Mid-State Health Network Utilization Management Plan

Pre-Paid Inpatient Health Plan

Mid-State Health Network, Utilization Management Committee Approved: 9/22/2016
Mid-State Health Network Medical Director Approved: 10/31/2016
Mid-State Health Network, Operations Council Approved: 11/14/2016

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
- Utilization Management: Access System

In addition, the following service related policies 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
- Service Delivery System: Autism Spectrum Disorder Benefit
- Service Delivery System: SUD Services – Women's Specialty Services

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 concurrent 1915(b)/(c) Waiver Program, i.e., those for individuals experiencing mental illness, serious emotional disturbance, substance use disorders and intellectual and developmental disabilities (i.e., challenges). The UM Plan is used by the MSHN Utilization Management Committee to:

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers 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;
- 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. Definitions

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

1. CMHSP Participant: refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in MSHN Regional Entity.
2. 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.
3. 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.
4. 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.
5. 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.
6. Provider Network: refers to MSHN CMHSP Participants and Substance Use Disorder (SUD) Service Providers 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.
7. 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.
8. Staff: Refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD Service Provider.
9. Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

III. Prospective, Concurrent and Retrospective Utilization Management Review

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 by 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. The following assessments/tools will be utilized in the MSHN region:

- Substance Use Disorder services
  - ASAM (American Society of Addiction Medicine) level of care placement criteria
- Children and Adolescents with Serious Emotional Disturbance
  - CAFAS (Child and Adolescent Functional Assessment Scale (for ages 5-19)
  - PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages 3-5, or age 7)
- 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 Clinical Global Impression Severity Scale (CGISS) 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 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 region's allocation of Habilitation and Support Waiver (HSW) certifications. CMSHP Participants will initially certify and annually recertify those persons enrolled in the HSW. The MDHHS regulates the number of certificates available to the region. Eligibility requirements including outlined in the MSHN HSW policy.

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 CareNet.

4. 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 *General Management: 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:

- Medication Assisted Treatment for SUD
- Detoxification/Withdrawal Monitoring (Residential Treatment for SUD)
- 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 Access System 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 the CareNet record keeping system.

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

Effective FY17, MSHN will have access to a new dataset, the Mid-State Supplementary Values (MSSV). The MSSV system will collect information regarding functional needs and diagnostics at the point of screening/ assessment, annually, and at the point of discharge. MSSV data will be collected and reported by CMHSP Participants and SUD Providers.

> See the MSHN Box website for MSHN Supplementary Data Coding Instructions, MSHN Field Specifications and more information about the MSSV system.

The following metric(s) will be used for 2016 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	Quarterly
		Consistency of application of criteria	MSSV (MSHN 'Supplemental' Data)	Population distributions; *Definition will continue to evolve as we pilot the data - please refer to mock data dashboard for examples*	Most common (i.e., mode) clinical profiles per population	Quarterly
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Disposition of Service Requests	Annual Submission			

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 coordination of benefit requirements as defined by the State Medicaid Agency.
- Mid State Supplemental Value eligibility logic for the purposes of identification of inconsistent access data patterns. The logic outlines potential minimum criteria that would needed to be met for each population.

MSSV Logic:

Developmental Disability

Data Element	Value
Developmental Disorders	Yes
Functional Impairment: Relationships	Three or more yes within functional impairments
Functional Impairment: Learning	Three or more yes within functional impairments
Functional Impairment: Self-Care	Three or more yes within functional impairments
Functional Impairment: Understanding	Three or more yes within functional impairments
Functional Impairment: Receptive and Expressive Communication	Three or more yes within functional impairments
Functional Impairment: Behavioral	Three or more yes within functional impairments
Functional Impairment: Mobility	Three or more yes within functional impairments
Functional Impairment: Life Activities	Three or more yes within functional impairments

Severe Emotional Disturbance

Data Element	Value
Psychiatric symptoms	Yes
Functional Impairment: Relationships	Three or more yes within functional impairments
Functional Impairment: Learning	Three or more yes within functional impairments
Functional Impairment: Self-Care	Three or more yes within functional impairments
Functional Impairment: Understanding	Three or more yes within functional impairments
Functional Impairment: Receptive and Expressive Communication	Three or more yes within functional impairments
Functional Impairment: Behavioral	Three or more yes within functional impairments
Functional Impairment: Mobility	Three or more yes within functional impairments
Functional Impairment: Life Activities	Three or more yes within functional impairments

Severe Persistent Mental Illness

Data Element	Value
Psychiatric symptoms	Yes
Functional Impairment: Relationships	Three or more yes within functional impairments
Functional Impairment: Learning	Three or more yes within functional impairments
Functional Impairment: Self-Care	Three or more yes within functional impairments
Functional Impairment: Understanding	Three or more yes within functional impairments
Functional Impairment: Receptive and Expressive Communication	Three or more yes within functional impairments
Functional Impairment: Behavioral	Three or more yes within functional impairments
Functional Impairment: Mobility	Three or more yes within functional impairments
Functional Impairment: Life Activities	Three or more yes within functional impairments

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 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.

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 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 Monitoring (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)
- Annually:
  - ASAM
  - LOCUS (for MI Adult)
  - ADOS-2 and CGISS (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(b)(3) 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(b)(3) 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 CareNet record keeping 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 for 2016, 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	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: • Inpatient Psychiatric • Crisis Residential • Crisis Stabilization • Emergency Services	Encounters; use Census Data rather than persons served	Count each of the four services that comprise crisis/acute services to calculate rate by CMH and by region	Most common (i.e., mode) clinical profiles per population	Quarterly
		SUD: Residential Utilization	CareNet claims; use Census Data rather than persons served	Count by four services to calculate rate by CMH and by region	Most common (i.e., mode) clinical profile	Quarterly

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Attachment P7.9.1		Detox Recidivism	CareNet data; use Census Data rather than persons served	The percent of adults with SUD readmitted to an detox unit within 30 days of discharge.	15% or less.	Quarterly
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Utilization of ACT, HB, emergency services?	Encounters			

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(b)(3) 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
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 the MSSV data previously identified in this plan, as well 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 2016 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	Utilization Cost Data with Outcome Data Overlay	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.	Quarterly
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Outcome/Assessment Data (i.e. CAFAS, LOCUS, SIS, ASI)	CAFAS, LOCUS, SIS, ASI and encounters			

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
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.

Establish 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): percentage of members 12 months to 19 years of age who had a visit with a PCP.	ICDP	See link	State average for MHP performance, national performance via NCQA	Quarterly
		Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	ICDP	See link	State average for MHP performance, national performance via NCQA	Quarterly