NMRE Utilization Management (UM) Program and Protocols

SUBJECT: UM Program and Protocols	ACCOUNTABILITY NMRE, NMRE Provider Network	Effective Date: March 26, 2014	Pages: 8
REQUIRED BY	PIHP Contract Section: "Utilization Management,", PCP Planning, Practice Guidelines, QAPIP Other: Michigan Parity Compliance Plan, Michigan Mental Health Code	Last Review Date: June 4, 2020	Past Review Date: July 19, 2019 October 29, 2025
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: NMRE CEO	Responsible Department: Access & UM	Reviewers: NMRE CEO

Definitions

Assessment: Comprehensive psychiatric evaluation, psychological testing, substance use disorder screening or other assessments conducted to determine a person's level of functioning and behavioral health treatment needs. Physical health assessments are not part of the CMH/PIHP services.

Authorization: The documented approval for services, ensuring they are medically necessary and meet program criteria, as appropriate for the conditions, needs, and desires of the member served.

Adverse Benefit Determination (ABD): A decision that adversely impacts a Medicaid beneficiary's claim for services due to: (42 CFR 438.400)

(1) Denial or limited authorization of a requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. [42 CFR 438.400(b)(1)]
(2) Reduction, suspension, or termination of a previously covered service. [42 CFR 438.400(b)(2)]
(3) Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)]
(4) Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for services. [42 CFR 438.210(d)(1)]

(5) Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. [42 CFR 438.210(d)(2)]
(6) Failure to provide services within 14 calendar days of the start date agreed upon during person-centered planning and as authorized by the PIHP. [42 CFR 438.400(b)(4)]
(7) Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. [42 CFR 438.408(b)(2)]
(8) Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3)]
(9) Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)]
(10) For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a beneficiary's request to exercise his/her right under §438.52(b)(2)(ii) to obtain services outside the network. [42 CFR 438.400(b)(6)]
(11) Denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial responsibility. [42 CFR 438.400(b)(7)]

Advance Notice of Adverse Benefit Determination: A written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid beneficiary at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect.

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or their representative.

CMHSP: Community Mental Health Services Program. For the purposes of this document, a CMHSP member is one or more of the following: Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority, and Wellvance.

Co-Occurring: A term used when a beneficiary has co-existing mental health and substance use disorders.

Concurrent Review: An assessment that determines the medical necessity or appropriateness of services as they are being rendered, such as an assessment of the need for continued inpatient care for hospitalized patients.

Medical Necessity: A determination, by appropriately credentialed practitioner, that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with the NMRE or its CMHSPs, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the NMRE's Specialty Supports and Services Contract with the State.

Northern Michigan Regional Entity (NMRE): The Prepaid Inpatient Health Plan (PIHP) for Region 2, the 21-counties located in Michigan's northern lower peninsula.

Northern Michigan Regional Entity (NMRE) Internal Operations Committee: A committee comprised of key, senior NMRE staff.

Northern Michigan Regional Entity (NMRE) Operations Committee: A committee comprised of the NMRE Chief Executive Officer and the five CEO's/Executive Directors of its Member CMHSPs.

Northern Michigan Regional Entity (NMRE) Quality and Compliance Oversight Committee: Regional quality improvement committee comprised of NMRE staff and quality leaders from the five Member CMHSPs. Additional Members may be appointed as appropriate, including members from the SUD Provider panel and services beneficiaries.

Over-utilization: Provision of clinical services that were not clearly indicated or that were indicated in either excessive amounts or in a higher-level setting than required.

Parity: Based on the Mental Health Parity Act of 1996 (MHPA), standardized criteria and assessments employed by all PIHPs to ensure equitable assessment of need and distribution of treatment services.

Prepaid Inpatient Health Plan (PIHP): One of ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, development disabilities, and substance use.

Person-centered Planning: The process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities.

Practice Guidelines: Tools that describe processes found by clinical trials or by consensus opinion of experts to be the most effective in evaluating and/or treating persons served who have a specific symptom, condition or diagnosis or describe a specific procedure.

Prospective Review: A utilization review conducted prior to the delivery of the requested medical service. Prospective reviews include the initial review conducted prior to the start of treatment, and the initial review for treatment to a different body part.

Retrospective Review: An assessment of the appropriateness of clinical services on a case-by-case or on an aggregate basis after the services have been provided.

Substance Use Disorder: The taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety or welfare, or a combination thereof.

Utilization Management: The examination and evaluation of the appropriateness of the utilization of an organization's resources.

Utilization Management Review: A process in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources.

Under-utilization: Failure to provide appropriate or indicated services or the provision of an inadequate or lower level of care and services than required.

Protocols

A. Mission

The mission of the Northern Michigan Regional Entity (NMRE) is: Develop managed care structures to support publicly funded behavioral health services.

B. Authority

The counties of Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford, through their designated Community Mental Health Service Program (CMHSP) Authorities or Organizations, created a Regional Entity (NMRE) pursuant to the authority granted under the Michigan Mental Health Code, MCL 330.1001 et seq., Section 1204b as amended, and, as applicable, the Michigan Public Health Code, MCL 333.1101, et seq., as amended.

The NMRE serves as the Prepaid Inpatient Health Plan (PIHP) to directly contract with the State as a managed care entity for its 21-county region. The NMRE receives State funding and contracts for behavioral health and certain substance use disorder services with its provider sponsored Community Mental Health Service Programs (CMHSPs) including: AuSable Valley Community Mental Health Authority d.b.a. Wellvance, Manistee-Benzie Community Mental Health d.b.a. Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Menta Health Authority, and Northern Lakes Community Mental Health Authority. As a PIHP, the NMRE provides, arranges for, or otherwise has the responsibility for the provision of any inpatient psychiatric hospital or institutional services, ensures compliance with the state partial risk contract, ensures adequacy of its provider network and available services, and manages substance use disorder (SUD) funding for Medicaid, block grant, and liquor tax.

C. Structure

The Utilization Management Program (UMP) is designed to ensure the provision of medically necessary services determined by qualified professionals provided through a person-centered planning process in a timely manner utilizing the adequate amount, scope, and durations of services. To ensure timely access to care in a largely rural region (21 counties covering 11,000 square miles), access to care and medical necessity determinations, along with initial and ongoing service authorizations, are carried out by the Member CMHSPs and their respective satellite programs. For SUD services, the NMRE has a central screening and authorization process using a network of providers that conduct face-to-face assessments. The NMRE “Access to Care Policy”, “Service Authorization,” “Access to Care Program,” and “Beneficiary Grievance and Appeals” policies describe the expectations of the access system, coverage determinations, and grievance and appeals processes.

Using criteria for medical necessity, the PIHP may deny services that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care that are experimental or investigational in nature, or 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. The PIHP may employ various methods to determine the amount, scope, and duration of services, including prior authorization for certain services, concurrent and post-service utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines. The PIHP may not deny services based solely on preset limits of the cost, or the amount, scope, and duration of services. Instead, determination of the need for services will be conducted on an individualized basis

The NMRE will ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. Utilization Management (UM) staff must sign a Utilization Management acknowledgement attestation affirming that the UM Program and Protocol is not structured to provide compensation or incentives to staff making authorization decisions.

D. Program Components

The NMRE measures and provides data about access to services and the appropriateness of rendered care using the following priorities:

(1) Federal requirements for Prepaid Inpatient Health Plans,
(2) MDHHS – PIHP contractual requirements (specifically indicators regarding access to care),
(3) Medicaid Provider Manual requirements for medical necessity and service eligibility,
(4) Stakeholder and beneficiary surveys related to satisfaction and health/function status,
(5) Additional items as indicated through analysis of measured performance data.

The review of utilized services will consist of multiple tools, including, but not limited to:

(1) ongoing concurrent reviews of each case;
(2) retrospective reviews of problem cases and random samples of all cases;
(3) special studies;
(4) analysis of grievances and appeals; and
(5) ongoing measurement, monitoring, and assessment of provider network system trends.

Proper program reviews are intended to reveal trends in over-utilization, under-utilization, and inappropriate utilization of the provider network's service continuum. The NMRE requires that each Member CMHSP has a Utilization Management program that minimally meets these needs. The NMRE will review processes during the annual monitoring of its provider network. The NMRE and its five member CMHSPs must have standing utilization review committees that meet at least quarterly. The NMRE and its CMHSPs utilize the Milliman Care Guidelines (MCG) system for medical necessity determinations for all levels of care pertaining to behavioral health services, as aligned with the Michigan Parity Compliance Plan.

1. <u>Concurrent Review</u>

The purpose of a concurrent review is to allow for the examination of requested services prior to providing an authorization. This examination ensures that the requested service, number of units of service, and the duration of the service meets criteria for medical necessity. Concurrent reviews are typically conducted on requests for inpatient services.

2. Retrospective Review

The purpose of the retrospective review is to allow for the examination of services requested and/or provided in the past. Retrospective reviews are conducted utilizing established data collection protocols. These reviews provide information about the services rendered in the provider panel, and about the quality of the referral decisions and authorizations. Retrospective reviews are used to monitor the appropriate use of the practice guidelines in delivering the services the organization is contracted to deliver through its provider network.

Retrospective reviews are conducted on a case-by-case basis on those cases identified as having encountered problems in the care episode, either due to provider or access management difficulties. These problems may include, but are not limited to, treatment failures, problems in gaining access and extended lengths of stay, change of insurance benefits, beneficiary complaints, or other concerns and disputes about the type, quality, or quantity of treatment rendered.

Open and closed cases may be identified for retrospective review through numerous mechanisms. Retrospective reviews may be completed on:

a. Cases in which an appeal or grievance was filed;
b. Cases in which an inquiry was made regarding provided services;
c. Cases identified by NMRE or Network Provider staff as being problematic;
d. Cases involving lengths of stay that exceed selected statistical levels (outliers) for that age, sex, and diagnosis group;
e. A percentage of a Network Provider's open and closed cases selected randomly;
f. Cases in which the insurance eligibility has changed.

The NMRE reviews aggregate data on retrospective reviews as needed. Appropriate Network Providers are given summary reports for review. These reports are refined and standardized. When possible, comparisons are made across the CMHSP services area. The level of detail is commensurate with the level of review (i.e., provider-specific for providers, provider and population comparisons for the NMRE service delivery area, and regional for the NMRE Operations Committee.) This method of quick comparisons across CMHSP service area provides a useful overview and identify areas for further review.

Utilization management reports are reviewed by NMRE licensed clinical staff. Summaries of these reports are provided to the Regional Quality and Compliance Oversight Committee (QOC) at least quarterly.

3. Prospective Review

The purpose of prospective review is to examine and analyze regional data and apply it when making predictions of capacity, service volume, and cost.

Prospective reviews are conducted by reviewing the findings of concurrent and retrospective reviews and broadly applying them to the NMRE's entire region. The NMRE reviews this information making comparisons across the CMHSPs' services area. The level of detail is commensurate with the level of review (i.e., provider-specific for providers, provider and population comparisons for the PIHP service delivery area, and regional for the Operations Committee.) This method of quick comparisons across CMHSP service may identify areas for further review. This broad analysis of performance, when applied to what was anticipated or predicted, may allow leaders to make informed judgments about processes, define opportunities for improvement and design, and decide whether existing services are meeting program objectives.

Summaries of these reports are provided to the QOC at least quarterly.

4. Special Studies

Special studies, clinical and non-clinical, are conducted each year, or as appropriately indicated by data, to research and evaluate the impact of various clinical operations, conditions, or situations on the frequency, types, and quality of services rendered. These studies may focus on various patterns of utilization, outcomes for certain treatments or member groups, or any other emerging issues that impact quality care. Potentially, two special studies, one concurrent and one retrospective, may be conducted each year. The NMRE consults with the QOC to define these targeted studies.

Network Provider staff at any level within the organization may submit issues of concern to the NMRE. For example, a manager who identifies a concern with a certain diagnostic group or treatment approach may make a request for a more formal assessment regarding the concern. After reviewing the request, the NMRE may implement a directed study. Findings are disseminated to the Network Provider to consider a modification in its procedures.

5. Grievances and Appeals

Grievances and appeals are often a reaction to improper utilization management of services and are an important measure of a Network Provider's ability to engage beneficiaries in treatment and work with them on their presenting problems. For each denial, reduction, or restriction of care, beneficiaries have an opportunity to grieve or appeal decisions.

Grievance and appeal information is collected from each Member CMHSP and maintained by the NMRE; this allows for analysis regarding trends around types of complaints, complaints about facilities or Network Providers, and outcomes. Specifically, the number of grievances and appeals, and the number of upheld and overturned decisions aggregated and reported to the QOC. Information gained is used for system improvements, provider network development, and Network Provider credentialing.

6. Adverse Benefit Determinations

NMRE monitors Adverse Benefit Determinations (ABD) at least quarterly to ensure the NMRE and its providers utilize the appropriate action notices and procedures. Notice of Adverse Benefit Determination must include information as specified in 42CFR 438.10 and comply with the NMRE's "Beneficiary Grievance and Appeals" policy.

7. Data Reports

Data reports are constructed to serve various functions. The reporting format facilitates a quick review and identification of potential issues for further review.

Aggregate utilization management reports are generated as needed to identify and analyze trends in the delivery of clinically necessary care. Data gained from concurrent reviews, retrospective reviews, special studies, and grievances and appeals are available from the NMRE to Network Providers as requested. Data may be reported and organized by provider, benefit plan, payer, group, diagnostic group, and other categories or combinations of categories to include care service types, settings, levels, intensities and modes. Information about findings from these reviews, such as length of stay, incidence rates and overall utilization, is acquired and organized into reports that are reviewed quarterly for the purpose of formulating recommendations regarding NME and its Network Providers' operations.

Aggregate data collected accurately and systematically is the source for:

a. Establishing baseline performance,
b. Describing processes,
c. Assessing program stability by describing program functions and outcomes,
d. Identifying areas for improvement, and
e. Determining whether changes have met established objectives.

Specific reports are defined and analyzed by the NMRE. These reports and any program change recommendations are shared with the QOC, Operations Committee, Internal Operations Committee, Regional Consumer Council, and Network Providers as appropriate. The Operations Committee may request additional data analysis and reports. Examples of service and utilization data and cost analysis reports are:

a. Penetration rates by populations,
b. Numbers of individuals served per month by diagnosis,
c. Hospital bed days per thousand members by quarter by population, and
d. Outpatient units of service per 1000 members by month

Cases involving lengths of stay that exceed defined and selected statistical levels for that age, sex, and diagnosis group are considered "outliers," or unusual cases. In any aggregate data or analysis of data, "outliers" may be evident and defined statistically.

Monitoring these "outliers" from a utilization management perspective may yield valuable information. "Outliers" may indicate exceptional success or less than optimum success when measuring outcomes. Accurate and systematic information regarding "outliers" may also be relied upon for:

a. Establishing baseline performance,
b. Describing processes,
c. Assessing program stability by describing program functions and outcomes,
d. Identifying areas for improvement, and
e. Determining whether changes have met established objectives.

Areas of NMRE interest may include:

a. Increasing or decreasing inpatient day,
b. Increasing or decreasing required staffing levels,
c. Changing living arrangements,
d. Reviewing persons receiving Specialized Residential Services (SRS) after 180 days.

E. Program Evaluation

The entire NMRE utilization management process and UMP are reviewed on an ongoing basis. When requested, the NMRE completes a UMP evaluation including a review of:

1. The Utilization Management Plan,
2. All utilization oversight activities, policies, and procedures,
3. The appropriateness and relevance of under- and over-utilization measures.

Documentation of the UMP findings and recommendations are compiled and shared with the QOC, Operations Committee, Internal Operations Committee, the Regional Consumer Council, and Network Providers as appropriate. The UMP evaluation may lead to:

1. Identification of education/training needs,
2. Recommendation to revise procedures related to utilization,
3. Recommendations pertaining to credentialing,
4. Changes in operations to minimize risks in the delivery of quality services,
5. Development of objectives for the coming year.

Approval Signature

NMRE Chief Executive Officer

October 29, 2026

Date