

Utilization Management Considerations for Care Management Entities

Technical Assistance Brief

June 2013

A number of states and regions have begun to demonstrate cost savings and improved clinical and functional outcomes for youth with severe behavioral health needs through a Care Management Entity (CME) approach.¹ CMEs provide accountable care for children with behavioral health needs who experience high costs and poor outcomes and are typically involved with multiple child-serving systems. These entities may be government agencies, interagency bodies, private nonprofit agencies, or commercial companies (e.g., managed care organizations).

CMEs incorporate health home concepts and core system of care elements² to provide: (1) a youth-guided, family-driven, strengths-based approach to care; (2) intensive care coordination across public child-serving agencies and providers; and (3) access to home- and community-based services and peer supports as alternatives to costly residential and hospital care. They employ a high fidelity Wraparound approach,³ which is a structured, prescribed, team-based service planning and care coordination process with an emerging evidence base.

To facilitate the provision of comprehensive care for youth with complex behavioral health needs, a CME must coordinate a range of services and supports across various clinical, administrative, and governing entities, especially for youth involved in multiple public systems (i.e., Medicaid, mental health, child welfare, juvenile justice). Two specific functions – utilization management and quality management – are essential in equipping CMEs to serve as centralized and accountable hubs for youth with severe behavioral health needs and their families. Utilization and quality management are particularly important in a CME context, where the individualized needs of youth and families are given as much precedence as the concerns of efficiency, quality, and cost. In a CME approach, utilization management and quality management functions are closely aligned.

This technical assistance brief outlines utilization management activities that CMEs should undertake – either directly (in-house) or by partnering with an external administrative services organization (ASO) or managed care organization (MCO) – to ensure access to appropriate services and supports while reducing unnecessary use of costly services. It profiles three CME models – in Wisconsin, Massachusetts, and New Jersey – to highlight variations in approaches. A companion brief focuses on quality management activities essential for a successful CME.

BACKGROUND

This resource was developed by the Center for Health Care Strategies (CHCS) through its role as the coordinating entity for a five-year, three state Quality Demonstration Grant project funded by the Centers for Medicare & Medicaid Services under the children's Health Insurance Program Reauthorization (CHIPRA) Act of 2009. The multi-state grant is supporting lead-state Maryland, and partner states Georgia and Wyoming, in implementing or expanding a CME approach to improve clinical and functional outcomes, reduce costs, increase access to home- and community-based services, and increase resiliency for high-utilizing Medicaid- and CHIP-enrolled children and youth with serious behavioral health challenges. Visit www.chcs.org for more information.

Utilization Management for Care Management Entities

Utilization management involves systematically reviewing and controlling the use of services to optimize efficiency and appropriateness of care. It can be accomplished through activities like preadmission certification, prior authorization, concurrent review, second opinions, retrospective review, discharge planning, and appeals and grievances. For a CME, utilization management aims to determine:

- Who is using services;
- What services are being used;
- How much of a certain service is being used;
- The cost of services being used; and
- The impact of the services on those using them.⁴

As in most managed care arrangements, the goals of utilization management are to manage costs and promote efficiency and effectiveness of care. However, in a CME context, utilization management activities are also focused on how the child and family are experiencing care and whether goals articulated in the plan of care are being met and/or revised as necessary. The dual concern for efficiency and genuine child/family involvement ensures that every child receives the right services and supports, in the right amount, at the right time, and for the right duration. Often, if a CME exists within a larger Medicaid managed care environment, in which the managed care organization (MCO) is responsible for utilization management, the plans of care developed by child and family teams drive medical necessity, with the MCO's role shifting to management of outlier utilization.

Approaches for the implementation of utilization management activities in CMEs can vary considerably. A CME may perform utilization management functions close to the point of care and manage these functions through in-house mechanisms, working directly with clinicians, care coordinators, family and youth partners, and quality assurance staff to review and act upon utilization information. In other models, utilization management may be chiefly the responsibility of a state's ASO, or CMEs may be part of an MCO's provider network and the MCO performs most of the utilization management functions. In instances where utilization management is overseen largely by an organization external to the CME, such as an ASO or MCO, there must be close working relationships with the CME and an understanding that the plan of care developed by the child and family (Wraparound) team primarily determines what services are medically necessary, and the responsibility of the ASO or MCO is to perform outlier review and management. There are pros and cons to these various approaches, and local governmental and financing structures, provider relationships, and politics impact the approach taken in a given locality or state.

Because a CME itself has substantial knowledge about the complex population(s) it serves, has closer or direct linkages to providers who are subject to utilization management oversight activities, and because youth and family participation is central to CME models, retaining utilization management as an in-house function is the most direct way to ensure that utilization management practices consider the youth and family voice. On the other hand, MCOs and ASOs often have greater technical capacity and expertise in utilization management strategies as they regularly perform these activities as part of their other lines of service. CMEs may struggle with ensuring that necessary technical and analytic systems are in place to effectively engage in utilization management activities in-house. At a minimum, in the context of utilization management for CMEs, the following principles must be taken into account:

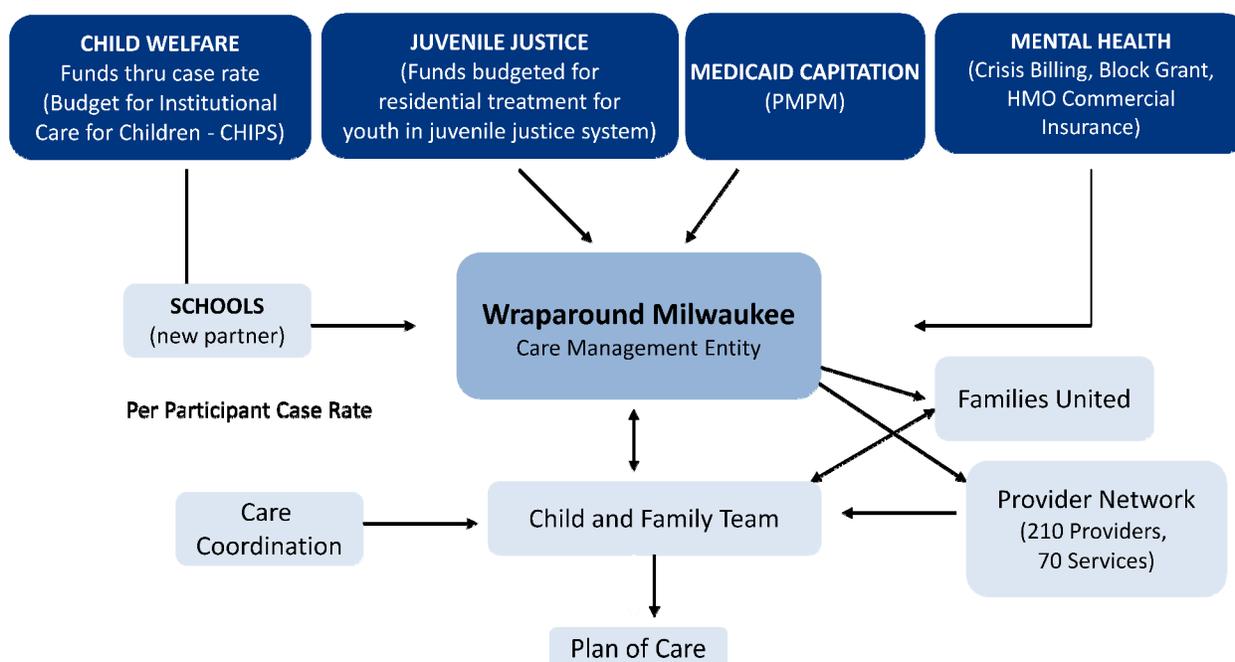
- Stakeholders, including youth and families, care coordinators, providers, state agencies, and others, must have knowledge of and buy-in for utilization management activities;
- In addition to a focus on cost and quality, receptivity to the needs of the youth and family is essential; and
- Utilization management activities must inform and be informed by CME quality improvement activities.⁵

The following sections provide an overview of the utilization management approaches of CMEs in Wisconsin, Massachusetts, and New Jersey.

Wraparound Milwaukee – Utilization Management through a Government “Lead” Agency

Created in 1995, Wraparound Milwaukee is a CME that serves various populations of children with serious behavioral health challenges, including children in or at high-risk for entering residential treatment through child welfare and other systems; youth diverted from juvenile detention and state corrections facilities; and non system-involved children with complex behavioral health issues.⁶ Utilizing section 1915(a) of the Social Security Act, the state Medicaid agency has a contract with Wraparound Milwaukee to serve as a specialized managed care entity for these child populations. Wraparound Milwaukee also has contracts and agreements with the child welfare, juvenile justice, and school systems. Funding for Wraparound Milwaukee blends a Medicaid capitation payment with population-based case rates and other funds from child-serving agencies including child welfare, juvenile justice, mental health, and education (Figure 1).

Figure 1: Wraparound Milwaukee Structure



Source: Wraparound Milwaukee . *What are the pooled funds?* Milwaukee County Mental Health Division, Child and Adolescent Services Branch, 2010.

Wraparound Milwaukee conducts all utilization, quality, and information management functions internally. The organization’s Quality Assurance/Quality Improvement unit collects, analyzes, and distributes data to internal and external stakeholders related to the functions of quality assurance, utilization review, outcomes, complaints/grievances, family/provider satisfaction, programmatic auditing, and state Medicaid contract requirements. This unit also tracks and reports on service utilization trends; costs of services being authorized and delivered; the service mix being used; and service outliers. At the same time, the Quality Assurance/Quality Improvement unit is tasked with developing, implementing, and tracking family satisfaction at the child and family team and provider levels; assuring that strength-based, individualized, culturally sensitive care is delivered; and handling the processing and investigation of complaints/grievances at participant and provider levels, among other activities. The integration of quality assurance/quality improvement and utilization management functions ensures that both quality and youth/family experience of care are a priority in the organization’s utilization management activities.

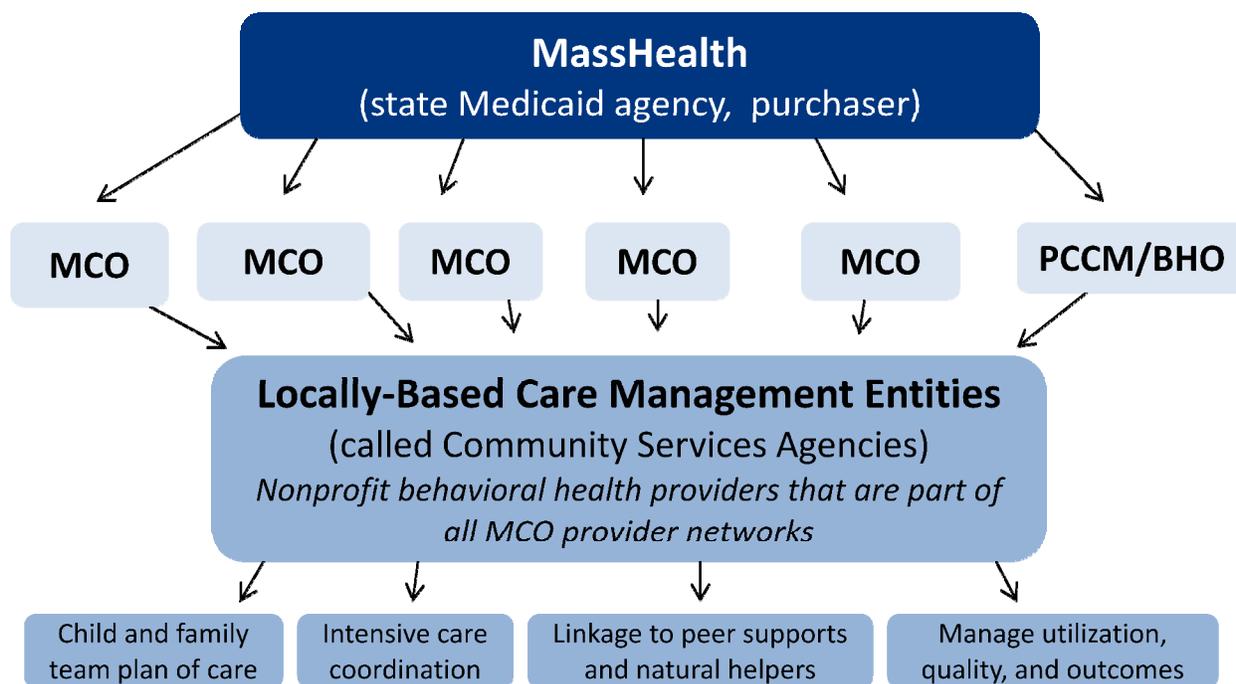
Massachusetts – Utilization Management through Managed Care Organizations

Massachusetts implemented CMEs statewide in response to a class action lawsuit filed against the state’s Medicaid agency under the federal Early and Periodic Screening, Diagnostic and Treatment statute in 2001, widely referred to as “Rosie D.” Settled in 2007, the remedy to the lawsuit required MassHealth (the Massachusetts state Medicaid agency), to provide: improved behavioral health screening in primary care; standardized behavioral health assessments; service coordination; and home- and community-based behavioral health services to children and youth with severe emotional disturbances who are enrolled in MassHealth. The remedy services include intensive care coordination using high fidelity Wraparound; family support and training; mobile crisis intervention; mentoring; and in-home behavioral therapy.

CMEs in Massachusetts, called Community Service Agencies (CSAs), are provider agencies that are required to offer intensive care coordination and family support and training services and may also provide one or more of the other remedy services. As a Medicaid managed care state with six contracted MCOs (one managed behavioral health organization aligned with a primary care case management program, and five integrated physical health/behavioral health plans), formal utilization management functions are primarily retained by the MCOs. The CSAs are responsible for monitoring utilization at the child/family level and ensuring that plans of care meet quality and cost goals.

Massachusetts’ MCOs must contract with all of the CSAs, establishing a uniform provider network across the state. To address provider concerns about navigating six different systems with unique authorization parameters, medical necessity criteria, and processes and procedures, the MCOs are required by MassHealth to adopt uniform performance specifications for the remedy services and common definitions of medical necessity criteria. The MCOs must also use the same authorization parameters and uniform reporting requirements. MCO staff are trained in the Child and Adolescent Needs and Strengths (CANS) tool adopted by the Commonwealth for behavioral health assessments, which also guides the utilization review process between providers and MCO clinical staff. This allows for greater consistency across MCOs for children and youth who receive CME services from the CSAs.

Figure 2: Massachusetts CME Structure



Source: S. Pires. Human Service Collaborative, 2010.

MassHealth employs safeguards to ensure that the MCOs, which have considerable authority and responsibility for utilization management, do not unreasonably deny services requested by the CSAs. For instance, if an MCO denies a service requested by a child's care planning team, the MCO is required to report the denial and submit information on prior authorization and medical necessity to the state for review. To ensure that the family and youth voice is a part of this process, MassHealth holds regular meetings with provider and parent advocacy groups to discuss service denials and other prior authorization-related issues.

New Jersey – Utilization Management through State, CME, and ASO Partnership

New Jersey's CME model emerged from a federal system of care grant awarded in 1999 by the Substance Abuse and Mental Health Services Administration (SAMHSA). The governor at the time endorsed the system of care in New Jersey with two caveats: (1) it must be statewide, and (2) it must be funded primarily by expanding Medicaid through the Rehabilitation Services Option.⁷

The first care management organizations (CMOs), as CMEs are called in New Jersey, were implemented in three counties in 2001. Since then, CMOs have been implemented in every county and local urban area throughout the state. CMOs are nonprofit organizations tasked exclusively with providing intensive care coordination utilizing high quality Wraparound to youth with complex needs and their families. CMOs partner with family service organizations in each county, which provide family-led support for CMO-involved families, in addition to community education, warm lines, and advocacy.

The state's contracted system administrator (i.e., the ASO, which is a commercial MCO in New Jersey) registers, authorizes, and coordinates services for children, youth, and young adults who are experiencing emotional and behavioral challenges or have developmental and intellectual disabilities. The ASO provides a central point of access to care that includes a single statewide call center and 24-hour access to mobile response and stabilization services. The Child and Youth Behavioral Electronic Record (CYBER), developed by the state, provides a single information technology portal for collecting and managing data.

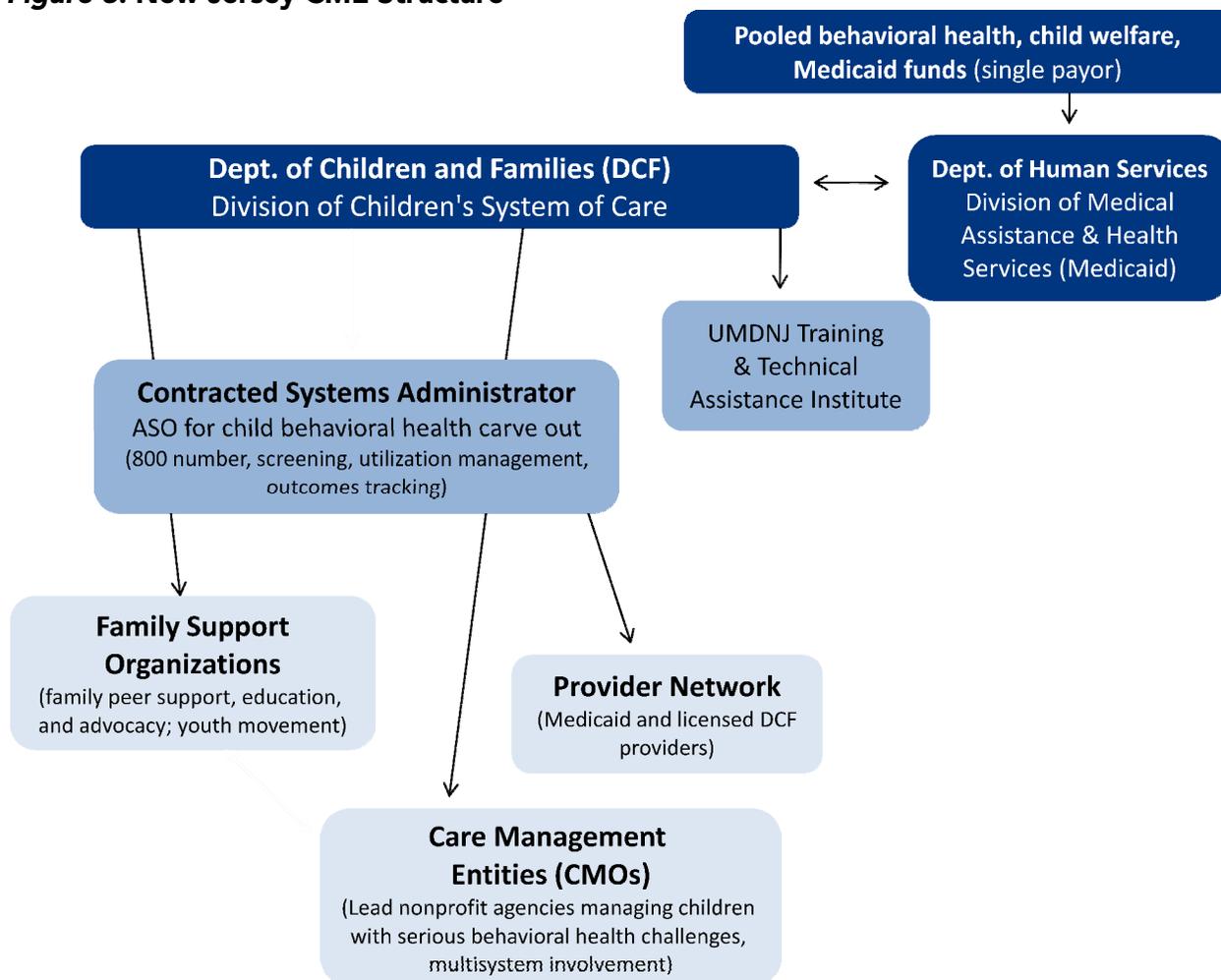
Utilization management in New Jersey is a shared process, involving the state, ASO, and CMO. The ASO's role is to review plans of care for medical necessity and quality, while the CMO's role is to create plans of care, taking into account actual need and family vision. The interaction between these entities is therefore critical, and is managed through clearly defined expectations (which are regularly reviewed with both parties) and the use of standardized tools (including the CANS). Service plans, assessments, and training materials are standardized across all CMOs, and training is managed by the state and housed at the University of Medicine and Dentistry of New Jersey.

The state's Department of Children and Families is responsible for the ongoing review of utilization patterns— both at the CMO level and at the state level – to make sure that funding and service capacity are adequate. New Jersey's utilization management principles include a focus on:

- Effectiveness and cost efficiency (i.e., cost cannot be viewed only in monetary terms);
- Outlier management, examining both over- and under-utilization; and
- A data-driven approach that not only uses data to determine effective utilization patterns, but shares the data with CMOs and child and family teams, in particular, to ensure that care plans meet quality and cost goals.

Though responsibilities are shared, New Jersey's strategies help to ensure that utilization management activities are consistent with a system of care framework and are respectful of the strengths and needs of the child and family.

Figure 3: New Jersey CME Structure



Source: S. Pires. Human Service Collaborative, 2010.

Conclusion

The capacity to manage utilization and evaluate the appropriateness, efficiency, and quality of services delivered to children and youth with severe behavioral health needs is an essential component of CMEs. In their role as centralized vehicles for coordinating the full array of services and supports for children and adolescents with complex behavioral health issues, CMEs must incorporate utilization management strategies and activities into their overall quality approach. Whether utilization management activities are performed by the CME itself, as in the case of Wraparound Milwaukee, or shared with a statewide ASO (New Jersey) or Medicaid MCOs (Massachusetts), they are an integral part of the operational and administrative activities of CMEs, supporting their ability to deliver appropriate services in a timely way for children with complex needs, while improving quality and cost outcomes.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality. We work with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve low-income Americans, especially those with complex and high-cost health care needs.

Visit www.chcs.org for additional resources and tools for improving the quality and cost-effectiveness of care for Medicaid beneficiaries with complex needs.

Endnotes

¹ "Care Management Entities: A Primer." CHIPRA Quality Demonstration Webinar, presented by Sheila Pires, May 12, 2010. Center for Health Care Strategies. http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261112.

² S. Pires. *Building Systems of Care: A Primer*. Georgetown University Center for Child and Human Development, 2002. <http://gucchd.georgetown.edu/72377.html>.

³ For more information on the Wraparound approach, visit the National Wraparound Initiative website: www.nwi.pdx.edu.

⁴ S. Pires, op cit.

⁵ Ibid.

⁶ Wraparound Milwaukee. *Who We Are, Who We Serve*. <http://county.milwaukee.gov/WraparoundMilwaukee.htm>.

⁷ Under the Rehabilitative Services Option, states can cover "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Source: § 1905(a)(13) of the Social Security Act.

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