COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Utilization Management Plan

FY 2023

Mission Statement

Community Mental Health of Ottawa County partners with people with mental illness, intellectual and/or developmental disabilities, substance use disorders and the broader community to improve lives and be a premier mental health agency in Michigan.

Utilization Management

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

The Goal 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 behavioral health and substance use disorder services.

I. Utilization Management

Community Mental Health of Ottawa County (CMHOC) will develop and maintain a Utilization Management (UM) program within the organization. The UM 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 CMHOC.

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, in consultation with the Medical Director as needed, will have clear functions in UM.
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.
8. Consumers and stakeholders will have access to the review of UM data, and recommendations from these groups will be received and acted upon.

II. Utilization Management Committee

The purpose of the UM Committee is to ensure the delivery of timely, quality, and cost-effective services in the most appropriate treatment setting. The committee will meet the following requirements.

1. The committee will meet on a monthly basis.
2. The committee will include membership of representatives from access, customer service, services to persons with mental illness, services to persons with intellectual and/or developmental disabilities, services to persons with substance use disorders, and quality improvement. The Medical Director will be an ad hoc member of the committee. The Medical Director will review second opinions and hospital denials when consumers request such a review.
3. The CMH IT Department will provide committee support and coordinate data needs with the committee chair.
4. Data reports will be reviewed and reported on a regular basis to the committee. Outcome data will be included in the data that is reviewed by the committee.
5. The Leadership Group and UM Committee meet jointly once a month. Information presented will include data analysis and QI recommendations.
6. Agendas, minutes, and data reports will be maintained for committee meetings.
7. Mechanisms to identify, review, and report on overutilization and underutilization of services will be developed and maintained. Minimally, this will include a review of utilization in the following programs: Assertive Community Treatment, Home Based Services, and Health Benefits Waiver (HBW) consumers.
8. The committee will develop methods to review consistency of authorizations for network providers.
9. Practice guidelines outlined by the Medicaid Provider Manual, the Michigan Medicaid Provider Manual, Evidence Based Practices, and state mandates

through the MDHHS contract may be used for prospective authorization as well as concurrent and retrospective reviews.

10. EBP measures may be included as part of the committee's functions.
11. Review of outliers and case reviews will be delegated to appropriately qualified professional staff.
12. Bi-annually, data will be presented to the Board of Directors.

III. Eligibility and Medical Necessity

1. The agency will develop and maintain an Access Center Manual which meets 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. The agency will employ various methods to determine medical necessity for amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
4. The agency will not deny services based solely on preset limits of the cost, amount, scope, and duration of services.
5. Determination of the need for services shall be conducted on an individualized basis. Furthermore, determination will be based on information provided by the beneficiary, family of the beneficiary, and/or other individuals who know the beneficiary. Evaluations by the beneficiary's primary care physician or other health care professional will also be considered.
6. Decisions to deny or reduce services will only occur if one of the following is met a) not medically necessary or ineffective for a given condition based upon professional and scientifically recognized and accepted standards of care b) experimental or investigational in nature, or c) services for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services.
7. Decisions to deny or reduce services will only be made by qualified professionals, and consistent with MDHHS contract requirements, well publicized mechanisms for second opinions and appeals 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. Rationale for denial of services will be provided to any network provider requesting the initiation or reauthorization of services.
10. Decisions related to utilization and eligibility will be made according to required time frames.

IV. Utilization Management Program Plan

1. Current Available Data: The following list is currently available data that will be analyzed by the UM Committee.
    a. *Costs and Utilization*
        i. Average cost per case by program.
        ii. Amount of service provided to Home Based, Assertive Community Treatment, and waiver consumers in the organization.
        iii. Inpatient admissions, days, and length of stay.
        iv. Crisis residential admissions, days, and length of stay.
        v. High ED Utilizers.
        vi. Number and percent of Spenddown consumers.
    b. *Risk Management*
        i. Persons without a primary health care provider.
        ii. High ED Utilizers.
        iii. Persons who filled a Second-Generation Antipsychotic Medication and who have not received a HbA1c, FPG, or Lipid Panel for the purpose of screening for the identification of individuals at risk and/or already diagnosed with Diabetes.
        iv. *Diabetes Monitoring for People with Diabetes and Schizophrenia:* The percentage of adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
    c. *Quality and Effectiveness*
        i. Inpatient recidivism rate (goal: less than 15%).
        ii. CMH Staff Productivity.
        iii. Discharge reason.
        iv. ANSA Outcomes.
        v. DD ANSA Outcomes.
        vi. CAFAS/PECFAS Outcomes.
    d. *Access*
        i. Days from request to assessment. (no target)
        ii. Days from assessment to ongoing services. (no target)
        iii. CMHOC service requests with disposition.
        iv. CMHOC denials following intake assessment.
        v. Persons are seen within 3 hours of a request for inpatient (goal: 95% in 3 hours or less).

vi. Persons are seen within 7 days of discharge from inpatient care/detox (goal: 95% within 7 days).
vii. Medicaid Penetration

e. *Data Integrity*
   i. BH TEDS Data Completeness
   ii. Statewide initiatives for data integrity and completeness
      1. LOCUS scores
      2. Veteran/Military data

V. Utilization Management Goals

1. Improve UM dashboarding with Power BI software and continue to share information with the Board, consumers, staff, and other stakeholders.
2. Redesign case specific concurrent reviews based on regional UM administration processes (LRE IRR process per UM ROAT).
   a. Update: Staff will utilize MCG 26th edition for clinical determination of medical necessity criteria and complete MCG education annually. LRE will provide oversight by auditing pre-admission screens and CSR's quarterly.
3. Review and adjust to funding model suggested by the actuarial study (PEPM funding model, BH Fee Schedule, Standard Cost Allocation).
4. Evaluate data sources available: ICDP, GLHC, CC360, EMR, SIS, LOCUS, ANSA, CAFAS, PECFAS, DECA, ADOS, ADI-R, Clinical Global Severity Impression Scale, VB-MAPP, ABLLS-R, AFLS, LRE PowerBI Dashboard.
5. Evaluate SUD data presentation and reporting.
6. ANSA scores will decrease from time one to time two.
7. CAFAS/PECFAS scores will decrease from time one to time two.
8. A UM Matrix will be updated to specify all performance indicators and outcomes of which the UM Committee will analyze.
9. Review MDHHS Performance Indicators and Key Metrics and align UM reporting.
10. Review LRE UM structure and align strategic goals of Ottawa with LRE.
11. Review other CMH and PIHP UM plans. Compare and enhance our plan.
12. Review available data sources and create reports for internal monitoring of HEDIS measures tracked by LRE.
13. Enhance procedures for case/outlier follow up and documentation.
14. Review of CSR Reports from LRE. Get feedback and input from team on performance and process.
15. Create UM goal tracking method.
16. Implement KPI Dashboards and Power BI and ensure appropriate staff have access to reports needed.
17. Evaluate the impact of SIS going away.
18. Review and align with LRE PIP.
19. Follow up on LRE HEDIS measures as part of the LRE Dashboards.

Double click below to see full UM Matrix of Reports:

Report Name		Description of Report	Frequency	Method of collection	Responsibility	Reason for Monitoring	Follow Up Expectations
1.	CC360 High Utilizers	MDHHS reports available via CC360. Identifies high inpatient utilizers.	Monthly	Report: High Utilizers (CC360), High Utilizers (PBI)	Report: UM/EDI Data Technician (Tiffany) Follow Up: PS	UM Mission	To follow up with open clients on the list; reduce future ER visits if applicable
	CC360 Trending High Utilizers	MDHHS reports available via CC360. Identifies trending high inpatient utilizers.	Monthly	Report: Trending High Utilizers (CC360), Trending High Utilizers (PBI)	Report: UM/EDI Data Technician (Tiffany) Follow Up: PS	UM Mission	To follow up with open clients on the list; reduce future ER visits if applicable
2.	BH-TEDs Data Completeness	The report monitors data completeness in non-crisis MH BH-TEDs records.	Monthly	Report: Missing BH TEDS (CR)	Report: UM/EDI Data Technician (Tiffany) Follow Up: PS	Contract Requirement	Program supervisors review non-compliant cases and follow up with staff to correct
	BH TEDS - LOCUS	The report monitors LOCUS completeness for MI Adults in BH-TEDS records.	Monthly	Report: LOCUS BHTEDS Completeness	Report: UM/EDI Data Technician (Tiffany) Follow Up: PS, QI Data Technician (Jeevan)	Contract Requirement	Program supervisors review cases on the list and follow up with staff to correct; QI Data Technician (Jeevan) updates BH TEDS where newer LOCUS exists
	BH TEDS - Veteran	The report monitors completeness of Veterans and Military fields in BH TEDS.	Quarterly: March, June, September, December	Report: Veteran BHTEDS Completeness (PBI)	Report: UM/EDI Data Technician (Tiffany)	Contract Requirement	Ongoing monitoring
3.	Primary Care Physician Report	The report determines the number & percent of consumers who do not have a primary care physician. The benchmark for this report is 95% completeness.	Monthly	Report: Missing PCP (PBI)	Report: UM/EDI Data Technician (Tiffany) Follow Up: PS	Contract Requirement	Program supervisors review consumers on missing list to assist in obtaining a PCP for those that do not have one.
4.	ANSA Outcomes	This report compares two assessments per consumer over a year to identify number of consumers with changes. Emphasis on key measures: suicide risk, self mutilation, depression, anxiety, psychosis.	Biannually: April, October	Report: ANSA Outcomes First in Time Period with Program (CR), ANSA Outcomes Most Recent with Program (CR)	Report: UM/EDI Data Technician (Tiffany)	CARF	Ongoing monitoring of outcomes