Region 10 PIHP UM Redesign Pilot Project Parking Lot
Pilot Project Kiosk and Q/A
Update 6/10/19

Questions/Concerns from the Trainings	Response	Disposition	Follow-Up Entity
How will case holders know when their authorizations are running out? Currently, if they run out of authorizations they simply enter more, and the supervisor approves.	There is no need for the PIHP to act on this issue, as there is a section in OASIS that informs the case holders regarding current to-date service utilization; also, there may be a local CMH training opportunity in OASIS navigation and routine monitoring.	Resolved	NA
Regarding time-based service authorizations – Can the case holder request a total amount of units for services that have different HCPCs based on time (e.g. Individual Therapy per 30 minutes, 45 minutes and 60 minutes)?	Region 10 will contact PCE to see how bundled time-based services are currently handled.	Pending	TBDS, PIHP DM Director, CCO
Wraparound Community Team (CT) – What if the CT accepts a case that Region 10 UM determines to be not eligible for Wraparound?	The use of CTs has never emerged as a regional concern as these local administrative entities apply structured review and consensus process to help establish rational parameters around excessive or uninformed authorization requests. CTs may continue as within the person-centered planning process and as informed by SAG COC information, and accordingly, any UM would follow that internal process. Any disagreements whould be resolved between the CMHSP and Region 10 UM.	Resolved	NA
LOCUS Score/ACT +1, and Inpatient utilization concern – the current SAG COC model	Region 10 recognizes these concerns and they will be monitored and assessed, moving forward, mindful of what is in the best interests of the individual. These will be opportunities for clinical judgement and	Resolved	NA

will likely under-assess the needs of an ACT individual because he/she will likely not have any recent hospitalizations due to intensive supports being offered and/or due to LOCUS score being lower due to intensive supports being offered	rationale to help inform and resolve such concerns. And so, as the case holder selects the overall SAG COC category, he/she can ensure the most appropriate category is assigned, regardless of what category aligns with the LOCUS score and the previous acute/crisis service utilization.		
Add "No previous service utilization" (for acute/crisis services).	Region 10 will add an item to this section that states "no acute or crisis service utilization in the past 12 months".	Resolved	TBDS, CCO
How should IMH be handled, as this population does not use PECFAS/CAFAS.	Region 10 will exempt IMH case holders from the Pilot activities. It will confer with IMH supervisors and champions to help create service authorizations for this population (birth through age 4 in the in the upcoming months.	Resolved	CCO, TBDS
As Sanilac currently authorizes all services for 12 months, case holders ask what to do for those services on the service grid that have a six-month maximum authorization duration, since these authorizations during the pilot will expire in November, December, or January.	The Pilot will operate with the current SAG services grid durations.	Resolved	NA
Fix the typo, "minimal" in the under-utilization section.	This was not a typo, but it is confusing, and it will be rewritten for greater clarity.	Resolved	TBDS, CCO

Add clinical descriptions to final section.	The vast majority of trainees reported that they prefer the current format. Trainee feedback also indicated that the SAG COC webinar and a few case holder repetitions using tool will help address any significant issues with current cleaner format.	Resolved	NA
Does ABA count as behavior plan?	Yes, and the applicable forms for go-live this fall to will include this in the operational definition.	Resolved	TBDS, PIHP DM Director, CCO
Consider adding extra information on the worksheet, such as definitions and descriptors from the logic document.	The vast majority of trainees reported that they prefer the current format. Trainee feedback also indicated that the SAG COC webinar and a few case holder repetitions using tool will help address any significant issues with current cleaner format.	Resolved	NA
The COC does not take into account psychiatric hospital length of stay and IP per state facility.	The acute/crisis service utilization descriptions will be revised to include these elements.	Resolved	TBDS, CCO
Medicare hospitalization information is not electronically available.	Agree - this is not available to PCE (not included in CC360 extract) and so a note should be added regarding this limitation to the logic document.	Resolved	TBDS, CCO
Is the COC logic model sensitive to age changes?	Because there is no way to assess at this point in time, Region 10 will assess when one year's data becomes available.	Resolved	TBDS, CCO
Can a CMH in Region 10 accept another Region 10 CMH's SAG COC if the individual transfers between CMHs?	Yes. Given that in most instances the person is simply relocating to anther residence, the receiving case holder reviews current OASIS documentation and documents that in an updated IPOS/periodic review; that said, another Bio and SAG COC worksheet should be completed if the move was also linked to a significant clinical status change.	Resolved	NA

Does the Pilot apply to individuals who are SUD primary?	*No.*	Resolved	TBDS, CCO
Summer Camp – Lapeer reports H2015 TT for a five-day summer camp program – will this be allowed within the Pilot SAG COC?	Yes, as it was clarified that circumstance involves the provision of active treatment.	Resolved	CCO, Lapeer DM Director
In OASIS the IPOS is automatically routed to the supervisor for review/signature when the case holder signs – this may pose problem for the SER process.	The Pilot was designed assuming the case holder will wait to submit the IPOS to the supervisor until he/she has received the SER UM disposition. Region 10 is only asking supervisors to hold on signing IPOS that *resulted in an SER*. Those IPOS *that did not result in a* SER can be signed immediately upon receipt.	Resolved	NA
Request for vignettes	Based on the training materials, resources, and exercises, vignettes will not be written. Nevertheless, case holders are encouraged to confer with their supervisor to determine what SAG COC is appropriate. Also, they may confer with their UM Pilot Implementation work group member (the CMHSP representative on the Region 10 UMC) or send questions / feedback to the CCO.	Resolved	CCO
One trainee stated that there is a need for LOCUS training because not all SMI case holders are trained.	This has been recognized as an expected, ongoing challenge due to inevitable staff turnover and practitioner-fidelity drift. This has been an ongoing discussion item with the CMHSPs through the Region 10 Improving Practices Leadership Team (IPLT) that meets monthly and periodically monitors each CMHSPs LOCUS Implementation Plan. Currently, each CMHSP must have a go-to supervisor/administrator assigned to ensure LOCUS trainings and as-needed LOCUS fidelity reviews, as offered through the MDHHS' Improving MiPractices.	Resolved	NA

	Through a state grant, LOCUS training and fidelity review resources are currently available to all CMHSPs.		
Individuals served in St. Clair's Medication Only clinic – how will these individuals be handled within this model?	Region 10 has identified that this service population does not need a SAG COC worksheet completed during the pilot. However, given that active CMHSP cases must receive some kind of appropriate case management, this service population will need to have a SAG COC completed for this population when the model rolls out in the fall.	Resolved	TBDS, CCO
What are the timeframes for the presence of items in the clinical assessment section (the "plus 1" section) of the SAG COC?	It is recommended that case holders focus on current symptoms and functional impairment. For ongoing cases, 'current' is basically defined as the status assessed at the last periodic review. If past issues appear critical, the case holder can use that information to inform the overall COC determination. Region 10 also encourages case holders to ensure the LOCUS is up-to-date and valid based on current symptoms, as per fidelity to use of the LOCUS. We are adding a statement to the SAG COC logic documents stressing that a +1 should only be given if the criteria are currently present or have been present within the past three months.	Resolved	NA
Probate Court-ordered treatment, Mental Health Court, assigned Guardianship – do these examples count for multisystem involvement?	Probate Court-ordered treatment and Mental Health Court are good examples of multisystem involvement. For the purposes of the Pilot, Assigned Guardianship may be included, i.e. payor, partial, full plenary; public, private.	Resolved	CCO, Implementation Work Group
Should mental health signs / symptoms be represented in the SAG COC for the IDD Populations?	It may, if the individual is taking a medication for mood. Currently MH diagnosis may be captured in the +1 for chronic medical condition, +1 two or more chronic medical conditions, and may be captured in +1 for psychiatric medication. Any need for change will be monitored and assessed per the Pilot.	Resolved	CCO, TBDS, Pilot Implementation Work Group
Should psychotropic drugs be a +1 in the SAG COC for SED?	Not for now. This prospect will be reassessed at the end of the pilot. A related consideration is prescribed psychostimulants.	Resolved	CCO, TBDS, Pilot

			Implementation Work Group
Regarding the COC section on previous crisis services utilization, assessing clinical severity for individuals with SED will biased, because psychiatric inpatient and crisis residential are fewer and / or because they receive intensive services in the community, and so they will have little to no such prior service utilization to take into consideration.	Agree. Region 10 will include a statement about lack of beds/hospital access for youth.	Resolved	TBDS
Please add a SIS N/A option to the SAG COC Worksheets.	Agree. Region 10 will update.	Resolved	TBDS
Please fix the Foster care typo in the SAG COC.	Agree. Region 10 will update.	Resolved	TBDS
Should adoption be included in the SAG COC foster care item?	Not for now. This prospect will be monitored and reassessed at the end of the Pilot.	Resolved	CCO, TBDS, Pilot Implementation Work Group
Who is going to complete the SAG COC worksheet?	As explained during the training, it will be up to the local CMHSP to decide if the intake worker (assessor) completes it or the receiving case holder. The trainers also emphasized that the worksheet must be completed at some point after the Biopsychosocial assessment and prior to the IPOS.	Resolved	NA
What constitutes as a behavior plan?	A behavior plan is one written by a CMHSP practitioners, and it does not include school behavior plans.	Resolved	NA

SED has a foster care option but IDD youth does not.	This will be added at the end of the pilot.	Resolved	TBDS, CCO
The second section in the COC assessment for IDD Youth (ages 0-4 years) should be revised because not all of the section items apply.	The point made is appreciated and it is under further study and discussion.	Pending	TBDS, CCO
Provide guidance on the two IDD criteria that do not really fit adults.	The point made is appreciated and it is under further study and discussion.	Pending	TBDS, CCO
Does the SAG COC occur at the annual or initial assessment?	It is completed at both.	Resolved	NA
Where can I find an ABE Score?	The ABE is a score developed by HSRI. It is derived from the A, B, and E subscale scores, along with the Behavioral and Medical scale scores. Although the ABE Score is not computed automatically within the AAIDD SIS output, all of the above scale scores are noted on the SIS assessment page in OASIS. Following feedback received from select SIS administrators, a regionally coordinated training / guidance document will be disseminated to case holders regarding the SIS ABE score and its calculation.	Resolved	TBDS, CCO
Regarding local requirements to calculate and enter monthly authorization amounts, case holders report they are required to determine the monthly amount for some services (such as CLS and/or skill building) – will this local	Region 10 will confer with PCE to determine if/how PCE can accommodate this.	Pending	TBDS, PIHP Data Director, CCO, PCE

process be permitted in the future-state model, and will it cause any potential issues?			
How will preliminary / interim treatment plans be handled?	Please continue current local processes, unless/until other directives are sent.	Pending	TBDS, CCO, Pilot Implementation Work Group
Psychiatric services without a service goal – at times, psychiatric services are provided prior to a treatment plan being written, and so, how does Region 10 want to handle this?	Any service provided needs to be associated with a goal in a treatment plan and authorized, therefore the current process described does not appear to be in compliance.	Resolved	NA
There is concern that the CLS and TCM services grid maximum amounts are too low - are the data incorrect?	The amounts listed are correct. Reg 10 doublechecked the previous utilization data and confirmed it is aligned with the grid ranges. However, some of the comments within the grid have been updated. Region 10 will monitor SERs related to these services during the pilot and will make any needed revisions to the grid following the pilot. It is important to recall from the training that this is an iterative process.	Resolved	TBDS
Questions/Concerns from the Webinar	**Response**	**Disposition**	**Follow-Up Entity**
Some groups in the Adult Unit are Peer lead and use H2015TT or H0038TT....I don't see those on the chart. How should we handle those?	If the code and modifier does not appear on the grid as a distinct service group, the modifier is included in the service code (for example H2015 on the grid includes H2015TT, as well as any other modifiers, as this is not displayed as a separate service). We recognize this logic may need to be modified prior to go-live this fall. As a service can have multiple modifiers, this can quickly become complex. We welcome input on how to best represent modifiers in the grid.	Resolved	TBDS, CCO

It does not appear that the group therapy authorizations are adequate. TREM and DBT are 12-month groups	DBT group will be addressed using the DBT code, H2019. As TREM does not have a distinct HCPC code, it will be included in the group therapy, 90853.	Resolved	TBDS, CCO
How do you authorize service based on 2 months when we do quarterly at every 3 months?	The 2-month authorization durations are tied to the minimal SAG COC category. This category is only to be used for step-down from services once an individual has met his/her goals and is transitioning out of care. Therefore, a 3-month period would not apply in this instance.	Resolved	TBDS, CCO
In the assessment for a I/DD child, will we be able to put a child with no PECFAS/CAFAS in Home-Based services?	Homebased services are included on the IDD youth grid – so yes, you can request this service without a PECFAS/CAFAS being completed.	Resolved	TBDS, CCO
Will we have access to a breakdown to a breakdown - per category before we go live?	All CMHs currently have access to the service grid and can view the services authorization ranges for each SAG COC category.	Resolved	TBDS, CCO
What does 2X mean on last column?	The last column is “max units for remaining duration”. “2x” referred to the units for the remaining duration were the same as the first 6 month. As this is confusing, we have revised the grid to reflect the actual number of units.	Resolved	TBDS, CCO
What if a currently authorized service is much higher than the grid and it is denied? Then what?	Upon completion of the IPOS, the case holder will complete a Service Exception Request and submit this to Reg 10 UM for review. If UM approves the request, the service will be provided. If UM determines that service amount is not medically necessary,	Resolved	TBDS, CCO

	the case holder will serve notice and appeal paperwork. The consumer can file an appeal if they disagree with the UM decision. If an appeal is filed, services will be provided until the appeal is resolved. If no appeal is requested, the IPOS will be amended and/or rewritten (based on local process).		
If authorizing over limit and it is not approved, does the auth revert to the max or is there no service authorized?	If UM determines the service is medically necessary, but the amount was not, UM would provide a partial denial. If UM determined the service is not medically necessary, this would result in a denial. In both cases the CMH has to follow the notice and appeal process.	Resolved	TBDS, CCO
If I use up the authorizations, do I do indirect code if needing to see the individual?	No. The proper code should always be used to report the service provided. It is the case holder's responsibility to monitor the utilization of authorization to ensure a service is not provided without an auth. The case holder is expected to proactively request additional authorizations if they are running low before the anticipated next IPOS review date.	Resolved	TBDS, CCO
Remaining duration still doesn't make sense	Remaining duration simply refers to the number of months left within a 12-month period. If the service has an auth duration of 12 months, remaining duration will always be 0. If the service has an auth duration of 6 months, the remaining duration would be 6 months.	Resolved	TBDS, CCO
So, for 6-month duration, do we have to re-request every 6 months? Or - we can just put them in if it is the max remaining duration amount?	For service authorizations with a six-month duration, a new authorization request is needed prior to the end of the first six-month period.	Resolved	TBDS, CCO

Are we to do the SAG COC form for only admits to CMH? Or denial at intake as well?	The SAG COC worksheet is only required for individuals that are referred for ongoing CMH services following the biopsychosocial assessment. If someone is determined to be ineligible for CMH services and referred out, another SAG COC is not required.	Resolved	TBDS, CCO
What do we do if someone is currently in more than one program that uses the same code, therefore will use up the max authorizations more quickly? Just complete a SER?	Request all the units of the service code that are needed, for both programs. If the total amount of units used in both programs exceeds the max amount for the selected SAG COC category, a SER does need to be completed.	Resolved	TBDS, CCO
At the webinar, the minimum SAG COC category was described as a "step-down" due to the duration being 2 months. In theory then, should we not have anyone at intake falling into this minimum category? What happens if we do?	Individuals that fall into the SAG COC minimum category at intake should be referred out to a mild/moderate provider in the community.	Resolved	TBDS, CCO
As far as the durations, If we do an IPOS for 12 months duration, but the codes on the grid say the max duration is 6 months, do we only put in authorizations for the 6 months and at their review if still needed, then add up to the remaining max units for the other 6 months?	Yes, another authorization request would need to be entered just prior to the first six-month period expiring.	Resolved	TBDS, CCO
Questions/Concerns Post-Webinar	**Response**	**Disposition**	**Follow-Up Entity**

Has there been any changes to content? (I see the "2x" for the CLS in SED Severe was removed, but that was the only example we had discussed at webinar.)	The latest version includes all of the following changes: i. Change "2X" to be actual value of units associated with remaining duration ii. Update Respite Camp to be a 12 month duration for levels Moderate, Serious, Severe iii. Added Respite Camp to I/DD Adult and I/DD Child service grids (with same recommended thresholds as SED) iv. Removed Private Duty Nursing from both the I/DD Adult and I/DD Child service grids as these services are always provided per a physician's order v. Added column heading to denote which service grid is being viewed/printed (i.e. MIA Service Grid vs. SED Service Grid) vi. Added functionality to include column headings and page numbers on every page when printed vii. Changed the orientation of the print to landscape and legal-size paper	Resolved	TBDS, CCO
St. Clair CMH is doing 90-day authorizations, but for the grid amounts that are 6, 10, or 12 months, should they be calculating the 3-month amount, and if they are projecting needing more units, do the SER immediately? Or wait until the end of the time frame listed in the grid?	A big part of the Pilot is to generate authorization requests as per within the Pilot, and accordingly there is no 90-day interval for the CMHSPs to work with.	Resolved	TBDS, CCO
If the IPOS was done after 5/28/19 but the initial intake was completed before this	Yes, please complete the form. In the training, we presented the flow of relevant tasks as follows: Intake > SAG COC Selection > PCP/IPOS > (service grid) > Auth Request.	Resolved	TBDS, CCO

date, would the case holder need to complete the forms?	And it was noted that the most critical task in connection to the 5/28 launch date is SAG COC Selection, because that is the task that helps inform the IPOS and Auth Request		
If the authorizations requested fall with-in the guidelines / grid, does a SAG COC need to be done?	Yes, you may recall from the training the flow of tasks noted on page 12, and that the completed SAG COC worksheet (Overall Assessment) informs what point along the continuum (minimal, moderate, serious, severe) you would refer to on the service authorization grid.	Resolved	TBDS, CCO
Regarding COFR, do we complete the SAG COC if the case is a COFR and the other county is actually doing the authorizations requested? When we accept a consumer from another county, let's say the person belongs to Gen. Co. we do an IPOS the requested authorizations are sent to them to review approve, modify or deny. The COFR is actually finalizing the requested Authorizations and approval into services.	Yes, in that example we would not include in the Pilot.	Resolved	TBDS, CCO