VIII. Clinical Decision Making and Management Mechanisms

Medical Necessity Criteria

Early state surveys revealed that nearly all states (86% in 1997/98) used medical necessity criteria in their managed care systems. Given their widespread use, the feedback provided by stakeholders regarding medical necessity criteria assumes particular significance. Stakeholders from most states in both impact analyses felt that the initial implementation of medical necessity criteria was problematic. Reported problems included narrow definitions of medical necessity based on a medical model, failure to consider the need to link treatment with the appropriate social and environmental supports, and inconsistent interpretation and application of medical necessity criteria across MCOs. An additional problem identified by stakeholders was overly rigid interpretation of medical necessity criteria by some MCOs, resulting in a serious barrier to service delivery by limiting both the types and duration of services for children and their families.

The 2000 and 2003 State Surveys built on these earlier findings and added items to: 1) determine the extent to which medical necessity criteria permit the consideration of psychosocial and environmental factors in clinical decision making, and 2) assess how MCO interpretation and application of medical necessity criteria affects clinical decision making and service delivery.

The 2003 State Survey found that the majority of managed care systems (89%) reportedly now have medical necessity criteria that allow for consideration of environmental and psychosocial factors in clinical decision making. **Table 73** shows that most carve outs (91%) and integrated systems (87%) have medical necessity criteria that include psychosocial and environmental considerations. In comparison with 2000 findings, the greatest increase in the use of broad medical necessity criteria is in the integrated systems –71% of the integrated systems reportedly used broad medical necessity criteria in 2000 as compared with 87% of integrated systems in 2003.

Table 73

Percent of Managed Care Systems in which Medical Necessity Criteria Allow Consideration of Psychosocial and Environmental Factors

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Medical necessity criteria allow for psychosocial and environmental factors	82%	91%	87%	89%	7%
Medical necessity criteria do not allow for psychosocial and environmental factors	18%	9%	13%	11%	-7%

Problems reportedly persist in some systems, however, with respect to MCO interpretation of medical necessity criteria (**Table 74**). In both the 2000 and 2003 State Surveys, MCOs in about three-fourths of the managed care systems (73% in 2003) reportedly interpret medical necessity criteria broadly enough to include psychosocial and environmental factors. However, in some managed care systems (20% of carve outs and 27% of integrated systems), rigid MCO interpretation of these criteria may still present a barrier to service delivery. Thus, although most managed care systems have medical necessity criteria that permit consideration of psychosocial and environmental factors in clinical decision making, MCOs in some systems may still interpret and apply these criteria rigidly, without sufficient attention to these factors.

Table 74

Percent of Managed Care Systems in which Medical Necessity Criteria Allow Consideration of Psychosocial and Environmental Factors

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Medical necessity criteria are interpreted narrowly by MCOs	26%	20%	27%	23%	-3%
Medical necessity criteria are interpreted broadly to include psychosocial and environmental factors	74%	80%	73%	77%	3%

Level of Care and Patient Placement Criteria

The state surveys have studied the use of clinical decision making criteria, including level of care criteria for children's mental health and patient placement criteria for substance abuse services, that are specific to children and adolescents. Since 2000, there has been a substantial increase in the percent of managed care systems that use child-specific clinical decision making criteria. In 2003, almost all managed care systems (94%) reported the of use child-specific criteria, as compared to 63% of the systems in 2000 (**Table 75**). The increase from 2000 to 2003 is especially noticeable for the integrated systems, with 38% using child-specific level of care and/or patient placement criteria in 2000, in comparison with 92% in 2003.

Table 75

Percent of Managed Care Systems that Incorporate Child-Specific Clinical Decision Making Criteria

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care systems incorporate child-specific clinical decision making criteria	62%	63%	95%	92%	94%	32%	31%
Systems do not incorporate child-specific clinical decision making criteria	38%	37%	5%	8%	6%	-32%	-31%

In the 2003 State Survey, of the 33 managed care systems that reported having child-specific clinical decision making criteria, almost all (97%) have level of care criteria for children's mental health, and about two-thirds (65%) have patient placement criteria specific to adolescent substance abuse treatment. These results are consistent with 2002 findings indicating that level of care criteria for children's mental health are more common than decision making criteria for adolescent substance abuse treatment. However, the percent of managed care systems that use patient placement criteria for adolescent substance abuse has increased from 41% in 2000 to 65% in 2003 (**Table 76**).

Table 76

Type of Criteria in Managed Care Systems that Include Child-Specific Criteria

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Level of care criteria for children's for mental health	100%	100%	91%	97%	-3%
Patient placement criteria for adolescent substance abuse	41%	60%	73%	65%	24%

The impact analyses raised questions about whether consistency in clinical decision making was improved by using level of care and patient placement criteria. Stakeholders noted a number of problem areas:

- Where there are multiple MCOs, each has developed its own criteria, resulting in considerable variation within a state with respect to the type, level, and duration of services that children and adolescents may receive.
- Even with standardized criteria prescribed by the state, differing interpretations by MCOs and providers may compromise consistency.
- Criteria may be applied too rigidly, forcing children to change service levels or modalities too often, or impeding the ability to provide flexible, individualized care.

The 2000 and 2003 State Surveys explored this issue further across all states. In 2003, 94% of the managed care systems (as compared with 62% in 2000) reported improved consistency in clinical decision making (**Table 77**). Increases in reports of consistency in clinical decision making due to the use of child-specific criteria between 2000 and 2003 occurred in both carve outs (67% in 2000, up to 100% in 2003) and in integrated systems (33% in 2000 up to 82% in 2003). These findings are consistent with the finding of increased use of child-specific clinical decision making criteria in managed care systems, thus providing a vehicle for increasing consistency in clinical decision making.

Table 77

Percent of Managed Care Systems Reporting Improved Consistency in Clinical Decision Making Resulting from Use of Child-Specific Clinical Decision Making Criteria

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Consistency in clinical decision making improved	62%	100%	82%	94%	32%
Consistency in clinical decision making not improved	38%	0%	18%	6%	-32%

Another potential contributor to the reported improvement in clinical decision making consistency is the use of clinical decision making criteria that are standardized across the state. As shown on **Table 78**, clinical decision making criteria reportedly are standardized across all MCOs in the state in about half of the managed care systems in both 2000 and 2003. It is interesting to note that the use of standardized statewide criteria by integrated systems increased from 0% in 2000 to 38% in 2003. This increase in standardization may be one reason for the reported substantial improvement in clinical decision making consistency in the integrated systems. It should be noted, however, that, even with standardization, the problem of differing interpretations of criteria by different MCOs and providers within a state could persist.

Table 78

Percent of Managed Care Systems in which Clinical Decision Making Criteria are Standardized Across the State

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Criteria are standardized across state	54%	59%	38%	50%	-4%
Criteria differ with each MCO	46%	41%	62%	50%	4%

Management Mechanisms

Survey findings reveal an increase in the reported use of various management mechanisms from 2000 to 2003. Most systems (82% or more) continue to report using the various management tools typically associated with managed care (prior authorization, concurrent review, and retrospective review). **Table 79** shows that the most commonly used management mechanism is prior authorization, used by 77% of the systems in 2000 and in 97% of the systems in 2003. Prior authorization was followed by concurrent review, used by 81% of the systems in 2003, and by concurrent review, used by 73% of the systems.

Table 79

Percent of Managed Care Systems Using Various Management Mechanisms

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Prior authorization	Not asked	88%	77%	95%	100%	97%	NA	9%	20%
Concurrent review	Not asked	Not asked	74%	86%	73%	81%	NA	NA	7%
Retrospective review	Not asked	Not asked	69%	82%	60%	73%	NA	NA	4%
Case management	89%	76%	66%	59%	73%	65%	-24%	-11%	-1%
No management mechanisms are used	Not asked	Not asked	Not asked	5%	7%	5%	NA	NA	NA
Other	Not asked	Not asked	6%	9%	0%	5%	NA	NA	-1%

NA=Not Applicable

In both 2000 and 2003, case management reportedly is used as a management tool by about two-thirds of the systems. It is interesting to note, however, that the use of case management as a management mechanism has declined since 1995 by 24%. Thus, although intensive case management services for children with serious and complex needs has increased as a result of managed care and is now used by all managed care systems (see **Table 42**), the use of case management as a management tool for the general population apparently has decreased over time.

Although the 2003 State Survey and previous surveys show extensive use of prior authorization as a management tool, stakeholders in most states in both impact analyses noted that prior authorization processes were often cumbersome, time consuming, confusing, and created barriers to access. These complaints were voiced less frequently in systems which routinely allowed a certain level of services without prior authorization. The 2000 and 2003 State Surveys explored the extent to which managed care systems allow certain services without prior authorization. In 2003, 86% of the systems (a 10% increase from 2000) reportedly allow provision of certain services without prior approval (**Table 80**).

Table 80

Percent of Managed Care Systems that Allow Provision of Certain Services up to a Specified Amount Without Prior Authorization

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Systems allow certain services without prior authorization	76%	86%	85%	86%	10%
Systems do not allow certain services without prior authorization	24%	14%	15%	14%	-10%

The 2003 State Survey asked states to specify which services are allowable without prior authorization. The service categories that most often are allowed without prior authorization are emergency services, outpatient services, assessment and diagnostic evaluation, and medication management. In some states, even greater flexibility is permitted.

Three-quarters of the systems reported having strategies to manage the utilization of intensive services, such as inpatient and residential treatment services in 2003 (**Table 81**). Control over utilization of intensive services is used at about the same rate by carve outs (77%) as by integrated systems (71%). More rigorous prior authorization requirements, more intensive clinical reviews of need, more frequent concurrent reviews, more intensive case management, more scrutiny of treatment plans, and more aggressive discharge and aftercare planning are among the strategies cited by respondents as examples of their efforts to manage the utilization of intensive services.

Table 81

Percent of Managed Care Systems with Strategies to Manage Utilization of Intensive Services

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Strategies to manage intensive services	80%	77%	71%	75%	-5%
No strategies to manage intensive services	20%	23%	29%	25%	5%