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Managing Managed Care: An Introduction to Managed Care for Massachusetts Substance Use Providers

Sponsored by the MA Department of Public Health, Bureau of Substance Abuse Services & AdCare Educational Institute, Inc.

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Welcome!

- **Introductions**
  - Technical Assistance Collaborative (www.tacinc.org)
    - Kelly English
  - Parker Dennison & Assoc. (www.parkerdennison.com)
    - Susan Parker
    - Rusty Dennison
- **Learning objectives**
  - Explain how medical necessity, service authorization, and payment are connected.
  - Identify the core documentation requirements for establishing medical necessity.
  - Detail actions staff persons can take to adequately prepare for a review with an insurance company.
  - Understand the core competencies of internal UM/QM
- **Logistics for the day**

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Agenda

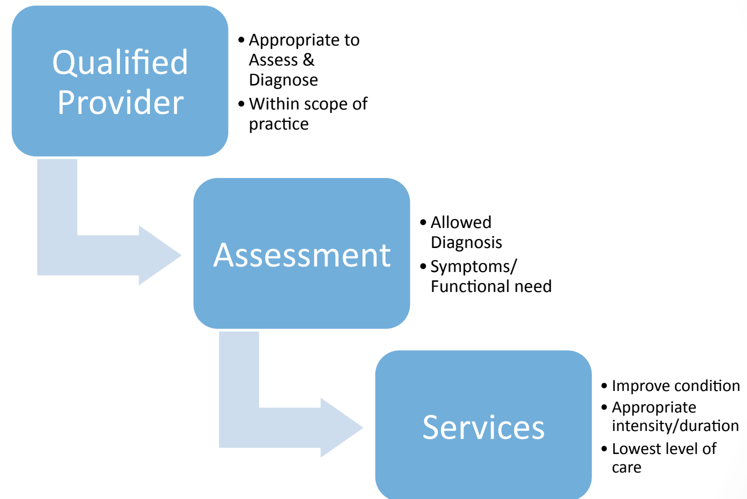
Agenda – Making the Clinical Case

- Medical Necessity and Clinical Documentation
- UM/QM Core Competencies
- Preparing for MCO Authorizations
- UM MIS Requirements
- Determining UM Resources Required
- UM/QM and Internal Clinical Practice
- Implementation Issues
- Bringing It Home – Building a Development Plan

What is Medical Necessity?

- **In general:**
  - A payment concept that establishes the definition of clinical/ medical "need" which is required in order for a service to be eligible for reimbursement
  - Each payer will have their own definition
  - While often viewed as part of a "medical model", the term and model is applied to behavioral health services
  - In a fee for service reimbursement, EACH SERVICE must meet the threshold for medical necessity established by the payer.

Core Components



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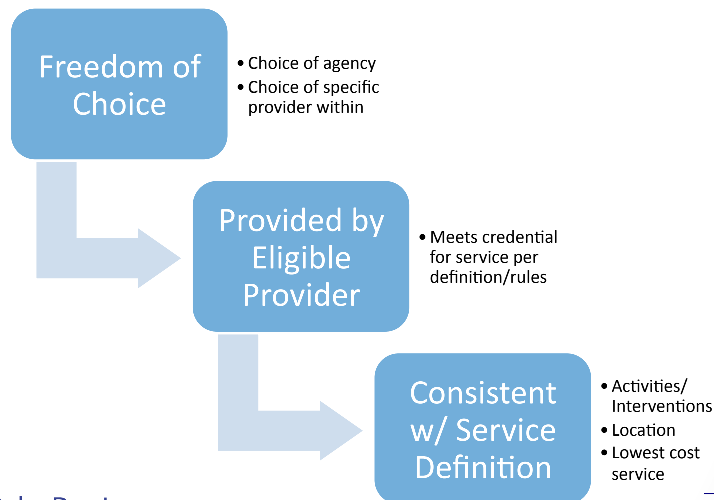
And More for Medicaid



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Definition Example

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care.

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MassHealth Definition

(A) A service is "medically necessary" if: (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

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Beacon Health Strategies

Medically necessary services are health care and services that (1) are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap; (2) for which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; (3) are of a quality that meets generally accepted standards of health care; and (4) that are reasonably expected to benefit the person. This definition applies to all levels of care and all instances of Beacon's utilization review.

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MBHP

1. The proposed service must be reasonably calculated to prevent, diagnose, alleviate, correct, prevent the worsening of, or cure conditions in the Member that:

- *endanger life;*
- *cause suffering or pain;*
- *cause physical deformity or malfunction; and*
- *threaten to cause or aggravate a handicap or result in illness or infirmity.*

2. There is no other medical service or site of service comparable in effect and available or suitable for the Member requesting the service that is more conservative or less costly.

3. The service meets professionally recognized standards of healthcare and is substantiated by records, including evidence of such medical necessity and quality.

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Medical Necessity: Underlying Clinical Questions

- **Assessment**
  - Why did the consumer seek services?
  - What are the presenting and historical issues, problems, strengths, and needs?
  - What worked and what did not if the individual has received services in the past?
  - What are the current issues placing the individual most at risk?
  - What is the individual's functional level in daily life?
  - How should these and other needs be prioritized and addressed?
  - What interventions are needed, when, how quickly, in what services and settings, and with what provider(s)?
  - What is the individual's diagnosis?

  Key Issues
  - Sufficient to support the recommended level of care?
  - Is the diagnosis supported by the information in the assessment?
  - Is the diagnosis allowed by the individual's benefit package?

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Medical Necessity: Underlying Clinical Questions

- **Individualized Action Plan—the "Orders"**
  - What are the prioritized problems, strengths and needs?
  - Which goals will facilitate achievement of stated hopes, preferences and desired outcomes?
  - What are the selected services and interventions (right duration, intensity and frequency) to best accomplish these?
  - The qualified staff person(s) responsible for the provision of services are identified and are appropriate?
  - Are the outcomes, discharge criteria and desired changes in levels of functioning and life quality by which to objectively measure progress defined?

  Key Issues
  - Based on assessment and diagnosis?
  - Evidence of the individual's concurrence?
  - Spans all treatment interventions?

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Medical Necessity: Underlying Clinical Questions

- **Progress Notes**
  - Contains observations of the symptoms, behaviors, affect, level of functioning, skills deficiencies, strengths and reassessment for risk when indicated?
  - Documents information regarding the exact nature, duration, and frequency of the service?
  - Services relate directly to the Individualized Action Plan?
  - Describes outcomes/result of the service/intervention?
  - Describes the next steps?

  Key Issues
  - Demonstrates that the service or intervention is in compliance with service definitions?
  - Supports that the services were rendered by an appropriately credentialed person?
  - Demonstrates the individual's ability and willingness to participate?
  - Demonstrates progress towards goals?
  - Shows "active" treatment?

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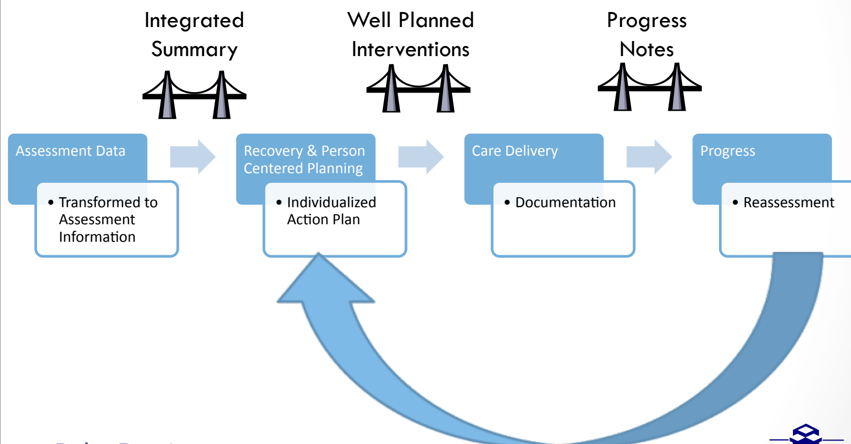
The Essential Bridges



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Additional Resource

Massachusetts Standardized Documentation Project (MSDP)

An initiative to develop statewide standardized integrated clinical and medical services forms and processes that provide enhanced compliance and quality for mental health and substance use disorder service delivery throughout Massachusetts. All documentation processes were designed to accommodate and comply with the following documentation requirements:

- **State Payers**: Medicaid/DMA; DMH; DPH-BSAS; and DPH-HCQ
- **Managed Care**: MCEs
- **National Accreditation**: JCAHO; COA; CARF; and NCQA
- **Federal Payers**: Medicaid and Medicare
- **Medicaid/Medicare Documentation Support Focus**: Medical Necessity; Person Served Participation; and Person Served Benefit

http://www.abhmass.org/site/msdp/forms-and-manuals.html

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Utilization Management

To assure that treatment being provided is in compliance with external & internal treatment criteria or standards, allowing for positive outcome of all clients' treatment in an appropriate & least restrictive, least costly manner.

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Utilization Management

Ensuring that the RIGHT ***SERVICE***, is being provided at the RIGHT ***TIME***, for the RIGHT ***DURATION*** in the MOST ***EFFICIENT*** manner.

Key UM/QM Functions

Function	Details
Utilization Review	• Level of Care • LOS/Units • Clinical Protocol
External Review Interface	• Track/Respond to all Auths/Reauths • Follow up/Liaison to Internal Clinical Team • Manage Appeals
Quality Assurance	• Payer/Procedural Requirements • Compliance • Documentation
Quality Management	• Indicator Development • Profiling/Analysis • Feedback Loop Management
Staff Development	• Education/Training • Coaching

UM/QM Core Competencies

- **Allocated Staff Time**
  - Dedicated utilization management staff & support
- **Proficient Interface w/External Reviewers**
  - Aware of all contractual requirements
  - Customer service orientation
  - Ready access to real-time clinical info
- **Assessment of Care Placement**
  - As financial risk ↑, UM/QM must be closer to front door

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UM/QM Core Competencies

- **UM/QM Organization Structure**
  - Committee(s)
  - Functional peer review process
  - Leadership
- **Annual UM/QM Plan**
  - Scope, Objectives, Structure, Resources
  - Include Education, Training, Development
- **Quality Assurance Role**
  - Documentation quality assurance
  - Contract/procedural compliance

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UM/QM Core Competencies

- **Clinical Standards of Care/Protocols/Criteria**
  - Must be reflective/inclusive of payers/contracts
  - Adopted by clinical staff
- **Data Management Capabilities**
  - Data gathering, reporting, analysis, & feedback
- **Profiling**
  - Organization, Program, Staff
  - Linkage to Peer Review/Care Review Process
  - Linkage to reappointment/performance appraisal

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Factors Affecting Resources

- **Model of Payer Review**
  - Methodology
  - Frequency
  - Volume
- **Clinical Record**
  - Ease of use
  - Location
  - Accessibility
  - Timeliness
  - Format & behavioral specificity

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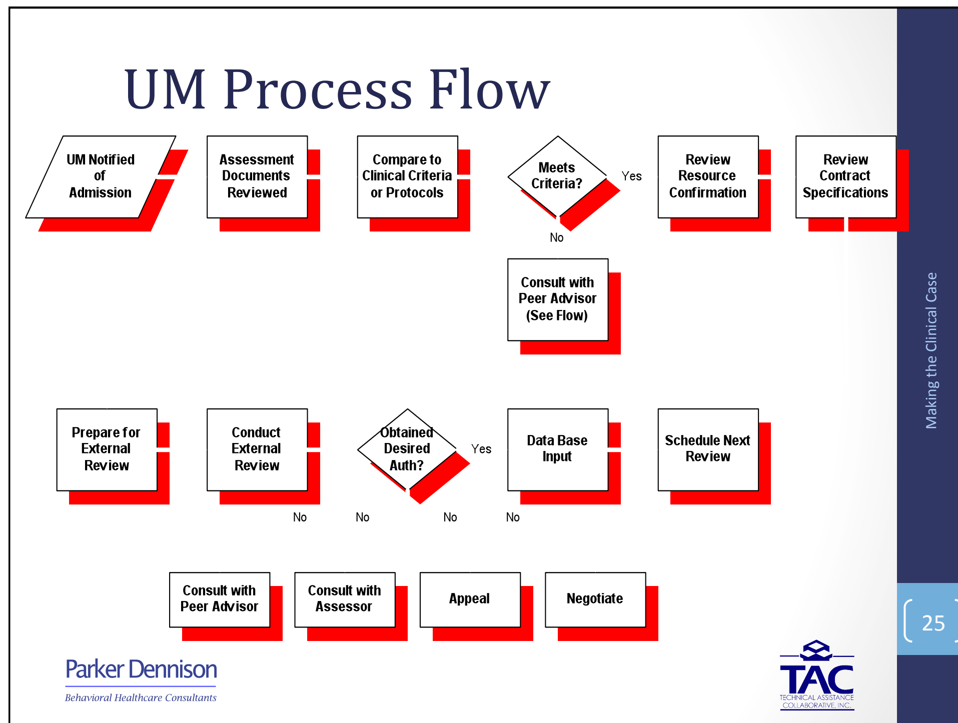
Factors Affecting Resources

- **Treatment Sites**
  - Number of sites
  - Location/distance between
- **Information System**
  - Networked sites
  - Clinical records components on-line
  - Automated tracking & notification
- **Practice Patterns**
  - Compatibility with MCO expectations

Organizational Alignment of UM

- **Org Chart Positioning**
  - Positioned to span across program boundaries
  - Have clear clinical linkage
  - Easy access to operations senior management
  - May be combined with Quality Management


UM Process Flow
UM Notified of Admission
Assessment Documents Reviewed
Compare to Clinical Criteria or Protocols
Meets Criteria?
Yes
No
Review Resource Confirmation
Review Contract Specifications
Consult with Peer Advisor (See Flow)
Prepare for External Review
Conduct External Review
Obtained Desired Auth?
Yes
Data Base Input
Schedule Next Review
No
No
No
No
Consult with Peer Advisor
Consult with Assessor
Appeal
Negotiate
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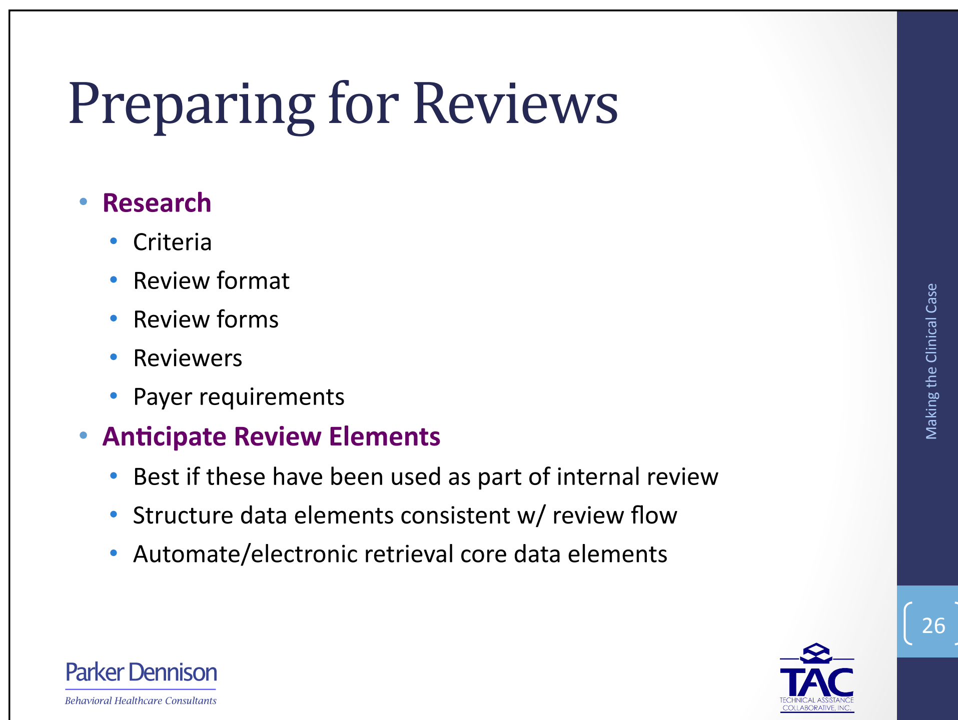
Preparing for Reviews
Research
Criteria
Review format
Review forms
Reviewers
Payer requirements
Anticipate Review Elements
Best if these have been used as part of internal review
Structure data elements consistent w/ review flow
Automate/electronic retrieval core data elements
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Preparing for Reviews

- Review the record/case in advance
- Fill gaps/track down missing info
- Anticipate issues/problems
- Schedule review in advance
  - establish a connection with a particular reviewer & schedule with them if possible
- Organize review materials
- Be on time & complete

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UM MIS Requirements

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UM Review Data Elements

- Admission date
- Initial Authorization date
- Internal/external reviewers
- Information provided
- Authorized level of care/procedure code (s)
- Authorized units
- Authorization expiration
- Authorization number
- Next review date
- Interim follow up required
- Specific info requested for next review

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Profiling

- A summary of measurements of performance.
- A "picture" of data.
- Does not inherently make value judgments.
- Often used to compare results across a peer group or to a standard or expectation.

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How Profiling Is Used

- **Externally**
  - Provider network selection and retention
  - An indicator for intensity of utilization or quality review
  - A consideration in rate negotiation
  - A consideration for referrals
  - A tool to focus quality improvement efforts and related training/ development
  - Published on consumer information and quality websites

How Profiling Is Used

- **Internally**
  - To establish a base line of practice patterns
  - To focus and prioritize managed care readiness development and training needs
  - As a tool to predict utilization patterns (for staffing, development, and capitation)
  - A quality improvement tool to identify best practices & enhance their use & effectiveness

Profile Elements

- **Cost of Care Elements**
  - Per case
  - Per admission
- **Care Access Elements**
  - Timeliness
  - Hours of availability
  - related communication/notifications

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Profile Elements

- **Denials**
  - Types of denials
  - Denials disposition
- **Client Diagnosis and Acuity**
  - Severity of illness indicators
- **Consumer Satisfaction Elements**
  - Complaints
  - Survey ratings

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Profile Elements

- **Documentation Quality Control Elements**
  - Timeliness of required components
  - Required data elements
  - Clinical pertinence of content
- **Other Quality Elements**
  - Performance on key quality indicators

Profile Elements

- **Volume of Activity**
  - Admissions, reviews, discharges, transfers
- **Source and Disposition of Referrals and Discharges**
  - Self referral, exclusive relationships, unplanned d/c
- **MCE Utilization Management Interface**
  - Adherence to policies and procedures
  - Complaints
  - Appeals

Profile Elements

- **Billing Practices**
  - Timeliness/frequency
  - Accuracy
  - Completeness
  - Multiple service units and/or service types
  - Combining outpatient services with per diems

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Profiling Implementation Process

- **Educate those affected**
  - Recognize that more than clinical staff have impact
  - Describe a context for profiling
  - Emphasize development and education value
  - Explain link to CQI process
  - Describe internal/external uses of data

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Profiling Implementation Process

- **Identify Work Group**
  - Include representatives from all groups affected
  - Consider break-out groups by functional area
  - Include someone managed care knowledgeable
  - Include data management staff
- **Define Profile Elements for Pilot Project**
  - Prioritize

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Profiling Implementation Process

- **Identify Means to Collect Data**
  - Routine/existing data
  - Information system based
- **Set Data Collection Time Span**
- **Collect/Extract Data**

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Profiling Implementation Process

- **Identify Data Presentation Methodology**
  - Graphical
  - Comparative to the norm/mean/average
  - Protect confidentiality via coding (if necessary)
  - Maintain source data for detail/validity check
- **Present Pilot Project Results to Stakeholders**
  - Non-judgmental
  - No conclusions drawn by data collectors

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Profiling Implementation Process

- **Validate Results**
  - Investigate questions/issues from stakeholders
- **Modify Data Elements as Indicated**
  - Recognize elements that may/should not be changed
- **Collect Additional Data**
  - Re-validate as needed
- **Fully Operationalize**
- **Expand Profiled Elements**

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Profiling Implementation Process

- **Address Systemic Needs as Highlighted**
  - Education
  - Restructuring
  - Development of new tools
- **Set Standards/Norms as Targets**
- **Link Profiles Back to Performance Improvement and Appraisals**

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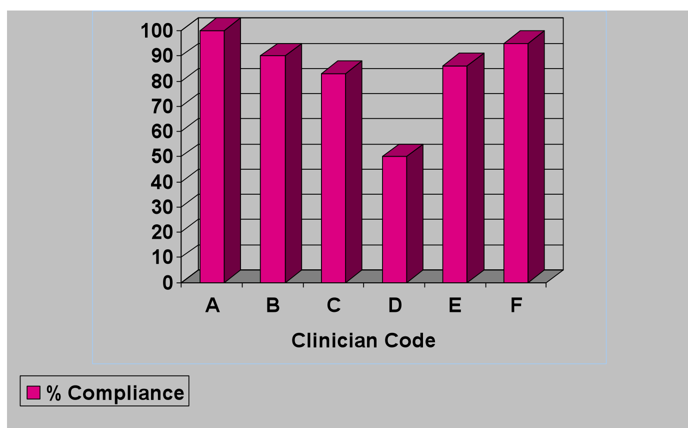
Admission - Initial Assessment



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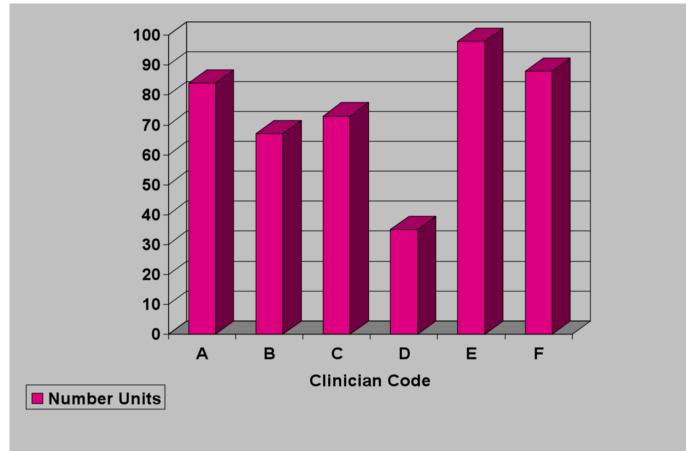
LOS by Diagnosis by Clinician (Major Depression)



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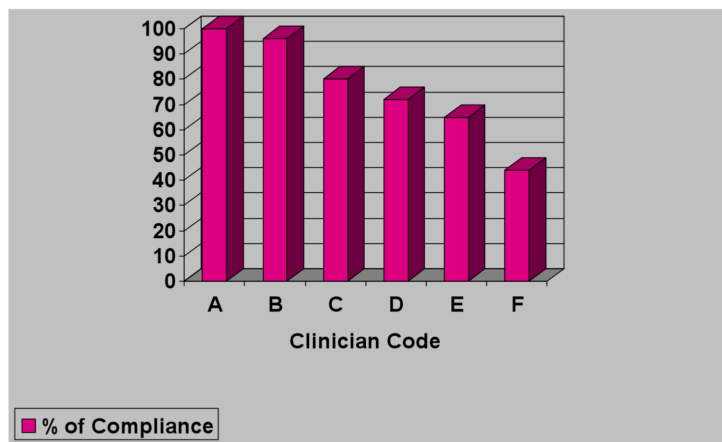
Appropriate Care Level - Initial



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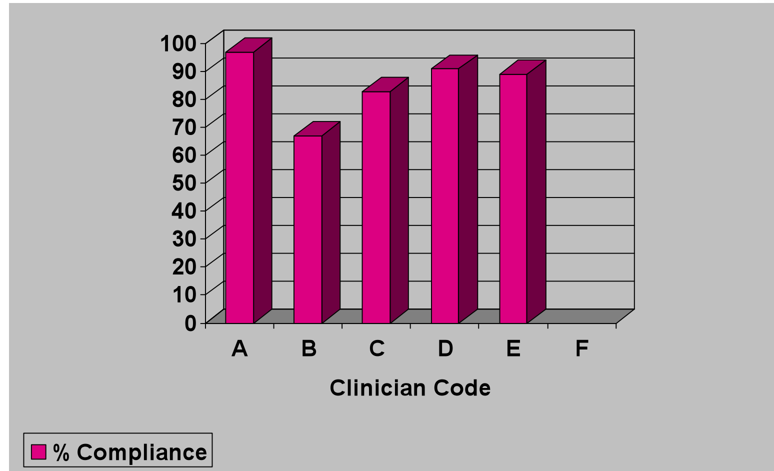
Appropriate Care Level - Ongoing



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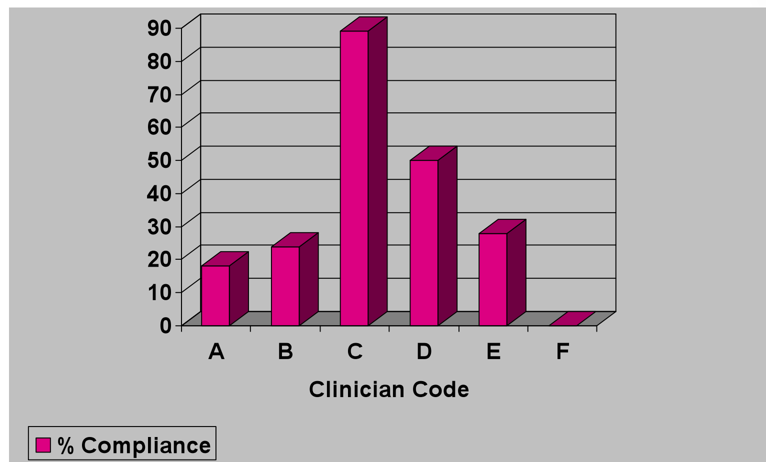
Treatment Plans



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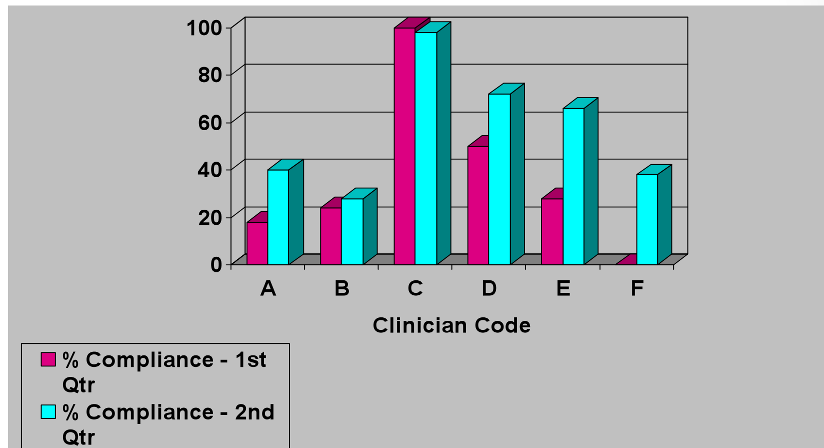
Treatment Plans - Concurrent Quarterly Comparison



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Utilization Management Implementation Issues

- Management Support and Direction
- Clinical Leadership Support
- Clinical Staff Issues
- Qualified UM Staff
- Information System Capabilities & Use

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Utilization Management Implementation Issues

- Interdepartmental Linkages & Communication
- Intake/Access System
- Allocation of Staff/Resources
- Customer Service Attitude

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That's A Wrap

All Presentation Materials, Tools & Resources May Be Found

- http://parkerdennison.com/library/project-documents/other

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And If You're A Bit Nerdy…

The following slides lay out a method to calculate resource needs for a dedicated internal utilization management function. The results have proven to be a good "ball park" for the amount of resources, which then can be adjusted for individual organization circumstances.

Its easier than it looks!

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Calculating UM Staff Needs

- **Variables**
  - $T_{(type)}$ = Time per review by type, e.g. outpatient, rehab, inpatient, residential
  - $C_{(type)}$ = Estimated annual number of cases by type
  - $V_{(type)}$ = Volume of review by type
  - $F_{(type)}$ = Frequency of review by type
  - $L_{(type)}$ = Length of stay by type
  - $X_{(type)}$ = Total review minutes by type
  - $P_{(type)}$ = Total review person hours by type

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Calculating UM Staff Needs

- **Variables**
  - $Q_{(type)}$ = Admin./Collateral Time per review by type
  - A = Total Admin./Collateral Time
  - Y = UM staff productivity (as a percentage)

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Calculating UM Staff Needs

$X = (T \times V) + A$

$V = \{(L \div F) + 1\} \times C$

$A = V \times Q$

$P = X \div 60$ (minutes)

$FTEs = P \div \{Q(2080)\}$

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Calculating UM Staff Needs Example

$V_{(rehab)} = \{(L_{(rehab)} \div F_{(rehab)}) + 1\} \times C$
$V_{(rehab)} = \{(180 \text{ days} \div 60 \text{ days}) + 1\} \times 400$
$V_{(rehab)} = \{3 + 1\} \times 400$
$V_{(rehab)} = 1600$ rehab reviews per year
$A_{(rehab)} = V_{(rehab)} \times Q_{(rehab)}$
$A_{(rehab)} = 1600 \times 20 \text{ minutes} = 32000 \text{ minutes}$
$X_{(rehab)} = (T_{(rehab)} \times V_{(rehab)}) + A$
$X_{(rehab)} = (10 \text{ min.} \times 1600 \text{ rehab reviews}) + 32000$
$X_{(rehab)} = 48000$ minutes review time for rehab

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Calculating UM Staff Needs Example

$P_{(rehab)} = X_{(rehab)} \div 60 \text{ minutes}$
$P_{(rehab)} = 48000 \text{ minutes} \div 60 \text{ minutes}$
$P_{(rehab)} = 800$ total rehab review person hours

$FTE_{(rehab)} = P_{(rehab)} \div \{Q(2080 \text{ hours/year})\}$
$FTE_{(rehab)} = 800 \div \{.60(2080)\}$
$FTE_{(rehab)} = 800 \div 1248$
$FTE_{(rehab)} = .64$ FTE required for rehab reviews

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Calculating UM Staff Needs Example

$FTE_{(rehab)} + FTE_{(inpt)} + FTE_{(etc)} =$ Total staff needed

Caveats

- Should be used as a general guide
- Should serve as the test for practicality
- May be applied to calculate de-centralized model staff time impact
- Can be useful to set UM productivity guides

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