

NORTH COUNTRY COMMUNITY MENTAL HEALTH  
NORTHERN AFFILIATION  
UTILIZATION MANAGEMENT PLAN  
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## I. MISSION

The mission of North Country Community Mental Health, Northern Affiliation, is to provide or facilitate, in a value added, cost effective way, functions which promote consumer and organization success in a managed care environment. The Northern Affiliation is committed to the management and delivery of necessary services that ensure consumers 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 Management Plan is to describe the collection and use of aggregate data from Northern Affiliation service delivery activities. Upon receipt of properly analyzed and reported data Northern Affiliation leaders and service providers can make informed judgments about their processes, define opportunities for improvement and redesign, and decide whether existing services are meeting program objectives.

The Utilization Management Program Plan focuses upon the consumer's use of services. Utilization management evaluates appropriate allocation of resources so as to provide quality consumer care in the most cost-effective manner. Northern Affiliation measures and provides data about the access to services and the appropriateness of rendered care. The performance measures employed in this plan will be based upon the following priorities:

1. Federal requirements for Prepaid Inpatient Health Plans
2. MDCH/PIHP, MDCH/CMHSP and PIHP/CMHSP contractual requirements
3. Stakeholder and consumer surveys related to satisfaction and health/function status
4. Additional items as indicated through analysis of measured performance data

## II. SCOPE

Northern Affiliation's Utilization Management Program is comprehensive in nature extending to all member organizations delivering community mental health services. The Northern Affiliation reviews and indirectly manages consumer care from the point of entry, through treatment and delivered services, to discharge. All delivered consumer services are subject to review. Examined data will include utilization patterns in access to service, initial and on-going care and treatment authorizations, appeals, person-centered planning and discharges. Utilization management is intended to complement quality improvement activities of provider organizations.

## III. PHILOSOPHY

Mental health services provided by Northern Affiliation providers will be managed in a manner that appropriately allocates resources in order to provide an optimum, achievable quality of consumer care in a cost-effective manner. A continuous, periodic review and assessment of the utilization and success of applied resources aids 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 North Country Community Mental Health, Northern Affiliation, an affiliation of Community Mental Health Services Programs (CMHSPs) organized in the "Hub and Spoke" model described in the Michigan Department of Community Health's Revised Plan for Procurement of Medicaid Specialty Prepaid Inpatient Health Plans, September 2000. The participants in this affiliation are AuSable Valley Community Mental Health, North Country Community Mental Health, and Northeast Michigan Community Mental Health. North Country Community Mental Health has been selected as the "Hub," and as such, serves as the Prepaid Inpatient Health Plan (PIHP) and contract holder for the Spokes. Specific authority for Northern Affiliation's operations is through contact with Michigan's Department of Community Health via agreements consistent with the Intergovernmental Transfer of Functions and Responsibilities Act (Public Act No. 8 of the Public Acts of 1967, Extra Session). The Director of North Country Community Mental Health, the designated "Hub," will establish a Utilization Management Committee to implement this plan.

#### V. UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee is the primary body responsible for evaluating the utilization of Northern Affiliation provider services. Members of this committee will represent the Northern Affiliation, provider organizations, and consumers and/or family members. The committee will review and approve reports submitted to, and received from, the State of Michigan, Boards of Directors, Operations/Advisory Committee and provider organizations. The Utilization Management Committee is accountable to the PIHP Quality Improvement Committee and reports to the Quality Oversight Committee.

The goal of the Utilization Management Committee is to monitor the medical necessity, intensity of service, appropriateness, and efficiency of the use of defined mental health services. The ultimate objective is to make the most effective use of designated resources available for the care of the consumer.

The Utilization Management Committee is responsible for analyzing, and reporting service utilization data. These data are reported as described in section VI, 6. Data Reporting.

The Director of North Country Community Mental Health, the "Hub" organization, appoints, upon nomination by the Operations/Advisory Committee, members to the Utilization Management Committee. Membership includes:

1. Northern Affiliation Administration member
2. Quality Oversight Committee member
3. Consumer
4. Northern Affiliation Medical Director
5. Northern Affiliation Access Center Director
6. Clinical services representative for children and adolescents
7. Clinical services representative for persons with a developmental disability
8. Clinical services representative for persons with a mental illness

Each comprehensive provider organization; e.g., each existing “board area,” will have at least one representative on the Utilization Management Committee.

All Utilization Management Committee meeting minutes with supporting attachments will be kept and approved. Minutes will be organized by date, most recent first, by calendar year and a copy retained by the “Hub” organization.

## VI. PROGRAM COMPONENTS

Utilization review 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 review of problem cases and random samples of all cases; special studies; analysis of grievances and appeals; and 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.

### 1. Concurrent Review

The purpose of concurrent review is to allow for the examination of requested services at the time of the request. This examination includes the requested service, justification for the service, number of units of service, and the duration of the service. Concurrent reviews are typically only conducted on requests for inpatient services.

Concurrent review is conducted by Access Center care managers and representatives at each clinical decision point in the inpatient episode of care. These reviews occur whenever services are requested: i.e., at the initial request for treatment, and at each subsequent request for ongoing authorizations of treatment and services. Care managers and representatives use the practice guidelines contained in the Michigan DCH Medicaid Provider Manual and the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY03-04 in authorizing, pending or denying requests. Information from these reviews is recorded into the regional information management system documenting the authorization of services. Once authorizations are approved claims for services may be submitted and paid.

### 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 in the provider panel, and about the quality of the referral decisions and authorizations made by access managers. 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 on a case by case basis may be conducted by Access Center care managers and representatives on those cases identified as encountering 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, member complaints, or other concerns and disputes about the type, quality, or quantity of treatment rendered. Information from these reviews is recorded into the regional information management system documenting the authorization of services.

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 percentage of a provider's open and closed cases selected randomly
- Cases where the insurance eligibility has changed

The Utilization Management Committee will review aggregate data on retrospective reviews. Summary reports provided by the PIHP will be reviewed. These reports are defined in Attachment A: Information Review Plan. The Committee will review this information making comparisons across CMHSP services area. 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 Affiliation 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 reviewed by the Utilization Management Committee are defined in Attachment A. Summaries of these reports will be provided to the PIHP Quality Improvement Committee and the Provider Quality Oversight Committee at least quarterly.

### 3. Prospective Review

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

Prospective review is conducted by the Utilization Management Committee by reviewing the findings of concurrent and retrospective reviews and broadly applying them to the Northern Affiliation's entire region. The Committee will review this information making comparisons across CMHSP services area. 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 Affiliation and regional for the Operations Committee. This method of quick comparisons across CMHSP service area 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 design, and decide whether existing services are meeting program objectives.

Summaries of these reports will be provided to the PIHP Quality Improvement Committee and the Provider 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 care. Potentially, two special studies, one concurrent and one retrospective, should be conducted each year. The Utilization Management Committee will participate with the PIHP Quality Improvement Committee and Provider Quality Oversight Committee in defining these targeted studies.

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

#### 5. Grievance and Appeals

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

Grievances and appeals information is collected from each Board and maintained in a database. This allows information 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. Attachment A to this plan describes the sort of routine data reports that will be reviewed in an effort to gain an overview of utilization patterns. The reporting format is constructed to facilitate quick review and identification of potential issues for further review. Attachment A is not intended to represent the only data reporting related to utilization of services.

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 Northern Affiliation, Access Center, network provider management information systems, clinical records, and consumers. Data may be reported and organized by Access Center care manager, 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 Northern Affiliation's operations and providers.

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

The specific reports will be defined and analyzed by the Utilization Management Committee. These reports and any program change recommendations will be shared with the Quality Oversight Committee, Operations/Advisory Committee, and CMHSP's Consumer Councils as appropriate. The Operations/Advisory 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:

1. Penetration rates by populations
2. Numbers of individuals served per month by diagnosis
3. Hospital bed days per thousand members by quarter, by population
4. Outpatient units of service per 1000 members by month

Cases whose length of stay exceeds 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 these "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 finally determine if change has met established objectives. Areas that may be examined for "outliers" are:

1. Increase or decrease in inpatient days
2. Increase or decrease in use of natural supports
3. Increase or decrease in number of crises

## VII. UTILIZATION REVIEW STANDARDS

Northern Affiliation's Utilization Management Committee will define and monitor the utilization indicators and standards that are necessary to support its contract with the Michigan Department of Community Health. It will also protect the quality of services delivered by providers, funding sources and standing with accrediting bodies. Of special significance is the Michigan Mission-Based Performance Indicator System which was implemented in 1998 with the signing of CMHSPs Managed Specialty Supports and Services Contracts. The indicators examined in this report are organized about four essential domains of quality: access, efficiency, outcomes, and quality and appropriateness (Michigan Mission Based Performance Indicator System, Version 6.0). This report provides valuable information that lends itself to examination from the "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.

### VIII. PROGRAM EVALUATION

The entire Northern Affiliation utilization management process and Utilization Management Plan is reviewed on an ongoing basis and is formally reviewed annually. The Utilization Management Committee completes the program evaluation including a review of:

1. The year's Utilization Management Plan
2. The function of the Committee
3. All utilization oversight activities, policies and procedures
4. 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 Utilization Management Committee and shared with the Quality Oversight Committee, Operations Committee, PIHP Quality Improvement Committee and CMHSP's Consumer Councils as appropriate. The annual program evaluation may lead to:

1. Identification of education/training needs
2. A recommendation to revise procedures related to utilization
3. Recommendations pertaining to credentialing of practitioners
4. Changes in operations to minimize risks in delivery of quality services
5. 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. (Comprehensive Accreditation Manual for Managed Care Organizations, 2005-2006, Joint Commission on Accreditation of Healthcare Organizations).

**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.

**Consumer:** Individual who is currently receiving services and/or supports from a CMHSP, a contractor provider or vendor through a voucher under contract with a CMHSP to provide services and /or support.

**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 03-04).

**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 FY 03-04).

**Practice Guidelines:** Tools that describe processes found by clinical trails or by consensus opinion of experts to be the most effective in evaluating and/or treating a consumer who has a specific symptom, condition or diagnosis or describe a specific procedure. (Comprehensive Accreditation Manual for Managed Care Organizations, 2005-2006, Joint Commission of Accreditation of healthcare Organizations).

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

**Utilization Management:** The examination and evaluation of the appropriateness of the utilization of an organization's resources. (Comprehensive Accreditation Manual for Managed Care Organizations, 2005-2006. Joint Commission on Accreditation of Health Care Organizations).

**Utilization 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.