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Of Behavioral Health & Family Services Providers

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Behavioral Health Utilization Management Summary and Recommendations

Summary

The Ohio Council sponsored four regional events, *Connecting for Collaboration: Preparing for Medicaid BH Prior Authorizations,* to support members in understanding the system wide and organizational culture impacts of the new ODM utilization management policy decisions and to facilitate development of provider led best practices for managing new prior authorization requirements. The information gathered across the four regional sessions indicates that the new Medicaid behavioral health utilization thresholds are not simply adding another prior authorization task. The thresholds extend prior authorization requirements to services commonly used to support the ongoing management of chronic and recurring behavioral health conditions once specified levels of utilization are reached. The sessions exposed broader challenges in how clinical care, documentation, operations and payment processes connect across the full course of care. Responding successfully requires an organization-wide change in practice and culture, with clinical, administrative, scheduling, billing, quality and leadership teams working from shared information and understanding how their responsibilities affect access, authorization and reimbursement. Ongoing training and communication are necessary so staff understand how their responsibilities connect and can respond consistently as requirements change and organizational experience grows.

At the center of this work is the individual receiving care. Engagement throughout assessment, treatment planning, intervention delivery, and reassessment helps identify the individual's goals, current needs, functional impairment, and other providers or services involved in their care. Functional assessments and measurement-based care provide objective information that can establish a baseline, track changes in symptoms and functioning and indicate when treatment may need to be adjusted. The Golden Thread of documentation is an essential strategy that connects this information from assessment, treatment plans, interventions, service frequency and intensity and the individual's response over time. Care management and transition and discharge planning then use the same clinical picture to inform decisions about admission, continued need, changes in service intensity and movement between levels of care and/or programs and services.

Prior authorization processes require system and culture change – it is not just a clinical or billing responsibility. A prior authorization request is the midpoint of this longer clinical and operational process rather than a separate administrative event. Its success depends on whether the individual's needs, services and progress (or lack thereof) have been consistently understood, evaluated and documented before the request is submitted. Success will also require organizations to define payer-specific workflows that identify the individual's Medicaid managed care plan, monitor utilization and assign clear roles and responsibility for authorization and follow-up across all organizational functions Internal policies are needed to guide decisions when authorization is required, pending, or denied, including how clinical needs, appeal options, payer requirements, and the possibility of nonpayment will be considered. When these connections and

responsibilities are unclear, organizations are more likely to encounter preventable denials, duplicated work, delayed responses, potential disruptions in care, or services that are not reimbursed.

Data and reporting need to connect clinical, utilization, authorization and claims information so organizations can respond to individual cases and identify broader patterns. Those patterns can inform quality improvement, workflow adjustments, staff training, financial oversight, and MCO contract management. Technology may strengthen this work by harnessing EHR functionality, reports, dashboards, alerts, automation, and AI, but it cannot establish the underlying clinical practices, workflows or accountability. Technology decisions need to reflect organizational capacity and available resources, and implementation may begin with a dependable manual process before progressing to more advanced tools. A new form, tracking system, technology platform, or designated staff position may address part of the process, but no single change will resolve gaps across the organization.

The regional discussions also revealed that some challenges cannot be resolved by individual organizations alone. Providers may strengthen their own utilization oversight but still lack complete information about services delivered through other providers or payers. Greater consistency in managed care plan processes and centralized visibility into individual-level utilization will require coordination across the broader Medicaid provider and MCO system. Taken together, the following recommendations support an approach that is proactive, clinically grounded, operationally sustainable, and focused on protecting access to appropriate care.

Recommendations

1. **Standardize Agency-Wide Workflows, Roles, and Responsibilities**
   Organizations should establish a clearly documented utilization management and prior authorization workflow that connects clinical and business operations. The process should begin with intake, eligibility verification, and identification of the individual's specific Medicaid managed care plan. It should continue through service delivery, utilization monitoring, prior authorization submission, communication of payer decisions, denial response, appeals, billing, and quality improvement.

   Organizations should not assume that Medicaid managed care plans use the same authorization processes. Workflows should account for differences in submission methods, plan-specific documentation expectations, appeal procedures, and contractual requirements. Organizations should maintain a current, centralized reference that identifies each plan's submission methods, required forms, documentation instructions, response timeframes, procedures for checking request status, appeal routes, and key contacts. Responsibility for maintaining this information and communicating changes should be clearly assigned. Current plan-specific information should be accessible to staff responsible for scheduling, service delivery, authorization, billing, and communication with individuals receiving care and relevant collateral contacts.

The specific staffing structure may vary based on organizational size and workload. Some organizations may establish a dedicated utilization management or prior authorization function, while others may distribute responsibilities across existing clinical, administrative, and billing staff. Regardless of the staffing model, responsibility for each step should be clearly documented and assigned in organizational policy or procedures. Organizations should identify who initiates, reviews, submits, tracks, and follows up on authorization requests, as well as who communicates authorization decisions, service limits, expiration dates, and denials to clinical and administrative staff.

Organizations should also establish internal policies for situations in which authorization is required, pending, or denied. These policies should identify who has authority to decide whether services will begin or continue. Decision-making should account for the individual's clinical needs, authorization status and applicable timeframes, available appeal or review options, contractual requirements, and the possibility that services may not be reimbursed. The policies should also address how decisions affecting care will be communicated to the individual, appropriate staff, and relevant collateral contacts.

Regular communication across departments will be necessary to prevent prior authorization from becoming isolated within one area of the organization. Cross-functional meetings or utilization reviews can help identify individuals approaching authorization thresholds, pending requests, expiring authorizations, documentation needs, denials, appeals, and claims issues. Patterns in authorization decisions, appeals, and claims outcomes should be incorporated into quality improvement and MCO contract management so organizations can identify internal process gaps, recognize recurring payer issues, and determine when workflow changes or payer escalation are needed. Organizations should designate backup coverage and escalation pathways so authorization work does not depend on one person.

2. **The Golden Thread - Strengthen Medical Necessity and Clinical Documentation**
   Medical necessity should guide clinical decision-making, service delivery, and documentation throughout the course of care. Engagement during assessment, treatment planning, intervention delivery, reassessment, and discharge planning gives individuals an opportunity to identify their goals and priorities, describe how symptoms and functional impairment affect their daily lives and participate in decisions about their care. Documentation needs to reflect that individualized clinical picture while clearly establishing why the services being provided are necessary.

   Assessments, treatment plans, progress notes, level-of-care decisions, discharge plans, and prior authorization requests should present one current and consistent clinical story. The Golden Thread connects identified needs and functional impairments to treatment goals,

interventions, service frequency and intensity, the individual's response to treatment, and discharge criteria. Information from functional assessments, standardized measures, and level-of-care tools contributes to that clinical picture, but the record also needs to explain what the information means for the individual rather than relying on scores or assessment results alone.

Progress notes should demonstrate more than the activities completed during a service. Documentation needs to clearly identify the interventions being delivered along with the symptoms, functional needs or treatment goals being addressed, and show how the individual responded. Progress notes should also discuss why continued care is needed or what would be a likely outcome if services were reduced or terminated. Over time, the record should demonstrate progress, continued barriers or changes in need, and explain why the current service, frequency, intensity, and level of care remain appropriate.

Continued medical necessity cannot be demonstrated simply by documenting that an individual continues to have symptoms or has not yet met treatment goals. When progress is limited or needs change, the clinical record should show that the treatment approach has been reconsidered. This may include changes to treatment goals, interventions, service frequency or intensity, referrals, coordination with other providers, or movement to another level of care. When the current treatment approach remains appropriate despite limited progress, the record needs to explain the clinical basis for continuing services at the same level, identify the barriers or circumstances affecting the individual's response, the lack of deterioration or return of symptoms with current service intensity, and the likely outcome if services were terminated or reduced.

Treatment plans are active documents that change or are updated as the individual's needs, progress, and services change. They support decisions about continued treatment, intensity and duration of care, as well as transition and discharge. Documentation across the record needs to make it possible to understand not only why treatment began, but why the current approach remains necessary and what would indicate that services should change or end.

Clinical supervision, peer review, self-audits, and targeted chart audits can reinforce these practices. Review activities should examine whether the Golden Thread is evident across the record, whether documentation supports the services being delivered, and whether treatment plans and clinical decisions are updated when the individual's needs or response to treatment change. Findings can then inform staff development, supervision, and changes to documentation workflows.

3. **Functional Assessment and Measurement-Based Care to Guide Treatment**
   Organizations should establish a consistent measurement-based care process that uses functional assessments, symptom measures, and other appropriate clinical tools to supplement professional judgment and strengthen treatment decisions. The process begins with establishing an objective baseline and continues throughout treatment so clinicians and individuals receiving care can evaluate whether symptoms, functioning, and other treatment targets are changing over time.

   Organizations can initiate measurement-based care incrementally for a service, program, location, or move forward organization wide. Regardless of your approach, starting somewhere is important. To begin, organizations need to identify which measures are appropriate for the populations and services they provide, when the measures will be administered, who is responsible for reviewing the results, and how the information will be incorporated into clinical practice. Measures should be completed at clinically meaningful points, including initial assessment, reassessment, and other clinically appropriate intervals so current findings can be compared with earlier results and meaningful changes in the individual's condition or response to treatment can be identified.

   Measurement becomes clinically useful when results are interpreted and acted upon rather than simply completed and placed in the record. Clinicians should compare current findings with the individual's baseline and previous results and consider whether the information demonstrates improvement, continued impairment, emerging concerns, or limited response to treatment. Results also need to be considered alongside the individual's experience, clinician observations, functional changes, and other relevant clinical information.

   When measures indicate that expected progress is not occurring, the information should prompt further clinical review. The question is not only whether services remain medically necessary, but whether the current treatment approach is producing the intended result, which could include preventing further deterioration or return of symptoms for individuals with chronic, recurring conditions. Clinicians may need to reconsider treatment goals, interventions, frequency or intensity of services, barriers to engagement, coordination with other providers, referrals, or the appropriateness of the current level of care. Repeated measures can then help determine whether those changes are having the desired effect.

   Improvement should also lead to active clinical decision-making. Meaningful and sustained progress can inform decisions about reducing service frequency or intensity, moving to another level of care, or beginning transition or discharge planning. In this way, measurement-based care supports both continued treatment when need remains and movement toward less intensive care when clinically appropriate.

Results should be discussed with the individual receiving care. Comparing objective findings with the individual's own experience can help identify progress that may otherwise be overlooked, clarify continuing concerns, and support shared decisions about treatment. This helps keep measurement-based care focused on the individual's goals rather than turning it into a compliance exercise.

The specific tools used will vary by population, condition, and service. Examples discussed during the regional sessions included the DLA-20 and WHODAS for functioning, the PHQ-9 and GAD-7 for specific symptoms, the ASI for substance use, and the ACT Transitional Readiness Scale for readiness to transition from ACT services. Organizations may also use age- or condition-specific measures, including child behavioral assessments or ADHD rating scales. Applicable level-of-care criteria, including ASAM for SUD services, should be used consistently when determining the appropriate intensity of care. These tools provide objective information to support clinical judgment but do not replace individualized assessment or professional decision-making.

Organizations should also evaluate whether measurement-based care is functioning as an active part of treatment rather than as an additional documentation requirement. Using the information must be evident in the clinical record. Clinical supervision and quality review can examine whether measures are being completed consistently, whether clinicians understand and interpret the results, whether results are discussed with individuals receiving care, and whether the information leads to reconsideration of treatment when progress or changing needs indicate that a different approach may be appropriate.

A consistent measurement-based care process also strengthens the information available when prior authorization is required. When the clinical record includes a baseline, subsequent results, the individual's response to treatment and evidence of how treatment has been adjusted over time, organizations are better positioned to demonstrate progress, continued impairment, and the clinical rationale for continued services. Prior authorization is therefore supported by the measurement-based care process rather than becoming the primary reason for implementing it.

4. **Practical, Scalable Technology, Automation, and AI**

   Technology solutions are tools to make utilization management processes more reliable, visible, and efficient. Organizations can use a combination of existing EHR functionality, spreadsheets, reports, dashboards, alerts, automation, and AI. The goal is to reduce administrative burden, identify approaching authorization thresholds, improve documentation, and ensure that staff have access to timely information. Technology

decisions need to reflect the organization's size, service mix, staffing capacity, available resources, and existing systems. Implementation may occur in phases, beginning with a dependable manual process before adding more advanced reporting or automation.

Organizations should first understand and maximize the capabilities already available within their EHR and reporting systems. Alerts can identify approaching utilization thresholds, authorization expiration dates, overdue reassessments, and treatment plans requiring review. Alerts need to provide enough advance notice for clinical reassessment, documentation review and timely submission, with responsibility for response and follow up clearly assigned. Reports and dashboards can provide clinical and administrative staff with centralized information about units used, authorization balances, pending requests, payer decisions, authorized dates and units, expiration dates, denials, appeals, and related claims outcomes. Organizations need to assign responsibility for entering, validating, updating, and reconciling this information. Regular review can identify individuals with unusually high or low utilization, utilization approaching authorization thresholds, authorizations expiring within the next 30 days, and requests requiring follow-up. Reports can also track request volume, payer turnaround times, approval and denial rates, denial reasons, the outcomes of peer-to-peer reviews, appeals and external medical reviews, claims payment outcomes and clinical or documentation quality measures. Organizations can use these findings to organize and centralize data to guide individual case follow-up, workflow improvements, documentation review, staff development and discussions with managed care plans. When existing technology does not support these functions, spreadsheets and other manual tracking systems may remain necessary.

AI can be considered as a solution to assist with documentation review, documentation scrubbing, transcription, prior authorization summaries, identification of missing information, utilization review, and trend analysis. AI should be treated as one possible tool within a broader technology strategy, not as a requirement for successful implementation. Organizations also need to determine what operational or clinical functions would result in anticipated benefit that justifies the cost and staff time required to implement, develop, and oversee the technology. AI-assisted work requires appropriate testing and ongoing review before it is used for clinical, authorization or compliance purposes. AI alone does not replace professional judgment, but may be a time-saving augmentation to support professional clinical care.

5. **Ongoing Education, Communication, and Change Management**
   Implementation of system and organizational culture change will require continued education, communication, reinforcement, and continuous feedback rather than a single training event. Staff need to understand the new requirements, the organization's internal

processes, and their individual responsibilities within the workflow. Education and implementation support should be tailored to the needs of clinical, intake, scheduling, billing, administrative, compliance, and quality staff. Staff also need to understand how their responsibilities connect with the work of other departments and how information and decisions move across the organization.

Ongoing education, supervision, and implementation support should address medical necessity, documentation, functional and level-of-care tools, utilization monitoring, prior authorization, denials and appeals, EHR changes, and the appropriate use of automation and AI. Organization-wide education can be reinforced through department meetings, clinical supervision, written guidance, practical examples, and targeted training when needed. Staff should understand why workflows and documentation expectations are changing and have opportunities to identify barriers and recommend adjustments. Documentation audits, denial and appeal patterns, performance data and staff feedback can help organizations identify where additional education, reinforcement, supervision, or workflow changes are needed.

Clients and families also need information about prior authorization requirements, authorization timelines, possible delays, and appeal rights. Staff will need training and tools to explain managed care policies and strategies to patients as supporting patient care and outcomes while managing costs along with the patient's rights and responsibilities in participating in those care decisions. Referral sources and community partners, including courts, law enforcement, schools, and hospitals, will need clear information about service options, referral pathways, and changes that may affect access. Consistent talking points and educational materials can help staff communicate these changes clearly. Continued regional and statewide peer learning can also help organizations compare workflows, tools, costs, and implementation lessons as the requirements take effect.

6. **Create Centralized, Standardized Utilization Visibility Across Providers and Payers**
   Authorization thresholds apply at the individual level across providers and managed care plans, but providers do not have a reliable way to view all services used by an individual. This creates a significant implementation risk because an organization may need to account for utilization that occurred elsewhere but cannot independently verify it.

   Presently, providers will need to establish processes or tools to interface with each Medicaid MCO to determine a patient's service utilization. At a minimum, providers need access to current information about services received across organizations, units used and remaining by service, the payer and provider associated with the service, existing authorizations, authorization periods, and changes in eligibility or payer responsibility. Organizations will

need to define when and the frequency with which the organization will check a patients utilization history. Clearly, the focus will be on high service utilizers, but also presents an opportunity to engage individuals that are underutilizing services but may be at risk of deterioration or decompensation that results in acute care needs. Organizations may consider how their current EHR or other technology tools could be of assistance in tracking and monitoring service utilization. Further, this presents an opportunity for more engagement with other service providers, key stakeholders, and revisiting the convening of local team meetings when a patient is receiving care from multiple providers.

Organizations should consider strategies that centralize utilization data, ideally at a local provider level not just within a single organization, to create opportunities for greater consistency and transparency across managed care plans. This approach, much like restoration of local team meetings, would support continuity of care and reduce administrative burden across local systems until a broader system wide approach is available.

Ideally, a centralized and standardized source of utilization information is needed so providers can make timely clinical and operational decisions. The PNM may be one potential mechanism, but the priority is establishing the required function at the individual plan level rather than selecting a single specific platform before the necessary capabilities are defined. Developing this capability will require coordination among ODM, managed care plans, and providers to define common data elements, update frequency, provider access, responsibility for maintaining accurate information, and a process for resolving discrepancies.

Ultimately, providers need clear information about submission methods, required documentation, confirmation of receipt, service definitions, clinical criteria, turnaround times, authorization status, and denial reasons. More consistent processes and data would reduce duplicative administrative work, support timely authorization requests and allow organizations to focus more attention on clinical care and service access.

- Ohio Council Regional BH UM Training Slides
- Wright State Regional Session Summary
- Grove City Regional Session Summary
- NEOMed Regional Session Summary
- Firelands Regional Session Summary