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MCTAC Overview

What is MCTAC?
MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
Setting the Stage...
Medicaid Expenditures: 2013

$49.1 billion
Managed Care: Key Components

• Care Management

• Vertical and Horizontal service integration and coordination

• Financial risk sharing with providers
Managed Care: Key Components Continue

1. Network of providers created via contracting
2. Utilization Management
3. Benefits package with a defined set of covered services
4. Contained list of covered pharmaceuticals (Formulary)
5. Credentialing
Triple Aim

• Improve Patient Experience

• Improve Health of Population

• Reduce Cost of Healthcare
What is Utilization Management?

- The process by which an MCO decides whether specific health care services, or specific level of care are appropriate for coverage under an enrollee’s plan.

- Primary purpose of the program is to ensure that services are medically necessary, appropriate, and cost-effective.
Why do MCOs Conduct Utilization Management?

• Managed Care is an integrated system that manages health services for an enrolled population rather than simply providing or paying for the services (outcomes, service quality and service expenditures).

• Generally MCOs are paid for health benefits administration on a capitated basis (a fixed amount for each member each month/Per Member Per Month -PMPM).

• The MCO’s role is to make sure the individual receives services in the least restrictive care.

• Involves a determination of whether the service is medically necessary and appropriate for the patient’s symptoms, diagnosis, and treatment and recovery. Also reviews for the appropriate length of care.

• The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary.”
What does it mean to be Medically Necessary?

• Involves a determination of whether the service is necessary and appropriate for the patient’s symptoms, diagnosis, treatment, and recovery.

• Many MCO contract definitions of “medically necessary” state that services may not be provided primarily for the convenience of the patient or the provider.

New York State Department of Health requires the following definition of Medically Necessary:

- Medically necessary means health care and services that 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.
Types of UM Reviews?

UM will occur at different points in the healthcare delivery cycle:

• **Prior authorization:** is a Service Authorization Request by the enrollee, or a provider on the enrollee’s behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the enrollee.

• **Concurrent review:** is a Service Authorization Request by an enrollee, or a provider on Enrollee’s behalf for continued, extended or additional authorized services beyond what is currently authorized by the Contractor within an existing authorization period.

• **Discharge Review:** occurs prior to discharge to assure that plans are in place for a safe and supported transition to another level of care or independent community living

• **Retrospective review:** review that takes place, on an individual or aggregate basis, after the service is provided
Utilization Management Process

• Review Level of Care (LOC) criteria as determined by LOCADTR for the service being requested/discussed

• Review the specific information regarding the individual (presenting problem, current symptoms, medications, recent treatment) and formulate a rationale for the requested LOC and anticipated service units

• Be Ready to Provide
  o Patient Name
  o Date of Birth (DOB)
  o Medicaid Number (CIN) and/or Insurance ID Number
  o Your Name
  o Facility Name and Contact Information
  o Identify the start date for treatment being requested
  o Request the services and number of service units (days, visits, etc.) necessary to deliver these services
  o Present rationale for request
Utilization Management Process Cont.

• Discuss planned treatment changes (if any) and anticipated service units.

• Might need to include overview of the long term treatment/support plan including discharge planning steps
  o Communication with other treatment providers
  o Family Involvement
  o Medications (new, existing, changes)
  o Patient involvement (person centered approach)

• Obtain decision from MCO, document
  o If adverse decision:
    i. Request rationale and Alternative Treatment
    ii. Consider MD to MD review
    iii. Appeal
Thank you for participating!

Visit www.mctac.org to view past trainings, sign-up for updates and event announcements, and access resources.
THE ROLE OF THE LOCADTR IN UTILIZATION MANAGEMENT
Overview

- The most common utilization management techniques are:
  - Precertification,
  - Concurrent review, and
  - Case management

- The LOCADTR can be utilized at these points as a component of utilization management
UM Clinical Explanations

• Precertification/Notification
  o Understand medical necessity language and how it applies to respective levels of care
  o Be prepared to present clinical information to support level of care recommendation
  o *Inpatient*: withdrawal symptoms, risk for medical/psychiatric complications, need for supportive environment
  o *Outpatient*: severity and frequency of use, need for rehabilitation skills
  o *OTP*: inability to maintain sobriety without MAT
  o Develop process for communicating LOCADTR information to plans
UM Clinical Explanations

• Concurrent Review
  o Provide a summary of effectiveness and progress in treatment
  o Document that services in treatment plan are appropriate to patient needs
  o Document the need for continued services

• Case Management
  o Recommend additional services to maintain progress and/or forestall relapses
Clinical Examples of LOCADTR Use

• **Step down**
  o Client has completed inpatient rehab and is transitioning to intensive outpatient

• **Relapse**
  o Client has attended 3 months of outpatient services and begins to use heavily again
  o Needs supportive environment to discontinue use

• **Transition**
  o Client’s living situation has changed/obtained employment and requires a different level of care
Outlier Management

• Plans may conduct UM reviews on cases that are deemed “outliers”

• Possible examples include:
  o IOS services longer than 6 months
  o 6x per week pick-up schedule without clinical intervention longer than 1 year
  o Greater than 1 Detox admission within 30 days

• Provide clinical rationale for treatment decisions

• Document clinical progress and or need to remain at the level of service being delivered
Patient Confidentiality

• Ensure that patients have signed release of information/consents for MCOs

• Educate patients regarding the communication with MCOs

• Discuss implications of MCO decisions
Administration Considerations

• Set aside time for MDs to respond to peer-to-peer reviews

• Revise clinical documentation to incorporate concurrent review requirements

• Research and develop alternative levels of care
THANK YOU

www.casacolumbia.org