Magellan in Louisiana – Louisiana Behavioral Health Partnership
Governance Board Minutes of August 21, 2013

PRESENT:

<table>
<thead>
<tr>
<th>Community Members of Governance Board:</th>
<th>Magellan Members of Governance Board:</th>
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<tr>
<td>H. T. “Ted” Cox, Juvenile Court/Shreveport, Community Member at Large</td>
<td>Dr. Craig Coenson, Board Chair, Chief Executive Officer, Magellan in Louisiana</td>
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<td>Judy Disotell, NAMI, Parent of Child/Youth Receiving Services</td>
<td>Kathleen Coenson, VP of System Transformation, Magellan in Louisiana</td>
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<td>Kimberlyne Roundtree, Primary Care Solutions, Inc., Adult and Child/Youth Service Provider</td>
<td>Neal Cohen, Chief Operating Officer, Magellan in Louisiana</td>
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<td>Lisa Schilling, South Central Louisiana Human Services Authority, LGE</td>
<td>Dr. Richard “Dick” Dalton, Chief Medical Officer, Magellan in Louisiana</td>
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Staff to Governance Board
Jill Dyason, Governance Board Lead, System Development Manager, Magellan in Louisiana
Lisa Faust, Chief of Staff, Magellan in Louisiana
Deborah Hernandez, Executive Assistant, Magellan in Louisiana

Governance Board Members Present via Conference Phone
Deborah Warren, Interim Quality Management Administrator, Magellan in Louisiana

ABSENT:
Joan Guillory-Williams – Board Co-Chair, Adult Service Recipient
Rick Wheat, Louisiana United Methodist Children and Family Services, Child/Youth Provider

Guests:
Anita Byrne, SSA Consultants
Michelle Kulpa, Magellan in Louisiana
Rebecca Bradley, LHA
Kevin Bridwell, LHA

IN SESSION:

This meeting was called to order at 12:00 pm
Board minutes submitted for July 17, 2013

Ted Cox moved that minutes be approved. Lisa Schilling seconded the motion. The Board unanimously approved the Minutes.

Board Announcements
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Developing Therapeutic Group Homes (TGH) Progress Update

Shannon Ost, Network Administrator, Magellan in Louisiana updated Board Members on Therapeutic Group Homes Progress. Ost shared that earlier that day a Provider Forum was conducted with TGH providers with open discussion and productive feedback regarding the transitioning from a Nonmedical Group Home (NMGH) into Therapeutic Group Home (TGH) services. Numerous questions/issues were discussed and good dialog took place.

Magellan is currently researching what other States are doing in regard to Therapeutic Group Homes. We are open to potentially implementing possible changes and looking to what an ideal model for TGHs in Louisiana will be. We will be seeking State, Medicaid and Health Standards feedback on the research and possible changes. Once received, we will begin working towards a proposal with a September 13 deadline.

Accreditation Discussion

Craig Coenson reintroduced the discussion of the accreditation process for Rural Hospitals providing additional information requested by Board Members. Coenson asked for approval from Board Members to have public comment directly following this discussion. Board Members agreed by consensus.

Lisa Faust introduced Michelle Kulpa, Network Management Administrator who has previous experience within the public sector and supports Magellan’s PRL staff, as well as works with numerous stakeholders on this issue. Faust reminded Board Members that information regarding the policy guiding the accrediting of Rural Hospitals that are defined by the Federal Government as Rural Hospitals was asked to be brought back for discussion.

Magellan’s policy (CR.1107.04-2013). (B)) states that if a provider is not accredited then we accept one of the following:

- a) **Magellan Site review**, the site visit includes processes for insuring that the organization credentials its practitioners. Policies and procedures, as well as a sample of practitioner credentialing files, are reviewed by the Magellan staff member conducting the site visit, per V. Evaluation Standards, H. Licensed Professional Staff, Other Direct Care Staff and Clinical Human Resources, below.

  Magellan site reviews may not be greater than one (1) year old when non-accredited organizational providers are reviewed for credentialing or re-credentialing.

- b) **Magellan may substitute a CMS or state licensing/certification review in lieu of the Magellan site visit.**

- c) **For organizations with multiple sites or for those adding a new site, a site visit to the primary organization address is sufficient, unless contractually required or required for accreditation.**

- d) **A site visit may be waived if all of the following conditions are met:**
  
  i. The provider is not accredited, **and**
  ii. The state or CMS has not conducted a site review of the provider, **and**
  iii. The **provider is in a rural area**, as defined by the U.S. Census Bureau

This policy also mirrors both the Bayou Health Plan policy and the policy for private insurers.

Lisa Schilling stated that the original question she had was where Magellan was in regards to the accreditation of all providers because this was what providers had to comply with to continue to be a provider with Magellan. She wanted confirmation that the Magellan policy stated is what providers had to abide by. Faust stated that the State requires that a community-based provider be accredited within 18 months of contracting with Magellan. For those
who did not have accreditation in place while they were contracted, Magellan performed a site visit or we took the State and/or CMS visit. As long as it was within one year of the credentialing period for that provider, this adheres to the policy. Therefore, when we speak about accreditation for our providers it is a moving target. As additional providers join the Magellan Network, we still have some providers not accredited. Those who have been in the network for a while are now being re-certified with the State. Barriers have been identified, such as financial cost of accreditation.

Kulpa stated that we currently have eleven (11) rural hospitals not accredited. When looking at access to Rural Hospitals, we have eighty-five (85) providers at eighty-two (82) locations that include seven (7) Rural Hospitals in that group not accredited. When looking at the Network without the seven (7) Rural Hospitals it would be seventy-eight (78) providers at seventy-five (75) locations.

The seven (7) Rural Hospitals of interest that do not have accreditation are:

- Abrom Kaplan Memorial Hospital covering Vermilion Parish
- Bunkie General Hospital covering Avoyelles Parish
- Acadia St Landry Hospital covering Acadia Parish
- Allen Parish Hospital covering Allen Parish
- Homer Memorial Hospitals covering Claiborne Parish
- South Cameron Memorial Hospital covering Calcasieu Parish
- Jackson Parish Hospital covering Jackson Parish

These Rural Hospitals are in a 30 – 60 mile radius of a member, which is a requirement. Magellan looked at how many more miles a member would need to travel with/without access to these Rural Hospitals.

Public comment was offered by Kevin Bridwell, Louisiana Hospital Association in regards to Rural Hospitals requiring accreditation. Bridwell updated Board Members on the historical background of the seven (7) hospitals noted. The Medicaid program does not require Rural Hospitals to be accredited and no Joint Commission Accreditation is required either. He explained that these hospitals are very small and in isolated areas and do provide a large quantity of outpatient services to the Medicaid population. He described that to take the bed count of Psych services away from these areas would be a disservice to the Medicaid population. Bridwell asked the Board to reconsider taking the rural hospitals out of the Network because they are not accredited.

Lisa Schilling stated again that the original question was where Magellan was in regard to the providers that were supposed to have accreditation. Michelle Kulpa is managing this and added that most providers are obtaining or in the process of obtaining accreditation. Magellan is reaching out to providers in this process, asking what the barriers are and assisting them to overcome them. Some providers were affected by Hurricane Sandy in that our office was closed down in New Jersey and was unable to close out their accreditation in the period needed. Kulpa’s team is not aware of any provider that is not re-certified at this point because of accreditation. Eighteen (18) months (September 2013) is the timeline for obtaining accreditation.

Kulpa will bring back to the Board the information of outstanding providers who are not accredited.

Kimberlye Roundtree mentioned that she knows of a provider who has their accreditation with CQL. She stated that this provider was unsure of how to proceed and wanted to know if their current accreditation could be accepted. She followed by indicating that she was unsure if they had begun a different process with another accreditation body. Kulpa stated that Magellan credentials providers every three (3) years and will look at the providers accreditation at the three (3) year mark whereas OBH certifies providers every year. In turn, OBH communicates the provider recertification to Magellan. From this point, Magellan takes action. Craig Coenson added that the difference is as a hospital there is a licensing that follows whereas as one of the CPST and PSR providers you go to certification from the accredited body.
Coenson stated that since there is provider accreditation history noted and Magellan states that the accreditation process occur within 18 months, there needs to be consistency in communication. Magellan will review the accreditation policy with the 18-month accreditation for non-hospital providers and bring information back to the Board.

**Rate Increase Proposal for Select Services Discussion/Consideration**

Lisa Faust presented the proposed rate increase for adult Medicaid select services that are tied around physician services – Psychiatrists, Medical Psychologists, APRN’s. Magellan is proposing rate increases across the board for specific CPT codes. They are basically, medication management services and adjustment. Magellan is attempting to meet a need that has been unmet which has been identified in compiled data. The LA CMC identified these two (2) key areas to ensure access to care and ensure stability among critical portions of the network. The rationale for these increases and adjustments include:

- Ensuring seamless access to care: Agencies report that medication management is often dropped from the service array because they have difficulty retaining physicians.
- Improving member experience: Of all the questions on the member survey, among the lowest rate of positive responses was around timely access to a psychiatrist.
- Securing critical provider community: Public sector clinics are struggling to meet revenue projections, due in part to reductions in the reimbursement schedule for medical management services, which makes up a bulk of clinic services for many.
- The increase will assist Magellan in protecting the capitation rate for adults by ensuring that appropriate dollars go directly to patient care.

**Recommendations are:**

**Medication Management (CPT Codes 99211-99214, 90863)**

Current Reimbursement rate = $12.73 - $64.57, $31.13
Recommended Reimbursement rate = $22.1 - $116.23, $56.03
Anticipated Impact = $1,500,000 - $2,000,000
Effective date – 3/01/13

**90844/90837 Adjustment**

Analysis was completed by Bruce Heck to better align new outpatient psychotherapy codes, as providers were taking advantage of the crosswalk to bill the higher reimbursement (90837). Anticipated impact = $3,000,000 (based on existing utilization pattern)
Effective date – 01/01/2014

Ted Cox asked how these rates compare to the juvenile rates. Coenson stated that rates for juveniles are not capitated rates. Magellan only provides administrative services so; those are direct State Medicaid dollars. Therefore, the State published Medicaid rates are the rates that are used. Magellan does not have the ability to renegotiate those rates. For the adults, they were prepaid and we have the ability to flux the rate as appropriate. This can also help subsidize the providers who provide services to both adults and children.

Coenson reminded that when Magellan makes these suggestions and once board approved that it does take time to operationalize these approved changes. He explained that part of the audit mentioned the RN. The RN was not part of the original service definition. Magellan understood that this was a service for reimbursement. Magellan is still working to operationalize this. Once the Board approves the rate changes, it does not mean that Magellan can begin the rate changes immediately, but will begin this process.
Coensen asked for a motion to approve the two proposed rate changes. Dick Dalton motioned to approve and Lisa Schilling seconded the motion.

**Quality Improvement Report**

Neal Cohen gave the Quality Improvement Report. He reported on two elements on the Quality Program, the performance guarantees and the components of the Quality Improvement Committee Meeting that was held last month.

**Performance Guarantees**

In regards to points considered in the Legislative audit, Magellan’s claims metrics are well below the threshold. Our customer service metrics has been strong since startup. Ambulatory follow-up continues to trend up and re-admissions continue to trend down. These were Magellan’s first year benchmarks. As the second year is a penalty year, we will continue to watch them closely.

The first year threshold for the provider and member (adult and youth) satisfaction survey was 75% and we achieved that target at 80%.

The only performance guarantee that is creating a challenge at this point for Magellan is the percentage of high utilizers who are engaged in an assertive community treatment program category. At this time, the percentage is at 27%, which is lower than where Magellan would like this to be. We will continue to study this population to determine the appropriate threshold goal. Members must agree to these services and many refuse high-end services. The majority of high utilizers are not in ACT, CPST for adults, NST for children and have refused services. This provides an opportunity for the peer support specialist to become involved and look at other ways to intervene with medical action plans. Cohen stated that we now have a formal process for an improvement project implemented to achieve services for these members.

Cohen gave an overview of the QI Committee July meeting where sub-committees reports are given. He explained that the meeting is held on a monthly basis and that Dr. Dalton is the Chairman.

The Interagency Monitoring Team (IMT) reported that we are on track with contract deliverables.

The Member Service Committee reported that their metrics are strong.

The Regional Credentialing Committee did not report since they did not meet, but will report in August.

The Network Strategy Committee reported that they are in the transitioning phase of the non-medical group homes.

The Race and Equity Committee reported that they are conducting a survey by outreaching to community providers on their cultural awareness. At this time, there are no results yet reported.

The Family/Member/Stakeholder Advisory Committee reported that they have not met in several months. The committee is being re-tooled and has been challenged. There has been activity with the Recovery and Resiliency program that includes that the Warmline RFP responses have come in and the Seed Grant opportunities have gone out.

Cohen gave an update on complaints/grievances and appeals for the month of June. There were 162 appeals, 83 provider dispute reviews, 117 adverse incidents, and 33 quality of care service issues.
Community Reinvestments Discussion

Craig Coenson opened the Community Reinvestments discussion up for the Board. He explained that these dollars will be available to use for reinvestment in the community. As a Board, this is an opportunity for suggestions and ideas on how to reinvest in the community while assuring that these dollars be used for initiatives that support meeting our deliverables and increase access to care.

He continued by sharing that Magellan has asked for clarification from the State on whether these dollars would need to be applied to the adult Medicaid population, i.e. use group home seed money to apply to the community investment or since we are capitated with the adults, are we able to apply this to the Medicaid Adult population.

In discussing this with the State and Magellan Legal Department reviewed, we can possibly apply the dollars to initiatives that the whole community can benefit from – the uninsured, children/adults, but possibly allocate 40% to each service group.

Lisa Faust stated research was conducted with other Magellan CMC’s regarding their handling of reinvestment dollars. In reality, all CMC’s are different based on the contract with their state or public entities (require a set amount of dollars or percentage amount). Our reinvestment dollar amount is not set and will fluctuate from year to year. When Magellan has available dollars, we want a process in place to direct the reinvestment in the community. Faust asked Board Members to think of ideas to model making these community reinvestment decisions.

Discussion was held among the Magellan Governance Board Members with the suggestions below.

- Lisa Schilling suggested a survey be administered to her community on what programs are in need of assistance to best serve the Behavioral Health Medicaid population.
- Adult transitional housing was suggested by Lisa Faust due to the fact that very little is offered in Louisiana.
- Assistance towards training providers to provide evidence-based practice for adults was suggested by Kimberlyne Roundtree.
- Family Focused Therapy was suggested by Dick Dalton.

Lisa Schilling asked if the budgeted dollars for reinvestment will be spread out over the 10 Regions or if it would go mostly towards a pilot program.

Craig Coenson stated that the reinvestment process will need to be thoroughly thought out and that we will bring this as a follow-up agenda item at a future meeting.

Independent Assessment

Lisa Faust provided the Governance Board with some background on the Independent Assessment process. When the State developed the 1915i State Plan Amendment for Adults, it stated that “When adults meet a certain level of care or need (basically severe mental illness) that they have access to an array of home and community services with the goal of keeping those adults out of institutions”. Therefore, that State Plan Amendment has been part of Magellan’s and the Partnership’s plan since start up. There is language in the State Plan Amendment that is very detailed and specific, which is referred to as “Conflict Free Assessment”. This means that when a person is identified as potentially meeting the clinical standard for having 1915i services they must be assessed and have a treatment plan developed independently from the people who will provide the services.

Early on when Magellan became the SMO, State Management Organization there was concern about this having a very difficult impact for members. There was no infrastructure in place. Magellan worked with the State to place a temporary fix to allow, with some restrictions, the providers providing the service to collect the information for the assessment and then Magellan would have people who were independent from Magellan staff review the assessment and identify the person as clinically eligible to ensure proper levels of care.
Faust explained that now that the infrastructure is in place and in understanding the Conflict Free Assessment that this assures that our members are not pressured and have choice in decisions and that the provider giving services is not approving the assessment to benefit payment to themselves. She explained that Magellan needs to adopt the State Plan Amendment language given and operationalize it fully now. This will be a massive transformation of how the State operates at this time.

Currently, if a provider and/or agency is providing the assessments/treatment plans and providing the services, the provider will need to make a choice of which he wants to provide, as they cannot do both functions.

Within the State Plan Amendment, there is no mention of the acceptance of a firewall and OBH has made the statement that a firewall within an agency providing both services will not suffice. Lisa Faust stated that if OBH changes this decision, it would then need to be approved by Medicaid and CMS as well.

Neal Cohen updated the Board on Magellan’s progress in the developing of the RFI to allow for the Conflict Free Assessment and in providing case management with ongoing changes to the Plan of Care separate from the individual providing care. Details to reimbursement rates and coding are currently being developed for the services. He stated that once all of the details for the RFI are finalized, it will then be submitted to the State.

Craig Coenson stated that CMS audits Magellan on these waivers. This is a waiver that Magellan is currently operationalizing. He pointed out that the reality is that these waivers are written on a policy standpoint. Our strategy and focus is to be compliant and receive CMS and State feedback on what is working well and what is not and then possibly make modification suggestions to the waiver going forward.

Lisa Schilling suggested that we keep this as a standing agenda item for ongoing discussion.

The RFI will provide some level of detail to any interested person who can then contact Magellan with any questions.

Some suggestions for an RFI announcement included:

- Newsletter
- E-mail Blast
- Educational Forum
- Provider Calls
- Message Center

Lisa Schilling also suggested the possibility of forming a small work group to work on the announcement to providers. It was discussed that sub-committee members could be Lisa Faust, Lisa Schilling, Kimberlyne Roundtree, Joan Guillory-Williams, and Judy Disotell if this process is implemented.

CEO MESSAGE TO THE BOARD

Craig Coenson, Board Chair, Chief Executive Officer, Magellan in Louisiana gave several updates to the Board.

Coenson discussed the recent media coverage that pertained to the Legislative Audit and pointed out that the audit was for 1500–1700 providers across Louisiana. The biggest challenge was the performance guarantees that are reported each month that are tied to sanctions. Also reported on was Clinical Advisor (CA) Meaningful Use, which is not part of the original contract, which the auditor noted. The CA Meaningful Use is a separate Amendment, which we are presently working with DHH on. Magellan has paid out more than $300 million in Medicaid claims alone since March 1, 2012. Since July 1, 2013, Magellan has paid out more than $10 million in claims submitted through Clinical Advisor, averaging more than $1 million per week.
Board Members discussed the Legislative Audit. Lisa Schilling shared that her agency and three (3) other LGE providers participated in the audit. After their annual audit, they were given a three-page document to complete and submit to the auditors.

Magellan’s biggest concern was the media and taking issues out of context. Magellan will let this play out and respond as appropriate.

Lisa Faust gave an overview of the audit findings. She provided substantive talking points for use out in the community regarding statistics and overall helpful information. She then summarized the specific items in the audit. She elaborated that items are not addressed between the districts and the Office of Behavioral Health. She pointed out that some focus was around claim payments and contract deliverables and provided additional information on key areas.

- **18-21 Year Olds**
  - Financed by Federal Block Grant money to assure care in adult facilities
  - Contracted with one (1) provider for 18-21 year olds – New Day Recovery in Monroe
- **Claim payments have been problematic**
  - Magellan’s timely payment rate on clean claims meets contract requirements and clean adult claims have a 72 hour turn around
  - Magellan works consistently with all providers through the transition and provides significant technical assistance to public sector providers with dedicated billing calls and site visits
  - Magellan is assisting providers to rectify remaining denied claims
- **Changes in claims billing, fee schedules, coding issues, and numerous district/authority claims have been rejected and denied. The districts/authorities may not be able to collect for these services because they have been unable to file or correct the claims prior to the billing expiration dates.**
  - Magellan lifted timely filing edit deadlines for these specific providers. We recognize this transition has been difficult and want to ensure they can collect on any monies owed and have worked through any outstanding claim issues that were due to items not having authorizations in place or not having appropriate eligibility for services provided.
- **Required provider agreements significantly changed which district/authority services are billed, who can provide billable services, and how claims are filed.**
  - Absolutely true. Magellan will continue to work with the district and authorities to assist them in shaping their business models to align with the LBHP, which improves member outcomes.
- **Certain requirements not met regarding implementation planning – documentation of attendee lists at trainings and a communication/outreach plan.**
  - Since the implementation phase, OBH/Magellan have had significant turnover and not all documentation could be retrieved. The communication/outreach plan was done and tracked by both Magellan and OBH and can be produced.

- **Significant technical requirements were not met for the electronic health records system. Specifically, the Meaningful Use and LaHIE connectivity requirements, as well as, private pay and third-party billing functionality.**
  - Outlines in the original contract contingent on being “accomplished under a separate contract and for a fee which is reasonable, customary and consistent with current market rates.” While Magellan is required to produce these items, we must agree with the State on a separate contract and acceptable fee. This contract is currently being worked on between OBH and Magellan.

Ted Cox stated that after the media statement, he was contacted by a constituent saying that the bottom line was that the Magellan contract was supposed to save the State money. He asked how the dollars compared to what the State was paying out before Magellan was contracted. Coenson stated that we have 270,000 adults that are capitated that produces an instant savings to the State - $24 million in savings. Magellan also pays $15 million to the Department of Insurance to protect and assure provider payments in the event that the contract is ever eliminated. We also pay a
premium tax - 2.5% and an administrative rate of 7% to adjudicated claims. Therefore, the majority of the Magellan contract is 85% MOR.

Coenson mentioned that several providers have reached out to him expressing a desire to speak on Magellan's behalf on many occasions and in regard to the Legislative Audit.

Coenson updated the Board on Magellan staff changes. He informed that Magellan has hired a Chief Medical Administrator, Jodie Holloway who will start on September 16, 2013.

Seth Kunen is transitioning out of the Quality Administrator position to fill the role of a Psychologist Reviewer to review cases and perform Psych testing. We are actively looking for a Quality Administrator. Deborah Warren, VP Quality Administrator for Corporate Magellan will serve as Interim Quality Administrator for Magellan in Louisiana until this position is filled.

Bill Phipps, CM/UM Administrator will be transferring to the Virginia account that we are now implementing for Magellan and will serve as the General Manager.

Magellan is now implementing accounts in New Mexico, Virginia, and Nebraska. We are expanding our Complete Care services in Florida as well.

Coenson stated that Amendment # 7 has been approved for Public Supportive Housing (PSH). Magellan is in week seven (7) of implementing the PSH program and progressing very well. He informed the Board that we would bring more details as developing.

Another update to the Board included some information on the court order to manage the Chisholm Children – Applied Behavioral Analysis benefit (ABA Autism). Magellan is now working on an Amendment with the State to manage that benefit for the Chisholm Children of Louisiana.

### NEW BUSINESS

- None

### PUBLIC COMMENT

- None

### NEXT MEETING

The next meeting of the Governance Board is Wednesday, September 18, 2013.

### ADJOURN

Lisa Schilling moved to adjourn. Kathy Coenson seconded the motion. The Board voted unanimously to adjourn.

The meeting adjourned at 2:00 pm.