Policy 5.0

POLICY TITLE:	**UTILIZATION MANAGEMENT**	**POLICY #: 5.0**	
Topic Area:	**UTILIZATION MANAGEMENT**	Page 1 of 6	**REVIEW DATES**
Applies to:	LRE Operations, Member CMHSPs, and Provider Network	**ISSUED BY:** Chief Executive Officer	11/21/2013 / 1/1/2015 10/1/2021
Review Cycle:	Annually	**APPROVED BY:** Board of Directors	
Developed and Maintained by:	CEO and Designee		
Supersedes:	N/A	**Effective Date:** January 1, 2014	**Revised Date:** 6/16/2022

I. POLICY:

It shall be the policy of the Lakeshore Regional Entity (LRE) to have a comprehensive Utilization Management (UM) Program that meets the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Contract, and the Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR).

The LRE's Utilization Management (UM) Program ensures the delivery of high quality, medically necessary care through appropriate utilization of resources in a cost effective and timely manner.

The LRE UM Program shall operate as a sub-component of the LRE Quality Assessment and Performance Improvement Plan (QAPIP). The UM Program is designed to ensure mechanisms to detect and correct under-and over-utilization of services and identify procedures for conducting prospective, concurrent and retrospective reviews.

LRE's UM Program includes oversight and monitoring of regional Access and Eligibility Standards, Service Authorization and Reauthorization, Utilization Review (UR), and Clinical Protocol Standards.

Standards and Guidelines:

A. **Program Oversight, Governance and Authority**: The LRE UM Program shall operate under the oversight of the LRE's Clinical Manager, and LRE's Medical Director.
B. **Regional Utilization Management/Clinical Practices**: LRE shall maintain a Utilization Management Regional Operations Advisory Team (UM ROAT), consisting of both LRE and Member Community Mental Health Service Programs (CMHSP) Utilization Management representatives. The UM ROAT shall serve in a support and advisory capacity to the UM Program.

a. Utilization management activities within the LRE are reviewed by the UM ROAT.
b. The UM ROAT membership is comprised of utilization management representatives from each of the five Member CMHSPs and is chaired by the LRE Clinical/UM Manager or their designee. Ongoing consultation and ad hoc representation from the LRE Medical Director is available to the committee.

C. **Program Structure**: The written UM Program description shall describe the program structure, lead staff, involvement of practitioners in its development, implementation of behavioral healthcare practitioners in its implementation.
D. **Financial Incentives**: The LRE and Member CMHSPs do not provide financial incentives, reimbursements or bonuses, to staff or providers, based on customer utilization of covered services. UM activities shall not be structured to provide incentives for individual or entities to deny, limit, or discontinue medically necessary services to any beneficiary.
E. **Annual Program Evaluation**: The UM ROAT shall clearly demonstrate that it has annually evaluated the UM Program, addressed trends, made systemic changes as indicated and has updated the UM Plan to reflect current need, as necessary.
F. **Satisfaction with the UM Process**: LRE, through various avenues including stakeholder satisfaction surveys and customer services, shall have a mechanism for tracking feedback regarding satisfaction with the UM Process from customers and providers.
G. **LRE Staff Roles**: The UM Program description shall clearly designate the LRE and CMHSP staff involved in the implementation, supervision, oversight and evaluation of the LRE UM Program.
H. **Program Information Sources**: In implementing the annual UM Program Plan, Member CMHSPs will use the publicly available clinical practice guidelines in conducting their reviews of the various clinical components of the LRE plan. These include contractually identified practice guidelines, MDHHS public policy guidelines, technical advisories, nationally recognized medical necessity criteria, and clinical practice guidelines (CPG's).
I. **Utilization Management Review Mechanisms**: LRE will assure inter-rater reliability related to LRE policy and criteria annually as identified through the UM Program and UM ROAT.
J. **UM Decision-Making Criteria**: LRE and Member CMHSPs shall use medical necessity written criteria based upon sound clinical evidence and specifics procedures for appropriately applying the criteria to make utilization decisions. Do we need to mention MCG here?
K. **Service Authorizations**: LRE and Member CMHSPs shall have UM review criteria that reviews utilization management decisions being made across its network for consistency and alignment with its clinical practice guidelines. They shall ensure, through sampling reviews of the UM decisions, that all regulatory, statutory and policy requirements are met. Service determinations resulting in denials are made by appropriately licensed and credentialed staff.
L. **Level of Care Decisions**: Level of Care UM decisions shall be based on MDHHS Specialty Services Contract, Michigan Mental Health Code and Medicaid Provider Manual, medical necessity criteria, American Society of Addiction Medicine (ASAM) Level of Care Criteria, Child and Adolescent Functional Assessment Scale (CAFAS), Level of Care Utilization

System for Psychiatric and Addictive Services (LOCUS), Supports Intensity Scale (SIS), and clinical practice guidelines. Level of care decisions shall only be made by qualified staff with the expertise to make decisions and are reviewed, as appropriate, through supervisory, peer case and random UM review mechanisms. Service determinations resulting in denials are made by appropriately licensed and credentialed staff that has appropriate clinical expertise in treating the customer's condition.

M. **Authorization and Denial Review Criteria/Procedures**: The LRE and Member CMHSPs shall consistently apply medical necessity criteria. Denial/appeal reviewer will review service authorization decisions rendered by UM staff and service denial decisions.
N. **Practitioner Access to UM Decision Criteria**: LREand its Member CMHSPs ensure customers and practitioners have access to the utilization decision criteria used by the network, have received information or training on the use of the criteria, and how to access it, as requested.
O. **Appropriate UM Professionals**: As identified via MDHHS contracts and BBA standards, LRE and Member CMHSPs shall ensure that only qualified licensed professionals assess the clinical information used to support and oversee the UM decisions.
P. **LRE Review Case Selection**: Specific cases for UM Review are identified by LRE and the Member CMHSPs in accordance with the annual guidelines set forth in the UM Plan. In this regard, LRE and Member CMHSPs may choose specific cases for review according to the UM Plan and may include random or targeted samples and cases of over-utilization and under-utilization.
Q. **UM Program Monitoring Results and Reporting**:
    a. Results of UM Reviews will be aggregated in a common format and compared across the LRE region for improvement of service delivery and cost effectiveness and to address over and underutilization. Those will include recommended increases, decreases, changes or services that stay the same.
    b. The UM ROAT will review all aggregated data on UM and service authorization trends on a regular basis. The efficacy of services, the quality of the services and supports as well as their cost-effectiveness will be assessed and decisions regarding improvements and needed changes in the system(s) will be discussed and reviewed.
R. **Delegation**: The LRE delegates the UM process to the Member CMHSPs. All requirements set forth by the MDHHS shall be met with the CMHSP UM process. LRE maintains its oversight and monitoring responsibilities of all delegated UM functions, and shall annually evaluate the delegate entity in accordance with the requirements
S. **Retrospective Reviews**: LRE and CMHSPs shall maintain policies and procedures for retrospective reviews of CMHSP UM decisions. These policies shall be posted on the LRE and Member CMHSP websites. LRE shall ensure there is a full and fair process for resolving disputes and responding to an individual's request to reconsider a decision they find unacceptable. The LRE retrospective review process shall address regulatory and contractually mandated processes.

II. PURPOSE:

To establish the standards and guidelines that detail how LRE and its Member CMHSPs comply with the federal laws and MDHHS Contract requirements pertaining to the UM responsibilities of LRE.

To ensure a comprehensive integrated UM process that provides verification that individuals who are Medicaid recipients served by LRE Member CMHSPs and affiliated providers receive the right service at the right time and in the right amount sufficient to meet their needs.

III. APPLICABILITY AND RESPONSIBILITY:

This policy applies to LRE, its Member CMHSPs and contracted providers of Medicaid funded services.

IV. MONITORING AND REVIEW:

This policy will be reviewed by the CEO or designee on an annual basis.

V. DEFINITIONS:

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

Authorization - Approval of Medicaid payment for a covered service on behalf of the LRE or CMHSP.A process designed to ensure that planned services meet eligibility and medical necessity criteria, as appropriate for the conditions, needs and desires of the member served.

Clinical Practice Guideline - Clinical practice guidelines, protocols or service selection guidelines promulgated by the LRE and CMHSPs, guide clinical decisions regarding individuals' access to covered services. These documents identify service eligibility criteria and the typical amount, scope and duration of covered services.

Concurrent Review- Concurrent review encompasses those aspects of utilization review that take place during the course of facility-based or outpatient treatment.

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

Independent Review Organization (IRO) - Independent Review Organization, typically employing board certified psychiatrists or Addictionologists who provide clinical review and treatment recommendations.

Medical Director - Physician, Psychiatrist, Addictionologist serving in a leadership capacity for the LRE or partner CMHSPs.

Medically Necessary - A determination that a specific service is clinically appropriate, necessary to meet the person's needs, consistent with the person's diagnosis, symptoms and

functional impairments, is the most cost-effective option in the least restrictive setting, and is consistent with the LRE's medical necessity criteria and service selection guidelines.

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 standards of medical practice.

Prior or Prospective Authorization - The process of obtaining approval or authorization to perform a covered service in advance of its delivery.

Utilization Management Program - The LRE managed care system that ensures that eligible recipients receive clinically appropriate, cost-effective services designed to meet their needs.

Utilization Review - The LRE's service review process established to ensure that the UM Program's service standards, protocols, practice guidelines, authorization and billing procedures, and documentation standards are adhered to by all member CMHSPs and network service providers.

VI. RELATED POLICIES AND PROCEDURES

A. LRE Utilization Management Procedure
B. LRE Quality Policies and Procedures
C. LRE Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY:

A. LRE Quality Assessment and Performance Improvement Plan (QAPIP)
B. LRE Utilization Management Plan
C. LRE/CMHSP Sub Contract (Delegation Grid)
D. Michigan Mental Health Code, Chapter 3
E. Balanced Budget Act of 1997
F. Medicaid Managed Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/21/2013	New Policy	Chief Clinical Officer
1/1/2015	Annual Update	Chief Clinical Officer
6/16/2022	Review/update	CEO and Designee

Policy 5.1

POLICY TITLE:	**PERSON- CENTERED PLANNING**	**POLICY # 5.1**		
Topic Area:	**UTILIZATION MANAGEMENT**	Page 1 of 4	**REVIEW DATES**	
Applies to:	LRE Staff and Operations, Member CMHSP's and Contracted Providers	**ISSUED BY:** Chief Executive Officer	8/21/14	11/1/15
			9/21/2017	
Review Cycle:	Annually	**APPROVED BY:** Board of Directors		
Developed and Maintained by:	CEO and Designee			
Supersedes:	N/A	**Effective Date:** January 1, 2014	**Revised Date:** 6/16/2022	

I. POLICY

Person-Centered Planning (PCP) is a process mandated through the Michigan Mental Health Code (MMHC) for all individuals/families receiving publicly funded mental health services. It shall be the policy of Lakeshore Regional Entity (LRE), Member Community Mental Health Service Programs (CMHSP) and contracted providers to adopt the Michigan Department of Health and Human Services (MDHHS) Policy and Practice Guideline on Person-Centered Planning.

Standards and Guidelines

All persons requesting services through LRE shall have their Individual Plan of Service (IPOS) developed through a person-centered planning process. Each Member CMHSP and its contracted providers shall establish procedures and provide supplemental information for carrying out the Person-Centered Planning Practice Guidelines.

The policy is intended to outline the required elements of Person/Family Centered Planning as required by LRE and informed by the Michigan Medicaid Provider Manual (MMPM), Section 2:

a. A preliminary plan of service is developed within seven (7) days of the commencement of services that will include a treatment plan, a support plan, or both.
b. Consumers are given information as needed on the array of mental health services, community resources and available providers.
c. Ensure that for each Person/Family Centered Plan, a pre-planning meeting is completed that includes addressing the information below. Documentation should reflect that the process took place in a timely manner (Items below are not required for those who receive short term outpatient therapy only, medication only, or those who are incarcerated)
    i. Who to invite;

ii. Where and when to have the meeting;
iii. What will be discussed, and not discussed, at the meeting;
iv. Any accommodations the consumer may need to meaningfully participate;
v. Who will facilitate the meeting;
vi. Who will record what is discussed at the meeting; and
vii. The pre-planning meeting is to be completed with sufficient time to take all necessary/ preferred actions.

d. Provide information/education on what an Independent (or External) Facilitator (IF) is and how to request the use of one. Not required for consumers receiving short term outpatient therapy or medication only. Consumers must have a choice of at least two facilitators.
e. Each plan is individualized to meet the consumer's medically necessary identified needs and includes:
    i. A description and documentation of the consumer's individually identified goals, preferences, strengths, abilities, and natural supports.
    ii. Outcomes identified by the consumer and the steps to achieve the outcomes.
    iii. Risk factors and measures in place to minimize them, including backup plans and strategies.
    iv. Services and supports needed to achieve the outcomes (including community resources and other publicly funded programs such as Home Help).
    v. Amount, scope and duration of medically necessary services and supports authorized by and obtained through the CMHSP.
    vi. Estimated/prospective cost of services and supports authorized by the community mental health system.
    vii. Roles and responsibilities of the consumer, the CMHSP staff, allies, and providers in implementing the plan.
    viii. The plan should be written in plain language that is easily understood by the individual and others supporting them. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.
    ix. The plan should be finalized and include informed consent of the individual and their representative (if applicable).
    x. Signatures on the plan should include the consumer, their representative (if applicable) and the providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports).
f. A plan of service shall be completed within 30 days of the initial psychosocial assessment absent extenuating circumstances. The plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the consumer's needs, changes in the consumer's condition as determined through the PCP process or changes in the consumer's preferences for support). A review

of the plan can be requested at any time by the consumer or his/her guardian. A formal review of the plan with the consumer and his/her guardian or authorized representative shall occur at least every 12 months or more frequently if the consumer requests it or there is a change in service needs. Reviews should work from the existing plan of service to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the consumer.

g. The consumer is provided a copy of the plan within 15 business days of the conclusion of the PCP process.
h. There is a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in the implementation of the PCP are provided with additional training, including direct care level staff being trained on consumer specific plans of service.

II. PURPOSE

To establish the standards that define, guide and detail how LRE and its provider network comply with the State laws and MDHHS Contractual requirements pertaining to the practice of Person-Centered Planning including the MDHHS Person-Centered Planning Policy and Practice Guideline. LRE and its Member CMHSPs shall have a consistent service philosophy across its network of care related to Person/Family Centered Planning. LRE promotes a Person/Family Centered approach to the development of the individual plan of service and the delivery of supports and services in accordance with established state and federal regulations

III. APPLICABILITY AND RESPONSIBILITY

The policy applies to Lakeshore Regional Entity staff and operations, Member CMHSP's and any regional organization that develop an IPOS.

IV. MONITORING AND REVIEW

This policy will be monitored by the CEO or designee on an annual basis.

V. DEFINITIONS

Independent Facilitator (IF): A person the individual chooses to facilitate and support him/her in the Person-Centered Planning process. An individual can be his/her own Independent Facilitator. An Independent Facilitator:

- Responds directly to one's dreams, desires and personal goals.
- Coordinates the planning process, assures that the IPOS is clear to all planning participants, and is ready for implementation.
- Is someone that the individual trusts or someone trained as an IF;
- Can be someone other than the person's existing Supports Coordinator/Case Manager, is not an employee of the agency serving the individual. The IF does not

have any other role with the organization from which the individual receives his/her services.

Individual Plan of Service (IPOS): A written Individualized Plan of Service directed by the individual as required by the Michigan Mental Health Code. This may be referred to as a treatment plan or a support plan.

Person-Centered Planning: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Self-Determination (SD): A set of principles that people with disabilities should have the support to be part of their communities, so they can live the lives they want. In arrangements that support Self-Direction, an individual controls an individual budget for his/her IPOS. The individual chooses who supports him/her and when and how that support is provided.

VII. REFERENCES/LEGAL AUTHORITY

- MDHHS Person-Centered Planning Policy and Practice Guidelines
- LRE Policy 5.0 Utilization Management Policy
- LRE Policy 5.9 Practice Guidelines Policy
- Michigan Medicaid Provider Manual (Section 17.2 - Criteria for Authorizing B3 Supports and Services)

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
8/21/2014	New Policy	Chief Clinical Officer
11/1/2015	Annual Review	Chief Clinical Officer
9/21/2017	Annual Review	Chief Clinical Officer
6/16/2022	Annual Review	CEO and Designee

Policy 5.2

POLICY TITLE:	ASSESSMENTS AND SCREENS	POLICY # 5.2	REVIEW DATES	
Topic Area:	**UTILIZATION MANAGEMENT**			
Applies to:	Lakeshore Regional Entity, Member CMHSPs, Network Providers	**ISSUED BY:** Chief Executive Officer		
Review Cycle:	Annually	**APPROVED BY:** Board of Directors		
Developed and Maintained by:	CEO and Designee; LRE UM ROAT			
Supersedes:	**N/A**	**Effective Date:** June 16, 2022	**Revised Date:**	

I. POLICY

It is the policy of the Lakeshore Regional Entity (LRE) that evidenced-based, and strength-based standardized tools will be utilized in eligibility and on-going assessment of recipients of Medicaid funded behavioral health services within the lakeshore region to promote recovery and meeting the clinical needs of the individual served. LRE shall assure through contract, policy and procedure that Member CMHSP and regional provider network members are administering the noted standardized assessments as required. These assessments include:

- The American Society of Addiction Medicine (ASAM) Criteria
- ASAM Continuum
- Global Appraisal of Individual Needs (GAIN)
- Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS)
- Level of Care Utilization System (LOCUS)
- Supports Intensity Scale (SIS)
- Devereaux Early Childhood Assessment (DECA)

When needed, LRE shall work with Member CMHSPs and the Provider Network to establish regional procedures for the administration and monitoring of standard assessment compliance. LRE staff, Member CMHSPs, and/or provider network members shall participate in Michigan Department of Health and Human Services (MDHHS) selection, planning and monitoring of standardized assessment administration as required.

II. PURPOSE

In accordance with best practice standards and the LRE contract with the MDHHS, LRE's provider network inclusive of Member Community Mental Health Service Program (CMHSP) and the Provider Network shall administer or require administration of standardized

assessments, for specific populations served, as defined by the Medicaid Managed Specialty Supports and Services Contract with the Pre-Paid Inpatient Health Plan (PIHP). Standardized assessments will ensure that beneficiaries of Medicaid funded behavioral health services across the LRE region are assessed in a manner that promotes equitable and fair distribution of publicly funded behavioral health services while ensuring medical necessity and that services are provided in the appropriate amount, scope, and duration to meet the needs of the individual.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to member CMHSPs and any network provider who is responsible for eligibility and on-going beneficiary assessment

IV. MONITORING AND REVIEW

This policy will be reviewed annually by the CEO and designee.

V. DEFINITIONS

ASAM: American Society of Addiction Medicine
CAFAS: Child and Adolescent Functional Assessment Scale
CMHSP: Community Mental Health Services Programs
DECA: Devereaux Early Childhood Assessment
LOCUS: Level of Care Utilization System
MDHHS: Michigan Department of Health and Human Services
PECFAS: Preschool and Early Childhood Functional Assessment Scale
PIHP: Pre-paid Inpatient Health Plan
SIS: Supports Intensity Scale

VI. RELATED POLICIES AND PROCEDURES

A. LRE Policy 13.8 – Supports Intensity Scale (SIS)
B. LRE UM Plan

VII. REFERENCES/LEGAL AUTHORITY

A. Medicaid Managed Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
6/16/2022	New Policy	CEO and Designee

Policy 5.6

POLICY TITLE:	**INTEGRATIVE CARE COORDINATION**	**POLICY # 5.6**		
Topic Area:	**UTILIZATION MANAGEMENT**	Page 1 of 3	**REVIEW DATES**	
Applies to:	LRE staff and operations, Member CMHSPs, and contracted Providers	**ISSUED BY:** Chief Executive Officer	8/21/14	
			10/7/2020	
Review Cycle:	Annually		10/1/2021	
		APPROVED BY: Board of Directors		
Developed and Maintained by:	CEO and Designee			
Supersedes:	N/A	**Effective Date:** January 1, 2014	**Revised Date:** 6/16/2022	

I. POLICY

A. The LRE is committed to local health care for local communities. Across our region, the people that the LRE serves receive care from a broad array of hospital providers and an even broader array of primary care providers. While the LRE will set guidelines and expectations for coordinated care, the delivery of coordinated care will look different in different communities. Individuals receiving services will obtain health care that is specifically tailored to their needs and optimizes the unique resources offered by health care providers in their communities.

B. The foundation of care coordination is timely communication of relevant health information among providers. The LRE will establish guidelines for bi-directional information sharing, that is, the types of information to be shared and collected at specified points in care (including but not limited to notification of Emergency Room (ER) visits and hospitalizations). The LRE will participate in the state-wide data analytics process and will work with Member CMHSPs to ensure access to meaningful integrated healthcare data to enhance the quality of care for consumers across the region. The common goal is real-time sharing of useful health information across SUD, behavioral and physical health care providers.

C. Within communities served by the LRE, Member CMHSPs will pilot or plan integrated care models ranging from facilitated referral to fully integrated co-located services. All models share the common element of enhanced communication between SUD providers, behavioral health and physical health providers, which will be guided by the LRE guidelines mentioned above. Care will be coordinated between the provider network and primary care practitioners to assure that appropriate preventative and ambulatory care are provided, and existing health care conditions are treated and monitored by the health care team. Follow up care after ER visits and hospitalizations will be coordinated among health team members.

D. Strategies to reduce and prevent avoidable ER visits and hospitalizations (both for physical health and mental health treatment) will be employed across the region. The various models share in common an emphasis on training staff, building relationships with hospital systems and primary care providers, sharing information, and enhanced care coordination.

E. CMHSP members of the LRE will implement various strategies for educating the primary care community on approaching and treating the people we serve. Several CMHSPs provide psychiatric consultations to community prescribers on an as-needed basis. Other strategies include offering informative lectures and dinners to members of the medical community. Education occurs back and forth in informal settings such as the professional interactions that go along with our relationship-building efforts, the process of care coordination, and simply doing our work in a shared space in the instance of co-located services.

F. LRE shall work cooperatively with other MHPs and PIHPs to jointly identify priority need populations for purposes of care coordination and population health activities including but not limited to:
    1. Development of individualized care plans for persons with complex physical and behavioral health needs.
    2. Partnering with MHPs to manage transitions of care between hospital and community-based settings and prevent avoidable hospital readmissions.
    3. Identifying health disparities and engaging in practices that promote health equity for all Medicaid enrollees.
    4. Implementing and monitoring joint quality health metrics.

II. PURPOSE

Integrated healthcare aims to improve the quality of care, improve outcomes and control costs by moving beyond care coordination, in which primary and specialty providers inform each other regarding their treatment of an individual, to actual collaboration regarding the needs of the patient/individual and acting together to develop and implement a plan and ongoing care in a manner that eliminates barriers to and duplication of services.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to Lakeshore Regional Entity, Member CMHSPs and Contracted Providers.

IV. MONITORING AND REVIEW

This policy will be reviewed annually by the Chief Clinical Officer or Designee.

V. DEFINITIONS

Care Coordination: A process used by a person or team to assist beneficiaries in gaining access to necessary Medicare, Medicaid, and waiver services, as well as social, educational, and other support services, regardless of the funding source for the services.

VI. RELATED POLICIES AND PROCEDURES

A. LRE UM policies and procedures
B. LRE Care Coordination with Medicaid Health Plans Procedure

VII. REFERENCES/LEGAL AUTHORITY

A. Medicaid Managed Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
1/1/2014	New Policy	Chief Clinical Officer
10/7/2020	Annual Review	Chief Clinical Officer
6/16/2022	Annual Review	CEO and Designee

Policy 5.15

POLICY TITLE:	ADOPTION OF CLINICAL PRACTICE GUIDELINES AND EVIDENCE BASED PRACTICES	POLICY #5.15	REVIEW DATES	
Topic Area:	**UTILIZATION MANAGEMENT**		5/9/2022	
Applies to:	Lakeshore Regional Entity, Member CMHSPs, Network Providers	**ISSUED BY:** Chief Executive Officer		
		APPROVED BY: Board of Directors		
Developed and Maintained by:	CEO and Designee			
Supersedes:	**N/A**	**Effective Date:** August 20, 2020	**Revised Date:** 6/16/2022	

I. POLICY

Lakeshore Regional Entity (LRE) adopts and promulgates Clinical Practice guidelines (CPGs) for the provision of acute and long-term care services that are relevant to the targeted populations served by the Michigan Medicaid Managed Specialty Supports and Services Programs. CPGs will be promulgated by the LRE for individuals and families served by the Member CMHSPs and contracted providers, including those receiving substance use disorder services. CPGs and assessment tools will include those attachments to the contract between the Michigan Department of Health and Human Services (MDHHS) and the LRE, and will be adopted or developed by the LRE based on the requirement outlined in the Balanced Budget Act, assuring that CPGs "are based on valid and reliable clinical evidence or a consensus of health care professional in the particular field, consider the needs of the enrollees, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate." CPGs will be used to inform the person-centered planning process and will not result in setting caps for specific services.

LRE supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including EBPs to ensure the use of research-validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

While LRE does support the use of promising and emerging practices, interventions that are considered experimental or indicate risk of harm to human subjects are not supported within the Prepaid Inpatient Health Plan (PIHP) region unless approved in accordance with LRE's Research Policy and by the MDHHS.

A. The LRE adopts CPG's from nationally recognized sources and scientific bodies including professional organization (e.g., American Psychiatric Association) based on:
    1. Scientific evidence;
    2. Best practice professional standards; and
    3. Expert input from board-certified physicians.
B. Input will be gathered from a representative cross-section of member CMHSPs, consumer organizations, network providers and community partners, especially when required by contract or regulation.
C. To establish the LRE's policy and procedures for developing, adopting, revising, disseminating, and monitoring treatment guidelines, CPGs are made available to:
    1. Assist practitioners and members to make decisions about appropriate health care for specific clinical circumstances;
    2. Help to ensure the highest quality care for consumers through use of acceptable standards of care;
    3. Reduce undesirable variance in diagnosis and treatment by ensuring utilization of established CPGs; and
    4. Provide the provider network with widely accepted established care guidelines to improve treatment efficacy.
D. The LRE will assure that CPGs will not be utilized in the following ways:
    1. As an arbitrary methodology for determining the amount, scope, and duration of services implemented outside of a person-centered planning process.
    2. As a means for achieving budget reductions.
    3. As a process which supplants use of medical necessity criteria for evaluating the need for services.
E. As a part of any assessment, screening tool, or CPGs, the LRE will assure that individuals are provided proper notice of their rights if they are not satisfied with the outcome of their person-centered planning process. This will include providing individuals with dispute resolution options and required notices when they disagree with the developed plan of service.
F. Monitoring and Evaluation
    1. Oversight of practice guidelines and EBPs will be provided by the responsible contractor and will be reviewed as part of the LRE site review and monitoring process.
    2. Contractors must report to LRE any practices being used to support and/or provide clinical interventions for/with individuals.
    3. Evidence-based practices will be monitored, tracked, and reported, including summary information provided to LRE through the annual assessment of Network Adequacy.
    4. Requisite staff training, supervision/coaching, certifications and/or credentials for specific clinical practices as needed will be required, verified, and sustained as part of the credentialing, privileging and/or contracting processes.
    5. Fidelity reviews shall be conducted and reviewed as part of local quality improvement programs or as required by MDHHS

II. PURPOSE

CPGs assist clinicians by providing an analytic framework for the evaluation and treatment of individuals and populations receiving services. CPG's organize and codify the body of knowledge, skills and information that make up the clinical practice of specialty mental health services and support and the provision of substance use disorder services.

III. APPLICABILITY AND RESPONSIBILITY

The policy applies to all staff of the LRE, providers contracting directly with the LRE, and member CMHSPs as a part of their contract with their LRE. It applies additionally to Network Providers when provider network functions are delegated to the CMHSPs.

IV. MONITORING AND REVIEW

A. This policy will be reviewed annually by the LRE UM ROAT and the LRE Executive Operations Committee.

B. The LRE reviews and/or updates CPGs a minimum of every two years through the LRE UM Clinical Steering Committee, or more often if CPGs are updated. The LRE consults with CMHSPs and/or network providers at a minimum of every two years to review and update the CPGs.

C. Relevant new guidelines can be reviewed, adopted, and approved at any time through the regional Operations Committee and LRE UM Clinical Steering Committee.

V. DEFINITIONS

Clinical Practice Guideline (CPGs):Systematically developed tools that help practitioners make decisions about appropriate care in specific clinical populations and individual treatment services.

Evidence-Based Practice: the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient

Medical Necessity: 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. Medical necessity of a service shall be documented in the individual plan of services.

VI. REFERENCES/LEGAL AUTHRITY

A. Federal Balanced Budget Act 42 CFR 438.236(b, c, d)
B. MDHHS Medicaid Managed Specialty Services and Supports Contract
C. Medicaid Provider Manual
D. Health Services Advisory Group, Inc. – Standard 3 Practice Guideline

VII. RELATED POLICIES AND PROCEDURES

A. LRE Policy 5.0 – Utilization Management
B. LRE Policy 5.1 – Person-Centered Planning
C. LRE Operational Procedure 5.15A – Adopting Clinical Practice Guidelines

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
8/20/2021	New Policy	UM Clinical Steering Committee
10/1/2021	Annual Review	UM Clinical Steering Committee
6/16/2022	Annual Review	CEO and Designee