Region 10 PIHP UM Redesign Pilot Project Parking Lot
Pilot Project Kiosk and Q/A (update 5/28/19)

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 will likely under-assess the	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 rationale to help inform and resolve such concerns. And so, as the case	Resolved	NA

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	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?	This remains under discussion with Lapeer to clarify all information and issues.	Pending	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. Through a state grant, LOCUS training and fidelity review resources are currently available to all CMHSPs.	Resolved	NA

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. Assigned Guardianship as noted in the question warrants further discussion, i.e. payor, partial, full plenary; public, private.	Pending	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?	This prospect will be assessed at the end of the pilot. A related consideration is prescribed psychostimulants.	Pending	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?	This prospect will be monitored and assessed at the end of the Pilot.	Pending	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, and not computed automatically within the AAIDD SIS output. The SIS Assessors will likely not know what this is, as it is an aggregate of the questions and sections they ask, but not computed by them or part of the output they typically see. Region 10 is following up to learn who can access this score from SIS online. Region 10 also will assess whether additional local and/or regionally coordinated training or guidance is needed for case holders regarding the SIS ABE score and its calculation.	Pending	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 process be permitted in the	Region 10 will confer with PCE to determine if/how PCE can accommodate this.	Pending	TBDS, PIHP Data Director, CCO, PCE

future-state model, and will it cause any potential issues?			
How will preliminary / interim treatment plans be handled?	Please continue current local processes during the pilot. Region 10 will need to determine what if any steps need to Does anyone know of a place in Michigan that provides microblading? Preferably experienced with individuals with alopecia be taken to standardize this process for go-live this fall. In doing so, Region 10 will assess how each CMH is doing this task.	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.		

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.		
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.		
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.		
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.		
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.		
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,		

	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.		
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.		
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.		
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.		

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.		
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.		
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.		
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.		