minutes of April 20, 2022. Motion carried unanimously.**

RECEIVE AND FILE
The approved Finance Committee minutes from the meeting of March 2, 2022 were received and filed. The approved minutes from Program Compliance Committee from the meeting of April 13, 2022 were received and filed**.**

ANNOUNCEMENTS

Network Announcements

None.

Board Announcements

None.

BOARD COMMITTEE REPORTS

Board Chair Report

Board Chair, Glenn requested an update on the Wayne County appointments. It was reported by Ms. B. Blackwell, Chief of Staff that Wayne County has completed its' appointments; Ms. Ruth and Ms. Brown were sworn in during the Finance Committee meeting held on May 4, 2022.

The Chamber of Commerce Policy Conference is scheduled for May 31st through June 3rd on Mackinac Island. There are several Board members and staff members that will be attending the conference. The lobbyists are scheduling meetings with legislators and a schedule will be forthcoming.

Community Mental Health Association of Michigan Annual Summer Conference -June 6th – June 8th will be held in person at Grand Traverse. The Board Chair; Vice Chair and several board members will be attending the conference.

Community Mental Health Association of Michigan Annual (CMHAM) Metro Region Officer Vacancy. It was reported by Ms. Blackwell that Mr. Glenn will be on the ballot for the position of 1st Vice President and that board members have to be present to vote and there is no proxy voting. DWIHN has five votes which include four board members and the vote of the CEO.

There was no further discussion on the Board Chair report. The report was received and filed.

Executive Committee

The Board Chair Mr. Glenn reported. A verbal report was provided. It was reported that the Executive Committee met on Monday, May 16, 2022. It was recommended by staff that the Board develop a DWIHN Board Resolution Memoriam Policy. This policy would allow the Board to recognize someone that had impact in the community or had passed away. It was also noted that as a region there should be some action given the racial tensions and shootings that have taken place. The item is to be added to the Policy/Bylaw committee agenda for their upcoming meeting.

The New Board Member Virtual Orientation for Ms. Eva Garza Dewalesche is scheduled for Thursday, May 19th from 9:00 a.m. to noon. Board members and staff will be in attendance; the orientation will provide information on the board composition; Executive Leadership; Board Bylaws and policies; an overview of DWIHN and information on the SUD Oversight Policy Board.

It was reported that a Board Study Session will be planned in the next upcoming months. B. Blackwell, Chief of Staff noted that she will work with the Board Liaison to determine a meeting date and with Executive Leadership and the Board Chair on the agenda.

The Budget Hearing will take place on August 3, 2022 and will be a joint meeting of the Finance and Program Compliance Committees. Further information will be forthcoming. The meeting is normally a little longer; will be an in-person meeting and will be scheduled from 1:00 p.m. to 4:00 p.m.

DWIHN will host the Metro Region meeting; it will be held virtually and is scheduled for June 9th from 6:00 p.m. to 9:00 p.m. Ms. Blackwell reported that the agenda is being prepared and they are working on a number of items with Macomb and Oakland.

The Executive Committee meeting for June will be held on Monday, June 13, 2022 which is the 2nd Monday of the month instead of the 3rd Monday; this change is to accommodate the Full Board meeting that is scheduled for June 15 which is the 3rd Monday of the month.

It was reported that the Annual Meeting is scheduled for July 20, 2022; this will be a hybrid meeting; the Full Board will meet in person; the public will attend both virtually and in person. The Full Board meeting will start at 11:00 a.m. and will be an abbreviated meeting. The annual meeting will highlight our programs, incoming and outgoing board members and our CIT program. We will recognize first responders; both those in the community and staff members. Discussion ensued regarding a speaker; possibly someone that could speak on mental health needs and the individual did not have to be someone in our network. Staff will work on the request. There was no further discussion.

The Chair reported there is a DWIHN vacancy on the SUD Oversight Policy Board; it was noted that in the past the SUD Oversight Policy Board recommended a candidate for approval to the Full Board. An invitation was extended to Board members that if anyone was interested in serving on the SUD Oversight Policy Board to send an email to him stating their interest. It was also reported that the SUD Oversight Policy Board according to the Board Bylaws could have no more than four Full Board members serving on both boards.

The Executive Committee report was received and filed.

Finance Committee

Ms. Brown reported. The meeting was held on May 4. Ms. Watkins of Plante Moran presented the fiscal year 20/21 audit. She answered all of the committee's questions and provided a very good presentation concerning the financials. She informed of two findings. The first was due to misappropriated funds by a sub-recipient and those funds were replenished by that sub-recipient and DWIHN has modified our procedures and policies to eliminate this in the future. The second finding was concerning reporting of claims activity from a provider for the fiscal year ended September 30, 2021 that was pending from the state warehouse and therefore, not reflected in the financial statements which resulted in the accounts receivable and revenue balances being overstated due to the impact of the cost settlement. MDHHS has since revised the final billings, however, they did not remove the finding because the change did not occur until after the quarter end date in question.

The first quarter 5% rate increase was paid of the $5.79 million to providers. Two board actions were reviewed BA#20-54 (Revised) and BA#22-17 (Revised) both were recommended for approval by the full board. Our cash flow remains sufficient to support operations and liquidity remains strong. There was no further discussion.

The Finance Committee report was received and filed.

Program Compliance Committee

Ms. Jawad, Committee Chair provided a verbal report. The committee met on May 11 Board members were encouraged to consult the meeting packet and or the meeting minutes for more details on any of the topics. The following highlights were provided; there was a follow up to a board action #22-59 regarding HUD Supportive Housing program and the process for receiving services which was clarified for the committee; a report from the Chief Medical Officer and Corporate Compliance Officers were received. Corporate Compliance presented a list of proposed compliance objectives with the primary objective aimed

at an internal audit function to review provider compliance related to employee qualifications corresponding with MDHHS staff requirements. Quarterly reports were received from Managed Care Operations; Residential Services and Substance Use Disorder. The Strategic Plan Pillar for Access was reviewed and the committee also received a Quality Work (QAPIP) Plan update for FY22. The committee recommends for Full Board approval BA #22-16 (Revised) Substance Use Disorder Prevention Tobacco Initiative; BA#22-17 (Revised) Substance Use Disorder Annual Conferences; BA#22-29 (Revised) Jail Diversion/Police Partnership Expansion and BA#22-62 Summer Youth Employment Program which is a continuation of the summer youth program that takes place each year throughout Wayne County. There was no further discussion.

The Program Compliance Committee report was received and filed.

Recipient Rights Advisory Committee

Ms. Ruth, Chair of the Recipient Rights Advisory Committee noted there was no report as the committee did not meet for the month of April.

AD HOC COMMITTEE REPORTS

Policy/Bylaws Committee

It was reported that a Policy/Bylaw Committee meeting has been scheduled for Thursday, June 16th 2022 from 9:00 a.m. to 11:00 a.m.

SUBSTANCE USE DISORDER OVERSIGHT (SUD) POLICY BOARD REPORT

Ms. Judy Davis, Substance Use Disorder Director reported on behalf of Mr. Thomas Adams, Chair. SUD Oversight Policy Board. It was reported the SUD Oversight Policy Board met on April 18, 2022. A SUD Oversight Policy Board Study Session was held on March 30, 2022. There were overviews given by our CEO as well as overviews and reports given from the Call Center and the Chief Clinical Officer. SUD reports were also provided in each of our departments. Dr. Arfken, Epidemiologist also gave an overview on the drug overdose deaths in Michigan. There was one Board action that was reviewed which involved Tobacco funds for prevention. There was no further discussion.

The report was received and filed.

FY21 AUDIT REPORTS

The Chair, Mr. Glenn noted that the FY21 Audit Reports had been received at the Finance Committee meeting and called for a motion on the reports. **Motion: It was moved by Ms. Garza Dewaelsche and supported by Ms. Brown approval of the FY21 Audit Reports which included the AU260 Letter; the Financial Report; The Federal Awards Supplemental Information (Single Audit) and the Compliance Examination.** It was requested that CFO S. Durant provide an overview for board members that were not in attendance at the Finance Committee meeting. Ms. Durant provided a high-level overview. She reported that there were three Audit reports that were required; she noted the AU260 letter is the communication that is required to those individuals that are charged with Governance which is the Board. She reported on the information under corrected and uncorrected misstatements; it was reported by Management that there was a reporting of claims activity from a provider for the fiscal year ended September 30, 2021 for $440,000 that was pending from the state warehouse and therefore, not reflected in the financial statements which resulted in the accounts receivable and revenue balances being overstated due to the impact of the cost settlement. Discussion ensued and it was noted that there should be correspondence from the state this week regarding the claims; the $440,000 is currently a receivable on DWIHN books; once verification is received the payment will made in FY2022 this will reduce the receivable. It was also reported that this is a claims adjustment and the auditors found it be immaterial.

Discussion ensued regarding the Continuing Care Program Monitoring Visits and the contracts for In-network Providers. It was noted that DWIHN's Continuum of Care program was subject to a monitoring visit by the U.S. Department of Housing and Urban Development (HUD) Detroit field office related to grant programs spanning the period from fiscal year 2017 to fiscal year 2019. Among the outcomes there was a finding related to DWIHN's staff reimbursing certain subrecipient's payment for costs incurred with insufficient payment supporting documentation, which resulted in funds being misappropriated by an individual who was employed by the subrecipient. The subrecipient has replenished the funds, such that this did not result in ineligible cost activity as part of this grant program; however, it did raise awareness about the risk and opportunity for misappropriation of funds to occur when certain controls are not in place. DWIHN has since modified its related procedures and policies to require that cancelled checks be included in the subrecipient's billing submission. Compliance was made aware of the issue and has conducted a review. This was reported as a finding in the Single Audit report because HUD is a Federal program.

It was noted that there was an exception identified during their testing under Contracts for In-network Providers. It was reported that services were being provided by and payments remitted to one in-network service provider without an executed contract in place. It was understood that certain out-of-network providers are precluded from having a contract; however, DWIHN's policies do require signed contracts to be in place for in-network providers. DWIHN's team has made active attempts to obtain a signed contract and will continue to do so. Ms. Durant noted that usually on October 1st there may be contracts that are unsigned; however, since we do not want to hinder payment or services to our consumers we typically do not interrupt services and we usually will have the signed contracts in a few weeks; this provider took longer than usual to return the signed contracts which is why it is noted as an exception. This did not reach the level of a finding; however, the auditors wanted the Board to be made aware of the exception.

It was reported that the Financial Report is the audited financial statements and is due to the Department of Treasury within 180 days after the end of the fiscal year. An overview was provided of the various documents within the audit. She encouraged board members to review the report in its entirety as it provides historical information and other noteworthy information and is an unaudited document. Reference was made to the management discussion analysis which is an audited document and details what occurred during the fiscal year. The Independent Auditors Report was noted and stated that the opinion received was deemed to be an unqualified opinion which meant our financial statements were free from material misstatement.

An overview was provided regarding the Statement of Revenue, Expenses and Changes in Net Position. Ms. Durant noted that operating revenue is approximately $93 million dollars as of September 30, 2021; there was an increase in expenses of 5%; overall the net position was increased by $65 million dollars; cash increased by $14 million dollars. An overview was provided on the ISF; accounts payable; provider stability payments; retention payments and monthly liquidity. A budgetary comparison of the original budget; amended budget and actual budget was also provided for the board.

The Compliance Exam is required by the Michigan Department of Health and Human Services and is specific to our PIHP and CMH contracts. An overview was provided of the results of the audit; it was noted there were no findings for fiscal year 2021.

The Federal Awards Supplemental Information also referred to as the Single Audit report was noted. An overview was provided of the report; it was reported that we had a significant deficiency identified but not considered a material weakness; Federal Awards there was a material weakness identified and we had a significant deficiency identified that are not considered to be material weakness. There were audit findings disclosed that are required to be reported in accordance with Section 2 CFR.

There were three programs that were tested; the Medicaid Cluster; the State Opioid Targeted Response grants and the Block Grants for Community Mental Health services. The opinion of the auditor was unmodified. In regards to the State Opioid Targeted Response and State Opioid Response II program it was noted that MDHHS conducted a virtual financial site visit for the quarter ended December 31, 2020. As part of that visit, MDHHS reviewed expenses reported by DWIHN on the FSR for the State Opioid Targeted Response and State Opioid Response II programs. MDHHS' report included several findings related to the FSRs not being completed properly as it relates to reporting indirect costs, including indirect costs being incorrectly categorized as salaries and wages, fringe benefits, and supplies and materials. It was reported that all expenses reported were eligible costs of the grant program, were supported by appropriate records and were reconciled to the expenses in the accounting records. The finding was solely a reporting finding as it is specific to the accuracy of how certain program expenses were reported on the FSR. It was recommended that relative to the timing for filing monthly FSRs, DWIHN was encouraged to ensure the reports are completed within the 30- day requirement going forward. DWIHN did not concur with the MDHHS findings. The 10 Michigan PIHP chief financial officers met with the MDHHS Bureau of Audit and the Office of Recovery Oriented Systems of Care (OROSC) in an effort to explain the relationships PIHP's share with their provider network. The meeting resulted in MDHHS allowing the PIHPs to update their final billings based on their relationship. DWIHN requested OROSC remove the finding; however, OROSC stated that at the time of the report for the period under review (quarter ended December 31, 2020), the billing amounts were incorrect and refused to remove the finding. Discussion ensued regarding the reporting of contractors versus subrecipients; the 10 percent de minimis rate for indirect costs and the overall reporting. CFO Durant noted that she was available to meet with any board member that may have additional questions. The Chair and Mr. Parker thanked Ms. Durant and her team for a job well done on the audits. Mr. Parker noted that this was an outstanding job for an organization of this size. She thanked the board for there generosity in providing Provider and employee retention payments; Provider stability payments and assistance with health care benefits. The Chair called for a vote on the motion. **Motion carried unanimously.**

PRESIDENT AND CEO MONTHLY REPORT

Mr. Doeh reported. He also provided a written report for the record. He briefly updated on several items from his written report. It was reported the budget is at the state level; conversations are going on between the two houses; there is talk that the budget may be done by July. /there are some items in the budge that tremendously affect us – additional dollars for clinicians within the school setting; additional dollars for retention payment to keep workers within the field are important. There are items that are specifically related to DWIHN however, it would be premature to discuss at this time, but will hopefully have something to report to the board by the end of June. An overview as provided on the "Putting Children First" Initiative; it has been tremendous on all fronts – our partners and with the law enforcement community – all have been instrumental in programs that were conducted on the weekend and in the schools. It was noted that a detailed report was presented by the Director of Children's Initiative about some of the work that we are doing within the network. Our Behavioral Health Home launch was May 2nd and there was awesome work done; out of the 10 PIHP's we are one amongst five that actually have this service – it was tremendous to be recognized to do this for the people we serve. The CCBHC application was due yesterday and our application was submitted. This will put us in a different platform along with our partnerships with the FQHC's.

An update was provided on the Shirkey bill. It was noted that this bill is currently dormant and there has been talk that he is trying to link items to the budget. The labor department along with advocacy groups have been in support of the public system. The Care Center construction will begin at the end

of the month; DWIHN will appear before the city for our last hearing in regards to parking variance which means there needs to be additional parking spaces as a result of the structure. We have had an opportunity to meet with folks at the city and county level who are excited about DWIHN having a Crisis Center in Wayne. Our building on Woodward, which will be our headquarters, will have a new board room, office spaces for administration and will put us in a whole new category considering the new book of business. An update was provided on the finances and the monies that were poured into the system for the Providers and on the Autism service changes that were being recommended by the Michigan Department of Health and Human Services. It was noted that with the Autism services a parent had to go directly to a primary care physician for a referral; after some advocacy we were able to convince the department to give parents the ability to have a direct referral to a provider. A workgroup has been established to work on the intricate pieces to build out the programs. There has also been discussion with licensing to reduce some of the requirements to get clinicians into the system. We have met with local universities such as Wayne State and University of Michigan to develop programs where a graduate would be able to hire into the system and have additional grant dollars augment what they would be paid by the provider network. The staff shortage for clinicians continues to be a concern throughout the network.

He commended the Quality department on the work that was done on the QAPIP audit in which we received full compliance. He also commended the finance department for their work on the audit and the tremendous contribution of all of the staff, and the providers. He also thanked the board for their autonomy in allowing staff to get the work done.

There was no further discussion on the report of the CEO. The report of the CEO was received and filed.

INTEGRATED HEALTHCARE INITIATIVES PRESENTATION –– Ms. Vicky Politowski, Director of Integrated Health Care Initiatives submitted and gave a presentation on the Integrated Health Care Initiative. Ms. Politowski reported on the following: **Population Assessment** – DWIHN recognizes the importance of analyzing member data to assure that our programs and services meet the diverse needs of the members we serve. Staff uses this information to create topic and language appropriate materials, establish partnerships with other organizations serving ethnic communities, inform vendors about specific ethnic and cultural need and develop competency training for staff. DWIHN also gathers demographic data for its' members on an annual basis. The information includes gender, age, primary language spoken, ethnic background, disability designation, residency and insurance. The top five behavioral health diagnosis for children in 2021 were ADHD, Oppositional Defiant Disorder, Major Depressive Disorder, Adjustment Disorder and Mood Disorder. The top five medical diagnosis for children in 2021 are Asthma, other seasonal allergic rhinitis, headaches, other seizures and Eczema. The top five behavioral health diagnosis for adults in 2021 were Major Depressive Disorder, Anxiety Disorder, Schizoaffective Disorder, Alcohol Dependence and Opioid Dependence. The top five medical diagnosis for adults in 2021 are Essential Hypertension, other chronic pain, Pure Hypercholesterolemia (unspecified), Diabetes Mellitus and Asthma. **Complex Case Management (CCM)** - This is a free and voluntary program that's available to all of DWIHN's members. The managers work with current case managers and care teams to help members achieve their desired goals, assists members with being connected to community resources, peer advocates and other needed services/supports, aims to reduce hospitalizations, reduce gaps in care and increase participation in outpatient visits and aims to progress movement towards recovery. **MI-Health Link** – There are five Integrated Care Organizations (ICO) that service our members (Aetna, Amerihealth, HAP, Meridan and Molina). There were 5,805 served in 2021 and 3,763 in 2022. Staff is working to increase the number of members being served. **Omnibus Budget Reconciliation Act 1987 Pre-Admission Screening and Resident Review (PASRR)** – Anyone needing a nursing home

who may have a behavioral health or intellectual/development disability must have a PASRR assessment. This guarantees that the individual is not being placed in a nursing home due to MI or I/DD. DWIHN contracts with Neighborhood Service Organization (NSO) to provide services. There were 218 PASRR Assessments in 2022. **Special Integrated Projects** – ***Vital Data*** – HEDIS Quality Score Card, 15 NCQA Certified measures, one custom measure, data is obtained from CC 360 data warehouse, all CRSP's staff have access through MH-WIN, rolled-out to CRSP in March, will expand to have data for OHH, BHH, CCBHC and health plans in the next six months, development of a shared platform to use with health plans and build reports to close gaps in care. Examples of gaps in the care reports was covered as well as Pay for Performance Measures; and Hospitalization for Mental Illness. The board noted that this was a very thorough report and thanked Ms. Politowski for the report.

QUARTERLY COMMUNICATIONS PRESENTATION

Ms. Tiffany Devon, Director of Communications and Ms. Janell Hearns, Community Outreach and Communications Liaison reported. A PowerPoint presentation was provided for the record and included the Board packet. It was noted Communications ensures all stakeholders are informed and educated on how DWIHN and its Provider Network are serving and supporting people. Department is responsible for internal and external community engagement and outreach; social media; website content; media outreach and advocacy efforts. An overview was provided on various campaigns such as Mental Health "Putting Children First" which includes special populations such as children ages 0-6; Diversity/Inclusion/Equity; Foster Care; Juvenile Justice and Young Adults ages 18 to 21. An overview was provided on DWIHN's Social Media activity which includes -Facebook; Twitter; TikTok; Instagram and LinkedIn. It was also reported that there is an outdoor Media Campaign that covers Bus stops and Bike racks. A high-level overview was provided on the SUD Market Campaign which includes but is not limited to Ask the Messenger; Comcast; Cumulus Radio; Metro Parent and Fox2 News. It was also reported that from the beginning of fiscal year2021 through the end of May DWIHN has attended 75 events. A monthly calendar is published and community outreach materials are also printed in Spanish. The committee thanked the Communications department for the report. Discussion ensued regarding the addition of other venues.

UNFINISHED BUSINESS

Staff Recommendations:

A. BA #20-54 (Revision 5) – HEDIS/NCQA Professional Consultant Services- Contract Extension (Joseph J. Barr) – The Board chair called for a motion on BA#20-54 (Revision 5). **It was moved by Mr. Parker and supported by Ms. Brown approval of BA#20-54 (Revision 5).** M. Singla, Chief Network Officer reported. This board action is to request terms and funding extension of contractual Professional IT services for the period from 7/1/22 to 12/30/22. $41,470.00 is the additional fund allocation needed to support the additional six months of the contract. It is requested that Mr. Barr continue assisting on a part-time basis with helping generate HEDIS measures which is one of the prime requirements from a data standpoint when it comes to both state reporting and NCQA compliance. Mr. Barr has been instrumental in developing Risk Matrix and is continuing to help extend the functionality and rollout to entire network. There was no further discussion. **Motion carried.**

B. BA #22-16 (Revision 2) – Substance Use Disorder (SUD) Prevention Tobacco Initiative. The Board Chair called for a motion on BA#22-16 (Revision 2). **It was moved by Dr. Carter and supported by Ms. McNamara approval of BA#22-16 (Revision 2).** Judy Davis, Director of SUD reported. Staff requesting board approval to accept and disburse Treatment Block Grant Funding from the Michigan Department of Health and Human Services (MDHHS) in the amount of $4,000.00 to educate the retailers and the community on Electronic Nicotine Delivery System (ENDS) products. The Tobacco Section is providing funding for the period of May 1, 2022 through September 30, 2022. Strategies to Overcome Obstacles and Reduce Recidivism (SOOAR) is the chosen provider to implement this service. The Chair

called for a motion on BA #22-16 (Revised 2). The FY '22 SUD Prevention Services program of $6,715,938.00 is increased by $4,000.00 to $6,719,938.00 and consists of Federal Block Grant revenue of $4,704,938.00 and $2,015,000.00 is designated to Public Act 2 (PA2) Funds. There was no further discussion. **Motion carried.**

C. BA #22-17 (Revision 1) Substance Use Disorder Treatment Services Network FY2022. The Chair called for a motion on BA#22-17 (Revision 1). **It was moved by Ms. Brown and supported by Ms. Jawad approval of BA#22-17 (Revision 1).** J. Davis, Director of SUD reported. This revised board action is requesting the inclusion of Cumulas Radio that was inadvertently omitted from the initial board action. MEA-TV was overallocated $10,000 that should have been allocated to Cumulas Radio. The total amount and terms of the board action remains the same. Discussion ensued regarding the total amount of the contract, the amount that was being allocated to the new provider and the adding of the additional provider. There was no further discussion. **Motion carried.**

D. BA #22-17 (Revision 3) Substance Use Disorder (SUD) Annual Conferences. The Chair called for a motion on Board action #22-17 (Revision 3). **It was moved by Ms. Jawad and supported by Mr. Parker approval of BA#22-17 (Revision 3)** J. Davis, Director of SUD reported. Staff requesting board approval to receive and disburse additional PA 2 funding in the amount of $85,000.00 to provide community SUD Annual Conferences (Annual Men's Conference, Annual Faith-Based Conference, The Women's Conference, and the Annual Opioid Summit). The conferences are aimed to educate and bring awareness to important topics. The FY '22 SUD Treatment Program of $8,528,522.00 is increased by $85,000.00 to consists of Federal Block Grant revenue of $7,208,474.00 and Public Act 2 (PA2) Funds $1,405,048.00 to provide community SUD Annual Conferences. There was no further discussion. **Motion carried.**

E. BA#22-29 (Revised Jail Diversion/Police Partnership Expansion - The Chair called for a motion on BA#22-29 (Revised) **It was moved by Ms. Jawad and supported by Ms. Brown approval of BA#22-29 (Revised).** Andrea Smith, Director of Innovation and Community Engagement reported. This revised board action is requesting board approval to increase the contract by $300,000.00 for the period of May 1, 2022 through September 30, 2022 for a total amount not to exceed $1,305,000.00 for the Mental Health Crisis Diversion program. It is proposed that DWIHN expand efforts into Out-Wayne County to further support the organizations mission of prevention, treatment and recovery for individuals within the system of care, and those who have not yet obtained access, but need behavioral health support. There was no further discussion. **Motion carried.**

NEW BUSINESS

Staff Recommendations:

A. BA #22-62 Summer Youth Employment Program - The Chair called for a motion on Board Action #22-62. **It was moved by Mr. Parker and supported by Ms. Brown approval of Board Action #22-62.** A. Smith Director of Innovation and Community Engagement reported. Staff requesting board approval of a one-year term in an amount not to exceed $1.9 million. The DWIHN's Summer Youth Employment Program (SYEP) is a continuation from the last four fiscal years with organizations intending to foster growth and enhance communities. These organizations thrive on community outreach to adolescents focusing heavily on youth recruitment plans and educational and mentoring goals to be accomplished over the summer months. There was no further discussion. **Motion carried.**

PROVIDER PRESENTATION – Ms. Sallie Smith Brown, President/CEO and Ms. Trinilda Johnson, Chief Operating Officer Assured Family Services dba Juvenile Assessment Center reported. A PowerPoint presentation was provided for the record. It was reported that the Mission and Vision of Assured Family Services is to promote successful living, healthy development, and safe environments by identifying the unique needs of the youth and families we serve, thus enabling the recommendation and administration of appropriate quality services and effective partnering with community organizations. We envision healthy families and safe environments where each child has the opportunity to live fully and be successful in life. Assured Family Services has provided behavioral health services for over 22 years to Wayne County and the surrounding areas. It was reported there are three locations to serve the community and Assured Family Services functions as a single gateway to access Juvenile Justice services. They handle court- based services which includes access to dentation and dentation alternatives; diversion assessment and assignment and the Right TRAC initiative. An overview of AFS Access and Social Clinical Assessment; Psychological Testing and Evaluation Process along with the Integrated Community Based Services and their Community Health Outreach Intervention Clinical Engagement Services (Choices) Program was provided. It was also noted that the services covered under the Child Welfare Client Population -Therapeutic Services included but were not limited to in-home family support; parenting/caregiver skills education; anger management and domestic violence counseling. Ms. Smith Brown and Ms. Johnson also shared with the Board their Investment in Professionals of the Future Initiative. Mr. Glenn thanked the Provider for their presentation.

Both Ms. Smith Brown and Ms. Johnson thanked the board for the opportunity to give the presentation.

REVIEW OF ACTION ITEMS

GOOD AND WELFARE/PUBLIC COMMENT
The Board Chair, Mr. Glenn read the Good and Welfare/Public Comment statement. Ms. Warwick addressed the board and noted that the Full Board agenda was not posted on the website. The agenda is to be sent to Ms. Warwick following the meeting. She also noted that she disagreed with the way contracts are written.

ADJOURNMENT
There being no further business, the Board Chair, Mr. Glenn called for a motion to adjourn. **It was moved by Mr. Parker and seconded by Mr. Ruth to adjourn. The motion carried unanimously and the meeting adjourned at 3:15 p.m.**

Submitted by:
Lillian M. Blackshire
Board Liaison

FINANCE COMMITTEE

MINUTES **MAY 4, 2022** **1:00 A.M.** **707 W. MILWAUKEE ST. DETROIT, MI 48202 (HYBRID/ZOOM)**

MEETING CALLED BY	I. Mr. Kevin McNamara, Vice Chair called the meeting to order at 1:01 p.m.
TYPE OF MEETING	Finance Committee Meeting
FACILITATOR	Mr. Kevin McNamara, Vice Chair
NOTE TAKER	Lillian M. Blackshire, Board Liaison
ATTENDEES	**Finance Committee Members Present:** Ms. Dora Brown, Chair (Sworn In) Mr. Kevin McNamara, Vice Chair Ms. Eva Garza Dewaelsche Mr. Bernard Parker Ms. Kenya Ruth (Sworn In) **Committee Members Excused: None** **Board Members Present:** Mr. Angelo Glenn, Board Chair **Board Members Excused: None** **Staff:** Mr. Eric Doeh, CEO; Ms. Stacie Durant, CFO; Ms. Yolanda Turner, Deputy Legal Counsel; Mr. Manny Singla, CIO; Ms. Jean Mira, Procurement Manager **Guests:** Ms. Alisha Watkins, CPA, Partner - Plante & Moran, PLLC

AGENDA TOPICS

Roll Call Ms. Lillian Blackshire, Board Liaison

II. Swearing in Ceremony – Honorable Judge F. Burton
Judge Burton welcomed the committee members and the public to the meeting and noted that he would be swearing in the two County Board members Ms. Dora Brown and Ms. Kenya Ruth, both had been reappointed to the DWIHN Board of Directors. Judge Freddie Burton administered the oath and both Board members were sworn in. Judge Burton thanked DWIHN for their continued services in the community.

III. Roll Call
Roll Call was taken by the Board Liaison and a quorum was present. The Vice Chair, Mr. McNamara turned the meeting to Chair and Treasurer Ms. Dora Brown who presided over the remainder of the meeting.

IV. Committee Member Remarks
The Chair, Ms. Dora Brown called for any Committee remarks. Mr. McNamara noted that May is Mental Health Month and everyone should take a moment to take care of oneself.

Ms. Brown noted that Finance Committee meeting was not held during the month of April and she welcomed Ms. Garza Dewaelsche to the Board and to the Committee.

V. Approval of Agenda
The Chair, Ms. Brown called for a motion on the agenda. There were no changes or modifications requested to the agenda. **Motion:** It was moved by Ms. Ruth and supported by Mr. Parker approval of the agenda. **Motion carried.**

VI. Follow-up Items:
It was reported that there were two follow-up items; the first was the Procurement Report which the committee requested be placed on the agenda with corrections and the second follow up item was an update to Board Action #21-71 (Revised) Leadership Training, American Society of Employers. The additional information was provided and the Board Action was presented and approved at the Full Board meeting in March.

VII. Approval of the Meeting Minutes
The Chair Ms. Brown called for a motion on the Finance Committee minutes from the meeting of Wednesday, March 2, 2022. **Motion:** It was moved by Ms. Ruth and supported by Mr. Parker approval of the Finance Committee minutes with any necessary corrections from the meeting of Wednesday, March 2, 2022. There were no corrections to the minutes. **Motion carried**. Minutes accepted as presented.

VIII. Presentation of the FY 21 Annual Audit Reports – Plante Moran
CFO S. Durant provided an overview of the AU260 letter which she noted was a communication to those individuals, which is the Finance Committee that are charged with Governance. The Financial Report is the Financial Statement on the audit and is a requirement with the State of Michigan Department of Treasury; the Compliance Examination is the report required by the Michigan Department of Health and Human Service in accordance with the PIHP and CMHA contracts and the last report that will be reviewed is the Federal Award Supplemental Information which is referred to as the Single Audit. This audit is required by the Federal Government. Ms. Durant introduced Ms. Toni Jones, Supervisor of Auditing and noted she is responsible for coordinating the activity between Plante & Moran, staff and the Board and she is lead on the audit. She thanked Toni and her team for their hard work.

Ms. Alisha Watkins from Plante Moran and who is the new partner on the Plante & Moran rotation presented the FY 21 AU260 letter; the Financial Report; the Federal Awards Supplemental Information and the Compliance Examination. Written documents of each audit report was presented to each committee member. Ms. Watkins reported and gave an overview of the rotation and the importance of having a fresh set of eyes on information and noted there is recognition within the industry regarding rotations; she also noted that she has access to other partners in the firm as well as access to digital information and she understood that the rotation was important to DWIHN and the board.

Financial Report with Supplemental Information – Highlights of the report was provided. It was reported that pages 8 & 9 was the Independent Auditor's Report and management was responsible for the preparation and fair representation of those financial statements in accordance with generally accepted accounting principles. An overview was provided regarding the Statement of Revenue, Expenses and Changes in Net Position which was noted

on pages 17-19. Ms. Watkins noted that operating revenue is approximately $93 million dollars as of September 30, 2021; there was an increase in expenses of 5%; and there was a lot of cost containment efforts being done during the pandemic at DWIHN; overall the net position was increased by $65 million dollars; cash increased by $14 million dollars. An overview was provided on the ISF; accounts payable; provider stability payments; retention payments and monthly liquidity. A budgetary comparison of the original budget; amended budget and actual budget was also provided for the committee.

AU260 Letter – Ms. Watkins noted that this letter is standard language of the audit and conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States and they are obligated to communicate certain matters that come to their attention related to the audit to those responsible for the governance of DWIHN among other things. It was reported there were no significant difficulties in dealing with management in performing and completing the audit. It was noted that under Corrected and Uncorrected Misstatements that management identified approximately $440,000 of claims activity from a provider for the fiscal year ended September 30, 2021 that were pending from the state warehouse and, therefore, not reflected in the financial statements, which resulted in accounts receivable and revenue balances being overstated due to the impact of the cost settlement. Management has determined that their effects are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. The reporting of the claims did not change the opinion of the auditor. Discussion ensued regarding risk and management bringing the issue to Plante & Moran.

Discussion ensued regard the Continuing Care Program Monitoring Visits and the contracts for In-network Providers. It was noted that DWIHN's Continuum of Care program was subject to a monitoring visit by the U.S. Department of Housing and Urban Development (HUD) Detroit field office related to grant programs spanning the period from fiscal year 2017 to fiscal year 2019. Among the outcomes there was a finding related to DWIHN's staff reimbursing certain subrecipient's payment for costs incurred with insufficient payment supporting documentation, which resulted in funds being misappropriated by an individual who was employed by the subrecipient. The subrecipient has replenished the funds, such that this did not result in ineligible cost activity as part of this grant program; however, it did raise awareness about the risk and opportunity for misappropriation of funds to occur when certain controls are not in place. DWIHN has since modified its related procedures and policies to require that cancelled checks be included in the subrecipient's billing submission. Compliance was made aware of the issue and has conducted a review. Bank statements and wire transfer processes have been put in place by DWIHN and we will continue to internally monitor all such program activity periodically to ensure that controls over such disbursements continue to remain in place and are effective going forward.

It was noted that there was an exception identified during their testing under Contracts for In-network Providers. It was reported that services were being provided by and payments remitted to an in-network service provider without an executed contract in place. It was understood that certain out-of-network providers are precluded from having a contract; however, DWIHN's policies do require signed contracts to be in place for in-network providers. DWIHN's team has made active attempts to obtain a signed contract and will continue to do so. Ms. Durant noted that usually on October 1st there may be contracts that are unsigned; however, since we do not want to hinder payment or services to our consumers we typically do not interrupt services and we usually will have the signed contracts in a few weeks; this provider took longer than usual to return the signed contracts which is why it is noted as an exception.

There was a brief discussion regarding the language used in the explanation to describe the provider; it was requested that for clarity purposes the statement could the statement read "one provider" which would have indicated that it was not an extensive problem.

Compliance Examination – It was noted that there were no findings or exceptions and this Examination is required by the Michigan Department of Health and Human Services.

Federal Awards Supplemental Information – It was noted this report is required by the Federal Government. There were three programs that were tested; the Medicaid Cluster; the State Opioid Targeted Response grants and the Block Grants for Community Mental Health services. The opinion of the auditor was unmodified. In regards to the State Opioid Targeted Response and State Opioid Response II program it was noted that MDHHS conducted a virtual financial site visit for the quarter ended December 31, 2020. As part of that visit, MDHHS reviewed expenses reported by DWIHN on the FSR for the State Opioid Targeted Response and State Opioid Response II programs. MDHHS' report included several findings related to the FSRs not being completed properly as it relates to reporting indirect costs, including indirect costs being incorrectly categorized as salaries and wages, fringe benefits, and supplies and materials. It was reported that all expenses reported were eligible costs of the grant program, were supported by appropriate records and were reconciled to the expenses in the accounting records. The finding was solely a reporting finding as it is specific to the accuracy of how certain program expenses were reported on the FSR. It was recommended that relative to the timing for filing monthly FSRs, DWIHN was encouraged to ensure the reports are completed within the 30- day requirement going forward. DWIHN did not concur with the MDHHS findings. The 10 Michigan PIHP chief financial officers met with the MDHHS Bureau of Audit and the Office of Recovery Oriented Systems of Care (OROSC) in an effort to explain the relationships PIHP's share with their provider network. The meeting resulted in MDHHS allowing the PIHPs to update their final billings based on their relationship. DWIHN requested OROSC remove the finding; however, OROSC stated that at the time of the report for the period under review (quarter ended December 31, 2020), the billing amounts were incorrect and refused to remove the finding. Discussion ensued regarding the reporting of contractors versus subrecipients; the 10 percent de minimis rate for indirect costs and the overall reporting.

The Chair called for a motion on the Financial Audit Statements for fiscal year 2021. **Motion:** It was moved by Mr. Parker and supported by Ms. Garza Dewaelsche to move the Financial Audit Statements for Fiscal Year 2021 to Full Board for approval. There was no further discussion. **Motion carried.**

Ms. Brown, Chair complimented the team and thanked Plante & Moran for coming to the meeting; reporting to the committee and providing the overview. She also noted that findings are not unusual; many organizations have findings; however, having a rationale for them makes it easier to determine what happened and how to correct the issue moving forward. She thanked Ms. Jones, Ms. Durant and her entire staff along with the CEO on a job well done and noted to be able to walk away with the year that we have had and be on solid footing is a job well done. The Board Chair, Mr. Glenn extended his congratulations to the Executive Leadership team and staff on a fine job and he was excited to see what the future will bring; Mr. Parker also congratulated the team on another good audit even with the small findings and thanked the team for their hard work.

IX. Presentation of the Monthly Finance Report

S. Durant, CFO presented the Monthly Finance report. A written report for the six months ended March 31, 2022 was provided for the record. Network Finance accomplishments and noteworthy items were as follows:

1. DWIHN's annual audit reports have been completed and there were two findings in the Single Audit Report – (a) HUD site review that noted the CCIH finding regarding the rental payments not made to landlords discovered in fiscal year 2019; and (b) 2020 MDHHS site review noting expenses were inaccurately reported on the Egrams billings. It should be noted that DWIHN disagreed with the MDHHS site review finding.

2.DWIHN paid out the 1st quarter 5% rate increase totaling $5.7 million. After more in-depth analysis of January and February 2022, DWIHN will issue retroactive payment accordingly.

A. Cash and Investments – comprise of funds held by three (3) investment managers, First Independence CDARS, Comerica, and Flagstar accounts.

B. Due from other governments – comprise various local, state and federal amounts due to DWIHN. The account balance primarily related to $5.6 million and $7.6 million for MDHHS performance incentive and HRA payment, respectively. In addition, there is $5.0 million due from MDHHS for SUD and MH block grant.

C. Accounts receivable and allowance for uncollectible – Approximately $3.5 million due from Wayne County for March local payment and the estimated 2nd quarter PA2. In addition, approximately $1.0 due from the ICO's for cost settlements; $1.0 million due from CLS for prior year cost settlement. DWIHN recorded $.5 million in an allowance for two SUD providers due to length of amount owed and likelihood of collections.

D. IBNR Payable – represents incurred but not reported (IBNR) claims from the provider network; historical average claims incurred through March 31, 2022 including DCW hazard pay and 5% rate increases, was approximately $354.2 million however actual payments were approximately $290.8 million. The difference represents claims incurred but not reported and paid of $63.4 million.

E. Due to other governments – includes $8 million due to MDHHS for death recoupment and $12.3 million for the hazard pay cost settlement. In addition, the amount includes $2.3 million in IPPA tax payments due 4/30/22, and $1.8 million due to MDHHS for FY20 general fund carryover in excess of 5%.

F. Federal revenue/grant program expenses – variance due to budget assumes revenues are incurred consistently throughout the year.

G. Autism, SUD, Adult, IDD, and Children services – $67 million variance due to impact of COVID, the workforce shortages and timing in services and payment (i.e. summer programs, financial stability payment).

There was no further discussion. The Chair, Ms. Brown noted the Monthly Finance Report ended March 31, 2022 was received and filed.

VIII. FY 22 1st Quarter Procurement Report Non-Competitive Under $50,00 and all Cooperative Purchasing– Ms. S. Durant and J. Mira reporting. A corrected written document was provided to the committee. It was reported that the contract percentage for Wayne County was at 12.50% and out county was 87.50%; the Funding percentage without IT with Wayne County was 49.32% and Out County was 50.68%. Discussion ensued regarding the Verizon cost and the rationale of the purchase and the purchase of COVID testing kits from Great Lakes Medical located in Farmington Hills versus purchasing the kits from companies located in Detroit and Wayne County. The purchase of shredding services was also discussed. Mr. Parker encouraged DWIHN to utilize Wayne County and City of

Detroit vendors when possible. There was no further discussion. The report was received and filed.

IX. Unfinished Business – Staff Recommendations:

a**. Board Action #20-54(Revision 5) – HEDIS/NCQA Professional Consultant Services – Contract Extension (Joseph Bar)** The Chair called for a motion. **Motion:** It was moved by Mr. McNamara and supported by Ms. Ruth approval of BA #20-54 (Revision 5) M. Singla, Chief Network Officer reporting. This board action is to request terms and funding extension of contractual Professional IT services for the period from 7/1/22 to 12/30/22. $41,470.00 is the additional fund allocation needed to support the additional six months of the contract. It is requested that Mr. Barr continue assisting on a part-time basis with helping generate HEDIS measures which is one of the prime requirements from a data standpoint when it comes to both state reporting and NCQA compliance. Mr. Barr has been instrumental in developing Risk Matrix and is continuing to help extend the functionality and rollout to entire network. There was no further discussion. **Motion carried.**

b. **Board Action #22-17 (Revision 1)- Substance Use Disorder Treatment Services Network FY 2022.** The Chair called for a motion. **Motion:** It was moved by Mr. Parker and supported by Ms. Garza Dewaelsche approval of BA#22-17 (Revision 1) T. Devon, Director of Communications reporting. This revised board action is requesting the inclusion of Cumulas Radio that was inadvertently omitted from the initial board action. MEA-TV was overallocated $10,000 that should have been allocated to Cumulas Radio. The total amount and terms of the board action remains the same. Discussion ensued regarding the total amount of the contract, the amount that was being allocated to the new provider and the adding of the additional provider. There was no further discussion. **Motion carried.**

X. New Business – Staff Recommendations: None

XI. Good and Welfare/Public Comment – The Chair read the Good and Welfare/Public Comment statement. There were no members of the public to address the committee and there were no public comments.

XII. Adjournment – There being no further business; The Chair, Ms. Brown called for a motion to adjourn. **Motion:** It was moved by Mr. Parker and supported by Ms. Ruth to adjourn the meeting. **Motion carried**. The meeting adjourned at 2:11 p.m.

FOLLOW-UP ITEMS		
a. None.		

PROGRAM COMPLIANCE COMMITTEE

MINUTES **MAY 11, 2022** **1:00 P.M.** ***IN-PERSON MEETING***

MEETING CALLED BY	I. Michelle Jawad, Program Compliance Chair at 1:03 p.m.
TYPE OF MEETING	Program Compliance Committee
FACILITATOR	Michelle Jawad, Chair
NOTE TAKER	Sonya Davis
TIMEKEEPER	
ATTENDEES	**Committee Members:** Dorothy Burrell; Dr. Lynne Carter; Michelle Jawad; Commissioner Jonathan Kinloch; William Phillips; and Dr. Cynthia Taueg **Staff:** Brooke Blackwell; Jacquelyn Davis; Judy Davis; Eric Doeh; Dr. Shama Faheem; Shirley Hirsch; Sheree Jackson; Tania James; Sharon Matthews; Melissa Moody; Vicky Politowski; April Siebert; Manny Singla; Andrea Smith and Yolanda Turner

AGENDA TOPICS

II. Moment of Silence

DISCUSSION	The Chair called for a moment of silence.
CONCLUSIONS	Moment of silence was taken.

III. Roll Call

DISCUSSION	The Chair called for a roll call.
CONCLUSIONS	Roll call was taken by Board Liaison, Lillian Blackshire. There was a quorum.

IV. Approval of the Agenda

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the agenda. **Motion:** It was moved by Dr. Taueg and supported by Mr. Phillips to approve the agenda. Mrs. Jawad asked if there were any changes/modifications to the agenda. There were no changes/modifications to the agenda. **Motion carried**

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS	A. **BA #22-59** – Dept. of Housing and Urban Development (HUD) – Provide the process for receiving and disbursement of funding for the HUD Continuum of Care (CoC) Permanent Housing Grant at the next Program Compliance

	Committee meeting - On behalf of June White, Tania James submitted and provided the process for receiving and disbursement of funding for the HUD Continuum of Care (CoC) Permanent Housing Grant. The committee requested a copy of the phone numbers and links to this program. **(Action)**

VI. Approval of the Minutes

DISCUSSION/ CONCLUSIONS	The Chair called for approval of the April 13, 2022 meeting minutes. **Motion:** It was moved by Dr. Taueg and supported by Commissioner Kinloch to approve the April 13, 2022 meeting minutes. Mrs. Jawad asked if there were any changes/modifications to the meeting minutes. There were no changes/modifications to the meeting minutes. **Motion carried.**

VII. Reports

DISCUSSION/ CONCLUSIONS	A. **Chief Medical Officer** – Dr. Shama Faheem submitted and gave an update on the Chief Medical Officer's report. Dr. Faheem reported: 1. ***Behavioral Health Outreach*** – DWIHN continues outreach efforts for behavioral health services. There is a Behavioral Threat Assessment and Management (BTAM) training for school counselors and some internal DWIHN staff on May 26, 2022. "Ask the Doc" Newsletter continues with the most recent addition addressing Mental Health Awareness Month as well as videos addressing important mental health and COVID related questions. 2. ***Quality Department*** – DWIHN was recognized by MDHHS for doing an outstanding job on the QAPIP for FY '22. We were found to be in full compliance with the Administrative Review, policies, practices and procedures, the BTPRC process and in all areas of the Substance Use Disorder Protocol. There were findings on the adult and children waiver services and currently awaiting on a full report from the State to address it with a Corrective Action Plan (CAP). ***Michigan Mission Based Performance Indicator (MMBP)*** – Staffing shortages continue to be a major barrier in securing timely intake appointment for our members, getting Biopsychosocial completed in 14 days Performance Indicator 2 (PI2). DWIHN closed the Q1 FY 2022 reporting at a 52.85% compliance rate for PI#2a, DWIHN's highest rate since Q4 FY 2020. Staff will continue efforts to accomplish higher scores with the ability to sustain improvements. Q2 FY 2022, the preliminary rate is currently at 58.25%. Staff continually review providers' data and meeting with CRSPs on a monthly basis to discuss Indicators. Q2 FY 2022 reporting period will be finalized on June 30, 2022. 3. ***Improvement in Practice Leadership Team (IPLT)*** – The committee looked at three important Performance Improvement Projects, two of which are also HEDIS measures, "Reducing Racial Disparities in Hospital Discharge Follow-up (HSAG PIP)", "Diabetic Screening for People with Bipolar Disorder and Schizophrenia who are on Antipsychotics" and "metabolic Monitoring for Children who are on Antipsychotics". Various interventions were discussed that can potentially improve outcomes. 4. ***Med Drop Program*** – There are 44 active members with five new members enrolled during the month of April. There are 13 more members who are being referred and awaiting intake in May. We were at 42 active members last month. 5. ***Quality Improvement Steering Committee*** – Utilization Management Program Description for 2022-2024, Customer Services Survey, Peer

Support/Mentor Data Collection and Performance Indicator Data Analysis were reviewed during the month of April.

6. ***Integrated Health Care*** – **Coordination with Health Plans** – Staff performs Data Sharing with each of the eight (8) Medicaid Health Plans (MHP) serving Wayne County in accordance with the MDHHS Performance Metric to Implement Joint Care Management between the PIHP and MHPs. Data Sharing was completed for 41 individuals in April. Joint Care Plans between DWIHN and the MHPs were developed and/or updated and outreach completed to members and providers to address gaps in care. **HEDIS Measures** – Staff continues to educate our providers on the importance of HEDIS measures. **Complex Case Management Services** – There are 14 active cases, 10 new cases opened, two (2) cases closed (met treatment goals) and no pending cases for the month of April.

Mrs. Jawad opened the floor for discussion. There was no discussion. The Chair has noted that the Chief Medical Officer's report has been received and placed on file.

B. **Corporate Compliance Report** – Sheree Jackson, Compliance Officer submitted and gave an update on the Corporate Compliance report. Mrs. Jackson reported:

1. ***Internal Audit Function for FY 2022-2023*** – Corporate Compliance presented a list of proposed compliance objectives for presentation to the Compliance Committee. The primary objective is to implement an internal audit function to review provider compliance as it relates to employee qualifications that correspond with MDHHS' staff requirements for Direct Care Workers.
2. ***Consultation with the Attorney General*** – A meeting with a Special Investigator from the Attorney General's office was convened to discuss a matter arising from billing practices and unqualified staff employed by the provider that is currently under investigation by the Attorney General, Wayne County, Oakland County and Macomb County. The consultation is ongoing and the Attorney General has provided information to support the Compliance Department's investigation. The provider being investigated is a staffing agency and does not provide medications to clients. An update will be provided as information becomes available.

Mrs. Jawad opened the floor for discussion. Discussion ensued. The Chair noted that the Corporate Compliance report has been received and placed on file.

VIII. Quarterly Reports

A. **Managed Care Operations** – Sharon Matthews, Senior Network Manager on behalf of June White, Director of Managed Care Operations, submitted and gave highlights of the Managed Care Operations' quarterly report. Ms. Matthews reported that DWIHN will have over 400 providers receiving contracts for FY 2023. Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general among all of our providers resulting from the pandemic statewide. DWIHN continues to support the Network through supportive efforts of training and educating providers; advocating at the State level for overburden reporting requirement/increased funding to assist providers with the staff shortage; finding ways to automate process/procedures to reduce stress on providers from the staff shortages; and meet with providers to find solutions that will better all during these times. ***Internal/External Training Meetings Held*** – Met with 12 CRSP providers regarding the performance indicators most providers continue to experience staff shortages in the intake department for new intakes as well as ongoing services they provide; Access Committee meeting held to discuss network adequacy and provider gaps

in services; reviewed all changes to the Provider Manual for FY 2022; and weekly meeting with Continuum of Care (CoC) to discuss HUD/Homeless projects. ***Goals Executed –*** Improved relationships with providers through training and one-on-one provider virtual visits quarterly; improved the Online Provider/Practitioner Directory; enhanced/improved our Provider Manual; monitor compliance and non-compliant providers in regards to Recipient Rights complaints, timely billing and proper utilization of service codes; ensure our compliance and network adequacy with state regulations based on members served to the number of provider/practitioners and type of services; and improve/implement a network adequacy process/procedure that will assist in structuring our network based on the needs of the members to identify any gaps in services we offer our network based on the needs of the members. Mrs. Jawad opened the floor for discussion. There was no discussion.

B. Residential Services – Shirley Hirsch, Director of Residential Services submitted and gave highlights of the Residential Services' quarterly report. Ms. Hirsch reported that there were 646 referral requests for Q2. The Inpatient Penetration Rate for Q2 is 54%, down from Q1 (89%). There were 58 ED cases, an increase from Q1. There was 12 State Hospital Discharges in Q2, a decrease from Q1 (18). There were 17 facility closures for Q2 due to staffing shortages. There were 3,024 authorizations completed for Q2, an increase from Q1 (2,693). Mrs. Jawad opened the floor for discussion. Discussion ensued.

C. **Substance Use Disorder** – Judy Davis, Director of Substance Use Disorder Services submitted and gave highlights of the Substance Use Disorder Services' quarterly report. Mrs. Davis reported that during Q2 of FY '22, 24,138 individuals received prevention services throughout the region. In Wayne County, 13% of high school students reported recent alcohol use and 2.5% reported recent binge drinking during Q2. Underage drinking has been declining and continues to be lower than statewide rates of 25.4% of high school students. In 2021, 13.2% of high school students in Wayne County reported recent use of marijuana. Rates are higher than the statewide rates and have increased during FY '22 (Q2). There were 187 drug overdose deaths during the first three months of FY '22, a decrease from FY '21 during the same period (235). Fentanyl remains the driving force in the drug overdose deaths. DWIHN's Naloxone Initiative program has saved 792 lives since its' inception. Staff continues to train entities on how to reverse opioid overdoses in person and via Zoom. Staff has received 12,516 calls for SUD services, 4,540 were screened and 697 individuals were from the priority population. DWIHN's SUD held two Active Shooter trainings (January 27, 2022 and April 22, 2022) in response to the recent active shooter situations. There will be an Active Shooter training for adolescents on May 18, 2022. The Michigan Department of Corrections (MDOC) and DWIHN have joined in a collaborative effort that will ensure that MDOC offenders with SUD receive medically necessary services from DWIHN's SUD Provider Network. There were 872 calls received from MDOC from January-March 2022. DWIHN has two mobile units that provide SUD screenings for services, referrals to treatment, peer services, drug screenings, therapy and relapse recovery services, Naloxone training and distribution on Narcan kits. The Epidemiologist that sits on the SUD Oversight Policy Board gets information from the Medical Examiner's office and gives that Board a full report on the overdoses in Wayne County but due to recent changes at the Medical Examiner's office she is not able to do that right now. Mrs. Jawad opened the floor for discussion. Discussion ensued. The committee requested a breakdown of the overdose data by race, age and the area of which they reside. **(Action)** Commissioner Kinloch stated he will follow-up at the next

	Commission's meeting on receiving updated information from the Medical Examiner's office and will report back. **(Action)** The Chair noted that the Managed Care Operations, Residential Services; and Substance Use Disorder Services' quarterly reports have been received and placed on file.

IX. Strategic Plan Pillar - Access

DISCUSSION/ CONCLUSIONS	Jacquelyn Davis, Clinical Officer submitted and gave an update on the Strategic Plan Access Pillar report. Ms. Davis reported that the Access Pillar is at 88% completion. There are four (4) high-level goals under this pillar. The goals under this pillar ranges from 80%- 98% completion: A. **Create infrastructure to support a holistic care delivery system (full array) by December 31, 2022** – Increased from 75% to 80% from last report in February. Working to make additional refinements to the Risk Matrix Score Card. Including Customer Service's annual audits and an internal workgroup has begun meeting monthly to review and assess data. B. **Create Integrated Continuum of Care for Youth by September 30, 2022** – Increased from 86% to 90% from last report in February. DWIHN has been educating the community with additional media, billboards, mobile outreach efforts, brochures and recent addition of the QR code as well as continuous education to the Network Providers. The QR code takes you right to the services we offer to learn more and staff recently provided updates on the Clinical Care Center to the Children's System Transformation and the Cross-System Management groups. C. **Establish an effective crisis response system by September 30, 2022** – Percentage is the same (82%), however, work on the center continues. DWIHN is moving forward with beginning work on the building and involving consultants on programming. D. **Implement Justice Involved Continuum of Care by September 30, 2022** – Percentage is the same (98%), need to identify the recommendations and addition of the new educational topics. The additional training will be included in the updated report for the next quarter report. Mrs. Jawad opened the floor for discussion. There was no discussion. The Chair noted that the Strategic Plan Access Pillar has been received and placed on file.

X. Quality Review(s) -

DISCUSSION/ CONCLUSIONS	A. QAPIP Work Plan FY '22 Update – April Siebert, Director of Quality Improvement submitted and gave an update on the QAPIP Work Plan FY '22. Ms. Siebert reported: 1. **Goal II (Access Pillar (Quality of Clinical Care and Services)** – ***Michigan Mission Based Performance Indicators (MMBPI)*** - The 1st quarter Performance Indicator data was submitted to the MDHHS on March 31, 2022. Standards were met for all populations for all Performance Indicators with the exception of PI 4a (7-day follow after hospitalization) for Adults for Q1. We achieved a compliance score of 94.80%, the standard is 95%. Steps have been taken to address and ensure we meet this standard with better outcomes for Q2. ***Quantitative Analysis and Trending of Measures*** – DWIHN continues to meet Indicator 1 (Pre-Admission Screening in 3 hours) for adults after not meeting it for three of quarter in FY 2021. We met Indicator 10 (Recidivism or Re-Admission within 30 days) standard, 15% or

less. DWIHN has not met this Indicator for adults in over three years but had shown improving trends each quarter to our most recent progress of meeting the standard at 14.93% Q1 FY '22. We have continued to meet this Indicator for children. ***Evaluation of Effectiveness*** – DWIHN continues to meet the standards for PI-1 (Children and Adult), PI-4a (Children), 4b (SUD) and 10 (Children). Indicator 2a (Completing Biopsychosocial within 14 days of the request), a new indicator with no standard/benchmark set by MDHHS. DWIHN closed Q1 FY '22 reporting rate at a 52.85% for PI-2a. The preliminary rate is currently at 58.36%. We continue to show ongoing improvement with an increase of 5.51% from Q1 to Q2. The average score for the State is noted at 59.61%. The Q2 FY '22 reporting period will be finalized on June 30, 2022. ***Barriers*** - Providers are experiencing staffing challenges as a result of many factors associated with the pandemic, which is impacting their ability to schedule intake appointments at the high rate we have in the past. Member no-shows have also been a significant barrier. Steps have been taken to address these issues. ***Opportunities for Improvement*** – DWIHN continues to collaborate with Wayne State University in an effort to address current workforce shortages; staff working with the Crisis Team to identify potential delays in care; working on expansion of the Med Drop program to improve outpatient compliance; engagement and collaboration with members' outpatient CRSP providers to ensure continuity of care; and continue coordination and collaboration with crisis screeners on measures to decrease inpatient admission.

2. **Goal V – Quality Pillar (Safety of Clinical Care)** – ***Critical/Sentinel Event Reporting*** – Quality Performance Improvement Team continued to focus on the review of FY 21/22 event processing including Root Cause Analysis (RCA) reviews; provider network training and technical assistance; improvement/streamlining of CE/SE reporting; completion of the RCA template with implementation scheduled for mid-May (including development of a template for MH-WIN) as soon as possible; QPI team continues to review requirements for the HSAG audits. Weekly huddles are being implemented to focus on review of RCAs to determine if they are complete. Six-month Annual Data report currently in process to be submitted the first week of May.
3. **Goal VII – External Quality Reviews (Quality of Service)** – ***MDHHS Full Waiver Review of DWIHN's HSW, CPW and SUD services*** – MDHHS has completed the Annual Home and Community Based Waiver Review of DWIHN-Region 7 Network. The site review was from March 14, 2022 through April 22, 2022. MDHHS will send out the final report to DWIHN within 15 days. We will have 30 days to submit corrective action plans (with input from CMHSP/Providers). MDHHS will conduct a 90-day follow-up from the date the CAP is approved by MDHHS, which will reflect both individual and systemic remediation with timeliness.
4. **Health Services Advisory Group (HSAG) Activities** – ***Performance Measurement Validation (PMV)*** – The 2022 PMV Annual Review is scheduled for June 9, 2022. The review will be conducted virtually, requiring HSAG access to the MH-WIN system (for the specific member-level detail files being reviewed). ***Compliance Review*** – The HSAG second half of the three-year Compliance Review is scheduled for July 29, 2022. The final review of this three-year cycle will happen 2023. ***Performance Improvement Project (PIP)*** – DWIHN has identified existing racial or ethnic disparities within our provider network for populations served which is based on our review and analysis of the Michigan Mission Based

	Performance Indicator (MMBPI) reporting data for PI-4a (The percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within seven days for the 2022 submission to MDHHS and HSAG. The write-up of the PIP is due to HSAG for validation on July 15, 2022. Mrs. Jawad opened the floor for discussion. Discussion ensued. The Chair noted that the QAPIP Work Plan FY '22 Update has been received and placed on file.

XI. Integrated Healthcare Initiatives' Presentation -

DISCUSSION/ CONCLUSIONS	Vicky Politowski, Director of Integrated Health Care Initiatives submitted and gave a presentation on the Integrated Health Care Initiatives. Mrs. Politowski reported: 1. **Population Assessment** – DWIHN recognizes the importance of analyzing member data to assure that our programs and services meet the diverse needs of the members we serve. Staff uses this information to create topic and language appropriate materials, establish partnership with other organizations serving ethnic communities, inform vendors about specific ethnic and cultural need and develop competency training for staff. DWIHN also gathers demographic data for its' members on an annual basis. The information includes gender, age, primary language spoken, ethnic background, disability designation, residency and insurance. The top five behavioral health diagnosis for children in 2021 were ADHD, Oppositional Defiant Disorder, Major Depressive Disorder, Adjustment Disorder and Mood Disorder. The top five medical diagnosis for children in 2021 are Asthma, other seasonal allergic rhinitis, headaches, other seizures and Eczema. The top five behavioral health diagnosis for adults in 2021 were Major Depressive Disorder, Anxiety Disorder, Schizoaffective Disorder, Alcohol Dependence and Opioid Dependence. The top five medical diagnosis for adults in 2021 are Essential Hypertension, other chronic pain, Pure Hypercholesterolemia (unspecified), Diabetes Mellitus and Asthma. 2. **Complex Case Management (CCM)** - This is a free and voluntary program that's available to all of DWIHN's members. The managers work with current case managers and care teams to help members achieve their desired goals, assists members with being connected to community resources, peer advocates and other needed services/supports, aims to reduce hospitalizations, reduce gaps in care and increase participation in outpatient visits and aims to progress movement towards recovery, enhance wellness, and build resiliency through self-care and empowerment for members with medical and behavioral health concerns. There are 43 members being serviced in 2022 and on track for a 20% increase. 3. **MI-Health Link** – There are five Integrated Care Organizations (ICO) that service our members (Aetna, Amerihealth, HAP, Meridan and Molina). There were 5,805 served in 2021 and 3,763 in 2022. Staff is working to increase the number of members being served. The health plans participate in care coordination and data sharing monthly. Staff follow up with members and CRSP for FUH (follow up after hospitalization) appointment and any barriers; DWIHN and Health Plan staff discuss medical needs and who will follow up; and DWIHN maintains documentation in MH-WIN and CC360. Staff manages five Quality Improvement Plans (QIPs) that are in alignment with NCQA requirements. 4. **Omnibus Budget Reconciliation Act 1987 Pre-Admission Screening and Resident Review (PASRR)** – Anyone needing a nursing home who may have a behavioral health or intellectual/development disability must have a PASRR assessment. This guarantees that the individual is not being placed in a nursing home due to MI or I/DD. DWIHN contracts with Neighborhood Service

	Organization (NSO) to provide services. There were 218 PASRR Assessments in 2022. 5. **Special Integrated Projects** – ***Vital Data*** – HEDIS Quality Score Card, 15 NCQA Certified measures, one custom measure, data is obtained from CC 360 data warehouse, all CRSP's staff have access through MH-WIN, rolled-out to CRSP in March, will expand to have data for OHH, BHH, CCBHC and health plans in the next six months, development of a shared platform to use with health plans and build reports to close gaps in care. 6. **Examples of Gaps in Care Reports** – Build reports based on zip code, insurance; reports on diagnosis and services by CPT code; LOCUS score, MI/I/DD diagnosis and physical health; LOCUS, CRSP, insurance, CCBHC/BHH/OHH; and language spoken, diagnosis, services provided and zip code. 7. **Pay for Performance Measures** - The Veterans-Comparison of BH TEDS first submission was January 22, 2022 and the second submission is due July 1, 2022 (25 points); Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY '22 is due July 31, 2022 (25 points); Initiation and Engagement and treatment (IET) of alcohol and other drugs – Completed the participation in IET measure data validation work with MDHHS and submitted an IET data validation response file by March 3, 2022 (50 points); Increased participation in patient-centered medical homes narrative, due November 15, 2022 (20% of withhold); Joint Care Management completed monthly by IHC staff (35 points); Follow-Up after (FUH) hospitalization for Mental Illness – The Contractor must meet set standards for follow-up within 30 days for each rate (ages 6-17years and 18 years and older). The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Data will be stratified by race/ethnicity and provided to plans. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with Calendar year 2021 (40 points). As of 9/30/21, DWIHN is at 56.19% for adults and 78.57% for children. Follow-Up after (FUA) Emergency Department visit for alcohol and other drug abuse – The Contractor must meet set standards for follow-up within 30 days. The Contractor will be measured against a minimum standard of 27%. Data will be stratified by the State by race/ethnicity and provided to plans. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with calendar year 2021 (40 points). As of 6/30/21, DWIHN is at 18.7%. Mrs. Jawad opened the floor for discussion. Discussion ensued. The Chair noted that the Integrated Health Care Initiatives' presentation has been noted and placed on file.

XII. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS	Melissa Moody, Chief Clinical Officer submitted and gave highlights of her Chief Clinical Officer's report. Mrs. Moody reported: 1. **COVID-19 & Inpatient Psychiatric Hospitalization** – There were 666 inpatient hospitalizations and 3 COVID-19 Positive cases as of 5/4/2022. 2. **COVID-19 Intensive Crisis Stabilization Services** – There were 192 members that received Intensive Crisis Stabilization Services from COPE and 86 members received Intensive Crisis Stabilization Services from Team Wellness (significant drop) in April 2022. Team Wellness CSU was closed due to a critical event on March 31, 2022 and has had resultant staffing issues.

3. **COVID-19 Recovery Housing/Recovery Support Services** – A total of 16 members received Recovery Housing/Support Services in April 2022 an increase compared to only two (2) in March.
4. **COVID-19 Pre-Placement Housing** – There were no members serviced for Pre-Placement Housing in April 2022.
5. **Residential Department (COVID-19 Impact)** – There were four (4) members that tested positive for COVID-19 with no related deaths in April 2022. There were no residential staff that tested positive for COVID-19 and no related deaths in April 2022.
6. **Vaccinations – Residential Members** – There was no increases in vaccinations or boosters in the month of April. There are over 200 members interested in getting the vaccine.
7. **COVID-19 Michigan Data** – ***State of Michigan*** (66.6%-first dose initiated and 60.3%-fully vaccinated) – The total number of confirmed cases in Michigan is 2,127,459 with 33,178 confirmed deaths; ***Wayne County*** (74.5%-first dose initiated and 67.7-fully vaccinated) – The total number of confirmed cases in Wayne County is 256,528 with 4,047 confirmed deaths; and ***City of Detroit*** (49.5%-first dose initiated and 41.9%-fully vaccinated) – The total number of confirmed cases in the City of Detroit is 127,724 with 3,327 confirmed deaths. ***(Source: www.michigan.gov/Coronavirus)***
8. **Integrated Services/Health Home Initiatives** – The goal of Health Homes is to increase outcomes and decrease costs by eliminating barriers to care through enhanced access and coordination. Michigan has two integrated health homes for the specialty behavioral health population (Behavioral Health Home for Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) and the Opioid Health Home for opioid use disorder. ***Behavioral Health Home (BHH)***– Launched on May 2, 2022 and one member has been enrolled. DWIHN is one of the five PIHPs in the State that participates in the Behavioral Health Home Model. It is comprised of primary care and specialty behavioral health providers, thereby bridging two distinct delivery systems for care integration; utilizes a multi-disciplinary team-based care comprised of behavioral health professionals, primary care providers, nurse care managers and peer support specialists/community health workers; and utilizes a monthly case rate per beneficiary served. ***Opioid Health Home (OHH)*** – There are 203 members currently enrolled. It is comprised of primary care and specialty behavioral health providers, thereby bridging the historically two distinct delivery systems for optimal care integration; predicated on multi-disciplinary team-based care comprised of behavioral health professionals, addiction specialists, primary care providers, nurse care managers and peer recovery coaches/community health workers; utilizes a monthly case rate per beneficiary served; and affords a provider pay-for-performance mechanism whereby additional monies can be attained through improvements in key metrics. ***Certified Community Behavioral Health Clinic (CCBHC) – State Demonstration*** – This State demonstration model launched on 10/1/2021. The Guidance Center currently has 2,715 members that have been enrolled and are actively receiving CCBHC services. The recipients are funded using a prospective payment model. DWIHN has requested ARPA funds and additional general funds for CCBHC non-Medicaid recipients. Provided training on the Vital Data platform which allows the provider to monitor quality and HEDIS measures and assist in evaluating program effectiveness. ***Certified Community Behavioral Health Clinic (CCBHC) – SAMHSA Grant*** – SAMHSA recently released the CCBHC Expansion Grant with a submission date of May 17, 2022. DWIHN is currently working on this grant in an effort to provide services to underserved populations and where

	there is reported gaps in care. The expected grant completion and submission is May 10, 2022. 9. **MDHHS Collaboration** – ***Autism Services*** – In March 2022, under the direction of MDHHS, DWIHN revised its' access procedure for children and families seeking autism services that required the family to obtain a physician order prior to being referred for an autism diagnostic evaluation. This process created an extra step for families trying to engage in services. DWIHN's Chief Clinical Officer and Clinical Officer met with MDHHS' department leads to discuss in April 2022. It was determined that MDHHS will temporarily allow flexibility on the physician referral requirement prior to scheduling an autism diagnostic evaluation. MDHHS will continue to allow this practice while they develop a workgroup to review this process. This workgroup will include representatives from all PIHPs. ***1915(i) SPA*** – Medicaid B3 services will be transitioned to 1915(i) SPA services on July 1, 2022. All eleven (11) services included in this category will remain unchanged, but will now require provider agencies to complete an evaluation, submit it into the MDHHS' Waiver Support Application (WSA), receive PIHP approval and finally, MDHHS' approval. DWIHN has provided training to all CRSPs on this new process and the State will be providing WSA training on June 9, 2022. Mrs. Jawad opened the floor for discussion. There was no discussion. The Chair noted that the Chief Clinical Officer's report has been received and placed on file.

XIII. Unfinished Business

DISCUSSION/ CONCLUSIONS	A. **BA #22-16 (Revised 2)** – DWIHN's Substance Use Disorder (SUD) Prevention Services Network FY 2022 – Staff requesting board approval to accept and disburse Treatment Block Grant Funding from the Michigan Department of Health and Human Services (MDHHS) in the amount of $4,000.00 to educate the retailers and the community on Electronic Nicotine Delivery System (ENDS) products. The Tobacco Section is providing funding for the period of May 1, 2022 through September 30, 2022. Strategies to Overcome Obstacles and Reduce Recidivism (SOOAR) is the chosen provider to implement this service. The Chair called for a motion on BA #22-16 (Revised 2). The FY '22 SUD Prevention Services program of $6,715,938.00 is increased by $4,000.00 to $6,719,938.00 and consists of Federal Block Grant revenue of $4,704,938.00 and $2,015,000.00 is designated to Public Act 2 (PA2) Funds. **Motion:** It was moved by Dr. Taueg and supported by Dr. Carter to move BA #22-16 (Revised 2) to Full Board for approval. Mrs. Jawad opened the floor for discussion. There was no discussion. **Motion carried.** B. **BA #22-17 (Revised 3)** – DWIHN's Substance Use Disorder (SUD) Treatment Services Network FY 2022 – Staff requesting board approval to receive and disburse additional PA 2 funding in the amount of $85,000.00 to provide community SUD Annual Conferences (Annual Men's Conference, Annual Faith-Based Conference, The Women's Conference, and the Annual Opioid Summit). The conferences are aimed to educate and bring awareness to important topics. The FY '22 SUD Treatment Program of $8,528,522.00 is increased by $85,000.00 to consists of Federal Block Grant revenue of $7,208,474.00 and Public Act 2 (PA2) Funds $1,405,048.00 to provide community SUD Annual Conferences. The Chair called for a motion on BA #22-17 (Revised 3). **Motion:** It was moved by Dr. Taueg and supported by Mr. Phillips to move BA #22-17 (Revised 3) to Full Board for approval. Mrs. Jawad opened the floor for discussion. Discussion ensued. **Motion carried.**

	C. **BA #22-29 (Revised)** – Jail Diversion – This revised board action is requesting board approval to increase the contract by $300,000.00 for the period of May 1, 2022 through September 30, 2022 for a total amount not to exceed $1,305,000.00 for the Mental Health Crisis Diversion program. It is proposed that DWIHN expand efforts into Out-Wayne County to further support the organizations mission of prevention, treatment and recovery for individuals within the system of care, and those who have not yet obtained access, but need behavioral health support. The Chair called for a motion on BA #22-29 (Revised). **Motion:** It was moved by Dr. Carter and supported by Dr. Taueg to move BA #22-29 (Revised) to Full Board for approval. Mrs. Jawad opened the floor for discussion. There was no discussion. **Motion carried.**

XIV. New Business: Staff Recommendation(s)

DISCUSSION/ CONCLUSIONS	A. **BA #22-62** – Summer Youth Employment Program (SYEP) – Staff requesting board approval of a one-year term in an amount not to exceed $1.9 million. The DWIHN's Summer Youth Employment Program (SYEP) is a continuation from the last four fiscal years with organizations intending to foster growth and enhance communities. These organizations thrive on community outreach to adolescents focusing heavily on youth recruitment plans and educational and mentoring goals to be accomplished over the summer months. The Chair called for a motion on BA #22-62. **Motion:** It was moved by Mr. Phillips and supported by Dr. Carter to move BA #22-62 to Full Board for approval. Mrs. Jawad opened the floor for discussion. There was no discussion. **Motion carried**.

XV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS	Victoria, Professor at Lawrence Technological University had questions pertaining to receiving resources in multiple languages and information for adults who are seeking a late diagnosis on autism evaluations. Staff will get her contact information and answer those questions after the meeting and provide information on making services more accessible.

ACTION ITEMS	Responsible Person	Due Date
1. **Follow-Up from Previous Meeting: BA #22-59 – Dept. of Housing and Urban Development (HUD)** – Provide committee with phone numbers and links to this program	Tania James	**COMPLETED**
2. Quarterly Reports – Substance Use Disorder – Provide a breakdown of the overdose data by race, age, and where they reside with a comparison from the previous year	Judy Davis	**TBD**

The Chair called for a motion to adjourn the meeting. **Motion:** It was moved by Dr. Carter and supported by Dr. Taueg to adjourn the meeting. **Motion carried.**

ADJOURNED: 2:52 p.m.
NEXT MEETING: Wednesday, June 8, 2022 at 1:00 p.m.

Policy/Procedure Statement

- **POLICY NO.: 2016-012**
- **ISSUE DATE: April 20, 2016**
- **REVISED ON: November 16, 2016**
- **ORIGINATOR: Compliance Officer**
- **BA #: 15-67**

SUBJECT: BOARD CONFLICT OF INTEREST POLICY

I. POLICY:

It is the policy of Detroit Wayne Integrated Health Network ("Network") that representatives of the Network (i) shall not have a direct or indirect interest (financial, personal or otherwise) in a corporation or business, (ii) engage in a professional activity, or (iii) incur an obligation of any nature, that conflicts (as defined in Article III below) with the discharge of the representative's official duties on behalf of the Network.

II. APPLICATION:

This Conflict of Interest Policy applies to all Network Board members (hereinafter "Board").

III. CONFLICT OF INTEREST:

3.1 An actual or potential conflict of interest occurs when there is a deviation between an individual's private interests and his or her legal or professional obligations to the Network, such that an independent observer might reasonably question whether the individual's actions or decisions are influenced by private or professional gain, financial or otherwise.

3.2 Conflicts of interest usually fall into one of the following three areas:

3.2.1 *Personal Conflict of Interest***:** Personal conflicts of interest arise when actions occur that are influenced by, or are reasonably perceived to be influenced by, a desire for personal gain, to the detriment of the Network. Personal gains could also include a benefit of the board member or an Immediate Family Member of a Board member.

3.2.2 *Business Conflict of Interest:* A business conflict of interest arises when an individual's actions are influenced by, or are reasonably perceived to be influenced by, the outside business involvement of the Board member, or their Immediate Family Member. A business conflict of interest may also arise when the Board member's outside business

activities or interests impinge on, or conflict with, the Network's business activities or interests.

3.2.3 *Procurement Conflict of Interest:* Any personal or business conflict of interest involving an organization that is presently acting as, or is competing to become, a vendor or independent contractor for the Network. Conflicts of this variety are additionally subject to the limitations expressed in the Network's Procurement Ethics Policy.

3.3 A conflict of interest arises when a Board member is presently, or has within the prior 12 months, been employed by a vendor or independent contractor that is contracting with the Network. Conflicts of interest may also arise with regard to the employment of individuals who may be "Immediate Family Members" (e.g., a spouse, former spouse, children (blood, step or adopted), parents, brothers, sisters, grandparents, brother-in-law, and sister-in-law) of staff members.

3.4 Financial interests are anything of monetary value, including, but not limited to:

3.4.1 Salary or other payments for services (e.g. consulting fees or honoraria);

3.4.2 Equity interests (e.g., stocks, stock options, or other ownership interests);

3.4.3 Intellectual property rights (e.g., patents, copyrights, & royalties); and/or

3.4.4 Gifts (monetary or non-monetary).

A conflict may arise when outside financial interests' compromise, or have the appearance of compromising, a Board member's duty of loyalty and/or fiscal responsibility toward the Network.

3.5 In evaluating the possibility of a conflict of interest, Board member should consider the following points:

3.5.1 Board member shall always keep in mind the possibility of a conflict of interest when entering into a business transaction with an entity other than the Network.

3.5.2 Board member shall never enter into a business transaction of any type that would compromise (or reasonably appear to compromise) the Board member's responsibilities to the Network.

3.5.3 If a Board member becomes aware of a conflict of interest, or a situation that might appear to be a conflict of interest, he or she should immediately report the conflict, or potential conflict, to the Compliance Officer.

In the event there is any question regarding whether a situation constitutes an existing or potential conflict of interest, the situation may be disclosed to the Compliance Officer, who shall make a determination as to whether a conflict (or the potential for a

conflict) exists, and whether there is a need to disclose the situation formally through the execution of a Conflicts of Interest Disclosure Form or disclosure to the Board.

3.6 Board members shall not knowingly use any confidential information about a specific parcel of real estate; a case, bid or contract; or other Network business information, which is available to the Board member as a result of his or her status as a member of the Board, and which is not a matter of public knowledge, for actual or anticipated personal gain, or for the actual or anticipated personal gain of any other person.

3.7 Prohibited Acts

3.7.1 Board members may not solicit or accept anything worth more than minimal value (i.e. less than $50.00 per year from a person or $100 a year from a business), including a loan, reward, material or property, from a patient or a patient's family, a visitor, contractor, provider, supplier or any other person or entity associated with the Network. However, it is recognized that situations sometimes arise where refusal of a small token of appreciation from a Consumer, such as candy or cookies, would be awkward and embarrassing. In these situations, acceptance of such small items is permissible, including complimentary tickets or admission to events in support of non-profit or charitable organization.

3.7.2 Board members shall not meet or confer with any employee that they are aware of (including board members) of any business, which is seeking to be, a vendor or contractor of the Network during the period after the issuance of a competitive solicitation, during evaluations and prior to award. The intent of this is to avoid the appearance of a conflict of interest.

3.7.3 The use of a Board member's position with the Network to further the Board member's personal gain, or that of family members, associates, or a business with which the Board member or a member of their family is associated, is unacceptable behavior.

3.7.4 Kickbacks and Improper Referrals

3.7.4.1 No Board member shall be permitted to offer, pay, solicit, or receive remuneration (e.g., kickbacks, bribes, and rebates) in order to induce or reward the referral of business reimbursable under any federal health care program.

3.7.4.2 No physician employed by a Network Provider shall be permitted to make referrals for Designated Health Services payable by Medicare or Medicaid to an entity with which such physician (or an immediate family member) has a financial relationship, unless a specific exception applies. Board members shall report any observed deviances from this practice to the Compliance Officer.

IV. DISCLOSURE:

4.1 Upon the date when a Board member begins their term, each Board member shall file a "Conflicts of Interest Disclosure Form" (see Exhibit A), with Compliance Officer. This Form shall be updated annually.

4.2 Board member shall file the Conflicts of Interest Disclosure Form at any time that there may be a potential conflict arising from a new business or professional activity, or other

conflicting interest as defined in this policy. One form must be submitted for each new conflict or potentially conflicting situation.

4.3 Copies of Board members' Conflicts of Interest Disclosure Form(s) shall be kept in the Board member's Human Resources personnel file, until updated or replaced by new annually filed forms.

V. MISCELLANEOUS PROVISIONS.

5.1 *Conflict Waivers.* The Compliance Officer shall review a list of all disclosed conflicts of Board members prior to the Network contracting with a business that has a potential or actual conflict. In addition, the Compliance Officer shall review *all disclosed* conflicts and be responsible for the following:

a. Prior to a vote by the Board, provide guidance to the Board members how to resolve the conflict during a Board meeting on a pending vote.
b. If needed, provide written Conflict Waivers to the Board members outlining applicable law and process to resolve the conflicts.

5.2 *Compliance with Applicable Law.* All Board members are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives in effect and as amended.

Attachments:

"Conflicts of Interest Disclosure Form" (Exhibit A)

DETROIT WAYNE INTEGRATED HEALTH NETWORK

CONFLICTS OF INTEREST DISCLOSURE FORM

Board Member Name:

Submitted To:

THE PURPOSE OF THIS FORM IS TO DISCLOSE ANY ACTUAL OR POTENTIAL CONFLICTS OF INTEREST. REVIEW THE FORM CARFULLY AND RESPOND ACCURATELY AND COMPLETELY.

Note: For purposes of this disclosure, "Immediate Family Member" means, as defined in the Conflict of Interest Policy, a spouse, a former spouse, children (blood, step or adopted), **parents, brothers, sisters, grandparents, brother-in-law, or sister-in-law.**

1. If you have no actual or potential conflicts of interest, check below and proceed to the acknowledgment/signature sections of this form.

___ I have no actual or potential conflicts of interests to report at this time.

2. If you have an actual or potential conflict of interest, check below and provide the requested information:

___ I am disclosing an actual or potential conflict of interest. The conflict arises because I, or an Immediate Family Member, has one or more of the following relationships with a business ("Business") that is, or wishes to become, a provider, vendor or contractor for the Network:

- I, or an Immediate Family Member, receives or may receive payment for services or any other monies or compensation from the Business.

- I, or an Immediate Family Member, have a financial interest (ownership, loans, etc.) in the Business which results in the receipt of $500 or more per year. (Market-rate from a financial institution or income from the ownership of less than $10,000 of stocks and bonds traded on the national stock exchanges are exempted.)

- I, or an Immediate Family Member, hold intellectual property rights (e.g., patents, copyrights) used by the Business.

- I, or an Immediate Family Member, now holds, or in the past 12 months has held, a key position in a Business, such as an officer, director, trustee, partner, or held a board seat or management or policymaking position in the Business.

- I, or an Immediate Family Member holds an ownership or financial interest in or with a business of which a partner, shareholder or owner has a financial interest in the Business that is or seeks to be a vendor, provider or contractor for the Network.

- I, or an Immediate Family Member, have any other actual or potential conflicts of interest arising from any relationship with the Business or its owners, employees or affiliates.

- None of the above apply, but I have an actual or potential conflict of interest for another reason.

Provide a full description of the actual or potential conflict and provide copies of all relevant documents. If the documents are confidential, submit them in a sealed envelope marked “Confidential”:

_____

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ACKNOWELDGMENT AND SIGNATURE

My signing below, I acknowledge that (i) I have received a copy of the Detroit Wayne Integrated Health Network Conflict of Interest Policy, and I have read and understand it, (ii) my responses set forth in this form are accurate and complete, and (iii) I agree to abide by the Conflict of Interest Policy and, accordingly, I will immediately update this form and disclose any new or different actual or potential conflicts of interest as they may arise, in accordance with the policy.

_____ _____

Signature Printed Name

_____ _____

Department Date

Board of Directors

- **POLICY NO.: 2016-011**
- **ISSUE DATE: April 20, 2016**
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- **ORIGINATOR: Board of Directors**
- **BA NO. : 15-67**

SUBJECT: BOARD SELF-ASSESSMENT

The Detroit Wayne Integrated Health Network Board of Directors is committed to assessing its own performance as a Board in order to identify its strengths and areas which may improve its functioning.

Consistent with evidence based best practices for governance, the Board shall conduct an annual self-assessment. The process for evaluation shall be recommended by the Executive Committee and approved by the Board. All Board members will be asked to complete the evaluation and submit the completed assessment to the CEO or his designee. A summary of the results shall be analyzed by the Executive Committee to determine appropriate strategies for action as a result of the assessments.

The goals of the self-assessment are to clarify roles, improve the efficiency and effectiveness of the Board meetings and to improve the operations of the DWIHN for the benefit of all served.

PROCESS

1. The Executive Committee initiates the assessment annually.

2. Completed assessment forms are submitted to the Board Liaison or as designated by the Executive Committee.

3. Results are compiled and presented to the Executive Committee.

4. The Executive Committee reviews, develops and recommends an action plan to the Full Board.

5. The Full Board reviews and approves the recommendations.

The Importance of Board Self-Assessment

By Berit M Lakey, Senior Consultant, Board Source

Ensuring organizational accountability is a key role for any nonprofit board. On behalf of the public and the people or causes served, the board must ensure that organizational resources are effectively used to serve the mission. Accordingly, the board holds the staff responsible for good management and program implementation but must hold itself accountable for the quality of the organization's governance. Through periodic performance assessments a board can identify ways to strengthen its operations in service to the organization and its mission.

A number of tools are available to help nonprofit boards achieve greater clarity about their own effectiveness. Most are designed as self-assessment questionnaires which ask directors to rate the board's performance in major areas of board responsibility.

Why conduct a board self-assessment?

Board assessments serve many purposes, some internal to the board and some in relation to other constituencies. A systematic assessment process will:

- Give individual board members an opportunity to reflect on their individual and corporate responsibilities
- Identify different perceptions and opinions among board members
- Point to questions that need board attention
- Serve as a springboard for board improvements
- Increase the level of board teamwork
- Provide an opportunity for clarifying mutual board and staff expectations
- Demonstrate to the staff and others that accountability is a serious organizational value
- Provide credibility with funders and other external audiences

A board assessment must be legitimate in the eyes of board members. The opinions of outsiders can be discounted, but what a board says about itself must be taken seriously. A self-assessment is more likely to lead to changes in the way the board operates. However, a self-assessment does not necessarily exclude input from other sources. The board may, for example, choose to ask the executive director and senior staff to provide feedback.

When to conduct a board self-assessment

A full-scale assessment may be desirable only once every two or three years, with interim assessments conducts to monitor progress on objectives set after the last assessment. Times when a self-assessment may be particularly useful include:

- At the outset of a strategic planning process
- In the preparation for major expansion or capital campaign

- When there is a sense of low energy, high turnover, or uncertainty about board responsibilities
- After a financial or executive leadership crisis

How to conduct a self-assessment

An assessment process involves a number of steps:

- Decide to conduct the assessment. This must be a board decision. Assign the responsibility for making the necessary arrangements to a small task force or to the governance committee
- Decide whether to use a standard instrument designed for board evaluations or to design a process from scratch
- Decide whether to use an outside consultant to administer and facilitate the process. Using an outsider to administer the questionnaire will make it more likely that board members will give frank answers. An outside facilitator of the board's follow-up discussion will encourage open and constructive debate.
- Distribute the instrument and ask board members to complete and return the questionnaire to the designated person.
- Compile, analyze, and present responses in a written report that is distributed to board members.
- Discuss the findings, perhaps in a retreat setting, and identify actions that will lead to improved performance. If an outside facilitator has been engaged, this person will already have collected additional information about the board (bylaws, meeting minutes, committee structure, etc.), and will have discussed the agenda with the person(s) charged to arrange for the assessment.

Is it worth it?

Properly conducted and followed up with action, evaluation can have a profound impact upon a board. As reported by two directors "Ultimately, the process transformed us from a traditional show-and-tell to a much more dynamic give-and-take board, "said one. "It provided the impetus to move our board forward on issues that had been simmering on the back burner, "another commented. "It brought our board members closer together as people…helping to break down barriers, establish camaraderie, and open up dialogue."

Self-assessment may be the best way to reach the root of the governance problems and find lasting solutions that will make your board better.

Board of Directors Full Board Evaluation

*Rankings go from 1 = Low/Strongly Disagree to 5 = High/ Strongly Agree

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Board Activity:

Board Activity:	1	2	3	4	5
1. The board operates under a set of policies, procedures, and guidelines with which all members are familiar. **Comments:**					
2. The Executive Committee reports to the board on all actions taken and topics discussed. **Comments:**					
3. There are standing committees of the board that meet regularly and report to the board. **Comments:**					
4. Board meetings are well attended, with near full turnout at each meeting. **Comments:**					
5. Each board member has at least one committee assignment. **Comments:**					
6. Appointments to committees follow clearly established procedures. **Comments:**					
7. Newly appointed board members receive adequate orientation to their role and what is expected of them. **Comments:**					

8. Each board meeting includes an opportunity for learning about the organization's activities. **Comments:**					
9. The board fuly understands and is supportive of the strategic planning process of the Network. **Comments:**					
10. Board members receive meeting agendas and supporting materials in time for adequate advance review. **Comments:**					
11. The board adequately oversees the financial performance and fiduciary accountability of the organization. **Comments:**					
12. The board receives regular financial updates and takes necessary steps to ensure operations of the organization are sound. **Comments:**					
13. The board regularly reviews and evaluates the performance of the CEO. **Comments:**					
14. The board actively engages in discussion around significant issues. **Comments:**					
15. The board chair effectively and appropriately leads and facilitates the board meetings and the policy and governance work of the board. **Comments:**					

Mission and Purpose:	**1**	**2**	**3**	**4**	**5**
1. Statements of the organization's mission are well understood and supported by the board. **Comments:**					
2. Board meeting presentations and discussions consistently reference the organization's mission statement. **Comments:**					

Governance/ Partnership Alignment:	**1**	**2**	**3**	**4**	**5**
1. The board exercises its governance role: Ensuring that the organization supports and upholds the mission statement, core values, vision statement, and partnership policies. **Comments:**					
2. The board periodically reviews, and is familiar with, the organization's core documents. **Comments:**					
3. The board reviews its own performance and measures its own effectiveness in governance work. **Comments:**					
4. The board is actively engaged in the board development processes. **Comments:**					
5. Each board member adequately performs its duties and responsibilities as outlined in the Bylaws and Board policies. **Comments:**					
3. The board reviews the organization's performance in carrying out the stated mission on a regular basis. **Comments:**					

***Rankings 1 = Low/Strongly Disagree to 5 = High/ Strongly Agree**

Board Organization:	**1**	**2**	**3**	**4**	**5**
1. Information provided by staff is adequate to ensure effective board governance and decision-making. **Comments:**					
2. The committee structure logically addresses the organization's areas of operation. **Comments:**					
3. All committees have adequate agendas and minutes for each meeting. **Comments:**					
4. All committees address issues of substance. **Comments:**					

Rankings 1 = Low/Strongly Disagree to 5 = High/ Strongly Agree

Board Meetings:	**1**	**2**	**3**	**4**	**5**
1. Board meetings are frequent enough to ensure effective governance. **Comments:**					
2. Board meetings are long enough to accomplish the board's work. **Comments:**					
3. Board members fully and positively participate in discussions. **Comments:**					

Board Membership:	**1**	**2**	**3**	**4**	**5**
1. The board has a range of talents, experience, and knowledge to accomplish its role. **Comments:**					
2. The board uses its members' talents and skills effectively. **Comments:**					
3. The board makeup is diverse with experience, skills, ethnicity, gender, denomination, and age group. **Comments:**					
4. Fellow board members review each Officers performance annually. **Comments:**					
5. Board Officers perform their duties as outlined in the By-Laws. **Comments:**					

Administration and Staff Support:	**1**	**2**	**3**	**4**	**5**
1. The committee structure provides adequate contact with administration and staff. **Comments:**					
2. Communication is strong and clear between the board and staff. **Comments:**					
3. Staff support before, during, and after-board meetings is effective. **Comments:**					

Please note any additional comments about the work and effectiveness of our board.

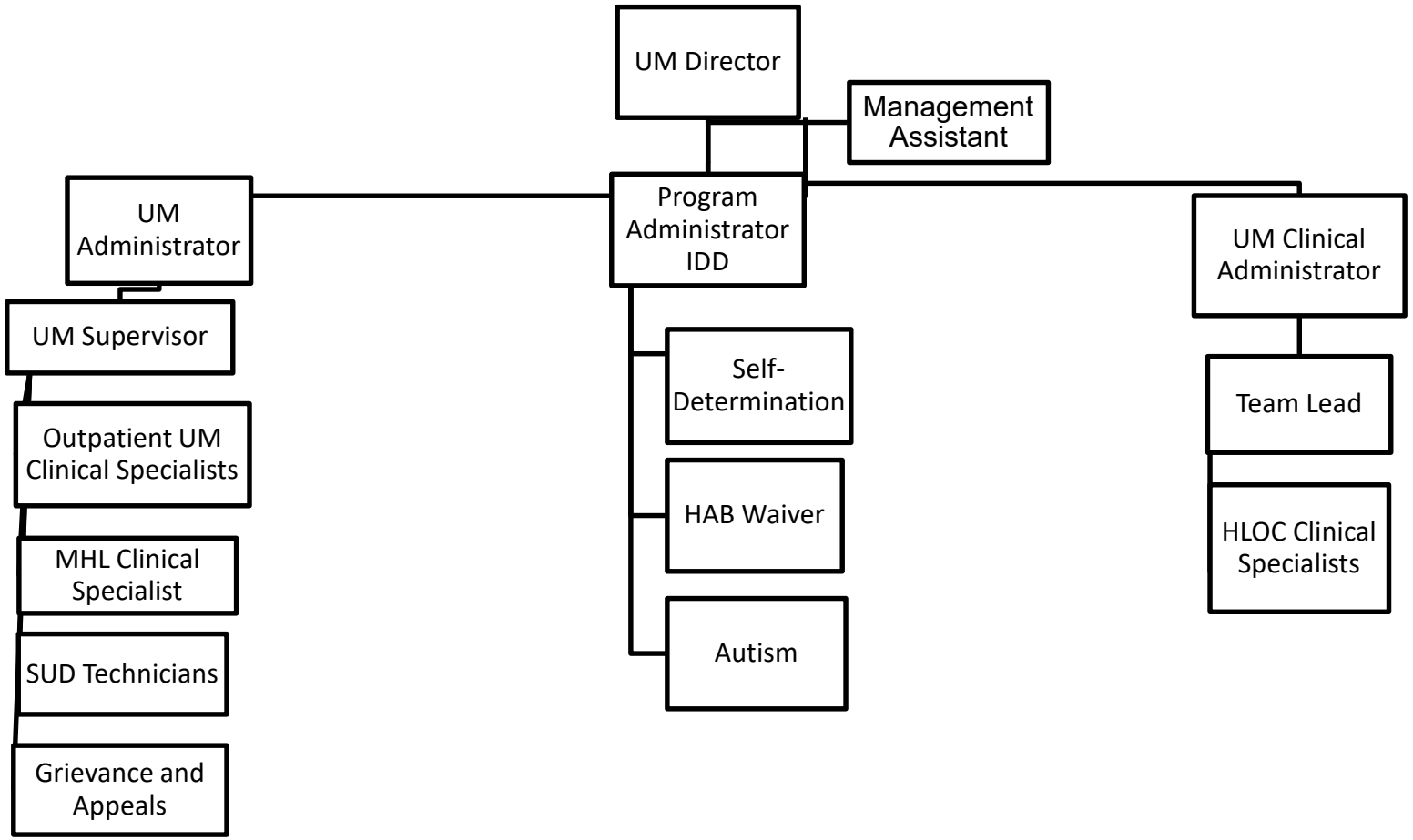
Utilization Management Program Description

October 1, 2022- September 30, 2024

Changes from FY 20-22 to FY23-24 UM Program Descriptions

- Remove System Transformation (formerly Section VIII)
- Remove Access Center as a Delegated Entity as it is now in house (formerly Sections XIII-XVII)
- Revision of Program Structure (Section VIII, pages 6-11)
- New Program Goals (Section X, pages 15-16)
- Discontinued the use of the DWIHN Eligibility of Service Review Tool with updated information and new title of Continued Stay Prior Authorization Audit Tool (Attachment #3, pages 55-58)

UM Department Structure



UM Program Goals

Access Pillar

UM Program Description Goal 1

Evaluate DWIHN's UM Program Description to assure effective and efficient utilization of behavioral health services identifying any barriers, analyzing metrics, utilization trends and quality of care concerns.

UM Program Description Goal 2

Monitor the use of specialty behavioral health waiver programs: Autism Spectrum Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children's Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.

UM Program Description Goal 3

Analyze populations served examining services received and services available to identify any gaps.

Advocacy Pillar

UM Program Description Goal 4

Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.

Customer Pillar

UM Program Description Goal 5

Utilizing Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.

Utilization Program Description Goal 6

Enhance provider satisfaction by ensuring a more meaningful experience through use of customer service driven language to improve network relationships.

Finance Pillar

UM Program Description Goal 7

Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.

***Strategic Plan Goal D**: Develop a system that helps track over and under utilization*

Quality Pillar

UM Program Description Goal 8

Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration.

UM Program Description Goal 9

Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities

Workforce Pillar

UM Program Description Goal 10

Develop standardized guidelines for intradepartmental, interdepartmental and network wide training based on clinical concepts and DWIHN policies and procedures that align with UM reviews and documentation criteria.

DETROIT WAYNE INTEGRATED HEALTH NETWORK
UTILIZATION MANAGEMENT PROGRAM
DESCRIPTION FY 23 and FY 24
October 1, 2022 - September 30, 2024

Approved by
(Detroit Wayne Integrated Health Network Board of Directors 3/20/2019)
(Reviewed and Approved with no Changes at UMC 4/25/2022)
(Presented to QISC and approved 4/26/2022)
(Presented to PCC on 6/8/2022)
(Presented to Full Board of Directors -- 2022)

Table of Contents:

Attachments:

1. UM Functions for MI Health Link Program
2. Waiver and State Plan Amendments
3. Continued Stay Prior Authorization Review (PAR) Audit Tool
4. DWIHN Eligibility of Service Review Tool
5. DWIHN'S Quality Department Clinical Record Review Tool (or its Successor)
6. Crisis Service Vendors' UM Annual Evaluation Template
7. Crisis Service Vendors' UM Plan Outline
8. Crisis Service Vendors' UM Plan Audit Tool

References:

1. DWIHN Affirmative Statement Policy
2. DWIHN Appropriate Professionals for Making UM Decision Policy
3. DWIHN Behavioral Health Utilization Management Review Policy
4. DWIHN Behavioral Health Medical Necessity Policy
5. DWIHN Benefit Policy and Benefit Grid
6. DWIHN Denial of Service Policy
7. DWIHN HIPPA Privacy Manual and Policy
8. DWIHN HIPAA Security Policy
9. DWIHN Individual Plan of Service Policy
10. DWIHN Inter Rater Reliability Policy
11. DWIHN Local and Alternative Dispute Resolution Policy
12. DWIHN UM/Provider Appeal Policy
13. MDHHS Person Centered Planning Policy Practice Guidelines (3/15/11)
14. Michigan Medicaid Provider Manual

I. INTRODUCTION:

Utilization Management (UM) functions are driven by the Detroit Wayne Integrated Health Network (DWIHN) Board's commitment to the provision of effective, consistent and quality care for behavioral health services that produces financial outcomes. The Utilization Management Program Description reflects the expectations and standards of the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS). The DWIHN Chief Medical Officer has substantial involvement in the development, implementation, supervision and evaluation of the UM program. The Board of Directors (BOD) has the ultimate responsibility for ensuring overall quality of supports and services delivered to Wayne County residents and oversight of UM functions.

II. MISSION:

DWIHN is a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system.

III. VISION:

To be recognized as a national leader that improves the behavioral and overall health status of the people in our community.

IV. VALUES:

- We are a person centered, family and community focused organization.
- We are an outcome, data drive and evidenced based organization.
- We respect the dignity and diversity of individuals, providers, staff and communities.
- We are culturally sensitive and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration.

V. PURPOSE:

The purpose of the UM Program Description is to define and describe processes that will align the Utilization Management program with DWIHN'S Strategic Plan as identified by the Board of Directors.

The UM program description will:

- Guard against conflict of interest and protects the integrity of clinical decision making through the use of written evidence based and professional consensus criteria;
- Promotes DWIHN accountability for any delegated functions and responsibilities;
- Confirm that individuals have a significant role in the design of the systems that support them;
- Promise UM decisions are made in a fair, impartial and consistent manner that is in the best interest of the person;
- Assure UM decisions are timely, efficient and consistent with standardized guidelines to increase the likelihood that services for vulnerable persons are equal in amount, duration and scope;
- Ensure compliance with state and federal law as well as regulatory and accreditation standards. Ensures use of Level of Care Criteria, Clinical Practice Protocols and best practices to improve process and reduce inappropriate variations in practice;
- Assure that people get individualized, appropriate behavioral health services and supports that are sufficient in scope, frequency and duration to achieve effective outcomes;
- Encourage equitable access to behavioral health services across the network; and
- Promote the availability of cost-effective behavioral health services within available resources for a greater number of people;
- Respond in a timely manner to member and practitioner/provider complaints/appeals regarding UM issues after coordinating a comprehensive and timely investigation.

VI. SCOPE:

The Behavioral Health UM Program consists of activities that promote appropriate allocation of behavioral health and substance use resources for individuals managed by staff in the DWIHN office, and Crisis Service Vendors. Processes used within the context of UM include: pre-service, concurrent and post-service review; denials and appeals; discharge planning and other care management activities.

DWIHN'S UM department maintains standardized policies and procedures that are created by the UM Director or their designee and reviewed by the Chief Medical Officer and Directors of all DWIHN departments through Policy Stat (DWIHN'S software policy and procedure management system) and are ultimately reviewed and approved by the Chief Operating Officer. The policies are reviewed on an annual basis. In addition, procedures are reviewed annually and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority in which the UM program operates. The UM staff are authorized to make decisions that operate within the framework described within these policies and procedures. The Crisis Service Vendors' policies and procedures must align with DWIHN policies.

Depending on the level of care, certain behavioral health and substance use services require prior authorization. For example, acute inpatient hospitalization, state hospitalization, partial hospitalization, crisis residential services and withdrawal maintenance/sub-acute detox are some of the services that need prior authorization. Along with monitoring the appropriate level and allocation of care, DWIHN assesses Ambulatory Follow-Up (AFU) rates. Ambulatory Follow-Up activities serve to ensure that enrollee/members are provided with a timely out-patient appointment after they are discharged from the hospital. Care Coordinators and Support Care Coordinators provide support to enrollee/members following discharge to ensure appointment compliance within seven (7) days following discharge and assist with rescheduling of appointments on an as needed basis.

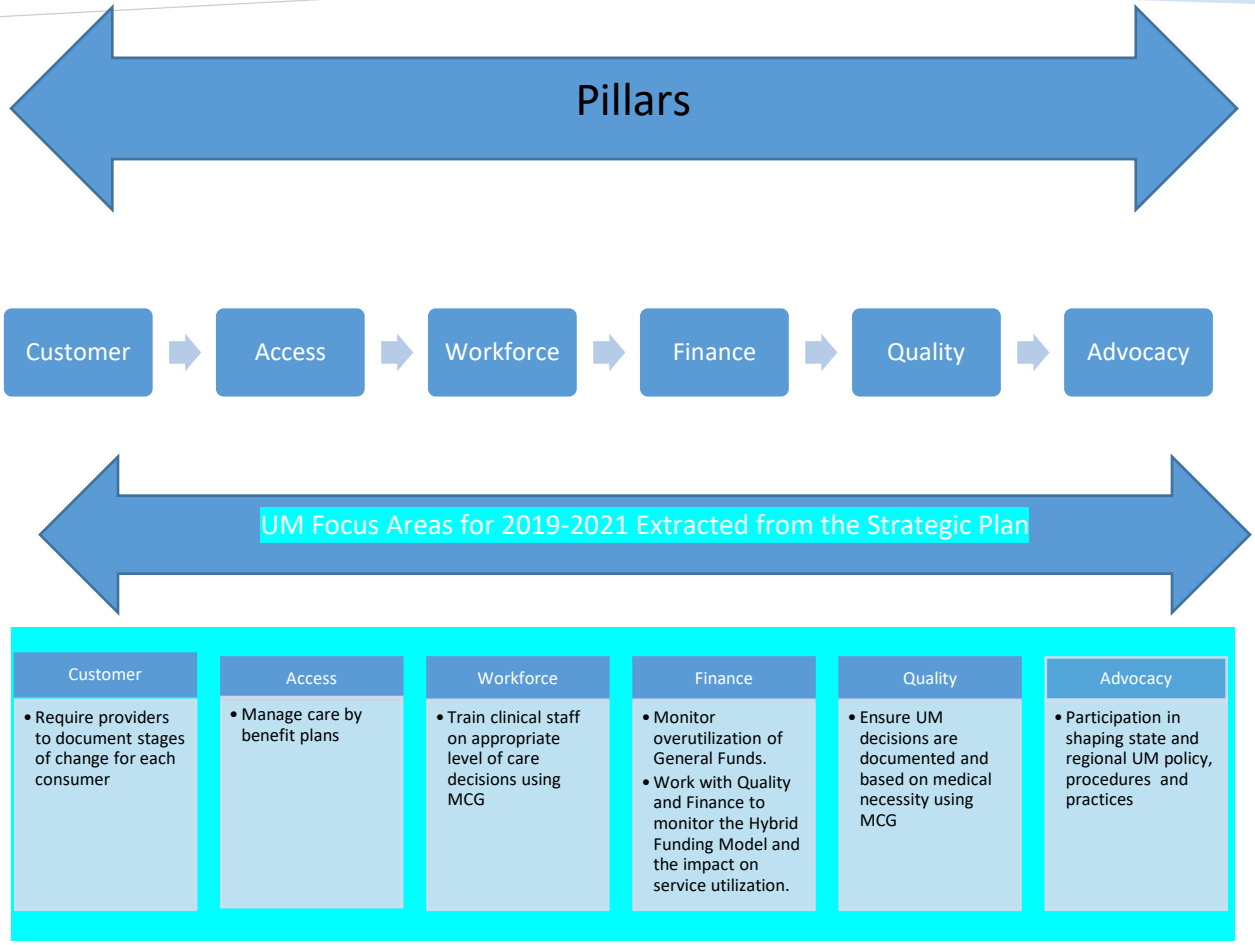
DWIHN staff, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations, and policies, all federal requirements, state and county contractual requirements, polices and administrative directives in effect and as amended.

VII. DWIHN'S STRATEGIC PLAN AND THE UTILIZATION MANAGEMENT PROGRAM:

The DWIHN Board Strategic Plan is an overarching framework that strives towards common goals, establishes agreement around intended outcomes/results, and assesses and adjusts the organization's direction in response to a changing environment. The UM Program is one of the mechanisms to accomplish this. It is a systematic approach to providing independent, unbiased determinations of medical necessity using evidence-based treatment criteria and guidelines to enhanced the quality and effectiveness of care. The DWIHN'S approach to utilization management is based on the following six (6) pillars with support from six (6) focus areas under each pillar in the DWIHN'S Board approved Strategic Plan.

Strategic Plan Pillars by Definition:

- Customer: Services should be designed to meet the needs and expectations of consumers. An important measure of quality is the extent to which customer needs and expectations aremet.
- Access: Provide affordability of the services provided to the customer. To ensure availability and accessibility of the services.
- Workforce: Provide staff development activities while empowering staff in the competitive and market-driven workforce.
- Finance: Ensure the Administrative Cost as a portion of the Total Cost is low and reasonable.
- Quality: Deliver a robust decision support system as DWIHN will be recognized as the Behavioral Health Subject Matter expert through the use of standardized treatment protocols and guidelines.
- Advocacy: Establish leadership in shaping public policy for behavioral health in Michigan that fosters regional cooperation and informs and engages local and state resources as well as stakeholders.



VIII. PROGRAM STRUCTURE:

DWIHN'S UM staff are highly skilled, experienced professionals who are required to have ongoing training and participate in regularly scheduled case consultations with the DWIHN Chief Medical Officer. DWIHN is committed to increasing competency and the quality of services through continuous staff development activities.

UM Staff Members' Assigned Activities and Professional Qualifications:

1. Board of Directors (BOD):
   - The BOD's primary responsibility is to provide leadership, governance and oversight of the region. The Board is a policy-setting body, and the fiduciary of Medicaid funds.

2. Chief Medical Officer (CMO):
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is required;
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
   - At least five (5) years of administrative experience as CMO in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e. nurses, social workers, etc.);
   - Responsible for setting UM behavioral healthcare policies;

- Develop policies, procedures and protocols for the delivery of psychiatric and medical services;
- Guides, leads and assesses the overall clinical knowledge of the UM staff;
- Provides on going oversight of the UM Program;
- Reviews and updates the behavioral health medical necessity criteria;
- Reviews UM behavioral healthcare cases including appeal cases;
- Maintain accurate records of all communications and interventions in clinical software system, Mental Health Wellness Information Network (MHWIN);
- Chair of the UM committee;
- Active Participation in the Peer Review Committee Activities;
- Active Participation in the Sentinel Events Committee Activities;
- Active Participation in the Review of Death Committee;
- Active Participation in the Executive Leadership Team;
- Participates on various internal and external committees;
- Serves as a liaison to the medical community on all issues designed to improve the quality of behavioral health services to enrollee/members;
- Develops continuing education and in-service training opportunities for Board staff, Board of Directors, and Community Mental Health (CMH) network;
- Functions as a liaison with local, state, and national psychiatric and medical organizations for the purpose of information gathering, networking to keep the Board of Directors and staff aware of trends in psychiatric and medical practice, research, training, and issues;
- Develops advisory committees of CMOs of Access Center, Crisis Screening Entities and Providers to meet on a regular basis and provide input into psychiatric and medical standards, policies, procedures, and protocols;
- Provides oversight of DWIHN contracted behavioral health psychiatrists;
- Presents to the Board of Directors and Board subcommittee meetings;
- Collaborates with Director of UM to set UM department yearly goals;
- Assists with the development of quality improvement processes and ensure accreditation and regulatory requirements are met;
- Conducts analysis of internal and external reports to evaluate UM outcomes and performance;
- Collaborates with Director of UM to develop annual UM program description and work plan and revise based on UMC recommendations; and
- Reviews and provides oversight to the annual UM Program evaluation.

3. DWIHN Psychiatrist:
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require;
   - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME);
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
   - At least five (5) years of administrative experience as Medical Director in a Mental Health Program with experience in: policy writing; accreditation activities, staff development; peer review management of direct report staff (i.e. nurses, social workers, etc.);
   - Reviews UM behavioral healthcare cases including appeal cases;
   - Maintains accurate records of all communications and interventions in clinical software system (MHWIN);

- Participates on the UM committee;
- Participates on various internal and external committees;
- Administration of clinical aspect of Medicaid Fair Hearings;
- Administration of the Death Review Program;
- Assists in Behavioral Health Policy development and review;
- Provides Staff Training and Development;
- Participates in Peer Reviews;
- Provides leadership within committee structures, i.e. Utilization Management, Sentinel Events, Quality Management, Child Death Review Team etc.; and
- Provides clinical consultation to Recipient Rights.

4. Crisis Service Vendors Medical Director:
   - Must have a valid Michigan License to practice as a physician, and Michigan controlled substance license. Additionally, they must have a valid and current Drug Enforcement Authority Registration. Board certification by the American Board of Psychiatry and Neurology as an adult psychiatrist is preferred but not require;
   - Must have completed a Psychiatric Residency approved by Accreditation Council for Graduate Medical Education (ACGME);
   - Five (5) years of experience working in a state or community psychiatric hospital or outpatient setting, as a direct provider of mental health services;
   - At least one (1) year of administrative experience as Medical Director in a mental health program with experience in policy writing, accreditation activities, staff development, peer review management of direct report staff (i.e. nurses, social workers, etc.);
   - Reviews UM behavioral healthcare cases including first level appeal cases; and
   - Assist in DWIHN Behavioral Health Policy development and review.

5. Director of Utilization Management:
   - Minimum Master's Degree in Mental Health Field with a valid Michigan licensure/certification as a Psychologist (LLP, FLP), Social Worker (CSW, ACSW), Counselor (LPC), Marriage and Family Therapist (LMFT), or Nurse (RN)
   - Ten (10) years' supervised experience with adults who are seriously mentally ill, or persons with a developmental disability, or with children who have serious emotional disturbances or elderly persons with serious mental illness. Knowledge and experience with Co morbid conditions. Cultural competence training required.
   - Minimum eight (8) years' management & supervisory experience in managed care clinical setting.
   - Eight (8) years post Master's degree, administrative utilization management experience at least six (6) years of which must have been in a hospital, school or community mental health agency that provides care to mentally ill and emotionally disturbed adults children and adolescents.
   - Responsible for the development and continual updating of all UM processes, policies and procedures within department;
   - Co-chair of UM committee;
   - Provides supervision and implements development plans for all UM staff;
   - Makes recommendations regarding staffing, hiring, training and allocation of resources;
   - Oversees the on-going utilization review activities to monitor usage of services across all covered populations;
   - Assists with the development of quality improvement processes and ensure accreditation and regulatory requirements are met;
   - Leads multidisciplinary case reviews, to recommend/develop alternative treatment plans for complicated consumer cases;

- Conducts analysis of internal and external reports to ensure compliance with contract, accreditation and regulatory requirements;
- Performs analysis of internal and external reports to evaluate UM outcomes;
- Collaborates with other departments and agencies;
- Sets yearly UM goals for department;
- Represents DWIHN as assigned, in collaborative meetings or presentations with DCH, Board Association, and contracted entities;
- Responsible for all UM reporting requirements;
- Prepares annual UM program evaluation;
- Provides oversight of staff audits and evaluations; and
- Provides oversight of outcomes of delegated entities.

6. UM Administrator:
   - Minimum of five (5) years' experience working in mental health services;
   - UM Experience strongly preferred;
   - At a minimum a Bachelor's degree in social work or psychology;
   - For Bachelor degree social work or sociology, valid Michigan license required;
   - Knowledge and skills in community based behavioral health care and case management preferred;
   - Assists UM Director in developing policies and procedures for daily operations of the UM staff;
   - Assists UM Director and CMO in writing the UM program description, work plan and annual UM evaluation;
   - Works collaboratively to implement UM model with affiliated providers;
   - Works with behavioral health provider organizations to develop and update the UM program;
   - Works collaboratively with other DWIHN departments to implement and improve the utilization management program at DWIHN;
   - Assists UM Director in providing oversight of the UM program processes for different lines of business;
   - Works collaboratively with the Integrated Care Organizations in relation to UM program for MI Health Link enrollee/members;
   - Participates in meetings, committees, and collaboration internally and externally;
   - Offers training and education to DWIHN staff, providers, stakeholders and the community at a large specific to medical necessity criteria and DWIHN'S UM program;
   - Participates in audit activities as required;
   - Develops written and timely reports as requested; and
   - Provides timely reporting of pertinent observations and system challenges which may directly impact the achievement of expected outcomes.

7. UM Clinical Specialist Substance Use Disorder (SUD):
   - Master's degree in nursing or social work preferred. Bachelor's degree in psychology, social work, or related human services required. Certification as an addiction drug counselor (CADC) or certification as advanced addiction drug counselor (CAADC) or an approved development plan by the Michigan Certification Board for addiction professional (MCBAP) required;
   - Promotes and facilitates specific communication and coordination of care with providers and behavioral health practitioner(s);
   - Supports discharge planning activities that include aftercare referrals and referrals to community resources;
   - Facilitates complex care management services through treatment plan review and provider consultation;
   - Conducts ongoing assessment of clinical status and functioning;
   - Monitors enrollee/member progress and outcomes;

- Facilitates communication with medical and behavioral health providers regarding the enrollee/member's treatment plan;
- Ensures the enrollee/member receives appropriate and medically necessary services thru out the continuum of care as well as coordination of care;
- Reviews targeted case management needs, vocational and/or housing assistance and interacts with providers as needed;
- Maintains accurate records of all communications regarding the authorization process in the clinical software system (MHWIN); and
- Provides education and motivation to enrollee/members.

8. UM Clinical Specialist:
   - Master's degree in nursing or social work preferred. Bachelor's degree in nursing, psychology, social work required;
   - Qualified Mental Health Professional certification preferred;
   - Eight (8) years' experience in mental health field and five (5) years' experience in managed care;
   - Reviews pre-service behavioral health requests for benefits and/or medical necessity;
   - Refers cases as appropriate to physician for review;
   - Reviews clinical information for BH concurrent reviews, extending the length of stay for inpatient admissions as appropriate;
   - Participates in discharge planning activities post inpatient behavioral health admission;
   - Provides appropriate consultant information to case management staff;
   - Assists in the identification of appropriate resources for each individual case to fully utilize all available resources;
   - Maintains accurate records of all communications and interventions in clinical software system (MH-WIN); and
   - Prepares denial letters.

9. DWIHN UM Integrated Care Clinical Specialist:
   - Master's degree in nursing or social work preferred. Bachelor's degree in nursing, psychology, social work, or sociology required;
   - Qualified Mental Health Professional certification preferred;
   - Eight (8) years' experience post-degree in mental health field and five (5) years' experience in managed care;
   - Reviews pre-service behavioral health requests for benefits and/or medical necessity for dual eligible MI Health Link enrollee/members;
   - Refers cases as appropriate to physician for review;
   - Reviews clinical information for behavioral health concurrent reviews, extending the length of stay for inpatient admissions as appropriate for dual eligible MI Health Link enrollee/members;
   - Participates in discharge planning activities post inpatient behavioral health admission;
   - Provides appropriate consult information to case management staff.
   - Assists in the Identification of appropriate resources for each individual case to fully utilize all available resources;
   - Maintains accurate records of all communications and interventions in clinical software system (MH-WIN) in compliance with regulatory and accreditation standards; and
   - Prepare denial letters for all dual eligible MI Health Link enrollee/members.
   - Conducts first level review of concurrent and post-service appeals;
   - Reviews clinical documentation to determine completeness of information submitted.

10. DWIHN UM Appeals Coordinator:
    - Conducts first level review of concurrent and post-service appeals;
    - Reviews clinical documentation to determine completeness of information submitted;
    - Requests additional information as needed to assist with review of appeals;
    - Coordinates case review with DWIHN physician consultants on clinical cases that are not meeting the medical necessity criteria;
    - Prepares appeals for independent medical review and other state and federal government reviews;
    - Responds to inquiries regarding status, process and outcome of UM appeals;
    - Communicates either verbally or in writing regarding outcome of UM appeals
    - Interfaces with other DWIHN departments to resolve UM appeals issues;
    - Completes appropriate documentation in clinical systems (MHWIN) in compliance with regulatory and accreditation standards;
    - Participates on committees or special projects as needed; and
    - Manages the data gathering and analysis of reports regarding UM appeal activity as well as preparation for appeal audits.

11. DWIHN Hospital Liaison:
    - Master's degree in nursing or social work preferred. Bachelor's degree in nursing, psychology, social work required;
    - Qualified Mental Health Professional certification preferred;
    - Communicates with the enrollee/member, family and treatment team on enrollee/members admitted to hospital/facility for behavioral health condition(s);
    - Attends team meetings;
    - Works with enrollee/member, family and treatment team and/or providers to ensure safe and appropriate and timely transitions after an inpatient behavioral health admission;
    - Enters authorizations for post admission services as needed;
    - Completes appropriate documentation in clinical systems in compliance with regulatory and accreditation standards; and
    - Participates on committees or special projects as needed.

    NOTE: Staff performing UM reviews and/or UM functions such as initial, concurrent and post-service reviews, denials and appeals must be credentialed and re-credentialed. The credentialing process defined by DWIHN supports our commitment to ensure that each provider, directly or indirectly or contractually engaged, meets at least MDHHS licensing, training and scope of practice, CMS, contractual and Medicaid Provider Manual requirements. Only highly qualified clinicians (MD, DO, PhD, LPC, LMSW, LLP, MSN, NP and BSN) who have demonstrated experience in the specialty areas in which they are making decisions may initiate and carry out UM reviews and duties. Clinicians authorizing SUD services must have certification as a Certified Addiction Drug Counselor (CADC) or a Certified Advanced Addiction Drug Counselor (CAADC) or have an approved development plan by the Michigan Certification for Addiction Professionals (MCBAP), or be certified as a Qualified Mental Health Professional (QMHP). A clinician must be credentialed and re-credentialed as Qualified Mental Health Professional (QMHP), Qualified Intellectual Disability Professional (QIDP) and/or a Child Mental Health Professional (CMHP), if authorizing those populations in order to be certified to complete the pre-admission review (PAR) or Utilization Management (UM) staff functions. Due to a conflict of interest, these practitioners may not provide direct services, including crisis intervention, for the enrollee/member they are screening for pre-admission review. See DWIHN Appropriate Professionals for Utilization Management Decision Making Policy for more details.

IX. COMMITTEE STRUCTURE:

A. Utilization Management Committee (UMC):

DWIHN'S UM Department supports a Utilization Management Committee. The CMO is the chairperson and the UM Director is the co-chair. The UMC is a standing committee reporting up to The Quality Improvement Steering Committee (QISC), which makes reports to both the Program Compliance Committee (PPC) of the Board of Directors (BOD) and the President/CEO, who both report up to the Board of Directors (BOD). The DWIHN BOD has granted the UMC the authority to develop, monitor and annually evaluate the UM Program.

Membership includes:

- Chief Medical Officer-Chair
- Utilization Management Director-Co-Chair
- DWIHN Psychiatrist
- UM Clinical Specialist
- UM Hospital Liaison
- Children's Initiatives Representative
- Customer Service Representative
- IT Representative
- Finance Representative
- Quality Improvement Representative
- Network Administrators and Contract Manager Representative
- Substance Use Disorder Director or designee
- Peer Specialist

Others may be invited for specific projects and/or issues to serve on an as needed basis and providers will be invited to participate quarterly.

The purpose of the committee is:

- Provide on-going review and oversight of the UM program;
- Evaluate the utilization of services with the goal of ensuring that each enrollee/member receives the right services, in the right amount and in the most appropriate time frames to achieve the best outcomes. To accomplish this, the committee reviews specified aggregate data in order to identify over or under utilization of services. With improved reporting capabilities in the Mental Health Wellness Information Network (MH-WIN) computer system, including Pivot Tables, Cube Analytics and newly developed dashboards, the committee coordinates and recommends quality improvement efforts that may impact structure, process and outcomes. Opportunities for improvement are prioritized based on risk factors, performance history, and effect on overall DWIHN system performance;
- Review of standing UM reports on inpatient admissions, length of stay, denials and appeals, timeliness of decisions and notifications and readmissions;
- Review monthly reports on Autism, Waivers, Hospital Liaison Activity, Crisis Service Vendor functions, County of Financial Responsibility (COFR), Substance Abuse Disorders (SUD) and Integrated Care;
- Monitor, document and submit for review any potential quality of care concerns, for both inpatient and outpatient care;
- Monitor utilization practice patterns of contracted providers to identify variations;
- Ensure that UM inter-rater reliability audits are conducted; and

- Review, evaluate, revise and approve the UM Program Description, UM work plan and UM Program evaluation annually.

The UMC meets monthly. Minutes are maintained and distributed to all committee members. The minutes are also reviewed and approved at the next meeting. The UMC has ground rules for meeting operations and membership including the decision-making process, attendance, goals, participation, preparation, and discussion and reporting formats.

B. Quality Improvement Steering Committee (QISC):

The QISC is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of the DWIHN'S continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for the DWIHN.

Membership includes:

- Chief Medical Officer
- Directors or designee from UM, Customer Service, Quality Management, Recipient Rights, Risk Management, Compliance, SUD, Managed Care Operations, Integrated Care
- Enrollee/members
- Advocates
- Direct contracted providers of service to enrollee/members with SMI, SED, SUD, I/DD.

The purpose of committee:

- Participate in the development and review of quarterly/annual reports to the Quality Improvement Program Compliance Committee and the Board of Directors (BOD) regarding Quality Management System;
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program (QAPIP);
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination;
- Examine quantitative and qualitative aggregate data at predetermined and critical decision-making points and recommend courses of action;
- Review reports from regulatory DWIHN reviews;
- Review of DWIHN improvement plans and make recommendations based on these reviews;
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWIHN or by regulatory organizations;
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task and work groups
- Identify training needs and opportunities for staff development in the quality management process;
- Identify future trends and make recommendations for next steps; and
- Leadership in practice improvement projects.

The QISC meets at least ten (10) times per year. The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, and the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement. The UM Program Description and Evaluation are also reported by the UM Director or designee to the QISC annually for approval, prior to review and approval by the Program Compliance Committee and the Board of Directors.

C. Program Compliance Committee (PCC):

The PCC, which consists of members from the BOD, meets monthly to provide leadership for the Quality Improvement process. This is achieved through supporting & guiding implementation of DWIHN quality improvement activities, including annual approval of the Quality Improvement Plan. PCC also reviews changes and evaluates the need for board actions.

The purpose of the committee:

- Annual evaluation of the effectiveness of the Quality Assurance Performance Improvement Program (QAPIP) and recommends approval of reports and standing committee and department evaluations to the BOD;
- Monitor the system-wide trends and patterns of key indicators and attainment of goals and objectives;
- Identify opportunities for improvement;
- Establish and support specific quality improvement initiatives;
- Recommend studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns;
- Assist in the development and approval of the Quality Improvement Plan; and
- Recommend board actions to the full Board of Directors.

The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement. The UM and Quality Improvement Program Descriptions and Evaluations are reported to the PCC annually for approval prior to review and approval by the full Board of Directors.

D. Board of Directors (BOD):

The DWIHN BOD's primary responsibility is to provide leadership, governance and oversight of the region. The Board is a policy-setting body, and the fiduciary of Medicaid funds. The membership is comprised of professionals in the behavioral health field and community leaders with varied backgrounds and experience which helps sustain diversity throughout the organization. There are twelve (12) board members including the Chairman, Vice-Chairman and Secretary. The UM and Quality Program Descriptions and Evaluations are reported to the BOD annually for approval.

The BOD meets monthly. The committee establishes and annually reviews committee operational guidelines, meeting frequency, management of information requests, membership, the number of members required for a quorum. It annually establishes committee goals and timelines for progress and achievement.

E. Reporting Flow of Committees:

X. PROGRAM GOALS:

DWIHN'S Board Strategic Plan is an overarching framework that strives towards common goals, establishes agreement around intended outcomes/results and assesses and adjusts the organization's direction in response to a changing environment. The following UM related goals shall be incorporated in DWIHN'S 2022-2024 Fiscal year Quality Assessment and Performance Improvement Plan (QAPIP). The goals and objectives shall be completed by DWIHN and when applicable, the Access Center, Crisis Service Vendors and/or Service Providers and can be modified to move DWIHN toward desired outcomes.

Customer Service Pillar

A. Utilize Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.
B. Enhance provider satisfaction by ensuring a more meaningful experience through use of customer service driven language to improve network relationships.

Access Pillar

C. Evaluate DWIHN's UM Program Description to assure effective and efficient utilization of behavioral health services identifying any barriers, analyzing metrics, utilization trends and quality of care concerns.

D. Monitor the use of specialty behavioral health waiver programs: Autism Spectrum Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children's Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.

E. Analyze populations served, examining services received and services available to identify any gaps.

Finance Pillar

F. Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over- and underutilization of services using dashboards.
G. Develop a system that helps track over- and underutilization.

Workforce/Quality Pillar

H. Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addition Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter rater reliability process system wide.

Quality Pillar

I. Monitor the effectiveness of processes that promote clinical review procedures established from accrediting and regulatory agencies by evaluating the efficiency of targeted metrics during UM activities through interdepartmental collaboration.

J. Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (ie. timeliness of UM decisions and notifications), outcome measurements and remedial activities.

Advocacy Pillar

K. Promote need for enhanced use of Social Determinants of Health in making clinical decisions within standardized guidelines as part of the clinical review process.

XI. BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA AND BENEFITS:

Development and Description of Medical Necessity Criteria:

1. DWIHN has adopted nationally developed and published Behavioral Health guidelines from MCG which is part of the Hearst Health Network. MCG utilizes clinical editors who analyze and classify more than 100,000 peer reviewed papers and research studies each year. By applying rigorous evidence classification techniques, they select more than 25,000 unique references to formulate into medical necessity clinical guidelines. Nationally recognized quality measures from the Hospital Quality Alliance are also embedded in the guidelines. The clinical editors are supported by a team of data analysts, librarians, and medical copy editors who together have over 115 cumulative years of guideline development experience. In addition, the team coordinates peer reviews by panels that include approximately 100 additional clinicians. The MCG Behavioral Health Medical Necessity guidelines describe best practice care for the majority of mental health and substance related disorder diagnosis, covering 15 diagnostic groups with graded evidence from published resources.

   Some of the best-known resources include the American Psychiatric Association, the American Association of Pediatrics, the American Society of Addiction Medicine, the National Institute on Alcohol Abuse and Alcoholism and the Local and National Coverage Determination criteria due to their acceptance as the best of evidence-based/best practice and emerging practice for mental health and substance use disorders. This criterion then serves as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. DWIHN believes its criteria should be transparent and available to everyone and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

   The MCG Behavioral Health guidelines are available through a secure website at the following URL, http://cgi.careguidelines.com/login-careweb.htm. Since the guidelines are proprietary, access is limited to the DWIHN provider network. A login and password can be obtained from the DWIHN UM Department.

   DWIHN and their UM delegated entities utilize an MCG software called Indicia. DWIHN requires these entities to have at least one machine installed with the online version of the MCG Behavioral Health guidelines and to make it accessible to all their clinical practitioners during hours of operation.

2. The MCG Behavioral Health Care criteria includes:
   - Behavioral health guidelines which identify the most effective level of care for specific behavioral health conditions;
   - Level of care guidelines that assess a patient's level of care needs in situations where a diagnosis-specific guideline does not apply.

- Five (5) levels of care covering inpatient, residential, partial hospitalization, intensive outpatient, and outpatient.
- Therapeutic and testing procedures that provide specific criteria for determining when a procedure, treatment, or diagnostic test may be indicated.
- Detailed discharge criteria focus on specific care elements to consider when discharging patients to a lower level of care.
- Flexible recovery courses manage longer behavioral health episodes with recovery courses listed in care days for in-patient treatments and stages for out-patient treatments.
- Alternative care planning help to select effective alternative therapies and levels of care based on specifics of a patient's case.

3. For MI Health Link enrollees/member, the National Coverage Determination (NCD) criteria developed by the Centers for Medicare and Medicaid Services (CMS) is utilized. If no NCD has been issued, or an NCD requires further clarification, a Local Coverage Determination (LCD) criteria will be utilized. LCDs are developed by the Medicare Administrative Contractor for the geographic service area and either supplement or explain when an item or service will be covered if there is no NCD. Michigan is in jurisdiction 8. In addition, the CMS Coverage Manual or other CMS-based resources, such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD or guidance on coverage in original Medicare manuals, DWIHN may make its' own coverage determination utilizing the MCG criteria or send out to an Independent Review entity. Communication will also be sent to the Medicare Administrative Contractor to be addressed in a future version of the LCD.

4. DWIHN adopted nationally developed and published criteria from the American Society of Addiction Medicine (ASAM) to determine medical necessity and level of care decisions for substance use disorders (SUD). This criterion has become the most widely used and comprehensive of guidelines for placement, continued stay, and transfer/discharge of enrollee/members with addiction and co-occurring conditions. ASAM's criteria provide separate placement criteria for adolescents and adults developed through a multidimensional assessment over five (5) broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety, and security provided and the intensity of treatment services provided. It uses six (6) dimensions including Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional/ Behavioral Conditions, Treatment/Acceptance/Resistance, Relapse/Continued Use Potential and Recovery Environment to create a holistic assessment of an individual to be used for service planning and treatment across all service and levels of care. Through this strength-based multidimensional assessment, the ASAM criteria addresses the individual's needs and obstacles as well as their strengths, assets, resources and support structure. The website (https://ASAM.org.)further describes the medical necessity criteria. The ASAM Criteria, Third Edition, is copyrighted but can be purchased by contacting the American Society of Addiction Medicine located at 11400 Rockville Pike, Suite 200, Rockville, MD 20852, telephone: (301) 656-3920, fax: (301) 656-3815.

   Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The Coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The Coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employer purchasers and providers of care in both the public and private sectors.

Criteria Review, Approval and Distribution:

1. The MCG Behavioral Health Medical Necessity guidelines, ASAM criteria, NCD and LCD criteria and DWIHN'S procedures for application are reviewed at least annually or as new treatments, applications and technologies are adopted as generally accepted professional practice by the DWIHN CMO and is

based on the most current research, relevant quality standards and evidence based/best practice, emergency practice models of care and the local delivery system (LCD/NCD).

2. The MCG, ASAM, NCD and LCD criteria are then reviewed by the committees below and approved with applicable clinicians at the Improving Practices Leadership team meetings and the UM committee.
    - Practice collaborative such as the Intellectual/Developmental Disabilities (I/DD), Adult Mental Illness and Child Seriously Emotionally Disturbed (SED);
    - Provider partnership meetings;
    - DWIHN Improving Practices Leadership Team Meetings; and
    - The UM Committee.

3. Once approved by the DWIHN CMO and Committees above, DWIHN makes the most current version of the online version of the MCG behavioral health medical necessity guidelines available to be installed on at least one computer accessible to all DWIHN, the Crisis Service Vendors' clinical practitioners during normal business hours of operation. DWIHN also makes the most current version of the personal computer software of the behavioral health MCG medical necessity guidelines available for download at the time of initial distribution through various means such as secured Google Drive or removable media such as a flash drive or CD thus allowing access to the criteria in the event of a mass or individual internet outrage or for contracted practitioners without internet access. Notification is emailed, mailed or faxed to all contracted providers using Indicia advising them when the criteria or updates to the criteria are available.

4. Enrollee/members and both network and out of network practitioners/providers can request a copy of the medical necessity criteria in relation to a specific requested service by contacting DWIHN'S UM Department, and this will be provided free of charge.

5. In accordance with the American with Disabilities Act, the criteria is available in other formats such as Braille or larger font if needed.

6. DWIHN has an established process for recognizing and evaluating new technologies and new applications of existing technologies to ensure individuals have access to safe and effective care. Proven Behavioral health clinical technology (PT) includes practice standards as well as technology that have undergone extensive practical evaluation as well as research via external mechanisms and are mandated covered services through DWIHN contracts. PT's that are not included in a benefit plan are uncovered services meaning they are not reimbursable for that benefit plan. There are a variety of mechanisms by which they may progress to covered services.
    - Providers may propose a pilot utilizing a PT for a specific population to the Research Advisory Committee.
    - Improving Practices Leadership Team (IPLT) may determine that there is a gap in service delivery across the network which current covered services are not addressing.
    - PT's may be covered by General Funds, Local Funds, or other appropriate resources when not covered by the member's benefit plan.

    Technology/Clinical practices that have been demonstrated through controlled trials, meta-analysis of the literature to be ineffective, or whose safety profile results in a negative risk-benefit from a negative risk-benefit ratio, will not be supported nor covered by DWIHN. Technology/Clinical practices that are not sufficiently researched and/or published so as to qualify as PT's may be presented to the Research Advisory Committee for consideration as a trial. DWIHN'S medical staff participate in regional and state level medical directors' meetings which include reviews of medical procedures, pharmaceuticals, health practices and devices, regulatory changes and scientific data.

MCG Behavioral Health Guidelines:

1. The published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline.

2. All retrieved publications are individually reviewed by an MCG clinical editor and assessed in terms of quality, utility and relevance. Preference is given to publications that:
   - Are designed with rigorous scientific methodology.
   - Are published in higher-quality journals (i.e. journals that are read and cited most often within their field).
   - Address an aspect of specific importance to the guideline in question (i.e. admission criteria, length of stay).
   - Represent an update or contain new data or information not reflected in the current guideline.

3. Annually undergoes external review by clinically active experts (i.e. board-certified specialist physician without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity and applicability of each guideline and then a supervising clinical editor evaluates all comments from these external reviewers and makes necessary changes to the guideline.

4. Oversight and revision of the criteria is collaborative between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM

   Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the criteria adequately serves and supports medical professionals, employer purchasers and providers of care in both the public and private sectors.

Benefit determinations are based on the following sources:

To assist the UM staff in determining services that are available based on clinical findings and available resources, DWIHN has developed a Benefit Management grid that outlines the services available by funding stream, patient population, and level of functioning. The primary funding sources currently include Medicaid, MI-Child, Healthy Michigan Plan, Medicare/Medicaid, and General Fund. Each of the Waiver programs (Serious Emotional Disturbance (SED), Habilitation and Supports Wavier (HAB), Children's Waiver Program (CWP) and the Autism Spectrum Disorder (ASD) Benefit provide an array of services based on consumers meeting admission and eligibility criteria and subsequently receiving services that are medically necessary and clinically appropriate.

In the area of Substance Use Disorders, a varied array of services is available based on the funding sources of block grant, Public Act 2 monies, Medicaid and Healthy Michigan. The Benefit Management Grid and the SUD UM Guidelines provide the foundation for UM initial and continued stay service authorizations that must be supported by documentation that supports medically necessary services. As funding changes, the benefit grid is adjusted.

Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, lifetime and annual limits.

With the enactment of the federal Mental Health Parity Act (MHPA) in 1996 and the Mental Health Parity and Addition Equity Act (MHPAEA) in 2008, insurers are now required to make formulation of benefits, utilization management, and out-of-pocket payments equivalent between behavioral health services and other medical services.

The regulations delineate the following classifications of benefits:

1. Inpatient in-network
2. Inpatient out-of-network
3. Outpatient in-network
4. Outpatient out-of-network
5. Emergency care
6. Prescription drugs

If a plan covers mental health or substance use services, in any of the above classifications, the plan must provide coverage for all classifications, as long as it also provides medical/surgical benefits in the classifications.

Under MHPA (1996):

- Lifetime & annual dollar limits for mental health services had to be equivalent to other health services.
- Parity applied only to commercial plans offering mental health benefits.

Under MHPAEA (2008) and the interim final rule (2010):

- Parity was extended to substance use services.
- Financial requirements and quantitative treatment limitations for mental health & substance use services had to be equivalent to other health services.

- Utilization management techniques had to be formulated in a manner similar to that for mental health & substance use and other services.

Application of benefits design for mental health & substance use and medical/surgical services had to be equivalent by classification and network.

Pre-existing conditions are medical conditions or other health issues that existed before a person's enrollment in a health plan. Examples include chronic conditions such as asthma, heart disease and schizophrenia. Under the Affordable Care Act, health insurance companies including Medicaid cannot refuse to cover an individual and refuse to pay for essential health benefits for a condition he/she had prior to the onset of coverage. See DWIHN Benefit Policy for more details.

Pharmaceuticals are covered by the Medicaid health plans or Part D plans with the exception of medications that are carved out by the state and covered by the state.

Inter Rater Reliability:
Review of consistency of Behavioral Health UM decision making Inter-rater reliability testing is administered annually for UM reviewers and psychiatrists involved in UM reviews. DWIHN utilizes the MCG web-based Inter-Rater Reliability module which tests the proper use of MCG guidelines with clinician-developed case studies. It evaluates an individual's ability to find and apply the appropriate guideline based on a specific scenario. DWIHN has a benchmark standard of scoring 90% or greater.

Any UM reviewer or physician reviewer with an inter-rater reliability score less than 90% will be placed on a corrective action plan (CAP) with the expectation that he/she pass a re-test administered within thirty (30) days. CAPS can involve such activities as face to face supervision and coaching and/or education and re-training. During the time period of the CAP, random samples of the person's current

cases may be audited. If upon re-testing, he/she does not achieve 90% or greater, the person will be subject to a transfer to a role outside the UM Department or termination. Note that annual education and training on the criteria is provided for all staff performing UM activities that involve application of the medical necessity criteria. MCG does have web-based on-demand training modules available 24/7. The results of inter-rater reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions and will help to identify opportunities for improvement as well as future training needs. See DWIHN Inter Rater- Reliability Policy for more details.

Clinical Chart Audits:
Audits of UM Reviews are also conducted on a quarterly basis to ensure appropriate documentation and appropriate level of care decisions. DWIHN has a benchmark standard of scoring at least 85% on each documentation audit. Any UM Reviewer with a documentation audit score less than 85% will be placed on a corrective action plan (CAP) with the expectation that the person passes at the next review. CAP's can involve such activities as face-to-face supervision and coaching and/or education and re-training. If upon the next review, the staff person does not achieve 85% or greater, he/she may be subject to a transfer to a role outside the UM Department or termination.

XII. DELEGATION OF UM FUNCTIONS AND DWIHN OVERSIGHT:

Delegation occurs when DWIHN gives to another organization the decision-making authority to perform UM functions on their behalf. It is a formal process, contractual and consistent with accreditation, state and federal regulations.

DWIHN has delegated several UM functions to the Crisis Service Vendors. As a result, these entities must develop and implement an UM Plan that meets regulatory and contractual requirements and mirrors DWIHN'S UM Plan. The regulatory and contractual requirements are articulated in the following documents:

- The Center for Medicare and Medicaid services, 42 CFR 438.210
- The External Quality Review Health Services Advisory Group Corrective Action Plan, Standard 5, Utilization Management
- The MDHHS-PIHP Contract, Section 6.8, Service and Utilization Management
- The MDHHS-PIHP Contract, Attachment P.6.7.1.1
- Substance Abuse & Mental Health Service Administration Guidelines
- MDHHS Provider Manual
- Application for Renewal and Recommitment (ARR)
- NCQA UM 1

The federal law and MDHHS contracts are clear that where any DWIHN UM functions are delegated, DWIHN UM staff must evaluate the entity's ability to perform the delegated activities prior to delegation. DWIHN must actively oversee delegated functions using clear criteria and performance expectations, including potential contract termination. If DWIHN identifies any deficiencies or areas for improvement, the appropriate entity must take corrective action to address and provide DWIHN with documentation of completed action(s).

DWIHN will provide training to the Crisis Service Vendors to assure consistent understanding and application of the MCG Medical Necessity Criteria Clinical Protocols and Evidence Based and Promising Practices. Credentialed staff must be available with expertise in each population group served by DWIHN. Cultural competency is practices and staff is also trained in specific competencies related to key ethnic groups and trans-gender groups within the community annually. Each staff person shall have credentials and licensure necessary to provide direct service to the population or group for whom he/she reviews care.

The Crisis Service Vendors must:

1. Have mechanisms to identify and correct under- utilization and over utilization;
2. Follow pre-service, concurrent and post-service (retrospective) policies and procedures established by DWIHN;
3. Have qualified medical professionals to supervise review decisions;
4. Ensure decisions to approve, deny or reduce services are made in a fair, impartial and consistent application of review criteria that best serve the enrollee/member;
5. Ensure decisions to approve, deny or reduce services are made by physicians who have the clinical expertise to treat the conditions;
6. Ensure efforts are made to obtain all necessary information including pertinent clinical information and consult with the treating provider/physician as appropriate.
7. Have the reasons for decisions clearly documented and appeal rights are available to the enrollee/member;
8. Have well-publicized and readily available appeal mechanisms for both providers and enrollees/members;
9. Have written notification of the denial sent to the provider and the enrollee/member;
10. Have written notification of a denial including a description of how to file an appeal.
11. Ensure decisions and appeals are made timely as required by exigencies of the situation;
12. Ensure there are mechanisms to evaluate the program using data on recipient satisfaction, provider satisfaction, or other appropriate measures and data is presented to DWIHN for identification of opportunities for improvement;
13. Ensure when the organization delegates responsibility for any aspect of utilization management, it has mechanisms to ensure that the delegate meets these standards;
14. Ensure the Crisis Service Vendors oversee and are accountable for any functions it delegates to any subcontractor;
15. Ensure that before any delegation, the Crisis Service Vendors must evaluate the subcontractor's ability to perform the delegated activity;
16. Ensure the Crisis Service Vendors have a written agreement that specifies the activities and responsibilities designated to any subcontractor;
17. Ensure the written agreement provides for revoking delegation or imposing other sanctions;
18. Ensure the Crisis Service Vendors shall monitor their subcontractor's performance on an ongoing basis and subjects their performance to a formal review according to a periodic schedule established by the State, consistent with applicable federal laws, Medicaid Statutes, MDHHS Regulations and Industry Standards; and
19. Ensure if deficiencies or areas for improvement are identified, the Crisis Service Vendors will place their subcontractors on a corrective action plan and notify DWIHN.

Below is a chart of the Utilization Management Monitoring Activities of the Delegates:

Monitoring Activity	Frequency	Compliance Goal
DWIHN & the Crisis Service Vendors must conduct & submit a sampling of case reviews for all staff making UM decisions utilizing the DWIHN Prior Authorized Service UM Chart Review tool to the DWIHN UM Department.	Quarterly Results will be reported to the Utilization Management Committee (UMC)	85% or greater*
Crisis Service Vendors must conduct and submit 100% of denials utilizing the DWIHN Prior Authorization UM Chart Review tool to the DWIHN UM Department.	Monthly Results will be reported to the UMC	90% or greater*
Crisis Service Vendors must submit denial tracking logs & 100% of case files of any denied case to be audited by the DWIHN UM Appeal Coordinator utilizing Denial & Appeal Audit tools.	Monthly Results will be reported to the UMC	90% or greater*

DWIHN must maintain a tracking log of all appeals and conduct 100% of case files of all appeals to be audited utilizing the Denial & Appeal Audit tools.	Monthly Results will be reported to the UMC	90% or greater*
The Access Center must conduct & submit reviews of sampling of eligibility denials & a sampling of eligibility approvals using DWIHN's Access Center Service Eligibility Review Tool to the DWIHN UM Department.	Quarterly Results will be reported to UMC	90% or greater*
Crisis Service Vendors must submit timely decision & timely notification reports to the DWIHN UM Appeals Coordinator	Quarterly Results will be reported to UMC	90% or greater for each type of decision & notification *
Crisis Service Vendors must submit UM Program Plans for review by DWIHN UM Director or his/her designee utilizing the UM Plan Audit tool.	Annually Results of audit will be included in annual DWIHN UM evaluation & reported to UMC	100%*
Crisis Service Vendors must submit results of the inter-rater(s) on all staff performing UM functions utilizing the medical necessity criteria.	Annually Results will be reported to UMC	90% or greater*
Affirmative Statement will be sent annually to all staff performing UM functions.	Annually	100%*

*Delegated entities not meeting compliance goals will be reported to the DWIHN'S Quality Improvement Department for follow up and to the DWIHN Quality Improvement Steering Committee (QISC) as needed.

XIII. UM METHODS AND ORGANIZATIONAL PROCESS FOR MAKING DETERMINATIONS OF MEDICAL NECESSITY AND BENEFIT COVERAGE FOR INPATIENT AND OUTPATIENT SERVICES:

DWIHN safeguards confidential recipient information and makes disclosures only within the limits of informed consent of the parties involved and in accordance with HIPAA, state and federal law, as well as industry standards and professional ethics. Therefore, all proceedings, records, writings, data, reports, information, and any other material labeled as "utilization management" are held in strictest confidence and protected from disclosure. Clinical review and information used in activities and functions of the UM program are appropriately safeguarded by DWIHN, Crisis Service Vendors and Service Providers. Confidentiality safeguards apply to all UM/QI committee recipients, reports, and any employee of DWIHN whose duties require knowledge of, and access to UM information and committee activities. The UM Department collects only the information necessary to certify the admission, procedure, treatment, length of stay, frequency and/or duration of behavioral health and substance use services. See DWIHN HIPAA Privacy Manual and Policies and DWIHN HIPAA Security Policies and Procedures for more details.

The purpose of the UM review is to determine enrollee/member eligibility, benefit coverage, and/or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Services may include requests for all levels of behavioral health care and substance use and requests for services from enrollees/members and behavioral health providers. The UM process provides a clear and timely response to enrollees/members and providers regarding requests for authorization of services.

DWIHN establishes UM Authorization Guidelines and Benefit Plans based on funding sources, various standard functional assessment tools and clinical presentation. It is the expectation of DWIHN that delegated entities manage adherence to the DWIHN UM Authorization and Benefit Plans. The Guidelines do not replace clinical judgement, and as such, all delegated entities must implement a clinical review process for cases that fall outside the Authorization Guidelines.

The UM review staff uses all available information along with clinical judgment, department policies and procedures, needs of the enrollee/member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, to make a decision. The UM review staff will request additional information if needed. The UM reviewer has the authority to approve services based on medical necessity criteria and the benefit grid. If the UM reviewer is unable to approve the request for service, the case is referred to the physician for determination.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests must indicate that the enrollee/member has a specific clinical need that the provider believes cannot be met in-network (i.e. a service or sooner than able to be provided or allowed by DWIHN'S access or availability standards) as long as covered by the enrollee/member's benefit plan. If the request does not indicate the enrollee/member has a specific clinical need for which out-of-network coverage may be warranted, the UM reviewer will contact the requestor for more information.

Emergent and Urgent Service:
Emergency services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent layperson, possessing average knowledge of health and medicine, to result in:

- Placing the person's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; *or*
- Serious impairment of bodily functions; *or*
- Serious dysfunction of any bodily organ or part; *or*
- Serious harm to an enrollee/member or others due to an alcohol or substance use emergency; *or*
- Injury to self or bodily harm to others; *or*
- With respect to a pregnant woman who is having contractions:

    1. That there is inadequate time to affect a safe transfer to another hospital before delivery; *or*
    2. That transfer may pose a threat to the health or safety of the woman or the unborn.

Urgently-needed services are covered services that:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and where application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the individual or others, due to the person's psychological state or in the opinion of a practitioner with knowledge of the Individual's medical or behavioral health condition, would subject the person to adverse health consequences without the care or treatment that is the subject of the request.
- Are provided when the individual is temporarily absent from the plan's service (or, if applicable, continuation) area, or under unusual and extraordinary circumstances, when the member is in the service or continuation area, and the network is temporarily unavailable or inaccessible; *and*
- It was not reasonable given the circumstances to wait to obtain the services through the plan network.

Urgent service request designations should only be used if the treatment is required to prevent serious deterioration in the person's health or could jeopardize his/her ability to regain maximum function. Requests outside of this definition will be handled as non-urgent.

XIV. ACCESS, TRIAGE AND REFERRAL PROCESS FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES:

Serving as the central front door and screening agent for DWIHN, the Access Center is operated twenty-four (24) hours a day, seven (7) days a week. The Access Center runs with a "no-wrong door" philosophy regardless of where the person contacts the public mental health system including those with co-occurring mental health and substance use disorders. The DWIHN Access Center's purpose is to link individuals with DWIHN'S provider network by ensuring eligible persons are appropriately linked with a Service Provider for a face-to-face comprehensive intake assessment.

The Access Center provides most of the core functions of DWIHN'S access system and works with the local Service Providers to ensure an overall integrated and effective access system for persons with severe mental illness (SMI), severe emotional disturbance (SED), intellectual developmental disabilities (I/DD), substance use disorders (SUD) and persons with co-occurring conditions (COD).

The Access Center is responsible for the following:

- Coverage and Eligibility Determination
- Clinical Screening
- Referral and linkage to a Service Provider for enrollees/members admitted into the public health system
- Referral, linkage and follow up to enrollees/members deemed not eligible for the public mental health system
- Substance Use Disorder Authorizations for services not requiring medical necessity review.

The Access Center makes triage and referral decisions according to protocols that define the level of urgency and appropriate level of care. They adopt triage and referral protocols that are based on sound clinical evidence and are currently accepted practice within the industry. The protocols are reviewed and revised, as needed, annually. Triage and referral staff are supervised by a licensed behavioral healthcare practitioner with a minimum of a master's degree and five (5) years of post-master's clinical experience. A licensed psychiatrist oversees triage and referral decisions.

Enrollee/members are instructed by the health plan to contact DWIHN through the twenty-four (24) hour Access Center toll free number 1-800-241-4949 or the TYY number 1-866-870-2599 for the hearing impaired. All calls are answered by a live trained Access Center Customer Service Technician (CST) who identifies themselves by name, title and organization. The CSTs are required to have at least a bachelor of arts degree in the human services field (LBSW preferred but not required) and must have at least three (3) years of experience working in human services or one (1) year of experience working in human services with an LBSW. The CST initially ascertains if it is a "crisis call" based on safety concerns and immediacy challenges as well as protocols that define the level of urgency and appropriate level of care, and if yes, collects the required demographic information and immediately warm transfers the caller to DWIHN'S Behavioral Health Emergency Response Call Center. This organization is an integral part of the overall DWIHN'S crisis safety net, both for active enrollees/members of DWIHN services as well as for the community at large. The organization holds the highest accreditations with the American Association of Sociology (AAS) and the Commission of the Accreditation of Rehabilitation Facilities (CARF). Using licensed Master level (or above) clinicians, the organization provides telephonic crisis intervention and stabilization services, twenty-four (24) hours a day, seven (7) days a week. All of their clinicians are professionally credentialed experts in crisis work or Suicidology. The organization integrates and coordinates with other established components of the existing DWIHN'S safety net, including but not limited to the Mobile Crisis Team, 24/7 clinical services teams (ACT and Home-based) and contracted hospital providers.

For more information on triage tools used by the Access Center see the UM Program Description Policy attachments regarding clinical assessment tools and flow.

DWIHN also contracts with another vendor to provide mobile crisis stabilization services and in-home/community-based crisis stabilization services to enrollees/members. Mobile Crisis is a behavioral health service which serves the community by providing urgent response and emergency evaluations. The program operates twenty-four (24) hours a day, seven (7) days a week. Calls for mobile crisis services, including inpatient services are directed through the Access Center which will contact the Crisis Service Vendor. However, calls may also come directly to the Crisis Service Vendor at 1-800-844-296-2673 (TYY 248-424-4800 for hearing impaired) from 8am-5pm Monday-Friday and 248-995-5055 after normal business hours when the enrollee/member is reported to be in crisis. A team comprised of a master degree clinician and a peer support staff person travel together in the community and are backed up with telephonic assistance by a nurse and psychiatrist as needed.

The team is expected to respond to the enrollee/member's location, including but not limited to Hospital Emergency Rooms, Specialized AFC Homes, law enforcement settings, homeless shelters, public locations (like restaurants), private residence, or other appropriate location. The team provides mobile outreach crisis services, including screening and assessment, counseling/therapy, and therapeutic support services. The team attempts to defuse a crisis situation, enacting a person's crisis plan when available and appropriate; resolve presenting problems; procure needed services and resources; and arrange extended support. Extended support may include daily on-site visits, or it could mean that a team member-most likely a trained paraprofessional – remains with the client for a number of hours as needed, to provide supervision, monitoring, support and assistance.

If determined that more intensive services are needed, the team then performs an inpatient assessment in collaboration with other team members, care givers, or other contributors, and authorize the appropriate, indicated level and type of services. The team also assists with transportation, preplacement housing or referral support on an as-needed basis. The team's face-to-face assessment may occur at a Hospital Emergency Room or when an enrollee/member has walked into the Crisis Service Vendor Center.

For individuals calling the Access Center who do not require crisis response services and are requesting entry into the public health system, the CST collects the demographic information and screens the enrollee/member for initial eligibility by verifying he/she is a resident of Wayne County. The CST uses the DWIHN electronic system, MHWIN, to verify Medicaid, Medicare, MI-Child and Healthy Michigan insurance and current enrollment. Other insurance information is obtained verbally from the caller. If the caller does not require a clinical screening to determine eligibility for community mental health service and is seeking information and community resource referrals, the CST completes a warm transfer to a community resource and provides the telephone number of at least one more community resource.

For enrollees/members who require a clinical screening, the CST warm transfers the caller to an Access Center Clinician in either the mental health, intellectual developmental disability screening unit or the substance use screening unit.

All Access Center Clinicians are licensed/certified, credentialed and trained practitioners capable of rendering clinical triage and screening services to ensure appropriate level of services determination and eligibility coverage. All of the Clinicians are supervised by a fully licensed master level practitioner with at least 5 years post master clinical experience. There is also a fully licensed psychiatrist who oversees all triage and referral decisions.

XV. EMERGENCY CARE RESULTING IN ADMISSIONS:

DWIHN provides coverage to enrollees/members if they require emergency or urgently needed services. Prior authorization is not needed for emergency room services or any emergent services needed to stabilize the emergent or urgent condition. Emergent and/or urgent care should be rendered as needed with notification of any admission to the Crisis Service Vendor within forty-eight (48) hours of the admission. A Crisis Service Vendor UM staff will review emergent and/or urgent admissions within one (1) calendar day of request for services and make a determination.

XVI. PRE-SERVICE AND CONCURRENT REVIEWS:

DWIHN makes efforts to assure the enrollee/member receives individualized, appropriate and efficient services and supports that are sufficient in scope, frequency and duration to achieve effective outcomes.

DWIHN uses a prior authorization review process designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the enrollee/member's needs in a timely manner. The purpose is to determine enrollee/member eligibility, benefit coverage and or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services.

Medical Necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the enrollee/member's circumstances, relative to appropriate clinical criteria and DWIHN'S policies.

All acute inpatient treatment, partial hospitalization, crisis residential services, substance use disorder services, state hospitalization, psychological and neuropsychological testing and electroconvulsive therapy and all out of network services require authorization prior to service being rendered from the DWIHN and/or the Crisis Service Vendors.

All authorizations shall be in compliance with the Medicaid Code of Federal Regulations 42 USC § 1396u-2(b) (8) provisions related to manage care and 42 C.F.R. § 438.210 provisions related to coverage and authorization of services.

Pre-service (initial) reviews are conducted telephonically. The information for the UM activity comes from the Access Center, the requesting facility or practitioner/provider and/or enrollee/member. The request for authorization may come from the psychiatrist, physician, treatment team, enrollee/member, family or advocate or facility representative. If the caller is someone other than the enrollee/member, they should be familiar with the case as a result of a face-to-face meeting with the enrollee/member or as a result of an informed review of the clinical record.

Initial reviews will include, but are not limited to, the following relevant information:

- Presenting problem including current symptoms
- History of presenting problem(s)
- Precipitant(s) to services
- Results of clinical examination
- Diagnosis
- Current level of functioning and baseline level of functioning
- Prior psychosocial, psychiatric, and substance abuse history and prior treatment
- Mental status
- Current and Past Medications (dosage and side effects)
- Results of diagnostic testing
- Results of the Urine Drug Screen
- Blood Alcohol Level
- Medical complications and significant medical history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Support Systems
- Specific Severity of Illness/Intensity of Service Criteria
- Treatment plan and progress notes
- Discharge Plan
- Information gained through peer to peer conversations with treating providers

Providers are given an opportunity to discuss any behavioral health or SUD decision with a DWIHN, Crisis Service Vendor physician (MD or DO) upon request during any review. Certified addiction medicine physicians are available to review substance use medical necessity cases if needed. The DWIHN Chief Medical Officer is also available twenty-four (24) hours a day, seven (7) days a week as well.

With medical oversight, continuing (concurrent) care reviews are completed at an interval dictated by the clinical severity of the case. Concurrent reviews are conducted prior to the end of the authorized period. Concurrent reviews will consistently include, but are not limited to, the following relevant information:

- Progress toward treatment goals and any changes in treatment goals
- Current and any changes in medications (dosage and side effects)
- Current level of functioning
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Intensity of Service Criteria
- Status of discharge plan
- Information obtained through peer to peer conversations with treating providers

DWIHN and the Crisis Service Vendors must adhere to the following:

Type of Review	Decision Timeframe	Exception to Decision Timeframe	Provider Notification Timeframe
Non-Urgent Pre-Service Review	Within 14 calendar days of receipt of request.	N/A	Written Notification within 14 calendar days of receipt of provider's request. Verbal Notification within 3 hours of decision.
Non-Urgent Concurrent Service Review	Within 14 calendar days of receipt of request.	N/A	Written Notification within 14 calendar days of receipt of provider's request. Verbal Notification within 3 hours of decision.
Urgent Pre-Service Review	Within 24 hours of receipt of request if all information is received.	Timeframe extends to 72 hours if additional information is requested & the request for the information is within 24 hours of receipt of the provider's request.	Written Notification within 72 hours of the decision. Verbal Notification within 3 hours of decision.
Urgent Concurrent Service Review	Within 24 hours of receipt of request if all information is received & request is made 24 hours prior to expiration of current authorization period.	Timeframe extends to 72 hours if additional information is requested & the request for the information is within 24 hours of receipt of the provider's request or if the provider's request for service is not made prior to the 24 hours before the expiration of the current authorization period.	Written Notification within 72 hours of the decision. Verbal Notification within 3 hours of decision.

DWIHN only allows physicians (MD or DO) to render behavioral healthcare and SUD non-authorization decisions. DWIHN ensures that practitioners/physicians have the opportunity to discuss any UM decision with a physician.

For non-authorization determinations, the physician reviewers must provide written documentation to justify the clinical non-authorization, and the documentation must include a description of due process rights and appeal procedures. They must also have their complete written name, signature and credentials on the written notification document.

DWIHN ensures that annually an affirmative statement about incentives to all employees of DWIHN, the Crisis Service Vendors who make UM decisions is distributed. UM decisions are based only on the appropriateness of care and services, as well as the existence of coverage or service or reducing the provision of care which is deemed medically necessary. See DWIHN'S Behavioral Health Utilization Management Review Policy, DWIHN Denial of Service Policy and DWIHN'S UM Affirmative Statement Policy for more details.

XVII. POST-SERVICE REVIEWS:

A post-service review involves a review of the medical record *after* the services have been provided. The review may be conducted for all or part of the treatment service/or encounter. A determination is made

within thirty (30) calendar days of receipt of the request. A *post*- service review resulting in an authorization determination or a non-authorization is communicated in writing to the enrollee/member and provider within thirty (30) calendar days of receipt of the request as well.

Post-service reviews will include, but are not limited to, the following relevant information:

- Presenting problem including current symptoms
- History of presenting problem(s)
- Precipitant(s) to services
- Results of clinical examination
- Diagnosis
- Current level of functioning and baseline level of functioning
- Prior psychosocial, psychiatric, and substance abuse history and prior treatment
- Mental status
- Current and Past Medications (dosage and side effects)
- Results of diagnostic testing
- Results of the Urine Drug Screen
- Blood Alcohol Level
- Medical complications and significant medical history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Support Systems
- Specific Severity of Illness/Intensity of Service Criteria
- Treatment plan and progress notes
- Discharge Plan
- Information gained through peer to peer conversations with treating providers

DWIHN only allows physicians (MD or DO) to render behavioral healthcare and SUD non-authorizations. DWIHN ensures that practitioners/physicians have the opportunity to discuss any UM decision with a physician.

For non-authorization determinations, the physician reviewers must provide written documentation to justify the clinical non-authorization, and the documentation must include a description of due process rights and appeal procedures. They must also have their complete written name, signature and credentials on the written notification document.

See DWIHN'S Behavioral Health Utilization Management Review Policy, DWIHN Denial of Service Policy and DWIHN'S UM Affirmative Statement Policy for more details.

XVIII. DISCHARGE PLANNING:

Discharge planning supports continuity of care and efficient use of resources, and incorporates the involvement and decision-making process with the enrollee/member. DWIHN'S UM reviewers collaborate with hospital discharge planners and case managers to support the facility's discharge planning arrangements.

XIX. UTILIZATION MANAGEMENT/PROVIDER APPEALS AND ALTERNATIVE DISPUTE RESOLUTION:

The types of UM/Provider appeal and alternative dispute resolution reviews are as follows:

Administrative- an appeal or dispute review involving utilization management issues such as denials resulting from not obtaining a prior authorization and/or continued authorization for some or all types of services and/or for all dates of services.

Benefit- an appeal or dispute review involving a request that is not a benefit or where the benefit limit has been exceeded.

Medical Necessity- an appeal or dispute review involving a decision that a service does not meet MCG, ASAM, NCD, or LCD medical necessity criteria or is considered to be experimental or investigational. The medical necessity appeal is reviewed by a DWIHN, Crisis Service Vendor or physician with the same or similar credentials as would usually treat the condition which is being appealed. The physician reviewing the appeal does not have any involvement in the initial denial.

Expedited/Urgent-a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.

Standard-a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received services or is currently receiving services but a delay in decision-making does not jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.

In the event an enrollee/member, enrollee/member's representative, or practitioner/provider disagrees with a non-authorization, an appeal process is available for redetermination of the request for services or payment for services. Enrollee/members and providers are notified of how to initiate the appeal process and the steps in the appeal process at the time of the non-certification notification. The following is a summary of the steps in the appeal process.

In the event an enrollee/member, enrollee/member's representative, or practitioner/provider disagrees with a non-authorization, an appeal process is available for redetermination of the request for services or payment for services. Enrollee/members and providers are notified of how to initiate the appeal process and the steps in the appeal process at the time of the non-certification notification. The following is a summary of the steps in the appeal process.

A. UM/Provider Appeals for **Medicaid** Covered Services

Pre-Service or Post-Service Medicaid Medical Necessity or Benefit (Redetermination) Appeal:

a. If an enrollee/member, enrollee/member's representative or practitioner/provider chooses to appeal an initial non-authorization of benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWIHN of an internal appeal request within sixty (60) calendar days from receipt of the standardized Advance or Adequate Notice of Adverse Determination form or the standardized Notice of Denial of Medical Coverage form for Medicaid Covered Services. If the enrollee/member is enrolled in a Managed Care Health Plan, MI Health Link, CMHSP/PIHP or MI Choice Waiver program, he/she must also have exhausted the internal appeal process before he/she can request an external Medicaid State Fair Hearing. A Medicaid State Fair Hearing is an impartial state level review of a Medicaid enrollee/members appeal of an action presided over by a MDHHS Administrative Law Judge.

   However, if the enrollee/member does not receive the standardized Notice of Appeal Approval form or the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD or SUD population or the Notice of Appeal Decision form for the MI Health Link population within the mandated time frame, he/she may request a Medicaid State Fair Hearing as well.

b. There is only one (1) internal level appeal process for all pre-service, concurrent and/or post-service provider/practitioner medical necessity or benefit denials.

c. The request for a pre-service Medicaid (redetermination) medical necessity or benefit internal appeal can be verbal or in writing to DWIHN. However, the request for a post-service Medicaid (redetermination) medical necessity or benefit internal appeal must be in writing.
d. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Any additional supporting documentation such as additional clinical information that had not been previously submitted;
    - The staff member preparing case for physician review will review all information in their electronic medical record system and gather any other information available such as previous denials and appeals and follow-up care that has occurred after the denial.
    - However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.
e. The provider and/or enrollee/member can ask for an expedited (redetermination) internal medical necessity or benefit appeal as long as the enrollee/member has not been discharged from the treatment.
f. After receiving an internal medical necessity or benefit appeal request, DWIHN must complete and send the standardized Notice of Receipt of Appeal form within twenty-four (24) hours of receipt of an expedited appeal request and within five (5) calendar days of receipt of a standard appeal request.
g. Upon receipt of the medical necessity or benefit appeal request, DWIHN is required to review the case including all documentation submitted and to fully investigate all aspects of the clinical care provided without deference to the initial determination and make a decision within the following timeframes:
    - For a pre-service expedited 1st level request, within seventy-two (72) hours of receipt of the request;
    - For a pre-service standard request, within thirty (30) calendar days of receipt of the request; *and*
    - For a post-service, which are all standard, within thirty (30) calendar days of receipt of the request.
h. The enrollee/member and/or DWIHN may need to ask for an extension to obtain more information that will assist in the processing of the appeal. All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.
i. The physician with the same or similar specialty will review the appeal and will not be a subordinate of the physician who rendered the initial denial.
j. The physician when reviewing a medical necessity appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines which include but are not limited to third party guidelines, CMS guidelines, and State guidelines, recommendations from professional societies and advice from authoritative review articles and text books.
k. The physician who made the original denial determination may review the case and overturn the initial denial.
l. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD and SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

m. The Notice of Appeal Denial form for the Medicaid SMI, IDD and SUD population and the Notice of Appeal Decision form for the MI Health Link population must include a statement that this is the only internal level of appeal.
n. The Notice of Appeal Denial form and the Notice of Appeal Decision form must also include a statement that the enrollee/member has a right to an external State Fair Hearing after he/she has exhausted the internal appeal process and an explanation of the process to file a State Fair Hearing which is at no cost to the enrollee/member.
o. If the decision results in overturning part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. For a complete overturned determination, written notification using the standardized Notice of Appeal Approval form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to the provider and enrollee/member within twenty-four (24) hours of the determination. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the Medicaid SMI, IDD, SUD population or the standardized Notice of Appeal Decision form for the MI Health Link population and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exceptions are when the decision for a pre-service expedited appeal is made on the last/3rd calendar day or when the decision for a pre-service standard appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.
p. A DWIHN physician is available to discuss a pre-service or post-service Medicaid (redetermination) denial.

When DWIHN fails to make a timely decision for a MI Health Link enrollee/member, the enrollee/member and provider will be sent the standardized Notice of Our Failure to Make a Coverage Determination form.

1. *Post-Service Medicaid Admirative (Redetermination) Appeal:* The provider and/or enrollee/member has up to sixty (60) calendar days from the receipt of the standardized Adequate Notice of Adverse Benefit Determination form or the Advance Notice of Adverse Benefit Determination form for the Medicaid SMI, IDD or SUD population or the standardized Notice of Denial of Medical Coverage form for the MI Health Link population to request an internal administrative appeal for a post-service Medicaid covered service

a. DWIHN and the Crisis Service Vendor has a one (1) level appeal process for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.
b. The provider's request for a post-service Medicaid (redetermination) administrative internal appeal must be in writing to DWIHN or the Crisis Service Vendor.
c. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.
d. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). In addition, documentation of the reason for notification outside of DWIHN'S or the Crisis Service Vendor's notification time frames must be provided.
e. DWIHN'S Customer Service Department handles all enrollee/member administrative appeals for Medicaid covered services. Enrollees/members are held financially harmless for any provider/practitioner administrative denial for Medicaid covered services.

f. After receiving an administrative appeal request from a provider, DWIHN or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Appeal form within five (5) calendar days of receipt of the standard appeal request to the provider and enrollee/member.

g. Upon receipt of the administrative appeal request, DWIHN or the Crisis Service Vendor Professional staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframe:

- For a post-service request, which are all standard, within thirty (30) calendar days of receipt of the request.

i. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.

j. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.

k. A DWIHN and/or Crisis Service Vendor professional staff is available to discuss a post-service Medicaid (redetermination) administrative denial.

B. UM/Provider Appeals for **Medicare** Covered Services:

Pre-Service or Post-Service Medicare Medical Necessity or Benefit First Level (Redetermination) Appeal:

a. If an enrollee/member, enrollee/member's representative or provider chooses to appeal an initial non-authorization of eligibility, benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWIHN of an appeal request within sixty (60) days from the standardized Notice of Denial of Medical Coverage form for Medicare Covered Services.

b. The request for a pre-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal can be verbal or in writing to DWIHN. However, the request for a post-service Medicare 1st level (redetermination) medical necessity or benefit internal appeal must be in writing.

c. All requests must include at a minimum the following:

- An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal;
- Any additional supporting documentation not submitted previously; *and*
- The staff member preparing the case for physician review will review all information in their electronic medical record system and gather any other information available such as previous denials and appeals and follow-up care that has occurred after the denial.
- However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.

d. The provider and/or enrollee/member can ask for an expedited (redetermination) internal medical necessity or benefit appeal as long as the enrollee/member has not been discharged from the treatment.

e. After receiving an internal medical necessity or benefit appeal request, DWIHN must complete and send the standardized Notice of Receipt of Appeal form within twenty-four (24) hours of receipt of an expedited appeal request and within five (5) calendar days of receipt of a standard appeal request.

f. Upon receipt of the 1st level medical necessity or benefit appeal request, DWIHN is required to review the case including all documentation submitted and to fully investigate all aspects of the clinical care provided without deference to the initial determination and make decisions within the following timeframes:

- For a pre-service expedited 1st level request, within seventy-two (72) hours of receipt of the request;
- For a pre-service standard 1st level request, within thirty (30) calendar days of receipt of the request; *and*
- For a post-service 1st level request, which are all standard, within thirty (30) calendar days of receipt of the request.

g. The enrollee/member and/or DWIHN may need to ask for an extension to obtain more information that will assist in the processing of the appeal. All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.
h. The physician with the same or similar specialty will review the 1st level appeal and will not be subordinate of the physician who rendered the initial denial.
i. The physician when reviewing a medical necessity 1st level appeal, in conjunction with independent professional medical judgment, will use nationally recognized guidelines which include but are not limited to third party guidelines, CMS guidelines, and State guidelines, guidelines from professional societies and advice from authoritative review articles and text books.
j. The physician who made the original denial determination may review the case and overturn the initial denial.
k. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Decision form and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.
l. The Notice must include an explanation that the case is automatically forwarded to the Qualified Independent Contractor, MAXIMUS Federal Services for a pre-service Medicare 2nd level (reconsideration) appeal if the determination is to uphold all or part of the non-authorization of eligibility, screening admission, continued/concurrent stay or other behavioral healthcare services.
m. A DWIHN is available to discuss a pre-service or post-service Medicare (redetermination) denial.
n. When DWIHN fails to make a timely decision, the enrollee/member and provider will be sent the standardized Notice of Our Failure to Make a Coverage Decision form.

Pre-Service or Post-Service Medicare Second Level Medical Necessity or Benefit (Reconsideration) Appeal:

a. DWIHN automatically forwards the case to MAXIMUS for a pre-service Medicare 2nd level (reconsideration) appeal.
b. MAXIMUS review and make decisions regarding a case. Notification of the decision is provided to DWIHN, the provider, and the member within thirty (30) calendar days of receipt of the request.
c. If MAXIMUS upholds part or all of the 1st level redetermination decision, they provide written notification of the decision to DWIHN, the provider and the enrollee/member. The Notice also includes an explanation of the next (3rd) level appeal process. However, if they overturn the 1st level redetermination decision and approve some or all of the services/days, DWIHN has thirty (30) calendar days to effectuate (pay claim) and provide MAXIMUS with the check number, check date, amount paid and explanation of benefits no later than thirty (30) calendar days from the MAXIMUS decision.

Pre-Service or Post-Service Medicare Third Level Medical Necessity or Benefit Appeal:

a. The 3rd level appeal is the Administrative Law Judge (ALJ) Hearing. This hearing allows the provider to present the appeal to a new person who will review the facts independently and listen to testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. To secure an ALJ hearing, the minimum amount of the case must be $150. All requests for an ALJ hearing must be written and forwarded to the Office of Medicare Hearing and Appeals (OMHA). The address is documented in the MAXIMUS

decision notice. In most cases, the ALJ sends a written decision within ninety (90) days of receipt of the request.

b. If the ALJ upholds part or all of the 2nd level decision by MAXIMUS, they provide written notification of the decision to DWIHN, the provider and the enrollee/member. The Notice also includes an explanation of the next (4th) level appeal process.

Pre-Service or Post-Service Medicare Fourth Level Medical Necessity or Benefit Appeal:

a. A 4th appeal level can be sought if the provider is dissatisfied with the decision made in the hearing. The request for a Medicare Appeals Council (MAC) review must be submitted in writing within sixty (60) calendar days of the ALJ decision and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.) In general, the MAC will issue a decision within ninety (90) days of receipt of a request for review. However, that timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Medicare Appeals Council to escalate the case to the next (5th) level, the Judicial Review.

b. If the MAC upholds part or all of the 3rd level decision by the ALJ, they provide written notification of the decision to DWIHN, the provider and the enrollee/member. The Notice also includes an explanation of the next (5th) level appeal process.

Pre-Service or Post-Service Medicare Fifth Level Medical Necessity or Benefit Appeal:

a. If at least $1,460 or more is still in controversy following the MAC decision, the provider on behalf of the enrollee/member may request judicial review before a U.S. District Court judge; this is the fifth and final level of appeal. The provider must file the request for review within sixty (60) days of receipt of the MAC's decision, which contains information about the procedures for requesting judicial review. There is no statutory timeframe for the Federal Court decision.

b. If the US District Court Judge upholds part or all of the 4th level decision by MAC, they provide written notification of the decision to DWIHN, the provider and the enrollee/member. The Notice also includes an explanation that this is the final appeal level.

Post-service (Retrospective) Medicare Administrative First Level (Redetermination) Appeal:

a. The provider and/or enrollee/member has up to sixty (60) calendar days from the receipt of the standardized Notice of Denial of Medical Coverage form to request an internal administrative appeal for a post-service Medicare covered service.

b. DWIHN and the Crisis Service Vendor have a one (1) level appeal process for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.

c. The provider's request for a post-service Medicare 1st (redetermination) administrative internal appeal must be in writing to DWIHN or the Crisis Service Vendor.

d. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.

e. All requests must include at a minimum the following:
    - An explanation of what is being appealed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). In addition, the reason for the notification outside of DWIHN'S or the Crisis Service Vendor's notification time frames must be documented.

g. DWIHN'S Customer Service Department handles all enrollee/member administrative appeals for Medicaid covered services. Enrollees/members are held financially harmless for any provider/practitioner administrative denial for Medicaid covered services.

h. DWIHN or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Appeal form within five (5) calendar days of the standard appeal request to the provider and enrollee/member upon receipt of a 1st level administrative appeal from a provider.

i. Upon receipt of the 1st level administrative appeal request, DWIHN or the Crisis Service Vendor Professional Staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframe:
    - For a post-service 1st level request, which are all standard, within thirty (30) calendar days of receipt of the request.

j. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.

k. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.

l. A DWIHN or the Crisis Service Vendor professional staff are available to discuss a post-service Medicare (redetermination) administrative denial.

When a non-contracted provider files an appeal for a MI Health Link enrollee/member, he/she must forward a complete and signed Waiver of Liability (WOL) form with the 1st level (redetermination) appeal request. Section 60.1.1 of Chapter 13 of the Medicare Managed Care Manual states: "A non-contract provider, on his or her own behalf, is permitted to file a standard or expedited appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal." DWIHN cannot proceed in reviewing a non-contracted provider's request for a 1st level appeal if there is no complete and signed WOL form. DWIHN will make three (3) attempts via telephone or in writing to secure all needed documents including the WOL. If no WOL is forwarded to DWIHN'S UM Department within sixty (60) calendar days from the denial notice date, DWIHN must send the case to a MAXIMUS requesting a dismissal. DWIHN will also forward a written notification of the dismissal to the non-contracted provider within five (5) calendar days of the request for the dismissal.

C. UM/Provider Local and Alternative Dispute Resolution for the **Uninsured or Under Insured using General Fund** to cover services:

Pre-Service or Post-Service Medical Necessity or Benefit (Redetermination) Local Dispute Resolution Review:

a. If an uninsured or under Insured enrollee/member, uninsured or underinsured enrollee/member's representative or practitioner/provider chooses to request an internal local dispute resolution review of an initial non-authorization of benefit coverage, screening, admission, continued/concurrent stay or other behavioral healthcare service, they must notify DWIHN to request a local dispute resolution review request within thirty (30) calendar days from the receipt of the standardized Advance or Adequate Adverse Determination form for the uninsured or under Insured. The uninsured or underinsured enrollee/member can request an external Alternative Dispute Resolution with the Michigan Department of Health and Human Services (MDHHS) **after** the local dispute resolution review process.

b. There is only one (1) internal local dispute resolution review level for all pre-service, concurrent and/or post-service provider/practitioner medical necessity or benefit denials.

c. The request for a pre-service (redetermination) medical necessity or benefit internal local dispute resolution review can be verbal or in writing to DWIHN. However, the request for a post-service (redetermination) medical necessity or benefit internal local dispute resolution review must be in writing.

d. All requests must include at a minimum the following:
    - An explanation of what is being dispute and the name, address and telephone number of the person responsible for filing the local dispute resolution request; *and*

- Any additional supporting documentation such as additional clinical information that had not been previously submitted;
- The staff preparing the case for physician review will review all information in their electronic medical record system and gather any other information available such as previous local dispute review denials and follow-up care that has occurred.
- However, for **post-service requests**, the complete medical record (at a minimum the intake, psychiatric evaluation, psychiatric progress notes, social work evaluation, social work progress notes, nurse evaluation, nurse progress notes, medication administration notes and discharge summary) if not provided previously.

e. The provider and/or uninsured or under insured enrollee/member can ask for an expedited (redetermination) medical necessity or benefit local dispute resolution review request as long as the enrollee/member has not been discharged from the treatment. DWIHN will assess the request for an expedited local dispute resolution review and determine if there is clinical rationale that shows the decision or delay in making the decision may have an adverse impact on the enrollee/member's health or well-being. If the request does not meet the expedited criteria, the local dispute resolution review is re-directed through the standard review process.

f. After receiving a medical necessity or benefit local dispute resolution review request, DWIHN must complete and send the standardized Notice of Receipt of Local Dispute Resolution Request form for the uninsured or underinsured form within twenty-four (24) hours of receipt of an expedited review request and within five (5) calendar days of receipt of a standard review request.

g. The Uninsured or Under Insured enrollee/member and/or DWIHN may need to ask for an extension to obtain more information that will assist in the processing of the local dispute resolution review. All extensions can request the necessary information as long as the request is within fourteen (14) calendar days of the initial request.

h. Upon receipt of the medical necessity or benefit local dispute resolution review request, DWIHN is required to review the case including all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the initial determination and make decisions within the following timeframes:
    - For a pre-service expedited local dispute resolution review request, within seventy-two (72) hours of receipt of the request;
    - For a pre-service standard local dispute resolution review request, within thirty (30) calendar days of receipt of the request; *and*
    - For a post-service local dispute resolution review request, which are all standard, within thirty (30) calendar days of receipt of the request.

i. The physician with the same or similar specialty will review the local dispute resolution review and will not be a subordinate of the physician who rendered the initial denial.

j. The physician when reviewing a medical necessity local dispute resolution review, in conjunction with the independent professional medical judgment, will use nationally recognized professional societies and advice from authoritative review articles and text books.

k. The physician who made the original denial determination may review the case and overturn the initial denial.

l. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Notice of Appeal Denial form for the uninsured or under insured and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a pre-service expedited appeal is made on the last/3rd calendar day, when the decision for a pre-service standard appeal is made on the last/30th day or when the decision for a post-service appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

m. The Notice of Appeal Denial form for the uninsured or under insured must include a statement that this is the only internal level of appeal.

n. If the decision results in overturning part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. For a complete overturned determination,

written notification using the standardized Notice of Appeal Approval form for the uninsured or under insured and the standardized Physician Letter are sent within twenty-four (24) hours of the decision. For a partially overturned determination, written notification using the standardized Notice of Appeal Denial form for the uninsured or under insured and the standardized Physician Letter are sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exceptions are when the decision for a pre-service expedited appeal is made on the last/3rd calendar day or when the decision for a pre-service standard appeal is made on the last/30th day. In these cases, the Notice and Physician Letter must be mailed on the same day as the determination.

o. A DWIHN physician is available to discuss a pre-service or post-service local dispute resolution review (redetermination) denial.

Post-service Administrative (Redetermination) Local Dispute Resolution Review:

a. The provider and/or uninsured or under insured enrollee/member has up to thirty (30) calendar days from the receipt of the standardized Adequate Notice of Adverse Benefit Determination form or the Advance Notice of Adverse Benefit Determination for the uninsured or under insured to request an internal (redetermination) administrative local dispute resolution review.
b. DWIHN and the Crisis Service Vendor have one (1) level for a local dispute resolution review for post-service provider administrative denials. Examples of administrative denials are failure to authorize services according to required, contracted time frames.
c. The provider's request for a post-service 1st level (redetermination) administrative internal local dispute resolution review request must be in writing to DWIHN or the Crisis Service Vendor.
d. Once the service or procedure has occurred or the enrollee/member has been discharged from the facility, the provider must utilize the described post-service process in order to appeal.
e. All requests must include at a minimum the following:
    - An explanation of what is being disputed and the name, address and telephone number of the person responsible for filing the appeal; *and*
    - Documentation including the request, the reasons why the provider feels the services should be paid and a copy of the claim(s). It must also include the reason for notification outside of DWIHN'S and/or the Crisis Service Vendor's notification time frames.
f. DWIHN'S Customer Service Department handles all enrollee/member administrative local dispute resolution reviews. Enrollee/members are held harmless financially for any provider/practitioner administrative denial.
g. After receiving am administrative local dispute resolution review request from a provider, DWIHN or the Crisis Service Vendor must complete and send the standardized Notice of Receipt of Local Dispute Resolution Review Request form for the uninsured or under insured within five (5) calendar days of receipt of a standard review request to the provider and enrollee/member.
h. Upon receipt of the administrative local dispute resolution review request, DWIHN or the Crisis Service Vendor Professional Staff is required to review the case including all documentation submitted and to fully investigate all aspects of the case without deference to the initial determination and make a decision within the following timeframes:
    - For a post-service local dispute resolution review request, which are all standard, within thirty (30) calendar days of receipt of the request.
i. If the decision results in upholding part or all of the initial denial, verbal communication is given to the provider within three (3) hours of the decision. Written Notification using the standardized Administrative Appeal Determination form is sent to both the provider and enrollee/member within twenty-four (24) hours of the decision. The only exception is when the decision for a post-service administrative appeal is made on the last/30th day. In this case, the Notice must be mailed on the same day as the determination.
j. The Administrative Appeal Determination Form must state that this is the final level of appeal and that the enrollee/member is to be held financially harmless for any provider/practitioner administrative denial for Medicare covered services.
k. A DWIHN and/or Crisis Service Vendor professional staff is available to discuss a post-service administrative denial.

See DWIHN Denial of Service Policy, DWIHN Utilization Management/Provider Appeals Policy, DWIHN Utilization Management/Provider Local and Alternative Dispute Resolution Policy for more details.

XX. CONTINUOUS COVERAGE AND SERVICE REQUIREMENTS:

DWIHN and the Crisis Service Vendors must have continual capacity 365 days a year (24x7x365) to perform any needed inpatient stay review and/or appeals for inpatient psychiatric hospital services or any other service requiring prior authorization. Authorization by DWIHN or the Crisis Service Vendor must be based on MCG criteria. The Crisis Service Vendors are responsible for notifying DWIHN of their twenty-four (24) hour access numbers for prior authorization and any changes in access to the services or procedures for requesting prior authorization.

DWIHN UM Reviewers are accessible seven (7) days a week, twenty-four (24) hours a day via a published designated toll-free number to handle urgent requests. Non-urgent pre-service requests and/or communications received by telephone, fax or email are handled on the next business day. TYY services as well as calls through the Michigan Relay system are available for hearing impaired or speech impaired enrollee/members. Language assistance/interpretation is also available for enrollee/members to discuss UM issues.

XXI. INDIVIDUAL PLAN OF SERVICE/MASTER TREATMENT PLAN:

The Individual Plan of Service (IPOS) is a written comprehensive plan of services and supports developed through a person-centered planning process, in partnership with the enrollee/member or their authorized representative and their family/caregiver (if enrollee/member agreeable) and one or more qualified professionals (e.g. mental health professional (MHP) child mental health professional (CMHP) or qualified intellectual disability professional (QIDP)) to address the identified desires and needs and to establish meaningful and measurable goals that are prioritized by the enrollee/member. The IPOS is the fundamental document in the individual's record and must be authenticated by the dated legible signatures of the recipients/authorized representative and the person chosen by the recipient and named in the plan to be responsible for its implementation.

Currently, the Master Treatment Plan (MTP) is the guiding SUD treatment document produced by a collaborative planning effort of an interdisciplinary group of professionals (therapist/counselor and supervisor) who meet with the enrollee/member utilizing the Person-Centered Planning process. If required, the doctor must approve the Master Treatment Plan. However, no pre-planning meeting is required prior to the Master Treatment Plan. It must be completed within forty-eight (48) hours and prior to service delivery.

An IPOS/MTP must specify the following:

- Scope of Services
- Amount of Services
- Duration of Services
- Frequency of Services
- Service Provider
- Service Delivery Method
- Service Delivery Location
- Service delivery start and end dates

Depending on the funding stream and responsibility for payment of services, DWIHN and/or Service Providers approve the supports and services outlined in the IPOS/MTP system wide. The IPOS/MTP then serves as the authorization for the supports and services. However, the IPOS/MTP is a working document that is not meant to be a once and done document. As interventions are completed, objectives are

accomplished and goals are achieved, the plan should be updated to reflect current focuses and needs of the enrollee/member. See DWIHN'S Individual Plan of Service Policy for more details.

XXII. UTILIZATION MANAGEMENT'S ROLE IN THE QUALITY IMPROVEMENT (QI) PROGRAM:

The UM program provides the Quality Improvement (QI) program with data related to monitoring and improving care and services rendered. The UM Department and the QI Department work together to monitor the care and services provided to individuals. Through this partnership, DWIHN staff is able to identify opportunities for improvement, intervene to improve care and services and conduct re-measurement activities to determine whether objectives are achieved.

The DWIHN'S quality management system consists of standing committees that oversee ongoing monitoring, peer evaluation, and improvement function including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to enrollee/members, improve operations of providers and promote efficient and effective internal operations. Standing committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities established in the MDHHS contract and on the needs of high-risk enrollee/members and high volume/problem-prone programs. Results from the DWIHN'S Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committee develops plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. Quality Management staff work with the committees and assure that the principles of data based continuous quality improvements are followed.

The standing committees monitor improvements that are implemented for effectiveness and improved outcomes. Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring outside resources, if needed to facilitate the work of teams and to facilitate involvement of all team members. The Utilization Management Committee (UMC) is a standing committee of the Quality Improvement Steering Committee (QISC) who reports up to the Program Compliance Committee (PCC).

Annually, the DWIHN'S UM program is reviewed and evaluated for overall program effectiveness and its impact is documented within the annual QI program evaluation. Results of the Behavioral Health UM program are used to identify quality of care concerns among providers. Key quality indicators are established in the Quality Improvement program to monitor Behavioral Health UM processes. These results provide a basis for prioritizing quality improvement initiatives.

The DWIHN'S UM Annual Program Evaluation and DWIHN'S UM Program Description are approved on an annual basis by the Board of Directors, following a recommendation from the Program Compliance Committee.

Under or over utilization of services may indicate poor quality care to enrollee/members. To ensure that enrollee/members receive the appropriate level of services, DWIHN implements a program to monitor service sites and improve the level of services received by enrollees/members. The variation in use of services is monitored by the QISC. At a minimum, the following UM measures will be reviewed to determine over and/or under-utilization and reported to QISC.

Sources for UM data may include, but are not limited to:

- ✓ Care Management Technology (CMT)
- ✓ Care Connect 360
- ✓ My Care Connect
- ✓ DWIHN'S electronic system, MHWIN

- ✓ Access Center and/or the Crisis Service Vendors electronic systems

Service Event Volume including:

- Number of enrollee/members receiving services by disability designation of IDD, SED, MI, SED, SMI, age, gender, race/ethnicity, Medicaid vs. Non-Medicaid, residency
- Selected service encounter mixes for populations designated as SED, IDD, SMI
- Number of enrollees/members with co-occurring Mental Illness/Substance Use Disorders (MI/SUD)

Hospitalization and Recidivism Reports:

- Number of inpatient admissions per hospital type (community hospital, state facility, other)
- Average length of stay per hospital type
- Number of enrollees/members re-hospitalized within 30 days after discharge from hospital

Substance Use Disorder Monitoring and Reports:

- Number of Admissions by Level of Care
- Number of Unique Individuals Served
- Recidivism Reporting by Level of Care
- Length of Stay by Level of Care
- Monitoring and Evaluation of Service Utilization trends
- UM involvement with the SUD Advisory Board

Continuity of Care Reports:

- Percent seen within seven days' post inpatient (MI/SA) hospitalization by hospital type
- Average number of days from inpatient discharge to face to face with physician

Co-Occurring Management:

- Utilization of services for selected procedure codes

When potential under and/or over utilization is identified, the following steps may be taken to determine if there are, in fact, instances of actual under and over treatment:

- The number and type of enrollee/member complaints related to high volume facilities or outpatient providers associated with under/over utilization of care will be reviewed.
- If indicated based on average length of treatment, a sample review of medical records for facilities or outpatient providers will be conducted to identify any instances of under or over treatment.
- DWIHN will review the results of medical record reviews, utilization and/or readmission patterns, and any complaints received related to care delivery to determine if potential under or over utilization can be validated. If validated, the providers responsible will be targeted for educational outreach with primary intervention(s) to correct under or over service utilization.

DWIHN, the Crisis Service Vendors are expected to review a statistically sound sample of consumer records, conduct sufficient billing reviews and satisfaction surveys to assure a level of confidence in the utilization management process.

The DWIHN UM Appeal Coordinator is expected to audit all denials and all appeals rendered by DWIHN, the Crisis Service Vendors monthly using the standardized audit tools, collate the results of the audits and provide a monthly report to the DWIHN UM Director. Denial and/or appeal cases not scoring 90% or greater will be reviewed with the DWIHN, the Crisis Service Vendors UM Reviewer for the purposes of coaching and training. Any UM Reviewer that scores below 90% on the audit tool three (3) times or more will be placed on a Corrective Action Plan.

XXIII. SATISFACTION WITH THE UM PROCESS:

Practitioner, provider and enrollee/member surveys are conducted annually to assess UM satisfaction. Through the satisfaction surveys, as well as enrollee/member and provider complaint and appeal process, DWIHN continually evaluates the UM program to ensure that difficulties are not encountered when enrollee/members are seeking care and when providers are requesting care. The UMC reviews data at least annually to identify opportunities and develop interventions for improvement.

XXIV. BEHAVIORAL HEALTH UTILIZATION MANAGEMENT PROGRAM EVALUATION:

A. Frequency of the DWIHN UM Program Evaluation:
A formal evaluation of the UM program occurs annually. This annual evaluation includes, but is not limited to, the program structure and scope, UM processes, benefit coverage and medical necessity as well as the involvement of the Chief Medical Officer as well as member and provider experience. The evaluation is reported to the UMC and then reported to the QISC annually and to the PCC and then to the BOD for formal approval every two years and as needed. The UM Program evaluation is part of the QI evaluation that is reported to the PCC and to the Board annually. Results of the evaluation are used to guide the development and refinement of the Behavioral Health UM Program Description and Work Plan.

B. Responsibility for the DWIHN UM Program Evaluation:
The UM Program Evaluation is compiled by DWIHN UM Clinical Specialists and the DWIHN UM Director. It is then reviewed by the CMO prior to presentation to the UMC.

The UM Program Evaluation is organized around the DWIHN Strategic Plan and includes but is not limited to:

- Monitoring trends and patterns of key utilization management indicators for under and over utilization and appropriateness of care;
- Enrollee/member and Provider satisfaction with the UM process;
- Compliance with UM decision-making timeframes;
- Compliance with certification, non-certification and appeal resolution timeframes;
- Consistency of the selection and application of medical necessity criteria by UM decision-makers using standardized criteria and inter-rater reliability measures;
- Benefit Management;
- Quality improvement activities;
- Denial and Appeal category analysis; and
- New Technology Recommendations.

ATTACHMENT #1

Utilization Management Functions for the MI Health Link Program:

MI Health Link is a new health care option for Michigan adults, ages 21 and over, who are enrolled in both Medicare and Medicaid and live in Wayne County or one of the other participating regions.

The goal of MI Health Link is to provide seamless access to high quality care that reduces costs for those who are eligible. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet the individual needs of the enrollee.

The following integrated care organizations provide services to MI Health Link enrollees/members in Wayne County: Aetna, AmeriHealth, Fidelis, HAP Midwest and Molina.

The benefits of being enrolled in the MI Health Link program include:

- Having one plan for all your Medicare and Medicaid benefits including medications
- Not having to pay any co-payments or deductibles for in network services including medications (nursing home patient pay amounts still apply)
- Having an individual Care Coordinator to:
  - ✓ Work with the individual to create a person care plan based on personal goals
  - ✓ Answer questions and make sure the person's health care issues get the attention they deserve
  - ✓ Connect the individual to supports and services needed to be healthy and live where he/she wants.

Access to Behavioral Health and Substance Use Services:
The maximum time between a request for an appointment and the date offered is:

- Emergent / Life Threatening: 3 hours
- Emergent / Non-Life Threatening: 6 hours
- Urgent Care: 24 hours
- Routine Care: 7 business days
- If a provider's schedule cannot accommodate the person requesting any appointment within these time intervals, an appointment will be offered with an alternative provider at the same location, or if none available, at another location. The member may choose to decline alternatives and accept a delayed appointment.

Individual Integrated Care and Supports Plan (IICSP):
The Person Centered Planning process assists in the design of the Individual Integrated Care and Supports Plan (IICSP). This is the driving document for all supports and services for persons in the dual eligible project. However, for behavioral health services, the Individual Plan of Service (IPOS) is also developed and implemented; it is the document that the amount, scope and duration of behavioral health services to be provided to the member. The IPOS is incorporated into the Individual Integrated Care and Supports Plan (IICSP).

Emergency Care Resulting in Admissions:
DWIHN provides coverage to members if they require emergency or urgently needed services. Emergent and/or urgent care should be rendered as needed, with notification of any admission to the DWIHN UM Prior Authorization Department within forty-eight (48) hours of the admission. A DWIHN UM staff will review emergent and/or urgent admissions within one business day of receipt of clinical information.

Prior Authorized Services and Procedures:

All acute inpatient treatment, partial hospitalization, crisis residential services and withdraw maintenance (sub-acute detox), state hospitalization, psychological and neuropsychological testing and electroconvulsive therapy require authorization prior to service being rendered. Prior authorization is designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the enrollee/member's needs in a timely manner. The purpose is to determine enrollee/member eligibility, benefit coverage and or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Pre-certification is deemed necessary for all elective, non-emergent and urgent inpatient admissions and procedures rendered by a hospital/facility providing behavioral health services when consistent with current medical necessity requirements and current policies and procedures. Behavioral health care rendered by providers not participating in DWIHN network also require pre-approval for these services.

Authorizations are based on MCG criteria which is updated every year by the DWIHN CMO and is based upon the most current research, relevant quality standards and evidence-based models of care. DWIHN also has behavioral health clinical protocols. Providers are encouraged to review and use them, but they should not replace clinical judgment. A copy of the level of care criteria used in clinical decision making and/or the clinical protocols is available via email at **pihpauthorizations@dwihn.org.** Both documents are available in various formats to meet ADA requirements.

All authorizations shall be in compliance with the Medicaid Code of Federal Regulations 42 USC § 1396u-2(b) (8) provisions related to manage care and 42 C.F.R. § 438.210 provisions related to coverage and authorization of services. DWIHN also complies with CMS requirements and timeframes for historically Medicare primary paid services.

Pre-service reviews are conducted telephonically. The source of information for the UM activity comes from the requesting facility or provider and/or enrollee/member. The request for authorization may come from the psychiatrist, physician, treatment team member, enrollee/member, family or advocate. If the caller is someone other than the enrollee/member, they should be familiar with the case as a result of a face-to-face meeting with the enrollee/member or as a result of an informed review of the clinical/medical record.

Providers are given an opportunity to discuss any behavioral health or pharmacy decision with a DWIHN physician during any review. The DWIHN Chief Medical Officer is also available twenty-four (24) hours a day, seven (7) days a week for consultation.

Both inpatient and outpatient ECT must be preauthorized. If a provider is requesting inpatient ECT treatment, the member is required to meet criteria for inpatient level of care in addition to meeting medical necessity for ECT. If the member no longer meets criteria for the inpatient level of care, then outpatient ECT can and shall be considered unless medically contraindicated. All ECT services are reviewed by a DWIHN physician.

Psychological testing and neuropsychological testing requires the submission of a standardized preauthorization request form that is faxed or emailed to DWIHN for review by the Director of UM prior to service delivery. A determination is made within three (3) calendar days of receipt of the request

If medical necessity criteria is not met for inpatient admission or other high acuity service, the request for prior-authorization is denied. However, only a physician can render behavioral healthcare and pharmaceutical denial or a Doctoral-level clinical psychologist or certified addiction-medicine specialist can make a behavioral health denial or a pharmacist to render a pharmaceutical denial. A less restrictive alternative setting may be recommended, or, if no need for CMH services is identified, the applicant is referred to resources outside of the DWIHN network.

Utilization Management/Provider Appeals:

If a request for services is reduced, suspended or denied, the requesting provider is given verbal notification within three (3) hours of the decision. Written notification is mailed to the provider and the enrollee/member using the standardized Notice of Denial of Medical Coverage form within twenty-four (24) hours of the decision. The Notice describes the reasons for the reduction, suspension or denial of services and explains the due process procedures for both Medicaid and Medicare covered services.

Out of Network (Non-Contracted) Providers and Authorizations:
Occasionally, an enrollee/member may be referred to an out-of-network provider because of special needs and the qualifications of the provider. DWIHN will make such decisions on a case-by-case basis. Consultation with a DWIHN physician may be necessary as well. However, if a network provider refers an enrollee/member to an out of network provider, DWIHN will authorize the services as long as they are medically necessary and if the non- contracted provider has a current, unrestricted, license to practice.

When approving a service from a non-contracted provider, DWIHN assigns an authorization number which refers to and documents the approval. DWIHN sends documentation of the approval to the provider within the time frames appropriate to the type of request. By requesting authorization, the provider is affirming services are medically necessary and a covered benefit under the Medicare and/or Medicaid Program(s).

As a condition of the authorization for Medicare services, the out of network provider also agrees to accept no more than 100% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the date(s) of service, and any portion, if any, that DWIHN or the ICO would have been responsible for paying if the member was enrolled in the Medicare Fee-For-Service Program. Servicing out of network providers also shall recognize that members are not to be balanced billed for any uncollected monies for covered services.

Non-Prior Authorized Services and Procedures:
DWIHN has implemented the UM Guidelines document to serve as the basis for payment approval for all services that do not require prior authorization. The UM Guidelines detail the specific services, frequency per year and HCPCS codes available based on the enrollee/member's Level of Care Utilization Systems (LOCUS) Score or Supports Intensity Scale (SIS) Level Score. As long as the provider requests supports and services that do not exceed the UM guidelines for an enrollee/member, no authorization is required for payment; the provider simply submits the claims to DWIHN. However, if the claims for supports and services exceed the UM Guidelines, the provider receives a message that the payment is pending a review by a DWIHN UM staff. The provider then submits the clinical reasoning for use of requested supports and services to the DWIHN UM staff for review and a determination is made within 3 calendar days of the submission.

DWIHN Monthly UM Reporting Requirements for the MI Health Link Program:
Access to Services:

- Total number of emergent/life threatening requests for an appointment and the date offered is within 3 hours
- Total number of emergent/non-life-threatening requests for an appointment and the date offered is within 6 hours
- Total number of urgent requests for an appointment and date is offered is within 24 hours
- Total number of routine requests for an appointment and the date offered is within 7 business days

Hospitalization and Recidivism:

- Number of admissions per service type (acute in-patient, partial hospitalization, sub-acute detox, crisis stabilization, crisis residential)
- Average length of stay per service type
- Number of persons re-hospitalized within 30 days after discharge from hospital

Continuity of Care:

- Percent seen within 7 days post-acute inpatient hospitalization by a physician

- Percent seen within 7 days post-acute inpatient hospitalization by a health care professional other than a physician
- Average number of days from inpatient discharge to face to face with a physician
- Average number of days from inpatient discharge to face to face with a health care professional other than a physician

UM Decision Reviews:

- Total number of authorization requests by routine, urgent and emergent by contracted providers and by non-contracted providers
- Total number of denials for prior authorized service
- Total number of standard 1st level redetermination requests
- Total number of decisions upheld or resulting in a split decision by DWIHN for a standard 1st level redetermination appeal request and forwarded to MAXIMUS
- Total number overturned denial decisions by DWIHN for a standard 1st level redetermination appeal request
- Total number of expedited 1st level redetermination appeal requests
- Total number of decisions upheld or resulting in a split decision by DWIHN for an expedited 1st level redetermination appeal request and forwarded to MAXIMUS
- Total number overturned decisions by DWIHN for an expedited 1st level determination appeal request
- Total number of 2nd level reconsideration appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision for a 2nd level reconsideration appeal request by MAXIMUS
- Total number of decisions overturned by MAXIMUS due to case set up by DWIHN
- Total number of 3rd level ALJ hearing appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 3rd level ALJ hearing request
- Total number of 4th level Medicare Council appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 4th level Medicare Council Review
- Total number of 5th level Judicial appeal requests
- Total number of decisions upheld, total number overturned and total number resulting in a split decision by the 5th level Judicial court
- Total number of retrospective review requests
- Total number of retrospective review requests denied by DWIHN
- Total number of retrospective 1st level appeal requests
- Total number of decisions upheld or resulting in a split decision by DWIHN for a retrospective 1st level appeal and forwarded to MAXIMUS
- Total number overturned decisions by DWIHN for a retrospective 1st level appeal
- Total number of administrative provider appeal requests
- Total number of decisions upheld or resulting in a split decision by DWIHN and forwarded to MAXIMUS for an administrative provider appeal
- Total number of decisions overturned by DWIHN for an administrative provider appeal

UM Timeliness:

- Total number of expedited decisions made by DWIHN within 72 hours of receipt of the request for an expedited 1st level redetermination request
- Average turnaround time of expedited decisions made by DWIHN for an expedited 1st level determination request

- Total number of standard decisions made by DWIHN within 60 calendar days after receipt of the request for a standard 1st level redetermination request (standard medical necessity, retrospective and/or administrative)
- Average turnaround time of a standard decision made by DWIHN for a standard 1st level redetermination request
- Total number of notification letters sent for expedited, standard and post service decisions
- Total number of claims effectuated by DWIHN 30 calendar days from the date of the letter from the MAXIMUS documenting the denial decision was overturned (the 30 calendar days includes DWIHN forwarding the check number, check date, amount paid and EOB to MAXIMUS) for a 2nd level reconsideration (medical necessity, retrospective and/or administrative) appeal

Clinical, utilization management and denial and appeal data is secured using the DWIHN electronic system MHWIN as well as using Care Connect 360 and Care Management Technologies through the Population Health Management Application. Outcomes from the data is available to the Integrated Care Organizations (ICO) with customized dashboard. However, the UM Department will generate monthly reports with the above data to the ICO. For each denial, DWIHN will include a UM denial summary with the member name, the requesting provider name, request date, type of request (i.e. routine, urgent, emergency), decision date, denial reason and date member/provider was notified of the decision. DWIHN will also monitor over and under-utilization of services quarterly and will provide documentation of such monitoring and the findings to the Integrated Care Organizations on a quarterly basis.

Quality Assurance/Improvement:

Review of consistency of Behavioral Health and Substance Use UM decision making Inter-rater reliability testing is administered annually for UM reviewers and psychiatrists involved in UM reviews. DWIHN utilizes the MCG web-based Inter-Rater Reliability module, which tests the proper use of MCG guidelines with clinician-developed case studies. It evaluates an individual's ability to find and apply the appropriate guideline based on a specific scenario. DWIHN has a benchmark standard of scoring 90% or greater. Any UM reviewer or physician reviewer with an inter-rater reliability score less than 90% will be placed on a corrective action plan (CAP) with the expectation that the person pass a re-test administered within thirty (30) days. CAPS can involve such activities as face-to-face supervision and coaching and/or education and re-training. During the time period of the CAP, random samples of the staff member's current cases will be audited. If upon re-testing, the staff person does not achieve 90% or greater, he/she will be subject to a transfer to a role outside the UM Department or termination. Note that annual education and training on the criteria is provided for all staff performing UM activities that involve application of the medical necessity criteria. MCG also has web-based on-demand training modules that are available 24/7. The results of the inter rater reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will also help to identify opportunities for improvement as well as further training needs. MCG also provides reports outlining all of the training modules completed by each UM reviewer including physicians to ensure that all required training modules are completed.

ATTACHMENT #2

Waiver and State Plan Amendments (SPA):

State Plan Amendments and Waivers enable states expand their Medicaid programs and/or offer services that better meet the needs of Medicaid enrollees. In Michigan, DWIHN as a PIHP, manages the following:

1. State Plan Amendment for Autism Spectrum Disorder (ASD)
2. Children with Serious Emotional Disturbance Waiver (SED)
3. Children's Waiver Program (CWP)
4. Habilitation and Supports Waiver (HAB)

Each program has specific eligibility criteria, authorization process including certification and rectification and selected service array. As part of Medicaid funding, DWIHN is responsible to monitor each program's access and service delivery to ensure individuals receive the high-quality service, in the appropriate amount, in the most appropriate time frames, taking into consideration medical necessity, prevailing standard of care and the preferences and values of the person to achieve the best outcomes.

Autism Spectrum Disorder (ASD) Program and Benefit:

The Medicaid Autism Benefit is a benefit under the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) for individuals which provides access to evidence-based Applied Behavior Analysis (ABA) Services to individuals covered by Medicaid ages birth to twenty-one with an Autism Spectrum Disorder (ASD) Diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnosis Evaluations, Psychological Testing, Adaptive Testing, Behavior Assessments, Behavior Plans of Care, ABA Direct Services, Technician Direction and Observation (Supervision), and Parent/Guardian Training. Individuals receiving the Medicaid Autism Benefit also have access to any other medically necessary services covered by DWIHN.

To access the Medicaid Autism Benefit, parents/guardians or individuals contact the Access Center for screening by an Access Center Clinician using the Modified Checklist for Autism in Toddler–Revised (M-CHAT-R) or Social Communication Questionnaire (SCQ). The family is offered choice and then referred to an ASD Benefit Provider for further evaluation. The Provider in receipt of the referral receives an authorization for the evaluation, cognitive, and adaptive testing from the Access Center Clinician. To determine the diagnosis of ASD and the level of Applied Behavioral Analysis (ABA) services need by the individual, the Service Provider completes the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2) and the Autism Diagnosis Interview – Revised (ADIR)/Developmental Interview. For cases where it may be challenging to identify ASD Diagnosis based solely the ADOS-2 and ADIR and there is medical necessity for further evaluation, Providers are able to conduct cognitive and adaptive testing.

Families also are connected to a general Developmental Disability Intake Interview, which begins the Person-Centered Planning process to begin the pre-plan and Individualized Plan of Service (IPOS). This plan includes the ASD services along with all other medically necessary services for the individual.

After receiving a referral, completing the diagnostic testing and recommending the level of ABA services, the Service Provider forwards an application to DWIHN. The UM Reviewer then conducts a clinical review of the requested service plan and records the enrollment details including the service plan into the Waiver Supports Application (WSA) which is MDHHS's management tool for ASD services. An MDHHS Administrator then reviews the information, approves or denies the ASD benefit, uploads the decision in WSA and then forwards the decision to DWIHN. The DWIHN UM Reviewer, in turn, notifies the Service Provider. The UM Reviewer also enters re-enrollments, continued stay service plans and discharges into the WSA for MDHHS review and approval or denial.

Per the Michigan Medicaid Manual, the medical necessity and recommendations for ASD services is determined by a physician or other licensed practitioner working within their scope of practice under the state of Michigan. The child must demonstrate substantial functional impairment in social communication, patterns of behavioral and social interaction as evidenced by meeting criteria A or B (listed below); and required ASD services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
    1. Child is under 21 years of age.
    2. Child received a diagnosis of ASD from a qualified practitioner using valid evaluation tools.
    3. The child is able to benefit from the treatment.
    4. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the treatment interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
    5. Coordination with the social and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and prevent service duplication. Collaboration may take the form of phone calls, written communication logs, participation in team meetings.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavioral, interests and activities as manifested by at least two of the following:
    1. Stereotyped or repetitive motor movements, use of objects or speech (e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, and /or idiosyncratic phrases).
    2. Insistence on sameness, inflexible adherence to routines or ritualized patterns of verbal or nonverbal behavior (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals and/or need to take same route or eat the same food daily).
    3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
    4. Hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects and/or visual fascination with lights or movement).

DWIHN UM staff also tracks monthly the following data to ensure the ASD program operates within maximum capacity:

- Number of new referrals;
- Total number of children enrolled in the program;
- Total number of children actively receiving services;
- Number of children discharged from the program and the reason(s) for discharge;
- Number of service authorizations approved;
- Number of services authorizations denied;
- Number of services authorizations pending;
- Number of adjudicated (processed) claims
- Percentage of 0-5 years open cases;
- Percentage of 6-20 years open cases

Serious Emotional Disturbance (SED) Waiver:
The Children's SED waiver provides services that are enhancements or additions to Medicaid State Plan coverage for children through age 20 who have an SED. MDHHS operates the SED waiver through contracts with the Community Mental Health Service Programs (CMHSP's). The SED Waiver is a fee-for-service program administered by the CMHSP in partnership with other community agencies.

SED waiver services are intended for children with a Serious Emotional Disturbance (SED) who are at risk of hospitalization, had multiple placements or are youth/families who are in need of additional supports/services in order to maintain the young person in the home.

Eligibility:
The child must:

- Be under the age of 18 when initially approved for the waiver, but can remain in the waiver until age 21;
- Reside with birth/adoptive parents as a Temporary Court Ward (TCW), reside in foster care as a TCW/Permanent Court Ward (MCI), or have completed the adoption process through the Child Welfare system;
- Meet current MDHHS criteria for the state psychiatric hospital for children;
- Meet Medicaid eligibility criteria and become a Medicaid beneficiary;
- Be age 18 or 19 and live independently with supports.

The child must have at least one of the following:

- Severe psychiatric signs and symptoms;
- Disruptions of self-care and independent function;
- Harm of self or others;
- Drug/medication complications or co-existing general mental condition requiring care
- Special consideration: If substance abuse, psychiatric condition must be primary;
- Youth who have an Intellectual Developmental Disability (IDD) are not eligible for the SED waiver; or
- The child must demonstrate serious functional limitations that impair his/her ability to function in the community (functional criteria is identified using the Child and Adolescent Functional Assessment Scale [CAFAS] or Preschool and Early Childhood Functional Assessment Scale [PECFAS]):
  - CAFAS score of 90 or greater for children age 7 to 12; *or*
  - CAFAS score of 120 or greater for children age 13 to 18; *or*
  - For children age 3 to 7, elevated PECFAS subscale scores in at least one of these areas: self-harmful behaviors, emotions, thinking, communicating or behavior toward others; *and*
  - Youth can remain in the waiver even if their CAFAS or PECFAS score drops the 1-year commitment.

Covered SED Waiver Services:
Each child must have a comprehensive IPOS that specifies the services and supports the child and his/her family will receive. The IPOS is developed through the Wraparound planning process. Each child must have a Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating service delivery, as well as the child's health and safety, as part of their regular contact with the child and family, with oversight from the Community Team.

Wraparound Services:

Wraparound services is a highly individualized planning process facilitated by specialized supports coordinators. Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services, and other community services and supports.

Community Living Supports:

Community Living Supports are used to increase or maintain personal self-sufficiency, thus facilitating achievement of his/her goals of community inclusion and remaining in the home. Supports may be provided in the beneficiary's home or community settings (including, but not limited to, libraries, city pools, camps, etc.)

Respite:

Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Family Supports and Training:

This service is provided by a peer-parent who has completed specialized training. It is a family-focused service provided to families (birth or adoptive parents, siblings, relatives, foster family, and other unpaid caregivers) of children with SED for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in their ability to achieve goals of: performing activities of daily living; improving functioning across life domain areas; perceiving, controlling or communicating with the environment in which they live; or improving their inclusion and participation in the community or productive activity, or opportunities for independent living.

Therapeutic Activities:

A therapeutic activity is an alternative service used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the IPOS. The IPOS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the IPOS. Providers are identified through the wraparound planning process and participate in developing an IPOS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the IPOS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy.

Child Therapeutic Foster Care:

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- Intensive parental supervision
- Positive adult-youth relationships
- Reduced contact with children with challenging behaviors
- Family behavior treatment skills

Therapeutic Overnight Camp:

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Transitional Services:

Transitional services are a one-time only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g. governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Home Care Training, Non-Family:
This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians. Professional staff work with CLS staff to implement the consumer's POS, with focus on services designed to improve the child's/youth's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage.

SEDW Service Providers:

Black Family Development Inc.
2995 E. Grand Blvd.
Detroit, MI 48202
313-758-0150

Development Centers
17321 Telegraph
Detroit, MI 48219
313-531-2500

The Guidance Center
13099 Allen Road
Southgate, MI 48195
734-785-7718

Southwest Counseling Solutions
5617 Michigan Avenue
Detroit, MI 48210
313-963-2266

The Children's Center
79 Alexandrine Street
Detroit, MI 48201
313-831-5535

The Children's Home and Community Based Services Waiver Program (CWP) and Benefit:

The Children's Waiver Program (CWP) is a federal entitlement program that provides Medicaid funded home and community-based services to children (under age 18) who have developmental disabilities. The CWP waiver provides services to children with complex medical and behavioral needs who meet eligibility for the level of services similar to an Intermediate Care Facility/Individual with Intellectual Disability (ICF/IID). The CWP enables children to remain in their parent's home or return to their parent's home from out-of-home placements regardless of their parent's income.

The child must meet all of the following:

- Be below age eighteen (18);
- Meets financial eligibility for Medicaid as a "family of one";
- Reside with parent(s) or guardian (relative);
- Receive at least one waiver service per month;
- Be at risk of out of home placement; and
- Have a Developmental Disability as defined in the mental health code ***AND*** meet the criteria for an ICF/IID which implies the need for an active treatment program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary to function with as much self-determination and independence as possible.

CWP provides services that are enhancements or additions to regular Medicaid coverage to children up to age eighteen (18) enrolled in the program. It allows Medicaid to fund necessary home and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative named legal guardian under State law, regardless of their parent's income. The CWP is a fee-for-service program administered by the CMHSP (DWIHN). DWIHN is held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized and exceed the Medicaid fee screens or amount, duration and scope parameters.

The program has a capacity to serve 464 children statewide. Although the program is at capacity, a weighing list is maintained using a priority rating system to add new children to the program when openings occur.

DWIHN'S UM Department is responsible to:

- Monitor the CWP providers' activities of the CWP in the identification of potential waiver candidates, the completion of the pre-screening process in the WSA, the submission to the pre-screening information to MDHHS;

- Authorize the WSA roles (pre-screener, Support Coordinator and Supervisor) for each CWP provider and assuring they are current Coordination of the Child's Waiver Program;
- Provide technical assistance (TA) and disseminate CWP information to DWIHN staff, CWP service providers, families, and stakeholders;
- Manage the waiver enrollments, (by keeping track of pre-screenings, invitations to apply for the CWP, enrollments in the CWP, organize and chair the quarterly meetings;
- Conduct the LOC evaluation activities ((site visits, validation of Performance Measures (PM) reported quarterly through the self-monitoring tool);
- Assure the participants have been given freedom of choice of providers;
- Assure the participants have consented to CWP services in lieu of the ICF/IDD;
- Assure the family have been offered and explained the Choice Voucher option;
- Assure services are provided according to the Individual Plan of Service (IPOS) and within the Category of Care/Intensity of Care determination;
- Monitor the data in the WSA;
- Enter the PDN authorization for Private Duty Nursing Services into CHAMPS system.

A CWP Support Coordinator's activities include:

- Assisting the child and his family, friends, and other professional members work cooperatively to identify the child's needs and to secure the necessary services;
- Assuring all services and supports must be included in the child's IPOS;
- Assuring the IPOS is reviewed, approved and signed by the physician;
- Assuring each CWP beneficiary receives at least one children's waiver service per month in order to retain eligibility;
- Demonstrating the CWP participants meet the continued eligibility requirement;
- Submitting request to the MDHHS Clinical Review Team (CRT) for prior authorizations when required for Services, equipment and Environmental Accessibility Adaptations (EAAs). (The CWP Clinical Review Team at MDHHS is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.)

The services covered under the CWP are:
Community Living Supports (CLS)

- Enhanced Transportation
- Respite Care
- Family Training
- Fencing
- Non-family Training
- Specialty Services
- Home Care Training, Non-Family
- Specialized Medical Equipment & Supplies
- Environmental Accessibility Adaptations
- Fiscal Intermediary

The children enrolled in the CWP also can receive other services provided under the State Plan such as PDN, ABA, etc.

Habilitation and Supports Waiver (HSW) Program and Benefit:

The HSW is a Federal Program directed to provide services and supports for beneficiaries with Developmental Disabilities (Medicaid 1915 (c) HCBS Waiver) who meet the Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care (LOC). The services and supports are provided under the auspices of the PIHP (DWIHN) under contract with Michigan Department of Health and Human Services (MDHHS) and must be specified in the beneficiary plan of services developed through the Person Centered Planning (PCP) process.

DWIHN delegates the provision of services to the providers.
Participants enrolled may not be enrolled simultaneously in another of Michigan's 1915(c) waivers.
The beneficiary must also meet all of the following requirements:

- Has a developmental disability (as defined by Michigan law) no age restrictions;
- Is Medicaid eligible and enrolled;
- Resides in a community setting or will reside in a community setting;
- Would otherwise require level of services similar to an Intermediate Care Facility/Individual w/Intellectual Disability (ICF/IID);
- Chooses to participate in the HSW instead of ICF/IID services.

The services (and their codes) offered through HSW are:

- Community living supports (H2015, H2016, H0043, T2036, T2037)
- Enhanced medical equipment (T1999, T2028, T2029, S5199, E1399, T2039)
- Enhanced pharmacy (T1999)
- Environmental modifications (S5165)
- Family training (S5111)
- Goods and Services (T5999) (Only for those participating in self-determination)
- Out of home non-vocational habilitation (H2014)
- Personal Emergency Response System (PERS) (S5160, S5161)
- Prevocational services (T2015)
- Private Duty Nursing (PDN) (S9123, S9124) for those 21 years or older
- Supported employment (H2023)
- Respite Care (T1005, H0045)
- Support Coordination (T1016)

Service selection guidelines for the beneficiaries should be used for the determination of the amount, duration, and scope of services and supports to be used.

It is important to note that in order to retain eligibility, a HSW beneficiary must receive at least, one HSW service per month; DWIHN receives monthly reports from each provider to demonstrate this continued eligibility requirement.

The role of DWIHN'S UM Department is to perform the following tasks:

- Oversight, monitoring of the activities of HSW providers.
- Provision of technical assistance (TA);
- Organize and Chair the quarterly meetings;
- Perform monthly chart reviews and periodic provider site visits;
- Disseminate HSW information;
- Manage the waiver enrollments within the PIHP allocation;
- Review of HSW applications;
- Review the LOC evaluation for the authorization of HSW re-certifications;
- Assure the participants have been given freedom of choice of providers,
- Assure the participants have consented to HSW services in lieu if the ICF/IID,
- Monitor utilization management of waiver services by monthly tracking the total number of beneficiaries enrolled in the HSW program, the total number of available HSW slots, the number of HSW applications submitted to DWIHN, the number of applications reviewed, the number of applications pended for more information, the number of pended applications re-submitted, the number of applications withdrawn, the total number of application sent to MDHHS, the number of deaths, the number of annual recertification forms reviewed and signed, the number of dis-enrollments (not meeting HSW criteria).

ATTACHMENT #3

CONTINUED STAY PRIOR AUTHORIZATION REVIEW (PAR) AUDIT TOOL

IDENTIFYING INFORMATION				
Consumer Initials:	**Member ID**	**Adult**	**Child or Adolescent**	**Name of Facility:**
LEVEL OF CARE:	**Inpatient**	**Partial Hospital**		**Crisis Residential**
Admission Date:	**Discharge Date:**		**DWIHN UM Reviewer Name:**	
UM Staff Auditor			**Audit Date**	

REFERENCE TO:	MET	NOT MET	COMMENTS
1. Name, credentials, and telephone number of provider completing review.			
2. COVID status.			
3. Reason for admission/or factors contributing to current level of care.			
4. Psychiatric evaluation/or most recent physician assessment from the last 24 hours reflecting current level of functioning, symptoms, response to medication and treatment regimen present.			
5. Nursing/or staff most recent unit notes from the last 24 hours reflecting current level of functioning.			
6. If medically necessary, consultat providers is documented (nuero, n			

7. Treatment plan/goals established including, updated progress on goals.			
8. Crisis and Behavioral Management Plan has been identified.			
9. Evidence of baseline documented including, social hx, medication hx, outpatient & inpatient treatment hx, court/legal status, Parent/Guardian/Family/social involvement, APS/CPS, risks in the community & other social determinant factors).			
10. Evidence that outpatient provider has been contacted (therapist, case manager, ACT provider etc). If member is unassigned/or a new enrollee, provider has documented this in CSR.			
11. Estimated length of stay identified.			
12. Most recent diagnosis relevant to current admission (co-occurring & comorbidities). A) Mental Health. B) Substance Abuse. C) Medical Conditions			
13. Medication name, dosage, frequency in current treatment setting since admission.			
14. Whether or not individual is tal medications in the community or i N/A			
15. Justification for continued stay including, barriers to extended length of stay addressed in review (COVID, Placement, Court etc.).			
REFERENCE TO DISCHARGE PLANNING:	**MET**	**NOT MET**	**COMMENTS**
16. If clinically appropriate, docum request is present. N/A			
17. If medically necessary, docume MPRO submission/or case consulta			

18. Discharge plan is in progress and meets the individuals needs identified by treatment team and individual.			
19. If appropriate, residential place addressed and referral has been m Department. N/A			
20. Severity of illness & Intensity of services Criteria Identified for justification of need for continued stay.			
21. MCG indicia episode created by screening entity and optimal recovery course completed by UM specialist.			
CONTINUED STAY REQUEST DISPOSITION			
ELEMENT	**MET**	**NOT MET**	**COMMENTS**
22. Number of days authorized, name of facility and person notified of disposition, including date, time and next review date is present.			
23. (NCQA UM Standard 5, Timeliness) For urgent concurrent requests for authorization, a disposition was rendered within 72 hours of request			
24. (NCQA UM Standard 5, Timeliness) For urgent concurrent requests for authorization, the provider was given electronic or written notification of the decision within 72 hours of request.			
DISCHARGE SUMMARY			
ELEMENT	**MET**	**NOT MET**	**COMMENTS**
1. Date of admission			
2. Date of discharge.			
3. Reason for admission.			

4. Mental status at discharge			
5. COVID status at discharge.			
6. Discharge location (type of setting, address, phone number, emergency contact & discharge transportation).			
7. After care appointment is within 7 days of discharge (Facility name, address, phone number, appointment type, appointment date & time). N/A:			
8. If appointment is outside of 7 business days of discharge date, please provide justification. N/A:			
9. If discharged to medical unit, reason for transfer and transfer facility has been provided. N/A:			
10. Community resources and referrals offered including, crisis services, shelter resources, substance use services, suicide hotline etc. N/A:			
11. Discharge medication names, dosage, frequency, and if prescriptions were given documented.			
12. Discharge plan is patient centered including: Person's wishes, treatment goals and preferences, current baseline incl. ability to manage behavioral health crises in the community, involvement of support systems incl. outpatient provider, guardian and family, ability to access ongoing treatment, prior utilization of services including medication compliance, social determinants ie. homelessness, and co-occurring disorders.			
SCORE	**0**	**0**	0.00%

Attachment #4

DWIHN ELIBILITY OF SERVICE REVIEW TOOL			
Enrollee/Member Name:			
Date of Birth:			
Medicaid ID No.:			
Date of Screening for Eligibility			
Name of Access Center Clinician			
	Documentation Found	Documentation Not Found	Not Applicable
1. Insurance Information			
2. Wayne County Residency			
3. Start time of screening			
4. Name, address and phone number of caller			
5. Documentation of call being an Emergency or Crisis			
6. Reason for call/presenting problem identified			
7. Type of Services Request			
8. Contact Information			
9. Guardianship			
10. Past Treatment History			
11. History of Abuse (Sexual/Physical/Emotional)			
12. Current living situation			
13. Financial Information including Income			
14. Education Information			
15. Current Health/Medical Problems			
16. Referral to ER for Treatment/Clearance			
17. Time ER Contacted and Consumer Referred			
18. Medications (name, dose, prescribing 19. physician)			
20. Primary care physician information			
21. Mental Health Symptoms Identified			
22. Substance Use Issues			
23. Risk (Suicidal/Homicidal) assessment			
24. Autism Screening Tool Completed			
25. IDD Screening Tool Completed			
26. Provisional Disability Designation			
27. Diagnoses			
28. Medical and/or Advance Directives			
29. Diagnoses			
30. Medical and/or Psychiatric Advance Directives			
31. Eligibility Criteria Met			
32. Eligibility Criteria Not Met			
33. If Eligibility Criteria not met, member was given community resource referrals.			
34. If Eligibility Criteria Not Met, Access Center			

ATTACHMENT #5

DWIHN Quality Department's Case Record Review Tool

The Record Review tool is constructed to examine key supports, services, treatment and care. These areas should match the level of care established, should reflect natural and community supports and should clearly indicate progress or barriers to achieving the consumer's goals. Using the tool provides a standardized mechanism for specialists to determine if the consumer is getting the right service, the right amount of service, at the right time. Quality Management has implemented the tool which reviews the following areas as applicable to each consumer: General Record Documentation Assessment Substance Abuse Access and Treatment Person Center Planning Process Plan of Service Documentation Requirements Self-Determination Behavior Treatment Plan Review Coordination of Care Medication/Psychiatric Crisis residential Peer Delivered and Operated Drop In Centers Home Based Assertive Community Treatment Psychosocial Rehabilitation/Clubhouse Crisis Residential Targeted Case Management Personal Care in Residential Settings Inpatient Psychiatric Hospital Admission Intensive Crisis Stabilization Additional Mental Health Services HAB Supports Waiver An aggregate review score is calculated for reach case record review. Service Providers are expected to conduct a statistically sound sample of case records quarterly to monitor the direct provision of services using the tool. This process shall be monitored by DWMH who, in turn, review a statistically sound sample of Service Providers' case records. A plan of correction shall be implemented for all staff scoring below 95%. DWIHN then analyzes the findings for trends and outliers which may also result in a plan of correction.

General Documentation

1. The Ability to Pay/Fee Agreement (including insurance information) is current, signed and dated.

Not Met/Partial/Met N/A

2. The annual consent for treatment is current, signed and dated.

Not Met/Partial/Met N/A

3. The State standardized "Consent to Share Behavioral Health Information for Care Coordination Purposes" form is complete with the individual/legal representative's dated signature(s).

Not Met/Partial/Met N/A

4. The individual's/legal representative's signature indicates that the DWIHN Member Handbook was offered annually.

Not Met/Partial/Met N/A

5. If the individual has a legal guardian, there is current court papers in the file.

Not Met/Partial/Met N/A

6. Advanced Directive were explained and offered to the individual and/or legal representative. (Adults only)

Not Met/Partial/Met N/A

7. Self Determination was explained and offered to the individual and/or legal representative. (Adults only)

Not Met/Partial/Met N/A

8. Peer support services was explained and offered to the individual and/or legal representative.

Not Met/Partial/Met N/A

9. The individual and family and/or legal representative were informed of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) process for recipients under 21.

Not Met/Partial/Met N/A

10. There is evidence that recipient's rights have been explained at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

11. The individual and/or family/legal representative is informed of Person Centered Planning at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

12. The individual and/or family /legal representative is informed of Confidentiality at the time of the initial intake and annually thereafter.

Not Met/Partial/Met N/A

Assessments

1. The Integrated Biopsychosocial Assessment/Re-assessment is completed or updated prior to the IPOS or when there are changes in the level of care and is located in MH-WIN.

Not Met/Partial/Met N/A

2. There is evidence that the appropriate Level of Care assessment is completed. Adults-Level of Care Utilization System (LOCUS), Supports Intensity Scale (SIS), or American Society of Addiction Medicine (ASAM), Children/Adolescents (excluding I/DD)-Child, Adolescent Functional Assessment Scale (CAFAS), Preschool and Early childhood Functional Assessment Scale (PECFAS), or Devereux Early Childhood Assessment (DECA-I, DECA-T, DECA-C).

Not Met/Partial/Met N/A

3. Adults with a serious mental illness (SMI) and/or substance use disorder (SUD) had a Patient Health Questionnaire (PHQ-9) completed at intake.

Not Met/Partial/Met N/A

4. Adults with a positive PHQ-9 screen, defined as a score of 10 or greater, have a follow up screen within three (3) months.

Not Met/Partial/Met N/A

5. Natural supports are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

6. Health and safety needs, risk/at-risk behaviors are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

7. Risk/at-risk behaviors are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

8. Substance use, risk and patterns are assessed and documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

9. The Diagnostic Formulation/Summary which supports the diagnosis given and is documented in the Integrated Biopsychosocial Assessment.

Not Met/Partial/Met N/A

Implementation of Person-Centered Planning

1. Pre-planning meetings occur before a person-centered planning meeting, according to the individual's desires and needs.

Not Met/Partial/Met N/A

2. Independent facilitation is explained and offered to the individual and family/legal representative.

Not Met/Partial/Met N/A

3. Person-centered planning addresses and incorporates basic needs such as food, shelter, clothing and health care.

Not Met/Partial/Met N/A

4. Person-centered planning addresses and incorporates natural supports.

Not Met/Partial/Met N/A

5. Person-centered planning addresses and incorporates health and safety, including measures to minimize them, if applicable.

Not Met/Partial/Met N/A

6. Family-driven and youth-guided supports and services are provided for minor children.

Not Met/Partial/Met N/A

7. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life.

Not Met/Partial/Met N/A

8. The person-centered planning process is used to modify the individual plan of service in response to changes in the individual's preferences or needs.

Not Met/Partial/Met N/A

9. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.

Not Met/Partial/Met N/A

10. Individuals are provided an opportunity to develop a Crisis Plan.

Not Met/Partial/Met N/A

11. If a Crisis Plan was requested, it is located in MH-WIN.

Not Met/Partial/Met N/A

Plan of Service and Documentation Requirements

1. The individual plan of service addresses all needs, preferences, dreams and desires reflected in the planning process or provides an explanation for deferment.

Not Met/Partial/Met N/A

2. The individual plan of service contains measurable goals and objectives that are easily understandable by the individual and/or family with minimal clinical jargon

Not Met/Partial/Met N/A

3. Specific services, supports and treatment identified in the plan of service include the amount, scope and duration of services.

Not Met/Partial/Met N/A

4. The individual plan of service identifies the roles and responsibilities of the individual, the Supports Coordinator or Case Manager, the allies, and providers in implementing the plan.

Not Met/Partial/Met N/A

5. The plan of service includes an explanation of benefits and estimated/prospective cost of services.

Not Met/Partial/Met N/A

6. The plan of service identifies available Conflict Resolution processes.

Not Met/Partial/Met N/A

7. The individual plan of service is current and signed by the individual and/or legal representative, the Case Manager or Support Coordinator and the Support Broker/Agent (if one is involved).

Not Met/Partial/Met N/A

8. Individuals are provided a copy of their individual plan of service within fifteen business days after the planning meeting.

Not Met/Partial/Met N/A

9. There is evidence in the record that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency as specified in the service plan.

Not Met/Partial/Met N/A

10. The individual plan of service is reviewed/updated at intervals as specified in the IPOS but no less than annually.

Not Met/Partial/Met N/A

11. Individuals are provided timely ADEQUATE Notice of Action.

Not Met/Partial/Met N/A

12. Individuals are provided timely ADVANCE Notice of Action.

Not Met/Partial/Met N/A

Coordination of Care

1. There is evidence of the Behavioral Health Provider coordinating treatment with the Primary Care Physician.

Not Met/Partial/Met N/A

2. There is evidence that the Behavioral Health Provider received information from the Primary Care Physician. Enter "Y" for "yes", or "N" for "no" in the text field.

Test field N/A

3. There is evidence of the Behavioral Health Provider coordinating treatment with the Substance Use Disorder (SUD) Provider.

Not Met/Partial/Met N/A

4. There is evidence that the Behavioral Health Provider received information from the SUD Provider.

Test field N/A

5. There is evidence of the Behavioral Health Provider coordinating services with natural and other community supports.

Met/Partial/Met N/A

6. There is evidence that the Behavioral Health Provider received information and/or communication from the consumer's natural/community supports. Enter "Y" for "yes" or "N" for "no".

Text field N/A

7. If the individual has not visited a Primary Care Physician for more than 12 months, there is evidence of a basic health care screening, including height, weight, BMI and blood pressure.

Met/Partial/Met N/A

8. For consumers prescribed an atypical antipsychotic medication, there is evidence that the psychiatrist or primary care physician ordered a diabetic screening that includes an HbA1C or fasting blood sugar (FBS), with results documented in the case record. Enter "Y" for "yes" or "N" for "no".

Text Feld N/A

Targeted Case Management/Supports Coordination

1. Case Management/Supports Coordination documentation includes the nature of the service, the date and location, who was present, and whether the contacts were face-to-face.

Not Met/Partial/Met N/A

2. Case Manager/Supports Coordinator documentation of face-to-face contacts identifies the goal(s) being addressed.

Not Met/Partial/Met N/A

3. The Case Manager/Supports Coordinator "regularly" reviews the individual's health status, noting any issues, visits to the emergency room and hospitalizations.

Not Met/Partial/Met N/A

Medication/Psychiatric

1. All medications, (such as OTC and those prescribed by external physicians), are documented and updated as necessary.

Not Met/Partial/Met N/A

2. Medication Consents for all program-prescribed medications are current, include dosage (if outside therapeutic range), documentation of the right to withdraw consent verbally, are signed by consumer/guardian and prescribing physician.

Not Met/Partial/Met N/A

3. Evidence of drug-specific patient education is provided to individuals prior to administering each new drug, if prescribed by a Program Physician.

Not Met/Partial/Met N/A

4. The Physician/Medical Professional's handwriting is legible.

Not Met/Partial/Met N/A

5. Laboratory results ordered by Program Physician are reviewed, signed off by a Physician.

Not Met/Partial/Met N/A

6. Quarterly Tardive Dyskinesia testing dates and results are documented by Program Physician.

Not Met/Partial/Met N/A

7. A copy of the prescription, medical orders, or evidence of an eScript, is present in the record (if prescribed by Program Physician).

Not Met/Partial/Met N/A

Behavioral Treatment Plan-This applies to restrictive/intrusive plans only, not positive support behavior plans.

1. A Functional Behavioral Assessment was completed prior to the development of the Behavior Treatment plan.

Not Met/Partial/Met N/A

2. The record contains evidence that physical, medical and environmental causes of the challenging behavioral have been ruled out.

Not Met/Partial/Met N/A

3. There is evidence of positive behavior supports or interventions that have been tried and have proved to be unsuccessful.

Not Met/Partial/Met N/A

4. There is evidence of a current "special consent" before the behavior treatment plan is implemented.

Not Met/Partial/Met N/A

5. There is evidence the plan was approved by the Behavior Treatment Plan review Committee before implementation.

Not Met/Partial/Met N/A

6. There is evidence in the clinical record to verify that all staff have been duty trained on each behavioral intervention identified in the plan.

Not Met/Partial/Met N/A

7. There is evidence that the Behavioral Treatment Plan has been followed and outcomes are documented.

Not Met/Partial/Met N/A

8. There is evidence of Behavior Treatment Plan Reviews being completed as identified by the committee, but not less than quarterly.

Not Met/Partial/Met N/A

Additional Mental Health Services (b)(3)'s

1. Assistive Technology & Environmental Modifications: The need for assistive technology/environmental modifications is identified in one or more goals in the individual plan of service. There is evidence of prior authorization in accordance with the provider's process, including the physician's prescription for modification or assistive technology purchased within the year.

Not Met/Partial/Met N/A

2. Supported Integrated Employment: The need for supported integrated employment is identified in one or more goals in the individual plan of service and assists the individual with obtaining and maintaining paid employment that would otherwise be unachievable without such supports.

Not Met/Partial/Met N/A

3. Enhanced Pharmacy: There is documentation of physician ordered, non-prescription "medicine chest" items Not Met/Partial/Met N/A

Not Met/Partial/Met N/A

4. Housing Assistance: The need for housing assistance is identified in one or more goals in the individual plan of service. There is documentation of the beneficiary's control (i.e. beneficiary-signed lease, rental agreement, deed) of his/her living arrangement in the individual plan of service, and documentation of assistance with short-term interim, or one-time-only expenses for individuals transitioning from restrictive settings into more independent, integrated living arrangements while in the process of securing other benefits (i.e. SSI).

Not Met/Partial/Met N/A

MI Health Link Required Documentation

1. The signed "Consent to Share Your Health Information" form has been uploaded as a PDF and submitted to the ICO via MHWIN.

Not Met/Partial/Met N/A

2. The current Integrated Biopsychosocial Assessment has been submitted to the ICO via MHWIN within 14 days of the initial referral, or annually. For non-PCE users, the assessment has been uploaded as a PDF in MHWIN and submitted to the ICO.

Not Met/Partial/Met N/A

3. The appropriate assessment (LOCUS, SID or ASAM) has been submitted to the ICO via MHWIN within 14 days of receipt of the referral or as required. For non-PCE users, the assessment has been uploaded as a PDF in MHWIN and submitted to the ICO.

Not Met/Partial/Met N/A

4. If the 14 day requirement for the assessment was not met, there is documentation in the case record regarding the barrier(s) to timely completion and submission.

Not Met/Partial/Met N/A

5. There is evidence of communication and collaboration with the Integrated Care Team (ICT), including contact with the Health Plan Care Coordinator, when there are status changes, such as discharge from inpatient hospitalization, change in treatment services and/or change in medications.

Not Met/Partial/Met N/A

Personal Care in Licensed Residential Settings

1. Personal care services, including amount, scope and duration are identified in the individual's IPOS.

Not Met/Partial/Met N/A

2. The authorization for Personal care services are current and align with the amount, scope and duration identified in the IPOS.

Not Met/Partial/Met N/A

Self- Determination

1. The individual participating in arrangements that support self-determination has a Self-Determination Agreement that complies with the requirements.

Not Met/Partial/Met N/A

2. The individual budget and the arrangements that support self-determination are included as part of the person-centered planning process

Not Met/Partial/Met N/A

3. Individuals participating in self-determination shall have assistance to select, employ, and direct his/her support personnel and to select and retain the chosen qualified provider entities.

Not Met/Partial/Met N/A

4. Fiscal Intermediary Services (FI): The need for FI services is identified in one or more goals in the individual plan of service and assists the individual with managing and distributing funds contained in the individual budget and choosing staff who will provide the services and supports identified in th4e IPOS.

Not Met/Partial/Met N/A

Habilitation Supports Waiver

1. Eligibility: The Habilitation Supports Waiver Eligibility Certification is current and signed by the Clinically Responsible Service Provider, and MDHHS if new enrollment, OR, the PIHP if recertification. Not Met/Partial/Met N/A

2. There is evidence that the annual Waiver Services Consent under the Habilitation Supports Waiver Eligibility Certification Section 3 is current. Note: Consents are valid up to 36 months.

Not Met/Partial/Met N/A

3. There is evidence that the individual and/or guardian were informed of their right to choose among various waiver providers and waiver services. Evidence may be found in the Pre-Plan and/or IPOS.

Not Met/Partial/Met N/A

4. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS.

Not met/Partial/Met N/A

5. There is evidence of an annual physical exam.

Not Met/Partial/Met N/A

6. If the enrollee receives Environmental Modifications or Equipment, there is documentation that the selected modifications or equipment is the most cost-effective and fully functional option that meets the individual's needs.

Not Met/Partial/Met N/A

7. If the enrollee receives Environmental Modifications or Equipment, there is evidence of a physician's prescription for modifications or equipment purchased within the year.

Not Met/Partial/Met N/A

8. Physician prescriptions for PDN, OT and PT services, include the following: date of prescription, individual's diagnosis, the specific service or item being provided, expected start date of the order, and the amount and length of time that the service is needed.

Not Met/Partial/Met N/A

9. There is evidence that the member received at least one active habilitative treatment service per month as identified in the Individual Plan of Service (i.e. Community Living Supports, Out-of-Home Non-vocational Habilitation and Prevocational or Supported Employment).

Not Met/Partial/Met N/A

10. For individuals receiving Private Duty Nursing (PDN), there is evidence of the individual receiving at least one of the following habilitative services: Community Living Supports, Out-of-Home Non-vocational Habilitation and Prevocational or Supported Employment).

Not Met/Partial/Met N/A

Assertive Community Treatment (ACT)

1. Eligibility: There is evidence the individual has a primary diagnosis of a serious mental illness and, at the time of admission, demonstrated acute or severe psychiatric symptoms impairing the individual's ability to function independently, and whose symptoms impeded the return of normal function as a result of the diagnosis of a serious mental illness.

Not Met/Partial/Met N/A

2. There is evidence of a pre-admission screen completed by an ACT Team member.

Not Met/Partial/Met N/A

3. The IPOS addresses all services and supports to be provided to or obtained for the individual, including consultation with other disciplines and/or coordination of other supportive services as appropriate.

Not Met/Partial/Met N/A

4. The IPOS addresses both behavioral health and substance use disorders for individuals with co-occurring substance use disorders.

Not Met/Partial/Met N/A

5. The IPOS includes a discharge plan developed at the time of intake that includes a plan for transitioning from ACT to a less intensive service, and a plan for returning to Act should the need occur.

Not Met/Partial/Met N/A

6. There is evidence that a minimum of 80% of Act service contacts provided by the ACT team (as a whole) are in the individual's home or other agreed upon community location.

Not Met/Partial/Met N/A

7. There is evidence that services delivered and documented by the ACT team, promotes the individual's growth in recovery and progression into less intensive services.

Not Met/Partial/Met N/A

8. The individual's participation in the ACT program is documented in the ACT Team Meeting Minutes.

Not Met/Partial/Met N/A

9. If telemedicine is utilized, psychiatric services are the only ACT service provided in this manner.

Not Met/Partial/Met N/A

Intensive Crisis Stabilization Services

1. Eligibility: There is evidence in the clinical record that 1) the person has a diagnosis of mental illness or mental illness with co-occurring substance use disorder, or developmental disability, and 2) the person has been assessed to meet criteria for psychiatric hospital admission but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.
Not Met/Partial/Met N/A

2. There is evidence that Intensive Crisis Stabilization services include intensive individual counseling/psychotherapy, assessments (rendered by the treatment team), family therapy, psychiatric supervision and therapeutic support services by trained paraprofessionals.

Not Met/Partial/Met N/A

3. The record reflects that the initial IPOS was completed within 48 hours.

Not Met/Partial/Met N/A

4. There is evidence that the IPOS clearly identifies follow-up services and outlines on-going sources of assistance (i.e. case management) and referrals to other providers as needed. The role of the case manager must be identified where applicable.

Not Met/Partial/Met N/A

5. For children's intensive crisis stabilization services, there is evidence that the plan addresses the child's needs in context with the family's needs; considers the child's educational needs; and is developed in context with the child's school district staff.

Not Met/Partial/Met N/A

Crisis Residential Services

1. Eligibility: There is evidence the individual meets psychiatric inpatient admission criteria, but has symptoms and risk levels that permit them to be treated in alternative settings.

Not Met/Partial/Met N/A

2. The record reflects that the initial IPOS was completed within 48 hours of admission and has been signed by the beneficiary (if possible), the parent or guardian, the psychiatrist and any other professionals involved in treatment planning.

Not Met/Partial/Met N/A

3. The IPOS clearly identifies the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

Not Met/Partial/Met N/A

4. For children's intensive crisis residential services, there is evidence that the plan addresses the child's needs in context with the family's needs; considers the child's educational needs; and is developed in context with the child's school district staff.

Not Met/Partial/Met N/A

5. There is evidence the individual is receiving ALL of the following services: psychiatric supervision; therapeutic support services; medication management/stabilization and education; behavioral service and nursing services.

Not Met/Partial/Met N/A

6. The case manager is involved as soon as possible in treatment, as evidenced by the crisis residential notes as well as case management contact notes.

Not Met/Partial/Met N/A

7. If the length of stay in the crisis residential program exceeded 14 days, the interdisciplinary team developed a subsequent plan based on comprehensive assessments.

Not Met/Partial/Met N/A

Home-Based

1. Services provided by home-based service assistants/paraprofessionals must be clearly identified in the IPOS.

Not Met/Partial/Met N/A

2. There is evidence of an individualized and family-specific crisis plan.

Not Met/Partial/Met N/A

3. The record reflects a minimum of 4 hours of individual and/or family face-to-face home-based services per month are provided by the primary home-based services worker (or, if appropriate, the evidenced-based practice therapist).

Not Met/Partial/Met N/A

4. Home-based services are provided in the family's home or community.

Not Met/Partial/Met N/A

Wraparound Fidelity Standards

1. There is evidence that a Strength and Culture Discovery was completed for each member of the family, and for the family as a whole.

Not Met/Partial/Met N/A

2. There is evidence that results of the Strength and Culture Narrative has been incorporated in the Wraparound Plan of Care (POC).

Not Met/Partial/Met N/A

3. There is evidence that the child/youth and family chose who participates on the Wraparound Child and Family Team.

Not Met/Partial/Met N/A

4. There is evidence that the Wraparound Child and Family Team meetings were held at least weekly until the plan had been developed and implemented and then subsequently the meetings occurred no less than twice monthly while consumer was enrolled in the Wraparound/SEDW Program unless otherwise documented in a transition plan.

Not Met/Partial/Met N/A

5. There is evidence that a mission statement is developed/articulated for the Wraparound Child and Family Team.

Not Met/Partial/Met N/A

6. There is evidence that a Needs Assessment across all life domain areas is completed and prioritized by the family.

Not Met/Partial/Met N/A

7. There is evidence that the Wraparound Child and Family Team developed an action plan that identified alternative strategies (various ways) to meet identified needs.

Not Met/Partial/Met N/A

8. There is evidence that the Wraparound Plan of Care contains strategies or interventions that pertain to natural supports and/or other community resources, in addition to Medicaid services.

Not Met/Partial/Met N/A

9. There is evidence that the Pre-Plan Questionnaire, Plan of Care and Outcomes are written in the language of the family and are the result of families identifying their vision of how their lives will be different when the Wraparound Process is complete.

Not Met/Partial/Met N/A

10. There is evidence that the outcomes are measurable and method of measurement has been identified for each outcome.

Not Met/Partial/Met N/A

11. There is evidence that the Community Team reviews the Wraparound Plan/Plan of Care and budget on a regular basis. This means at least initially, every six (6) months and when developing the Continuing Care Plan.

Not Met/Partial/Met N/A

12. There is evidence that the Plan of Care and budget were updated to reflect new interventions and services.

Not Met/Partial/Met N/A

13. There is evidence that Flexible funds are used as a last resort and after community outreach efforts to meet some needs of the children and family.

Not Met/Partial/Met N/A

14. There is evidence that the Wraparound Child and Family Team identified and addressed crisis/safety risks in the Support Plan.

Not Met/Partial/Met N/A

15. There is evidence that an Initial Support Plan was completed and signed at the initial meeting with the family.

Not Met/Partial/Met N/A

16. There is evidence that the Support Plan identified both proactive and reactive steps/interventions and includes interventions that are culturally relevant and strength-based.

Not Met/Partial/Met N/A

17. There is evidence that all Wraparound Child and Family Team members have a defined role in implementing the Support Plan.

Not Met/Partial/Met N/A

18. There is evidence that a Continuing Care Plan was developed and approved by the Community Team.

Not Met/Partial/Met N/A

19. Services and supports are provided as specified in the plan including; type, amount, scope, duration and frequency.

Not Met/Partial/Met N/A

20. Level of Care evaluations are completed accurately.

Not Met/Partial/Met N/A

21. There is documentation that the Pre-Plan Questionnaire was completed.

Not Met/Partial/Met N/A

22. There is evidence that the Plan of Care (POC) was completed, signed, dated and a copy given to the family within 45 days of the Preliminary Plan.

Not Met/Partial/Met N/A

1. **There is evidence that the medial care needs are coordinated and monitored to ensure health and safety.**

Not Met/Partial/Met N/A

2. **Prescriptions for Sensory integration and other OT services ordered by a physician meet all the required elements in the Medicaid Provider Manual.**

Not Met/Partial/Met N/A

3. **There is evidence that a Transition Plan was developed. The transition plan outlined how the family will continue to get their needs met after the child/youth ends Wraparound/SEDW. The transitional plan was approved by the Community Team.**

Not Met/Partial/Met N/A

Serious Emotional Disturbance Waiver (SEDW)

1. The Initial Serious Emotional Disturbance (SEDD) Waiver Eligibility Certification is maintained in the child's case record. The Current Waiver Certification is signed and dated by the CRIPS, DWIHN and MDHHS. Services provided by home-based service assistants/paraprofessionals must be clearly identified in the IPOS.

Not Met/Partial/Met N/A

2. There is evidence that the SED Annual Re-certification is completed, signed and submitted to MDHHS within 365 days of the previous certification.

Not Met/Partial/Met N/A

3. Parent is informed of available options and chooses waiver services instead of psychiatric hospitalization; are aware of choices between and among qualified service providers.

Not Met/Partial/Met N/A

4. There is evidence that the consumer has received at least one SEDW service per month.

Not Met/Partial/Met N/

Autism Spectrum Disorder Program Requirements

1. There is evidence the individual, parent or guardian was informed of their right to choose among various Autism Spectrum Disorder Providers.

Not Met/Partial/Met N/A

2. The comprehensive diagnostic evaluation and psychological assessment were uploaded within 14 calendar days of the completed assessment.

Not Met/Partial/Met N/A

3. There is evidence that the ABA Assessment (ABLS, VB-MAPP, AFLS) was uploaded to MHWIN within 7 calendar days of the completed assessment.

Not Met/Partial/Met N/A

4. There is evidence that as part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable and realistic goals.

Not Met/Partial/Met N/A

5. There is evidence that risk factors have been identified for the child/family, a description of how the risks may be minimized and the backup plan for each identified risk.

Not Met/Partial/Met N/A

6. There is evidence the Beneficiary's ongoing determination level of service (which occurs every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the ABLLS-R or VB-MAPP.

Not Met/Partial/Met N/A

7. There is evidence the Individual Plan of Service has been updated within 365 days of the last plan of service.

Not Met/Partial/Met N/A

8. The average hours of ABA services during a quarter were within the suggested range for the intensity of services (+/-25%).

Not Met/Partial/Met N/A

9. The number of ABA hours of direction/observation during a quarter were equal to or greater than 10% of the total ABA direct service provided.

Not Met/Partial/Met N/A

10. There is evidence that the IPOS service reviews are completed on a quarterly basis (every 90 days).

Not Met/Partial/Met N/A

11. There is evidence that when three consecutive appointments were missed by the family (vacation, illness, etc.), inactivity was entered in the WSA.

Not Met/Partial/Met N/A

12. There is evidence of monthly contacts by the ABA provider and supports coordinator, regarding the consumer's progress, attendance (5), barriers to treatment, etc.

Not Met/Partial/Met N/A

13. There is evidence that the ABA provider made multiple attempts (weekly) to keep families engaged, when the family's attendance is sporadic.

Not Met/Partial/Met N/A

14. There is evidence the ABA provider's discharge policy was implemented when the consumer is inactive for 90 days.

Not Met/Partial/Met N/

ATTACHMENT #6

Template
(Name of Crisis Service Vendors)
Utilization Management
Annual Plan Evaluation

(FY Effective Date to FY End Date)

Name, Title of Person Submitting Report:

ANNUAL UTILIZATION MANAGEMENT (UM) PLAN EVALUATION

The Crisis Service Vendor's Utilization Management Plan shall be evaluated annually to determine its effectiveness in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, quality improvement and other management decisions.

Instructions: Please provide the requested qualitative and quantitative information as indicated in each section. Additionally, a description and narrative analysis of impact, trends or change from previous fiscal year is also required as appropriate. Portions of the information from the Crisis Service Vendor and the Access Center's Evaluation will be included in DWIHN'S Annual UM Program Evaluation.

INTRODUCTION:

Describe your Organization's Vision, Purpose, Scope

ORGANIZATION'S UTILIZATION MANAGEMENT COMMITTEE:

Describe your UM Committee's functions, consumer involvement, role of your Chief Medical Director, frequency of meetings, storage of meeting notes, goals for (*insert current FY*) and goal status, significant activities/achievements and outstanding issues that have not been addressed or completed.

ORGANIZATION'S UM STAFF MEMBERS ASSIGNED ACTIVITIES AND PROFESSIONAL QUALFIICATIONS:

Provide a list of all UM staff who conduct Pre-Admission Reviews (PAR) during the (insert current FY) using the following format:

- ✓ Provider Name
- ✓ Employee Last Name
- ✓ Employee First Name
- ✓ Date of Hire
- ✓ Degree
- ✓ Title
- ✓ License Type
- ✓ License Number
- ✓ License Expiration Date
- ✓ Comments (i.e., If person has a limited license, indicate name and credentials of supervisor such as LMSW)
- ✓ Date Employee signed the new hire/annual "Affirmative Statement"

ANALYSIS OF INTER RATER RELIABILITY *(INSERT CURRENT FY)*:

Include data and analysis of your staff's results of the MCG inter rater reliability module. Detail any documentation issues and plans of correction (if applicable).

ANALYSIS OF PRE ADMISSION SCEENING REVIEWS (*INSERT CURRENT FY)*:

Include data and analysis of your case reviews using the DWIHN Prior Authorized Service UM Chart Review tool. Detail any documentation issues and plans of correction (if applicable).

(INSERT CURRENT FY) TURNAROUND TIME FOR EMERGENCE AND URGENT AUTHORIZATION REQUESTS:

Provide the annualized data for the Crisis Service Vendor's performance for the following:

Indicator #1a for **children**
Table #1:
The percentages of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within **three hours**. **Standard=95%**

Indicator #1b for **adults**
Table #1
The percentages of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within **three hours. Standard=95%**Provide an analysis of the annualized 1st – 4th (insert current FY) quarter performance.

(INSERT CURRENT FY) DIVERSIONS:

Document the annualized number of diversions per quarter by population (SMI, IDD, MI Health Link and SUD). Document the diversions per quarter by the type of recommended diversion (level of care) for each population (SMI, IDD, MI Health Link and SUD). Detail any trends. Document the number of inpatient admissions due to the lack of crisis residential service beds. Document the number of individuals waiting more than 23 hours from the time of request to the time of placement by population.

CONTINUOUS PERFORMANCE IMPROVEMENT:

Describe any performance improvement projects, including the problem statement, performance improvement statement, target populations, data sources(s), measurement periods, initial measurement, performance improvement activities, re-measurement period findings and explanation of those findings, status of project at time of annual UM report, next steps, etc.

CONSUMER SATISFACTION SURVEY RESULTS:

Summarize type of any consumer experience studies done during *(insert FY*), targeted population(s), tool(s) used, survey methodology, survey time period(s), response rate, findings, any actions taken/to be taken as result of findings, recommendations, etc.

ANALYSIS OF THE PRE SCREENING REVIEW DENIALS FOR *(INSERT CURRENT FY)*

For **Medicaid covered services** include the number of denials and the number of action notices sent. Were the decisions made within the appropriate timeframes? Were the action notices sent within the appropriate timeframes? Discuss any trends.

For **General Fund covered services** include the number of denials and the number of action notices sent. Were the decisions made within the appropriate timeframes? Were the action notices sent within the appropriate timeframes? Discuss any trends.

REPORTING:

Which stakeholders have had an opportunity to review findings, provide comments on or provide input regarding each of these UM elements during the fiscal year?

Element	Consumers	Board of Directors	UM Committee	Providers	Crisis Service Vendor UM Staff
Utilization of different Levels of Care (Inpatient, PHP, ICR)					
Inter Rater Reliability					
PAR Case Reviews					
Performance Improvement Projects					
Customer Satisfaction Findings					
Who receives the UM (insert FY report?					

ADDITIONAL UTLIZATION MAGNEMENT INFORMATION OR DATA NOT COVERED IN THE ABOVE TOPICS:

ATTACHMENT #7

(Crisis Service Vendors)
Utilization Management Plan

(FY Effective Date to FY End Date)

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ATTACHMENT #8

Crisis Service Vendors UM Plan Audit Template

UM Element 1: The Organization's UM Program has clearly defined structures and processes and assigns responsibilities to appropriate individuals. *Intent: The organization has a well-structured UM Program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.*				
	MET	***PARTIALLY MET***	***NOT MET***	***COMMENTS***
Introduction				
Crisis Service Vendor Vision				
Crisis Service Vendor's Authority				
Crisis Service Vendor's Purpose				
Crisis Service Vendor's Scope				
Systems Transformation				
Crisis Service Vendor's Program Structure: **a. UM Staff Members' Assigned Activities including who has the authority to deny coverage** **b. UM Staff Members' Qualifications** **c. Process for evaluating, approving and revising the UM Program:** ➢ **Active involvement of a senior behavioral health practitioner**				
Crisis Service Vendor's UM Committee Structure: **a. UM Committee Purpose** ***b.* UM Committee Membership *(must include a senior behavioral health care practitioner)*** **c. Frequency of Meetings** **d. Minutes are maintained, approved and distributed** **e. UM Committee Reporting Structure to other organization committees and administration**				
Crisis Service Vendor's Program Goals *(must be aligned with DWIHN'S program goals)*				
Organization's Medical Necessity Criteria and Benefit:				

a. Development, Selection and Description of Medical Necessity Criteria: ➢ Evidence based practices ➢ Objective ➢ Includes individual needs and circumstances ➢ Assessment of local delivery system b. Frequency and Process for Criteria Review, Approval and Distribution: ➢ Involvement of appropriate practitioners ➢ Staff training ➢ Methods of Availability to stakeholders				
DWIHN'S Delegation and Oversight: a. Outline Delegated Functions by DWIHN b. DWIHN'S Monitoring: ➢ Inter Rater Reliability Reviews ➢ Case Record Reviews				
Crisis Service Vendor's Delegation of UM Functions *(if applicable)*: a. Identify Organizations b. Outline UM Delegated Functions c. Describe Methods and Frequency of Monitoring				
Crisis Service Vendor's UM Methods and Organizational Process for Making Medical Necessity and Benefit Coverage Determinations for In-Patient and Out-Patient Services: a. Confidentiality parameters b. Define Emergent and Urgent Services				
Access, Triage and Referral Process: a. Role of Access Center b. Role of Crisis Service Vendors c. Standardized Assessment Tools *(if applicable)*				
Emergency Care Resulting in Admissions (Crisis Service Vendor): a. Authorization process				
Pre-Service Review Process (Crisis Service Vendor): a. Identify Services Requiring Prior				

Authorizations for your organization b. Outline Clinical Information Collected to Determine *Initial* Medical Necessity Criteria and Level of Care c. Outline Clinical Information Collected to Determine *Concurrent (Continued)* Medical Necessity Criteria and Level of Care d. Physician to physician consultations e. Identify staff having the authority to deny coverage or services f. Turnaround Times for Decision ➢ Urgent pre-service ➢ Non urgent pre-service g. Turnaround Times for Notification ➢ Urgent pre-service ➢ Non urgent pre-service				
Post-Service Review Process (Crisis Service Vendor): a. Outline Clinical Information reviewed to Determine Medical Necessity Criteria and Level of Care b. Identify staff having the authority to deny coverage or services c. Turnaround Time for Decision d. Turnaround Time for Notification				
Discharge Planning (Crisis Service Vendor)				
UM/Provider Denials and Dispute Resolution: - Types: ➢ Administrative ➢ Benefit ➢ Medical Necessity ➢ Standard ➢ Expedited/Urgent				
b. Description of Process including decision timeframes and notification timeframes and methods to practitioner and member ➢ For Medicaid Covered Services ➢ For Medicare Covered Services ➢ For Uninsured or Under Insured Using General Funds				
Crisis Service Vendor's Continuous: Coverage and Service Requirements a. Toll Free Number b. TYY services c. Language assistance				

Crisis Service Vendor's UM Role in the Quality Improvement (QI) Program: **a. Outline of Core Measures** **b. Process for collection of UM data and reports** **c. Methods for using UM data and reports within QI functions**				
Satisfaction with UM Process **a. Customer/Member** **b. Provider/Practitioner**				
Crisis Service Vendor's Evaluation of UM Plan: **a. Frequency** **b. Responsible**				

Detroit Wayne Integrated Health Network

(DWIHN)

Utilization Management Department
Annual Evaluation FY 2021

Submitted by:
Jennifer A. Jennings – Director, Utilization Management

Presented to UMC on March 15, 2022
Presented to QISC on March 29, 2022
Presented to PCC
Presented to Full Board of Directors

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Overview

As a part of continuous quality improvement, the Utilization Management (UM) Program is evaluated annually and incorporated into the Quality Assurance Performance Improvement Plan (QAPIP). This report is submitted to the DWIHN Utilization Management Committee (UMC), to the Quality Improvement Steering Committee (QISC) and the DWIHN Board of Directors for approval. DWIHN's Board of Directors is committed to the provision of effective, consistent and equitable behavioral health services that produce functional outcomes, as articulated in the Strategic Plan. The Board is also responsible for ensuring overall quality of the behavioral healthcare services delivered to Wayne County residents, including oversight of UM functions.

The Chief Medical Officer (CMO) has substantial involvement in the development, implementation, supervision and evaluation of the UM program as evidenced by participation in the Utilization Management Committee (UMC) and Quality Improvement Steering Committee (QISC). On an annual basis, the Chief Medical Officer also reviews and approves all UM policies and procedures within the policy management system, as well as providing oversight of key UM documents.

The UM Department consists of 31 staff with responsibility for reviewing authorization requests and making medical necessity determinations for the following Benefit programs and Levels of Care: Inpatient psychiatric treatment, Outpatient services, HAB Waiver, ASD Benefit, General Fund, Partial Hospital, Crisis Residential, Substance Use Disorder services, Autism, MI Health Link population, and the processing of denials and appeals associated with service requests. Staff receive cross-training to fill in for periods of staff absence or high demand to ensure timely, continuous and consistent UM services. Of note was the coverage provided until the vacated UM Director, COFR Coordinator and SUD Technician positions were filled.

In accordance with the "Appropriate Professionals" UM policy, physicians and PhD clinical psychologists continue to be the only staff credentialled to deny medical necessity. This was achieved through a partnership with the Michigan Peer Review Organization MPRO) served as the independent review organization.

The UM Director continues to assess staffing needs based upon departmental operations and the volume of requests across the multiple programs and levels of care managed within UM.

Adequacy of Utilization Management Resources

The following chart is a summary of the positions currently in the UM department, and outside departmental staff with the percentage of their time allocated to UM activities:

Title	Department	Percent of Time allocated to UM
UM Director	UM	100
UM Administrator	UM	100
20 UM Clinical Specialist	UM	100
4 UM SUD Mental Health Technicians	UM	100
UM Administrative Support	UM	100
UM Grievance Coordinator	UM	100
Provider Network Program Administrator-Self Determination	UM	100
Utilization Manager	UM	100
UM Coordinator	UM	100
Chief Clinical Officer	Administration	.15
Clinical Officer	Clinical Practice Improvement	.15

Utilization Management Committee

During FY 21, the Utilization Management Committee (UMC) met monthly. The Chief Medical Officer is the chairperson, and the UM Director is the committee co-chair. Membership includes staff from the UM Department, Customer Service, Children's Initiatives, Managed Care Operations, Finance, Quality, Substance Use Disorder, Residential and Member Engagement. Other staff, departments or entities are invited as needed. The committee routinely addresses the following topics, and many are included in this evaluation for annual trending/reporting purposes:

- Appeals and Denials
- Waiver Reports
- Autism Reports
- General Fund Exception Reports
- Substance Use Disorder
- Authorizations (Preservice, Concurrent, Retrospective)
- Timeliness Reports
- Benefit Grid/Benefit Clarification
- Hospitalization Reports/MI Health Link Data
- Over and Under Utilization
- IT or Technology Assessments/Project Enhancements
- Milliman Care Guideline (MCG) issues
- Medical Necessity
- Inter-rater Reliability Testing Results

- Policy and Procedure Development and Review

The following MMBPI results and analysis are reviewed by the UMC annually:

- Follow-up within 7 and 30 days after a behavioral health hospitalization
- State measurement of readmission data

Review and analysis of the above reports, dashboards, and measures in relation to UM are addressed within the UMC with interventions to address opportunities for improvement.

Utilization Management leadership and staff also participate in multiple routine and ongoing collaborative committees and meetings with the provider network, consumers, heath plans, and departmental meetings which address and improve issues related to utilization management and are critical to the success of the UM department. Some of these are as follows: Provider Network meetings, Managed Care Operations meetings, Integrated Care Organization(ICO) meetings, Utilization Management Committee, COFR, Recidivism Work Group, Habilitation Waiver work group, Quality Improvement Steering Committee, Improving Practice Leadership Committee, Substance Use Disorder Bi-monthly Provider meeting, Michigan Consortium for Excellence quarterly meetings, Procedure Code Work Group meetings, Hospital Liaison meetings, COPE Crisis Huddle bi-weekly meetings, Children's Crisis Huddle bi-weekly meetings, Collaborative meetings, Behavioral Health Learning Collaborative and Assertive Community Team (ACT) monthly forums.

Additionally, the department collaborated with the Quality Department to develop the Discharge flow process including the creation of a discharge queue to support Michigan's Mission Based Performance Indicators 4a and 10. Members of the UM Team participated in interdepartmental focus groups to address the notification of CRSP providers when members present to the ERs and/or admissions and discharges, ensuring members are scheduled for timely discharge appointments, managing ACT referrals, increased use and implementation of Assisted Outpatient Treatment orders and utilization of Substance Use services for members with co-occurring disorders and frequent inpatient psychiatric admissions.

The FY 2021 annual Utilization Management Program Plan Evaluation report includes the following elements:

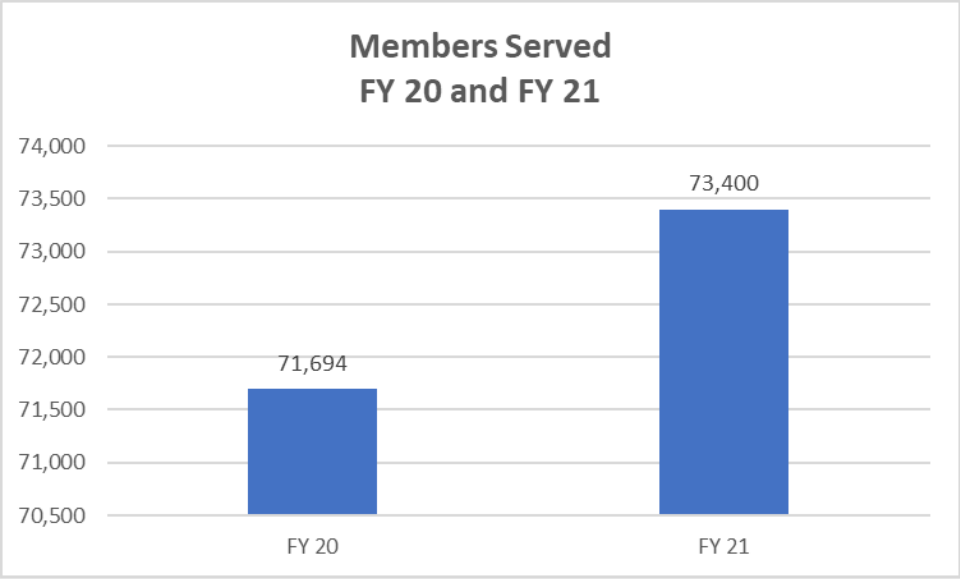
I. Populations Served

II. Status of Utilization Management Program and Strategic Plan Goals

III. Status of UM Department Technology/ Recommendations and Initiatives

I. Population Served

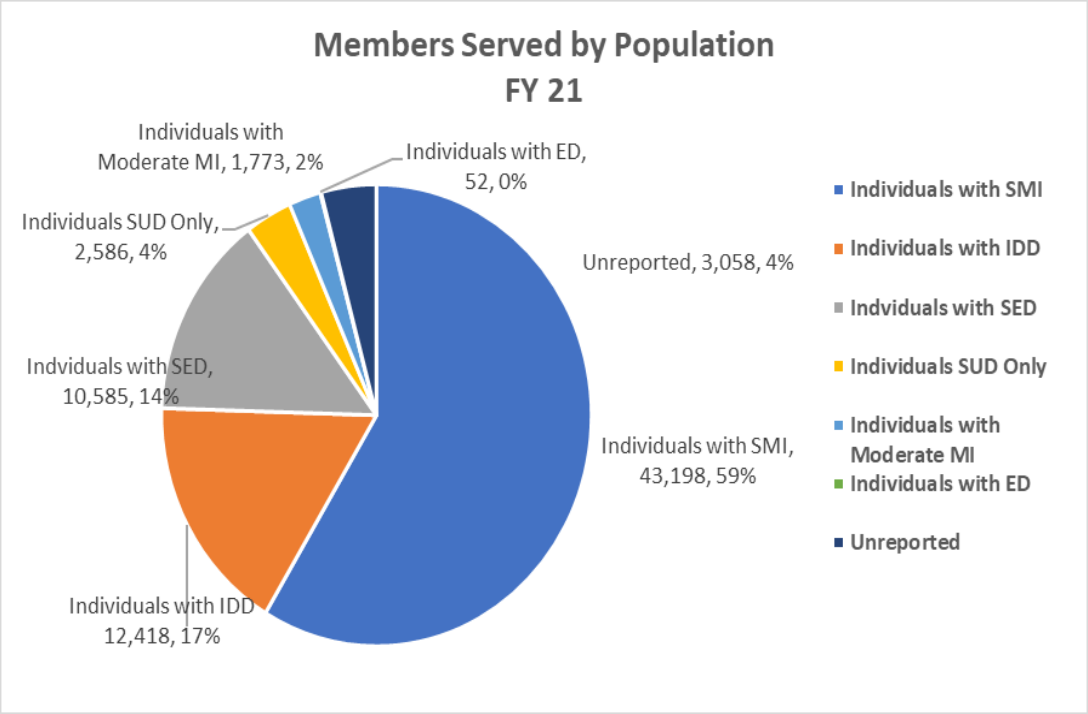
The chart below indicates the trend of unique members served based on the past two (2) Fiscal Years (FY). As can be seen from the chart, there was a 2% increase in the number of unique individuals served from FY 20 to FY 21.



Source: Agency Power BI Dashboard 1/24/2022

Disability Designation

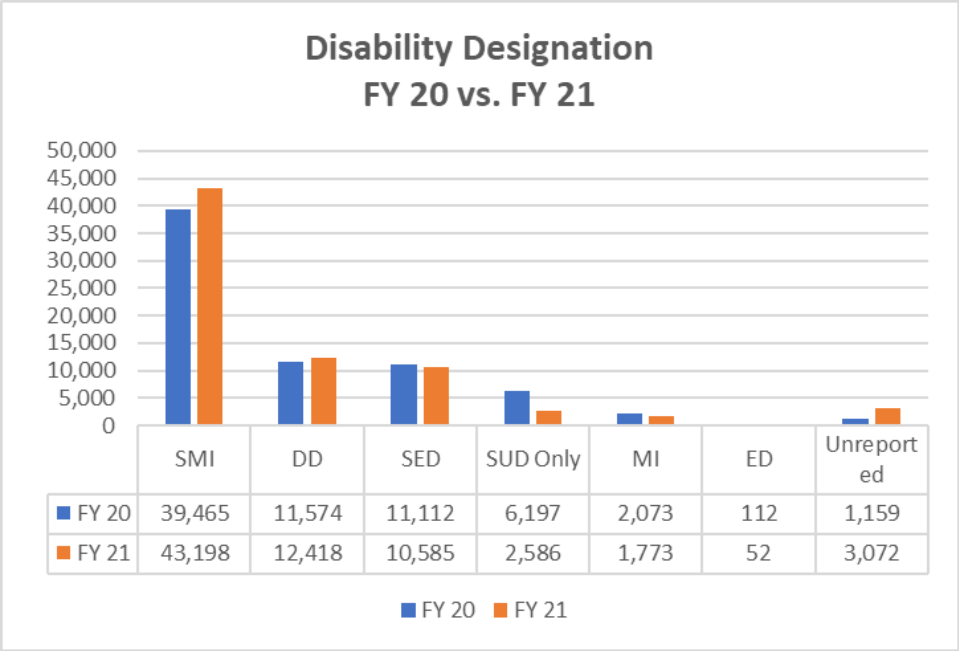
The pie chart below details members served by population and disability designation. DWIHN oversees and monitors services that are provided to Individuals with Serious Mental Illness (SMI), Children with Serious Emotional Disturbances (SED), Individuals with Substance Use Disorders (SUD), and Individuals with Intellectual and Developmental Disabilities (IDD). With the federal demonstration program, MI Health Link, DWIHN also serves individuals with Mild to Moderate Mental Illness (MI). Individuals with Substance Use Disorders may also be reflected in multiple categories due to co-occurring diagnoses. The unreported designation is either due to consumers being admitted to the system in unconventional pathways (not via the Access Center) or consumers that do not have an updated disability designation.



Source: Agency Power BI Dashboard 1/22/2022

Disability Designation 2-year Comparison

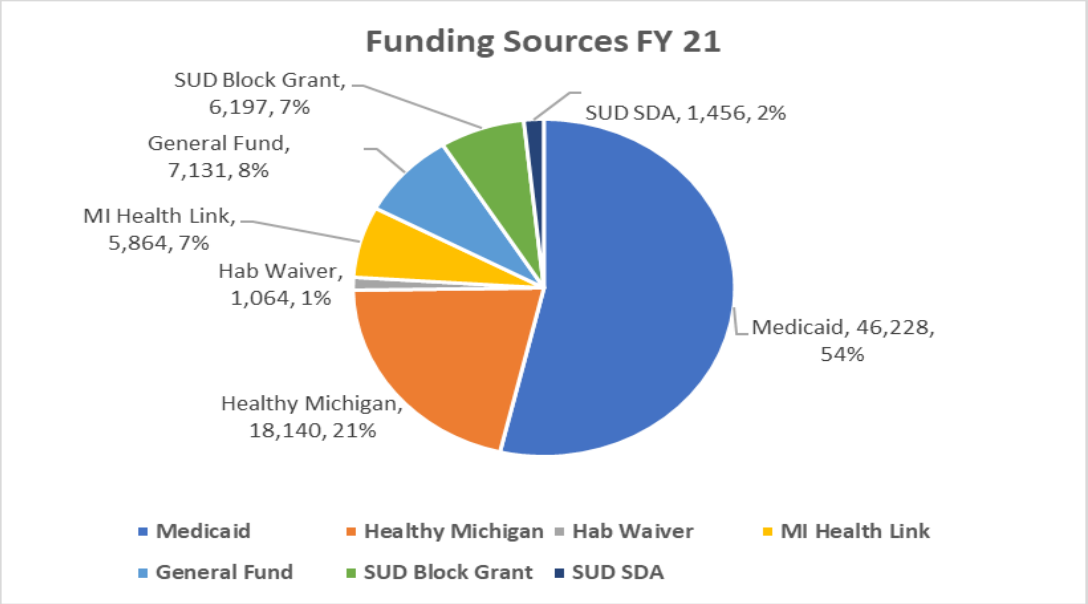
As previously noted, the number of members served this fiscal year increased by 2%. The graph below indicates the change in disability designations served over the last 2 fiscal years. Several categories showed an increase. Individuals with serious mental illness showed an increase of 9%. Individuals with developmental disabilities showed an increase of 5%. Unreported members also increased by 165% indicating a need for review and process improvement in the reporting and change process associated with disability designation. Children with serious emotional disturbance showed a decrease of 5%. Members designated as SUD only decreased by 58% in FY 21 from FY 20. There were revisions made to the Disability Designation document that inadvertently omitted the SUD only category. Unique members served for SUD and SUD admissions are referenced later in this report and are obtained from SUD admission records.



Source: Agency Power BI Dashboard 1/24/2022

Funding Sources

The chart below indicates funding sources utilized to pay for an individual's service in FY 21. When combining general Medicaid (54%), Healthy Michigan (21%), Habilitation Waiver (1%) which are all Medicaid, this accounts for 76% of the funding sources utilized. Utilizing last year's report, Medicaid funding sources were at 73%. Block Grant and State Disability Assistance (SDA) which is used to pay for SUD and Room and Board with Substance Use Disorders is reflected as funding sources totaling 9%, FY 20 was 11%. General Fund is reflected at 8%, FY 20, GF was 10%. MI Health Link is at 8% which is a 2% increase from FY 20. These are all consistent with the forecasting model.



Source: DWIHN Power BI dashboard, 1/24/22. Funding Source is the funding source that paid for the service. This is a potentially duplicated count as an individual's services can be paid for by multiple Funding Sources throughout the year.

II. Status of Utilization Management Program Description Goals and Strategic Plan Goals

The UM evaluation is based on six (6) pillars that are identified in DWIHN's Strategic Plan. These include the Customer Pillar, Access Pillar, Workforce Pillar, Finance Pillar, Quality Pillar and Advocacy Pillar. The UM evaluation reflects ongoing activities throughout the year and addresses areas of timeliness, accessibility, quality and safety of clinical care, quality of services, performance monitoring, member satisfaction and performance improvement projects. The data collected analyzes the year-to-year trends of the overall effectiveness of the UM program, indicating progress for decision making to improve services and the quality of care for members served.

The Program Compliance Committee is responsible for oversight of DWIHN's UM Program Evaluation. The UM Program Evaluation is reviewed and approved annually by DWIHN's governing body. Through this process, the governing body gives authority for implementation of the plan and its components. The UM Program Evaluation report is submitted to the Program Compliance Committee for review and approval annually. Below is a review of the Strategic Plan Pillars and UM Program Description Goals.

Customer Pillar

UM Program Description Goal 1: *Utilizing Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes.*

Goal Status: Partially Met

The sections below outline three strategic plan goals within the customer pillar and UM Goal 1. Strategic Plan Goal A pertains to self-determination, and the IPOS. Goals B and C pertain to provider and practitioner satisfaction. Goals A, B and C were partially met.

Strategic Plan Goal A:

• Build infrastructure to support the implementation of Self Determined/PCP/Shared Decision Making

• Develop components to support the Self Determination by enabling individualized budget, agreements in the MHWIN system along with standardized IPOS

• Increase the competencies around Self Determination, Shared Decision Making and Person-Centered Planning

• Self-Determination and Self-Directed Arrangements across all populations served.

Consumer/Member Involvement

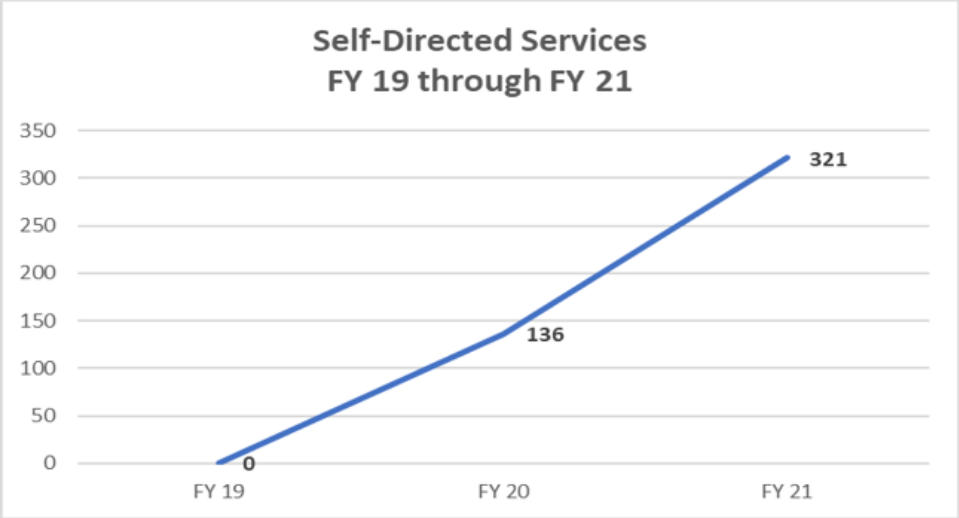
There is member representation at the monthly UM meetings. The Consumer Voice (Persons Points of View) is a quarterly newsletter, edited and written by consumers, that is distributed throughout the provider network. Each of the FY 21 editions contained language regarding Member's Rights and the "Affirmative Statement" to advise consumers that UM decision making is based only on appropriateness of care and no rewards or financial incentives influence those decisions. DWIHN's Customer Service Department instituted a Rapid Response process for inquires coming from consumers and other stakeholders via the DWIHN website. Questions are forwarded by IT to Customer Service staff and then directed to the appropriate department for a rapid response. The goal is to provide a prompt, positive, productive experience for anyone regarding DWIHN processes, clinical programs or procedures, or other practices impacting the community. Customer Service reported that two inquiries were directed to UM for FY 21 and resolved satisfactorily.

Standardized Individual Plan of Service (IPOS)

Having a standardized Individual Plan of Service (IPOS) provides a method for the network to consistently document the Person-Centered Planning process. Throughout this year, Clinically Responsible Service Providers (CRSP) converted their electronic health record to be able to transfer the essential elements of the standardized Individual Plan of Service (IPOS) to DWIHN or they entered the IPOS directly into MHWIN. Clinically Responsible Service Providers' electronic health records were fully transitioned by Quarter 4. To prepare the network workforce, system training on the standardized Individual Plan of Service (IPOS) was held prior to implementation.

Throughout the year, UM continued efforts to build the skillset of the network in the area of Person-Centered Planning. Person Centered Planning and IPOS Development training sessions were held in Quarter 3. Service Utilization Guidelines (SUG) were used throughout the year to offer a transparent and consistent guideline for service delivery. Services that did not fall within the guidelines, required an additional review for medical necessity prior to being authorized by the UM Department. In the prior SUG training sessions, there were additional

instructions on the Golden Thread which details the process of weaving relevant clinical information throughout the Assessment, IPOS, and Progress Notes. There is an *HSAG PIHP Corrective Action Plan for Standard V*—Coordination and Continuity of Care Requirement: Home and Community-Based Settings, April 1, 2022. The UM Department further demonstrated its commitment to support our members' ability to exercise autonomy over their life by developing the infrastructure so that all populations could Self-Direct their services if they choose to do so. This year DWIHN supported 321 individuals, primarily with IDD, in Self-Directed Arrangements. This is more than double the individuals in self-directed arrangements the previous year.



Source: *MH-WIN database, 12/14/21*

MDHHS put forth concerted efforts to distinguish the difference between Self-Determination and Self-Directing services. Self-Determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will. On an individual basis, the goals of SD are to promote full inclusion in community life, to have self-worth and increase belonging while reducing the isolation and segregation of people who receive services. Self-Determination builds upon choice, autonomy, competence and relatedness which are building blocks of psychological wellbeing. Self-Direction (Self-Directing services) is a method for moving away from professionally managed models of supports and services. It is the act of selecting, directing, and managing ones services and supports using an individual budget. People who self-direct their services can decide how to use their CMH dollars on authorized services to meet the outcomes identified in their Individual Plan of Service. Various Clinically Responsible Service Providers (CRSP) were trained on Self-Determination and Self-Directing services throughout the year. Weekly meetings have been added to welcome new families, answer any questions regarding self-direction, and sign agreements. DWIHN will continue to demonstrate the value of self-directing services in the upcoming year.

Strategic Plan Goal B:

- *Improve person's experience of care and health outcomes and ensure 80%-member satisfaction*

Enrollee Member Satisfaction Surveys

Crisis Consumer Satisfaction Survey

The children's crisis vendors do not conduct satisfaction surveys. COPE utilizes "Perception of Care" Surveys

COPE Mobile Crisis Services

During FY 21, Covid-19 and social distancing decreased distribution of surveys and consumer participation. COPE Mobile Crisis Services had a total of 239 surveys completed, which is a 34% decrease when compared to the last fiscal year (360). The overall satisfaction rate for FY 21 was 99%, which is a 1% increase when compared to the last fiscal year (98%).

COPE Intervention

During FY 21, there were a total of 144 consumers asked to complete a COPE Perception of Care Survey, which is a 40% decrease when compared to last fiscal year (239). Of this total 144 or (100%) of the consumers responded. Individual responses showed the positive perception rate for FY 21 fiscal year as 99%, which remained the same when compared to last fiscal year (99%).

COPE Stabilization

During the FY 21, there were a total of 95 consumers asked to complete a COPE Perception of Care Survey, which is a 21% decrease when compared to last fiscal year (121). Individual responses showed the positive perception rate for FY 21 as 99%, of 95 survey responses, which represents a 3% increase compared to last fiscal year (96%). Based on the above findings, no crisis access issues are identified.

DWIHN Member Satisfaction Surveys

Data from the 2021 the Customer Service Department Experience of Care and Health Outcomes (ECHO) survey for adults and children was not yet available at the time of this report. Historically, each department including UM, reviews findings to determine if there are opportunities for improvement. There were five survey questions related to *access* to services.

In 2020, there was one specific survey question directly related to approvals for services:

Domain III: Getting Treatment and Information from the Plan or MBHO Getting Treatment and Information: Score is the percentage of respondents who answered "Not a problem"

Q39: In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?

A big problem = 15%

A small problem = 30%

Not a problem = 55%

It is unclear how much of this response was directly related to DWIHN's approval process. The UM department continues to work to ensure all DWIHN, Access Center and Crisis Vendor practitioners and employees representing DWIHN in providing critically important services to individuals who suffer from mental illness, developmental disabilities, or substance use disorders and who make Utilization Management decisions, understand the importance of ensuring that all consumers receive clinically appropriate, humane and compassionate services of the same quality that one would expect for their child, parent or spouse by affirming the following:

1. Utilization Management decision making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or services.
3. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Members are informed of this in the quarterly "Persons Points of View Newsletter", in the "Members Handbook" and at other points in time, according to individual circumstances. Each DWIHN and crisis vendor UM decision maker reviews and signs the "Utilization Management Affirmative Statement About Incentives" annually, to acknowledge and affirm compliance with this practice standard. Records of signed affirmation statements are kept by administrative staff, as well as by and the UM department.

UM will continue this practice and will respond to any complaints that may occur, as well as to any concerns that may become known upon review of the 2021 survey findings.

Strategic Plan Goal C:

- *Enhance the Provider experience and ensure 80% Provider Satisfaction*

DWIHN Report on Practitioner Network Satisfaction Survey

During FY 17, FY 18, FY 19, FY 20 and FY 21, DWIHN collected survey data to determine network experiences with DWIHN. This report analyzes provider satisfaction with Utilization Management during the four fiscal years. This report addresses *NCQA UM 1, Element A, Factor*

2: The organization considers member and practitioner experience data when evaluating its UM program and updates the UM program based on its evaluation.

Survey Overview

The methodology for this survey is under the auspices of DWIHN's Customer Services division. There were 33 practitioner respondents for the FY 17 survey, 146 practitioner respondents for the FY 19 survey and 180 practitioner respondents for the FY 20 survey and 148 for FY 21. Participants were anonymous and were given the following options for scoring:

Completely Satisfied
Somewhat Satisfied
Somewhat Dissatisfied
Completely Dissatisfied

] Determinants used to calculate percentage of satisfied

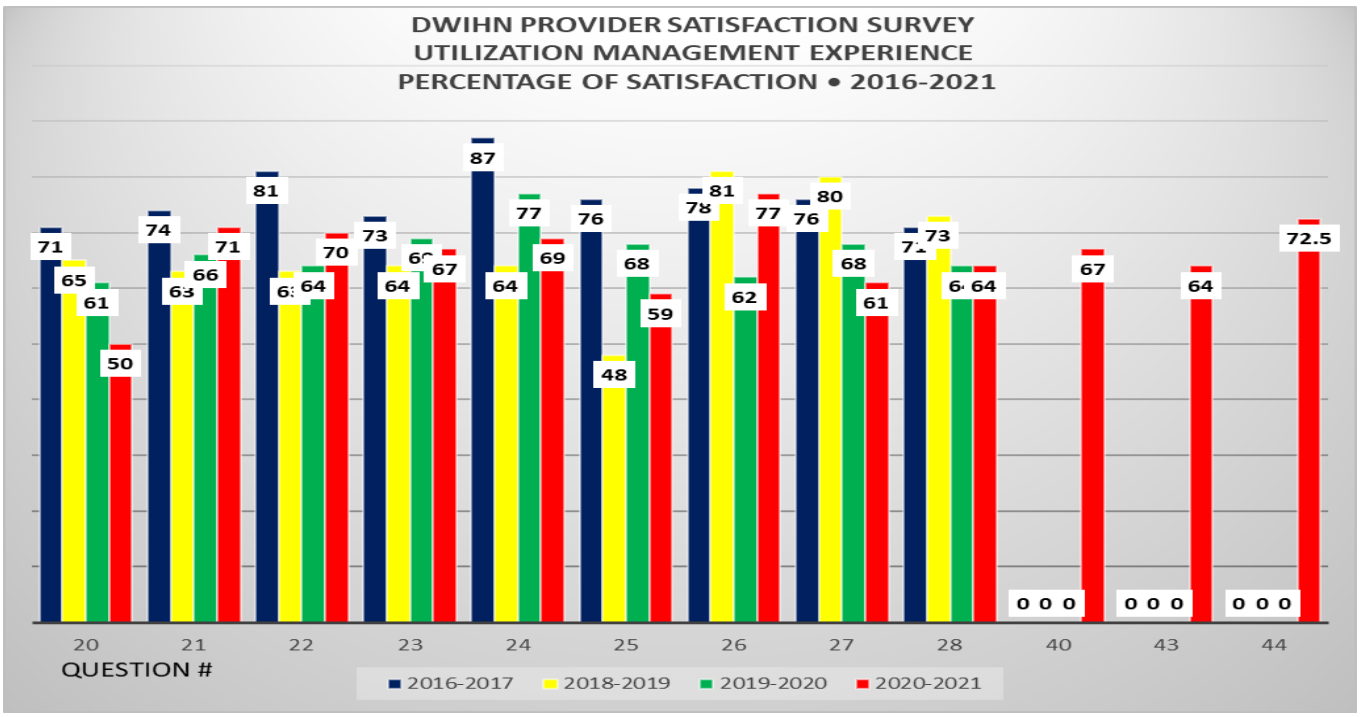
The survey tool underwent some revisions in the 2020- 2021 measurement period, resulting in add on question numbers 40, 43, 44 not having any previous data history.

Data:

QUESTION	2016-2017 %Satisfaction	2018-2019 %Satisfaction	Rate of Change	2019-2020 %Satisfaction	Rate of Change	2020-2021 %Satisfaction	Rate of Change
20. How satisfied are you with the ease of obtaining DWIHN's initial authorizations through COPE, SUD, Autism Spectrum Disorder, and/or MI Health Link? *	71%	65%	-6%	61%	-4%	**50%***	-11%
21. How satisfied are you with the ease of obtaining DWIHN's continued stay authorizations through SUD, Autism Spectrum Disorder, and/or MI Health Link? *	74%	63%	-11%	66%	-3%	**71%***	+5%
22. (42) How satisfied are you with the consistency of application of Medical Necessity Criteria for determination of appropriate level of care?	81%	63%	-18%	64%	+1%	**70%**	+6%
23. (38) How satisfied are you with the ease of placement in the suitable setting necessary for reduction or stabilization of symptoms/disabilities and improvement/stabilization of level of functioning?	73%	64%	-9%	69%	+5%	**67%**	-7%
24. How satisfied are you with the Provider Appeal process for denials?*	87%	64%	-23%	77%	+13%	**69%***	-8%
25. (37) How satisfied are you with the MH-WIN authorization functions?	76%	48%	-28%	68%	+20%	**59%**	-6%

26. (36) Access to knowledgeable DWIHN Utilization Management staff.	78%	81%	+3%	62%	-19%	**77%**	-0-
27. Procedures for obtaining pre-certification, referral, authorization information. (39. How satisfied are you with current procedures for obtaining pre-authorizations from DWIHN UM Team?)	76%	80%	+4%	68%	-12%	**61%**	-7%
28. (41) Timeless of obtaining pre-certification, referral, authorization information.	71%	73%	+2%	64%	-9%	**64%**	-0-
40. How satisfied are you with current procedures for obtaining referrals and authorizations from DWIHN UM Team?						**67%**	N/A
43. SUD/UM: How satisfied are you with authorizations specifically to address SUD services?						**64%**	N/A
44. UM/Autism: How satisfied are you with authorizations specifically to address Autism services?						**72.5%**	N/A

80% SATISFACTION STANDARD



Data Analysis

1. The 80% target has *not been* met on any measure since FY 19.

2. The average overall satisfaction score has remained stagnant in the high 60's since FY 19.
3. Overall, scores were higher in the FY 17 survey than during the subsequent measurement periods. The average score in the FY 19 was 9% lower than average score in the FY 17 survey. The average score in the FY 20 survey was 1.5% lower than the average score in the FY 19 survey. The average score in the FY 21 survey was .5% lower/higher than the average score in the FY 20 survey, without and with the addition of questions 40, 43 and 44.
4. The highest scoring questions over the four-year measurement period are #24: How satisfied are you with the Provider Appeal process for denials? #26: Access to knowledgeable DWIHN Utilization Management staff.
5. The lowest scoring questions over the four-year measurement period are questions #20: How satisfied are you with the ease of obtaining DWIHN's initial authorizations through COPE, SUD, Autism Spectrum Disorder, and/or MI Health Link and #25. (37) How satisfied are you with the MH-WIN authorization functions?
6. Over the course of four measurement periods, there have been 39 opportunities to meet or exceed the 80% target score. This occurred only four times; twice during the FY 17 and FY 19 measurement periods. This is a 10% level of overall compliance with the target 80% score.

Qualitative Data FY 21

Comments can be found in the DWIHN Network Satisfaction Survey for FY 21 Utilization Management

Recommendations

Specific interventions for opportunities for improvement are to be developed, implemented and tracked through a collaborative effort, inclusive of UM department staff, Residential Services, Crisis Services, network practitioners and the Utilization Management Committee (UMC).

Customer Pillar

Utilization Program Description Goal 2: *Engage community stakeholders in the development and implementation of processes that promote clinical review procedures, practices and corrective actions to ensure system wide compliance with DWIHN, State, Federal regulations. (Utilization Management Program Goal)*

Goal Status: Met

In addition to daily collaboration, the Network is provided ongoing training and guidance on requesting medically necessary services, documentation required to support requests, and the correct method and timeframes for submitting authorizations. UM responds to provider inquiries meets with providers as necessary to improve UM processes. UM also participates in DWIHN's

monthly outpatient provider and hospital liaison meetings as well as the bi-weekly huddles with the adult and children's screening entities. UM is also present at the SUD provider meeting, which is held bimonthly and includes key players from Access, Finance, IT, UM, Quality, and Managed Care Operations to discuss clinical and administrative operations. Akin to other areas of operation, the focus is on activities to improve efficiency, effectiveness, and overall quality of care of consumers receiving substance use disorder services. DWIHN meets quarterly with representatives of agencies providing Habilitation Supports Waiver services. Utilization rates, updates or changes to policy and procedures, including program incentives, potential barriers to participation of qualified individuals and similar topics are discussed at every meeting. Other topics, such as goal writing, accurate form completion, common reasons as to why applications or authorizations are returned, and other similar topics discussed throughout the year as needed.

Access Pillar

UM Program Description Goal 3: *Monitor the use of specialty behavioral health waiver programs: Autism Spectrum Disorder (ASD) benefit, Habilitation and Supports Waiver (HAB), Children's Waiver Program (CWP) and Serious Emotional Disturbances Waiver (SED) through the development and on-going review of DWIHN policies and procedures and monthly monitoring reports.*

Goal Status: Met

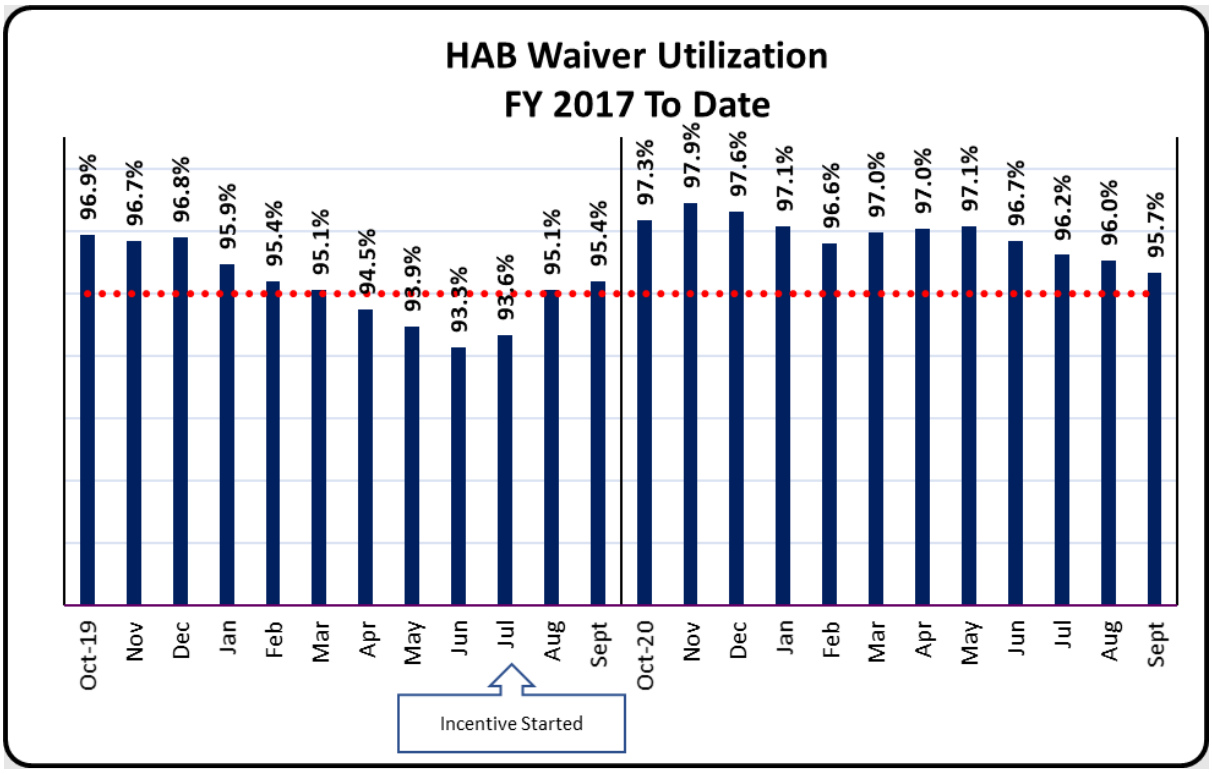
Habilitation/Supports Waiver (HSW)

Detroit Wayne Integrated Health Network (DWIHN) receives enhanced funding for participants enrolled in the 1915(b) Habilitation Supports Waiver (HSW) ranging from $3,500.00 to $5,500.00 per member/per month from the Michigan Department of Human Services (MDHHS). In order to be enrolled in the HSW program, applicants must meet the following requirements:

- Have an intellectual disability (no age restrictions),
- Reside in a community setting,
- Be Medicaid eligible and enrolled,
- Would otherwise need the level of services similar to an Intermediate Care Facilities/Individuals with Intellectual Disabilities, and
- Once enrolled, receive at least one HSW service per month

DWIHN modified our HSW rate structure in July of 2020. The revised structure was designed as an incentive program that provided a one-time payment of $1,000 per enrollee for contracted supports coordinator agencies. Additionally, the monthly payment rate for Supports Coordination was increased by 7%. As a result of the incentives, the percentage of filled slots for the year met or exceeded the MDHHS required minimum 95% each month of the fiscal year.

HSW Utilization summarized below:



HSW Planned Interventions for Upcoming Year

- HSW team will continue provision of direct support and technical assistance to providers.
- Continue to host quarterly provider meetings and discussion forums – Occurs quarterly; ongoing
- Host meetings with individual providers, as necessary, to identify and review potential HSW participants, suggest approaches to enrollment, discuss and address barriers, and offer direct provider support.
- Provide ongoing education to providers on ways to properly complete a waiver application with minimal errors and avoid disenrollment.
- Collaborate with other departments in the identification of potential HSW applicants.

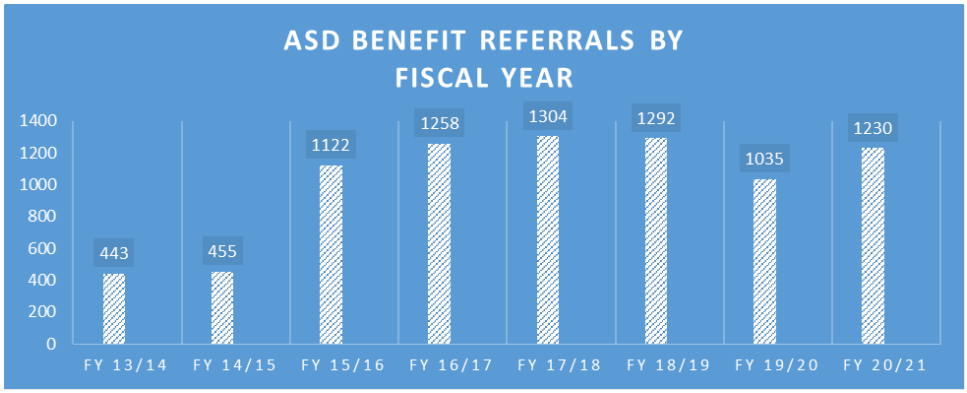
Autism Spectrum Disorder (ASD) Benefit

The ASD benefit is a MDHHS program that funds Applied Behavior Analysis (ABA), an evidenced based treatment for autism spectrum disorder. Medicaid consumers are eligible through age 21 years old. All referrals begin with DWIHN's access department. Parents wishing to have their child screened for the benefit call DWIHN's access department who completes a preliminary screening. Should the screening test positive, the member is then scheduled for an appointment for an in-depth evaluation to determine if the member has a diagnosis of autism spectrum disorder and if they are eligible for the ASD Benefit.

Effective 2/1/21 DWIHN began contracting independent evaluators to complete the initial eligibility evaluations. In previous years, the same providers who provided ongoing Applied Behavior Analysis (ABA) services also completed the initial eligibility evaluations. DWHIN identified this as a possible conflict of interest and contracted with several new providers who would only be providing the initial evaluations and not ongoing ABA services, thereby removing conflict of interest concerns in this process.

FY 20 saw a decrease in ASD referrals, most likely due to the impact of COVID-19. FY 21 saw an increase in referrals from last year and the number is more consistent with those of recent years prior to COVID-19. This may suggest that members and their families are feeling more comfortable engaging in center and home-based ABA now than they had at the onset of COVID-19. For members with concerns regarding their health and welfare, MDHHS continues to allow ABA services to be offered via telehealth, when clinically appropriate. The current MDHHS order allows services to be provided via telehealth until 12/31/21 but that date could be extended based on MDHHS orders.

Please refer to the graph below which illustrates the number of yearly referrals since the benefit launched.



Source: State of Michigan Waiver Support Application System 11.29.2021

There are currently 2,074 cases are open in the ASD benefit. Of those, 1181 are assigned to the comprehensive level of care (16 hours or more of ABA per week) and 531 members are assigned the focused level of care (1-15 hours of ABA per week). 362 open members do not have a level of care assigned. This typically occurs when a member has been opened in the WSA for the benefit but has not yet begun ongoing services. The table below reflects the number of individuals served by DWIHN since the launch of the Autism Benefit in 2013, along with their assigned levels of care.

Status	Level of Care		Did Not Receive ABA Direct Services	Total
	Focused Behavioral Intervention (*Lower Level of Care*)	**Comprehensive Behavioral Intervention** (*Higher Level of Care*)		
Closed	724	1310	4043	6077
Open	531	1181	362	2074
Total	1255	2491	4405	8151

Source: State of Michigan Waiver Support Application System 11.29.2021

Members who are indicated as open but have not received ABA Direct Services account for members who are currently open in the benefit but have not yet followed up on receiving direct services following their eligibility evaluation.

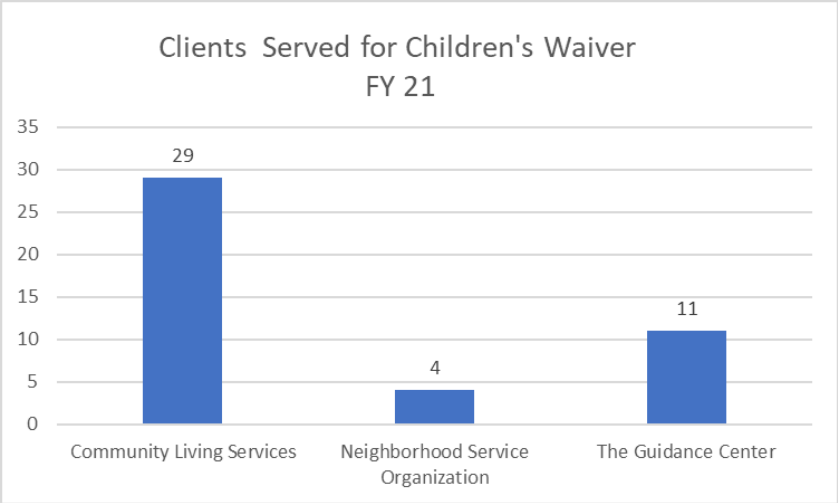
Please see table below for a breakdown of reasons for 4,043 members who are now closed and did not receive ABA direct services.

Closed Members Who Did Not Receive Services (All Data Since 2013)	
Rationale	**Number of Closed Members**
Not Qualified	1802
Not Interested	1304
Declined Services	662
Voluntarily Disenrolled from Services	155
Aged Out of Benefit	33
Re-evaluation Did Not Meet Medical Necessity	22
No Longer Eligible for Medicaid	17
Moved Out of State	16
No Longer Meets Requirements	9
Other	23
Total	**4043**

Source: State of Michigan Waiver Support Application System 11.29.2021

Children's Waiver Program

The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children with Intellectual and/or Developmental Disabilities who are under the age of 18 when they otherwise wouldn't qualify for Medicaid funded services. Three Provider Agencies deliver services to children and youth on this waiver: Community Living Services (CLS), Neighborhood Services Organization (NSO) Life Choices, and The Guidance Center (TGC). During FY 21, DWIHN had 44 children, youth and their families served by the different agencies on this waiver. This is an increase from FY 20 where 36 children were served.



Source: DWIHN Reports (11/29/2021)

Children's Serious Emotional Disturbance Waiver (SEDW)

Children's Serious Emotional Disturbance Waiver (SEDW) provides services that are enhancements or additions to Medicaid State Plan coverage for children and youth through age 20 with SED. The SEDW enables Medicaid to fund necessary home and community-based services for children and youth who have a serious emotional disturbance and meet criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and/or are at risk of hospitalization without waiver services. Wayne County has five providers that serve children' and youth in the SEDW, they are: Black Family Development Inc., Development Centers, Southwest Counseling Solutions, The Children's Center and The Guidance Center. During FY 21, Wayne County was able to serve 91 children and youth in the waiver.

Access Pillar

UM Program Description Goal 4: *Advance the implementation of DWIHN's standardized UM Program Description to assure effective and efficient utilization of behavioral health services through ongoing development and oversight of the following:*

1. *The Benefit Plans/UM Authorization Guidelines; and*
2. *Setting standards and monitoring adherence to the delegated entities UM Plans.*

Goal Status: Met

The Benefit Plans/UM Service Utilization Guidelines were finalized May 2020 and embedded in the MHWIN system June 1, 2020. There are Service Utilization Guidelines for the following levels of care: Seriously Mentally Ill (SMI), Intellectually Developmentally Disabled (IDD), Autism Spectrum Disorders, Uninsured and Underinsured Adult and Child, Substance Use Disorder

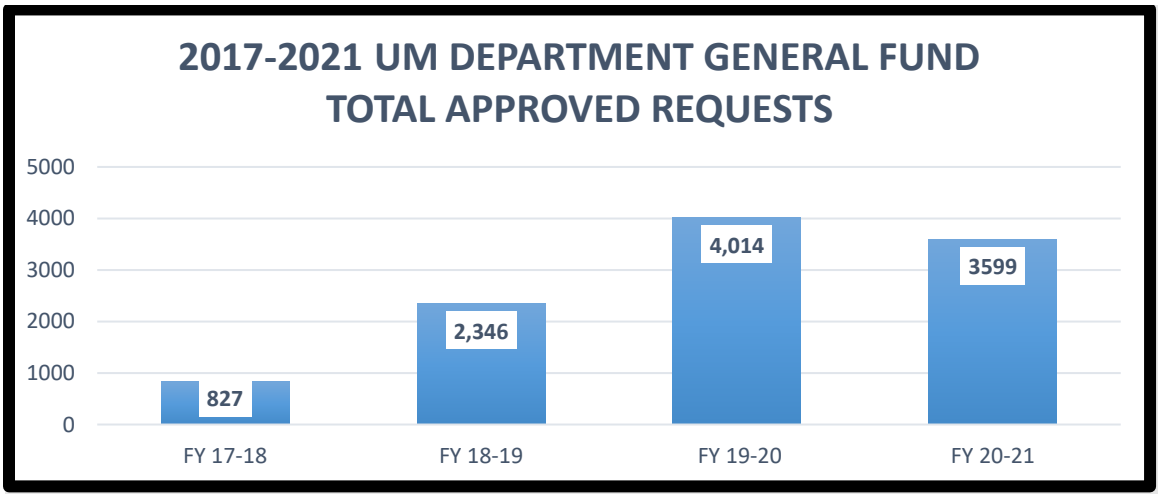
(SUD) and MI Health Link. The guidelines were implemented to automatically provide authorization for services that are found medically necessary for the assigned level of care. Requests for authorization that fall outside the guidelines, are reviewed by the UM Department's Clinical Specialists for medical necessity. For the substance use disorder line of business, service packages are auto-generated at the point of referral by the Access Department. The initial SUD service package includes a select and limited number of services such as assessment, urine drug screen and withdrawal management or residential services. All subsequent authorization requests are approved by SUD UM reviewers.

All guidelines are consistently reviewed and modified to meet members' needs and provider feedback is also taken into consideration when changes are made. The UM Department also participates in monthly provider meetings to share any changes and address provider concerns regarding the authorization process and guidelines. The delegated entities UM and DWIHN Program Descriptions will be updated in FY 22.

General Fund Exceptions

General Fund Exception is the process designed to prevent the interruption of needed services when the consumer is without health care insurance through the approval of service authorizations by Utilization Management. All General Fund approved services are expected to help achieve/sustain physical and emotional wellness and to support optimal functioning while participating in needed behavioral health services during a 90-day period that is within the date range of the IPOS. The time allotted allows for the Clinically Responsible Service Provider to work with the responsible party towards acquisition/reinstatement of insurance benefits.

The chart below depicts the trend in approved General Fund requests over a five-year period for a range of outpatient services for SMI, SED and IDD consumers.



Source: MHWIN 12/30/2021

The increase in requests began in October 2018 with the automatization of the authorization process in MHWIN and increased visibility to the provider network. There is an additional

unknown number of requests that have been reviewed and *not* approved because of eligibility or inadequate information or over usage issues. There is also an additional unknown number of automated General Fund Exception approvals that were generated through HIE at the time of the IPOS, beginning in August 2020.

Of special note, the following occurred during 2021:

- Clarification of ASD services and General Fund;
- General Fund provisions for TGC's CCBHC program;
- A pharmaceutical resource to allow for General Fund eligible consumers to obtain psychotropic/physical health medication and medical equipment was realized. An agreement was entered into with Genoa Healthcare, using CPT code T1999, Misc. Therapeutic Items. Currently in its early stages, requests for this service are made through MHWIN and the program is expected to become available at eight convenient locations for pickup and delivery services.

FY 2021-2022 Goals:

- Network wide implementation of the Genoa Healthcare pharmaceutical program for General Fund eligible consumers.
- Reduction in existing consumer need for General Fund Exception through a prevention messaging campaign.

County of Financial Responsibility (COFR)

County of Financial Responsibility ("COFR") provides a contractual basis with the Michigan Department of Health and Human Services ("MDHHS") for determining financial responsibility and a process for resolving disputes, regardless of funding source. The COFR Committee's main objective is to review and render a decision on the Out of County cases, as well as provide the mechanisms for contracting and payment for those members ongoing. The COFR Committee is composed of members from various departments, including Finance, Legal, Managed Care, and Utilization Management.

All referrals result in an open case. In FY21, there were 24 new COFR requests that came before the COFR Committee. Of the new COFR requests, 13 were determined to be the financial responsibility of DWIHN (approx. 54%). By the end of the fiscal year, there were 62 open COFR Cases: a decrease of 50% from the number of open cases in January 2021. The reduction was achieved through the increase in frequency of COFR Committee meetings from once weekly to two times weekly for a minimum of one hour. The full committee meets at the start of the week to render decisions on new and existing cases. A sub-committee meets at the end of the week to provide follow-up on work completed outside of the committee meeting. There are no pending or systemic changes statewide that may impact the work of the COFR Committee in 2022. There are also no unmet needs or resources the committee requires of DWIHN in general, or of the UM department.

Out of Network Requests/Service Authorizations

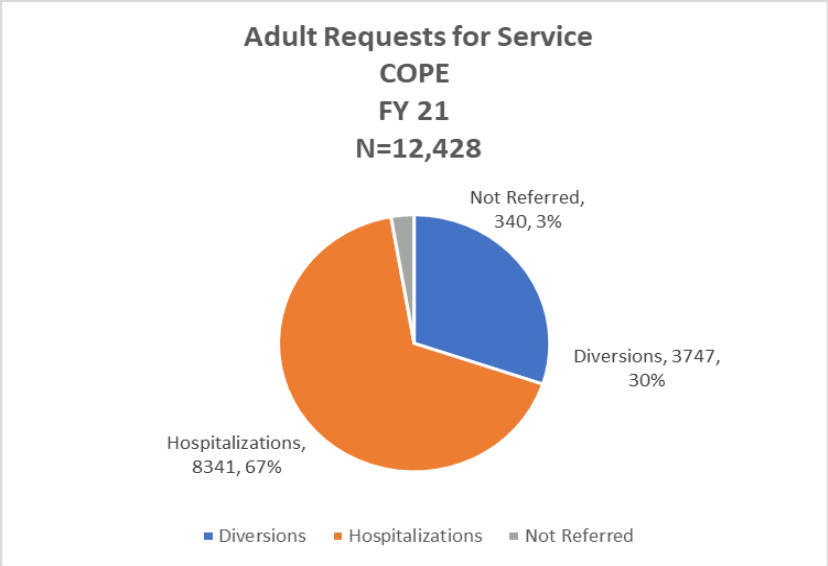
Out of Network requests for authorization require interdepartmental collaboration between Managed Care Operations, UM and Claims to ensure the request is processed within the appropriate timeframe and payment rendered to the provider for the service. Requests of this type also require a single case agreement to determine an agreed upon rate and for entry of the provider into MHWIN for authorization purposes. Out of network requests for urgent, pre-service authorizations are reviewed and processed within 24 hours, if UM is notified of the admission. Post-service requests from non-contracted providers are typically managed internally by DWIHN's UM staff within 30 days.

Evidenced Based Supportive Employment

Evidenced Based Supportive Employment (EBSE) are services that help support those with severe and persistent mental illness seek out, obtain, and maintain employment. Case managers assist consumers in developing employment skills such as writing resumes, development of interview skills, and managing mental health while being employed. After careful consideration, DWIHN determined in June 2021 that it was appropriate for service utilization guidelines to be entered into MHWIN to allow the majority of EBSE authorizations to be automatically approved should they fall within the service utilization guidelines. This change has resulted in many requests being automated that no longer require manual review. As a result, DWIHN's Utilization Management Department no longer tracks data related to EBSE authorization requests.

Requests for Service and Diversions from Hospitalization

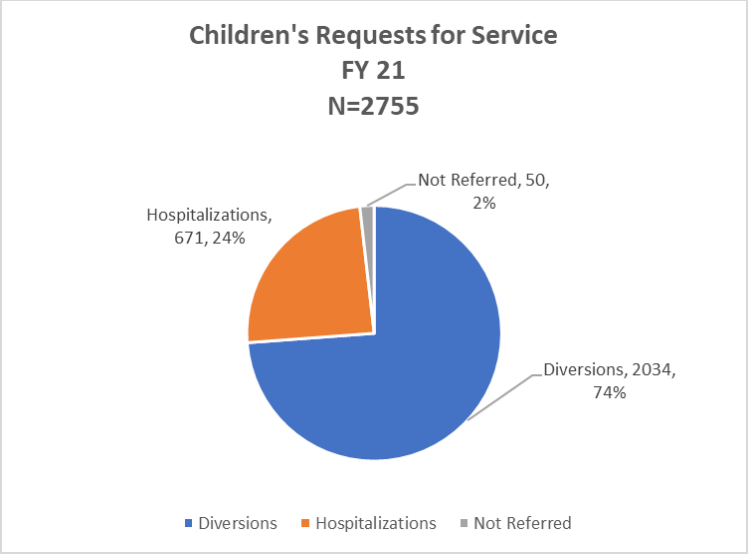
The following pie charts indicate the volume of requests for service received by COPE and the Children's Screening Entities. The screeners for children and adolescents are The Children's Center, The Guidance Center, and New Oakland Family Services. A preadmission review is conducted to determine need for hospitalization. Hospitalization is the most restrictive and expensive level of care. Diversions are not only cost effective but provide a less restrictive environment for consumers. UM is actively involved with both Adult and Children's bi-weekly huddles to address hospital and diversion issues/request. This includes but is not limited to: COPE, hospital liaison and children's huddles. UM staff enter the discharge summaries in MH-WIN after hospitalization to assist in tracking after-care appointments and success of consumer engagement.



Source: MH-WIN 1/10/2022

Results and Analysis

The above chart indicates that COPE screened 12,428 consumers. Sixty eight percent (68%) were hospitalized and the other 30% diverted to the other levels of care which include outpatient, crisis residential, partial hospital, SUD residential, withdrawal management and other. The not referred category, or category of "no" within MH-WIN are for other referral categories not within the DWIHN system, and may include home, health plans or other community resources. The disposition breakdown is very similar to last year. COPE had 8,341 hospitalizations and 1,311 or 16% had to wait more than 23 hours from time of request to time of placement. This is usually attributed to a bed wait. Additionally, 53 clients or 1% of those requiring crisis residential experienced an inpatient hospitalization due lack of a crisis residential beds. This is reduced significantly from the previous year where 132 were admitted due to lack of a crisis residential bed in FY 20.



Source: MH-WIN Reports 1/10/22

The chart above indicates children's screeners received 2755 requests for services, 74% (2034) were diverted to settings other than the hospital. The remaining 671, or 24% were hospitalized. The not referred category (2%), or other referral categories not within our system, may include home, health plan or other community resource. The Diversion category improved 5% from last year that was reported at 69%.

Wait for Hospital Bed FY 21

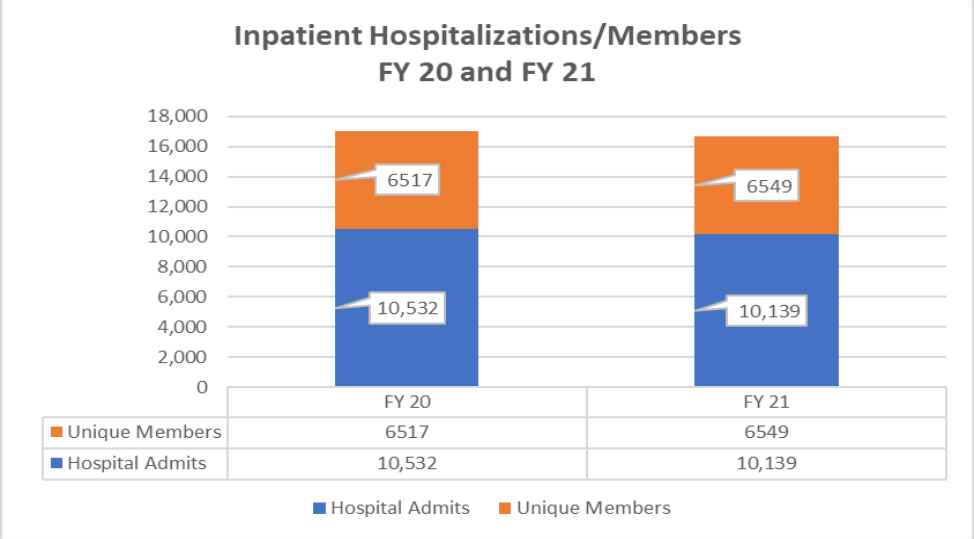
Concerns with the greater than 23- hour wait for hospital beds continued into FY 21. The chart below identifies the percentage of extended waits reported for each of the screening entities from data pulled from MH-WIN Request for Services Report. The calculation for wait time is determined from the count of those who are admitted where the number of hours from the PAR disposition date and time to the Placement Activity Log Date and Time is bigger than or equal to 23 hours.

CRISIS VENDOR	PERCENT OF 23* HOUR WAITS FOR HOSPITAL BED • FY 2021
COPE	16%
NEW OAKLAND	49%
THE GUIDANCE CENTER	28%
CHILDRENS CENTER	14%

New Oakland reports the highest percentage of wait time in their UM Annual Evaluation for FY 21. There are two factors that account for the wait in New Oakland screenings: 1) New Oakland is screening many consumers with IDD and 2) there has been limited bed availability for inpatient placement for consumers with IDD. Currently, only two facilities will review consumers with IDD for inpatient placement.

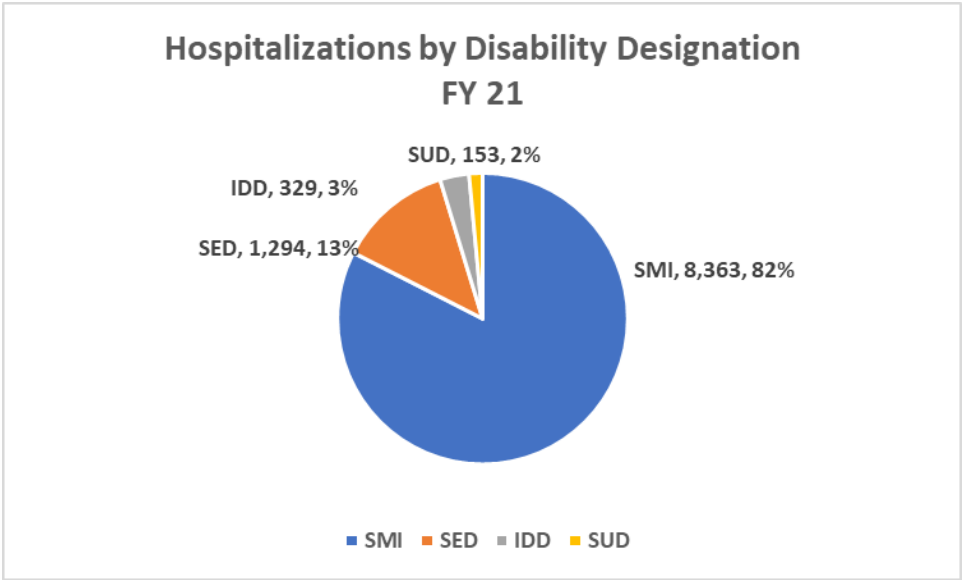
Inpatient Admissions and Other Metrics

The bar graph below depicts the number of hospital admissions for both FY 20 and FY 21. The number of admissions was reduced 4% from FY 20(10,532) to FY 21(10,139). Unique members hospitalized was increased by less than 1%.



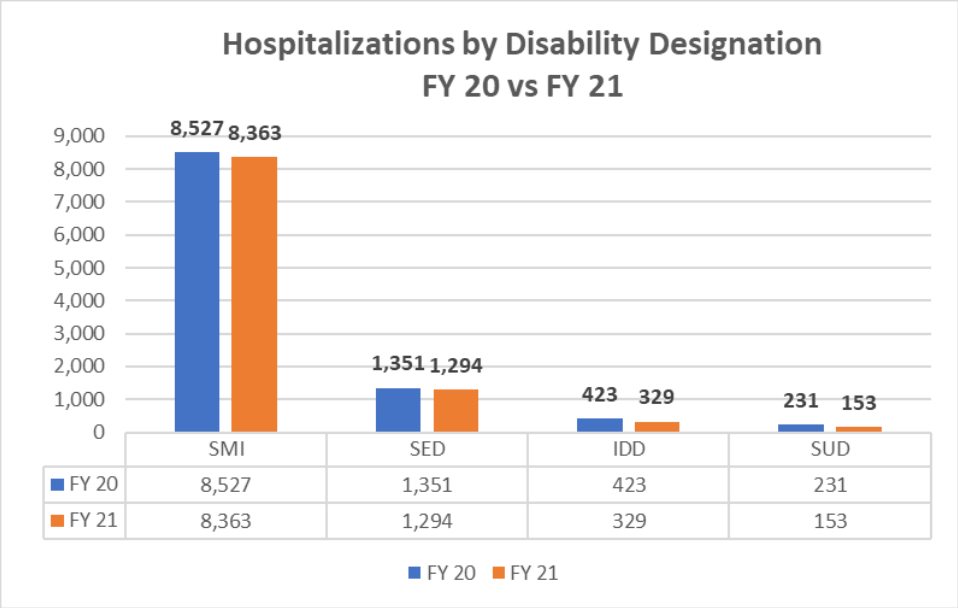
Source: Power BI Dashboard 2/2/2022

As indicted below, adults with mental illness account for 82% of the 10,139 hospital admissions. Children with serious emotional disturbance account for 13% of the hospital admissions, and individuals with developmental disabilities account for 3% of the hospital admissions. The new Power BI dashboard also includes the SUD category, which indicates that 153 admissions or 2%, of the admits had a designation of primary SUD in MH-WIN.



Source: Power BI Dashboard 2/2/2022

The bar graph below depicts the trend of Inpatient Admissions by disability designation admitted network wide for the past two fiscal years.

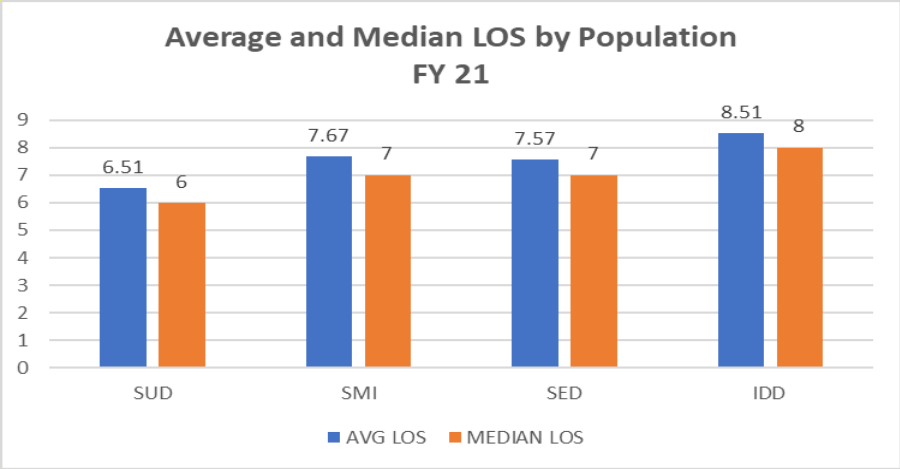


Source: Power BI Dashboard 2/2/2022

Results and Analysis

As indicated in the above bar graph and data table there is little variation of the disability designation mix from FY 20 to FY 21. In terms of percentage of admissions, individuals with Serious Mental Illness composed 81% of admits in FY 20 versus 82% in FY 21. Children with Serious Emotional Disturbance composed 13% of admits for both FY 20 and FY 21. Individuals with Intellectual Developmental Disabilities were 4% of the population in FY 20 and 3% in FY 21.

The first chart below depicts the average length of stay and median length of stay by population for FY 21. The second chart compares the median LOS for both FY 20 and FY 21.

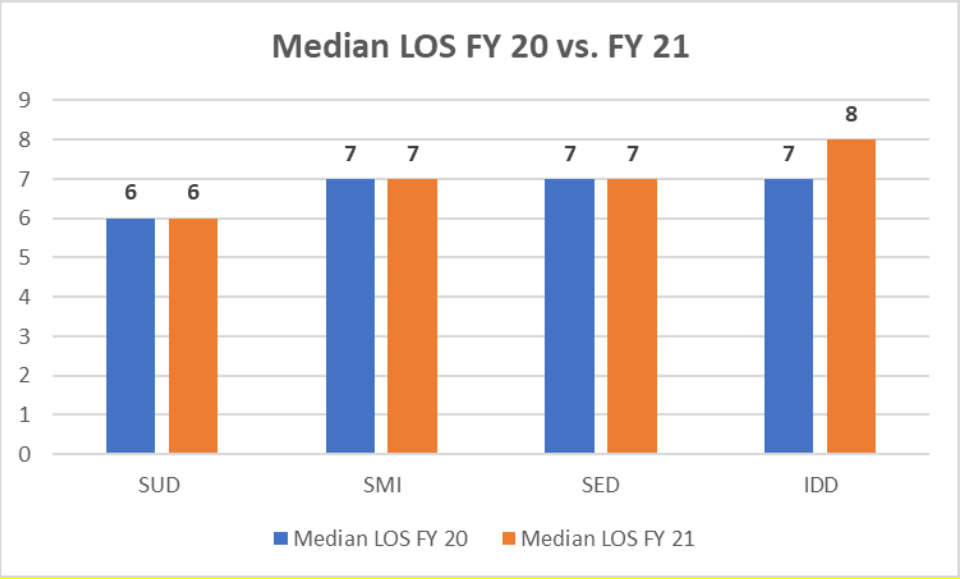


Source: Power BI Dashboard 2/7/2022

Results and Analysis

The chart above shows the average Length of Stay (LOS) for Adults with Severe Mental Illness was 7.67 days. The average LOS for Children with SED was 7.57 days. The average length of stay for Individuals with IDD was the highest at 8.51. The average LOS for individuals with primary substance use disorder was 6.51. National hospital databases do not usually distinguish the IDD population for statistical purposes as clients are hospitalized under a psychiatric diagnosis.

The median length of stay is a better measure of midpoints, as it is not affected by outliers. As seen here the median LOS is less than average LOS. The median length of stay chart shows the median Length of Stay for all populations was between 6-8 days. The median LOS for Adults with Severe Mental Illness was 7 days. The median LOS for Children with SED was 7 days. The median length of stay for Individuals with IDD was 8 days. Because hospitalizations are smaller in number for IDD, several long lengths of stays for a few members can alter the median LOS.



Source: Power BI Dashboard 2/7/2022

Benchmarking Length of Stay

It is important to compare DWIHN's performance to other entity's performance that are comparable and available regarding hospital lengths of stay. Some data bases may not include the Medicaid or uninsured population or take into consideration other social determinants that may vary by state or geographic location and may impact length of stay. The SAMHSA Uniform Reporting System reports on lengths of stay of psychiatric Inpatient hospitalizations, including Medicaid and Non-Medicaid, and is representative of the consumers we serve. The most up-to-date published data is from 2020. The table below compares DWIHN to the State of Michigan's reported performance:

	2020 SAMHSA Uniform Reporting System	**FY 21 DWIHN Power BI Dashboard (2/2/22)**
Child Average LOS	8 days	7 days
Adult Average LOS	9 days	6-9 days

Note: *The average LOS for DWIHN is listed as a range and includes the average LOS of Adults with MI, Adults with SUD, and Individuals with Intellectual Developmental Disabilities.*

DWIHN's Average Length of Stay data is consistent with the State average LOS. However, DWIHN reported an average LOS of 7 days for children compared to 8 days reported by the State. The 25th Edition of the MCG Criteria, updated in 2020, lists the National Average Length of Stay for some of DWIHN's most frequently seen diagnoses including bipolar

disorder (7.1 days), other psychotic disorders (7 days) schizophrenia (10.5 days), attention deficit disorder (6.6 days), major depression (5.8 days) and anxiety disorders (5 days). Although DWIHN current hospital metrics are not broken down by diagnosis, our average LOS of 6-9 days, in many diagnostic categories appear consistent with the national average length of stay metrics.

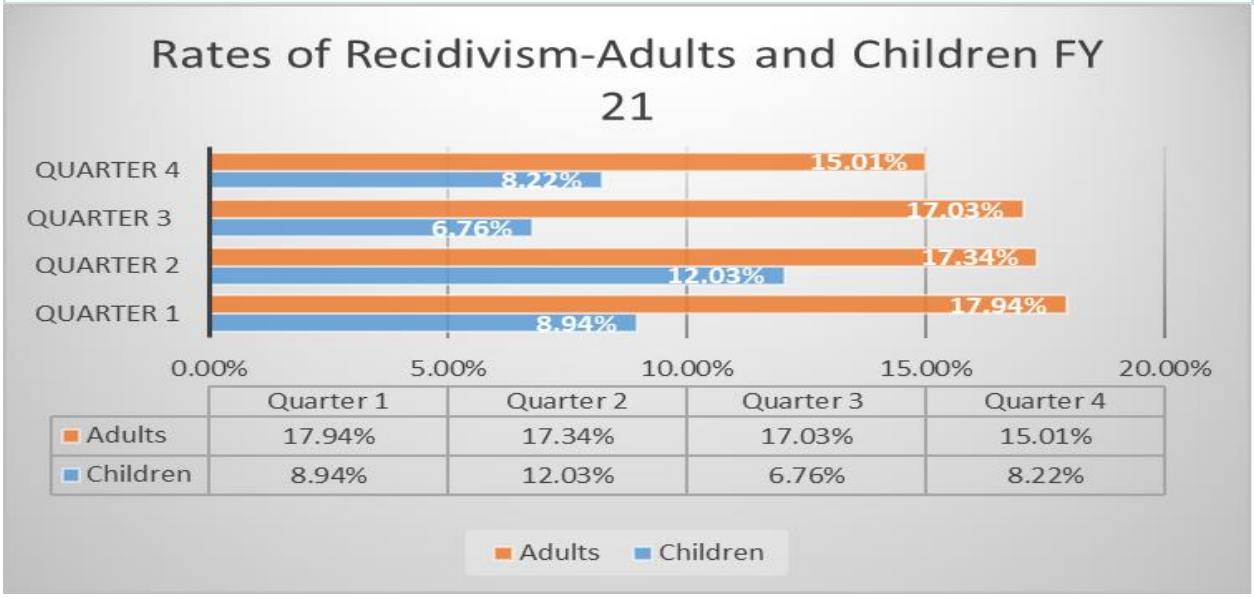
Results and Analysis

As noted above the median length of stay remained the same for the SUD, SMI, and SED population for FY 20 and FY 21. The median length of stay did increase for the IDD population from 7 days to 8 days in FY 21. In order to address length of stay and hospital admission issues, the Utilization Management department continues to meet with the physician consultant to review cases with length of stays greater than 14 days. Additionally, there is a Residential/UM work group that identifies cases with ability to transition from inpatient to Crisis Residential or from a Crisis Residential Unit to an Adult Foster Care facility.

Hospital Recidivism

MMBPI Indicator #10 - Inpatient Recidivism

The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge



Source: MHWIN MMBPI PIHP Report FY 20-21 (02/2022)

Results and Analysis

As part of the Michigan Mission Based Performance Indicator System, Indicator #10 tracks the percentage of members readmitted during the quarter within 30 days of discharge from an inpatient psychiatric hospital admission. FY 21 resulted in rates of recidivism for adults

over the 15% state threshold at 17% until Quarter 4. There was a 2% decrease from quarter 3 to quarter 4 for adults and a 1.46% increase in recidivism for children within the same quarters. The number of children admitted within 30 days of discharge, remained below the 15% threshold for the entire fiscal year; Quarter 2 saw the highest rates at 12.03%. Recidivism data for FY 21 is inclusive of the MI Health Link population.

Interventions During FY 2021

The Quality Department led DWIHN's interdepartmental efforts at reducing the number of members who are readmitted. During FY 2021, the DWIHN Recidivism Workgroup oversaw multi-directional approaches, including:

- Collaboration with members' outpatient (CRSP) providers to ensure
    - Continuity of care
    - Notification when members present to the ER in crisis including those members who may not require hospitalization and those that require treatment
- Mobile Crisis Stabilization services
- Chart alerts in MHWIN which notify the screening entities and CRSP of members who frequently present to the ER i.e., "Familiar Faces"
- Diversion to medically appropriate lower levels of care
- Referrals to Complex Case Management for consumers with high behavioral needs
- Increased tracking of members with court orders for treatment including an area in MHWIN designated for court activities

FY 2022 PLAN

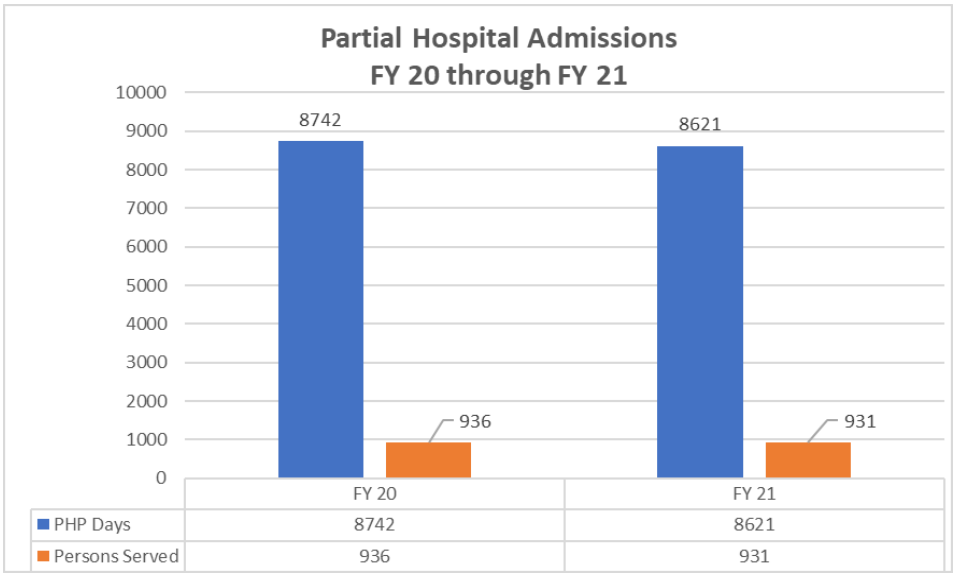
Continuous efforts towards the reduction of hospitalization recidivism includes:

- Ongoing interdepartmental collaboration including adequate use of the resources within the Provider Network i.e., Med Drop Program, ACT services and Complex Case Management
- Onboarding of 3 additional Hospital Liaisons to the Crisis Services team to enhance Discharge Planning and Crisis Planning.
- Implementation of the Behavior Health Homes to provide comprehensive Care Management, Care Coordination and Referrals to Community Social Supports Services
- Continued internal case conferences and discussions involving the Provider Network regarding members who require frequent, high intensity services due to severity of illness
- Development and participation of UM staff in the Outcomes Improvement Committee lead by Clinical Practice Improvement

Partial Hospitalization

Partial Hospitalization is a cost-effective diversion from inpatient hospitalization. New Oakland Child-Adolescent & Family Center (NOFC) served 931 consumers in FY 21. This was only 5

consumers (under 1%) less than in FY 20. NOFC continued to serve DWIHN consumers throughout the COVID-19 pandemic and adhere to all CDC guidelines. Average length of stay for Partial in FY 21 was 9.3 days.



Source: DWIHN Claims database as of 1/12/2022

Results and Analysis

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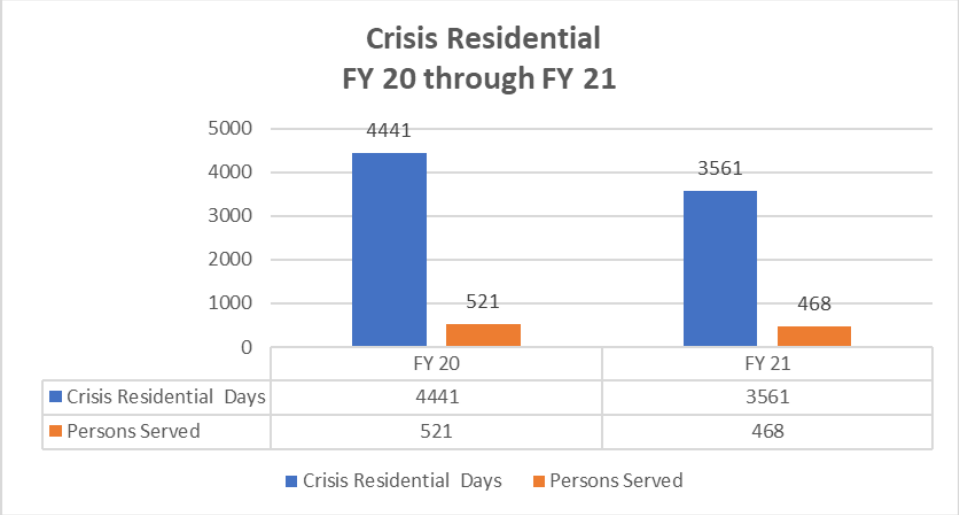
Crisis Residential Units



Source: DWIHN Claims database as of 1/12/2022

Results and Analysis

Hegira is the sole CRU adult provider with 2 locations: Oakdale House and Boulevard Crisis Residential. Inc. Safehaus serves children with serious emotional disturbance and served 142 children compared to 88 the previous year. Hegira served the remaining 326 adults with serious mental illness at Oakdale House and Boulevard Crisis Residential. The average LOS for Crisis Residential was 8 days in FY 21 down 9 days from FY 20. The number of available beds at both adult Crisis Residential decreased at the beginning of the pandemic (March 2020) from 21 total beds to 11 total beds. In accordance with the State of Michigan and CDC's guidelines for social distancing, only one member was allowed to occupy a room at a time, effectively cutting the bed capacity in half. These restrictions were lifted toward the end of the FY.

The number of consumers who received Crisis Residential Services decreased 10% from 521 consumers served in FY 20 to 468 served in FY 21. Likewise, the number of days utilized decreased 19% from 4441 in FY 20 to 3561 in FY 21. This decrease can be linked to DWIHN's efforts to ensure members receive medically necessary treatment at the appropriate level of care. There was also an internal workgroup that was formed to address the length of stay as well as the type of referrals best suited for CRU. Additionally, DWIHN continues to educate its screening entities on the types of services available for members.

The average LOS for Crisis Residential was 8 days in FY 21 down 9 days from FY 20.
In the FY 21 Utilization Management Annual Report, New Oakland reported, "Over the past 2 years, our volume for requests for services have remained steady, even during the peak of COVID-19. We have also seen more limitation of services being provided at both the outpatient level including CLS/Respite services, wraparound services, in-home services, etc. as well as higher levels of care including crisis residential bed availability and inpatient hospitalization bed

availability. Crisis Residential has never been available for individuals with intellectual disabilities making treatment and crisis planning as well as implementing diversion programs more challenging. A meeting with MDHHS and DWIHN was recently held regarding the special needs of the IDD population and to request funding be directed to these higher levels of service.

State Hospitalizations

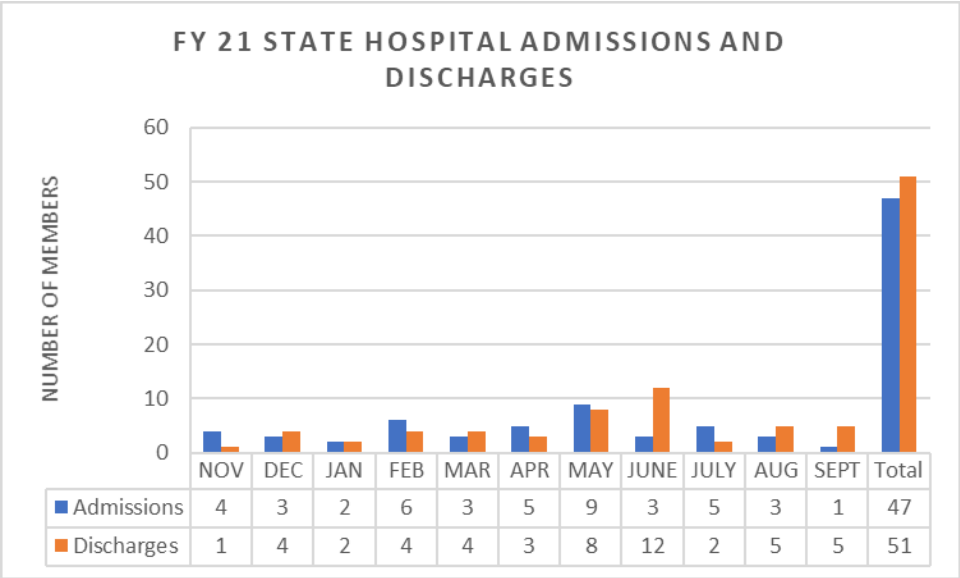
DWIHN monitors the admissions and discharges of all Wayne County consumers in the state hospital system. The system consists of the Center for Forensic Psychiatry, Hawthorn Center for Children and three psychiatric hospitals for adults: Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital. Walter Reuther is the assigned hospital for the Detroit-Wayne area, but consumers are placed according to their individual treatment needs. Specific to UM, the State Hospital Liaisons are embedded within hospital processes to facilitate coordination of activities between state hospital facilities and network providers such as placement and NGRI oversight. Liaisons also provide technical and subject matter expertise on DWIHN policies and procedures and ensure the best utilization of resources by managing state hospital length of stays via admissions and discharges.

Throughout FY 21, state hospital bed availability has been limited resulting in extended wait times for admission. At the end of the fiscal year, wait times in excess of six to twelve months were standard across all hospitals. Priority for forensic admissions, an increase in community hospital referrals, and limited community placement options remained challenges to the state hospital admission process. Additionally, the COVID-19 pandemic exacerbated these challenges as state hospitals were forced to place admissions and discharges on hold intermittently to treat and prevent COVID cases among patients and staff. Currently, all hospitals have established quarantine units and have restricted outside visitors/providers to prevent COVID transmission.

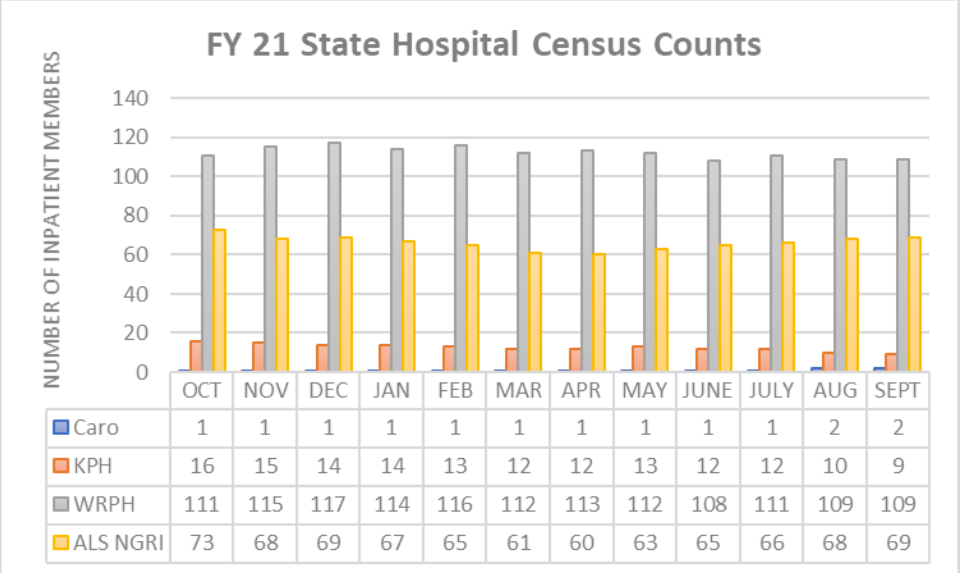
To address these challenges, DWIHN consulted with MDHHS to address the shortage of state beds and expanded efforts among the Wayne County Jail, Center for Forensic Psychiatry, COPE, and crisis providers to explore placement alternatives. Specifically, efforts from diversion programs such as the DCPP (Direct-to-Community-Placement Program) facilitated by MDHHS and coordinated by liaison staff have expedited the release of consumers found Not Guilty by Reason of Insanity (NGRI) and Incompetent to Stand Trial (IST). Additionally, implementation of the MCTP (MDHHS Community Transition Program) has assisted in liaison placement efforts for significantly challenging cases with multiple barriers resulting in high recidivism, acuity, and length of stay.

During the fiscal year, state hospital census counts were consistent despite COVID outbreaks and quarantines. Due to the extensive state hospital wait list, beds were immediately filled following discharge, leaving few vacancies and stagnant census counts.

Individual placement barriers include variables such as legal status, minimal family support, substance use history, criminal history, and co-morbid health conditions, have been longstanding challenges to discharge and were intensified by COVID-19. To address these barriers, the oversight of discharge and placement activities were transferred to the Residential Department at the end of the quarter for increased monitoring and supervision.



	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	Total
Admissions	4	3	2	6	3	5	9	3	5	3	1	47
Discharges	1	4	2	4	4	3	8	12	2	5	5	51



	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT
Caro	1	1	1	1	1	1	1	1	1	1	2	2
KPH	16	15	14	14	13	12	12	13	12	12	10	9
WRPH	111	115	117	114	116	112	113	112	108	111	109	109
ALS NGRI	73	68	69	67	65	61	60	63	65	66	68	69

Results and Analysis

During FY 21, state hospital admissions, discharges, and census counts remained relatively static. These numbers did not differ greatly from those of the previous fiscal year and in fact were nearly the same. This indicates that the impact of COVID-19 was not nearly as great on the overall maintenance of admissions and discharges but were more significant in the day-to-day functions of state hospital activities. Similarly, numbers of NGRI members on leave in the community were also consistent and relatively unchanged. Though, the number of members released on NGRI status in the community decreased over the course of the fiscal year with the lowest numbers occurring mid-year. This was likely due to the rebounding effects of COVID-19 following state and federal restrictions on all movement at the beginning of the pandemic. NGRI numbers were increasing toward the end of the fiscal year, but at a much slower rate than in previous years. An increase in discharge barriers, limited available placement settings, and staff shortages have also contributed to this decrease, but numbers are expected to improve next fiscal year with oversight and supervision now provided by the DWIHN Residential Department.

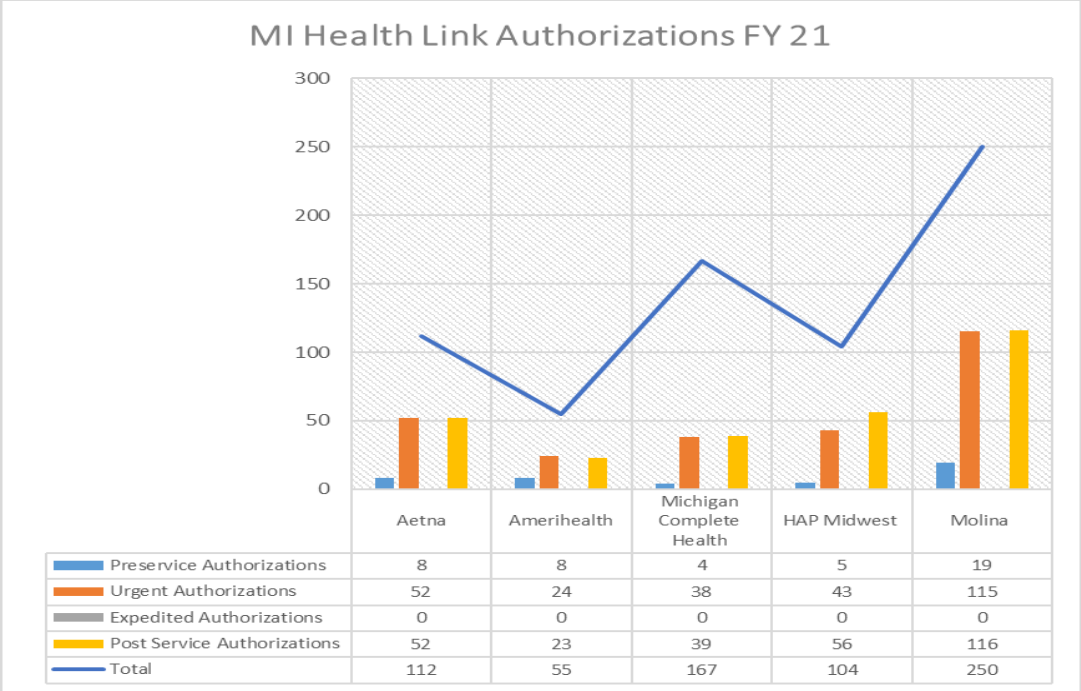
State hospital wait lists maintained by DWIHN will continue into the next fiscal year. Wait times have been increasing since the beginning of the fiscal year as MDHHS mandates have excluded state hospital admissions from the community with exceptions only for cases delayed in emergency departments. Wait times were initially as long as 9 months but increased to 12 months as state hospital beds were restricted. DWIHN has explored multiple options to divert state hospital admissions, but inpatient requests continue, highlighting the need for state hospital level of care. To address this ongoing issue, DWIHN must continue to work collaboratively with MDHHS to further define criteria for state hospital admission, expedite discharges, and educate community hospitals on appropriate state hospital referrals. Community resources must also be strengthened to support diversion efforts and decrease state hospital recidivism.

MI-Health Link (Dual Eligible) Program

MI Health Link is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual needs. Also, there are no co-pays for in-network services and medications.

For MI Health Link enrollees, all behavioral health services covered by Medicare and Medicaid are managed by Michigan Pre-paid Inpatient Health Plans (PIHPs). Behavioral health services are delivered through the local Community Mental Health Service Providers (CMHSP). DWIHN provides behavioral health services for members dually enrolled in one of 5 ICOs: AmeriHealth, Aetna, Michigan Complete, Molina and HAP Midwest. The Agency Profile within I-Dashboards indicates 5,199 MI Health Link consumers were enrolled with DWIHN in FY 21, compared to the

5,271 members reported as enrolled last fiscal year. MI Health Link enrollees are a significantly small subset of DWIHN members. (7.09%).



	Aetna	Amerihealth	Michigan Complete Health	HAP Midwest	Molina
Preservice Authorizations	8	8	4	5	19
Urgent Authorizations	52	24	38	43	115
Expedited Authorizations	0	0	0	0	0
Post Service Authorizations	52	23	39	56	116
Total	112	55	167	104	250

Source: Monthly ICO Authorization Reports 2/2022

Results and Analysis

The ICOs request data for authorizations that required manual approval. Outlined above are the number of authorizations by type per ICO for FY 21. Molina continues to have the largest volume of authorizations, with a total of 250 and Amerihealth has the smallest amount, with only 55 at the end of the FY. There were 112 authorizations for Aetna, 167 for Michigan Complete and 104 for HAP Midwest. From Quarter 1 to 2, there was a 24.7% decrease in authorizations. Authorizations increased 14.9% from Quarter 2 to 3 and decreased 13.2% from Quarter 3 to 4.

The UM Department was able to collaborate with IT to develop a monthly ICO report during FY 21 to provide a more accurate description of the number of authorizations by type and ICO. Further developments include a method for providers to request expedited authorizations and dismissal of authorizations entered in MHWIN. The Department continues to participate in monthly ICO meetings with each entity to ensure compliance with CMS and Medicare standards of service provision.

Outpatient Services

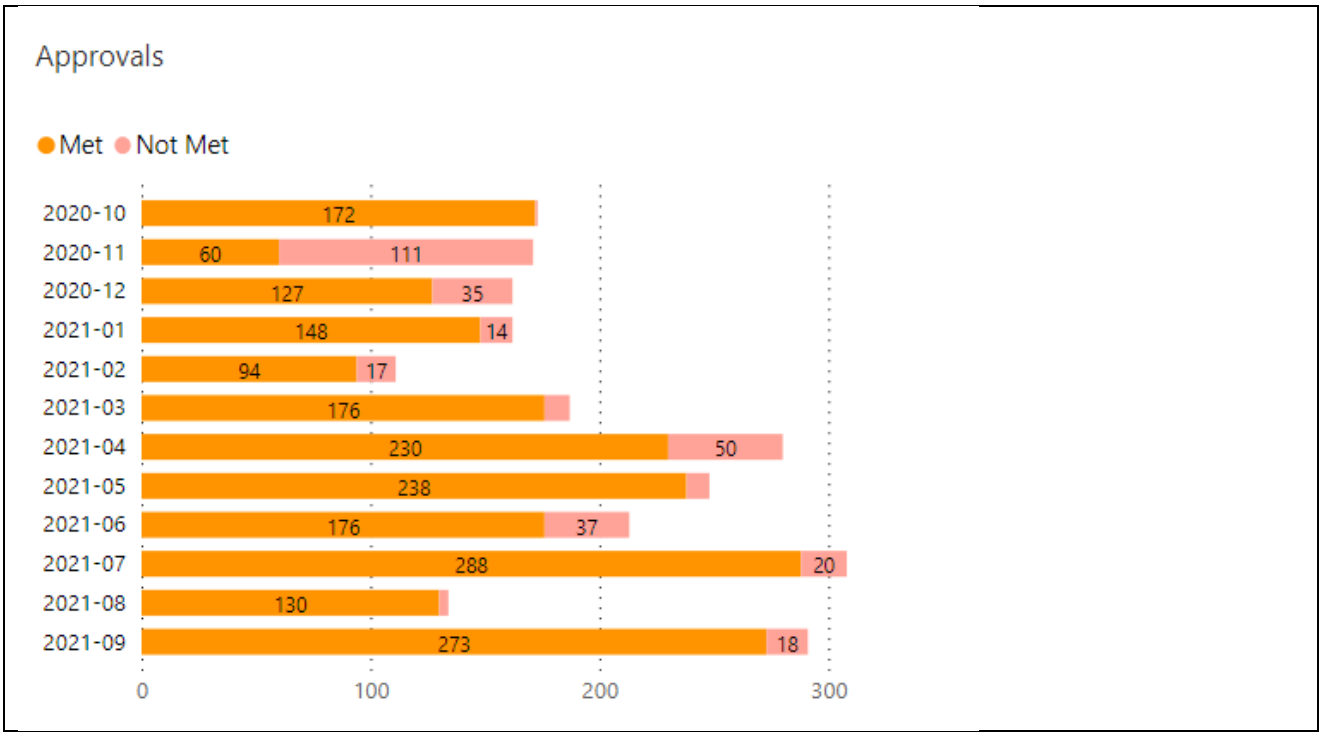
Service Utilization Guidelines (SUG) were developed and embedded into MHWIN for many of the outpatient services provided throughout the network. Requests for services are auto approved in MHWIN unless they fall outside of the SUG. This requires a manual review for medical necessity by UM Clinical Specialists within 14 days of the request. Updates to reporting and accessibility to data during FY 21 allowed for closer monitoring of the number of approvals by each UM Clinical Specialist as well as the volume of approvals beyond the 14-day timeframe for standard requests.

During FY 21, there were 2,440 outpatient authorizations manually approved by UM Clinical Specialists for adults and children within the Seriously Mentally Ill (SMI), Intellectually Developmentally Disabled (IDD), MI Health Link (MHL) and Serious Emotional Disturbances (SED) lines of business. There were 329,478 authorizations auto approved; meaning the request fell within with service utilization guidelines and required no involvement from the UM Clinical Specialists. This is inclusive of the lines of business outlined above. Out of the 2,440 authorizations, 13.44% were authorized beyond the 14-day timeframe while 86.56% were approved within 14 days, which is 3.44% below the 90% timeliness standard. There were 1370 (56.15%) authorizations approved within 1-4 days of receipt for the fiscal year.

July 2021 had the highest number of authorizations with 308, while there were only 134 authorizations approved in August. During November 2020, 64.91% of authorizations were approved after the 14-day timeframe due to issues with the outpatient authorization queues in MHWIN resulting in an increase of requests requiring manual review. Increases in the number of allowable units as well as technical assistance from PCE, resolved the issues and decreased the number of requests in the queues.

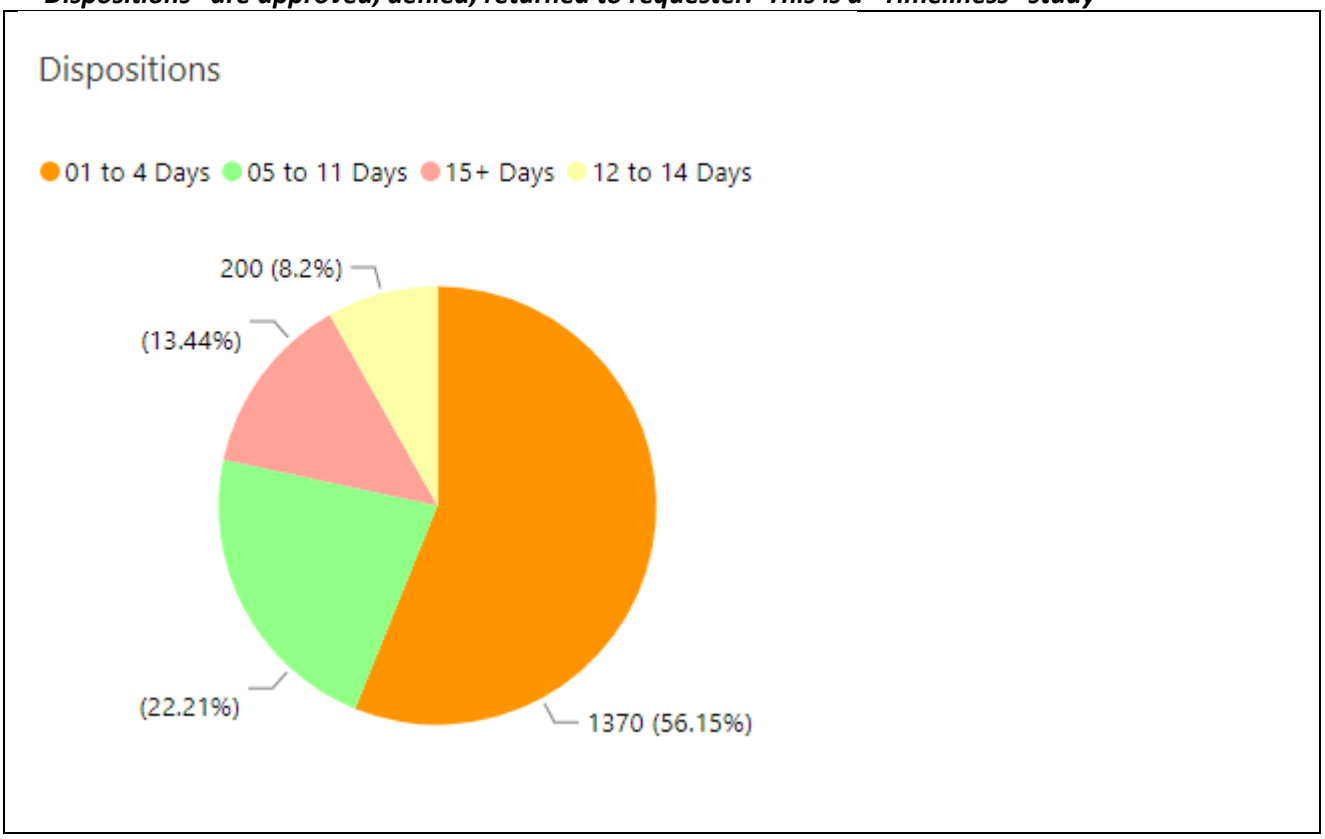
Planned Interventions for FY 22:

- An in-depth analysis of the number of auto-approved authorizations versus those authorizations that required manual review, by each line of business per population
- Continued review of the authorization process including reducing the number of provider errors resulting in returned requests
- Evaluate implementation of an administrative denial process for UM outpatient requests that require additional information, but the provider has been unresponsive or no provided the requested updates



Source: Power BI Authorization Approvals

"Dispositions" are approved, denied, returned to requester. This is a "Timeliness" study*



Source: Power BI Authorization Approvals

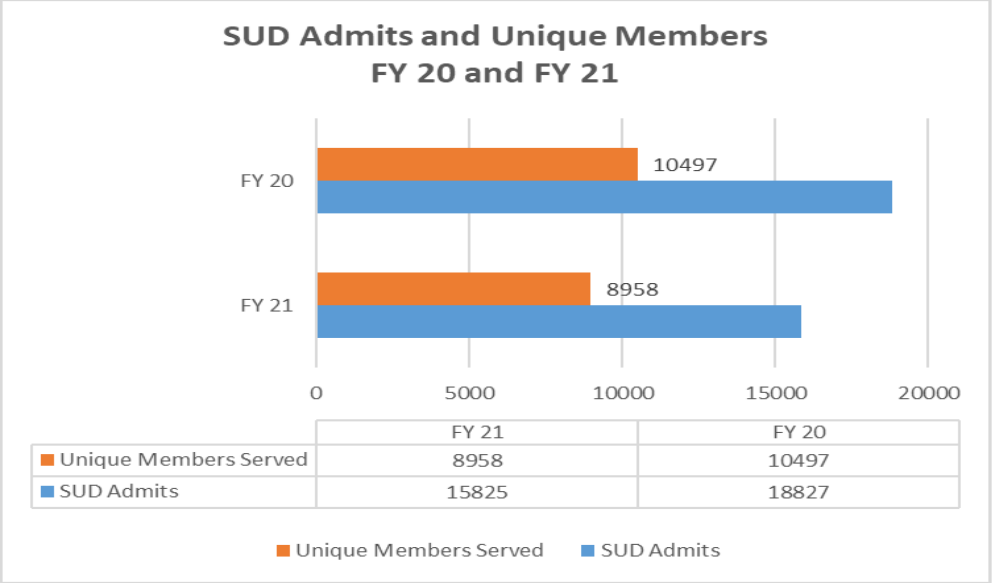
Substance Use Disorder Services (SUD)

DWIHN'S access center conducts initial screening and referral for SUD services based on the American Society of Addiction Medicine (ASAM) level of care and medical necessity criteria. The UM Department's SUD Review Specialists provide medical necessity reauthorization determinations of SUD services for all levels of care including withdrawal management, residential services, medication assisted treatment (MAT), intensive outpatient, outpatient, and recovery services. UM SUD staff completed 15,813 authorizations in FY 21.

There were 8,958 unique individuals that received SUD services for FY 21. This is a 15% decrease from FY 20 with 10,497 unique individuals served. Unique members can also be referred to as unduplicated clients. Consistent with the decrease in individuals served, there were 15,825 admissions, a decrease of 16% from FY 20 with 18,825 admissions. This decrease can be attributed to continuation of COVID-19 which reduces the capacity of many providers to serve consumers in both residential and outpatient settings.

Results and Analysis

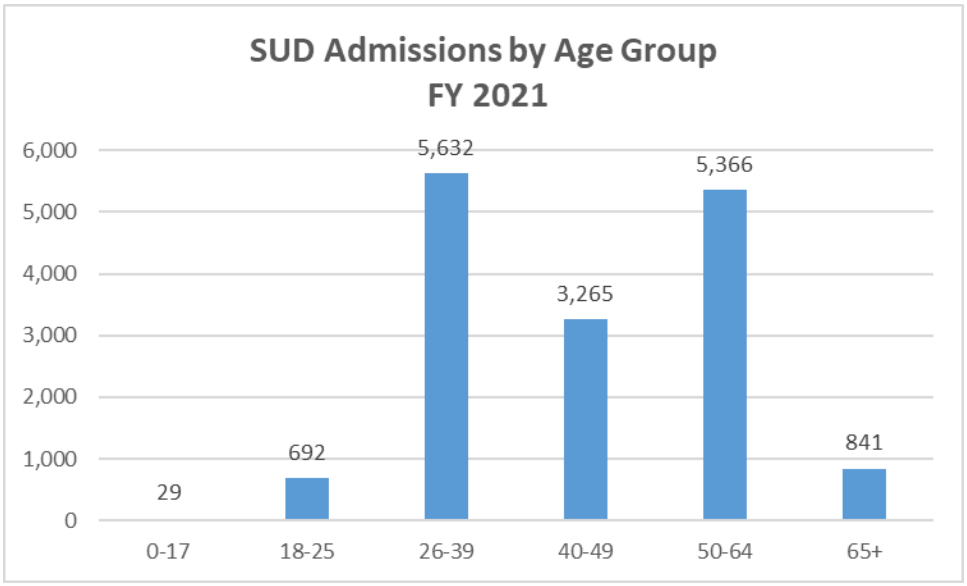
The bar graph below shows the trend of admissions and the number of unique individuals served for the past 2 fiscal years. From FY 20 to FY 21, there has been a 15% decrease in the number of individuals served. The decrease in persons served in FY 20 from FY 21 may be attributed to the continuation of the COVID-19 pandemic as well as staffing challenges at the provider level. Even though national statistics indicated an increase of people suffering with substance use disorders and anxiety and depression, admissions decreased by 16%. Consumers were reluctant to seek face-to-face services due to concerns of the pandemic in relation to health and safety. Each change in level of care is considered an admission. Some individuals receive more than one level of care, such as withdrawal management, followed by residential services and outpatient and/or recovery services. Each unique individual averaged 1.8 admissions.



Source: MH-WIN Admission and Discharge Records 1/7/2022

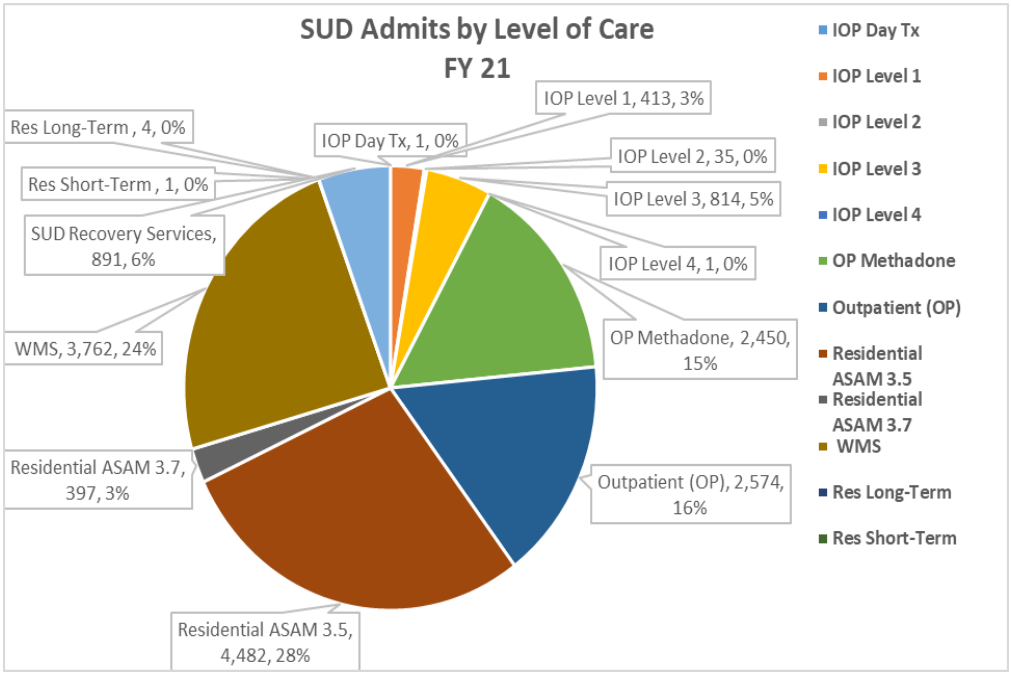
Results and Analysis Continued

The age distribution metric has remained relatively constant over the last several years. During FY 21, 36% percent of individuals admitted were between 26-39 years of age. Thirty-four percent (34%) of individuals admitted were between 50-64 years of age; 21% were between the ages of 40-49 years of age; 5% were for individuals between 65+ years of age and 4% were for individuals aged 18-24, and less than 1% were admissions individuals between 0-17. The gender distribution for admissions for FY 21 is 65% male and 35% female, very consistent with the previous FY that was 63% male and 37% female.



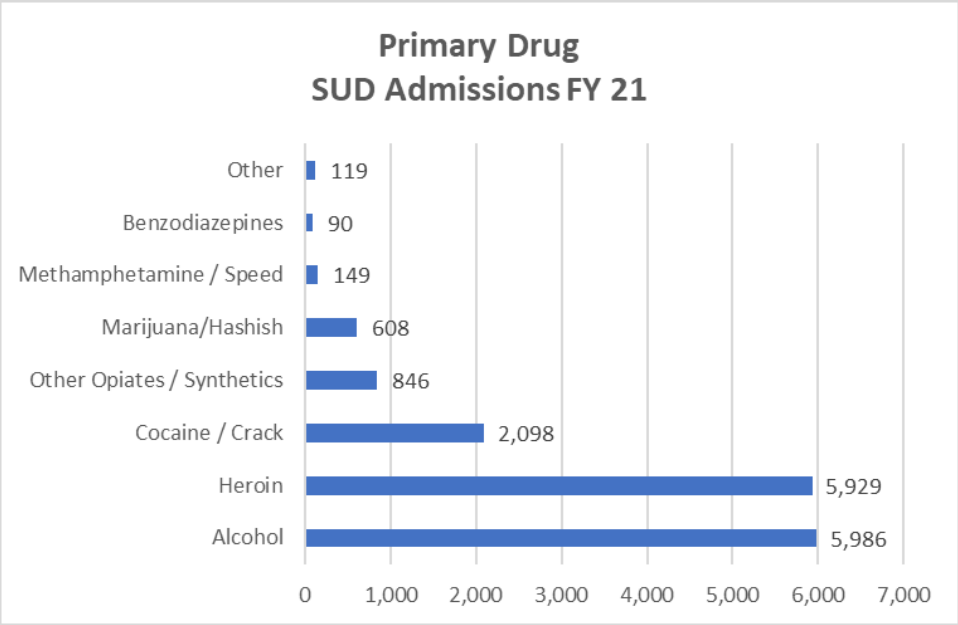
Source: MH-WIN Admission and Discharge Records 1/7/2022

Admission level of care is determined at time of access to services according to ASAM criteria. Any change in level of care after the admission requires review and approval of presented clinical justification by the provider to the Access Center. Later in treatment, changes in level of care must be approved by UM staff. The chart below shows the SUD admissions by level of care for FY 21. The admissions are inclusive of new admits that occurred in the current fiscal year. It should be noted that, MDHHS discontinued use of the labels "short-term" and "long term residential" and began using the ASAM levels of care of 3.3, 3.5 and 3.7. However, Short-term and long term residential is included in the pie chart below as COPE used for several cases.



Source: MH-WIN Admissions and Discharge Records 1/7/2022

For FY 21, Withdrawal management services (WMS) previously detoxification, accounts for 24% of admissions, up 2% from FY 20. If all levels of residential services are combined, it accounts for 31% of admissions, down 1% from 32% in FY 20. Outpatient admits account for 16% of admissions, up 3% from 13% last year. Intensive Outpatient, IOP Level 1 is 3%, IOP Level 2 and 4 less than 1%, and Intensive Outpatient Level 3 account for 5% of admissions. Admissions for Outpatient - Methadone account for 15% of admissions, down 1% from 16% followed by Recovery Services at 6%, down 3% from 9% last FY. (Note: some categories that are less than 1% of whole, reflect 0% even though there are admissions reflected in those categories). The percentage served in each category remains relatively consistent and is correlated with the available capacity of the provider network. Even though number of admissions was reduced overall, the level of care service mix remains consistent.



Source: MH-WIN Admissions and Discharge Records 1/7/2022

Thirty eight percent (38%) of the SUD admissions were for Alcohol, followed by 37% for Heroin, 13% for Crack/Cocaine, 5% Opiates, 4% Marijuana/Hashish and the remaining 1% each for Methamphetamine, Benzodiazepines, and Other.

UM SUD staff completed 15,813 authorizations in FY 21 compared to 24, 413 in FY 20. There were several system glitches that contributed to the reduction including authorizations auto-approving at provider levels. Additionally, the reduced number of admissions would contribute to the lower volume of authorizations. Timeliness of authorizations which measures how long it takes UM staff to render a disposition is addressed later in the report.

In 2021, UM worked with finance, IT, and SUD Administrators, to implement detailed and significant changes due to the MDHHS Modifier and Code changes effective 10/1/22. Several trainings were held with the SUD provider network and some of the issues and challenges continue to be addressed into FY 22. New procedure codes were rolled out and fee schedules were modified. All changes are reflected in the applicable rate sheets and service utilization guidelines. Several bulletins and memorandums were created to address the change.

Finance Pillar

UM Program Description Goal 5- *Promote collaboration and provide guidance to the system by identifying patterns of behavioral health service utilization by funding source and by monitoring over and underutilization of services using dashboards.*

Strategic Plan Goal D*: Develop a system that helps track over and under utilization*

Goal Status: Partially Met

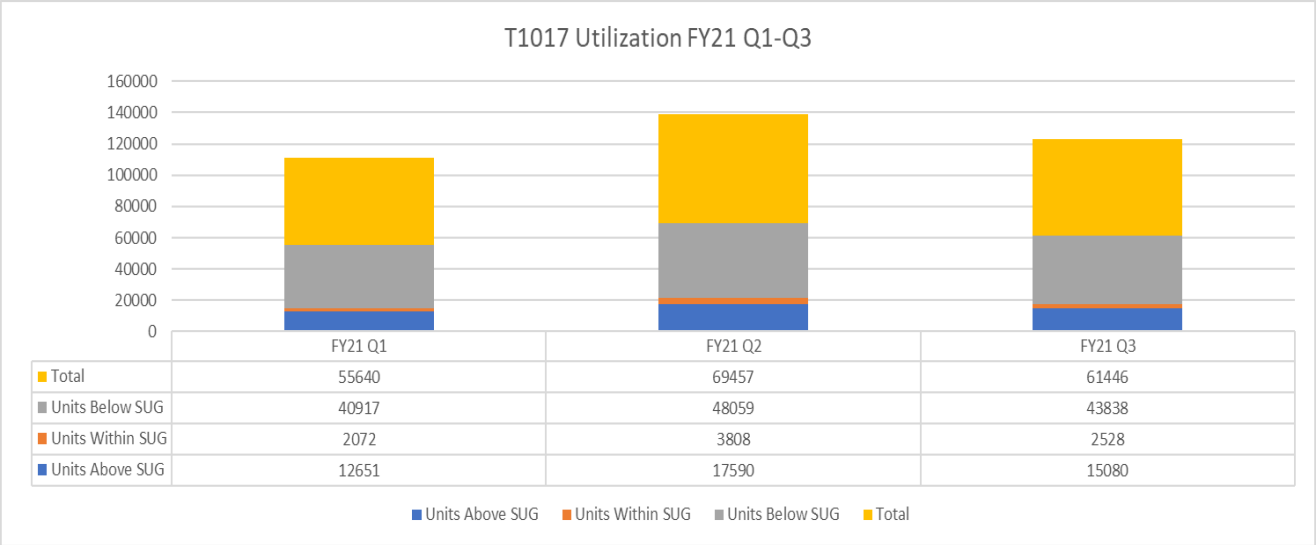
Over and Under Utilization

The UM Department has access to data to help monitor the over and underutilization of all behavioral health services. Adjustments to the Service Utilization Guidelines are also made based on the analysis of the data, feedback from the Provider Network and the volume of requests within the authorization queue for certain services. During FY 21, the number of allowable units for Case Management (T1017), Medication Administration (96372), Treatment Planning (H0032), Assessments by Non-Physician (H0031) and Mental Health Clubhouse services (H2030) were all increased.

The use of H2030 (Clubhouse) was reviewed during the 4th quarter of FY 21. The current SUG for code H2030 is 5840 units per year/1460 per quarter/486 units per month/6 hours per day. For Q4 of FY 21, there was consistent underuse of this service per claims reporting. Out of the 484 requests for this service, 50% (243) authorizations were submitted using the GT/telehealth modifier. The highest number of units received per quarter was 618 and the lowest was 1, averaging 92 units for the quarter/$345.47.

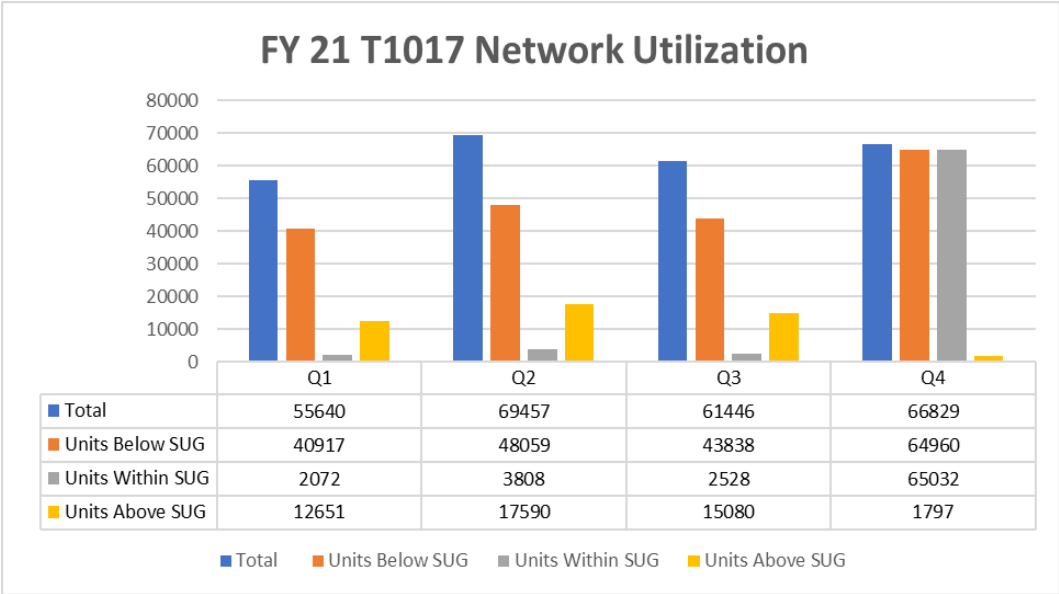
Overutilization can highlight an increased need for services due to changes in the assessed needs of the members. Further, an increased use of community-based services suggests that members may be receiving more treatment at lower levels of care. Contrarily, requests for increased number of units without clinical justification, highlights a potential need for education at the Provider level including discussions around waste and abuse. The Department will continue to explore and analyze factors contributing to over and under-utilization of codes and services in collaboration with Quality and the Provider Network

The use of T1017 (case management) and H0039 (ACT) during Quarters 1-3 of FY 21 were evaluated and the results were shared with the DWIHN Administrative team and the Provider Network and are depicted below, as an example. Of note, T1017 was increased prior to the utilization analysis conducted later in the fiscal year. The adjustment was in response to an influx of requests populating in the UM Authorization queue. Any subsequent requests after the increase to the SUG, would allow for auto-approval of the authorization. Quarter 4 data for T1017 and H0039 is also outlined below.



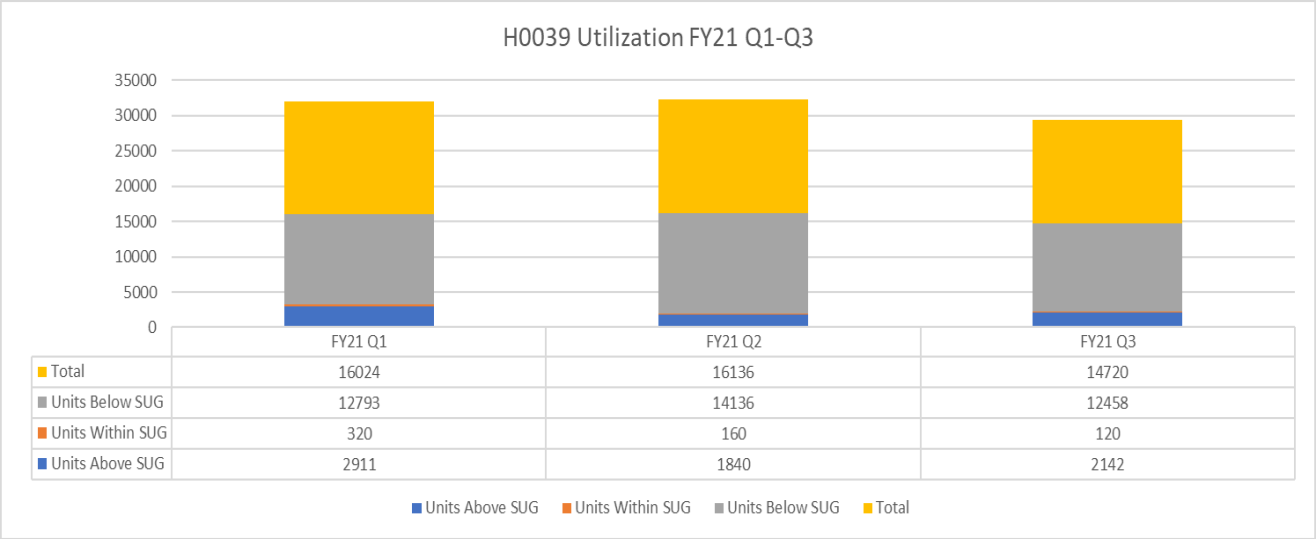
	FY21 Q1	FY21 Q2	FY21 Q3
Total	55640	69457	61446
Units Below SUG	40917	48059	43838
Units Within SUG	2072	3808	2528
Units Above SUG	12651	17590	15080

***The SUG for code T1017 is 8 units per month/24 units per quarter/96 units per year. Across the network for FY21, T1017 is utilized above the SUG approximately 24%. The average amount utilized above the SUG is 13 units per month; 5 units above the monthly SUG. Conversely, T1017 is utilized below the SUG approximately 71% across the network for FY21. The average amount received/utilized is 2 units per month per member, which is 6 units below the allotted monthly SUG. Across the Network, T1017 is utilized 1% of the time within the allotted SUG; 8 units per month/24 units per quarter/96 units per year.*



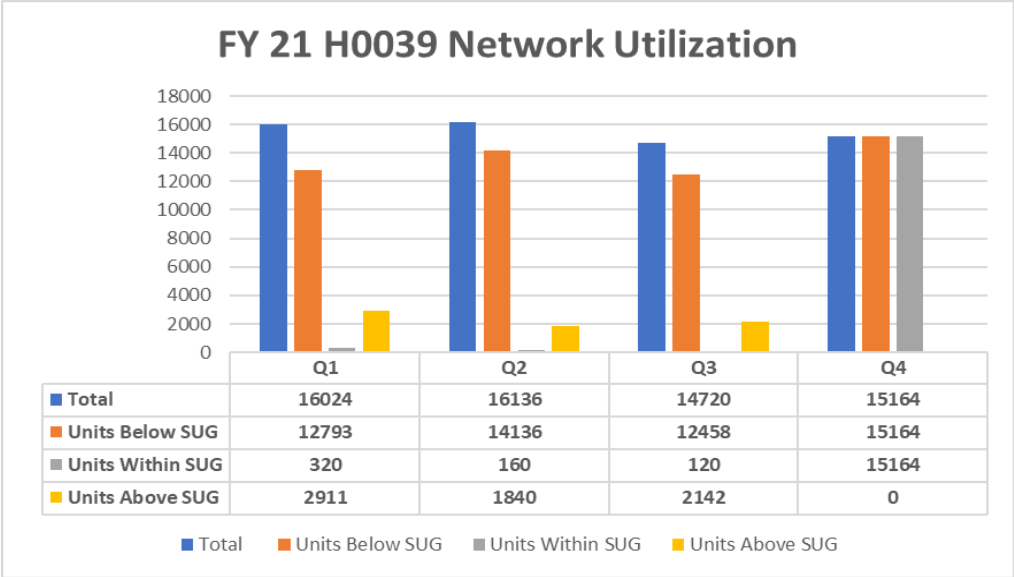
	Q1	Q2	Q3	Q4
Total	55640	69457	61446	66829
Units Below SUG	40917	48059	43838	64960
Units Within SUG	2072	3808	2528	65032
Units Above SUG	12651	17590	15080	1797

The graph above depicts the network utilization of Case Management, T1017 for FY 21. The SUG for code T1017 is 8 units per month/24 units per quarter/96 units per year. During FY 21, there was a 78% occurrence of units below the SUG and units above the SUG occurred in 18.59% of authorizations.



***The SUG for code H0039 is 40 units per month/120 units per quarter/480 units per year. Across the network for FY21, H0039 is utilized above the SUG approximately 14%. The average amount utilized above the SUG is 54 units per month; 14 units above the monthly SUG. Conversely, H0039 is utilized below the SUG approximately 84% across the network for FY21. The average amount utilized/received per ACT member is 10 units per month; which is 30 units below the monthly allotted SUG.*

Source: Impact of UM Guidelines on Utilization



The SUG for code H0039 is 40 units per month/120 units per quarter/480 units per year. The graph above depicts the network utilization of Assertive Community Treatment, H0039 for FY 21. During FY 21, there was an 87.9% occurrence of units below the SUG and units above the SUG occurred in 11.11% of authorizations. The number of units below the SUG increased 18.5% from Q1 to Q4.

Quality Pillar

UM Program Description Goal 6: *Engage community stakeholders in the development and implementation of processes that promote clinical review procedures, practices and correction actions to ensure systemwide compliance with DWIHN, State, Federal regulations and National Committee for Quality Assurance (NCQA).*

Strategic Plan Goal E- *Ensure compliance with monitoring standards*

Goal Status: Met

Timeliness of UM Decision-Making

NCQA UM 5: Timeliness of UM Decisions, Element A: Timeliness of UM Decision Making, Element B: UM Timeliness Report

The UM Program Description articulates the need to ensure fair and timely utilization decisions. Below is a breakdown of the timeliness of decision making for FY 21 by delegated entity and DWIHN line**s** of business. Timeliness of electronic or written notification of the UM decision is also required in accordance with the turnaround time frame given for the type of request. The Timeliness of UM Decisions Making and UM Notification is reported on a quarterly basis during the Utilization Management Committee meeting**.**

Results and Analysis

All the delegated entities met the 90% threshold for timeliness of urgent preservice UM decision making during FY 21.

Timeliness of UM Decision Making-COPE

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	N/A	5618	N/A	N/A
Denominator#	N/A	5984	N/A	N/A
Rate	N/A	93.8%	N/A	N/A

Source: COPE 12/16/2021

Timeliness of UM Decision Making Children's Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	129	N/A	N/A
Denominator #	N/A	129	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: Children's Center 12/16/21

Timeliness of UM Decision Making-The Guidance Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	153	N/A	N/A
Denominator #	N/A	153	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: Guidance Center12/16/21

Timeliness of UM Decision Making-New Oakland Family and Child Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	707	N/A	N/A
Denominator #	N/A	707	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: NOFC 12/16/21

Timeliness of UM Decision Making-DWIHN MI Health Link Program

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator *	10	3	184	4
Denominator#	10	3	245	4
Rate	100%	100%	.75%	100%

Source: DWIHN Dashboard 12/16/2021

Timeliness of UM Decision Making- Substance Use Disorder

SUD met the 90% threshold for timeliness of urgent concurrent UM decision making during FY 21. The non-urgent category for SUD has also met the 90% threshold for timeliness of UM decision making during FY 21.

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	4435	N/A	11173	N/A
Denominator#	4578	N/A	11279	N/A
Rate	96.8%	N/A	99%	N/A

Source: DWIHN Dashboard 12/16/21

Timeliness of UM Decision Non-Urgent Preservice Decision Making – Autism

Timeliness for UM Decision Making for Autism has met the 90% threshold for non-urgent preservice UM decision making.

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	N/A	N/A	3589	N/A
Denominator#	N/A	N/A	3593	N/A
Rate	N/A	N/A	99%	N/A

Source: DWIHN Dashboard 12/16/21

Denial and Appeal Category Analysis

Denials and appeals are one of the UM "must-pass" standards for NCQA accreditation. During FY 21, a review of all denials and appeals indicated each of the following was handled according to established procedures. During the NCQA accreditation review, all requirements in this area were met. However, there is an HSAG FY 21 PIHP Corrective Action Plan for Standard VI-Coverage and Authorization of Services. The timeline for completion of the corrective action plan is April 1, 2022. Also, during FY 21, the Michigan Peer Review Organization (MRPO) served as DWIHN's independent review organization.

Outlined below are denials that did not meet MCG medical necessity criteria for continued inpatient hospitalization. Also included are administrative denials due to the provider not adhering to timeliness guidelines for submission of authorizations. Lastly, are the total number of appeals and appeal dispositions.

Appeal Disposition	Denials	
	Medical Necessity Denial	Administrative Denials
	106	356
Appealed	42	22
Upheld	16	3
Overturned	20	16
Partially Denied	6	3

*Administrative denials issued due to provider not adhering to timeliness guidelines for submission of authorizations.

Quality Pillar

UM Program Description Goal 7

Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliability procedures and tools, pre-service, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications), outcome measurements and remedial activities

Goal Status: Met

Appropriately Licensed Professionals

NCQA UM Standard 4: Appropriate Professionals: Qualified licensed health professionals assess the clinical information used to support UM decisions. Each of the crisis vendors have presented a chart of crisis staff credentials, license dates and supervision of limited licensed staff by fully licensed staff.

UM Program Descriptions

All UM delegate FY 2019-2021 Program Descriptions are due for review/revision for FY 2022-2024.

Affirmative Statements

Each of the delegated entities provided spreadsheets and copies of Affirmative Statements signed by all UM decision makers for FY 2021.

Timeless of UM Decision Making by Delegated Entities

Below is a breakdown of the timeliness of decision making for FY 21 by delegated entity and DWIHN lines of business. All the delegated entities met the 90% threshold for timeliness of urgent preservice UM decision making during FY 21.

Timeliness of UM Decision Making-COPE

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post-Service
Numerator*	N/A	5618	N/A	N/A
Denominator#	N/A	5984	N/A	N/A
Rate	N/A	93.8%	N/A	N/A

Source: COPE 12/16/2021

Timeliness of UM Decision Making Children's Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	129	N/A	N/A
Denominator #	N/A	129	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: Children's Center 12/16/21

Timeliness of UM Decision Making-The Guidance Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	153	N/A	N/A
Denominator #	N/A	153	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: The Guidance Center 12/16/21

Timeliness of UM Decision Making-New Oakland Family and Child Center

	Urgent Concurrent	Urgent Preservice	Non-Urgent Preservice	Post Service
Numerator *	N/A	707	N/A	N/A
Denominator #	N/A	707	N/A	N/A
Rate	N/A	100%	N/A	N/A

Source: New-0akland 12/16/2021

Denials and Appeals

There were no denials and appeals from any of the crisis vendors during FY 21.

Interrater Reliability

DWIHN purchased the inter-rater reliability (IRR) module from MCG to be used with the screening entities, providers, and DWIHN UM staff. All staff who make UM decisions are tested with the IRR module to ensure consistent application of the guidelines and medical necessity criteria. The chart below includes only the delegated entities' performance. They are included again, later in the report, in the comprehensive IRR chart, that includes DWIHN, under the workforce pillar. During FY 2021, all delegated UM decision makers eventually met/exceeded the 90% passing score. There were 16 staff during test administration and report preparation that required corrective action.

FY 21 Interrater Reliability Summary- Delegated Entities Only

GROUP	# OF STAFF SUCCESSFUL AFTER 1ST/2ND ADMINISTRATION	# OF STAFF REQUIRING CORRECTIVE ACTION PLAN extending into FY 22	As of 10/21/2021 #Successfully Passed
COPE	36	10	36
New Oakland	14	0	14
Children's Center	7	0	7
TGC	8	1	8
ACT Staff – TGC, NEG, CCIH, LBS, AWB, CCS, Hegira, DCI, Team	43	5	43
TOTALS	108	16	108

Prior Authorized Review (PAR) Audits

Chart reviews of PARS were conducted quarterly by the Crisis Service Vendors & the Access Center and DWIHN. DWIHN also reviewed the submitted report. Documentation and content are the measures included in the tool. Per COPE's analysis of the Prior Authorized reviews, there were no omissions found in the request for service, PAR or PAR-D. New Oakland Family Centers reported no significant findings during their audit process. Out of the 41 PAR audits completed by The Guidance Center, there were no noticeable trends, however there were audits where vitals were not documented as well as full names of ER Social Workers with credentials. At the Children's Center, a change in management resulted in an interruption with this function. DWIHN will follow up with the provider to ensure ongoing compliance with this area.

There are noted improvements with the documentation provided by the screening entities but there were some instances in which DWIHN UM was required to inform COPE of missing MCG Indicia Episode as it supports the medical necessity criteria for the identified level of care. Failure to complete the episode of care within the PAR prevents the completion of the Optimal Recovery Course during the continued stay review process. This matter was discussed with COPE leadership and any occurrences are addressed in real time.

During FY 21, most of the inpatient providers were transitioned from telephonic and email submission of continued stay reviews to electronic submissions of requests via MHWIN. Trainings occurred with the Provider Network to ensure a seamless transition and to outline the

requirements for the requests. Chart audits were also conducted for the internal continued stay reviews. Upon review, the following areas are noted opportunities for improvement:

- Clear documentation of discharge plans within the continued stay review and discharge summaries, treatment goals and baseline functioning
- Documentation of members' participation in outpatient services and notation of previous treatment history
- Updating of the PAR audit form to eliminate any redundancies within elements and include component that monitor timeliness of review and disposition
- Ensure the audit form clearly reflects the areas within the continued stay/discharge modules
- Ongoing training for the Provider Network to ensure all components are included in the continued stay reviews and discharge summaries.

Crisis Vendor Covid-Related Practices

The screening entities experienced challenges due to the continuation of the pandemic and reported some of the following actions to continue safe and efficient care to consumers:

COPE

- Process for entering the building was updated. Currently employees must record when they come into the building and what their temperature is upon arrival. Staff also must log in and attest that they are not having any symptoms of COVID.
- A zero-tolerance process was put into place to ensure that all employees are wearing their masks appropriately.
- N95 masks were issued to employees working on the crisis stabilization unit. They were sent to Concentra to receive a fit test when issued the mask.
- All mobile staff are equipped with a kit containing masks, gloves, a face guard, and a thermometer to ensure that safety was taken. Cars have been assigned to specific staff per shift and each vehicle is stocked with cleaning supplies.

New Oakland

Many processes were shifted to accommodate the needs of the community while remaining safe. At the start of the pandemic, all screenings both in the community and in the Emergency, Departments were conducted via telehealth.

The Guidance Center

The Guidance Center slowly initiated in person screenings in October 2020 at Children's Hospital of Michigan, then returned to in person screenings at all Wayne County hospitals in July 2021 and continued with in person screenings throughout the remainder of the 20/21 fiscal year.

The Children's Center

Upon returning to in person services, both on campus and within homes and communities, TCC implemented health screenings for all clients. Even when clients were being seen via telehealth, the health screening to determine if there were symptoms or diagnosis for any illness that placed other clients and/or TCC staff and visitors at risk. There are air purifiers added throughout the building, hands free options for opening doors, single family/person restrooms, hand sanitizer throughout the building, temperature checks and health screenings for every individual entering the building. Requested that families only present with those necessary to participate in services. All individuals over the age of 2 are required to wear face coverings. All service areas were restructured to ensure appropriate physical barriers and social distancing for the safety of clients and staff. Processes are in place to notify Campus Operations staff when there is a need to "deep clean" areas related to potential exposures.
Telehealth services for clients who had a recent history of symptoms or diagnosis or were uncomfortable with reporting to campus have continued and have also pivoted to telehealth services in instances when there were potential exposures on campus.

UM Delegate Challenges and Opportunities for Improvement

NCQA UM Standard 12: Delegation of UM

Opportunities for Improvement

The organization uses the findings from the organization's pre-delegation evaluation, annual evaluation or ongoing reports to identify and follow up on opportunities for improvement.

COPE

- Acuity of client has increased and the number of consumers with suicidal and homicidal ideations with plans has increased.
- Request for service have increased since the start of COVID-19 while beds available in the community have decreased. It was difficult to place individuals having a psychiatric crisis but also had COVID.
- Staffing has been difficult due to applicants seeking work from home and employees choosing to find new employment that allows them to work from home as well. **Improvement Opportunity**: Morale has been a focus since the pandemic began. Focus has been dedicated to retention and employee satisfaction.
- Annual Core training series were implemented for each team at COPE. Training included the employees job expectations and documentation from the start of working with a client to when they are discharged.
- How to binders were created for each workstation according to the employees' job that sits at that desk. Includes workflows, processes, and steps to complete documentation.

- While staff recruitment remains a challenge, New Oakland has established new tools and methods for identification, recruitment and onboarding of new Mobile ICS team members.
- Outreach and training for potential candidates and existing staff are subject to continual evaluation and refinement.

New Oakland

Over the last 2 years volume for requests for services have remained steady, even during the peak of COVID-19. However, available services at the outpatient level including CLS/Respite services, wraparound services, in-home services, etc. and crisis residential and inpatient bed availability have been limited. All of these services have been limited or not available for some time. Respite and crisis stabilization for IDD population has not ever been available. The lack or reduction of services makes treatment and crisis planning as well as implementing diversion programs more challenging. **Improvement Opportunity**: The Director of Crisis services reports that a recent meeting was held with MDDHS regarding the need to increase funding to expand the service array, especially for the IDD population.

The Crisis Stabilization team lost staff members who were unable to fulfill these specific requirements. **Improvement Opportunity**: While staff recruitment remains a challenge, New Oakland has established new tools and methods for identification, recruitment and onboarding of new Mobile ICS team members. Outreach and training for potential candidates and existing staff are subject to continual evaluation and refinement.

Crisis Plans

The Children's Center states, "In order to support our compliance with Crisis Plans for clients who have been in inpatient settings having a crisis plan. **Improvement Opportunity:** Our Hospital Liaison now asks clients and parents/caretakers if they felt that their crisis plan was helpful in supporting them in their recent crisis and to alert the ongoing clinician when they have reported that it was not, and they would need a new/updated Crisis Plan completed at their aftercare appointment." This statement presents as an opportunity for all hospital liaisons.

Workforce Pillar

UM Program Description Goal 8 - *Assure fair and consistent UM/review decisions based on MCG, Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or American Society of Addiction Medicine (ASAM) medical necessity criteria by monitoring the application of the applied criteria and service authorizations for behavioral health services (including substance use disorders) using a standard inter-rater reliability process system wide.*

Goal Status: Met

MCG-Indicia

DWIHN was the first Prepaid Inpatient Heath Plan (PIHP) to implement use of the MCG Behavioral Health Guidelines in 2017. When first purchased and rolled out, the interactive software, Indicia was a stand-alone product, with users having to log into multiple applications. DWIHN actively participates in a consortium of the Prepaid Inpatient Health Plans called the Michigan Consortium for Health Excellence (MCHE). Due to requirements from the Parity Act, CMS (the Centers for Medicare and Medicaid Services) mandated MDHHS to have standardized medical necessity criteria to assist in demonstrating parity of behavioral health services statewide. MCHE initiated a Request for Proposal process and after review purchased the use of MCG Behavioral Health Guidelines in 2019. The majority of the PIHPs are using either the static (encyclopedic version of the guidelines) or interactive software in 2021. In FY 21, MCHE negotiated and signed a new three-year agreement for use of the MCG Behavioral Health Guidelines and interactive software, Indicia.

The guidelines are currently used to screen consumers for inpatient and partial hospitalizations as well as crisis residential services. During FY 21, our adult and children's' screening entities and ACT programs screened consumers using the MCG product, Indicia. As of September 30, 2021, 12,459 cases have been entered into Indicia, which averages 36 cases per day since the beginning of the FY 21. In 2021, UM staff began using a social determinant checklist which includes variables that may impact length of stay or hospital discharge. The checklist includes items to evaluate such as housing insecurity, food insecurity, insufficient transportation, utilities, and personal safety risks.

Each year, MCG updates the guidelines after an extensive review and analysis of research and literature. The updates are shared with various committees such as the Utilization Management Committee (4/20/21 meeting) and are available for review in both the MCG Learning Management System and within the guidelines. Each year the Improving Practice Leadership Committee (IPLT) and the Medical Director approve use of the guidelines. DWIHN is currently using the 25th Edition of the MCG Behavioral Health guidelines which were presented and approved at the 11/2/2021 IPLT meeting.

DWIHN recognizes that demonstrating consistent guideline application and identifying staff improvement opportunities can help improve the consistency and delivery of services. As a result, DWIHN purchased the inter-rater reliability (IRR) module from MCG to be used with the screening entities, providers, and DWIHN UM staff. All staff who make UM decisions are tested with the IRR module to ensure consistent application of the guidelines and medical necessity criteria. During 2021, a total of 146 staff received and passed cases studies score of 90% or above. This graph includes the 16 staff that at report preparation did not meet the 90% standard initially and required Corrective Action Plans, including activities such as face-to-face supervision, coaching, education, taking learning modules within the Learning Management System and/or

retraining. The table below reflects the staff groups and results of testing including the number requiring corrective action plans.

Interrater Reliability (IRR)

FY 21 Interrater Reliability Summary

GROUP	# OF STAFF SUCCESSFUL AFTER 1ST/2ND ADMINISTRATION	# OF STAFF REQUIRING CORRECTIVE ACTION PLAN	# Successfully Passed as of 10/21/21
COPE	36	10	36
New Oakland	14	0	14
Children's Center	7	0	7
TGC	8	1	8
DWIHN Residential Unit	17	0	17
DWIHN UM, MDs, SUD, Autism	21	0	21
ACT Staff – TGC, NEG, CCIH, LBS, AWB, CCS, Hegira, DCI, Team	43	5	43
TOTALS	146	16	146

Source: Learning Management System, 10/21/21

DWIHN continues to work with the vendor to assist in developing metrics and functionality that are user friendly to both front-end users and system administrators. MCG quarterly meetings are held with the vendor (MCG) and account representative to continually address any challenges with the system.

Advocacy Strategic Plan Pillar

UM Program Description Goal 9: *Provide collaboration in shaping state and regional policies, procedures and practices relative to utilization management development and implementation of processes that promote clinical review procedure, practices.*

Goal Status: Met

Michigan Consortium

DWIHN is an active member of the Michigan Consortium for Healthcare Excellence (MCHE), MCG was awarded the contract for use of its behavioral health guidelines statewide. This workgroup had focused on procurement of the MCG Behavioral Health guidelines to assist in demonstrating parity. The majority of the PIHPs continued to use or began using the static guidelines or interactive software, Indicia in FY 21. A new three-year contract between MCHE and MCG was negotiated and finalized in FY 21 and will expire on 9/30/2024. The Parity workgroup believes the MCG criteria is one tool that assists in determining medical necessity but must also be used in conjunction with standardized assessment tools while preserving person-centered planning values. MDHHS staff, on an as needed basis, attend the Parity workgroup meetings and will incorporate review and use of the MCG Behavioral Health Guidelines into upcoming state audits.

Results and Analysis

The Parity workgroup continues to work with MDHHS to ensure movement toward parity throughout Michigan. The Parity workgroup finalized a Principles of Parity document that includes the history of the federal mandate including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The document describes current assessment tools (Level of Care Utilization System (LOCUS); CAFAS (Child and Adolescent Functional Assessment Scale); SIS (Supports Intensity Scale) and ASAM-PPC (American Society for Addition Medicine-Patient Placement Criteria used in Michigan that assist in application of medical necessity and benefits. Also described is the need for exception processes to medical necessity guidelines which must include documentation to support exceptions and how they are applied to service planning discussions with individuals served.

III. Status of Utilization Management Department Technology Recommendations

Telehealth

The increased use of telehealth that has been prompted by the COVID pandemic is expected to be a part of the standard of behavioral health care. Barriers to access to care, such as transportation and childcare arrangements have been diminished and continued growth in the use of virtual care is expected to grow. UM proposes the following:

- Technology will need to be developed to track the use of virtual vs. face-to-face care services in the outpatient arena.

- Utilization of this access to service will need to be studied in communities with limited access to broadband and remedial action plans will need to be considered to ensure this does not result in disparity in access to services for the broadband limited communities.
- Provider and consumer experience surveys should be adjusted to evaluate the level of success DWIHN achieves at seamlessly and effectively integrating telehealth into its overall clinical delivery strategy and workflows, consumer/provider satisfaction, operational efficiency and clinical outcomes.

DWIHN addresses the inclusion of developments in technology related to service provision in the Proven Behavioral Health Technology Inclusion Application Guideline policy which establishes the mechanisms in which new behavioral health clinical technologies, or adaptations of existing clinical technologies, will be evaluated and accepted as acceptable practices.

Dashboard/Report Development/Technology

The UM Department continues to collaborate with IT on the development of the following dashboards/reports. The status is described below:

- Inpatient Recidivism – *Report is complete and available*
- Enhancements to the hospitalization dashboard – *The previously used software, I-Dashboards was discontinued and DWIHN is currently using Microsoft Power BI. Claims data is utilized and a 2-year fiscal year lookback is available. Recent enhancements were made in the hospital report to include Population Designations, unique members hospitalized and average and median length of stay.*
- Improved metrics for readmissions - *Report is complete and available*
- Development of Electronic Reviews – *The electronic review process was implemented to approximately 50% of the inpatient psychiatric providers during the second quarter and continued throughout FY 21. It has greatly streamlined the process for reviewing urgent concurrent requests for continued authorization. The electronic review process will be further expanded during FY 22.*
- Disability Designation recommendation - The form used to change disability designation was modified and did not include an SUD category. Impacted departments such as Access, IT and SUD need to address the process for designating and updating disability designation. *UM will collaborate with the Access Department, IT, SUD and Manage Care Operations to review and revise the process for updating members' designations.*
- Telehealth services continued to include screenings and outpatient mental health services. This presents as an opportunity to study the impact of telehealth services on the traditional barriers to treatment, including childcare and transportation issues.

Opportunities for Improvement FY 2022

Strategic Pillar	Goal and Timeline for Completion	Brief Description	Responsible Leader/UMC	2021 Status	2022 Plan
Customer	80% satisfaction standard for Member Experience Surveys Member satisfaction	Member Experience Surveys to improve member satisfaction	UM Director and designated staff	Report from Customer Services not yet available	Continue to practice the principals of the Affirmative Statement and implement additional steps in accordance with 2021 findings
Customer	80% satisfaction standard for Provider Experience Survey	Provider Experience Surveys to improve provider satisfaction	UM Director and designated staff	Not Met- Aggregate scores for each FY: 66% - FY 21 65.5% - FY 20 67% - FY 19 76% - FY 17	Specific interventions to be developed in collaborative effort, inclusive of UM department staff, Crisis Services, network practitioners and the Utilization Management Committee (UMC).
Access	UM will monitor timely written notification of ABA eligibility	Delegated functions	UM Director and designated staff	Timely notification of eligibility continues to be monitored. In FY 21, notification of ineligibility is no longer a delegated function.	Ongoing Monitoring
Access	Identify the impact of telehealth on access to behavioral health services	UM Performance Improvement Project	UM Delegated Staff	N/A	To be Determined
Quality	Fulfill terms of HSAG Plan of Correction	Standards VI, VII, VIII and X	UM Director, Denials & Appeals Coordinator	Plan of correction	April 1, 2022
Quality	Achieve MMBPI 15% or less hospital recidivism quarterly standard for adults and children	Recidivism Source: MHWIN Performance Indicators	UM Department and Recidivism Task Force, COPE huddle, Children's Screeners Huddle, Hospital Liaison Meetings	Recidivism rate for *children* consistently meeting standard, with quarterly rates of 8.94%, 12.03%, 6.76% & 8.22%. Recidivism rate for *adults* consistently did not meet 15% standard until 4th quarter with quarterly rates of 17.94%, 17.34%, 17.03% & 15.01%	Ongoing

Quality	DWIHN UM department & all delegated entities to have an approved 2022-2024 UM Program Description	UM Program Description policy	DWIHN UM Dept; COPE ; The Guidance Center; The Children's Center; New Oakland	UM Delegated Entities Program Descriptions expired 2021 UM Dept. Program Description Expires 2022	September 30, 2022
Finance	Over and Under Utilization Reports; Establish schedule and reporting of selected and prioritized data for review FY 21	Potentially select high volume, high cost, high risk service codes	UMC	UM presented data for Quarters 1-3 at the Quality Operations Technical Assistance Workgroup meeting in September.	Ongoing
Quality	Ensure 2 provider trainings per year regarding Service Utilization Guidelines (SUGs) by end of FY 21	Ongoing collaboration and improvement of service utilization guidelines	UM Administrator	The Provider Network was trained on at least one occasion during the FY and provided ongoing technical assistance with the SUGs.	Ongoing
Finance	Ensure application of level of care guidelines, use of assessment tools and application of medical necessity criteria across all service arrays	Minimum annual review of Service Utilization Guidelines, Level of Care Assessment tools, and medical necessity criteria	UM Department, UM Clinical Specialists, UMC and other committees and stakeholders as defined in UM program evaluation	Met	Ongoing
Advocacy	Continue bi-monthly meetings and contribution to Michigan Consortium for Healthcare excellence in ensuring access, parity, and uniform application of benefits for Michigan consumers	MCG Behavioral Health Guidelines, Interrater Reliability	Parity Workgroup; UM Administrator; UM Clinical Specialist.	Met: New three-year contract signed by MCHE; meetings moved to quarterly for FY 22	Ongoing; MDHHS to begin reviewing use of MCG behavioral health guidelines during audit
IT	Dashboard/Report Development/Technology			See opportunities identified in this report	Ongoing

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 21-72R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 6/15/2022

Name of Provider: Plante & Moran, PLLC

Contract Title: Annual Financial Statement Audits

Address where services are provided: None

Presented to Finance Committee at its meeting on: 6/1/2022

Proposed Contract Term: 9/1/2021 to 6/30/2024

Amount of Contract: $ 461,535.00 Previous Fiscal Year: $ 453,063.00

Program Type: Continuation

Projected Number Served- Year 1: Persons Served (previous fiscal year):

Date Contract First Initiated: 8/1/2021

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

DWIHN is requesting the approval of a three (3) contract with a two year option for renewal for the annual financial statement audit, Single Audit, and Compliance Examination for the fiscal years ended September 30, 2021, 2022, and 2023 consistent with the terms of the RFP.

In response to RFP Control #2021-004 issued on 4/27/2021 whereby three proposals were received and evaluated, Plante Moran PLLC. was recommended as the most responsive bidder for an amount not to exceed $461,535 for the three year period.

The board previously approved a one year contract under BA 21-72 for the audits for fiscal year ended September 30, 2021 which has been completed and issued.

Outstanding Quality Issues (Y/N)? If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N):

Revenue	FY 21/22	Annualized
Multiple	$ 461,535.00	$ 461,535.00
	$ 0.00	$ 0.00
Total Revenue	$ 461,535.00	$ 461,535.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: 64923.813000.00000

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Friday, May 6, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Thursday, May 5, 2022

Board Action Taken

The following Action was taken by the Full Board on the __15th__ day of June, 2022.

X Approved

☐ Rejected

☐ Modified as follows:

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Executive Director -initial here:_ _____

☐ Tabled as follows:

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Signature: *Lillian M. Blackshire* Date: June 15, 2022
Board Liaison

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DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-12 R5 Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 6/15/2022

Name of Provider: Detroit Wayne Integrated Health Network

Contract Title: FY 2021-2022 Operating Budget

Address where services are provided: None

Presented to Finance Committee at its meeting on: 6/1/2022

Proposed Contract Term: 10/1/2021 to 9/30/2022

Amount of Contract: $ 939,601,935.00 Previous Fiscal Year: $ 927,640,119.00

Program Type: Modification

Projected Number Served- Year 1: Persons Served (previous fiscal year):

Date Contract First Initiated: 10/1/2021

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

This board action is requesting to certify Federal Grant revenue of $875,000 per MDHHS authorization of use of State Opioid Response 2 (SOR2), Year 1 unspent funds from FY 2021. The additional funds will be used to enhance opioid disorder and stimulant disorder efforts for the SOR2 campaign.

The revised FY 2022 Operating Budget, in the amount of $939,601,935, includes revenue of: $25,955,085 (State General Funds); $714,969,459 (Medicaid, DHS Incentive, Medicaid-Autism, Children's/SED Waiver, HAB); $9,886,123 (MI Health Link); $118,163,663 (Healthy MI-Mental Health and Substance Abuse); $17,686,447 (Wayne County Local Match Funds); $4,040,539 (PA2 Funds); $4,988,982 (State Grant portion of OBRA, SUD); $42,630,637 (Federal Grant Funds); $241,000 (Local Grant Funds); $1,000,000 (Interest Income); and $40,000 (Miscellaneous Revenue).

Outstanding Quality Issues (Y/N)? _ If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N):

Revenue	FY 21/22	Annualized
Multiple	$ 939,601,935.00	$ 939,601,935.00
	$ 0.00	$ 0.00
Total Revenue	$ 939,601,935.00	$ 939,601,935.00

Recommendation for contract (Continue/Modify/Discontinue): Modify

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Tuesday, May 24, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, May 24, 2022

Board Action Taken

The following Action was taken by the Full Board on the __15th__ day of June, 2022.

X Approved

☐ Rejected

☐ Modified as follows:

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Executive Director -initial here:_ _____

☐ Tabled as follows:

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Signature: *Lillian M. Blackshire* Date: June 15, 2022
Board Liaison

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DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-22R Revised: Y Requisition Number:

Presented to Full Board at its Meeting on: 6/15/2022

Name of Provider: DWIHN Provider Network - see attached list

Contract Title: Provider Network System FY 21/22

Address where services are provided: Service Provider List Attached

Presented to Program Compliance Committee at its meeting on: 6/8/2022

Proposed Contract Term: 6/1/2022 to 9/30/2022

Amount of Contract: $ 678,243,988.00 Previous Fiscal Year: $ 681,873,376.00

Program Type: Continuation

Projected Number Served- Year 1: 66,950 Persons Served (previous fiscal year): 71,682

Date Contract First Initiated: 10/18/2022

Provider Impaneled (Y/N)? Y

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

Detroit Wayne Integrated Health Network (DWIHN) is requesting approval to add 17 additional providers to the Provider Network System for the fiscal year ending September 30, 2022. This will allow for the continued delivery of behavioral health services for individuals with: Serious Mental Illness, Intellectual/Developmental Disability, Serious Emotional Disturbance and Co-Occurring Disorders.

The services include the full array behavioral health services per the PIHP and CMHSP contracts. The services added will include 7 staffing agents providing services for self-determined members, camp services, licensed home services for person care and community living services. The amounts listed for each provider are estimated amounts and are subject to change.

In addition, it should be noted that the hospitals listed under HRA change based on consumers stay. As such, hospitals may be added and amounts reallocated without board approval to avoid delay of payment; the funds are a pass through from MDHHS.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized
Multiple	$ 678,243,988.00	$ 678,243,988.00
	$ 0.00	$ 0.00
Total Revenue	$ 678,243,988.00	$ 678,243,988.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)? Y

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Friday, June 3, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Friday, June 3, 2022

Board Action Taken

The following Action was taken by the Full Board on the __15th__ day of June, 2022.

X Approved

☐ Rejected

☐ Modified as follows:

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Executive Director -initial here:_ _____

☐ Tabled as follows:

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Signature: *Lillian M. Blackshire* Date: June 15, 2022
Board Liaison

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DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

Board Action Number: 22-63 Revised: N Requisition Number:

Presented to Full Board at its Meeting on: 6/15/2022

Name of Provider: AgreeYa Solutions Inc

Contract Title: DWIHN Mobile Application for Community Engagement

Address where services are provided: 'None'__

Presented to Finance Committee at its meeting on: 6/1/2022

Proposed Contract Term: 7/1/2022 to 6/30/2025

Amount of Contract: $ 244,260.00 Previous Fiscal Year: $ 0.00

Program Type: New

Projected Number Served- Year 1: 70,000 Persons Served (previous fiscal year): 0

Date Contract First Initiated: 7/1/2022

Provider Impaneled (Y/N)?

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

Development and implementation of Mobile App for community use on mobile devices. This will give users access to Health Screening, Resources, Education, Event calendars, and much more (see Scope of Service attached).

Three years Annual Support and Maintenance: $244,260

Project Phase:

- Consulting/Assessment: $26,055
- Design: $34,740
- Development/Testing $95,535
- Training/Instruction: $17,370

Support

- Year 1: $30,600
- Year 2-3: $39,960

GL Accounts:

- Development ($173,700) 00000.136003.00000
- Support ($70,560) 64914.815000.00000

Manny S. and Donna C. are collaborating on this project.

Outstanding Quality Issues (Y/N)? N If yes, please describe:

Source of Funds: Multiple

Fee for Service (Y/N): Y

Revenue	FY 21/22	Annualized
Multiple - Software	$ 173,700.00	$ 173,700.00
Multiple	$ 70,560.00	$ 70,560.00
Total Revenue	$ 244,260.00	$ 244,260.00

Recommendation for contract (Continue/Modify/Discontinue): Continue

Type of contract (Business/Clinical): Business

ACCOUNT NUMBER: VARIOUS

In Budget (Y/N)? N

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Signed: Tuesday, May 24, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Signed: Tuesday, May 24, 2022

Board Action Taken

The following Action was taken by the Full Board on the __15th__ day of June, 2022.

X Approved

☐ Rejected

☐ Modified as follows:

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Executive Director -initial here:_ _____

☐ Tabled as follows:

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Signature: *Lillian M. Blackshire* Date: June 15, 2022
Board Liaison

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