OnPoint
Caring for Allegan County

UTILIZATION MANAGEMENT PLAN
FY 2024

***ONPOINT VISION STATEMENT*:**

AN INCLUSIVE COMMUNITY WITH INTEGRATED BEHAVIORAL HEALTH SERVICES...

OnPoint provides public behavioral health care to residents of Allegan County. Services are also provided as a Certified Community Behavioral Health Clinic (CCBHC) to individuals of Allegan County and neighboring counties.

I. UTILIZATION MANAGEMENT PROGRAM PURPOSE

OnPoint has a Utilization Management (UM) Program to meet the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. The goal of the program is to ensure individuals receive **timely**, **high quality**, **cost-effective services** in the most **appropriate** and **least restrictive** treatment setting. OnPoint's UM Program ensures that services and UM activities are conducted in compliance with both federal laws and MDHHS contract requirements. The UM Program is designed to reflect OnPoint's Core Values of:

- Integrity
- Inclusivity
- Honor
- Equality
- Humility
- Innovation
- Teamwork
- Cultural Competence.

OnPoint's UM Program assures that it has a written utilization management program description that includes how medical necessity is defined, information sources, and the process to review and approve services. The UM Program also ensures, minimally, that OnPoint is meeting the following standards:

- Efforts are made to obtain all necessary clinical information to render a decision. *(Utilization Management – Policy #419)*
- Decisions to deny services are only made by qualified professionals and are based on medical necessity, ability to benefit for services, and/or service utilization. *(Utilization Management – Policy #419)*
- Senior level clinical staff provide or supervise the review of outliers, as well as review of preauthorization, concurrent reviews, and retrospective reviews of care. *(Utilization Management – Policy #419)*
- Decisions to deny or reduce the amount, scope, or duration are not made solely based on diagnosis, type of illness or condition, or cost of the service. *(Utilization Management – Policy #419)*

- Decisions and appeals are made in a timely manner as required by the specific of the situation. The standard timeline is 14 days. In extenuating circumstances, an expedited review is completed within 24 hours. *(Request for Authorization – Policy #434)*
- Use of incentives related to UM decisions is strictly prohibited. Service determinations are based solely on medical necessity criteria and benefits coverage.
- Rationale for denial of services is clearly documented and provided to the individual. Decisions to deny services are provided in writing to the individual with clear instructions for how to file an appeal. *(Notice of Adverse Benefit Determination – Policy #1105)*
- Key performance and outcome indicators are identified and reported regularly. Details underlying the aggregate information are shared with the appropriate department(s) for follow-up and quality improvement activities.
- Regular data reports must be received on utilization, and adjustments will be made in the organization based on the data.

II. OnPoint Utilization Management Structure and Activities

The implementation of the Utilization Management Plan is, at its core, a team effort. It is the responsibility of:

- ***OnPoint's Utilization Management (UM) Committee:*** The designated body at OnPoint to assure that the OnPoint UM Plan is being monitored and maintained. The UM Committee is responsible for annually reviewing the UM Plan to ensure completeness, accuracy, and clarity. The UM Committee includes representatives from Clinical Services, Utilization Management, Quality Innovation, and the Management Team. The Provider Network Management Team is also an ad hoc member of the committee. The UM Committee meets a minimum of nine times per year. Agendas, minutes, and data reports reviewed during the meetings are maintained.
- ***OnPoint's Utilization Manager:*** Provides guidance regarding best practices for Utilization Management to the UM Committee, Health Information Management, and Management Team.
- ***OnPoint's Health Information Management:*** Health Information Management is responsible for gathering data, assuring data quality, and synthesizing the data gathered.
- ***OnPoint's Management Team:*** The Management Team includes the Executive Director, Chief Operating Officer, Director of Evidence Based Programs, Director of Program Operations, Director of QI and Compliance, Administrative Services Director, and Chief Financial Officer. The Management Team is responsible for reviewing information gathered and summarized during UM activities. It is also responsible for setting the direction and prioritizing the change initiatives that may arise from information gathered.
- ***OnPoint's Team Managers/Supervisors:*** The Team Managers/Supervisors are responsible for reviewing information gathered during UM activities and providing feedback regarding change initiatives. This group is also responsible for assuring that policies and procedures related to UM are adhered to by OnPoint staff.

- ***OnPoint's Quality Innovation and Compliance Department:*** The Quality Initiative and Innovation Department is responsible for oversight and monitoring of change initiatives.

III. Utilization Management Standards

Clinical Practice Guidelines:
OnPoint utilizes the American Psychiatric Association Clinical Practice Guidelines as the established practice guideline for all Medicaid covered services *(Clinical Practice Guidelines – Policy #454).* Milliman Care Guidelines are utilized as additional factors and criteria for inpatient, partial hospitalization, and crisis residential decisions. Clinical Practice Guidelines are used to inform the person-centered planning process and will not result in specific caps for specific services.

Outlier Management:
According to Merriam-Webster, an outlier is a statistical observation that is "markedly different from the others of the sample" or something that is "atypical" within a particular group/class/category. Outlier management is the process of identifying and correcting both over and underutilization of services. Examples of outliers can include:

- Individuals who over or underutilize services by a variety of variables including too much or too little service utilization at the individual level, by service type or by provider.
- Levels of care that do not match the documented need or diagnosis.
- Lack of contact with or by service provider.

Outlier management activities happen in both scheduled and unscheduled reviews. Any findings below established benchmarks require that an action plan be developed to address any noted concerns.

Service Authorization:
Service authorization procedures are efficient and responsive to individual's served, while also consistent with requirements and both state and federal standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level. Service authorizations utilize level of care principles in which intensity of service is consistent with severity of illness.

Utilization Review Process
OnPoint utilizes prospective, concurrent, and retrospective reviews to inform the Utilization Management Plan. A prospective review is evaluation reviews the appropriateness of a service prior to the onset of the service. Concurrent reviews evaluate the appropriateness of the services throughout service delivery. Retrospective reviews evaluate the appropriateness of a service after the services have already been provided. The purpose of any review is to obtain the most current, accurate, and complete clinical presentation of a person's needs and to determine if requested services are appropriate, sufficient, cost effective to achieve positive clinical outcomes, and provided in the least restrictive setting/environment.

IV. Access Standards and Procedures

OnPoint's Access Department strives to be welcoming. One of the key components of a welcoming environment is timely access to services and a "no wrong door" approach to people attempting to receive assistance. The Access Department offers appropriate screenings, determines eligibility for specialty services, collects information, refers individuals when appropriate (utilizing a "warm hand off" when able/appropriate), and informs individuals about available services. The available services may also include community resources that may be of assistance in addressing the person's needs.

Any individual may access services for a mental health, developmental disability, and/or substance use disorder in any of the following ways:

- Requesting services directly during business hours or by calling the after-hours toll-free crisis line
- Face-to-Face evaluation
- Telephone screening
- Crisis behavioral health services.

OnPoint utilizes functional and clinical screening tools and assessments to support and inform the person/family centered planning process. Examples of the functional and clinical screening tools and assessments include:

- Level of Care Utilization System *(LOCUS)*
- Daily Living Activities Functional Assessment *(DLA 20)*
- American Society of Addiction Medicine *(ASAM)*
- Child and Adolescent Functional Assessment Scale *(CAFAS)*
- Preschool and Early Childhood Functional Assessment Scale *(PECFAS)*
- Patient Health Questionnaire *(PHQ)*
- Columbia-Suicide Severity Rating Scale *(CSSRS)*
- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult/Guardian/Child
- Adult Needs and Strengths Assessment *(ANSA)*
- Child and Adolescent Needs and Strengths *(CANS)*
- Modified Checklist for Autism *(MCHAT)*
- Social Communication Questionnaire *(SCQ)*
- Dvereux Early Childhood Assessment *(DECA)*
- Life Events Checklist for DSM-5 *(LEC-5)*
- CTAC Trama Screening Checklist

The choice of what screening tool or assessment may be utilized is grounded in the individual's presenting needs, age, and desired outcomes for service. The functional and clinical screening tools and assessments are a component in determining the person's intensity of service needs.

OnPoint has specific policies related to ACCESS standards and procedures. These policies include:

- Access – *Policy #402*
- Crisis Services – *Policy #405*
- Community Based Crisis Services – *Policy #406*
- Person Centered Planning – *Policy #446*
- Second Opinion (Denial from Intake) – *Policy #411*
- Denial of Inpatient Hospitalizations Second Opinion – *Policy#441*
- Rapid Re-Entry into OnPoint Services – *Policy #433*

These policies are regularly reviewed to assure that they are up to date and meet both state and federal standards.

V. Determination of Medical Necessity

OnPoint uses the Michigan Medicaid Provider Manual (MMPM) to define "medical necessity". Medical necessity, per MMPM, is the determination that a service is medically necessary as it is:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder.
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder.
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability or substance use disorder.
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder.
- Designed to assist the person to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

The manner in which OnPoint determines medical necessity includes the following additional standards of the MMPM:

- Based on information provided by the individual, the individual's family, and/or other people (e.g., friends, personal assistants/aides) who know the beneficiary.
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary
- For people with a diagnosed mental illness or developmental disabilities, based on person centered planning, and for people with a diagnosed substance use disorders, individualized treatment planning.
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience.
- Made within federal and state standards for timeliness.
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose.
- Provided in the least restrictive appropriate setting.
- Documented in the individual plan of service.

No additional standards in determining medical necessity, beyond what is defined in the MMPM, are utilized by OnPoint.