



Utilization Management Plan

FY 2019

Allegan County 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

Allegheny 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 ACCMHS.
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 9 times a year.
2. The committee will include membership of representatives from clinical services, medical services, customer services, utilization management, quality improvement, and the management team. 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. Collaboration will occur between the Utilization Management Committee and the Quality Improvement Committee.
5. Data reports will be reviewed and reported regularly 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 Management Team. 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.
9. Evidence Based Practice (EBP) measures will 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 ACCMHS 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 Health and Human Services (MDHHS), the Lakeshore Regional Entity (LRE), 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 and be based on medical necessity, ability to benefit for services, and/or service utilization.
4. Decisions regarding services will be consistent with MDHHS contract requirements.
5. Decisions to deny or reduce the amount, scope, or duration will not be made solely based on diagnosis, type of illness or condition.
6. Well publicized mechanisms for second opinions, appeals, and tribunals will be available to consumers consistent with their eligibility status.
7. 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.
8. Decisions related to utilization and eligibility will be made according to agency policies.

IV. Utilization Management Program Plan

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

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- b. Improve clinical process
 - i. Continuity of care is evident for individual consumers and for consumers as a group.
 - ii. Consumers will be offered services consistent with evidence based practices, as appropriate.
 - iii. Services are coordinated and delivered in a timely manner.
 - iv. Timely follow-up after discharge from inpatient is provided.

 - c. Improve 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 for adequate resources to serve the identified populations.

 - d. Improve 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 is at an appropriate level.
 - iv. Assess if we are meeting our contractual requirements of providing services to specific populations.

 - e. Increase Quality and Effectiveness
 - i. Increase the number of individuals who discharge from services with favorable outcomes.
 - ii. Ensure programs/clinicians deliver services that align with the individual's diagnosis and person-centered plan.
 - iii. Ensure that services are delivered according to Individual Plan of Service.

 - f. Reduce Costs and Improve Utilization
 - i. Identify how costs vary by program and population.
 - ii. Identify minimum service requirements for Home Based, Assertive Community Treatment, Autism Benefit, and HAB waiver consumers are satisfied.
 - iii. Ensure services provided to General Fund Consumers are monitored.
 - iv. Monitor inpatient admissions and length of stays.

V. Utilization Management Goals

1. A UM Matrix will be maintained specifying all performance indicators with outcomes and frequency of which the UM Committee will analyze.
2. The Triple Aim of Utilization Management will be strengthened through clinical review of appropriateness.
 - a. Consumers will report satisfaction with services.
 - b. LOCUS scores will be used to evaluate appropriateness of level of care.
 - c. CAFAS/PECFAS scores will be used to evaluate appropriateness of level of care.
 - d. SIS scores/arrays will align with need.
 - e. Outcomes data will be reviewed in aggregate form.
 - f. CAFAS/PECFAS scores will decrease.
 - g. The ANSA will be utilized for treatment planning, monitoring progress, and evaluating service effectiveness.
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. Eligibility criteria for admission, transition, and discharge will be outlined in policy and procedural documents.
8. A UM Manual will be developed that clearly defines all eligibility tools and other pertinent policy and procedural documentation.