Care Management Entity Quality Collaborative
Technical Assistance Webinar Series

Utilization, Quality, and Information Management in Care Management Entities

August 26, 2010, 2:00-3:30 pm, EDT

If you experience technical difficulties, dial 1-866-229-3239 for assistance, or click the question mark icon located in the floating toolbar at the lower right corner of your computer screen.

NOTE: To eliminate background noise, phone lines are being muted during today’s presentation.

This webinar is made possible through support from the State of Maryland and The Annie E. Casey Foundation.
Care Management Entity Quality
Collaborative Technical Assistance Webinar Series

Utilization and Quality Management and Information Management Systems

August 26, 2010

Bruce Kamradt, Director
Wraparound Milwaukee
Quality Assurance and Quality Improvement (QA/QI) Unit in Wraparound Milwaukee

- Consists of 4 staff:
  - Director
  - 2 Coordinators
  - Technician
- Works in conjunction with Families United of Milwaukee (advocacy organization)
- Works closely with Wraparound Milwaukee’s Program Evaluator and IT coordinator
Purpose of the QA/QI Unit

To review, evaluate and institute measures that ensure and improve the quality of services and care provided to youth with serious emotional, behavioral and mental health needs and their families.
Functions of QA/QI Unit

- Develop, implement and track family satisfaction at the care coordination and provider level
- Assure that strength-based, individualized, culturally sensitive care is delivered by partnering with families and other system stakeholders at the decision-making level of policy and program development
- Create, review and revise program policies and procedures
- Audit at the care coordination and provider level
- Process and investigate complaints/grievances at participant and provider level
- Monitor requirements of contract between Milwaukee County/Wraparound Milwaukee and the State Medicaid Agency
Functions of QA/QI Unit (cont.)

- Ensure program and fiscal responsiveness by engaging in monthly service utilization review
- Prepare, disseminate and review annual and semi-annual performance review (APR) of Wraparound Milwaukee’s Care Coordination Agencies
- Assist in preparation and review of Wraparound Milwaukee’s Provider Network Fee-For-Service Agreements
- Work with the Milwaukee County Contract Administration office and participate in monthly Milwaukee County QA/QI meetings
- Set agendas and coordinate meetings of the Wraparound Milwaukee QA/QI Advisory Committee
- Draft annual QA/QI plan for Wraparound Milwaukee
Wraparound Milwaukee QA/QI Plan

- Consists of 2 parts:
  - **Fidelity Indicators** – measure if services provided are consistent with the philosophy and values of Wraparound, maintaining the highest quality of service for families and achieving positive outcomes
  - **Process Indicators** – measure if approaches and practices that are consistent with Wraparound are being utilized and capture data that measures quality and effectiveness of the program
Fidelity Indicators

- **Functioning**
  - Child Behavior Checklist (CBCL) & Youth Self Report (YSR) measure if youth’s functioning improves at specified intervals (i.e. 6 months, 1 year, 2 years, etc. and at disenrollment)

- **Living Environment**
  - Percentage of days that a youth spends in a restrictive setting (e.g. RTC, detention, group home, etc.) will decrease while enrolled in Wraparound

- **Community Safety**
  - Criminal charges and adjudications will decrease while the youth is enrolled in Wraparound

- **School**
  - Youth’s school attendance will improve while the youth is enrolled in Wraparound

- **Family Satisfaction**
  - Caregivers and youth must be satisfied with Wraparound. In collaboration with our family advocacy organization, this data is compiled and measured using a 4.0 point scale
Fidelity Indicators (cont.)

- **Care Coordinator Productivity**
  - Care coordinators must spend at least 14 hours per month per family providing services to youth/family
  - Care coordinators must average one face-to-face contact with youth or parent each week

- **Child and Family Team (CFT) or Plan of Care Meetings (POC)**
  - At least 1 CFT or POC meeting must be held each month

- **Successful Disenrollment**
  - Threshold of 75% successful disenrollment will be maintained based on established criteria for such success (e.g. Needs Ranking System, attainment of Permanency Plan, etc.)

- **Informal Supports**
  - Average of 100% of all CFTs should be utilizing natural/informal supports

- **Family Activities**
  - 1 monthly activity with families is expected for each care coordinator agency
Process Indicators

- **Plan of Care (POC)**
  - Initial plan must be completed in first 30 days of enrollment and updated every 90 days

- **Documentation**
  - Progress notes must be continually updated in client record per policy

- **Service Authorization Request (SAR)**
  - Projected cost and utilization of services is documented every 30 days

- **Costs**
  - Cost of providing services for youth/families on average must be less than the cost of institutional placement

- **Evaluation Tools**
  - CBCL and YSR must be submitted at required intervals

- **School Data**
  - Care coordinators must report number of days a youth attended or was absent from school on a monthly basis
Day Treatment and RTC/Group Home Pre-Authorization
- Day Treatment and RTC/group home placements must be pre-authorized and re-authorized for continuing need

Submission of Legal Changes of Placements
- Written legal notice to court for change of placement of enrolled youth must be submitted in a timely fashion per Wraparound policy

Submission of Team Facilitator Reviews
- Reviews by supervisor of care coordinators conducting of CFT meetings must be submitted as required by policy

Number of Substantiated Complaints/Administrative Penalties
- It is expected that care coordination agencies have no substantiated complaints or penalties against their agencies

Wraparound Provider Network Credentials
- Credentialing requirements are established and maintained for participating agencies/providers serving youth and families.

Certification Training/In-Services
- Care coordinators must complete 54 hours of initial training within first 6 months of employment and attend monthly in-service training and other required meetings
Utilization Management

- QA/QI Unit and IT program share role and responsibility for utilization management

- QA/QI Unit prepares reports and monitors:
  - Service utilization trends
  - Cost of services being authorized and delivered
  - Service mix being used
  - Service outliers
    - Review of individual service plans in which either cost of service or type of service is outside of usual utilization for that service across all service plans for Wraparound enrollees
Performance Improvement Plan (PIP)

- Annual Performance Improvement Project (PIP) for Medicaid (as required for all Wisconsin HMOs), designed developed and implemented by QA/QI unit with Families United of Milwaukee

- Focus of 2010 PIP is on the coordination of specialty mental health care with primary medical care for youth in child welfare served by Wraparound Milwaukee, particularly those on psychotropic medications (CBAP Project)
To identify data and system needs, first identify your consumers:
- SED Youth
- Families
- Care coordinators
- Providers
- System Stakeholders i.e., Child Welfare, Juvenile Probation, etc.

Must have the financial and procurement means to build your own system – if not find an existing product that fits your business model.
Information Management System (Cont.)

- **Wraparound Milwaukee’s system, *Synthesis***
  - Developed in 1999 and built based on Wraparound Milwaukee’s business needs; did not use or attempt to modify an existing software system

- Built as an internet-based software system because user base is geographically dispersed

- Continually updated – 2 developers and an IT Coordinator work on-site
Data Tracked and Maintained by *Synthesis*

- **Demographic/Enrollment Data**
  - Includes client specific information, diagnostic information, placement data, Medicaid eligibility, child welfare and juvenile justice identifiers, arrest data, legal guardian, etc.

- **Credentialing & Other Provider Network Data**
  - Includes provider vendor licenses, insurance and other information used in credentialing providers; provider satisfaction surveys and complaint data.
  - Data from the vendor can be accessed by care coordinators and families through an on-line resource guide.

- **Authorization/Billing/Claims Processing Data Re: Service Provision**
  - Wraparound Milwaukee operates its CME as a type of special managed care entity or HMO model.
  - Authorization of services occurs through the Plan of Care and requests for authorization.
  - Vendors have access to review service authorizations to confirm service has been approved.
  - Invoices are entered directly on line by the vendor creating a paperless billing system.
  - Claims for payment of delivered services get adjudicated immediately and vendors get paid weekly.
  - Most importantly, Wraparound management has real-time access to reports to monitor service costs and service utilization.
Data Tracked and Maintained by *Synthesis* (cont.)

- **Plan of Care**
  - *Synthesis* utilizes an electronic Plan of Care that closely follows the Wraparound philosophy and approach. The 3 main elements of the Wraparound Plan are automated:
    - Strength discovery
    - Crisis/Safety Plan
    - Needs Identification and Service Planning
  - There is a built-in needs scoring system to determine family needs are being met. The system is designed to capture what needs are, in what service domains, utilizing what strategies and related youth or family strengths
- **School attendance data**
- **Medication data**
- **AODA history and other information is also captured**
- **Progress Notes**
  - Entered electronically by care coordinators
  - Used to track service hours, family contacts, Plan of Care meetings, etc.
  - Also entered by Mobile Crisis Teams, out-of-home providers, crisis 1:1 stabilization services, for medication visits and will next be extended to the clinical providers of office-based and in-home therapy
Data Tracked and Maintained by *Synthesis* (cont.)

- **Evaluation Data**
  - Critical in measuring the effectiveness of service delivery
  - Also critical to the system stakeholders who financially and programmatically support Wraparound Milwaukee
  - Wraparound Milwaukee currently uses the Child Behavior Checklist (CBCL) and Youth Self-Report (YSR). *Synthesis*
    - maintains and graphs the CBCL and YSR scores
    - keeps the school attendance information
    - will maintain juvenile justice information used to look at recidivism rates of enrolled youth
    - tracks the attainment of child permanency which is an important outcome for any system of care

- **Reports**
  - Provides users with direct access to data needed to do their day-to-day functions
  - Real-time reporting of revenues and expenditures is available to the Wraparound Business office; outcome data is available to the evaluator and QA/QI staff; vendors have access to their authorized services and services invoiced
Utilization Management, Quality Management, and Information Management Systems in the Care Management Entity (CME) Approach

Suzanne Fields, MSW, LICSW
Technical Assistance Collaborative

sfields@tacinc.org

August 26, 2010
Overview

• Massachusetts Context

• Utilization Management (UM) Challenges and Solutions

• Quality Management (QM) Activities and Reporting

• Lessons Learned
MA Context - Lawsuit

- *Rosie D. v. Patrick*, a class action lawsuit filed in 2001 on behalf of children and youth with serious emotional disturbance

- Alleged that MA Medicaid failed to meet obligations of the EPSDT statute

  - January 2006, the Court found that MA Medicaid had not provided sufficient:
    - Behavioral health screening in primary care
    - Behavioral health assessments
    - Service coordination
    - Home-based behavioral health services

- Final judgment issued June 2007, with implementation of care coordination and home-based services beginning July 2009

- Medicaid as the sole financer-no blending/braiding with other state systems
MA Context - Enrollment & Managed Care

• Approx 1.1 million Medicaid enrollees

• Approx 470,000 persons under 21 years old

• Five managed care entities (MCEs)
  o One MBHO for the PCCM
  o Four integrated physical health (PH) and behavioral health (BH) plans, some of which sub-contract out BH

• Decision **not** to enroll “the class” into one MCE
MassHealth Managed Care
Organizational Chart
Utilization Management: Challenges

1. Five different MCE contracts
2. New services
3. Concerns about the role of managed care in an individualized, team-based care planning process
Challenge 1: Five MCE Contracts

- Providers concerned about navigating five systems with different authorization parameters, processes, and procedures, while also trying to implement new programs
- MCEs have their own proprietary authorization and IT systems
- MCEs typically not used to working collaboratively - competitors for market share
- State concerned about providers inadvertently receiving mixed or different messages
Challenge 1: Five MCE Contracts

MassHealth Office of Behavioral Health:

• Convened weekly MCE Workgroup meetings with BH leadership at each plan to have the five competitors work toward arriving at as many commonalities as possible:
  o Provider network
  o Clinical review questions/inter-rater reliability testing
  o Billable activities definitions
  o Authorization parameters (time period and # of units)
  o Common reporting (required elements, data dictionary, quality checks)

• Held monthly individual UM meetings with each of the plans to provide technical assistance on issues unique to that plan
Challenge 1: Five MCE Contracts

MassHealth Office of Behavioral Health:

• Conducted a survey of providers at three months post-implementation to better understand areas of strength and opportunities for improvement

• Developed contract language that required that any changes to UM policies or procedures be approved first by MassHealth
Challenge 2: New Services

• New services for MCEs and provider community—small pockets of expertise in the state, but generally limited experience with provider-based care management using Wraparound process

• All utilization data based on estimates from other states or MA data for similar services, but not on actual utilization for these services—nobody really knew what to expect

• Common network of providers, but each had a separate contract with every MCE—possibility of mixed messages on expectations
Challenge 2: New Services

- Held multiple trainings for MCE staff **AND** the provider community on the Wraparound process ("Wrap 101"), the new services, and the vision of the Children’s Behavioral Health Interagency (CBHI) Initiative

- MCEs, most with at-risk fiscal contracts, held financially harmless for first year

- MCEs created common clinical review questions & a common inter-rater reliability test for clinical review staff

- Clinical review questions were tied to Wraparound fidelity (e.g., natural supports on the team, brainstorming of options, sustainability of services / supports considered, etc.)
Challenge 2: New Services

- Common service specifications, operations manual, definitions of the service and allowable billable activities

- Joint network management activities individually with each provider, and statewide with all providers as a group

- Did not mandate same authorization practices via contract to allow for identification of best practices in UM across the plans
Challenge 3: Managed Care Role in the Care Planning Team (CPT) Process

• Concerns that managed care processes would upset the integrity of the care planning process for youth and their families in intensive care coordination (ICC):
  o Prior authorization procedures
  o Service denials
  o Role and expertise of the team, especially of natural supports
  o Family voice about their needs
  o Unconditional efforts
Challenge 3: Managed Care Role in the Care Planning Team Process

• MCEs held financially “harmless” for new services for first year within their usual at-risk contracts

• MCE “denial” of authorization for service sent back to the Care Planning Team for discussion/solicitation of more information

• Created aggregated authorization / denial reports to review number of authorizations requested, authorized, and denied at each MCE

• Instituted a member-level, post-denial review process: MCEs required to complete and submit a form for any clinical denials of care to MassHealth Office of Behavioral Health for review
Challenge 3: Managed Care Role in the Care Planning Team Process

• Held regular meetings with provider and parent advocacy groups to learn in real-time about concerns related to service denials

• Conducted a survey of providers at three months post-implementation to better understand areas of strength and opportunities for improvement
Challenge 3: Managed Care Role in the Care Planning Team Process

• MCE role was NOT to determine medical necessity, but to ensure that the correct decision was made by the provider

• Different approaches were approved so the state could learn about “best” approaches that would later inform contract expectations
  o One plan implemented a whole care plan review that generated authorizations for all services identified on the plan
  o Another plan utilized a web-based interface (retrospective review of care only) for authorization of care that permitted providers of services identified on the care plan to obtain an authorization without requiring a clinical review or prior approval
Challenge 3: Managed Care Role in the Care Planning Team Process

• Service unit parameters across the plans were FLOORS not CEILINGS to allow for flexible use of service units based on the needs of the youth and family

• If the authorized units were utilized prior to the end of the authorization period, the service provider could contact the MCE to review for medical necessity and based on that review, receive additional units
Utilization Management: Lessons Learned

• Emphasize a culture of learning around UM for new services
  o Offer trainings on new practice models and services not only for providers, but also for MCE staff
  o No risk contracting
  o Be willing to change authorization processes or procedures based on learning from providers on what works
Quality (with a big Q)

• “Big picture” view of quality
  o Developing practice standards
  o Creating credentialing criteria
  o Training and coaching of staff
  o Designing certification programs (e.g., CANS, family partners, etc.)
Quality (with a big Q)

• Formalizing methods for providers and members to report grievances or quality of care issues
• Technical assistance for providers
• Telephonic reviews of care serve as an early warning system to trigger and mobilize MCE network staff around quality of care issues
• Record reviews
• Fidelity measures - Wraparound Fidelity Index (WFI) and Team Observation Measure (TOM)
• Surveys of providers and family members
## Quality Measures & Reporting

**Shared role between MCE and provider**

<table>
<thead>
<tr>
<th>Authorization / Claims Based Measure Examples</th>
<th>Non-Claims Based Measure Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth with ICC utilizing 24-hour level of care</td>
<td>% of enrolled children where 1\textsuperscript{st} Care Planning Team (CPT) meeting occurred within 28 days</td>
</tr>
<tr>
<td># of Authorizations requested, approved, denied</td>
<td>% of enrolled children where natural supports were present at CPT meeting</td>
</tr>
<tr>
<td>Service intensity</td>
<td>% of enrolled children for whom there was coordination / contact with primary care</td>
</tr>
</tbody>
</table>
| Readmission rates to ICC post discharge | Fidelity measures:  
WFI (provider-level aggregate)  
TOM (provider QI activity) |
| | CANS data (member-level) |
Quality Management: Lessons Learned

• Identify strategies to get a pulse on how things are going *early* in the process
• Create forums for sharing data to improve practice and learn
• Be aware of the temptation to get distracted by the issue of the day
• Build in feedback loops—do not let the data sit on the shelf
• Quantitative and qualitative processes
New Jersey System of Care Utilization and Quality Management and Information System

Brian Hancock, Esq.
Acting Director
NJ-DCBHS
Overview

- Information System: NJ CYBER
- Utilization Management
- Quality Management
- A Note on Data
**Child and Youth Electronic Behavioral Health Record**

- Part of ASO contract
- Used statewide by CMEs, Mobile Response, Residential, In-Home and some Outpatient providers (10000+ users, more than 1200 concurrent users)
- Contains full record including treatment plans, assessments, progress notes, etc...
- Interfaces with MMIS, eligibility database, and working on interface with statewide automated child welfare information system (SACWIS)
Utilization Management

- **ASO** role is to review plans of care for medical necessity and quality
- **CME** role is to create plans of care taking into account actual need and family vision
- **State** role is to engage in ongoing review of utilization patterns
- **ASO and CME interaction is crucial:**
  - Clearly Define Expectations
  - Use of Standardized Tools
Utilization Management Principles

- Focus on effectiveness and cost efficiency
  - cost cannot be viewed only in monetary terms
- Outlier management
  - look at both over and under utilization
- Data-driven approach
  - use data to determine effective utilization patterns
  - share data with CMEs, and child and family teams (CFTs) in particular
Quality Management

- Begin at the beginning
- Connect quality to utilization management
- Use quantitative and qualitative measures
- Use direct and indirect measures
- Ask the questions:
  - “What would a good care manager do?”
  - “What defines a good care manager?”
Quality Management: Data Dashboards

- Comprised of 4 domains:
  - Access
  - Utilization
  - Compliance
  - Outcomes

- Use standard measures across the state
- Produced quarterly
- Require CMEs to identify and focus on improving key areas
A Note About Data

- What gets measured gets done
- There is no substitute for measurement
- There is always a substitute measure