UTILIZATION MANAGEMENT PLAN

FY2023

LAKESHORE REGIONAL ENTITY
FY23 UTILIZATION MANAGEMENT PLAN

Lakeshore Regional Entity (LRE) is the public behavioral health plan for individuals with mental illness, developmental disability, and substance use disorders in Allegan, Kent, Lake, Mason, Muskegon, Oceana and Ottawa counties. As one of 10 Prepaid Inpatient Health Plans (PIHP) in Michigan, LRE manages the Medicaid and Block Grant services provided under a contract with the State of Michigan's Department of Health and Human Services (MDHHS) to residents in the region.

The LRE UM Program is designed to utilize mechanisms to detect and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent and retrospective reviews. The LRE's Utilization Management (UM) Program must ensure the delivery of high quality, medically necessary care through appropriate utilization of resources in a cost effective and timely manner. The UM program provides the framework for the region to ensure services and UM activities are conducted in compliance with federal law and MDHHS contract requirements.

LRE has adopted Utilization Management and Service Delivery Polices and Procedures that guide regional UM functions and effective oversight.

LRE UM POLICIES
LRE SERVICE DELIVERY POLICIES

The LRE UM Program must meet the following core objectives:

- Ensure both financial viability and effective provision of services across the region
- Ensure regional capacity to meet consumer needs
- Use of common tools and/or protocols to consistently evaluate medical necessity for services
- Ensure regional capacity for all Utilization Management functions to control costs and minimize risk while assuring quality care.
- Ensure that all services conform to accepted standards of care
- Improve the consumer's experience of care

UM PROGRAM OVERVIEW

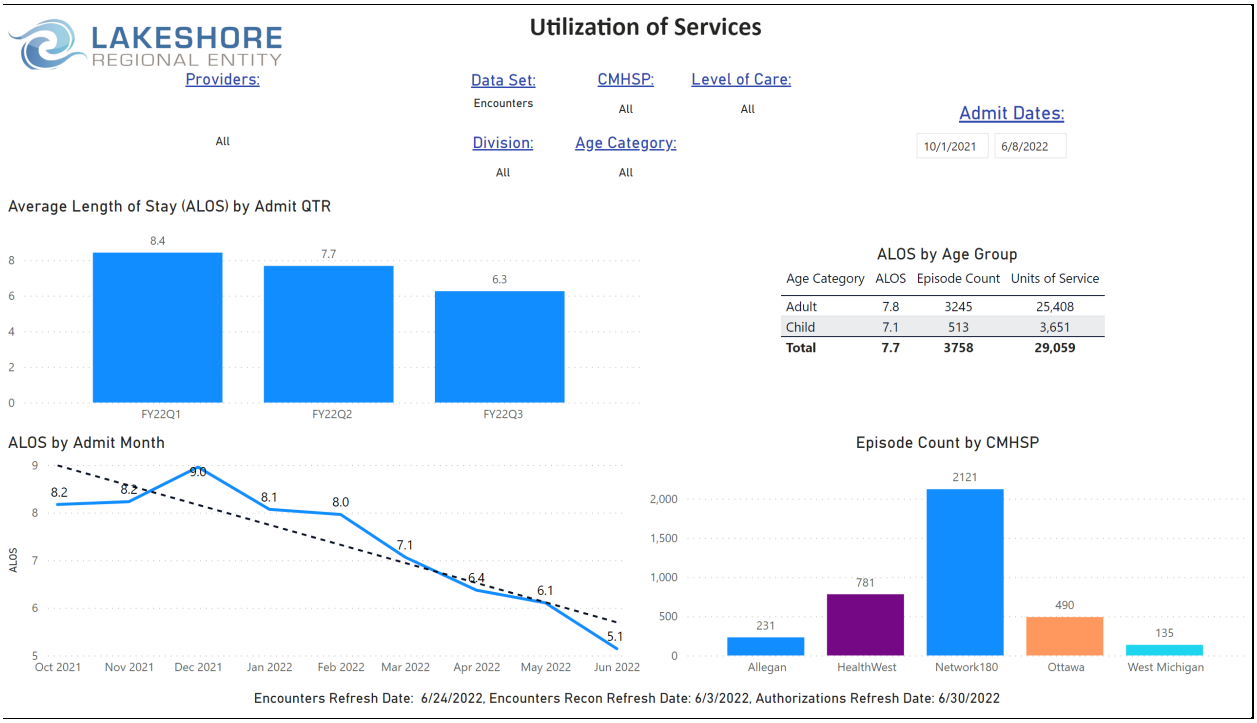
LRE must ensure regional access to public behavioral health services in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements. LRE has adopted the American Psychiatric Association Clinical Practice Guidelines as the established practice guideline for all Medicaid covered services. In addition, Milliman Care Guidelines (MCG) were adopted in 2020 and are utilized as an additional factor/criteria for decision-making and service authorization for inpatient, partial hospitalization, and crisis residential determinations

LRE currently provides oversight and monitoring of all delegated regional UM functions,

Over the past several years, LRE has engaged in significant redesign of its regional program to standardize UM functions across the region, including:

- Standardization of access to higher levels of care, including psychiatric inpatient, crisis residential, and partial hospitalization treatment
- Development of a regional policy and procedure to standardize continued stay review for inpatient, partial inpatient, and crisis residential placements.
- Methodologies to improve processes and reporting that assists CMHSPs with service eligibility determinations
- Standardized report sharing for higher level of care initial authorizations, continuing stay reviews, discharge reporting, multi-morbidity/high complexity case identification, and high-cost service reviews.
- Developed a regional auditing process to ensure Inter-Rater Reliability
- Created utilization data reports for higher level of care:
    - Psychiatric Inpatient ALOS (Example A)
    - Crisis Residential ALOS/Units
    - Partial Inpatient ALOS
    - Inpatient Admits/1000 and Inpatient Days/1000 (Example B)
    - Readmission Rates – 7/30 Days (Example C)

Example A



Example B

LAKESHORE REGIONAL ENTITY

UM HLOC Stats

Number of Medicaid IP Admits and Units of Service per 1,000 Medicaid Served

Latest Encounter Data Load Date:

Friday, May 27, 2022

Admit FY: FY22
- FY20
- FY21
- FY22

Admits per 1,000 Served

CMHSP	October	November	December	January	February	March	April	May
Allegan	27.15	21.94	18.65	19.14	22.25	15.93	1.28	
HealthWest	21.54	24.11	21.86	23.88	18.91	14.67	15.59	2.45
network180	26.51	24.52	25.43	20.17	20.65	20.25	17.23	
Ottawa	21.50	22.78	17.56	17.18	15.12	14.71	7.65	
West Michigan	8.37	6.90	6.85	13.56	9.12	8.11	8.88	0.84

Units of Service per 1,000 Served

CMHSP	October	November	December	January	February	March	April	May
Allegan	208.14	220.55	222.61	147.52	222.48	89.87	5.12	
HealthWest	161.53	196.61	203.75	217.64	145.21	116.65	88.76	7.85
network180	245.88	247.33	251.71	178.42	181.79	173.11	131.29	
Ottawa	214.99	183.89	143.91	147.45	77.91	127.83	31.37	
West Michigan	147.53	175.61	99.01	101.73	139.82	83.33	85.80	5.05

Example C

LAKESHORE REGIONAL ENTITY

Readmit Rates - 30 Day

Providers: All

Data Set: Encounters

CMHSP: All

Level of Care: All

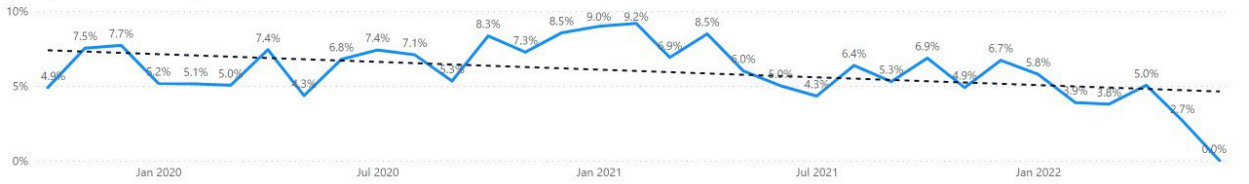
Division: All

Age Category: All

Readmit Dates: 10/2/2019 – 6/10/2022

30 Day HLOC Readmit % by Fiscal Year and Qtr

30 Day HLOC Readmit % by Year and Month



Encounters Refresh Date: 6/24/2022, Encounters Recon Refresh Date: 6/3/2022, Authorizations Refresh Date: 6/30/2022

The LRE will continue to focus on standardization of these activities in FY2023. Regardless of where these activities and functions occur, LRE retains responsibility to recommend and ensure improvement strategies across its service delivery network, particularly if adverse utilization trends are detected within the region.

In addition to continued standardization of regional UM functions, there will be continued efforts toward data integrity processes including identification of overlapping services and coding errors. LRE and CMHPSs continue collaborative work on authorization and claims files to provide greater visibility into real time medical expense via reporting tools and improved claims data exports/extracts to LRE from CMHSPs.

OVERSIGHT STRUCTURE

The LRE's UM Program operates under the oversight of the LRE CEO, Regional Operations Committee, and LRE UM Regional Operations Advisory Team (UM ROAT) and Clinical ROAT

LRE has delegated UM related activities to th Member CMHSPs. LRE staff manage the overall UM Plan as well as the direction and focus of the LRE UM and Clinical ROATs to achieve the strategic outcomes of the Lakeshore Regional Entity. Collaboratively, LRE and CMHSP designated staff are responsible to:

- Provide oversight to ensure that each CMHSP has policies and procedures that comply with State and federal requirements related to UM.
- Develop, monitor and track key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results across the region
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008
- Engage in studies of specific populations or sets of services based on identified factors or criteria. These may include populations or services with high risk, high costs, and presence of negative outliers or outcomes, or significant variance in utilization patterns
- Act as the representative for the region on any Utilization Management initiatives across the state

The LRE UM ROAT is the primary body responsible for evaluating the utilization of LRE services and making UM recommendations to the LRE Operations Committee.The UM ROAT is comprised of one Subject Matter Expert (SME) from each member CMHSP and the LRE UM/Clinical Manager. Other SME's may be invited by the Clinical ROAT for a specific agenda topic.

The responsibilities and duties of the UM ROAT include the following:

- Develop and monitor a regional utilization management plan.
- Set utilization management priorities based on the LRE strategic plan and/or contractual/public policy expectations.
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices.
- Participate in the development of access, authorization and utilization management

monitoring criteria and tools to assure regional compliance with approved policies and standards.

- Support development of materials and proofs for external quality review activities.
- Establish improvement priorities based on results of external quality review activities.
- Recommend regional medical necessity and level of care criteria.
- Perform utilization management functions sufficient to analyze and make recommendations relating tocontrolling costs, mitigating risk and assuring quality of care; review and monitor utilization patterns andanalysis to detect and recommend remediation of over/under or inappropriate utilization.
- Recommend improvement strategies where adverse utilization trends are detected; and
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Ensure UM ROAT coordination and information sharing to address continuity and efficiency of PIHPprocesses.

PROGRAM STRUCTURE

As required by the MDHHS contract, the UM Program must include the following:

- Ensuring a welcoming, responsive access system available 24 hours per day, 7 days per week. Member CMHSPS are responsible to manage all requests for services with prompt, consistent screening/assessment for services.
- Adoption of consistent regional access policies and procedures to assure compliance with LRE standards related to service eligibility and crisis response capacity.
- Mechanisms to identify and correct under and/or over utilization.
    a. The LRE UM ROAT is responsible for reviewing aggregated and trend data related to services delivered across the region.
    b. The LRE UM ROAT is responsible for identification of over and underutilization trends and identifying opportunities/interventions to correct significant variances.
- Procedures to outline utilization review work including UM authorization and denial decisions made by qualified and credentialed professionals. UM reviews are supervised by qualified and credentialed professionals.
- Efforts are made to obtain all necessary clinical information to render a decision. The rationale for all utilization review decisions are clearly documented and available to the LRE, CMHSP, provider, or the individual.
- Well publicized and accessible appeal mechanisms are available for both the providers and individuals receiving services. Notification of denials should include a copy of how to file an appeal.
- Appeals and Fair Hearings is a contracted function managed by Beacon Health Options from LRE. Appeals and Fair Hearing decisions will be made in a timely manner as required by the MDHHS contract.

SERVICE ACCESS AND ELIGIBILITY DETERMINATION

Initial access to care and authorization of medically necessary services occurs at the CMHSPs and in some instances (SUD Services) at other provider sites. Initial service eligibility, continued stay review activities and ongoing utilization management for all mental health and substance use disorder services must be based on common standardized screening and assessment protocols

consistent with the Medicaid Provider Manual and criteria/service selection guidelines specified by MDHHS contract. The LRE has delegated these activities to the 5 CMHSPs.

- The determination of medically necessary supports, services and/or treatments must be:
- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professional who have evaluated the beneficiary; and
- Based on person-centered or individualized treatment planning
- Made by appropriately trained and credentialed mental health and/or substance use disorder professionals
- Made within federal and state standards for timeliness
- Sufficient in amount, scope and duration to reasonably achieve its purpose
- Documented in the individual's record.

Intake assessments have an established uniformity across the region using common screening and assessment tools that are validated and standardized per the Michigan Medicaid Provider Manual.The LRE and regional Member CMHSPs adopted MCG medical necessity criteria for psychiatric inpatient, crisis residential and partial hospitalization levels of care. MCG criteria does not replace the Michigan Medicaid Provider Manual, rather it is supplemental criteria used to support the individualized plan of service.

Eligibility for services will be documented in the clinical record and specific data elements submitted to the PIHP as required by the PIHP/CMHSP sub-contract.

All screening decisions will be documented and shall include:

- Presenting problem and need for service and supports
- Initial identification of the population group that qualified the person for services and supports
- Legal eligibility and priority criteria (where applicable)
- Urgent and emergent needs including linkages to crisis services
- Screening disposition
- Rationale for admission or denial
- Ongoing service(s) required

LRE retains responsibility to ensure that screening and eligibility determinations are consistently made across the region.

AUTHORIZATION/UTILIZATION REVIEW

LRE and CMHSPs shall establish guidelines and utilization monitoring procedures in accordance with the Michigan Medicaid Provider Manual. LRE shall not use any medical necessity criteria that are more restrictive than those specified by MDHHS and/or the Medicaid Provider Manual to place appropriate limits on any service.

Level of care criteria shall be sufficient to address the severity of illness and intensity of services required by the individual. Some services that fall within established parameters may be "presumptively authorized" to expedite care (i.e., initial assessment)

LRE, and CMHSPs and contract providers shall not deny services based solely on preset limits of the cost, amount, scope, or duration of services. Instead, determination of the need for services shall be conducted on an individualized basis using established medical necessity criteria.

Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:

- Accurate and consistent with medical necessity criteria
- Consistent with established guidelines (ie: Medicaid Provider Manual, MDHHS contract)
- Adjusted appropriately as beneficiary's needs, status, and/or service requests change
- Timely
- Provided to the consumer in writing
- Accompanied by the appropriate notice to the beneficiary regarding their appeal rights.

Crisis services including pre-admission screening for and/or diversion from intensive services (Inpatient psychiatric, crisis residential, partial hospitalization services, SUD detox) and/or crisis stabilization services remain the responsibility of the CMHSP/Provider.

UTILIZATION MANAGEMENT /OUTLIER MANAGEMENT

Consistent with the Balanced Budget Act (BBA) and MDHHS contract requirements, the LRE, CMHSPs and contracted provider entities will ensure mechanisms are in place to detect over and under-utilization of services. This includes:

- Developing, monitoring, and tracking key performance indicators to detect patterns or trends
- Specific studies of certain populations or particular sets of services based on established factors or criteria. These may include populations or services with high risk, high cost,
- and/or presence of negative outliers or outcomes, or significant variation in utilization patterns.
- Conducting data-driven analysis of regional utilization patterns
- Requiring corrective action when necessary

DATA REPORTING AND ANALYSIS

UM activities delegated to Member CMHSPs, as contracted entities, collect, aggregate, and analyze data related to service utilization, costs, timeliness, and outcomes for all delegated UM activities. Data collected includes, but is not limited to:

- Service utilization and costs by service code
- Over / under utilization trends
- Denials of authorization
- Access and availability of services
- Population trends

- Penetration rates
- Readmission rates

LRE continues to develop, redesign and review reporting mechanisms via Power Bi Dashboards

OPERATIONAL GOALS - 2023

The activities described below identify how Lakeshore Regional Entity will achieve its Utilization Management Program goals.

1. Continue to develop standardized utilization management protocols & functions across the region. This will include review of the following functions.
   - Access and service eligibility determination
   - Authorization for services
   - Re-authorizations
   - Admissions and continuing stay reviews for intensive services.

2. Maintain progress and continue development and review of a regional Utilization Management framework that includes common screening and assessment, UM procedures (where appropriate) as well as continued development of enhanced data reporting (Power Bi Reports) which will be reviewed for trends and potential areas of growth.

3. Continue development and implementation of regionally uniform, standard processes across the region for determining service eligibility, level of care guidelines, standard assessment protocols, and regular monitoring and oversight to assure ensure effective use of resources.

   The Michigan Department of Health and Human Services (MDHHS) requires the use of standardized assessments or level of care determination tools during the initial assessment phase for specific clinical populations. Minimally, the tools are used to inform, and in some instances, guide decision making regarding the appropriate level of care. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care. The following assessments/tools will be utilized in the Lakeshore region:

   - Substance Use Disorder services
     - ASAM (American Society of Addiction Medicine) Continuum Assessment for adults (18 and older)
     - GAIN (Global Appraisal of Individual Needs) comprehensive biopsychosocial assessment for adolescents (17 and under)
     - ASAM Patient Placement Criteria (ASAM-PPC) for level of care determination

   - Children and Adolescents with Serious Emotional Disturbance
     - DECA (Devereaux Early Childhood Assessment, for ages birth-47 months)
     - CAFAS (Child and Adolescent Functional Assessment Scale (for ages7-17)
     - PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages 4-6)

- Adults with Mental Illness
  - LOCUS (Level of Care Utilization System) for Psychiatric and Addiction

- Services to Individuals (Adults and Children) with Intellectual/Developmental Disabilities
  - Supports Intensity Scale (SIS)

4. Finalize and implement regional Clinical Stay Review (CSR) auditing process and procedures, ensuring appropriate clinical determinations through monitoring and oversight.

5. Monitor discharge planning to ensure plans are appropriate, comprehensive and complete

6. At least annually, conduct an review (including an onsite monitoring) with each CMHSP to ensure Members are compliant with MDHHS and Balanced Budget Act (BBA) requirements related to utilization management

7. Identify high risk populations for focused analysis (e.g. using MDHHS data extract, Care Connect 360 or local data) and ongoing monitoring toward improved coordination of care

8. Based on review of regional utilization data or results of oversight and monitoring activities, determine specific areas or services for focused review or improvement. This may include monitoring and trending of regional claims and encounters

9. Participate on statewide work groups related to UM functions and share relevant information with LRE UM & Clinical ROATs and Operations Committee

10. Ensure LRE and Member CMHSPs are represented on cross regional UM related work groups

APPENDIX I: DEFINITIONS

These terms have the following meaning throughout this Utilization Management Plan

CMHSP Member: refers to one of the five-member Community Mental Health Services Program (CMHSP) participants in the Lakeshore Region.

Concurrent Review: During the course of service delivery (i.e. point of care), ensuring an appropriate combination of services is authorized; concurrent review occurs within the context of philosophical frameworks governing decision making regarding services (e.g., consumer self-determination, person centered planning and trauma informed and recovery oriented care); may include re-measurement(s) of need utilizing standardized assessment tools; for Medicaid enrollees, concurrent UM decision making includes Advance Notice to the consumer.

Crisis Residential: Services that are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries (adult or child) experiencing an acute psychiatric crisis when clinically indicated. Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size.

Crisis Stabilization: Structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Can be stabilized and served in the consumer's usual community environments.

Intellectual/Developmental Disability (I/DD): Developmental disability means If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements: Is attributable to a mental or physical impairment or a combination of mental and physical impairments, is manifested before the individual is 22 years old, is likely to continue indefinitely, results in substantial functional limitations in three or more of the following areas of major life activity, self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency; reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability. Intellectual disability means a condition manifesting before the age of 18 years that is characterized by significantly sub average intellectual functioning and related limitations in 2 or more adaptive skills and that is diagnosed based on the following assumptions: valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors, the existence of limitation in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the individual's particular needs for support, specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities, and with appropriate supports over a sustained period, the life functioning of the individual with an intellectual disability will generally improve.

Prospective Review: Determination of the appropriateness of a level of care or service setting before services are initiated; associated with admission to a program, agency or facility and the

application of medical necessity, benefit eligibility or access/admission criteria; may include baseline measurements of need utilizing standardized assessment tools; for Medicaid enrollees, prospective UM decision making includes Adequate Notice to the consumer.

Provider Network: Refers to LRE CMHSP Members and Substance Use Disorder Service Providers (SUDSP) directly under contract with the CMHSP/ PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.

Retrospective Review: After service delivery, evaluation of whether the scope, duration and frequency of services received met consumer need; includes determination of whether or not intended outcomes were achieved; may include post-discharge measurement of health outcomes or re-measurement of need utilizing standardized assessment tools; retrospective review may occur specific to a service, program or facility.

Serious Emotional Disturbance (SED): As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental
disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Staff: Refers to an individual directly employed and/or contracted with a CMHSP Members or SUD Service Provider.

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Substance Use Disorder (SUD): The taking of alcohol or other drugs as 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.

Appeal: A process to have an authorization decision that adversely affects services provided to an individual or a denial of services to an individual reviewed by a licensed professional, not involved in the original decision, to evaluate the medical needs of the individual for possible decision reversal.

Authorization: Approval of level of care and/or specific services

Denial: A determination that a specific service is not medically / clinically appropriate, necessary to meet needs, consistent with the individual's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care.

Medical Director: Physician, psychiatrist, addictionologist serving in a leadership capacity for the LRE or Member CMHSP's.

Medically Necessary: A determination that a specific service is clinically appropriate, necessary to meet an individual's needs, consistent with the diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive environment. Medically Necessary Services are intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness or substance use disorder, arrest or delay the progression of illness, and/or designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

Medical Necessity Criteria: Criteria used to determine which services, equipment, and/or treatment protocols are required for the diagnosis or severity of illness that meets accepted standard of practice.

Utilization Management: The LRE's managed care system that ensures eligible recipients receive clinically appropriate / medically necessary, high quality, and cost effective services.

Utilization Review: The LRE's review process established to ensure that the UM Program's service standards, protocols, practice guidelines, and documentation standards are adhered to by all Member CMHSP's.