



UTILIZATION MANAGEMENT PLAN

FY2026

LAKESHORE REGIONAL ENTITY FY2026 UTILIZATION MANAGEMENT PLAN

Lakeshore Regional Entity (LRE) is the public behavioral health plan for individuals with mental illness, intellectual/developmental disability (I/DD), and substance use disorders (SUD) 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.

LRE's Utilization Management (UM) Program is designed to detect and correct under-and over-utilization of services as well as implement procedures for conducting prospective, concurrent and retrospective reviews. LRE's 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 Policies and Procedures that guide regional UM functions and effective oversight. The policies and procedures comply with 42 CFR 441.301(c)(4) requirements for home and community-based settings. These policies and procedures are found on Lakeshore Regional Entity's website at:

[Policies and Procedures - Lakeshore Regional Entity \(lsre.org\)](https://www.lakeshoremi.org/um/policies-procedures)

UM PROGRAM OVERVIEW

LRE must ensure regional access to public behavioral health services in accordance with its contract with MDHHS while adhering to relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements and applicable federal rules and regulations. 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 implemented within the region in 2020 and are utilized as an additional factor/criteria for decision-making and service authorization/denial for inpatient, partial hospitalization, and crisis residential determinations.

LRE currently provides oversight and monitoring of delegated regional UM functions. LRE continues to redesign the UM program to improve uniformity and consistency across the region. Some processes include

- Standardization of access to higher levels of care, including psychiatric inpatient, crisis residential, and partial hospitalization treatment.
 - Developed a regional procedure to standardize continued stay reviews.
 - Development of a regional process for preadmission screening.
 - 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.
- Methodologies to improve processes and reporting that assists Member Community Mental Health Service Programs (CMHSPs) with service eligibility determinations.

- Developed a regional auditing process to ensure Inter-Rater Reliability (IRR) along with dashboard reports.
 - Annual training and testing of clinical staff responsible for determining medical necessity to ensure regional adherence to current MCG criteria.
- Created utilization dashboards for higher level of care, for example:
 - Psychiatric Inpatient Average Length of Stay (ALOS)
 - Crisis Residential ALOS/Units
 - Partial Inpatient ALOS
 - Inpatient Admits/1000 and Inpatient Days/1000
 - Readmission Rates – 7/30 Days

LRE will continue to focus on standardization of utilization management activities. 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.

There will be continued efforts toward data integrity processes including identification of overlapping services and coding errors. LRE and Member CMHSPs continue collaborative work on authorizations to provide greater visibility into real time medical expense via reporting tools and improved claims data exports/extracts to LRE from Member CMHSPs.

Exceptions to UM Plan: Certified Community Behavioral Health Center (CCBHC) Services.

The State of Michigan was granted approval by the Centers for Medicare & Medicaid Services (CMS) for participation in the federal Certified Community Behavioral Health Center (CCBHC) Demonstration. All five CMHSPs within the LRE are also CCBHCs. Eligibility requirements to receive CCBHC services differ significantly from eligibility requirements previously established for those seeking CMH services. CCBHC services are not subject to all of the same population eligibility guidelines or service utilization guidelines as described in the LRE UM Plan. The CMS CCBHC Demonstration sites within LRE will adhere to the eligibility and service provision requirements as outlined in the MDHHS CCBHC Handbook.

OVERSIGHT STRUCTURE

LRE’s UM Program operates under the oversight of LRE’s CEO, Regional Operations Council, and LRE UM Regional Operations Advisory Team (ROAT) and Clinical ROAT.

LRE delegates UM related activities to Member CMHSPs. LRE staff manage the overall UM Plan as well as the direction and focus through UM and Clinical ROATs to achieve the strategic outcomes in the region. Collaboratively, LRE and Member CMHSP designated staff are responsible to:

- Provide oversight to ensure that each Member 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

LRE ROAT is the primary body responsible for evaluating services and making UM recommendations to the Operations Council. The UM ROAT is comprised of one Subject Matter Expert (SME) from each Member CMHSP, LRE's UM Coordinator and Clinical Manager. Other SME's may be invited 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 LRE's 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 to controlling costs, mitigating risk and assuring quality of care; review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization.
- Recommend improvement strategies where adverse utilization trends are detected.
- Implement policies, procedures 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 PIHP processes.

PROGRAM STRUCTURE

The UM Program includes the following:

- Adoption of consistent regional access policies and procedures to assure compliance with LRE, MDHHS and federal standards related to service eligibility and crisis response capacity.
- Mechanisms to identify and correct under and/or over utilization.
 - a. LRE UM ROAT is responsible for reviewing aggregated and trend data related to services delivered across the region.
 - b. LRE UM ROAT is responsible for identification of over- and under-utilization 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 and are completed in ways to mitigate conflict of interest.

- Efforts to obtain all necessary clinical information to render a decision. The rationale for all utilization review decisions are clearly documented and available to LRE, Member CMHSP, Network Provider, or the individual.
- Well publicized and accessible appeal mechanisms are available for both Network Providers and individuals receiving services. Notification of denials should include a copy of how to file an appeal.
- Appeals and Fair Hearing decisions will be made in a timely manner as required by the MDHHS contract.

SERVICE ACCESS AND ELIGIBILITY DETERMINATION

CMHSPs have delegated responsibility to provide screening and authorization for medically necessary services. Services may be provided by the CMHSP or contractual community providers. 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 the MDHHS contract. LRE has delegated these activities to the five Member CMHSPs.

The determination of medically necessary supports, services and/or treatments must be delivered through person-centered planning:

- Based on information provided by the individual, the individual's family, and/or others who know the individual; and Based on clinical information from the individual's primary care physician or health care professional who have evaluated the individuals; and
- 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 (MMPM). LRE and Member CMHSPs have implemented Milliman Care Guidelines (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 level of care determinations.

Eligibility for services will be documented in the clinical record and specific data elements submitted to the LRE as required by the LRE/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; and
- Ongoing service(s) recommended.

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

AUTHORIZATION/UTILIZATION REVIEW

LRE and Member 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, Member CMHSPs and Network 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. LRE, Member CMHSPs and Network Providers must assure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any individual.

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: Michigan 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 Member CMHSP.

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

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 can include reviews of the following functions.
 - Access and service eligibility determination
 - Authorization for services
 - Re-authorizations
 - Admissions and continuing stay reviews for intensive services.
2. Continue with 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.

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. In accordance with MDHHS contractual requirements, the following assessments/tools must be utilized in the Lakeshore region:

Substance Use Disorder Services:

- ASAM (American Society of Addiction Medicine) Continuum Assessment for adults (18 and older)
- ASAM Patient Placement Criteria (ASAM-PPC) for level of care determination

Children and Adolescents with Serious Emotional Disturbance

- DECA (Devereaux Early Childhood Assessment, ages birth-47 months)
- MichiCANS (Michigan Child and Adolescent Needs and Strengths, ages 0-21)

- CAFAS (Child and Adolescent Functional Assessment Scale (for ages 7-17) for applicable waiver and iSPA programs
- PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages 4-6) for applicable waiver and iSPA programs
- GAIN (Global Appraisal of Individual Needs) comprehensive biopsychosocial assessment for adolescents (17 and under)

Adults with Mental Illness

- LOCUS (Level of Care Utilization System) for Psychiatric and Addiction

Adults with Intellectual/Developmental Disabilities

- WHODAS (World Health Organization Disability Assessment Schedule) -yet to be implemented.
4. At least annually, conduct a review (including an onsite monitoring) with each Member CMHSP to ensure Members are compliant with MDHHS and Balanced Budget Act (BBA) requirements related to utilization management.
 5. Analyze regional ability to increase authorization process consistency to monitor over/under utilization of services.
 6. Analyze regional ability to apply Interrater Reliability processes to specialized residential/CLS medical necessity criteria.
 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 with statewide work groups related to UM functions and share relevant information with LRE UM & Clinical ROATs and Operations Council.
 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:

Appeal: A review of an adverse benefit determination. 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.

CCBHC: Certified Community Behavioral Health Center; CCBHCs are considered a new Medicaid provider type and are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals.

Continued Stay 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.

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.

Intellectual/Developmental Disability (I/DD): : Is defined in the Michigan Mental Health Code as a condition showing before the age of 18 years that is characterized by significantly subaverage intellectual functioning and related limitations in 2 or more adaptive skills and that is diagnosed based on the following assumptions: (a) Valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors. (b) 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. (c) Specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities. (d) With appropriate supports over a sustained period, the life functioning of the individual with an intellectual disability will generally improve. 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.

Medicaid Long-Term Supports and Services (MLTSS/LTSS): Care provided in the home, in community-based settings, or in facilities, such as nursing homes for older adults and individuals with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their ability to care for themselves. They are a range of services to help individuals live more independently by assisting with personal and healthcare needs and activities of daily living, such as eating, taking baths, managing medication, grooming, walking, getting up and down

from a seated position, using the toilet, cooking, driving, getting dressed, and managing money.

LTSS programs provide service needs from complex-care to assistance with every day activities of daily living. Following are some of the services provided under Medicaid long-term services and supports:

Care Coordination

Chore Services (services to maintain a clean living environment)

Community Living Supports (promote participation in the community)

Home Delivered Meals

Home Modifications

Nursing Services

Personal Emergency Response Systems

Respite Services

Medically Necessary: A term used to describe one of the criteria that must be met for a beneficiary to receive Medicaid services. It means that the specific service is expected to help the beneficiary with his or her mental health, intellectual/developmental disability, substance use, or any other medical condition. Some services assess needs, and some services help maintain or improve functioning. PIHPs are unable to authorize (pay for) or provide services that are not determined as medically necessary for you.

Medically Necessary Services: The PIHP and designated CMHSPs are responsible for providing services that are no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability. These services must promote the ability for an enrollee to achieve age-appropriate growth and development; the ability for an enrollee to attain, maintain, or regain functional capacity; and the opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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.

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

Network Provider: Any provider, group of providers, or entity that has a provider agreement with LRE or Member CMHSP that receives funding directly or indirectly to order, refer or render covered services as a result. May also be referred to as CMH.

Preadmission Screen: 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.

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): Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral, or emotional disorder affecting an adult 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; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

Staff: Refers to an individual directly employed and/or contracted with LRE, Member CMHSP or Network Provider.

Substance Use Disorder (SUD): As defined in MCL 330.1100d(11) of the Michigan Mental Health Code: 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.

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

Utilization Review: 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.