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	BBA Section: PIHP Contract Section: 7.10, "Utilization Management," P4.4.1.1, PCP Planning Practice Guidelines, P7.9.1, QAPIP Other:	Last Review Date: June 4, 2020	Past Review Date: July 19, 2019 January 25, 2017
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: NMRE CEO	Responsible Department: Access & UM	Reviewers: NMRE CEO

Definitions

Assessment: A 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.

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

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

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 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 that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

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

Northern Michigan Regional Entity Leadership (NMRE) 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 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.

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 inadequately or lower level of 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, Manistee-Benzie Community Mental Health d.b.a. Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental, and Northern Lakes Community Mental Health. As a PIHP, the NMRE will provide, arrange for, or otherwise have the responsibility for the provision of any inpatient psychiatric hospital or institutional services, ensure compliance with the state partial risk contract, ensure adequacy of its provider network and available services, and manage substance use disorder (SUD) funding for Medicaid, block grant, and liquor tax.

C. Structure

The Utilization Management Program (UMP) will focus on the provision of medically necessary services determined by qualified professionals and that those services are provided through a person-centered planning process in a timely manner utilizing the adequate amount, scope, and durations of services. To assure 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, will be carried out by the Member CMHSPs and their respective satellite programs. For SUD services, the NMRE will have a central screening and authorization process using a network of providers that conduct face-to-face assessments. The NMRE "Access to Care Policy" and "Access to Care Program" will describe the expectations of the access system, coverage determinations, and a brief introduction to grievance and appeals processes.

The NMRE will assure that compensation to individuals or entities that conduct utilization management activities is not structured wo as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

D. Program Components

The NMRE will measure and provide data about the 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 review 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 review will reveal trends in over-utilization, under-utilization, and inappropriate utilization of the provider network's service continuum. The NMRE will require 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.

1. Concurrent Review

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

2. Retrospective Review

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

   Retrospective review will be conducted on a case-by-case basis on those cases identified as having encountered problems in the episode of care 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, 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 that had an appeal or grievance filed;
   b. Cases where an inquiry has been made regarding provided services;
   c. Cases identified by NMRE or Network Provider staff as beingproblematic;
   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 where the insurance eligibility has changed.

   The NMRE will review aggregate data on retrospective reviews as needed. Appropriate Network Providers will be given summary reports for review. These reports will be refined and standardized. When possible, comparisons will be made across the 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 NMRE service delivery area, and regional for the NMRE Operations Committee.) This method of quick comparisons across CMHSP service area will provide a useful overview and identify areas for further review.

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

3. Prospective Review

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

   Prospective reviews will be conducted by reviewing the findings of concurrent and retrospective reviews and broadly applying them to the NMRE's entire region. The NMRE will review this information making comparisons the 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 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 will be provided to the QOC at least 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 care. Potentially, two special studies, one concurrent and one retrospective, may be conducted each year. The NMRE will consult 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 will be disseminated to the Network Provider to consider a modification in its procedures.

5. Grievance 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 will have an opportunity to grieve or appeal decisions.

   Grievance and appeal information will be collected from each Member CMHSP and maintained by the NMRE; this will allow 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 will be aggregated and reported to the QOC. Information gained will be used for system improvements, provider network development, and Network Provider credentialing.

6. Data Reports

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

Aggregate utilization management reports will be 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 grievance and appeals will be 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, will be 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 will be 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 will be defined and analyzed by the NMRE. These reports and any program change recommendations will be shared with the QOC, Operations Committee, NRME Leadership 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 will be 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. Increase or decrease in inpatient day,

b. Increase or decrease in required staffing levels,

c. Changes in living arrangements,

d. Review persons receiving Specialized Residential Services (SRS) after 180 days.

E. Program Evaluation

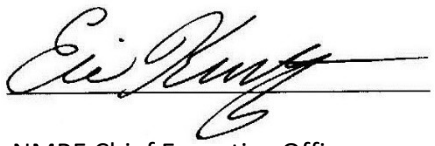
The entire NMRE utilization management process and UMP will be reviewed on an ongoing basis. When requested, the NMRE will complete a UMP evaluation including a review of:

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 will be compiled and shared with the QOC, Operations Committee, NMRE Leadership Committee, the Regional Consumer Council, and Network Providers as appropriate. The UMP evaluation may lead to:

1. Identification of education/training needs,
2. A 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

7/19/19

Date