Magellan of Louisiana

Annual External Quality Review Technical Report

Review Period: March 1, 2012-February 28, 2013

Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals
Office of Behavioral Health

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I. INTRODUCTION

The Louisiana Behavioral Health Partnership (LBHP) manages care for Medicaid and non Medicaid adults and children requiring specialized behavioral health services, including children at risk for out of home placement under the Coordinated System of Care (CSoC). The CSoC is managed by Magellan of Louisiana, the Behavioral Health Statewide Management Organization (SMO).

The LBHP is managed by the Office of Behavioral Health (OBH) and oversees Magellan of Louisiana. CMS requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations, including SMOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an SMO furnishes to Medicaid recipients.

In order to comply with these requirements, the State of Louisiana, Department of Health and Hospitals contracted with IPRO to assess and report the impact of its Medicaid managed care program and its participating managed care organizations on the accessibility, timeliness, and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by Magellan of Louisiana for the review period 3/1/12-2/28/13. The frame work for the assessment is based upon the guidelines and protocols established by CMS, as well as State requirements.

The following goals and priorities reflect the State's priorities and areas of concern for the population covered by the SMO:

- To improve accessibility to care and use of services
- Improve effectiveness and quality of care
- Improve cost effectiveness through reducing repeat ER visits, hospitalizations, out of home placements and institutionalizations
- Increase coordination and continuity of services

II. SMO Corporate Profile

Magellan of Louisiana (Magellan) is an affiliate of Magellan Health Services, a health care management company specializing in behavioral health care, pharmacy benefits management, and specialty health care solutions.

Magellan began operating the LBHP as a Prepaid Inpatient Health Plan (PIHP) in March 2012 for the management of Medicaid specialty behavioral health benefits for adults and children. Magellan also manages State funded specialty behavioral health services funded by the LBHP partner agencies.

Table 1. SMO Corporate Profile

Magellan of Louisiana Corporate Profile	
Type of Organization	SMO
Tax Status	For-profit
Year Operational	2012
Product Line(s)	Medicaid
Participating Parishes	Statewide for most services, CSoC services in all but 5 parishes
Total Medicaid Enrollment	1,181,746

III. QUALITY INDICATORS

Validation of Performance Measures

Performance measures provide information regarding directions and trends in the aspects of care and service being measured. The information is used to focus and identify future quality activities and direct interventions to improve quality of care and services. Performance measures are tracked and trended, and information will be used by the OBH to develop future quality activities.

This section of the report summarizes the MSO's reporting of select performance measures, as follows

1) Number of children, under age six, assessed and with early intervention service plans developed
2) Number and / or percent of participants reviewed who had plans of care that were adequate and appropriate to their needs and goals as indicated in their assessments
3) Re-admission to substance abuse facility
4) Number and / or percent of grievances filed by participants that were resolved within 14 calendar days according to approved waiver guidelines

Measure One: Number of children, under age six, assessed and with early intervention service plans developed

This measure addresses the importance of detecting behavioral health concerns early in a child's development, to mitigate more serious behavioral health concerns and / or diagnoses later in life. Early intervention efforts also have cost saving implications; such as possible mitigation or avoidance of institutional care.

The description indicates that the intent of this measure is two-fold; to focus on assessment completion for children under age 6, and, for those children assessed, the number of children with service plans in place based upon assessment results. However, the measure has been reported since the first quarter of Year One with only the number of completed assessments for children under age 6; there is no mention of service / treatment plans.

During Year One, Magellan has seen increases in the number of children less than 6 years of age receiving initial assessments. In the first quarter of 2012, Magellan reported that 1.48 children per thousand received an initial assessment. For the fourth quarter of 2012, 1.65 children per thousand received initial assessments.

IPRO attempted to validate the measure as documented, with both assessments **and** care plans as required numerator components.

Performance Indicator

1) *Numerator: the number of children with an initial assessment and with an early intervention service plan in place*
   Denominator: the number of children under age 6 enrolled [1915(b) membership]

Methodology

As IPRO's validation involved the review of clinical treatment records and assessments, the most current measure results were selected for validation, since these were considered the easiest records for providers to retrieve. Measure results were available for the third quarter of year 2 (9/01/13-11/30/13). For that period, 1296 children received assessments. IPRO selected a random sample of 30 children from this denominator, and requested assessments and care plans for each.

Validation

Assessments for each of the members in the sample were received and reviewed. IPRO was able to validate the assessment component of the measure; all of the records in the sample contained initial assessments. IPRO was unable to validate the service plan component of the numerator. Of the 30 records in the sample, only nineteen (19) records contained service/treatment plans.

Discussion with both the Office of Behavioral Health (OBH) and Magellan indicated that this measure addresses a specific component of a program no longer in existence in Louisiana. Many of the children in this measure are not managed by Magellan and care plans and services are outside of the scope of the plan.

IPRO's initial recommendation was to re-structure this measure, to address assessments only. The OBH indicated that this measure is under discussion, to determine its significance and future reporting usefulness.

Measure Two: Number and / or percent of participants reviewed who had plans of care that were adequate and appropriate to their needs and goals as indicated in their assessments

Plans of care are the driving force in a member's care and need to be appropriately developed in accordance with assessment needs. A significant finding in the Mercer compliance review was that plans of care do not often outline the number and scope of benefits that would address the assessed needs and goals of members.

Performance Indicator

Numerator: Number of treatment records deemed to be compliant with the three treatment planning standards related to plan of care goals
Denominator: Sample of treatment records, from six (6) HCBS providers [1915(i) membership]

For year one (3/1/12-2/28/13), Magellan reported a near 95% compliance rate. It should be noted that effective early in year two (5/13), an audit tool was developed by Mercer, for consistency in reviewing records.

IPRO selected the third quarter of year 2 (9/1/13-11/30/13) period for validation, as the most recent available for clinical record review.

IPRO's review of Magellan's third quarter year two results reflected a declining trend. For the 9/1/13-11/30/13 period, Magellan reviewed a sample of 103 treatment records from 6 HCBS providers. Of the records reviewed, 73 records were found to be compliant with the three treatment planning standards, using the 1915(i) Waiver Audit Tool. This rate (71%) declined from the 1st and 2nd quarters of 2013, with both quarters at 80% compliance, and declined notably from year one. Magellan's goal continues to be 100% compliance.

Methodology

IPRO selected a random sample of 30 members from the 103 member denominator. For each member in the sample, IPRO requested treatment records and completed audit tools.

The audit tool had three scoring options:

1= Met compliance
.5=Partially met compliance
0= Did not meet compliance

Validation

Of the 103 cases in the denominator for the third quarter of 2013, Magellan had reported 73 cases (71%) as compliant (Score of "1"). IPRO's review of the denominator list indicated the following:

- 50 cases with a "1" score (fully compliant)
- 46 cases with a .5 score (partially compliant)
- 7 cases with a "0" score (non-compliant)

Of the 30 records in the audit sample, twenty (20) were reported as fully compliant, 10 were partially compliant. IPRO's review of the scoring matrix, audit tool, and treatment records for the sample supported the fully or partially compliant scoring designations. Therefore, all of the records in the sample passed validation. However, the measure rate was incorrectly calculated, with inclusion of some partially compliant members in the numerator. IPRO therefore recommended that the measure results be restated to reflect 50 records as compliant, instead of the 73 reported by Magellan, with a measure rate of 48.3%, for the 3rd quarter of 2013. Magellan agreed with IPRO's findings. Reporting for this measure is being revised to exclude partially compliant members from the numerator. It is recommended that results for similar measures calculated with the same scoring matrix be revised accordingly.

Other validation observations were as follows:

- Six (6) of the 30 cases reviewed appear to have the incorrect diagnosis listed in the scoring matrix. This may have the potential to skew the scoring results.
- Due to inconsistent provider standards, Magellan used continued stay reviews with treatment goals as a substitute for treatment plans in some cases.
- A number of poor quality treatment plan concerns were observed with the Helping Hands for Community Development provider. This provider is no longer in the Magellan network.
- Magellan provided a number of corrective action plans for providers that appear to address the deficiencies observed.

IPRO has expanded the validation of this measure to the second quarter of year two (6/1-8/31/13), a random sample has been selected and the clinical documentation is expected to be provided shortly. Validation did not include year one, as the 1915 audit tool had not been utilized and results would therefore not be trendable.

Measure Three: Re-admission to substance abuse facility [1915(b) membership]

Mitigating inpatient re-admission rates for psychiatric care should be a key initiative for managed care organizations, and can be measured as a direct outcome of a focused transition of care system. Specifically, adequate discharge planning, medication adherence and outpatient follow ups all play a significant role in care transitioning from inpatient to home and can have a positive outcome on re-admission rates. Reductions in re-admissions and inpatient days have been translated into substantial cost savings.

For year one (3/1/12-2/28/13), for 1915(b) membership, Magellan's 30 day re-admission rate for chemical dependency was 9%, the re-admission rate for mental health conditions was 13.4%. Both rates were below the goal of 20% for mental health and 10% for chemical dependency. However, IPRO considers this to be an important measure to validate and to track going forward, given Magellan's action plans to mitigate re-admissions. Interventions include dedicating follow up specialists to specific facilities and encouraging facilities to schedule mental health appointments early in the treatment process.

Performance Indicator

Numerator: Number of unique members re-admitted in 30 days
Denominator: Total number of unique members discharged during period review [1915(b) membership].

For Chemical Dependency, the rate was 9% (89 members re-admitted / 988 members discharged)

Methodology

IPRO requested the source code (measure query) for numerator and denominator components, to determine if measure programming addresses all potential re-admission possibilities and the 30 day timeframe.

Validation

The source code reviewed captured the data for both mental health and chemical dependency re-admissions.

IPRO observed some recent modifications to the code. Some of the modifications corrected code errors, other modifications related to enhancements resulting in an accelerated process for measure generation. The code clearly captures inpatient discharges and re-admissions, for mental health and chemical dependency diagnoses separately. Appropriate re-admission timeframes (within 30 days) appear in the code.

IPRO's review indicates that the code appears to be pulling discharges and re-admissions appropriately for this measure.

Measure Four: Number and / or percent of grievances filed by participants that were resolved within 14 calendar days according to approved waiver guidelines

A plan's grievance system and grievance resolution protocols are a key to maintaining optimum levels of member satisfaction. Mercer's compliance review indicated that the overall volume of member grievances (as reflected by the plan's corporate grievance database) is lower than expected based on member size and complexity of the service delivery system.

Given the small grievance volume, it would appear feasible that resolution turnaround time would be expeditious. However, a review of grievances filed by the 1915i membership indicated that for Year One, only 43% of grievances were resolved within 14 days. Magellan of Louisiana is a young organization, in operation for approximately 2 years. It is therefore quite beneficial to closely monitor and track this measure, and identify grievance system issues as early on as possible. In so doing, possible quality of care concerns may be identified and levels of dissatisfaction can be mitigated.

Performance Indicator:

Numerator: Grievances resolved within 14 calendar days after filing
Denominator: Grievances filed by MSO members [1915(i) membership]

For the year ended 2/28/13, the rate was 43% (6 grievances resolved in 14 days / 14 grievances filed). The reported rate on the IMT, however, was 47%.

Data Sources:

1) CART reports (grievance system database)
2) Grievance logs
3) Resolution letters
4) Enrollment Information

Methodology:

IPRO requested grievance database reports and logs for the 3/1/12-2/28/13 period for the 1915i membership, as well as resolution correspondence (letters).

Validation

Magellan provided the grievance log for the 3/01/12 – 2/28/13 Year One period. The log contained documentation for ten (10) grievances. Of the ten grievances, only two (2) were validated as resolved within the 14 day timeframe, resulting in a measure rate of 20%.

By contrast, Magellan reported a measure rate of 47% for Year One on the IMT report, with different numerator and denominator components, as presented below:

3/01/12-2/28/13

Grievance Measure (Number/percent of grievances resolved in 14 days)	Reported by Magellan via IMT	Validated by IPRO
Numerator (Grievances resolved within 14 days)	6	2
Denominator (Total grievances)	14	10
Rate	43% (47% was reported via IMT)	20%

IPRO was therefore unable to validate the measure results as reported via the IMT for Year One.

IPRO expanded validation of this measure to Year Two. It should be noted that for the nine (9) months ended 11/30/13, Magellan's rate as reported on the IMT was 58.3% (14 grievances resolved in 14 days out of 24 grievances filed).

IPRO's validation of this measure for this Year Two period reflected the following:

The grievance log for the 3/1-11/30/13 period contained documentation for twenty four (24) cases (the denominator). For each case, IPRO validated the dates of the grievance as occurring within the 3/1-11/30/13 timeframe. A review of the grievance log indicated that 14 grievances were resolved within 14 days; these dates were confirmed through review of resolution letters.

IPRO was therefore able to validate the measure results as reported for the 3/1-11/30/13 period. One auditor observation pertained to two (2) grievances resolved verbally, within the same day of occurrence. For these grievances, it does not appear as though resolution letters were generated. Magellan may consider expanding the issuance of resolution letters to such same day resolved grievances.

Validation of Performance Improvement Projects

A Performance Improvement Project (PIP) is intended to improve care, services or member outcomes. The general expectations for PIPs include:

a) PIP development, appropriate study topic, clearly defined study question and indicators, correctly identified study population, baseline results, valid sampling methods, accurate and complete data collection, and analyses identified interventions for the re-measurement year.

b) Interventions implemented and results reported.

c) Re-measurement and ongoing improvement with adjustment in interventions, as appropriate.

d) Re-measurement demonstrating ongoing improvement or sustainability of results, and future years to be determined based on results, sustainability and member needs.

Magellan of Louisiana was required to perform two PIPs, one process and one clinical, from year one of the SMO contract. The two PIPs are Appointment Access and Number of CSoC Treatment Plans with Service Authorization at First Review.

In accordance with 42 CFR §438.358, IPRO conducted a review and validation of these PIPs using methods consistent with the CMS protocol for validating performance improvement projects. Summaries of each of the PIPs conducted by Magellan follow.

Appointment Access

Purpose

The purpose of the project is to improve member access to emergent, urgent and routine appointments, to impact satisfaction as well as care quality. Appointment access standards for Medicaid members in Louisiana are:

Emergent-1 hour
Urgent-2 calendar days
Routine-14 calendar days

Magellan set the following goals for the project:

Emergent-95% of members have 1 hour access to emergent care
Urgent-95% of members have 48 hour / 2 calendar day access to urgent care
Routine-70% of members have 14 calendar day access to routine care

Methodology

Five (5) quality indicators were utilized to establish baseline rates:

a) Members authorized within required timeframes for emergent, urgent, routine requests
b) Members obtaining services within required timeframes for emergent, urgent, and routine requests
c) Members satisfied with access to care (minors)
d) Members satisfied with access to care (adults)
e) Member grievances related to access

Interventions

Interventions include staff education regarding access standards, system documentation, and classification of urgent versus routine appointment access. A majority of the interventions focused on member education regarding access standards (via customer service calls). In reaching out to members and families, Magellan has been stressing the customer service department as a resource in scheduling appointments when necessary. Other interventions include educating providers to ensure they understand and are able to meet contractual expectations. A planned intervention for year 2 of the project includes quarterly surveys of samples of providers to monitor availability of emergent, urgent and routine appointments.

Results

Baseline year results (3/1-2/28/13) are presented below

Indicator 1: Percent of members who are authorized for service within required timeframes (defined as the time a member or provider requests service authorization to the time an organizational determination is made). Quarterly results (contract year quarters) are shown below.

Date	Numerator	Denominator	Emergent	Numerator	Denominator	Urgent	Numerator	Denominator	Routine
Q1*	3381	4394	**76.95%**	2951	2959	**99.73%**	41135	41157	**99.95%**
Q2	2314	2326	**99.48%**	2987	2993	**99.80%**	18325	18337	**99.93%**
Q3	2612	2633	**99.20%**	3377	3382	**99.85%**	20540	20553	**99.94%**
Q4	4702	4720	**99.61%**	3329	3331	**99.94%**	18906	18918	**99.94%**

* Q1 has 4 months due to startup in middle of quarter.

Due to high compliance rates, this measure was not identified as an opportunity for improvement and was not addressed in the PIP.

Indicator 2: The percent of members attending an appointment within time standards defined as date of request for service and date of first claim post request for service.

Annual (3/1/12 – 2/28/13) appointment access results provided in the table below are based on claims data with run out through May 2013.

Access Type	Performance Goal	Numerator	Denominator	3/1/2012 – 2/28/3013
Emergent	95% ≤ 1 hour	1,920	2,053	**93.5%**
Urgent	95% ≤ 48 hours/2 calendar days	16,175	22,718	**71.2%**
Routine	70% ≤ 14 calendar days	45,896	61,441	**74.7%**

Indicator #3 – 2013 Member satisfaction with access to care - Minors

	Question	Number Responded	% Positive
Q08	Staff was willing to see my child as often as I felt was necessary.	262	**87.0%**
Q09	Staff returned our call(s) in 24 hours.	266	**83.0%**
Q10	Services were available at times that were good for us.	264	**84.0%**
Q11	The time my child waited between appointments was acceptable.	265	**81.5%**
Q12	My family got as much help as we needed for my child.	270	**81.1%**
Q13	My child was able to see a psychiatrist when he/she wanted to.	251	**72.9%**

Indicator #4 – 2013 Member satisfaction with access to care – Adults

	Question	Number Responded	% Positive
Q8	Staff members were willing to see me as often as I felt was necessary.	276	**79.7%**
Q9	Staff members returned my call(s) in 24 hours.	269	**71.4%**
Q10	Services were available at times that were good for me.	285	**83.5%**
Q11	The time I waited between appointments was acceptable.	285	**79.7%**
Q12	Helped you connect to the services you needed.	277	**79.4%**
Q13	I was able to see a psychiatrist when I wanted to.	281	**76.1%**

Indicator #5 –Member grievances related to access

1st Qtr 2012	2nd Qtr 2012	3rd Qtr 2012	4th Qtr 2013	Total
0	1	2	4	7

Summary

Baseline year results reflected emergent access results as slightly lower than goal, urgent access results were nearly 24 percentage points lower than goal. It was recommended that monitoring of appointment access via claims data continue going forward; with focus on increasing the number of urgent appointments kept within the 48 hour time period. Magellan proposed a lower intermediate goal of 80% of urgent appointments within 48 hours for year 2 of the PIP.

It should also be noted that a root cause for lower than goal emergent and urgent access was identified during year 1, in that routine community based service appointments requiring authorizations were being classified as emergent or urgent. The authorizations take extra time to process and were considered a possible significant factor in affecting the access rates. A weekly reporting mechanism has been established to review outpatient services classified as emergent or urgent to address mis-classifications.

Access to care was also measured via member surveys; survey results for minors indicates that the majority of parents of minors are satisfied with their ability to access providers, with all survey results above the 80% goal, except the ability to access psychiatrists. Survey results for adults, while not as favorable as for minors, were overall close to goal, except for calls returned within 24 hours and ability to access psychiatrists.

Only seven (7) member grievances were reported for the baseline year, likely indicative of under reporting. Magellan recognizes the need to conduct staff training to ensure that all grievances are appropriately captured.

Coordinated System of Care (CSoC) Treatment Plans with Service Authorization at First Review

Purpose

Home and community based services (HCBS) are a key component of the Louisiana Behavioral Health Partnership. Evidence supports the concept that children receiving services in the home or community have a lower risk of out of home placement. One of the goals of the CSoC program is to ensure that children in out of home placement or at risk of out of home placement receive enough home and community based services to reduce their risk of future out of home placement.

The goal of this project is to ensure that CSoC members have authorizations and receive services prior to the first review.

Methodology

Two indicators were established for quality measurement. One indicator, determined through authorization data, measures the number of children with authorizations for services within 30 days of enrollment. A second indicator measures the number / percent of children with claims for services prior to first review.

Magellan established a goal for the authorization indicator of 95%, and a goal of 55% for the claims indicator.

Interventions

Interventions include the following:

- Increased outreach and interaction with providers (e.g. wrap around agencies), to stress the need to refer to community based services. One observed barrier related to providers not having a clear understanding of CSoC services or 1915c waiver requirements.
- Improved network access for members, to receive required one CSoC service per month.
- An improved tracking mechanism, in the form of a spreadsheet, to monitor service utilization, including a metric to monitor that each active member is receiving at least one service per month.
- A routine query / review of claims information for each of the 5 CSoC services (to allow for a 90 day claims run out)

Results

Baseline results (year one 3/1/12-2/28/13) are as follows:

Time Period	Denominator	Numerator	% with 30 Day Auth	Numerator	% With Claims for Any Service
Contract Year 1	933	895	95.9%	397	42.6%

Summary

Baseline results indicated that nearly all children had a 30 day review of the Plan of Care (POC) and authorizations for a CSoC service, as evidenced by authorization results of nearly 96%. This rate was slightly above goal. However, only 42.6% of these children had claims filed for services rendered during the study period. This rate was notably below goal. Key focus will be on increasing provider accountability to ensure that members receive services in a timely manner and interventions are being modified for this focus. An example of this can be seen with Magellan's accelerated efforts to work with wrap around agencies (WAAs) and the Family Services Organization (FSO) to increase referrals to community based services by providing education on the different provider types and services available to members.

IV.COMPLIANCE MONITORING

Medicaid Compliance Review Findings for Contract Year March 1st 2012 - February 28th 2013

This section of the report presents the results of the reviews by Mercer of Magellan of Louisiana's compliance with regulatory standards and contract requirements for contract year March 1st 2012 – February 28th 2013. Mercer conducted the compliance review in May 2013. The information is derived from IPRO's review of Mercer's compliance report.

Table 2: Sub Part C Enrollee Rights and Protections Results

Category	Regulation(s)	Addressed in Mercer Review	Compliant	Partially Compliant	Not Met	Not Addressed
Enrollee Right to Receive Information	438.100 (b) 438.10	X	X			
Mandatory Enrollment	438.6	X	X			
Available Treatment Options and Alternatives	438.100 (b)2(i) 438.10(f) 431.51 431.10(g)(3) 438.10(h) 438.106 438.108	X	X			
Staff and Affiliated Provider Compliance with Enrollee Rights	438.100(a)(1-2) 438.102	X	X			
Information on Emergency Maintenance and Post Stabilization Services	438.10 (f)(6) (viii-ix) 438.114 422.113©	X	X			
Information on Grievance System	438.10(f6)(iv) 438.10(g)	X		X		
Information on the Right to Participate in Decisions Regarding Care	438.100(b)(2-3) 438.100 ©	X	X			
Information on Provider /Enrollee Communication	438.100 (b)(2)(iv) 438.102)	X	X			
Information on Advance Directives	438.100(b)(2) (iv) 438.6 (1) 422.128 417.436(d)	X	X			
Information on Compliance with State and Federal Laws	438.100(d)	X	X			

Summary

Compliant Categories	9
Partially Compliant Categories	1
Not Met Categories	0
Not Addressed Categories	0

Magellan was found to be "partially compliant" with the following sub-regulations, based upon Mercer's comments and review of the sub regulations.

1. Member Information on Grievances : 438.10 (f) 6iv
2. Member Information on Appeals :438.10 (g)1
3. Member Information on Grievances Related to Advance Directives:438.10 (g)2

Mercer's review of member materials indicated that the term "complaint" in member materials suggested two levels of dissatisfaction, complaints as well as grievances. Mercer recommended that all expressions of dissatisfaction be addressed as grievances, without a separate process for complaints. In like manner, Mercer deemed that the term "complaint" was also inadequate when describing dissatisfaction with provider compliance with advance directives. Mercer recommended that the term "complaint" be changed to "grievance" in member materials.

Mercer also found that member materials imply, but not clearly indicate, whether enrollees must exhaust the Magellan appeal process before accessing the State Fair Hearing process. It was recommended that member and provider materials be updated to clarify whether enrollees must exhaust the Magellan appeal process before accessing the State Fair Hearing process.

Mercer recommended staff training on handling complaints as grievances, with no separate process for member complaints, and, assurance that staff understands the steps associated with the Magellan appeal /State Fair Hearing process.

Summary of Magellan Response to Sub Part C Elements Requiring Corrective Action Plans (CAPs)

The items primarily requiring corrective action include terminology in member materials surrounding grievances and appeals. Magellan's response to these deficiencies included an update of all member and provider materials to remove the term 'complaints,' modification of workflows, additional training, and updates to member and provider handbooks.

IPRO considers Magellan to be compliant with these regulations; the CAPs adequately address the compliance review findings.

Table 3: Sub Part D Quality Assessment and Performance Improvement Results

Condition	Regulation(s)	Addressed in Mercer Review	Compliant	Partially Compliant	Not Met	Not Addressed
Availability of Services, Furnishing of Services and Timely Access, Cultural Considerations	438.206 ©(1)(2)	X		X		
Assurance of Adequate Capacity of Services	438.207 (b), (c)	X		X		
Coordination and Continuity of Care	438.208 (a-c)	X			X	
Availability of Services: Coverage and authorization of services	438.210(b-d)	X			X	
Coverage and Authorization of Services-Emergency and Post Stabilization Services	438.114(c-f)	X	X			
Coverage and Authorization of Services-Clinical Practice Guidelines	438.236 (b-d)	X	X			
Provider Selection	438.214 (a-e) 438.12 (a-b)	X		X		
Confidentiality	438.224	X	X			
Enrollment and Disenrollment	438.226	X	X			
Grievance System	438.228	Reviewed in Sub Part F				
Sub-contractual Relationships and Delegation	438.230(a-b)	X		X		
QA/PI Program	438.240(a-e) 438.242 (a-b)	X			X	

Summary

Compliant Categories	4
Partially Compliant Categories	4
Not Met Categories	3
Not Addressed Categories	0

1. **Availability of Services, Furnishing of Services and Timely Access, and Cultural Considerations**

2. **Assurance of Adequate Capacity and Services**

Magellan was found to be "partially compliant" with the following sub-regulations:

a) Availability of Services, Furnishing of Services and Timely Access: 438.206(c)1
b) Availability of Services, Furnishing of Services and Cultural Considerations: 438.206 (c)2
c) Assurance of Adequate Capacity of Services: 438.207 (b), (c)

Gaps exist in provider availability for some specific services (Therapeutic Group Home, Therapeutic Foster Care, Residential Treatment Facility, and crisis stabilization. A request for proposal (RFP) was developed, as a step to expand these services. Low utilization of early and periodic screening, diagnosis, and treatment (EPSDT) services was observed.

Outreach to diverse communities to identify culturally competent providers has been conducted, and Magellan has established a Race and Equity Committee. At the time of the Mercer review, this committee had not met.

There is a clearly identified need to track service expansion and access to culturally competent services, including EPSDT services, to insure that utilization of medically necessary behavioral health services increases in underserved areas.

3. **Coordination and Continuity of Care**

Magellan was found to be "not compliant" with Regulation 438.208C (Additional Services for Enrollees with Special Health Care Needs). The onsite interviews and case management file reviews indicated that Coordinated System of Care (CSoC) members did not receive all medically necessary covered services. Social needs appear to be addressed, but behavioral health diagnoses of the children and the therapies needed were not documented as being addressed. Moreover, findings indicated that children in this program were being dismissed from services if CSoC eligibility requirements were not met. Regulations require that EPSDT services are to be provided regardless of CSoC eligibility and enrollment.

Furthermore, 1915(i) adults and other populations eligible for treatment planning did not receive case management outlined in the waiver and in the LBHP Services manual in compliance with these requirements. Ongoing monitoring is recommended to ensure that CSoC eligible members receive all medically necessary covered behavioral health services, and that plans of care address all assessed behavioral health needs. Non eligible CSoC members are entitled to have timely access to all medically necessary covered EPSDT services and 1915(i) adults and other populations requiring treatment planning receive case management services.

4. **Availability of Services: Coverage and Authorization of Services**

Magellan was found to be "not compliant" with the following sub-regulations:

a. Coverage and Authorization of Services: Plans of care that authorize and outline the amount, duration, and scope of behavioral health and Home and Community Based Services (HCBS) benefits and determinations if the assessed needs are addressed: 438.210 (a), (b)

b. Appeal Notifications Related to Coverage and Authorization of Services: 438.210(c)

The Mercer review found that plans of care for members in HCBS programs did not outline the amount, scope, duration of behavioral health and HCBS benefits that would address the goals and assessed needs of each individual. Issues were found with the authorization process, whereby each plan of care was not reviewed for completeness, whether or not assessed needs were addressed, or whether the outlined services were sufficient to meet the members' needs.

The review found that members are provided with formal appeal rights to appeal an action only if a provider makes a formal request for services. If a request for service is made directly from Magellan, or, if a member requests access to HCBS programs, but no action is taken, the member is not given a notice of action or given a right to appeal.

Care manager training was recommended to ensure knowledge of HCBS plan of care requirements. Training was also recommended to care managers, wrap around agencies, and customer service representatives on the right of members to appeal.

5. Coverage and Authorization of Services-Emergency and Post-stabilization services

Requirements for these regulations were found to be compliant.

6. Coverage and Authorization of Services-Clinical Practice Guidelines

Requirements for these regulations were found to be compliant.

7. Provider Selection

Magellan was found to be "partially compliant" with the following sub-regulation:

a. Provider Selection / Credentialing [438.214(b)2]

The review found that policies and procedures and Magellan's credentialing summary document did not indicate any evidence of requiring review of the provider qualifications for delivery of HCBS services, including 1915(i) services as specified in the LBHP Services manual. Also, most of the credentialing files contained one or more primary source verification items, but not all of the items. Inconsistent tracking and reporting on provider terminations was noted during the documentation review.

It was recommended that policies and procedures be developed and put into place to assure that providers are properly credentialed to deliver HCBS services. A more effective system of provider termination tracking and reporting should be developed.

8. Confidentiality

Requirements for this regulation were compliant.

9. Enrollment and Disenrollment

Requirements for the regulation were compliant.

10. Sub-contractual Relationships and Delegation

Magellan was found to be "partially compliant" with the following sub-regulation:

a. Sub-contractual Relationships and Delegation [438.230(b)2ii]

As mentioned in Provider Selection/Credentialing, Magellan's credentialing process should identify providers with necessary qualifications for HCBS services.

11. QA/PI Program

Magellan was found to be "partially compliant" with the following sub-regulation:

a. Basic Elements of Quality Assessment and Performance Improvement Programs [438.240(b)]

A comprehensive quality improvement program description and work plan were found to be in place. A committee structure is in place, with a "master" QA/PI committee overseeing a number of subcommittees. There was no evidence that two (2) of the sub committees have met. Also, the chief medical officer / designee has been consistently absent from the QA/PI committee. Coordination between the QA/PI committee and other committees was not clearly documented or evident.

Several performance measures documented within the Magellan Quality Work Plan had not been reviewed by the designated committee. Formal monitoring of under and over utilization of covered behavioral health services is not in place. It was noted also that significant progress has not been made with implementing the Medicaid program goals and CSoC goals, as laid out in the QI program description.

It was recommended that under and over utilization of covered behavioral health services be monitored. Notably, children in the HCBS programs need to be better monitored to ensure that they are receiving medically necessary services for assessed needs.

Direction should be given to the QA/PI committee, to ensure that the committee provides the oversight and coordination of activities across sub-committees. All identified performance measures need to be reviewed, tracked, trended and monitored by the assigned committee.

It was also noted that Magellan had not, at the time of the review, implemented the HCBS QA and reporting requirements.

Summary of Magellan Response to Sub Part D Elements Requiring Corrective Action Plans (CAPs)

The items primarily requiring corrective action include Geo Access issues regarding availability of covered services, coordination of care, plans of care, training regarding appeal rights, as well as QI reports and meetings. Magellan disputed items surrounding Geo Access availability and coordination of care, but addressed other findings by revising reporting, creating new trainings, and modifying QI reports and meetings.

IPRO considers Magellan to be compliant with these regulations, based upon CAP review. Based upon the information reviewed, the CAPs adequately address compliance review findings.

Table 4: Sub Part F Grievance System Results

Condition	Regulation(s)	Addressed in Mercer Review	Compliant	Partially Compliant	Not Met	Not Addressed
Statutory Basis and Definitions	438.400 438.402(a)	X		X		
General Requirements	438.402	X		X		
Notice of Action	438.404 (a-c) 438.10 431.211 431.213 431.214 438.210(d)	X		X		
Handling of Grievances and Appeals	438.406(a-b)	X	X			
Resolution and Notification: Grievances and Appeals, Expedited Resolution of Appeals	438.408 (a-e) 438.410 (a-c)	X		X		
Information About the Grievance System to Providers and Subcontractors Record Keeping and Reporting Requirements Effectuation of Reversed Appeal Resolutions Continuation of Benefits While Appeal and State Fair Hearing are Pending	438.414 438.10(g) 438.416 438.120 431.230 438.420 438.424	X		X		

Summary

Compliant Categories	1
Partially Compliant Categories	5
Not Met Categories	0
Not Addressed Categories	0

1. **Statutory Basis and Definitions**

Magellan was found to be "partially compliant" with the following sub-regulation:

a. Statutory Basis and Definitions : 438.400(b)

The dictionary section of the member handbook includes two separate definitions for "complaint" and "grievance/request for investigation", and is not consistent with Magellan policy. The member materials are misleading and suggest two categories for expressions of dissatisfaction.

All grievance-related policies, procedures and documents need to be made consistent with regard to definitions for complaints and grievances. All expressions of dissatisfaction are to be considered grievances.

2. **General Requirements**

Magellan was found to be "partially compliant" with the following sub-regulation:

a. General Requirements: 438.402 (2)

The member handbook distinguishes between the timeframe to resolve a complaint (30 days) and the timeframe to resolve a grievance (90 days). As noted previously, complaints are to be defined and handled as grievances and documentation should be consistent.

3. **Notice of Action (NOA)**

Magellan was found to be "partially compliant" with regulation 438.404, as follows:

It was not clear from the review that NOAs were being sent when a member, not a provider, requested a service or entrance onto the HCBS waiver but, clinically did not meet requirements. In these instances, an NOA should be sent to the individual and he or she should be afforded appeal rights.

4. **Handling of Grievances and Appeals**

Requirements for this regulation were considered compliant.

5. **Resolution and Notification: Grievances and Appeals , Expedited Resolution of Appeals**

The finding of the member handbook including a distinction that complaints are resolved within 30 days and that grievances are resolved in 90 days was addressed in the General requirements regulation 438.402(2).

6. **Information About the Grievance System to Providers and Subcontractors**
   Record Keeping and Reporting Requirements
   Effectuation of Reversed Appeal Resolutions
   Continuation of Benefits (While Appeal/Fair Hearing is Pending)

Magellan was found to be partially compliant with the following sub-regulation:

a. Continuation of Benefits While the Appeal and State Fair Hearing are Pending 438.420(b)

As discussed with regulation 438.404 (Notice of Action), it was not clear from the review that NOAs were being sent when a member, not a provider, requested a service or entrance onto the HCBS waiver but, clinically did not meet requirements. In these instances, an NOA should be sent to the individual and he or she should be afforded appeal rights. Therefore, Magellan was found in partial compliance with 438.420(b).

Grievance System File Review

A random sample of 48 files (17 grievance, 31 treatment appeal) was reviewed. Findings were considered partially compliant, generally relating to processes and timelines not consistently observed in file documentation.

Summary of Magellan Response to Sub Part F Elements Requiring Corrective Action Plans (CAPs)

The items primarily requiring corrective action include terminology in member materials surrounding grievances. Magellan's response to these deficiencies included an update of all member and provider materials to remove the term 'complaints' and modification of workflows.

IPRO considers Magellan to be compliant with these regulations; the CAPs adequately address the compliance review findings.

Care Management Record (CMR) Review

Mercer conducted CMRs as part of the compliance review. The sample included 20 child, 36 adult, and 30 denial (children and adults) records. Issues were found in the following areas:

- Medical necessity and quality of care oversight: Care managers were not necessarily aware of instances in which a higher level of care (LOC) was needed, than the LOC sought.
- Denials: Twenty five (25%) of the denial cases reviewed did not contain evidence that alternative services were offered.
- Treatment planning: Some of the complex cases in the sample (members with a dual mental health and substance use disorder diagnosis) did not contain case documentation identifying the members as eligible for enhanced treatment planning oversight.
- Home and community based services (HCBS) assurances:
    - LOC requirements: Clinical assessments are being used to identify the LOC delivered, but the results are not necessarily being used to determine eligibility. Adjusting eligibility levels would have placed more members (child cases were cited in the report) in a higher LOC.
    - Assessment independence: The majority of cases reviewed for HCBS assurances identified the evaluator/assessor as working for the same agency that delivered care.
    - Plan of Care (POC) Adequacy and Quality: POCs were found to be inadequate in a number of cases reviewed, with health and safety risks and POC goals often not addressed.
    - Service delivery: Lack of monitoring that POC services were delivered in order to ensure that identified needs of the member are met.
    - Form documentation: The BH142 form was often improperly documented (the documentation on the form did not match the LOC/LON determination.

IPRO notes that training, and enhanced supervision, are necessary to address these findings, focusing heavily on POC quality, POC accuracy, use of assessment tools, the need for follow up, and the need to manage care across benefit categories. If not already initiated, IPRO recommends that Magellan give consideration to developing a formal training program, or modify any existing programs, for care managers to address these critical areas. The training should include individualized, or one on one, components and should be conducted at the local (Louisiana) level, even if resources need to be obtained from the corporate office.

Summary of Magellan Response to CMR Review Elements Requiring Corrective Action Plans (CAPs)

The items primarily requiring corrective action include medical necessity and levels of care, alternative levels of care recommendations post-denial, enhanced treatment planning oversight requirements, documentation issues and reporting requirements. Magellan had several disputes with the corrective action plans in this category. Validating this category was challenging for IPRO as IPRO did not conduct the on—site review and many of the CAPs pertained to individual file reviews. However, Magellan did provide IPRO requested documentation in a timely manner, conducted additional trainings, and revised reporting.

It appears as though Magellan has addressed these findings; as is evidenced by CAP review.

Compliance with HCBS Requirements

The review cited Magellan as substantially out of compliance with HCBS requirements. As noted previously, CMR results indicated non-compliance issues with HCBS assurances. Magellan was also unable to provide sufficient evidence of complying with HCBS reporting requirements.

Training and enhanced supervision has been recommended to address the HCBS assurances concerns discussed in the previous section. Magellan needs to also insure that their reporting systems are enhanced to enable them to produce the required HCBS reports.

Summary of Magellan Response to HCBS Requirements Elements Requiring Corrective Action Plans (CAPs)

The items requiring corrective action in this category were reporting-related. Magellan addressed one item in this category by revising their reporting, but felt the other was too broad to measure.

IPRO notes that Magellan, in conjunction with the Office of Behavioral Health, has made considerable progress in implementing timely and accurate reports that fit HCBS specifications, and is considered compliant with these reporting requirements.

Certifications and Program Integrity [438.608(a-b)]

This regulation addresses safeguards, procedures and protocols to guard against fraud and abuse. The review indicated that a solid compliance plan is in place, and there are effective lines of communication within the organization to disseminate compliance issues to all necessary staff. Policies, procedures and standards of conduct address all federal and State requirements. Magellan's critical incident reporting process supports compliance policies. Requirements for these regulations were considered compliant.

Summary of Magellan Response to Financial and Reporting Elements Requiring Corrective Action Plans (CAPs)

The items requiring corrective action in this category were reporting-related. Magellan accepted the recommended reporting revisions and revised financial reports in completing the corrective action plan. Based upon the information obtained and reviewed, and the Office of Behavioral Health's comments pertaining to revised and enhanced reporting, IPRO considers Magellan to be compliant with financial and reporting requirements.

Prohibited Affiliations with Individuals Debarred by Federal Agencies [438.214 (d), 438.610 (a-d)]

This regulation insures that processes are in place to guard against knowingly entering into a relationship with an individual or an affiliate of an individual who is debarred, suspended or excluded by federal regulation from participating in federal procurement or non procurement activities. Mercer's review found Magellan "partially compliant" with this regulation, due to:

a) Large accruals on the balance sheet and income statement for certain claims payment issues, and a large ($1.1 million) cushion that needs resolution prior to the Medical Loss Ratio report
b) Administrative expense allocation methodology, resulting in large losses in certain categories while showing large profits on others
c) Non-completion of a Annual Disclosure Statement

Information Systems (IS) and Claims Processing

Mercer conducted an IS and claims processing review, which included a core systems overview, system testing procedures, ICD-10 planning, IT staff, claims department staff, and security. Data capturing systems (claims processing, enrollment, and provider) were reviewed as well. The review included an assessment of the plan's systems for data integration and reporting.

Findings (Magellan was found to be either partially compliant or not compliant):

a) IS Data Processing:
    - Clinical Advisor, Magellan's Electronic Health Record (EHR) software application, has limitations preventing it from being utilized by all State agencies and providers
b) Claims Processing:
    - Schools complete Individualized Education Plans (IEPs) for special education children requiring behavioral health services while in school. The IEPs are to be sent to Magellan, to indicate authorization for these services and then reconciled to claims. The authorization/reconciliation process is not yet complete and claims for these school based providers have not been received and processed.
    - For multiple reasons, there are claims pending resolution.
    - Processed claims are not always eligible for reportable auditing
    - Coordination of benefits; Magellan lacks processes to inform the State when other insurance information is discovered.
c) Ancillary Systems-Integration and Control of Data for Reporting:
    - Documented processes to validate completeness of data submissions were not provided.
d) Provider Data:

- Magellan had challenges implementing payments to residential providers; money needed to be advanced to providers due to payment delays. Therefore, the claims need to be fully reconciled to the advanced payments.

e) Encounter/Claims Data Submissions
   - Inpatient encounters total billed is based on all service lines even if the claim is priced using a diagnostic related grouper (DRG) or per diem methodology. Magellan needs to submit all service lines for institutional encounters to Molina, the State's fiscal intermediary.
   - Third party liability (TPL) amounts did not appear to be submitted on encounter data.

IPRO's review of these findings clearly indicate the need for Magellan to evaluate its IS systems, particularly processes to transmit encounter data, in an effort to maximize data completeness and accuracy. Enhancements need to be made to the Clinical Advisor system for maximum utilization by all State agencies.

Summary of Magellan Response to Information Systems Elements Requiring Corrective Action Plans (CAPs)

The items requiring corrective action in this category included Clinical Advisor reporting, claims issues, coordination of benefits, and other data element issues. Magellan revised reporting and developed training to address the areas of non-compliance found. IPRO's review indicates that the CAPs appear to adequately address compliance review findings.

V. STRENGTHS, OPPORTUNTIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by Magellan of Louisiana to Medicaid recipients based on data presented in the previous sections of this report. The plan's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

The State of Louisiana, Office of Behavioral Health (OBH), has worked closely with Magellan from a quality strategy standpoint, in documenting and reviewing CAPs, and in following up with Magellan for CAP updates and enhancements and monitoring CAPs progress.

Strengths

- Magellan appears responsive to feedback and was able to produce requested documents in a timely manner.
- Magellan was able to design responses to a large amount of CAPs in an adequate period of time, create appropriate trainings, revise reports, and modify workflows as needed.
- Magellan appears to have completed the bulk of corrective action plans in areas where partial-compliance or non-compliance was identified.
- Magellan appears to have used appropriate clinical judgment when utilizing audit tools in measures validated by IPRO.

Opportunities for Improvement

- Opportunities for improvement were identified during Mercer's compliance review and as a result of IPRO's CAP review and performance measure validation. These are:
  - Provider documentation reviewed by IPRO needs improvement in the area of treatment planning.

- Increased provider standards, such as requiring a separate treatment plan document instead of a continued stay review containing treatment goals.
- Access to providers continues to require focus
- Accurate performance measure reporting continues to require focus

Recommendations

- Continued ongoing audits in areas identified for improvement to ensure corrective actions have been sustained over time.
- Continued access improvement strategies. Magellan has initiated a provider access PIP, addressing member access to emergent, urgent and routine appointments. Results for critical appointments (emergent, urgent) were short of goal for the first project year.
- Training of providers to meet compliance standards – especially in the area of treatment planning documentation.
- Revise reporting of the POC measures calculated through use of the waiver audit tool, to ensure that these measures are reported accurately going forward.
- Annual compliance review to ensure new processes, workflows, reports, and trainings implemented are effective and remain effective over time.