NORTHERN MICHIGAN REGIONAL ENTITY
UTILIZATION MANAGEMENT PLAN
PLAN # 04-05-002-17

I. MISSION

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

The NMRE is committed to the management and delivery of necessary services that ensure individuals have timely access to quality care in the most clinically appropriate, least restrictive environment and in the most caring, sensitive, and confidential manner possible.

The purpose of the Utilization Plan (UM Plan) is to describe the collection and use of aggregate data from NMRE service delivery activities. Upon the receipt of properly analyzed and reported data, NMRE leaders and service providers can make informed judgments about processes, define opportunities for improvement and redesign, and decide whether existing services are meeting program objectives.

The NMRE acknowledges that comorbid mental health and substance use disorders is an expectation that must be addressed throughout the behavioral health system. All programs must address the likelihood that individuals served for mental health services may have substance use disorders; and that many individuals served for a substance use disorder may also need mental health services. The NMRE embraces a "no wrong door" policy in which an individual's needs and desires are addressed and linkages are made to appropriate providers in a seamless manner.

The UM Plan guides the use of services to benefit individuals served. Utilization management functions are driven by the NMRE's commitment to providing consistent and equitable, high quality care. These functions provide supports and promote opportunities to assist individuals served to achieve their full potential. Essential to UM is an evaluation of the appropriate allocation of resources to provide the highest quality care in the most cost effective manner. The NMRE measures and provides data about access to services and the appropriateness of services delivered. The NMRE's UM process reflects the expectations and standards of:

1. The Centers for Medicare and Medicaid Services (CMS)
2. The Michigan Department of Health and Human Services (MDHHS)
3. Medicaid Provider Manual requirements
4. Satisfactions surveys from stakeholders and individuals
5. Additional items as indicated through analysis of measured performance data

At the foundation of the NMRE UM process are the platforms of Recovery, Self-Determination, Self-Advocacy, Trauma Informed Care, and Family Resiliency through a Person/Family-Centered Planning Process.

II. SCOPE

The NMRE utilization management program is comprehensive, extending to all Community Mental Health Services Providers (CMHSP) and all providers delivering substance use disorder treatment. The NMRE reviews and indirectly manages services to individuals from the point of entry (access) through

treatment, and ultimately discharge. All services are subjected to the review process. Data examined includes utilization patterns of access to services, initial and ongoing care and treatment authorizations, appeals, person-centered planning, and discharges. Utilization management is intended to complement quality improvement activities of provider organizations.

In reviewing the person/family-centered planning process, the NMRE relies on functional assessments and authorization decision guidelines. Authorization decisions regarding the scope, frequency, and duration of planned services are made by CMHSP or substance use provider clinical staff. Ultimately, these are utilization management decisions.

The NMRE has developed standardized service arrays that equate to the needs of *most* individuals based on the results of functional assessments. The NMRE recognizes that these standardized arrays cannot address the unique needs of *all* individuals/families served. A specialized review process has been developed to ensure that all individuals/families served have access to all medically necessary services in the amount, scope, and duration needed to reasonably achieve the goals identified in the individualized plan of services.

The services authorization process combines the use of functional assessments such as the Child and Adolescent Functional Assessment Scale (CAFAS), the Level of Care Utilization System (LOCUS), and the Supports Intensity Scale (SIS) along with authorization guidelines to support and inform the person/family-centered planning process based on the needs, wants, and desires of those served.

The intent of using authorization decision guidelines is to identify initial and ongoing pathways for supports, services, care, and treatment that will empower individuals/families served and their support networks to make decisions about how best to lead self-determined lives to achieve their full potential and embrace the principles of recovery and resiliency.

Authorization decision guidelines match the intensity of services to the level of need in order to develop an individualized plan of services and supports to best direct an individual/family to achieve stated goals. Authorization guidelines are intended to focus clinical input on the needs, wants, and desires of individuals/families served and designed to ultimately support the strategies chosen in the individualized plan of services. The authorization decision guidelines take into consideration the factors that *most* clinicians/professionals would apply to determine how much, what type, and what duration of supports, services, treatment, and care an individual would *typically* need by considering the needs and symptoms in the context of broader person/family-centered resources and quality of life.

Authorization decision guidelines promote transparency for individuals, family/friends, support network and staff. To ensure transparency based on public policy and consistent across the NMRE provider network, reporting and auditing measures have been put in place. These include a variety of data analytics such as over/under authorization and utilization reports, audits of clinical protocols, and the use of dashboards and longitudinal reports.

III. PHILOSOPHY

Mental health and substance use disorder services delivered through the NMRE provider network will be managed in a manner that appropriately allocates resources in order to achieve an optimum, achievable quality of care in a cost-effective manner. A continuous, periodic review and assessment of the utilization and success of applied resources assists leaders in determining the quality and operation

of the provider network. Utilization management allows for ongoing development and enhancement of the access and continuum of care process.

IV. AUTHORITY

The utilization management program is under the direction and management of the NMRE. The NMRE was created under authorization of Section 330.1204(b) of the Michigan Mental Health Code. The member CMHSPs are: AuSable Valley Community Mental Health, Manistee Benzie Community Mental Health d.b.a. Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health, and Northern Lakes Community Mental Health.

Pursuant to federal regulations found in 42 CFR Part 438, as well as the MDHHS-PIHP Contract, the NMRE is responsible for utilization management. The NMRE delegates, via contractual arrangement, primary utilization management activities to the member CMHSPs. As such, the NMRE is required to monitor those activities as it remains the primary responsible entity.

V. UTILIZATION MANAGEMENT COMMITTEE

Purpose and Goals

The Utilization Management Committee is the primary body responsible for evaluating the utilization of NMRE/CMHSP managed services and is established consistent with the Operating Agreement approved by all five CMHSP members (stated under Section IV). Members of this committee will represent the NMRE, provider organizations, and individuals served and/or family members. The committee will review and approve reports submitted to, and received from, the State of Michigan, Boards of Directors, Operations Committee, advisory committees, and provider organizations. The UM Committee is accountable to the NMRE Quality Improvement Committee and reports to the NMRE Quality Oversight Committee.

The goal of the UM Committee is to monitor medical necessity, intensity of services, appropriateness, and efficiency of the use of defined behavioral health services. The ultimate objective is to make the most effective use of designated resources available for the care of individuals/families served.

The NMRE uses authorization decision guidelines intended to ensure that service authorizations are medically necessary and based on individual/family needs and person/family-centered planning and not compromised by financial considerations. This is accomplished using a variety of data analytics such as over/under utilization, and utilization reports, audits of clinical protocols, the use of dashboards and longitudinal reports. Making these reports publicly available on the NMRE website helps to promote transparency.

The NMRE and its providers take measures to ensure the proper use of functional assessments and authorization decision guidelines via staff training and communication with individuals/families served and their supports. The UM Committee will oversee the ongoing evaluation of the effectiveness of utilization management in measuring outcomes. The UM Committee, the Clinical Leadership Committee, and the Quality Oversight Committee are responsible for region-wide outcomes (macro-based monitoring).

Membership

Each Member CMHSP Director appoints two members to the UM Committee, at least one of whom must be involved in the CMHSP's UM process. The NMRE CEO will appoint NMRE staff, at least one of whom represents SUD services. Membership is representative of service populations and will include at least one individual served.

Utilization management of substance use disorder services is not a delegated function. As such, this activity is performed by appropriate NMRE SUD staff. This process involves prior authorization, periodic review, and onsite verification.

All UM Committee meeting minutes (with supporting attachments) will be approved by the Committee and kept on file.

VI. PROGRAM COMPONENTS

Utilization management accurately describes how the managed provider network services are utilized. The review of utilized services consists of multiple tools, including but not limited to: ongoing concurrent reviews of each case; retrospective reviews of outlier cases and random samples of all cases; special studies, analyses of grievances and appeals; and ongoing measurement, monitoring, and assessment of provider network system trends. The utilization review process captures information from numerous areas within the clinical record and places particular emphasis on timeliness of access to needed services, quality of life, individual outcomes, compliance with UM authorization decision guidelines, practice guidelines, protocols, satisfaction, and effectiveness. Most performance information is derived from record reviews and encounter data. Utilization management activities, both local and regional, include utilization reviews using standard audit tools. Proper program review will reveal trends in over/under utilization and inappropriate utilization of the provider network's service continuum. As a delegated function, each Member CMHSP must have a utilization management program that minimally meets these needs.

1. Concurrent Review

   The purpose of a concurrent review is to allow for the examination of requested services prior to providing an authorization. This examination includes ensuring the requested services, number of units of services, and the duration of the services meet medical necessity criteria. Concurrent reviews are typically only conducted on request 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 furnish information about the services rendered from the provider panel, and about the quality of the referral decisions and authorizations made by access care managers. Retrospective reviews monitor the appropriate use of practice guidelines in delivering the services the organization is contracted to deliver through the NMRE provider network.

   Retrospective reviews on an episode of care may be conducted on a case by case basis where specific questions or issues were identified either due to provider or access management difficulties. These problems may include, but are not limited to, treatment failures, problems in gaining access

and in extended lengths of stay, change of insurance benefits, member complaints, or other concerns and disputes about the type, quality, or quantity of treatment rendered. Summary information from retrospective reviews will be reported to the UM Committee.

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

- Cases that had an appeal or grievance filed
- Cases where an inquiry has been made regarding provided services
- Cases identified by Access Center Care Managers and CMHSP provider supervisors as being problematic
- Cases whose length of stay exceeds selected statistical levels (outliers) for that age, sex, and diagnosis group
- A random sample percentage of a provider's open and closed cases
- Cases where insurance eligibility has changed

The Utilization Management Committee will review aggregate data on retrospective reviews as appropriate. Summary reports from the NMRE will be refined, standardized, and reviewed by the UM Committee. The UM Committee will compare data across CMHSP services area. The level of detail will be 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 area is intended to provide an overview and identify areas for further review.

Utilization management reports are reviewed by the UM Committee. Summaries of these reports will be provided to the NMRE Quality Improvement Committee and the NMRE Quality Oversight Committee at least quarterly.

3. Prospective Review

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

Prospective reviews are conducted by the UM Committee by reviewing the findings of concurrent and retrospective reviews and broadly applying them to the NMRE's entire region. When reviewing the information, the UM Committee makes comparisons across CMHSP services areas. The level of detail is to be 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 areas is intended to 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 (re)design, and decide whether existing services are meeting program objectives.

Summaries of these reports will be provided to the NMRE Quality Improvement Committee and the NMRE Quality Oversight Committee quarterly.

4. Special Studies

Special studies, clinical and non-clinical, will be 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 can focus on various patterns of utilization, outcomes for certain treatments or member groups, or any other emerging issues that impact quality of care. Potentially, two special studies, one concurrent and one retrospective, should be conducted each year. The UM Committee will participate with the NMRE Quality Improvement Committee and the NMRE Quality Oversight Committee to define these targeted studies.

Managers and providers at any level within the organization may submit issues of concern to UM Committee members for consideration. 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. The UM Committee, after reviewing the request, may then implement a directed study. Findings are distributed to providers who may then recommend a modification in procedures.

5. Grievance and Appeals

Grievances and appeals are often a response to proper service utilization management and are an important measure of a provider's ability to engage individuals/families served in treatment and work with them to ameliorate presenting problems. At each denial, reduction, or restriction of care, individuals/families served are provided with an opportunity to grieve or appeal decisions.

Grievances and appeals information is collected from each Member CMHSP and maintained in a database; this allows information analysis regarding trends around types of complaints, complaints about particular facilities or providers, and the outcomes of the situations. Specifically the number of grievances and appeals, and the number of upheld and overturned decisions will be aggregated, and reported. Information gained may be used for system improvements, provider network development, and the credentialing of providers.

6. Data Reports

Data reports must be constructed to serve various functions. The reporting format is constructed to facilitate quick review and to identify 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 review, retrospective review, special studies, and grievance and appeals is available from NMRE, CMHSP Access Centers, network provider management information systems, clinical records, and individuals/families served. 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 NMRE operations and providers.

Aggregate data, collected accurately and systematically, may be relied on to establish baseline performance, describe a process, assess program stability by describing program functions and outcomes, identify areas for improvement, and determine whether change has met established objectives.

Specific reports will be defined and analyzed by the UM Committee. These reports and any program change recommendations will be shared with the NMRE Quality Oversight Committee, Operations Committee, the regional consumer council (REP group), and CMHSP consumer councils as appropriate. The Operations Committee may direct that specific data analysis and resultant reports be completed and presented. Examples of service and utilization data and cost analysis reports are:

- Penetration rates by populations
- Number of individuals served per month by diagnosis
- Hospital bed days per thousand members by quarter, by population
- Outpatient units of service per 1000 members by month

Cases with length of stay durations that exceed defined and selected statistical levels for that age, sex, and diagnosis group are referred to as outliers, or unusual cases. In any aggregate data or analysis of data outliers may be evident and defined statistically. The monitoring of outliers from the utilization management perspective yields 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 to establish baseline performance, describe a process, assess program stability by describing program functions and outcomes, identify areas for improvement, and determine whether change has resulted in established objectives. Areas of interest may include:

- Increase or decrease in inpatient hospital days
- Increase or decrease in required staffing levels
- Changes in living arrangements
- An NMRE review of individuals who are receiving Specialized Residential Services (SRS) after 180 days

VII. UTILIZATION MANAGEMENT STANDARDS

The NMRE's UM Committee will define and monitor the utilization indicators and standards that are necessary to support its contract with the Michigan Department of Health and Human Services. It will also protect the quality of services delivered by providers, funding sources, and standing with accrediting bodies. This includes performance measures required in the MDHHS-PIHP Contract. This report provides valuable information that lends itself to examination from "outlier" perspective. Access indicators, timeliness, average length of stay, and admissions per thousand are all examples of how data may be organized, examined, reported, and applied to program improvement efforts.

As utilization management is a delegated function, it is essential that consistent standards are developed and adopted. This is an ongoing process, led by the UM Committee.

VIII. PROGRAM EVALUATION

The entire NMRE utilization management process and Utilization Management Plan are reviewed on an ongoing basis and are formally reviewed annually and revised if needed. The UM Committee completes the program evaluation including a review of:

- The year's Utilization Management Plan
- The functions of the UM Committee
- All utilization oversight activities, policies, and procedures
- The appropriateness and relevance of under and over utilization measures

Documentation of the Utilization Management Plan annual review, findings, and recommendations are compiled by the UM Committee and shared with the Quality Oversight Committee, Operations Committee, NMRE Quality Improvement Committee, the regional consumer council (Regional Entity Partners), and the consumer councils of the Member CMHSPs as appropriate. The annual program evaluation may lead to:

- Identification of education/training needs,
- A recommendation to revise procedures related to utilization,
- Recommendations pertaining to credentialing of practitioners.
- Changes in operations to minimize risks in delivery of quality services,
- Development of objectives for the coming year.

IX. DEFINITION OF TERMS

Assessment: 1) For purposes of member assessment, the process established by an organization for obtaining appropriate and necessary information about each individual seeking entry into a health care setting or service. The information is used to match an individual's need with the appropriate setting, care level and intervention. 2) For purposes of performance improvement, the systematic collection and review of member-specific data.

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.

Persons Served: Individual who is currently receiving services and/or supports from a CMHSP, a contracted provider or vendor through an agreement with a PIHP/CMHSP to provide services and /or support.

Co-occurring disorder: Co-occurring disorders refers to co-occurring substance use (abuse or dependence) and mental disorders. Persons served said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. (Substance Abuse Treatment for Persons with Co-Occurring Disorders, TIP 42, USDHHS, Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, 2005).

Medical Necessity: A determination 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 (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY 11).

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.

Person-centered Planning: Means 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. It honors the individual's preferences, choices, and abilities (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY11).

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.

Recovery: Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, National Mental Health Information Center).

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. 0 +

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 inadequately or lower level of services than required.

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Signed copy on file at NMRE

Dave Schneider
Northern Michigan Regional Entity Chief Executive Officer

Date

Signed copy on file at NMRE

Dennis Priess
Northern Michigan Regional Entity Board Chair

Date