DEPARTMENT OF HEALTH AND HOSPITALS
FOLLOW-UP ON TRANSITION TO THE LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP AS EXPERIENCED BY FIVE HUMAN SERVICES DISTRICTS/AUTHORITIES
STATE OF LOUISIANA

INFORMATIONAL AUDIT
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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

September 24, 2014

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley
Speaker of the House of Representatives

Dear Senator Alario and Representative Kleckley:

We performed a follow-up to our August 14, 2013 informational audit of the transition issues for the Louisiana Behavioral Health Partnership at the Department of Health and Hospitals-Office of Behavioral Health. The scope of our audit was significantly less than an examination conducted in accordance with *Government Auditing Standards*.

The accompanying report provides information relating to the implementation and transition issues experienced by five human services districts/authorities: Capital Area Human Services District, South Central Louisiana Human Services Authority, Metropolitan Human Services District, Florida Parishes Human Services Authority, and Acadiana Human Services District. Our results, recommendations, and management's response are also included. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the Office of Behavioral Health, Capital Area Human Services District, South Central Louisiana Human Services Authority, Metropolitan Human Services District, Florida Parishes Human Services Authority, and Acadiana Human Services District for their assistance.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

DHH-LBHP 2014

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Department of Health and Hospitals - Follow-up on Transition to the Louisiana Behavioral Health Partnership as Experienced by Five Human Services Districts/Authorities

September 2014

Audit Control # 80140152

Introduction

In March 2012, the Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH) launched the LBHP using a private contractor, Magellan Health Services, as the manager of state behavioral health programs. When Magellan began providing behavioral health management, service providers of state behavioral health programs were required to enroll as a Magellan provider and meet Magellan provider requirements.

Our follow-up includes observations from five districts/authorities. These entities include Capital Area Human Services District (Capital Area) based in Baton Rouge, South Central Louisiana Human Services Authority (South Central) based in Houma, Metropolitan Human Services District (Metropolitan) based in New Orleans, Florida Parishes Human Services Authority (Florida Parishes) based in Hammond, and Acadiana Area Human Services District (Acadiana) based in Lafayette, which was not included in the prior report. For simplification in this report, we will refer to all of the districts and authorities as districts. The districts considered in this report are part of the provider network utilized by LBHP.

This report is a follow-up to our informational audit issued in August 2013 on the experience of four human services districts/authorities during the implementation and transition of the Louisiana Behavioral Health Partnership (LBHP). This report includes one additional district not included in the prior report.

We did not audit the LBHP or its full implementation. We focused only on the experience of the human services districts. The districts are a unique group of providers with substantial challenges and changes that other providers may not have experienced in the implementation of the LBHP. We also did not audit the state managing organization, Magellan. The focus of our audit was the human services districts and the DHH-OBH.

Our objectives were as follows:

1. How did DHH-OBH/Magellan changes and transition issues impact the human services districts?
2. Did DHH implement adequate fiscal controls to ensure that human services districts were paid accurately and timely for services provided?
3. Did DHH implement its corrective action plan from our prior audit for contract monitoring and compliance?

RESULTS

Although some transition issues identified in our 2013 report have been fully or mostly resolved, some districts continue to struggle with the challenges of meeting Magellan requirements, maximizing self-generated revenue, and delivering the services needed for their clientele.

DHH Fiscal continues to have inadequate processes and controls to ensure claims payments are identified, reconciled, and properly classified timely in the state's accounting system for the districts to access funds paid by Magellan for their services. As a result, the districts' access to these funds continues to be limited, which could potentially impair their ability to deliver future services.

While progress has been made for some contract requirements, DHH-OBH still has contract requirements that are not being met.

Appendix A contains DHH's response to this report and Appendix B provides our scope and methodology.

Observations From the 2013 Report

With the implementation of the Louisiana Behavioral Health Partnership (LBHP), we noted changes in the way the districts delivered services and how they were funded, with a greater reliance on fee-for-service billing. Our initial 2013 report focused on the experience of four districts during the transition as represented by district management. We reported on three objectives in the 2013 (prior audit) report:

Objective 1 - How did the DHH-OBH/Magellan changes and transition issues impact the human services districts?

In our prior audit, districts' management reported being impacted by the OBH/Magellan transition in several ways including:

- a possible gap in service for an at-risk population;
- claims payments that were difficult to reconcile with services delivered and claims filed;
- problems with using the required electronic health records system, Clinical Advisor;
- overly optimistic self-generated revenue budgets that were not being achieved; and
- significant changes in the billing process.

Objective 2 - Did DHH implement adequate fiscal controls to ensure that the human services districts were paid accurately and timely for services provided?

DHH Fiscal did not have adequate processes and controls to ensure that claims payments were identified, reconciled, and properly classified timely in the state's accounting system so that the districts could access funds paid by Magellan for their services. As a result, the districts did not have access to funds, which could potentially limit their ability to deliver future services.

Objective 3 - Did DHH-OBH adequately monitor the Magellan contract to ensure that contract requirements were met?

DHH did not maintain implementation records as required by the contract and did not adequately monitor the Magellan contract, particularly for some technical requirements, including:

- meaningful use requirements;
- interface with the Louisiana Health Information Exchange (LAHIE);
- third-party billing functionality; and
- block grant reporting.

Objective 1: How did DHH-OBH/Magellan changes and transition issues impact the human services districts?

In our prior audit report, we recommended that DHH-OBH and Magellan work closely with the districts to address the continuing transition issues and identify mutually beneficial solutions. Below, we will compare and contrast what we found in our prior and current audits.

GAP IN COVERAGE FOR AT-RISK POPULATION

Prior Year Results

At the implementation of the LBHP, there were no juvenile residential treatment facilities in the state that were licensed to treat Medicaid eligible substance abuse patients ages 18 to under 21, creating a possible gap in service for this at-risk population. The districts reported confusion and contradictory guidance on how to provide services to this population.

Current Year Results

As of November 2013, all four previous districts tested, and Acadiana, reported providing residential substance abuse treatment to the ages 18 to under 21 population, whether by direct care or through a contractor. Most of these services are paid for with federal block grant funds and are not generating the fee for service revenue for the districts as originally anticipated. However, if Medicaid could be billed for these services, the federal block grant funds could be used for services to other non-Medicaid eligible individuals.

During our follow-up for this issue, OBH noted there is now one facility, located in Monroe, that can provide residential substance abuse services to the ages 18 to under 21 population in compliance with Medicaid reimbursement guidelines. The facility has served 13 individuals over a 12-month period. However, Medicaid will only pay for treatment, not room and board. OBH is currently working with one district to establish a contract where the districts would pay for the room and board through state funding, while billing allowable treatment services to Medicaid.

CHANGES TO CLAIMS AND PAYMENT PROCESSES

In the prior report, the districts noted several issues with the new claims payments processes including additional administrative expense, numerous rejected or denied claims, confusing patient eligibility, and a lack of understanding of the Magellan reports.

Expired Claims - Medicaid

Prior Year Results

In our prior report, we noted that changes in claims billing, fee schedules, and coding issues led to numerous denied claims. We further noted that because of difficulties in correcting and refiling claims, the districts may not be able to collect for delivered services because they are unable to recycle claims prior to the billing expiration dates.

Current Year Results

During our current year review, in an effort to assist in the recycling of older claims, Magellan lifted the timely filing system edit in the claims payment process, allowing the districts to file or refile claims where the dates of service were beyond one year. However, payment of these older claims may violate Medicaid regulations.

When asked for documentation for the state approval to lift the timely filing edit, DHH-OBH noted there was no support related to the request or approval because the majority of the decision-making and discussion on this issue took place in meetings. DHH-OBH noted that the lifting of the timely filing system edit was requested by Magellan and approved by the state because of system issues that were the result of internal administrative processes inhibiting timely transmission of claims.

The timely filing requirement is a federal regulation that states the Medicaid agency must require providers to submit all claims no later than 12 months from the date of service. Louisiana Medicaid policy states that if a claim is originally filed on time and denied, the provider can correct and refile the claim within two years from the date of service. For a claim to be paid with a date of service greater than these additional two years, only a few specific exceptions apply. One applicable reason is that the error causing denial of payment was the state's fault, not the provider's, each time the claim was submitted.

Four districts noted that they were in the process of recycling all Medicaid claims since March 1, 2012, that had been unfiled or previously denied. However, based on Louisiana Medicaid policy as noted above, there are no guidelines for the payment of claims beyond 12 months from the date of service for claims that have never been filed; only those filed on time, but denied.

We will continue to follow this issue as part of our fiscal year 2014 DHH audit of Medicaid to determine if the period of availability compliance requirement has been violated by lifting the timely filing requirement for these Magellan claims.

Expired Claims - Third Party

Prior Year Results

At implementation of the LBHP, Magellan's electronic health records system, Clinical Advisor, was not designed to accommodate private payers or third-party payers, including Medicare, private insurance, and other guarantors.

Current Year Results

While Metropolitan and Capital Area have been billing third-party claims by using tools other than Clinical Advisor, the other three districts have not. South Central noted that approximately $600,000 in private insurance, Medicare, and other guarantors claims have exceeded the expiration billing date as of June 30, 2013, and are now uncollectable. Acadiana noted, as of April 2014, $218,000 in Medicare claims are greater than one year old and $63,000 in private insurance claims are greater than one year old. Florida Parishes noted approximately $200,000 in accounts receivable for Medicare and commercial insurance with dates of service over one

year old. Since these are all beyond claims expiration dates, it is unlikely that any of these claims totaling over $1 million will be collected.

Eligibility

Prior Year Results

In the prior report, district management noted difficulty with determining eligibility for a new population of patients created by the LBHP, the 1915(i) waiver recipients. The 1915(i) state plan option provides coverage under the Medicaid State Plan for behavioral health services rendered to adults with behavioral health disorders. The targeted population is the severely and persistently mentally ill. The districts also noted that the Medicaid eligibility population used by Magellan was different from the eligibility population for DHH Medicaid, resulting in confusion and rejected claims. They further noted that some proper and accurate claims received errors because of conflicting information between the claim data and the Magellan system.

Current Year Results

In our follow-up, four districts continue to experience a decrease in productivity because of difficulty in determining eligibility. Although the districts indicated improved processing time for eligibility determinations, Florida Parishes, Capital Area, and Acadiana indicated the process takes from three weeks to two months to receive an approval or denial of eligibility for 1915(i) recipients.

According to DHH-OBH, for Medicaid eligible recipients, the "active plan" listed in Clinical Advisor would indicate if an individual was excluded, so determining if an individual is excluded from the partnership should no longer be an issue. However, district management noted that DHH-OBH has not provided any formal protocol to them for distinguishing populations that are excluded. They are required to contact Magellan for each excluded individual to secure non-Medicaid funding for that individual.

One district still reported differences in recipient information on the Magellan provider website, Clinical Advisor, and the Louisiana Medicaid provider website, causing eligibility determination delays and/or denied claims. Some examples of potential differences include, but are not limited to, use of a maiden name versus a married name, use of middle initial in one system and not the other, and use of a nickname versus a legal name.

Metropolitan does not provide services that require 1915(i) eligibility determinations. All 1915(i) services that require utilization of the 1915(i) waiver are being performed by contractors. Metropolitan stated that it has developed an internal process to distinguish LBHP excluded populations and trained staff and contractors to resolve this issue.

New Eligibility Issue

To better meet Centers for Medicare and Medicaid Services (CMS) regulations, the client independent assessment process is changing. CMS requires assessments to be conducted by an independent entity that will not provide the 1915(i) service. Previously, some districts had provided the assessments through a separate set of staff professionals who do not provide the

services after assessment. These assessments are billable services for the districts. Now, Magellan has partnered with Pathways Community Health to implement a statewide network of independent assessors.

The employment of a single statewide provider to serve as independent assessor has created concern for four of the five districts included in our report. In addition to the loss of a billable service, there is a potential risk that the client will not be willing or able to go to an alternate location to complete an independent assessment prior to receiving services from the district. This additional step and extension of time prior to treatment for an at-risk population could increase the burden of seeking treatment or deter them from treatment altogether.

Reconciliation of Magellan Payments

Prior Year Results

At implementation, the districts did not understand the Magellan reports and the explanation of payments (EOP) and noted discrepancies between claims payment reports and the EOP. The lack of understanding on how to interpret Magellan's documentation and payment processes had contributed to the districts having difficulty reconciling payments received to patient records, bank deposits, and accounts receivable.

Current Year Results

In the current review, the districts noted improvements in Magellan claims reconciliations, but recoupments of prior claims payments continue to cause difficulties for all districts in reconciling patient accounts. In addition, the districts do not have access to all bank detail needed to fully reconcile payments made using electronic funds transfer. As part of our review of the reconciliation issues, we obtained examples of explanations of payments and deductions and noted that there were recoupments from one district for claims paid to other districts. Upon request for information, DHH-OBH, in conjunction with Magellan, determined that this is a result of multiple entities sharing a single federal tax ID number. In response to our inquiry, OBH indicated that Magellan identified 1,519 claims that were recouped from wrong districts for a total of $39,363 in inappropriate recoupments.

Initially, DHH indicated corrections for recoupments were to be made by the end of April 2014. On May 20, 2014, DHH Fiscal indicated that the corrections were completed May 15, 2014.

REQUIRED USE OF CLINICAL ADVISOR

Prior Year Results

In the prior report, we noted three districts forfeited funds for canceling existing contracts for an electronic health record (EHR) system after they were required to use Clinical Advisor. Metropolitan had already purchased and implemented another EHR. Metropolitan implemented its own electronic health records system prior to OBH's requirement to use Clinical Advisor, which it uses in billing all third-party claims. Metropolitan used Clinical Advisor to file Magellan claims only. Acadiana did not report this issue as it became a new district on July 1,

2013, and had not yet invested in another EHR system prior to the OBH requirement to use Clinical Advisor.

In addition, issues with Clinical Advisor included a lack of successful training for the use of Clinical Advisor, inability to bill third-party claims, and confusion in required claims coding.

Current Year Results

Required Use of Clinical Advisor

In the current year review, Metropolitan and Capital Area noted that using dual entry between two systems to log health records and bill for claims is more effective than using Clinical Advisor.

Metropolitan enters all patient records into Clinical Advisor and bills all Magellan claims through Clinical Advisor, but all other claims are billed using their other EHR system. They estimate the cost of double entry is approximately the cost of one full-time employee; $42,000 including salary and benefits.

Capital Area responded to the inability to bill Medicare and commercial insurance claims through Clinical Advisor by opening an account with an online practice management system at a cost of approximately $60 per month. The extra cost of dual entry between this system and Clinical Advisor was approximately $15,000 between March 2013 and April 2014.

Currently, with agreement from DHH-OBH, Capital Area and Metropolitan each purchased EHRs to be used for all claims, Magellan and non-Magellan, and are eliminating dual entry. Capital Area noted costs of approximately $130,000 annually for its new EHR that includes licensing, e-prescribing, user licenses, and processing approximately 3,500 claims filed per month. Capital Area began using the new system in December 2013.

Metropolitan noted that in May 2014 the district moved to using its EHR exclusively. Metropolitan noted that the cost of converting its software to a fully compliant EHR was $84,000 and will be funded with self-generated revenue. An additional monthly fee will be charged per concurrent user, averaging $7,500 per month.

Third-Party Rates in Clinical Advisor

In our prior report, we were told that the capability to bill third-party payers had been added to Clinical Advisor, but the Magellan rates were still the default within Clinical Advisor, making it impossible to bill third parties. As noted above, Metropolitan and Capital Area are using other resources to bill third-party claims. However, the other three districts are relying on Clinical Advisor and are still not able to bill third-party claims.

The districts noted that Clinical Advisor is still incapable of adapting the system rate tables to the providers' needs for third-party payers and Medicare. Magellan has addressed the issue of Magellan rates being the default rates by setting rates for Medicare, third-party payers, and private pay patients at 180% of Magellan Medicaid rates. However, rates in the system rate

tables cannot be changed by the districts. The districts that currently use Clinical Advisor were strongly encouraged to all agree to use 180% of the Medicaid rates as their third-party rate amounts, which they did despite the fact that some of their private insurance contract rates may exceed the system rates. In addition, private payers often pay on a sliding scale, which cannot be accommodated in Clinical Advisor.

Providers were also required to contract with a clearinghouse to bill third parties. Gateway EDI, a clearinghouse preferred by Magellan, was introduced to the districts in early 2013, providing an electronic data interchange between Clinical Advisor and third-party payers at no additional cost.

Subsequently, DHH-OBH required the districts to apply for their own federal tax ID numbers to facilitate revenue classification with a deadline of November 15, 2013. The overlapping timeline for establishing a relationship with Gateway EDI, re-establishing contracts with third-party payers in some cases, and applying and receiving a new federal tax ID was problematic for some districts. Even in cases where the paper work was submitted to Gateway and Magellan on time, no district was able to bill third parties within Clinical Advisor until February 2014. Also, Magellan has advised as of April 2014, that the districts should cease billing for claims under the new federal tax ID for dates of service after November 15, 2013, until further notice while additional issues are adequately addressed. Acadiana received notice in June 2014 that it could proceed with finalizing its Gateway EDI agreements under the new federal tax ID and begin billing when the agreements are complete. As of August 4, 2014, the district is awaiting final agreements to resume billing.

Clinical Advisor Training

The prior report noted that the lack of successful training required the districts to spend additional hours correcting errors.

During our current review, the districts did note that training had increased after the release of our prior report. Although training increased, the quality of the training continues to be a concern for some of the districts. Florida Parishes noted that the training offered has not always been effective because of system “fixes” that are needed, and the information provided seems limited and inconsistent.

South Central noted that it had received training from Magellan on episodes of care. An episode of care is the collection of care provided to treat a particular condition for a given length of time. South Central noted this training was not meaningful because OBH staff did not take part and were needed to answer questions on the Episode of Care Form that Magellan staff could not answer. Florida Parishes indicated that it had also received training from Magellan on episodes of care, but the staff came away from the training unsatisfied and frustrated, noting Clinical Advisor is still cumbersome and confusing for them.

In March 2014, while interviewing some of the districts, we were informed that Magellan had recently contacted them to inquire whether they were interested in scheduling additional training with the course topics to be selected by the districts. Some of this training was scheduled to take

place in late April and early May. On April 30 and May 1, Magellan held training to assist the districts with Clinical Advisor reconciliation. Each district that participated was provided with individual reports to assist with their reconciliations.

Coding in Clinical Advisor

In our prior report, according to district management, Clinical Advisor was not properly programmed to accommodate the use of diagnosis codes, procedure codes, and coding descriptions as required by the districts and their provider agreements with Magellan.

In the current audit, the districts noted that many of the Clinical Advisor coding issues have been resolved, but some applicable diagnosis codes are still omitted from Clinical Advisor. In addition, several instances were noted where districts were not able to modify the diagnosis when the district was the secondary provider.

OVERLY OPTIMISTIC SELF-GENERATED REVENUE BUDGETS

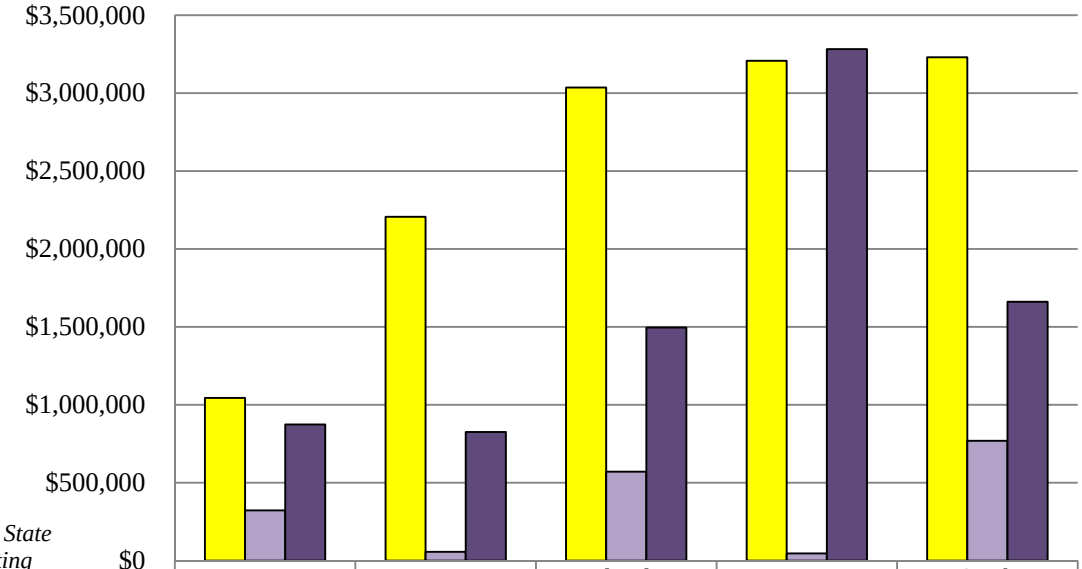
Prior Year Results

In the prior report, the estimate of self-generated revenue used in the budgets for the districts was overly optimistic and was not being achieved by the districts, which has essentially resulted in a budget cut.

Current Year Results

At June 30, 2014, we obtained self-generated revenue amounts for the fiscal year. As shown in Exhibit 1 on the following page, the collection at June 30, 2014, is $8,137,747 against a budget of $12,725,288. Differences between the budget and actual revenues collected are related to the overestimation of the Magellan revenue collections, inability to collect billable services performed in a timely manner, and untimely or incorrect classification of revenue by DHH Fiscal (see Objective 2).

Exhibit 1
FY14 Budget Compared to Classified Self-Generated Revenues



Source: State Accounting System (ISIS)

	Metropolitan	Acadiana	Florida Parishes	Capital Area	South Central
FY 14 Budgeted	$1,044,243	$2,206,681	$3,036,181	$3,207,781	$3,230,402
Actual @ 12/31/2013	$322,465	$56,396	$570,870	$45,606 [1]	$768,460
Actual @ 6/30/2014	$873,931	$824,806	$1,495,512	$3,282,400	$1,661,098

Over/(Under) Budget	**($170,312)**	**($1,381,875)**	**($1,540,669)**	**$74,619**	**($1,569,304)**
% of Budget Collected at 6/30/2014	**84%**	**37%**	**49%**	**102%**	**51%**

[1]*Capital Area historically does not deposit all Magellan payments into the state treasury as it receives the revenue. Late in the fiscal year, the district will deposit revenues into the state treasury up to the appropriated amount. The amount used for actual in the chart above for 12/31/13 was from ISIS, which would be representative only of the amount that had been deposited and classified at that date.*

NEW ISSUES NOTED IN THE CURRENT YEAR AUDIT - IMPACT ON SERVICES BECAUSE OF BUDGETED REVENUE SHORTFALLS

We noted that the districts either experienced reduced revenue, increased expense, decreased productivity, or some combination since the implementation of the LBHP, which has, in most cases, negatively impacted the services provided. Specifically, some districts noted an increase in vacant positions since the implementation of the LBHP and reduced services. In some ways the effect on services was a direct result of staff vacancies; in others, it was not.

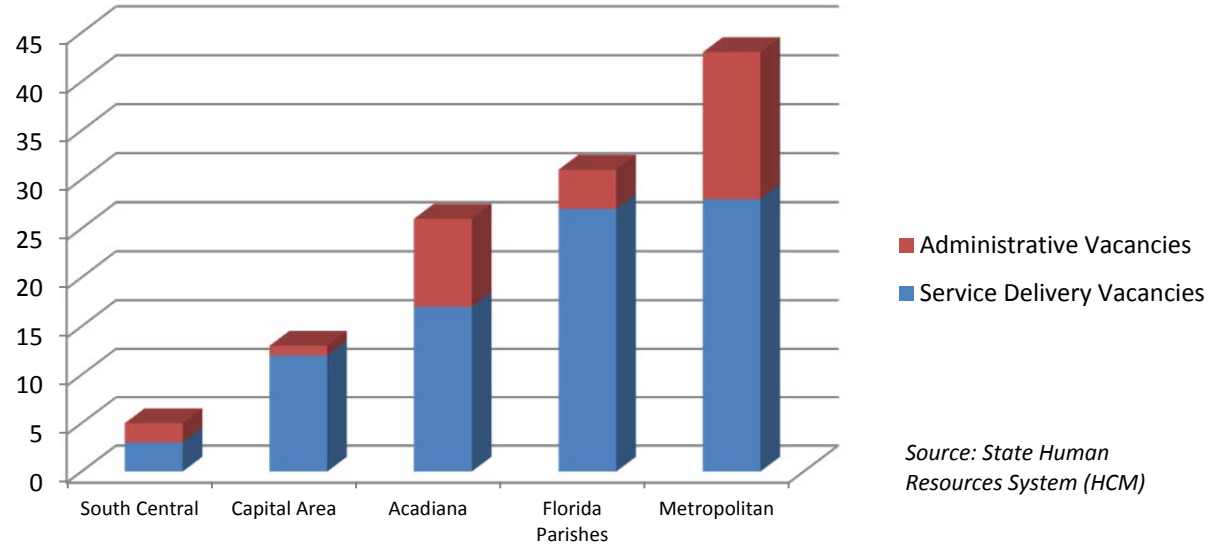
Increased Vacancies

Acadiana and Florida Parishes noted that they have experienced an inability to fill vacant positions due primarily to decreased revenue they have experienced. Each has approximately 30 new vacant positions since the implementation of the LBHP. Of these vacant positions, 17 positions for Acadiana and 27 positions for Florida Parishes are involved in service delivery.

Acadiana noted that the vacancies impacted its service output and potentially client care by increasing caseloads for staff and increased wait times for patients. Acadiana noted that one social worker has 225 clients and the addiction counselor positions serve a caseload of 120 clients each at any given time. Currently, it takes approximately two months for a patient to be treated from the time he/she schedules an appointment.

Florida Parishes noted that its vacancies impacted its service output and client care. Current staff members have higher caseloads and clients are not seen as frequently. Florida Parishes attempted to pull productivity data, which appeared to be lower than fiscal year 2013 productivity, but stated that the reliability of data pulled from Clinical Advisor is inconsistent.

Exhibit 2
Administrative and Service Delivery Vacancies



Source: State Human Resources System (HCM)

Reduced Demand

Capital Area had approximately 13 vacant positions out of 230 authorized positions. All 13 positions are new vacancies since the implementation of the LBHP, with 12 involved in service delivery and one administrative. When asked to estimate the impact of the vacancies on services provided, Capital Area noted that because the number of vacancies is fairly stable and often filled quickly, it has not had a significant impact on its clients.

However, Capital Area noted that while the LBHP has not impacted services because of the number of vacant positions, the new systems, Magellan's authorization process, and Clinical Advisor have increased the time needed to enroll and move clients into treatment programs. Subsequently, client volumes have decreased.

Capital Area noted a total decrease of 2,280 clients between 2011 (12,683 clients) and 2013 (10,403 clients), but warned us that it was not confident in the number provided because out of the five times the query was run in Clinical Advisor, Capital Area retrieved four different sets of

results. Therefore, a solid client volume amount could not be obtained because of the unreliability and inconsistency in Clinical Advisor data.

Maintaining Stability

South Central had approximately six total vacant positions out of 156 authorized positions. One of those vacancies was for a position created during 2013, which had never been filled, so five vacancies occurred since the onset of the LBHP. Of the positions vacant after the LBHP implementation, three positions are involved in service delivery and two are administrative. South Central later noted that the positions vacant at the time of our review have either been filled, converted to a contract employee, or unfunded to fund other vital positions and avoid negative impacts to service. When asked to explain its success in maintaining its workforce, South Central noted it is aggressive in recruitment actions for vacant positions.

Increased Efficiencies

Metropolitan adjusts expenses to match projected revenues rather than budgeted revenue by identifying operational efficiencies. For example, Metropolitan recently outsourced the pharmacy. Such efficiencies have allowed Metropolitan to eliminate positions through attrition and retirement. According to Metropolitan, the decrease in expenditures has had no impact on client service. Forty-three positions out of 186 total vacancies have become vacant since the onset of the LBHP. Of the positions vacant after the LBHP implementation, 30 positions are involved in service delivery and 13 are administrative.

Metropolitan noted that it does not adjust its vacancy totals by removing positions that have been internally eliminated, which has happened often as it has streamlined and sought more efficient means of service provision. Therefore, some of the vacancies noted are strategically not being filled (see Exhibit 2). For example, there were some positions that were inherited along with the children's facilities that previously belonged to DHH-OBH, which Metropolitan was able to eliminate, but management noted their efficiencies have had no impact on the services provided.

MAGELLAN PROVIDER AGREEMENTS

Prior Year Results

In our prior report, we noted difficulties for the districts with changes in which services were billable and who could deliver billable services. They also reported issues with their initial provider agreements with Magellan due to necessary services that were not included in the agreements.

Current Year Results

Provider Rates

In the current year review, the districts noted retroactive rate increases for specific procedure codes. Provider agreements were amended at various times, most recently April 2014, to accommodate these rate increases retroactive to March 2013.

In addition, nursing injections are now billable. According to Magellan, the State approved the addition of nursing injections on March 7, 2013, but the service was not billable in Clinical Advisor until Fall 2013.

Intensive Outpatient Therapy Services

In the prior year report, districts noted approved addiction services did not include intensive outpatient (IOP) therapy services. The provider agreements included addiction services as approved services for the three districts that provide these services but did not include IOP services.

In the current year, the three districts that were affected by this issue have received their amended certification letters from OBH and submitted them to Magellan. Once the provider agreements were corrected, the districts began receiving prior authorizations and payment for new IOP claims going forward. However, there was no solution put into place at that time for the districts to retrieve retro prior authorizations and payment for the IOP services provided prior to the provider agreement correction.

In August 2013, some districts were notified by Magellan to provide care plans, dates, and addiction information on patients that were served without prior authorizations to obtain retro prior authorization for each claim before Magellan would issue payment. The districts reported varying degrees of success thus far with one district reporting payment for "most if not all" of its outstanding IOP claims, while others reported they were still compiling the required documentation for Magellan.

SUMMARY OF RESULTS BY DISTRICT

Metropolitan Human Services District

District management reported that it has navigated the changes required by the implementation for the LBHP and are operating effectively. The district is routinely delivering services, submitting Magellan claims through Clinical Advisor, and receiving payment for services delivered. The district implemented a separate EHR to use for billing third-party claims and bill these claims routinely. It is reconciling payments to accounting records and client records, except for continuing issues with some recoupments. The district is not collecting the self-generated revenue budgeted, but did not operate its business with the original budget as a target. Metropolitan has voluntarily decreased its self-generated revenue budget to what it expects to collect and has adjusted its expenses accordingly. District management noted that although it

has experienced additional expense to accommodate the changes for the LBHP, the district has been able to adjust its operations through service delivery changes and efficiencies.

Currently, the district is stopping the use of Clinical Advisor and using its other EHR exclusively. It is also breaking away from DHH Fiscal as of July 1, 2014, and will be performing its own accounting services, payment management, and financial reporting.

Acadiana Area Human Services District

Acadiana management noted that, in its first year of full operations, it is experiencing all of the difficulties the other districts reported to us last year. The Magellan claims process is difficult because of the issues with Clinical Advisor and the slow eligibility determinations. Since the district uses Clinical Advisor exclusively, it has been unable to bill any third parties. The district is working and developing processes, but reconciliations of claims collections to accounting records and client files are proving difficult due to the same unexplained Magellan recoupments and lack of understanding of Magellan payments noted for some of the other districts. As with Florida Parishes, the additional administrative functions and expense to administer the new claims processes are absorbed as budget cuts and are primarily balanced through not filling vacant positions. Again, these actions increased caseloads and wait time, resulting in a drop in services. Acadiana has collected only 37% of its budgeted self-generated revenue this year. Acadiana may benefit from some direct assistance from DHH-OBH to work through its challenges.

Florida Parishes Human Services Authority

Authority management reports continuing struggles with the transition to the LBHP processes. The authority uses Clinical Advisor as its only client records and billing tool. According to Florida Parishes management, it began billing third-party claims and Medicare on March 28, 2014, more than two years after the LBHP implementation. Because of issues with Clinical Advisor and slow eligibility determinations, the authority is still having difficulty meeting all Magellan claims requirements. Additional administrative expenses for claims billing and collections are still creating budget issues and are absorbed by the authority primarily through not filling vacant positions. With vacant positions, caseloads and waiting times have increased, resulting in drops in services. The authority continues to make efforts toward reconciling Magellan payments to accounting records and client files, but with little success. Unexplained recoupments, lack of understandable payment information, and lack of access to some needed bank information continue to be obstacles to effective reconciliations. At June 30, 2014, Florida Parishes has collected approximately 49% of its budgeted self-generated revenue this year, resulting in another $1.5 million in cuts to expenses to balance its budget. The authority continues to use the resources and service delivery model provided to it by DHH-OBH, but is finding little success. Florida Parishes may benefit from significant assistance from DHH-OBH and Magellan to solve issues and identify changes needed to make the authority successful in the LBHP.

Capital Area Human Services District

District management reported that during this second year of implementation, it has adjusted for changes needed to operate routinely through the LBHP, but has absorbed significant additional expense for practice management resources, the purchase and operation of an additional EHR,

and additional administrative staff functions. The district is delivering services, billing Magellan claims, and billing third-party claims through another EHR. It is finding some success in reconciling payments to claims, accounting records, and client records, with the exception of continuing issues with Magellan recoupments. Performing these functions has come at a price of additional expenses and administrative effort. According to district management, new administrative requirements for pre-authorizations and eligibility determinations have increased the waiting time for potential clients to receive services and have decreased its number of clients served.

District management noted that it has purchased and implemented an EHR that they will use exclusively and discontinue using Clinical Advisor. The district received no additional funding to make this change and absorbed the cost through cuts in other operational areas.

South Central Louisiana Human Services Authority

Prior to May 2014, authority management reported that it continued using Clinical Advisor as its only health records and billing tool. As noted above, Clinical Advisor is still not an adequate tool for billing third-party claims. No third-party claims were filed from the implementation of the LBHP until May 2014. Each month, new claims reach the expiration date for billing and become uncollectible. District management noted that it elected to purchase and implement a separate EHR to bill third-party claims. The authority began the new system implementation in May 2014 and expects to be fully implemented by September 2014. It is submitting third-party claims for the third-party payers that have been implemented thus far. Management did note that Magellan claims are becoming more routine with fewer claims denied. The authority is able to reconcile claims payments to accounting records, with the exception of the recoupment issue previously noted. However, it is not able to reconcile payments to the client records. The authority continues to have difficulty and experience long waits for some eligibility determinations. It is not collecting its budgeted self-generated revenue and has to make cuts in expenses accordingly.

CONCLUSION

According to districts' management, some transition issues have been fully or mostly resolved and some remain problematic. Based on our review, some districts continue to struggle with the challenges of meeting Magellan requirements, maximizing self-generated revenue, and delivering the services needed for their clientele. The districts now vary in their degree of success in working through the LBHP.

RECOMMENDATIONS

DHH-OBH should work with the districts to ensure that claims filing, eligibility determinations, and payments reconciliations can be accomplished routinely by all districts. OBH and Magellan should provide an acceptable process to file third-party claims through Clinical Advisor or assist the districts in finding other resources. DHH-OBH should restructure the financing for the districts so that self-generated revenue budgets are reasonable and attainable.

DHH-OBH and Magellan should work closely with the districts to assist them in finding successful processes to eliminate the remaining obstacles they are experiencing. Since four new districts started operating on their own as of July 1, 2014, OBH should use the experience of the established districts to help these new districts find ways to navigate the LBHP process and avoid some of the difficulties previously noted.

MANAGEMENT'S RESPONSE

DHH management noted the following issues under Objective 1 as resolved: residential substance use treatment facilities for patients ages 18 to under 21; provider agreements billing restrictions; billing for nursing services; intensive outpatient therapy services; required use of Clinical Advisor, lack of training, and coding in Clinical Advisor.

Management outlined continuing corrective action for issues relating to eligibility/excluded populations; expired claims and state approval for lifting timely filing edit; independent 1915(i) assessments; third-party rates in Clinical Advisor; and self-generated revenue shortfalls.

See management's complete response at Appendix A.

ADDITIONAL COMMENTS

While DHH management noted the residential substance use treatment facilities for patients ages 18 to under 21 as resolved, it also noted continuing efforts to expand these services to other areas since only one facility in the state currently provides these residential services. Also, while DHH management noted the intensive outpatient therapy services issue as resolved, some districts have older claims that have not been authorized or paid.

DHH did not resolve the third-party claims issues by lifting the requirement to use Clinical Advisor exclusively and continues its use although it is deficient. Four new districts (Central Louisiana Human Services District, Imperial Calcasieu Human Services Authority, Northeast Delta Human Services Authority, and Northwest Louisiana Human Services District) were launched on July 1, 2014, after DHH OBH readiness assessments. However, the districts were given Clinical Advisor as their only electronic health record system, even though DHH OBH knew Clinical Advisor is inadequate for billing third-party claims. If the districts move to another electronic health record system, they would have to use their existing operating funds to obtain the system and make the modifications necessary to be compatible with Magellan requirements.

Regarding the issue of expired claims and state approval for lifting the timely filing edit, DHH management noted that Medicaid regulations are given broad interpretation under federal law and allow for exceptions to the timely filing requirement. As noted in our report, certain exceptions to the timely filing requirement are allowed under Medicaid regulations. However, the exceptions are specific and only apply to claims that have been previously submitted on time but denied. Claims that have never been submitted have no exceptions from the timely filing regulations. Based on our audit information, the districts are currently allowed to recycle claims that were previously filed and denied and claims that have never been submitted but are older than the one-year period of availability. These newly filed claims with dates of service older than one year may violate Medicaid regulations. The amount of unbilled claims could not be provided by DHH because Magellan did not capture and report the actual date that the original claim was filed, which is needed information to determine whether or not the claim met Medicaid regulations.

Objective 2: Did DHH implement adequate fiscal controls to ensure that human services districts were paid accurately and timely for services provided?

In our prior report, we noted that under the Louisiana Behavioral Health Partnership (LBHP), the districts were required to file claims with Magellan to receive a payment for each service delivered. These payments were not immediately available to the districts, but had to first be reconciled, classified, and deposited in the state treasury by the DHH Fiscal section before the districts could access the funds. We found that DHH Fiscal did not have adequate processes and controls to ensure that claims payments were identified, reconciled, and properly classified timely in the state's accounting system so that the districts could access funds paid by Magellan for their services.

For the purpose of our follow-up, we reviewed transactions from March 2013 through November 2013 for three human services districts: Metropolitan, Florida Parishes, and Acadiana. When reviewing Magellan payments for these three districts, cumulative payments of approximately $1.8 million were deposited into 17 different accounts.

The timely classification of funds for the districts continues to be an issue. We obtained payment registers from Magellan for the three districts and reconciled the payments to the state's accounting system. After the reconciliation, we were able to determine what amounts should have been made available to the districts for their use. The number of days from payment to classification by DHH Fiscal ranged from 4 to 272 days with some amounts remaining unclassified as of December 31, 2013, as shown in Exhibit 3.

Exhibit 3

	Amount Paid	Classified	Not Properly Classified and/or Not Classified at December 31, 2013	Days from Payment to Classification
Metropolitan	$611,029	$577,045	$33,984	4 days to 179 days*
Florida Parishes	651,486	559,722	91,764	20 days to 272 days*
Acadiana	519,036	125,873	393,163	32 days to 270 days*
Total	$1,781,551	$1,262,640	$518,911	

*Days as of December 31, 2013

Source: Magellan Payment Registers and ISIS

In an effort to implement controls to improve DHH Fiscal's reconciliation and classification of claims in a timely manner, the districts obtained separate federal tax ID numbers rather than using the previously shared DHH tax ID number. Also, new bank accounts were set up by DHH Fiscal and approved by the Cash Management Review Board on June 20, 2013. The intent was

that all Magellan electronic funds transfer (EFT) payments would be directly deposited into the districts individual accounts making identification and classification easier and more timely.

For immediate relief before the new tax IDs and bank accounts were established, EFT payments were redirected to a central depository at the state treasury. However, DHH Fiscal's classification of funds took from 31 to 46 days longer when the funds were deposited directly into the treasury than it did previously. The districts received their separate federal tax ID numbers by November 2013.

Although new bank accounts were established in June 2013, the districts continued to encounter delays with DHH Fiscal and Magellan using these accounts. In October 2013, Metropolitan began receiving EFT payments directly to its new account. DHH Fiscal was not aware of the use of the account and was not monitoring the account for activity. DHH Fiscal did not start classifying the funds in this account until December 4, 2013, after our discussion with them on December 3, 2013. In addition, the bank accounts for Acadiana and Florida Parishes were not being used by DHH Fiscal and Magellan until February 2014 and March 2014, respectively.

Misclassified Funds

At June 30, 2013, all agencies were instructed to classify outstanding deposits in the state treasury. DHH Fiscal did not reconcile and classify the outstanding Magellan deposits in the state treasury to the appropriate districts by fiscal year-end. DHH Fiscal classified the funds to DHH Medical Vendor Payments - Agency 306 to carry the funds into fiscal year 2014.

In October and November 2013, DHH Fiscal adjusted $260,559 out of Agency 306 into DHH-OBH and into two districts to classify the payments. However, $135,952 was classified to DHH-OBH in error and the funds should have been coded to Acadiana. The error was corrected on June 27, 2014, resulting in Acadiana not having access to earned funds for almost an entire fiscal year. These misclassifications prevented the districts from using earned funds timely (see Exhibit 4).

Exhibit 4
Unclassified Treasury Deposits That Needed to be Reclassified

Metropolitan	$537
Florida Parishes	$124,070
Acadiana	$135,952

Source: State Accounting System (ISIS)

On July 1, 2013, Acadiana became a district with its own appropriation number. At that point, all revenue should have been coded to the district, not to DHH-OBH. DHH Fiscal did not make this change and continued to code Acadiana's revenue to DHH-OBH until December 4, 2013, after our discussion with DHH Fiscal on December 3, 2013. Approximately $204,000 was improperly coded to DHH-OBH resulting in Acadiana not having access to the revenue until the correction was made.

CONCLUSION

DHH Fiscal continues to have inadequate processes and controls to ensure claims payments are identified, reconciled, and properly classified timely in the state's accounting system for the districts to access funds paid by Magellan for their services. As a result, the districts continue to not have timely access to funds, which could potentially limit their ability to deliver future services.

RECOMMENDATION

DHH Fiscal should design and implement adequate processes and controls to ensure claims payments are identified, reconciled, and properly classified timely in the state's accounting system so that districts have timely access to funds paid by Magellan for their services.

MANAGEMENT'S RESPONSE

Management noted that corrective action has been completed and this issue has been resolved since we completed our audit work.

See management's complete response at Appendix A.

ADDITIONAL COMMENT

We will follow up on the adequacy of DHH Fiscal controls during future audits of the LBHP and/or future audits of the districts.

Objective 3: Did DHH Implement Its Corrective Action Plan From Our Prior Audit for Contract Monitoring and Compliance?

The original Magellan contract began March 1, 2012, and terminated February 28, 2014, totaling $357,628,660. The contract had a one-year extension option. Amendment 9 exercised the extension option and extended the contract for another contract year. The contract currently extends through February 28, 2015, for a total of $544,804,729.

Exhibit 5

	Additional/(Reduced) Funding				Total for	
	FY 12	FY 13	FY 14	FY 15	Amendment	Total
Original	$59,604,777	$178,814,330	$119,209,553			$357,628,660
Amendment 1		(2,487,209)	(1,514,119)		($4,001,328)	353,627,332
Amendment 2		26,237	52,473		78,710	353,706,042
Amendment 3						353,706,042
Amendment 4		84,101	42,541		126,642	353,832,684
Amendment 5		253,584	126,792		380,376	354,213,060
Amendment 6						354,213,060
Amendment 7		3,720,000	4,960,000		8,680,000	362,893,060
Amendment 8			(1,461,474)		(1,461,474)	361,431,586
Amendment 9			60,708,166	$121,416,333	182,124,499	543,556,085
Amendment 10			242,206		242,206	543,798,291
Amendment 11			228,812	777,626	1,006,438	544,804,729
Total	$59,604,777	$180,411,043	$182,594,950	$122,193,959		

Source: Magellan Contract Documents

In the prior report, we noted significant contract technical requirements that were not met for the electronic health records system, Clinical Advisor.

Clinical Advisor Functions - Billing of Third-Party Payers

The contract requires that Clinical Advisor encompass all core functions and reporting provided through the previous DHH-OBH Accounts Receivable System. In the previous audit, while DHH-OBH considered these functions complete and delivered, districts' management reported that Clinical Advisor does not provide all required functions of the previous system, specifically for private pay or third-party billing and does not produce reliable reports. In the OBH response dated July 26, 2013, management noted that training and full implementation of third-party billing through Clinical Advisor was anticipated for October 2013.

Currently, the fee schedules in Clinical Advisor are set at 180% of the Medicaid rate and the districts are unable to bill third parties at appropriate rates.

In November 2013, the districts submitted new tax ID numbers to Magellan. The new tax ID was to aid, in part, with billing of third-party claims. In an email issued by Magellan dated April 24, 2014, at least two districts were instructed to stop billing third-party claims for claims with dates of service November 15, 2013 and after. Magellan indicated there was a problem associated with the tax ID changes made by the districts.

Electronic Health Records System - Meaningful Use

The contract required that Magellan's electronic health records (EHR) system, Clinical Advisor, meet the "meaningful use" standard by March 1, 2013. This requirement was not met as of the issue date of our initial report, August 14, 2013. Meaningful use is the set of standards defined by the Centers for Medicare and Medicaid Services that governs the use of electronic health records. The goal for these standards is to promote the spread of electronic records to improve health care in the United States of America.

In the DHH-OBH response dated July 26, 2013, DHH-OBH management noted that OBH was currently working on an amendment to the contract for Clinical Advisor to meet meaningful use standards and anticipated the standards would be met in 2014.

Amendment 10 to the Magellan contract was approved February 26, 2014. This amendment added funding to the contract between DHH-OBH and Magellan to accommodate Magellan meeting the original contract requirement of achieving EHR meaningful use. The amendment states that the parties anticipate that EHR certification will be completed by the end of the second quarter of calendar year 2014 (June 30, 2014).

DHH-OBH management also noted in its July 26, 2013 response that the districts are not subject to financial penalties since Louisiana Medicaid does not assess penalties for noncompliance with EHR meaningful use. While this is a correct statement regarding Medicaid, the districts with eligible providers who also provide Medicare covered professional services will be subject to payment adjustments/reductions beginning January 1, 2015, if they are unable to successfully demonstrate meaningful use. The payment adjustment will be applied to the Medicare physician fee schedule amount for covered professional services and starts at 1% and increases each year that an eligible professional does not demonstrate meaningful use, to a maximum of a 5% reduction.

Eligible providers who first demonstrate meaningful use in 2014 may avoid the Medicare payment adjustments. To avoid the payment adjustments, eligible providers must demonstrate meaningful use for a 90-day reporting period in 2014. This reporting period must occur in the first nine months of calendar year 2014 and eligible providers must attest to meaningful use no later than October 1, 2014. Eligible providers would need to begin their 90-day reporting period no later than July 1, 2014, to be able to attest by October 1, 2014.

Three of the five districts contacted for this follow-up report are still using Clinical Advisor. Two districts are now using other electronic health records that are meaningful use certified.

As of the date of this report, Clinical Advisor has not achieved meaningful use EHR certification and achievement of this certification is not anticipated until October 1, 2014, leaving the Clinical Advisor users that are Medicare eligible providers no time to meet federal requirements.

On July 22, 2014, OBH notified Magellan that a daily monetary penalty of $2,500 would be issued for each day from July 1, 2014, until the meaningful use certification is achieved; however, in lieu of the full amount, the state would collect 20% of the issued penalty in the amount of $500 from July 1, 2014, until the meaningful use certification is achieved.

Block Grant Reporting

According to technical requirements in the contract, Magellan's information system must support state and federal reporting requirements, including federal block grants. In the previous audit, Clinical Advisor was not capturing the appropriate data to meet federal block grant reporting requirements. In the OBH response dated July 26, 2013, DHH-OBH noted that changes for inclusion of the necessary data elements for block grant reporting were anticipated by December 2013.

In the current audit, DHH-OBH states that Magellan completed system improvements to enable block grant reporting. This was completed by December 2013 and DHH-OBH was able to timely complete required block grant reporting.

Louisiana Health Information Exchange

The contract requires that Clinical Advisor connect to the Louisiana Health Information Exchange (LaHIE) within six months of the contract date. This requirement was not met.

In the OBH response for our prior report dated July 26, 2013, DHH-OBH noted that anticipated implementation of features to allow connectivity to LaHIE would be no later than March 2014.

LaHIE is the electronic exchange of the Continuity of Care Document that provides authorized providers and organizations the opportunity to electronically access and share health-related information through a secure and confidential network to improve patient safety, quality of care, and health outcomes. Amendment 10 addresses connectivity to LaHIE. Clinical Advisor connection to LaHIE is noted as deliverable in Phase 3 of 4. The amendment was not approved until February 26, 2014.

We contacted DHH-OBH for an update on the progress of features to allow LaHIE connectivity. According to OBH management, it was anticipated that connectivity to LaHIE would occur by March 2014. However, Amendment 10, which functionally allows for this to happen, was not approved in a timeframe which supports this date. The LaHIE connectivity will not be completed until the required changes to Clinical Advisor are completed to meet meaningful use standards. Connectivity to LaHIE is now anticipated by October 1, 2014, more than two years after the date for the original contract requirement.

CONCLUSION

While progress has been made for some contract requirements, DHH-OBH still has contract requirements that are not met as indicated in the original contract approved in January 2012.

RECOMMENDATION

DHH should ensure that contracts are monitored closely and that all contact requirements are met timely.

MANAGEMENT'S RESPONSE

Management noted two issues under Objective 3 as resolved: data elements necessary for block grant reporting requirements and billing for third parties. In addition, management outlined continuing corrective action on meaningful use standards under the EHR incentive program and connectivity to LaHIE noting October 2014 as the completion date.

See management's complete response at Appendix A.

ADDITIONAL COMMENTS

While management mentioned that the issue of third-party billing has been resolved, it acknowledged that the districts still have a large volume of claims denied by third-party payers. As noted in our report, in addition to denied claims that have not been recycled and paid, some districts still have a large number to third-party claims that have never been submitted.

APPENDIX A: MANAGEMENT'S RESPONSE

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Behavioral Health

August 29, 2014

Mr. Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Dear Mr. Purpera:

Thank you for the continued discussions with our office concerning the Louisiana Behavioral Health Partnership (LBHP). The LBHP is a unique approach to behavioral health managed care, and the Office of Behavioral Health (OBH) continues to evolve in its role as contract monitor and oversight agency for the LBHP. Since the original Informational Audit dated August 14, 2013, regarding implementation of the LBHP with the Local Governing Entities (LGEs), OBH and its contractor for the Statewide Management Organization (SMO), Magellan of Louisiana, have been working toward resolution of the highlighted issues. Below is a summary of the issues that have been resolved since the previous Informational Audit, are still undergoing development, or are newly identified areas for improvement cited in the audit follow-up for SFY 14.

Resolved issues:

As indicated in the Informational Audit dated September of 2014, OBH and Magellan have resolved several issues emphasized in the prior year audit report including:

1. **Objective 1 - Residential substance use treatment facilities for patients ages 18 to under 21 -** Magellan is working with New Day Recovery to expand to other areas of the state to provide residential substance use treatment services for this population. OBH continues to work to identify other sources of funding for room and board costs.

2. **Objective 1 - Provider agreements billing restrictions** – Magellan has implemented rate increases for specific procedure codes and the provider agreements were amended to accommodate these rate increases retroactive to March of 2013.

3. **Objective 1 - Billing for nursing services -** Magellan has successfully implemented this systems change. Claims have been processed for all ten (10) LGEs.

4. **Objective 1 - Intensive outpatient therapy services –** All LGE provider agreements now include intensive outpatient (IOP) therapy services as approved services, and all LGEs are able to obtain retroactive authorization in order for claims to be paid.

5. **Objective 3 - Data elements necessary for block grant reporting requirements -** Magellan completed necessary changes to the Clinical Advisor system and OBH successfully and timely submitted the Mental Health and Substance Abuse Prevention & Treatment block grant report in December of 2013.

In addition to the aforementioned items, there are several issues that were resolved after the time period of the Auditor's review for the 2014 report. A summary of these items is given below:

6. **Objective 1 - Required use of Clinical Advisor and lack of training**
Recognizing the complexities of implementing an innovative and complicated managed care system like the LBHP, the need for a single electronic health record system was a necessary element during initial implementation. However, as noted in the 2014 audit report, the requirement for Clinical Advisor has since been lifted. Magellan continues to work closely with the LGEs to assist them in finding successful processes to eliminate the obstacles they are experiencing in LBHP implementation. Significant technical assistance has been provided through informational bulletins, webinars, and on-site technical assistance as requested by the LGEs. These visits and trainings have been geared to address specific LGE concerns, including use of Clinical Advisor for business practice purposes, health information record keeping, and billing. The training on April 30-May 1, 2014 mentioned in the 2014 audit report was provided to all of the LGEs (the Imperial Calcasieu Human Services Authority and MHSD chose not to participate). The training focused on billing, claims submission, and account reconciliation. Of the five LGEs reviewed, additional focused training was also provided to CAHSD and FPHSA both on-site at the LGE and at Magellan.

In addition to LGE specific training, Magellan continues to communicate to all providers on a regular basis in order to assist them in navigating the LBHP. Methods of communication include email distributions, postings on the Magellan web site and through the monthly Partnership Provider News. Specific topics that have been included in the email distributions included Clinic Advisor changes in payment methodology. The Partnership Provider News has been used primarily as an information sharing and provider education platform. Some topics have included frequent reasons for claims non-payment and steps to avoiding denials, authorization and review, and code changes.

OBH continues to monitor Magellan's training initiatives for all providers and routinely assists the LGEs navigate the LBHP. DHH acknowledges that ongoing training relative to Clinical Advisor will be needed to continue to assist LGEs. It is the role of OBH to assist with the provision of technical assistance and is open to feedback to better meet their needs. OBH is currently considering the use of surveys regarding future LGE trainings to continue to improve our training efforts.

7. **Objective 1 - Coding in Clinical Advisor**
This issue has been largely resolved. OBH continues to monitor Magellan's progress on claims issues as they arise through a claims dashboard outlining any new or outstanding items.

8. **Objective 2 - Fiscal controls**
In February 2014, DHH Fiscal began monthly meetings with LGE financial staff to discuss and resolve reconciliation and payment issues. DHH Fiscal also established electronic access to bank accounts for each LGE to assist them in their reconciliation of Magellan deposits. In April 2014, DHH Fiscal began sending the Magellan deposit/payment reports to the LGEs each week. Additionally, DHH has resolved the issue relative to reconciliation of Magellan payments to accounts in the state treasury in May 2014 and DHH Fiscal reports that deposits are currently classified within the month that they are deposited. Since the time of this audit, this issue has been resolved.

9. **Objective 3 - Billing of third party payers**
Full implementation of third party billing through Clinical Advisor was implemented in October of 2013. Some of the LGEs struggle meeting the requirements to align their tax identification numbers (TIN) and National Provider Identifier (NPI) numbers between Magellan and other payers with third party billing. OBH and Magellan will continue to provide support and technical assistance to aide these LGEs with their third party billing issues.

There is currently a large volume of LGE claims denied by third-party payers. Magellan noted the denial reasons varied from eligibility to timely filing to incorrect NPI numbers. Magellan now provides each LGE a reconciliation report that includes data for both their Magellan claims and third-party payer claims so that the

LGEs have the tools needed to assist with correcting denied claims. OBH continues to provide oversight of Magellan's implementation of Clinical Advisor as a tool for effective management of the LBHP clinical and billing processes.

Issues with ongoing resolution:

10. **Objective 1 - Eligibility Determinations/Excluded Populations**
Eligibility determination and excluded populations are a regular part of Magellan's new-provider training. Technical assistance is available both via telephone and during provider forums. Magellan has also recently fully integrated help desk functions and eligibility assistance into Member Services, so providers can receive assistance with eligibility determination and excluded populations. Additionally, on May 16, 2014, OBH hosted a technical assistance webinar on Medicaid eligibility and how to identify excluded populations within Magellan's system. However, for LGEs that are still having difficulty, OBH will work with Magellan to provide additional clear guidance and training.

11. **Objective 3 - Meaningful use standards under the EHR Incentive Program and connectivity to the Louisiana Health Information Exchange (LaHIE)**
Magellan anticipated completion of its meaningful use certification by the end of SFY 14; however, circumstances both within and beyond Magellan's control have delayed its progress and new timeline estimates project completion by October 2014. Being a component of meaningful use, OBH anticipates that the implementation of features to allow connectivity with LaHIE will parallel the timeline for meaningful use certification. Current regulations indicate that full funding for all five years of the EHR Incentive Program will be available for providers that enroll before 2016. Because DHH was thoughtful and proactive in its timeline for meaningful use certification, delayed certification of meaningful use should not impact the LGEs. OBH continues to monitor Magellan's progress toward meaningful use certification, including the interface needed for connectivity to LaHIE through bi-weekly meetings where it remains a standing agenda item.

Newly identified issues in FY 14 Informational Audit update:

1. **Objective 1 – Expired claims and state approval for lifting timely filing edit**
DHH approved lifting the timely filing edit as a result of issues beyond the control of the providers. In many instances the LGEs are the only providers available to Louisiana's most at-risk citizens. Since the LGEs were initially required to use Clinical Advisor for billing, and issues surrounding Clinical Advisor were responsible for these claims not being paid, DHH approved of the change to the timely filing edit. Medicaid regulations are given broad interpretation under federal law and allow for exceptions to the requirement of timely filing under certain circumstances. Given that services were provided in good faith, claims had to be processed through a new and complicated system, and the criticality of the LGE service infrastructure to the community, DHH determined that an exception was warranted to the standard timely filing requirements.

   DHH will coordinate with the LGEs on a quarterly basis regarding claims that are pending for over three months in order to work toward resolution. Upon notice, DHH can then coordinate with Magellan to ensure that claims processing issues are addressed timely to eliminate continued exceptions to the timely filing requirements and the LGEs can ensure continuity of services.

2. **Objective 1 - Independent 1915(i) Assessments**
The new Independent Assessment/Community-Based Care Management (IA/CBCM) process is a Centers for Medicare & Medicaid Services (CMS) requirement to be in compliance with the 1915(i) State Plan Amendment. The IA/CBCM process for adults seeking 1915(i) services will be implemented in phases across Louisiana. It is important to note that prior to the date of any given geographical implementation, licensed mental health providers performing eligibility determination assessments to adults seeking 1915(i) services may continue to provide assessments under their current guidelines, qualifications and restrictions. Any interested and qualified provider will need to complete training requirements for the new IA/CBCM process. The training requirement

is the first step of several in a process of becoming certified, credentialed, and contracted. The IA/CBCM standards were first implemented in 27 parishes as of June 1, 2014, with statewide implementation anticipated by October 1, 2014.

3. **Objective 1 - Third-party rates in Clinical Advisor**
   The Clinical Advisor system requires that the default rate for third-party payers be the same for each LGE. As such, the default rate was discussed extensively with the LGEs. Magellan will continue to work with the LGEs to meet their needs and adjust the rate based on the general consensus.

4. **Objective 1 - Self-generated revenue (SGR) shortfalls**
   The SGR collected by the LGEs matches the reported amounts in the 2014 follow-up audit report as of June 30, 2014. With the exception of CAHSD, the LGEs did not earn to the level of SGR budget authority included in their appropriation; however, none of the LGEs ended the state fiscal year with an expenditure deficit. DHH will work with each of the LGEs during the upcoming budget cycle to align their budget in a way that allows the LGEs to reflect projected SGR revenue collections from the LBHP.

Since the original Informational Audit dated August 14, 2013, OBH and Magellan have resolved a majority of the issues cited in the last report. The LBHP is a unique approach to behavioral health managed care, and OBH has greatly enhanced its monitoring efforts by filling key Health Plan Management positions, engaging an External Quality Review Organization, and streamlined the monitoring processes. Additionally, OBH and Magellan have provided extensive training and technical assistance to the LGEs Of the four LGEs mentioned in the previous report, significant operational improvements have been achieved as noted in the follow-up report including:

- The Metropolitan Human Services District (MHSD) has successfully "navigated the changes required by the implementation for the LBHP and are operating effectively" (Louisiana Legislative Auditor, p. 14, 2014);
- Using "Clinical Advisor as its only client records and billing tool," the Florida Parishes Human Services Authority (FPHSA) "began billing third-party claims and Medicare on March 28, 2014" (Louisiana Legislative Auditor, p. 15, 2014);
- The Capital Area Human Services District (CAHSD) has demonstrated successful self-generated revenue collections above budget and "has adjusted for changes needed to operate routinely through the LBHP" (Louisiana Legislative Auditor, p. 15, 2014); and
- The South Central Louisiana Human Services Authority (SCLHSA) has noted "that Magellan claims are becoming more routine with fewer claims denied" (Louisiana Legislative Auditor, p. 16, 2014), and that it's able to maintain stability in its service delivery through successfully sustaining its workforce due to aggressive recruitment strategies (Louisiana Legislative Auditor, p. 13, 2014).

OBH continues to work with Magellan to address the aforementioned issues and will continue to work with all providers, including the LGEs, to support smooth operations and ensure people with behavioral health needs receive necessary services. Thank you for your consideration and attention to this matter.

Sincerely,

Rochelle Head-Dunham, M.D.
Assistant Secretary

c: Kathy Kliebert, Secretary
Courtney Phillips, Deputy Secretary

RHD/jk

APPENDIX B: SCOPE AND METHODOLOGY

We conducted procedures for this follow-up informational audit to provide information to the Legislature on the implementation and transition issues for the Louisiana Behavioral Health Partnership (LBHP) as experienced by five human services districts/authorities. We did not conduct this audit in accordance with *Government Auditing Standards*. Our objectives were:

1. How did Department of Health and Hospitals - Office of Behavioral Health (DHH-OBH)/Magellan changes and transition issues impact the human services districts?
2. Did DHH implement adequate fiscal controls to ensure that human services districts were paid accurately and timely for services provided?
3. Did DHH implement its corrective action plan from our prior audit for contract monitoring and compliance?

To achieve our objectives, we:

- Interviewed Capital Area Human Services District, South Central Louisiana Human Services Authority, Metropolitan Human Services District, Florida Parishes Human Services Authority, and Acadiana Human Services District management to identify continuing transition issues and possible impact on service delivery.
- Conducted certain follow-up procedures at DHH-OBH and DHH Fiscal to access internal controls over the Magellan payments processes.
- Performed a reconciliation of Magellan payments to the human services districts from March 2013 to November 2013 for Metropolitan, Acadiana, and Florida Parishes.
- Reviewed the Magellan contract and performed certain follow-up procedures to assess DHH contract monitoring and Magellan contract compliance.
- Surveyed Capital Area Human Services District, South Central Louisiana Human Services Authority, Metropolitan Human Services District, Florida Parishes Human Services Authority, and Acadiana Human Services District management to compile the reported transition issues noted by the districts/authorities and possible impact on service delivery. The issues and impact reported are assertions of human services districts' management.
- Discussed the contents of the report with DHH management.