

Utilization Management Workgroup Recommendations

July 13, 2010

The state of Louisiana is undertaking the development of a Coordinated System of Care (CSoC) for Louisiana's at risk children and youth with significant behavioral health challenges or co-occurring disorders. In the initial planning retreat, over forty agency and stakeholder leaders agreed to the following goals, values and population of focus for the CSoC.

Goals of System of Care implementation	CSoC values and principles
<ul style="list-style-type: none"> ▪ Reduction in the current number and future admissions of children and youth with significant behavioral health challenges or co-occurring disorders in out-of-home placements 	<ul style="list-style-type: none"> ▪ Family-driven and youth-guided ▪ Home- and community-based ▪ Strength-based and individualized ▪ Culturally and linguistically competent ▪ Integrated across systems ▪ Connected to natural helping networks ▪ Data-driven, outcomes oriented
<ul style="list-style-type: none"> ▪ Reduction of the state's cost of providing services by leveraging Medicaid and other funding sources, as well as increasing service effectiveness and efficiency and reducing duplication across agencies 	
<ul style="list-style-type: none"> ▪ Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care 	
CSoC population of focus	
<p>Louisiana's CSoC will initially serve children and youth that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Out-of-home placements are defined as the following: detention, secure care facilities, psychiatric hospitals, residential treatment facilities, developmental disabilities facilities, addiction facilities, alternative schools, homeless as identified by the Department of Education (DOE) and foster care.</p>	

Purpose of the CSoC utilization management workgroup

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| <ul style="list-style-type: none">▪ The workgroup will recommend the key utilization management functions and supporting activities to be performed by the Care Management Entities (CME) and the Statewide Management Organization (SMO). |
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Utilization management workgroup recommendations

The Utilization Management (UM) Workgroup focused on the design of key utilization management functions and how these functions will be performed, including the roles of the SMO and CME. The key functions include: 1) member access, eligibility and triage; 2) initial and ongoing authorization of services; 3) Child and Family Team (CFT) wraparound planning; 4) development and implementation of an UM/quality management (QM) plan; and 6) grievances and appeals (G & A). The workgroup also considered: 1) the need for active pursuit of Medicaid enrollment; 2) provider training related to utilization management and Medicaid enrollment as part of the intake and access process; and 3) the process for building provider capacity.

Recommendation #1: SMO UM role

The SMO will establish and implement a UM system that follows national standards and promotes: 1) child/youth and family /caregiver choice; 2) quality of care; 3) adherence to standards of care, including evidence based practices (EBPs); 4) the efficient use of resources; and 5) the identification of service gaps within the service system.

The UM program:

- Addresses the goals, values and principles of Louisiana's CSoC.
- Ensures that services are based on the child/youth and family/caregiver's strengths and history of the needs and problems, the current context of strengths and needs, and desired outcomes.
- Ensures that children/youth receive services based on their current condition and effectiveness of previous treatment.
- Emphasizes relapse and crisis prevention, not just crisis intervention.
- Ensures that services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Does not arbitrarily deny or reduce the amount, duration or scope of a covered service solely because of the child or youth's diagnosis, type of illness or condition.
- Ensures that children/youth and families/caregivers have an optimal choice of CMEs and providers consistent with their strengths and treatment needs and available providers.
- Ensure that staff members that make UM decisions are master's degree clinicians or registered nurses with clinical experience in the mental health and/or substance abuse fields, including child and adolescent specialists. This includes master's equivalent certified nurse practitioners and clinical nurse specialists with a psychiatric certification,

in addition to other licensed master's level clinicians, such as licensed psychologists, social workers, professional counselors or certified alcohol and drug abuse counselors.

Recommendation # 2: Access and eligibility process

The workgroup recommends implementation of a central access point to the CSoC through the SMO, which will maintain a 24-hour, 7-days a week call center with a toll free line. The call center will have licensed mental health professionals on staff. Children/youth and their families/caregivers can contact the SMO directly, or contact the CMEs, State agencies, family service organizations, providers, and others for help in accessing the CSoC. The SMO will accept referrals on behalf of the youth or family.

The SMO eligibility determination process includes telephonic collecting of basic demographic information, including Medicaid eligibility, other insurance information, and conducting a brief screening by a licensed mental health professional to determine eligibility for the CSoC. For example, during the initial call to the SMO, the clinician will ask for information about the child or youth's needs, their involvement in multiple systems and clinical status, using criteria established by the state to determine target population eligibility. If the child or youth is eligible for the CSoC, the SMO refers the child to the CME closest to the home of the family or caregiver.

The SMO has the responsibility to conduct service and crisis triage for the non-eligible population to credentialed providers in the appropriate CME region. The State agencies will provide the SMO with a list of contracted providers in the CME region. Non-contracted providers may apply to SMO for credentialing and concomitant eligibility to receive referrals for both CSoC eligible and non-eligible consumers. Such providers must demonstrate by application to the SMO their eligibility to provide services to non-eligible consumers based upon credentialing requirements established by the SMO for the State of Louisiana (e.g., licensure and certification, accreditation, education, expertise, performance). The SMO develops provider network services for crisis intervention for both CSoC eligible and non-eligible families. The SMO forwards crisis calls from eligible clients to the CME during business hours (or to 911 for life threatening emergencies), and to 911 or crisis teams and professionals as appropriate after business hours with concomitant referral to the CME.

The Workgroup recommends that the State Purchaser and SMO work together to develop protocols to determine that the child/youth meets eligibility for the CSoC during the telephonic interview. The SMO shall immediately send the referral and initial 30 day authorization to the appropriate CME electronically upon termination of the telephonic interview for those applicants determined to be eligible for the CSoC. The SMO will ensure prospective reviews are conducted on designated CSoC services prior to the

commencement of those services.¹ The SMO will conduct prospective review of all but emergency services for which prior authorization is not required. The SMO will offer both urgent and non-urgent or routine prospective reviews. Urgent prospective reviews will be completed within 24-hours of receipt of request. Non-urgent or routine prospective reviews will be completed within five business days of receipt of request.

Recommendation #3: Initial authorization

The SMO will authorize CME services for up to 30 days to establish the CFT and begin the wraparound planning process. The CME shall begin service delivery immediately upon receipt of the referral by the SMO. Upon referral to the CME, the SMO will also authorize an assessment to be conducted by a licensed mental health professional using a standardized tool adopted by the state for the CSoC. The assessment findings will be sent to the CME care manager to assist the CFT with the wraparound planning process.

The CME care manager assembles the CFT, which conducts the wraparound planning process, identifies the individual needs and strengths of the child and family, and develops a customized wraparound approach. The child/youth and family support network comprise the majority of the CFT. The CFT, with the assistance of the CME care manager, develops a sustainable and Individualized Service Plan (ISP) consistent with the level of care assessment (use of standardized tools), individual needs, UM guidelines, evidence-based practices and use of natural and informal supports whenever possible. The SMO and CME shall expect providers to participate on the CFT and align incentives to support such participation. The CME's shall work closely with the child welfare and juvenile justice agencies to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies and the juvenile justice system have active involvement on the CFT unless clinically contra-indicated.

As part of the implementation planning process, the workgroup recommends reviewing the existing case management protocols of all child-serving State agencies and establishing guidelines for addressing the mandates of each agency through the CME care management process. This task is important for all agencies, but particularly important for DCFS and OJJ that have children in custody and must address federal and state laws and regulations, including those related to the safety of the child and the community.

Recommendation #4: CME/CFT wraparound planning process

The goals of the wraparound planning process are to help the child/youth and family/caregiver develop an ISP that: 1) is family-driven and youth-guided; 2) optimizes their

¹ Subject to Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 regulations for Medicaid Services that are expected in 2010 and the *Patient Protection and Affordable Care Act* (Pub.L. 111-148) (PPACA) of 2011.

strengths; 3) emphasizes natural supports to prevent long-term reliance on the “system”; and 4) recommends home, school and community-based services that are evidence-based or known best practices instead of more restrictive services that have poor outcomes.

The CME care manager works with the child/youth and family/caregiver to determine membership of the CFT. The CFT, with the assistance of the CME care manager, develops a sustainable ISP that is consistent with the wraparound planning goals. The CME care manager submits the ISP to the SMO for review prior to the end of the initial 30-day authorization period.

The providers and state child-serving agency caseworkers, and other representatives (courts, schools, etc.), are expected to participate as part of the CFT when clinically indicated. The local school systems and the state child-serving agencies (i.e., DCFS, OJJ, DOE, OBH, OCDD and OPH) will need to work closely with the CMEs to integrate care management responsibilities.

Recommendation # 5: Ongoing authorization

The SMO reviews the ISP for consistency with the child/youth and family’s strengths and needs (as identified by the assessment and the ISP) and utilization guidelines. If the ISP meets these criteria, the SMO provides authorization for a period of up to 90 days. Ongoing authorizations provided by the SMO will be for up to 90-day periods for most children/youth. (Authorizations may exceed 90 days for some children/youth, as determined by medical and social necessity for the service).

If the ISP appears to be inconsistent with assessed strengths and needs, and the utilization guidelines for the desired services, the SMO and the CME care manager discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT. The CME care manager will work with the CFT to develop a sustainable plan. The expectation is that the SMO will have clear, transparent utilization guidelines that are developed with and approved by the state CSoC governance and widely shared throughout the CSoC. The SMO and CME shall expect providers to participate on the CFT and align incentives to support such participation. The CME’s shall work closely with child welfare and juvenile justice agencies to integrate care management responsibilities. It is expected that personnel from State agencies and the juvenile justice system have active involvement on the CFT unless clinically contra-indicated.

Recommendation #6: Grievances and appeals

The SMO has the lead role in managing G & A consistent with State, Medicaid and other federal requirements. (The Centers for Medicare and Medicaid (CMS) have regulations that govern G & A for Medicaid participants that must be implemented by the SMO.) The SMO will track all G & A, by types and status, and report these to the State and other CSoC stakeholders. The youth or family or anyone caring for, serving or advocating for a child may

file a grievance, including the CME, foster parents or relative caregivers, caseworkers/custodial agencies, court appointed special advocates (CASAs), attorneys and courts. The SMO and CME have the responsibility to inform children/youth and families/caregivers of the right to appeal and assist them with the G & A process and to ensure that punitive action is not taken for filing a G & A. Due to the potential for overlapping state requirements of the state’s child-serving agencies related to the process for filing and reporting G & A, the workgroup recommends review of each agency’s requirements prior to implementation of the CSoC to identify coordination and reporting approaches.

Recommendation # 7: Utilization management/quality management plan

The SMO develops an annual utilization management/quality management (QM) plan that outlines goals and strategies for analyzing and routinely reporting on access, utilization and outcomes of services. Examples of the issues that may be addressed in a UM/QM plan include:

- Actively monitoring and analyzing utilization and cost data for services to maintain provider profiles.
- Identifying clinical criteria to facilitate the identification of quality of care issues (other than medical necessity).
- Conducting performance improvement projects, including special studies of utilization management practices and service outcomes

The SMO should routinely collect the following types of information:

SMO data collection examples	
<ul style="list-style-type: none"> ▪ Child/youth and family/caregiver satisfaction ▪ Service utilization reporting by service type (clinical and support): <ul style="list-style-type: none"> – By consumer/age/child welfare or juvenile justice system involvement – Aggregate by service type and consumer, child welfare or juvenile justice system involvement ▪ Performance metrics, including outcomes of care by service type ▪ Results of performance improvement projects ▪ Utilization outliers review and contributing factors ▪ SMO call center telephone responsiveness (e.g., average speed of 	<ul style="list-style-type: none"> ▪ CFT process: <ul style="list-style-type: none"> – Percent of CFT participants from the family or family support network – Percent of natural and informal supports included in each ISP – Provider participation in the CFT – Timeliness of ISP development and wraparound planning process, including time from approval of plan to first provider/service contact. ▪ G&A review of types, frequency and resolution, including participation of youth and families and other stakeholders in the review ▪ Total cost: <ul style="list-style-type: none"> – Cost x service type – Cost x consumer, including

SMO data collection examples	
<p>answer, dropped calls)</p> <ul style="list-style-type: none"> ▪ Tracking information on all referrals/requests for care, including denials and reasons for denial of care and referral source. ▪ Service mix: <ul style="list-style-type: none"> – By service types – By consumer, including differentiation by child welfare or juvenile justice system involvement and race/ethnicity – By CME – By provider ▪ Length of service: <ul style="list-style-type: none"> – By service type – By consumer, including differentiation as to child welfare or juvenile justice system involvement and race/ethnicity – In-home – Out-of-home 	<p>differentiation as to child welfare or juvenile justice system involvement and race/ethnicity</p> <ul style="list-style-type: none"> – Cost x CME – Cost x service type x consumer – Cost x service type x provider – Cost x service type x CME ▪ BH medication utilization ▪ Recidivism rates (to be further defined) ▪ Child welfare outcomes related to safety, stability and permanency ▪ Others, TBD

Recommendation #8: Active pursuit of Medicaid enrollment

Due to the importance of obtaining Medicaid reimbursement for services, the SMO will ask about Medicaid eligibility during the initial call. The SMO will verify eligibility through an electronic data exchange with the State Medicaid program. If the child/youth does not have Medicaid or other insurance, the SMO will request information necessary to enroll the child in the Medicaid program. The SMO will prepare and submit an electronic application to the state Medicaid Enrollment Center. The SMO will also notify the CME of the Medicaid application during the initial referral. The CME will assist the youth or family with obtaining the supporting documentation required for the Medicaid application and submitting it to the appropriate Medicaid office. The SMO will track Medicaid eligibility status and coordinate any required follow-up with the CME.

Recommendation #9: Training and Provider Capacity Development

The UM workgroup recommends adoption of the Provider Training and Capacity Workgroup recommendations for training on the wraparound process for the CME, CFT and providers and the state child-serving case management agencies. The SMO should provide training for CMEs, providers and staff from the state child-serving agencies on: 1) the utilization guidelines and use of evidence-based and best practices; 2) operating protocols related to UM and QM; and 3) filing and resolution of G & A.

The SMO will have responsibility for provider network development and include in the network the providers identified by the child-serving State agencies, subject to credentialing criteria (specific to Louisiana). The SMO will assign provider network development staff to cover each CME/region/HSDs/HSAs. The SMO will: 1) work with the CMEs and Regions/HSDs/HSAs, consumers, providers, family support organizations and others to identify service needs; 2) identify providers who can fill those needs in the short-and long-term (i.e. when needed to address urgent needs within an ISP or expansion of evidence-based practices); and 3) in conjunction with the CME and UM staff of the SMO, identify provider capacity and training needs that address both cross-CME/region topics as well as the training required for each CME/region, including expansion of evidence-based and best practices for children and youth.