Utilization Management Plan

FY 2017

AlleganCounty Community Mental Health

Utilization Management

The process by which a mental health organization ensures that individuals receive timely, quality, cost-effective services in the most appropriate and least restrictive treatment setting and ensures that the organization has an effective mechanism to manage the utilization of clinical resources.

The Purpose of Utilization Management

To achieve a balance between the demand for services, availability of resources, and the needs and well-being of individuals who need mental health services.

I. Utilization Management

Allegan County Community Mental Health will develop and maintain a Utilization Management (UM) program within the organization. The plan will meet the following requirements.

1. The written description of the UM Program will be developed, including structure and accountability for managing utilization at ACCMH.
2. Annually a review of utilization goals and objectives will be developed and presented to the appropriate leadership group in the agency.
3. Written criteria for benefit coverage, medical necessity, and clinical appropriateness will be utilized by the organization.
4. Senior clinical staff will have clear roles in UM functions.
5. A Utilization Management Committee will be delegated to oversee utilization management in the organization.
6. Key performance and outcome indicators will be identified and reported in the committee.
7. Regular data reports will be received on utilization, and adjustments will be made in the organization based on the data.

II. Utilization Management Committee

1. The committee will meet at least 10 times a year.
2. The committee will include membership of representatives from access, the medication clinic, services to persons with mental illness, services to persons with developmental disabilities, and quality improvement. The Medical Director will be an ad hoc member of the committee, and will receive all UM agendas, minutes, and reports.
3. Periodic summary reports will be given to the agency's Consumer Opportunities Advisory Panel (COAP) and consultation will be sought when appropriate.
4. The Quality Improvement Unit will provide committee support and coordinate data needs with the committee chair.
5. Data reports will be reviewed regularly and reported on a regular basis to the committee. Outcome data will be included in the data that is reviewed by the committee.
6. The committee will report on a bi-annual basis to Leadership Group. This report will include data analysis and recommendations from the committee.
7. Agendas, minutes, and data reports will be maintained for committee meetings.
8. Mechanisms to identify and report on overutilization and underutilization of services will be developed and maintained. Minimally, this will include a review of hospital utilization and programs.

9. Evidence Based Practice (EBP) measures may be included as part of the committee's functions.
10. Review of outliers and case reviews will be delegated to appropriately qualified staff.
11. Data will be presented to the Board of Directors at least annually.
12. Information will be shared with ACCMH staff on a bi-annual basis, and the committee will develop a regular method of reporting utilization trends to other stakeholder groups.

III. Eligibility and Medical Necessity

1. The agency will develop and maintain Clinical Practice Guidelines which meet all regulatory requirements, in order to guide decisions on eligibility and medical necessity. The manual will include criteria from the contract with the Michigan Department of Community Health (MDCH), the Lakeshore Regional Partners(LRP), and locally developed eligibility criteria.
2. Senior level clinical staff will provide or supervise the review of outliers, as well as the review of preauthorization, concurrent reviews, and retrospective reviews of care.
3. Decisions to deny services will only be made by qualified professionals.
4. Decisions to deny services will be made based on medical necessity, ability to benefit for services, and/or service utilization.
5. Decisions regarding services will be consistent with MDCH contract requirements.
6. Decisions to deny or reduce the amount, scope, or duration will not be made solely based on diagnosis, type of illness or condition.
7. Well publicized mechanisms for second opinions, appeals, and tribunals will be available to consumers consistent with their eligibility status.
8. Rationale for denial of services will be clearly documented and provided to the consumer. The medical record will include requirements for disposition, and decisions to deny services will be provided in writing to the consumer.
9. Decisions related to utilization and eligibility will be made according to required time frames.

IV. Utilization Management Program Plan

1. The Utilization Management Program will be responsible for monitoring and assuring:
    a. <u>Improved quality of clinical care</u>
        i. Consumer receives the right amount of service, frequency, location, type.
        ii. Services are proven to be efficacious.
        iii. Demonstrated clinical outcome from services delivered.

b. Improved clinical process
    i. Continuity of care is evident for individual consumers and for consumers as a group.

c. Improved efficiency in care delivery
    i. Identify services that are under or over-utilized.
    ii. Care is delivered in a way that is the most effective and efficient use of resources.
    iii. Consumers receive appropriate access to care.
    iv. Assessing thatwe have adequate resources to serve the identified populations.
    v. Services are coordinated and delivered in a timely manner.
    vi. Timely follow-up after discharge from inpatient is provided.

d. Improved understanding of the individuals that we serve.
    i. Identify who we are serving.
    ii. Identify who we are not serving.
    iii. Assess if our Medicaid penetration rate at an appropriate level.
    iv. Assess if we are meeting our contractual requirements of providing services to specific populations.

e. Improved Risk Management
    i. Ensure that we are coordinating care with other health providers.
    ii. Ensure that we are capturing physical health information on those that we serve.

f. Ensure Quality and Effectiveness
    i. The inpatient recidivism rate is below 15%.
    ii. Individuals discharge from services with favorable outcomes.
    iii. Programs/clinicians deliver services that align with the individual's diagnosis.

g. Reduced Costs and Improved Utilization
    i. Ensure that our cost of service is comparable to the State of Michigan's cost.
    ii. Identify how costs vary by program and population.
    iii. Minimum service requirements for Home Based, Assertive Community Treatment, and HAB waiver consumers are satisfied.
    iv. Services provided to General Fund Consumers are monitored.
    v. Inpatient admissions and length of stays are in control.

V. Utilization Management Goals

1. A UM Matrix will be maintained specifying all performance indicators and outcomes of which the UM Committee will analyze and how frequent.
2. Outcomes data will be reviewed in aggregate form.
3. Strengthen the use of Evidence Based Practices.
4. Strengthen the review of clinical appropriateness of services rendered.
5. Consumers and stakeholders will be included in the review of UM data, and recommendations from these groups will be received and integrated where clinically appropriate.
6. Standardized methodology will be utilized to monitor risks throughout treatment.
7. LOCUS scores will be used to evaluate appropriateness of level of care.
8. CAFAS scores will decrease.
9. SIS scores/tiers will align with need.
10. The ANSA will be utilized for treatment planning, monitoring progress, and evaluating service effectiveness.
11. A UM Manual will be developed that clearly defines all eligibility tools and other pertinent policy and procedural documentation.