Mid-State Health Network Utilization Management Plan

Pre-Paid Inpatient Health Plan (PIHP)

Mid-State Health Network, Utilization Management Committee Approved: Oct. 2023
Mid-State Health Network Medical Director Approved: November 2023
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I. Utilization Management Plan Overview

The structure of the Mid-State Health Network (MSHN) Utilization Management Program is described in the MSHN policy and procedure manual. MSHN policies and procedures outline the components of the MSHN UM program, including service access procedures, medical necessity standards, and service eligibility criteria.

See MSHN Policies and Procedures:

- Utilization Management: Utilization Management Policy & Procedure
- Utilization Management: Access System Policy & Procedure
- Utilization Management: Retrospective Sample Review-Acute Care Services Policy & Procedure
- Utilization Management: Level of Care System (LOC) for Parity Policy & Procedure

In addition, the following service-related policies and procedures address service-specific utilization management requirements where they exist, such as enhanced eligibility criteria and regulated service authorization procedures. Services which have specific UM requirements are typically those which are Medicaid waiver-based or grant funded, and therefore have individual enrollment or highly specialized requirements which must be met.

See MSHN Policies and Procedures:

- Service Delivery System: Habilitation Supports Waiver Policy
- Service Delivery System: Habilitation Supports Waiver Annual Recertification Procedure
- Service Delivery System: Autism Spectrum Disorder Benefit Policy
  Service Delivery System: Autism Benefit Re-evaluation Eligibility Procedure
- Service Delivery System: SUD Services – Women's Specialty Services Policy
- Service Delivery System: Children's Home and Community Based Services Waiver Policy & Procedure
- Service Delivery System: Serious Emotional Disturbance Waiver Policy
- Service Delivery System: Conflict-Free Case Management Policy
- Service Delivery System: SUD Case Management Services Procedure

The MSHN Utilization Management (UM) Plan is strategic in nature and serves to support compliance with the aforementioned UM and related service policies. It applies to managed specialty supports and services delivered through the 1115 Pathways to Integration Demonstration Waiver, i.e., those for individuals experiencing mental illness, serious emotional disturbance, substance use disorders and intellectual and developmental disabilities. The UM Plan is used by the MSHN Utilization Management Committee to:

- Define specifics of regional requirements or expectations for Community Mental Health Services Programs (CMHSP) Participants and Substance Use Disorder Service Providers (SUDSP) relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific services or types of services, if not already addressed in policy;
- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical

necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies;

- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable);
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization;
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization); and
- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

II. Exception 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 which began on 10/1/2021. As of 10/1/2023 (Fiscal Year 2024), four CMHSP Participants in the MSHN region are CMS CCBHC Demonstration sites. Eligibility requirements to receive CCBHC services differ significantly from eligibility requirements for specialty supports and services delivered through the 1115 Pathways to Integration Demonstration Waiver, i.e., those for individuals experiencing mental illness, serious emotional disturbance, substance use disorders and intellectual and developmental disabilities. CCBHC services are not subject to all of the same population eligibility guidelines or service utilization guidelines as described in the MSHN UM Plan. The CMS CCBHC Demonstration sites in the MSHN region will adhere to the eligibility and service provision requirements as outlined in the MDHHS CCBHC Handbook.

III. Definitions

These terms have the following meaning throughout this Utilization Management Plan.

1. 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.
2. CMHSP Participant: refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participants in MSHN Regional Entity.
3. Concurrent Review: During the course of service delivery (i.e. point of care), ensuring an appropriate combination of services is authorized; concurrent review occurs within the context of philosophical frameworks governing decision making regarding services (e.g., consumer self-determination, person centered planning and trauma informed and recovery oriented care); may include re-measurement(s)

of need utilizing standardized assessment tools; for Medicaid enrollees, concurrent UM decision making includes Advance Notice to the consumer.

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

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

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

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

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

9. 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.

10. 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.

11. Serious Mental Illness (SMI): As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.
12. Staff: Refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD Service Provider.
13. Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
14. Substance Use Disorder (SUD): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

IV. Prospective, Concurrent and Retrospective Utilization Management Review

A note about data processes for utilization management data review: Utilization management involves the review of data and this review should be preceded by the use of as many different systematic research methods as possible in that these processes are expected to be a study of evidence in order to answer a question that is raised in the data (Vogt, 2007). Methodology matters as does the reliability and validity of data collection/measurement and analysis, and thus, UM processes will employ techniques that are appropriate and consistent with prevailing behavioral science data gathering techniques intended to glean actionable information and insight into the behavioral health and substance use disorder systems of the MSHN region.

A. Prospective Utilization Review

MSHN will have a prospective utilization review process for non-emergent mental health and substance use disorder services, which will include the following components:

1. Service eligibility determination, through an access screening process
2. Verification of medical necessity, through a clinical assessment process (which may occur concurrently or sequentially with the access screening process)
3. Standardized assessments and/or level of care tools for certain clinical populations

4. Specialized testing/evaluations for certain services
5. Certification for certain enrollment-based services
6. Pre-authorization (amount, scope, and duration) for certain services

Service eligibility and medical necessity criteria for each clinical population are outlined in the MSHN Access System policy, including requirements for second opinions and advanced/adequate notice of denials.

1. Eligibility Determinations and Verification of Medical Necessity

Eligibility determinations and verification of medical necessity will be performed by CMHSP Participants for mental health services, and by SUD providers for substance use disorder services. An exception is Autism Spectrum Disorder services, which are may be initiated through a screening during well-child visits, and has a state-mandated comprehensive evaluation process, as discussed further below.

To ensure adequate integration, MSHN has established a coordinated service access process. CMHSPs and the SUD provider networks in their respective catchment areas will coordinate access processes, ensure there is 'no wrong door' for linking to services, and ensure there is a single point of contact for after-hours service inquiries from Medicaid enrollees and other individuals seeking mental health and SUD services. CMHSP Access Centers may assist with screening individuals seeking SUD services.

Coordination of care will also occur with primary health care providers.

2. Standardized Assessments and/or Level of Care Tools

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

- Substance Use Disorder services
  - ASAM (American Society of Addiction Medicine) Continuum Assessment for adults (18 and older)
  - GAIN (Global Appraisal of Individual Needs) comprehensive biopsychosocial assessment for adolescents (17 and under)
  - ASAM Patient Placement Criteria (ASAM-PPC) for level of care determination
- Children and Adolescents with Serious Emotional Disturbance
  - DECA (Devereaux Early Childhood Assessment, for ages birth-47 months)
  - CAFAS (Child and Adolescent Functional Assessment Scale (for ages7-17)
  - PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages4-6)
  - Effective 10/1/2024 (Fiscal Year 2025) the MichiCANS will replace the CAFAS and PECFAS as the required tool for all infants, children, and youth from ages birth through 20 (until 21st birthday)
- Adults with Mental Illness
  - LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services)

3. Specialized Testing/Evaluation and Certification

Certain Medicaid services have additional requirements for service eligibility or medical necessity,

including enrollment/certification and/or specialized testing/evaluation, which will be followed by the MSHN Region:

- Specialized testing/evaluation required:
  - Autism Spectrum Disorder Benefit
    - Full medical and physical examination, and screening for autism spectrum disorder performed by primary care provider
    - ADOS-2 (Autism Diagnostic Observation Schedule), comprehensive clinical interview and Developmental Disabilities-Children's Global Assessment Scale (DD-CGAS) completed by CMHSP Participant
- Additional documentation of medical necessity by an appropriately licensed/registered health professional:
  - Occupational Therapy (Physician's order is also required)
  - Physical Therapy (Physician's order is also required)
  - Speech, Hearing and Language Therapy
  - Behavior Treatment/Applied Behavioral Analysis (ABA)
  - Health Services
  - Private Duty Nursing (Physician's order is also required)
  - Medication Administration and Medication Review
  - Medication Assisted Treatment (MAT)
- Certification of need required:
  - Habilitation and Support Waiver (for Children and Adults with Intellectual and Developmental Disabilities)
  - Personal Care in Specialized Residential

MDHHS will retain lead responsibility for managing enrollment and eligibility determinations for the Autism Benefit (waiver). Additional requirements are outlined in the MSHN Autism Spectrum Disorder Benefit policy.

MSHN centrally manages the Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), and Waiver for Children with Severe Emotional disturbance (SEDW) certifications. CMSHP Participants will initially certify and annually recertify those persons enrolled in these waivers. The MDHHS regulates the number of HSW certificates available to the region. Eligibility requirements are outlined in the MSHN CWP, HSW, and SEDW policies.

MSHN also has responsibility to ensure that women who qualify for specialty substance use disorder (SUD) services are provided those services by designated providers and to ensure the provider network conveys an atmosphere that is welcoming, helpful and informative for its clients. See the MSHN Policy *SUD Services-Women's Specialty Services* for more information.

If not otherwise specified here, CMHSP Participants or SUD Providers, where applicable, will assess and document medical necessity by properly qualified professionals in their clinical records, including obtaining any required physician's orders. SUD Providers will use a centralized managed care software system for this purpose, called Regional Electronic Medical Information (REMI).

4. Level of Care Thresholds and Placement Criteria

Mid-State Health Network (MSHN) and its provider network shall ensure that determination decisions are informed by consistent application of medical necessity criteria by implementing regional admission and service guidelines that include service code-level thresholds for individuals via a nationally recognized recommended Level of Care (LOC) instrument (i.e. CAFAS/PECFAS, LOCUS, or ASAM), and person-centered

planning process. The MSHN Level of Care System (LOC) Policy and Procedure defines the regional expectations for level of care thresholds and placement criteria.

Any MDHHS-specified level of care thresholds and/or placement criteria which must be applied to the results of standardized assessments during the service eligibility determination process are outlined in the MSHN Access System policy. Requirements including a priority rubric for allocation of HSW slots are outlined in the MSHN HSW policy.

If not otherwise specified by MDHHS, once MSHN general service eligibility and medical necessity criteria are met, the level of care and/or placement for services will be based upon assessment of the individual consumer. Person centered planning activities, self-determination principles and individual goals for recovery define how the services are to be provided to address individual consumer goals. See the MSHN Policy *Service Delivery System: Person/Family Centered Plan of Service* for more information.

5. Pre-Authorization of Services

Pre-authorization for a defined episode of care will be required for the following services due to the cost and/or intensity of the service to require:

- Inpatient Psychiatric Hospital Admission
- Autism spectrum disorder services
- Crisis Residential Services
- Intensive Crisis Stabilization Services
- Outpatient Partial Hospitalization Services

In addition, the following services may have additional clinical review and/or administrative authorization at the CMHSP Participant or SUD Provider level to ensure required resources are available to support individual plans of service:

- Community Living Supports
- Recovery Housing
- Housing Assistance
- Assistive Technology
- Enhanced Medical Equip & Supplies
- Enhanced Pharmacy
- Environmental Modifications
- Goods & Services
- Personal Emergency Response Systems

For all other MSHN services, pre-authorization for mental health or SUD services will not be necessary. At their discretion, CMHSP participants use authorization of services to help manage provider network capacity and financial resources.

6. Service Denials Resulting from Prospective Utilization Review

CMHSPs and SUD Providers will offer second opinions and provide advanced/adequate notice of denials as outlined in the MSHN *Utilization Management: Access System Policy* and MSHN *Customer Service: Medicaid Enrollee Appeals/Grievances Policy*.

7. Monitoring Access Eligibility and Medical Necessity Determinations

Each CMHSP and SUD Provider will monitor individual service eligibility and medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether the individual eligibility and medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD eligibility determinations through its electronic managed care information system REMI.

The MSHN UM Committee in conjunction with MSHN staff will monitor regional compliance with the access eligibility and medical necessity criteria at the population level through the review of metrics.

a) Metrics

The following metric(s) will be used for purposes of monitoring medical necessity and service eligibility:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Medical Necessity: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Medical Necessity and Service Eligibility	Service penetration per population	MMBPIS data	Unduplicated consumers served by disability designation - MIA, SED, I/DD, SUD	MMBPIS data state average	Bi-Annually
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Disposition of Service Requests	Annual Submission	Number of persons who request services from CMHSP; Number served; Number who do not meet initial eligibility criteria	Qualitative Analysis	Annual

b) Interventions

If an individual record review during a site review raises questions regarding compliance with MSHN service eligibility and medical necessity criteria, the issue will be addressed with the CMHSP or SUD Provider through the site review process.

The MSHN UM Committee will review access and eligibility reports to identify potentially undesirable variances in access to service at the population level. For purposes of ensuring appropriate access to the Medicaid benefit managed by the region, undesirable variance will be defined as:

- Possible inconsistency with regional service eligibility and/or medical necessity criteria; and/or
- Possible inconsistency with recommended level of care service benefit array
- Possible inconsistency with coordination of benefit requirements as defined by the State Medicaid Agency.

Based upon its findings, the UMC will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following interventions, presented in order of intensity, from least to highest:

1. Verify data

2. Request further analysis and verification
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy
6. Re-evaluate required credentials and/or necessary training for access/intake staff

All official interventions that a stakeholder, CMHSP, or the UMC takes shall be documented on a "Change Strategy" form to record responses to data analysis that have occurred via the utilization management context (i.e., in UMC or local CMHSP UM processes).

B. Concurrent Utilization Review

Concurrent reviews will be performed by CMHSPs for mental health services and appropriate MSHN UM Specialist staff will perform concurrent SUD UM reviews.

Each individual receiving services will have an individual plan of service which outlines the services to be received, including the amount, scope and duration. The amount, scope and duration of each service, if not subject to the enrollment, authorization or other limitations described earlier in this plan, will be determined by the person who will be receiving the service and their SUD Provider or CMHSP, through a person-centered and recovery-oriented planning process.

Utilization decisions will not be made outside of the person-centered planning process unless otherwise required by MDHHS (as described in this UM Plan). The individual plan of service for each person receiving services will specify the frequency of periodic (i.e., concurrent) review as determined in dialogue with the person receiving services. Plans will be reviewed at least annually, or more frequently as needed to adjust for changes in functioning or at the person's request.

CMHSPs may utilize service authorization protocols at the local level in order to trigger additional review of medical necessity for service requests (generated through the person-centered planning) which reflect potential over or under utilization of services. The MSHN UM department will utilize service protocols based on assessed ASAM level of care in order to trigger additional concurrent review of medical necessity for SUD service requests which reflect potential over or under utilization of services (See MSHN SUD Benefit Plan).

The process of periodic and/or annual review of individual plans of service will incorporate documentation or re-assessment of the individual's continued service eligibility and medical necessity for the services being received.

1. Services Requiring Enrollment or Pre-Authorization

Concurrent review for the following services will be required to document continuing medical necessity and adherence to service specific eligibility criteria, if any. The review process may require re-administration of population/service specific assessments, renewal of certification, or re-authorization. Specific need thresholds may be required. These services will not continue unless re-authorization/re-certification takes place or thresholds are still shown to be met.

- Continuing Stay Reviews (i.e., per episode of care):
  - Psychiatric Inpatient Hospitalization
  - Crisis Residential Services
  - Crisis Observation Care
  - Intensive Crisis Stabilization Services

        - Outpatient Partial Hospitalization Services]
        - Medication Assisted Treatment (MAT)
        - Detoxification/Withdrawal Management
        - Residential Treatment for SUD
    - Semi-Annual Orders:
        - Physician Orders (for exceptions to standard hours for Private Duty Nursing)
    - Annual Orders, Authorizations and Certifications:
        - Autism Services Authorization
        - Habilitation and Support Waiver Re-Certification
        - Physician Orders for Occupational Therapy, Physical Therapy and Private Duty Nursing

2. Services Not Requiring Enrollment or Pre-Authorization

For services not requiring enrollment or pre-authorization, the person-centered planning process will determine whether services are to continue. However, the re-administration of standardized tools/assessments will be required for selected populations or services, to inform the person-centered planning process and to support decision making regarding continued eligibility and medical necessity:

- Quarterly:
    - CAFAS or PECFAS (for SED Children)
    - DECA
    - ASAM (or more frequently upon change in clinical status)
- Annually:
    - LOCUS (for MI Adult)
    - ADOS-2 and DD-CGAS (for Autism Services)
    - Assessment of Personal Care Needs (for Specialized Residential)
- Every 3 Years:
    - Supports Intensity Scale (SIS) (for individuals with Intellectual and Developmental Disabilities)

3. Required Related Service Needs

In addition to the above requirements for authorization of services, the following requirements will be met for HSW services, 1915(I)services and private duty nursing, as outlined in the MDHHS Medicaid Manual:

- A HSW beneficiary will receive at least one HSW service per month in order to retain eligibility.
- Individuals receiving Medicaid Waiver 1915(I) funded services will have one or more goals in their individual plan of service that promote community inclusion and participation, independence, and/or productivity.
- Individuals receiving private duty nursing will also receive at least one of the following habilitative services: Community living supports, out-of-home non-vocational habilitation, or prevocational or supported employment.

4. Service Reduction or Loss of Eligibility Resulting from Concurrent Review

CMHSPs and SUD Providers will provide advanced/adequate notice of denials as outlined in the MSHN Access System policy for any service reduction resulting from loss of eligibility or lack of medical necessity. Unless MSHN service eligibility and medical necessity criteria are not being met, all utilization decisions will be made in the context of person-centered planning activities.

5. Monitoring Continuing Eligibility and Medical Necessity Determinations

Each CMHSP and SUD Provider will monitor individual continuing stay/eligibility/medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether continuing stay/eligibility/medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD determinations through the electronic managed care information system as needed.

The MSHN UM Committee in conjunction with MSHN staff will monitor regional compliance with continuing stay/eligibility/medical necessity criteria at the population level through the review of metrics.

a) Metrics

The following metric(s) will be used, based upon a regional priority to address in particular crisis response capacity and utilization of detox services:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Over/Under Utilization: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Utilization of Acute Level of Care	Inpatient Recidivism	MMBPIS data	Percent of MI and DD children/ adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	15% or less.	Quarterly
		Crisis/Acute Service Utilization (MCG Behavioral Health Criteria): • Inpatient Psychiatric • Crisis Residential • Crisis Stabilization • Emergency Services	Encounters MCG Behavioral Health Guidelines	Count each of the four services that comprise crisis/acute services to calculate rate by CMH and by region Each CMHSP will choose one of the following options: 1. Conduct prospective/concurrent reviews for all persons receiving acute services; OR 2. Conduct quarterly retrospective reviews of a sample of crisis/acute cases to determine if MCG Behavioral Health Criteria were met for medical necessity for the service	Most common (i.e., mode) clinical profiles per population 95% or more of crisis/acute cases reviewed will meet medical necessity criteria for the service as defined by MCG Behavioral Health Criteria	Quarterly
		SUD: Residential Utilization	REMI claims	Count by ASAM Level of Care (3.1, 3.3, 3.5, 3.7) to calculate rate for region	Most common (i.e., mode) clinical profile	Bi-Annually
		Detox Recidivism	REMI data	The percent of adults with SUD readmitted to an detox unit within 30 days of discharge.	15% or less.	Bi-Annually
		Potential tools for identification of causal factors for desirable/ undesirable variance: Utilization of ACT,	Encounters			Bi-Annually

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
		Home-Based, emergency services				

In addition, CMHSPs will monitor to ensure required related services are being utilized, as previously addressed in this plan:

- HSW beneficiaries received at least one HSW service per month.
- Individuals receiving Medicaid Waiver 1915(I) funded services had one or more goals that promote community inclusion and participation, independence, and/or productivity.
- Individuals receiving private duty nursing received at least one of the following habilitative services: Community living supports; out-of-home non-vocational habilitation; or prevocational or supported employment.

b) Interventions

If an individual record review by MSHN during the site review process raises questions regarding compliance with continued service eligibility and medical necessity based on regional criteria, the issue will be addressed with the CMHSP or SUD Provider through the site review process.

The MSHN UM Committee will review access and eligibility reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring utilization of the Medicaid benefit managed by the region, undesirable variance will be defined as:

- Possible lack of continuing service eligibility and medical necessity over the course of an episode of care.
- Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e., mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

Based upon its findings, the UMC will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following interventions, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy and/or development of clinical service protocols
6. Set utilization thresholds or limits

All official interventions that a stakeholder, CMHSP, or the UMC takes shall be documented on a "Change Strategy" form to record responses to data analysis that have occurred via the utilization management context (i.e., in UMC or local CMHSP UM processes).

C. Retrospective Utilization Review

Retrospective review will be performed by CMHSPs for mental health services. MSHN UM Specialists perform the reviews for SUD services. Consistent with MSHN strategic plan efforts, the MSHN UM Committee, in conjunction with MSHN staff, will perform retrospective utilization review at the population level through the review of metrics.

Retrospective review will focus on the cost of care, service utilization, and clinical profiles. Analysis will consider encounter data in conjunction with level of care tools such as ASAM, LOCUS, SIS, CAFAS/PECFAS, DD Proxy Measures and other clinical need/outcomes data as available. BH-TEDS and Medicaid claims data will be incorporated as warranted.

a) Metrics

The following metric(s) will be used for purposes of monitoring utilization retrospectively:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Cost: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Service Utilization Data overlaid with Assessed Level of Need Data (ie: LOCUS, CAFAS, ASAM, SIS)	Cost ***Indicators*** by Code ***(i.e., Program Cluster)*** Per Member Per Month: - CLS - Autism	Sub-Element Report (*remember this is a reach back and accounts for all costs*); Compare to current encounter file data	Look at H2015, H2016, H0043 for CLS. Look retroactively for autism from previous benefit to expansion.	Cost for each member ID for CLS and Autism services, per month, in a histogram. Goal is a bell curve or normal distribution.	Fiscal Year
		Tools for identification of causal factors for desirable/ undesirable variance: -Level of Need Assessment Data (i.e. CAFAS, LOCUS, SIS, ASAM) -MSHN Level of Care Service Benefit Packages	CAFAS, LOCUS, SIS, ASAM and encounters	Review service grouping outliers and organizational outliers where there is considerable variance in the provision of services relative to the assessed level of need	Normal distribution of service provision relative to assessed level of need	Quarterly
Over/Under Utilization: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Utilization of Acute Level of Care	Crisis/Acute Service Utilization (MCG Behavioral Health Criteria): • Inpatient Psychiatric • Crisis Residential • Crisis Stabilization Emergency Services	Encounters MCG Behavioral Health Guidelines	Count each of the four services that comprise crisis/acute services to calculate rate by CMH and by region Each CMHSP will choose one of the following options: 1. Conduct prospective/concurrent reviews for all persons receiving acute services; OR 2. Conduct quarterly retrospective reviews of a sample of crisis/acute cases to determine if MCG Behavioral Health Criteria	Most common (i.e., mode) clinical profiles per population 95% or more of crisis/acute cases reviewed will meet medical necessity criteria for the service as defined by MCG Behavioral Health Criteria	Quarterly

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
				were met for medical necessity for the service		

b) Interventions

The MSHN UM Committee will review service utilization reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring effective management of Medicaid resources managed by the region, undesirable variance will be defined as:

- Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
- Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e., mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

Based upon its findings, the UMC will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy and/or development of clinical service protocols
6. Set utilization thresholds or limits
7. Address service configuration to affect utilization

c) Other Retrospective Review (Health Outcomes)

Identify population health outcomes metrics to be monitored by focusing on persons that have chronic health conditions which are co-morbid with a serious and persistent mental health illness, serious emotional disturbance, co-occurring substance use disorder and/or a developmental disability.

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-Paid Inpatient Health Plans (PIHPs), the Michigan Department of Health and Human Services has developed the joint expectations for both entities. The integration of physical and mental health services provided by the MHP and PIHP for shared consumer base plans and clinical pathways which encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. Coordinate the physical health assessment through the consumer's MHP as necessary.

Based on the findings, the UMC will identify improvement opportunities based upon health outcome indicators.

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Integration Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program)	Integration with Physical Health	Children and adolescents' access to primary care practitioners (PCP)	ICDP	The Percentage of members 12 months to 19 years of age who had a visit with a PCP.	>=75%, State average for MHP performance, national performance via NCQA	Fiscal Year
		Adults' access to preventive/ambulatory health services	ICDP	The percentage of members 20 years and older who had an ambulatory or preventive care visit.	>=75%, State average for MHP performance, national performance via NCQA	Fiscal Year
		Reduction in number of visits to the emergency room.	ICDP and integrated care cohort	The number of individuals who are on track to have less ER visits than they had during the 12 months previous to starting an integrated care plan.	State average for performance as available	Quarterly
		Follow up after Hospitalization for Mental Health (FUH) for Children	ICDP and Care Connect 360	The percentage of Beneficiaries ages 6-17 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	70%	Quarterly
		Follow up after Hospitalization for Mental Health (FUH) for Adults	ICDP and Care Connect 360	The percentage of Beneficiaries ages 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	58%	Quarterly

References

MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1115 Pathways to Integration Waiver Demonstration

MDHHS Medicaid Provider Manual, Mental Health/ Substance Abuse chapter

Michigan Mental Health Code, 330.1100a and b

Vogt, W.P. (2007). Quantitative research methods for professionals. Boston, MA: Pearson Education, Inc.