Behavioral Health Benefit Management Utilization Management & Care Management Program Description for the Louisiana Coordinated System of Care

2018

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Section I: Overview of Program

Introduction

This document outlines the scope, structure and activities of Magellan Behavioral Health (MBH) Utilization Management and Care Management (UM/CM) program. Detailed standards of the UM/CM program are in policies which are referenced in this document.

The term "insured individual" is used throughout the document to represent an individual who is the subscriber, policyholder or dependent of a private or public/government sponsored health insurance plan. It is interchangeable with beneficiary, consumer, member, enrollee and recipient.

Staff titles noted are current at the time this document was approved.

MBH UM/CM program was developed to align with Magellan Health Services organizational vision and mission; applicable federal regulation and national accreditation standards; and the UM program purpose for behavioral health benefits management. It is customized for state regulations and/or customer account contractual requirements as needed.

Magellan Health Services Vision – Sparking innovation to build healthier and brighter futures.

Magellan Health Services Mission – Magellan guides individuals to make better decisions, and live healthier and more fulfilling lives, by improving the overall quality and affordability of healthcare.

The MBH UM/CM program's purpose is to ensure that young people in or at risk of out of home placement with significant behavioral health challenges are able to receive the supports and services they need and to support optimal use of behavioral health services. To facilitate achieving its purpose the UM/CM program is based upon an approach intended to assist each young person and their family attain the highest degree of value through identification and treatment engagement to sustain positive outcomes.

- Consideration of the individual's clinical situation, cultural characteristics, safety and preferences.
- An available and accessible care delivery system through active development and maintenance of a behavioral health provider network.
- Proactive assessment and development of guidelines and predictors of new or updated behavioral health care services and support resources. Consistent application of Wraparound values:
    - Family driven
    - Youth guided
    - Culturally and linguistically competent
    - Home and community based
    - Strength-based
    - Individualized
    - Integrated across systems
    - Connected to natural helping networks
    - Data driven and outcomes oriented
    - Unconditional care

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), regulations were released for implementation in 2010. Organizations must be transparent with regards to their

implementation of MHPAEA requirements and to demonstrate compliance with the MHPAEA in the areas of network adequacy and access, as well as parity of BH benefits/coverage. As a BH benefits management vendor, Magellan Behavioral Health has coverage coordination programs to support accounts as they implement parity.

The UM/CM program contains 4 major components:

[1] Screening, referral, and clinical eligibility determinations for enrollment in the CSoC program.
[2] Benefit/coverage or covered service authorization as a provision before services delivered via review and approval of Plans of Care or real-time reviews of inpatient and crisis services.
[3] Care coordination: Behavioral Health service/resource coordination ranging from, inpatient to community transition to reengagement with MCO as participation in CSoC ends.
[4] Retrospective auditing of service utilization data for utilization trends and outliers.

Magellan does not reward, financially or through other mechanisms, actions that would deliberately result in inappropriate utilization of services, employed or contracted personnel who perform certification and appeal of benefit/coverage determinations. Employees and contracted personnel are made aware of this upon hire or initial contracting. This position is also communicated to providers and insured individuals, as allowed by account contract.

As a benefit management vendor, MBH does not delegate benefit certification determination and formal adverse benefit determination appeal rights afforded to the insured individual. In the unlikely event that this would occur the delegate applicant would be evaluated regarding the ability to meet performance expectations before executing a formal delegation agreement delineating: responsibilities of each entity including the delegate reporting performance to MBH; the specific UM activity delegated; provisions for PHI; process for evaluating the delegate's performance; and remediation steps applied to substandard performance. Oversight includes an annual audit of delegate performance and approval of the delegate’s annual UM program. Significant deficiencies are reported to the compliance department and applicable corporate committee.

MBH has developed or adopted evidence based criteria, guidelines or protocols for a wide variety of BH coverage. Each account delineates the BH services that are covered and delegated to MBH for benefit/coverage management.

Setting	Intensity Level	Location/type
Inpatient *(individual resides in the facility and staff are on-site to render care 24/7)*	Acute inpatient	General or psychiatric hospital acute care unit/floor.
Ambulatory *(Service is a visit or session lasting no longer than 23 contiguous hours)*	Acute or urgent ambulatory	Emergency room/department service. Crisis service in a facility outpatient or mobile team.
	Routine ambulatory	Office; clinic; Mental Health Clinic; facility outpatient dept.; mobile counseling; telehealth; waiver and non-waiver home and community based services

Wraparound agencies are the primary external entities focused on a recovery and resiliency support model that includes Medicaid agency covered services. Identification of individuals for this program is guided by the 1915(c) waiver and contractual requirements.

Structured resource and social support coordination models.	
Wraparound	Wraparound is an intensive, individualized care management program for children and adolescents with serious or complex emotional and/or behavioral challenges who are in or at risk of out of home placement. A trained “wraparound facilitator” convenes the child and family team comprised of family members, informal and natural supports, service providers, and agency representatives that collaboratively develop an individualized plan of care (professional care, community and interpersonal support services), implement this plan, and evaluate its success of maintaining the child/teen at optimal well-being in the community. The plan is designed to be culturally competent, strengths based, and organized around family members’ own perceptions of needs, goals, and likelihood of success. Wraparound program implementation requires that the child-serving system has key types of community and system supports including community partnership; stakeholder follow-though (paper to practice); realistic fiscal strategies; mechanisms for ensuring access to the services and supports; family engagement; and accountability.

Guidelines have been established for density and geographic distribution based on the covered population and the account service area and are used to develop and maintain a network of contracted behavioral healthcare providers ranging from individual practitioners to organizational providers (facilities and programs) with a wide range of expertise and clinical specialties to support insured individual access to covered BH services. Industry credentialing standards for BH providers are followed. Network providers are made aware of the UM/CM program activities conducted by Magellan via the *Magellan Behavioral Health Provider Handbook.*

Member information is safeguarded and disclosures made in accordance with federal regulations, HIPAA, state law, as well as industry standards and professional ethics. Privacy and confidentiality policies are in place describing standards for collecting and recording protected health information (PHI) as part of the UM/CM program PHI is removed when specific case information is used in proceedings, records, writings, data, or reports for committee review.

UM/CM Program Goals for 2018
Goals are in place to support improved outcomes and optimal BH service utilization and are annually evaluated via QI plan and updated as needed.

- Improve the quality of assessments and Plans of Care submitted by Wraparound Agencies, thereby providing youth and families with effective care, as evidenced by improvements in the Louisiana Department of Health (LDH) agreed upon Best Practice indicators to be implemented in contract year two.
- Increase post hospital appointment scheduling and other hospital aftercare Best Practice adherence, as evidenced by exceeding the National Committee for Quality Assurance (NCQA) 50th percentile for 7-day Follow-Up after Hospitalization (FUH) for Mental Illness rates.
- Improve community tenure as evidenced by percentage of children/youth requiring inpatient hospitalization less than or equal to five percent.
- Decrease the percentage of members enrolled in CSoC longer than 18 months by 10%.

The UM/CM program is supported at both the corporate and regional levels with designated staff and committees that include a BH practitioner.

Section II: Structure & Resources

Corporate UM/CM Program Support
Designated corporate staff and centralized operation support departments provide guidance and direction for implementation of UM/CM program activities carried out by regionally located Care Management Centers (CMC).

The UM/CM Program is under the leadership and direction of senior level BH practitioners and the Chief Medical Officer, who work together to develop and maintain core UM/CM policies and documents. The Compliance department provides regulatory guidance for core and customized UM/CM policies. Magellan's Human Resource (HR) department establishes core competencies and qualifications for all positions with input from corporate leadership in various departments. Newly hired employees attend orientation and complete required training courses on Privacy, Security, Fraud and Compliance. HR Learning & Performance provides instructional design, learning technology infrastructure and benefit management systems training support to CMC learning leads. Corporate Medical services conducts UM/CM program training for CMC Medical Directors and Physician Advisors.

Corporate Committee Oversight of UM/CM Program
The Magellan Board of Directors has the ultimate authority and responsibility for the quality of Magellan's services and the delivery of BH services to insured individuals of contracted accounts under Magellan's scope of services. The Board of Directors designates the Magellan Enterprise Quality Improvement Committee (QIC) to have broad oversight of the Magellan quality improvement program.

MBH (BH–QIC) was established by Magellan Enterprise QIC to fulfill its oversight role as well as enhance coordination of goals and objectives between departments. The role, functions and participants of the BH-QIC is fully described in the *Magellan Behavioral Health Quality Improvement Program Description.* This committee is led by the MBH Chief Medical Officer. Listed below are the BH-QIC functions associated with the UM/CM program.

- Review, revise as needed, and approve the MBH UM/CM Program, goals and related policies annually.
- Review and approve a formal annual evaluation of the MBH UM/CM Program contained within the MBH QI Program Evaluation.
- Recommend actions as needed to address aggregate and trended utilization program outlier performance.
- Oversight of assigned work groups designated to: develop or adopt; review; and update or re-adopt, the UM/CM clinical decision support tools: *Magellan Medical Necessity Criteria Guidelines,* and clinical practice guidelines (CPG).

MBH Care Management Center (CMC) UM/CM Program Support

The CSoC Program Director has oversight responsibilities for all day-to-day operations including UM/CM program activities. As senior level BH practitioners, the CMC CSoC Clinical Director and Medical Director are responsible for the implementation of the UM/CM program at the CMC in adherence with applicable federal and state regulations as well as account contractual requirements. Medical Directors are licensed psychiatrists and CMC Clinical Directors are at least a master's level BH practitioner. Both positions have additional experience qualifications.

Each CMC has authority to hire staff as well as monitor staff performance. Orientation, training and professional development of CMC personnel is conducted by designated CMC staff. Federal/state regulations, contractual obligations, and industry standards per accreditation entities are used in determining the types, frequencies and other requirements for training conducted to support UM/CM program activities.

Staff to perform UM/CM program activities are allocated and configured to best meet the UM program needs of the CMC's insured individual population.

Customer Service Associate (CSA) – CSAs perform administrative and insured individual services functions including referral and initial screening of benefit certification/authorization. A bachelors degree (or equivalent) in psychology, social services or healthcare is preferred, with previous experience in healthcare or a customer service environment.

Care Worker – paraprofessionals who provide specialized support to ensure waiver compliance, process eligibility, and navigate benefits and services such as post hospital transition service scheduling.

Care Manager (CM) – CMs screen for CSoC eligibility, review Plans of Care, perform initial clinical review during benefit certification and are able to authorize (approve) benefits based upon contract requirements and explicit clinical criteria. Care Managers are licensed behavioral healthcare practitioners (RN, masters or doctoral level).

Physician Advisor (PA) – PAs perform peer clinical review for benefit certification and review case management cases as assigned. PAs render medical necessity decisions that can result in the authorization (approval) or non-authorization (unfavorable) benefit determination. Physician Advisors are licensed board-certified psychiatrists or board certified in a specialty other than psychiatry and with additional background and training in addictions treatment.

CMC Committee Oversight

Each CMC has an independent UM Committee **or** standing UM agenda items integrated within its Quality Improvement Committee (QIC) to monitor the implemented UM/CM program for effectiveness and effect on its insured individual population within customer requirements and state regulations. The following committee functions are performed at least annually:

- Review, customize as needed, approve and implement policies and procedures that are associated with the scope and activities of the UM program including a UM program description.
- Review approved updates and implement use of *Louisiana Coordinated System of Care Medical Necessity Criteria.* Implement two clinical practice guidelines (i.e., Suicide Risk and ADHD) adopted by Magellan.
- Review findings, trends and interventions of QI Work Plan performance monitoring of the UM program.
- Evaluate the CMC UM/CM program's effectiveness and document within the CMC QI program evaluation.
- Develop and periodically revise as needed CMC thresholds for the quantitative and qualitative evaluation of optimal BH resource utilization (under or over utilization) in relation to experience, insured individual characteristics, behavioral healthcare delivery network characteristics and customer requirements.
- Solicit input from providers and insured individuals, as allowed by customer plan contract, for recommendations related to UM program.

Meeting frequency is determined by the CMC in order to meet fulfilling all UM/CM committee functions annually. Participation by the CMC Clinical Director and/or Medical Director, and QI/Compliance lead is required for a separate UM committee or the CMC QIC. The CSoC Program Director is required to participate in the CMC QIC. The committee chair or designee maintains approved meeting minutes.

Magellan policies provide comprehensive standards based upon regulations and accreditation requirements for UM program activities summarized in this document.

UM Clinical Decision Support Tools

Clinical Criteria Developed or adopted clinical criteria serves as the primary decision support tool for the UM program. Magellan BH has adopted a specialized set of clinical criteria, *Louisiana CSoC Medical Necessity Criteria,* used to decide the medical necessity and clinical appropriateness of services

Clinical Practice Guidelines (CPG) A designated work group is responsible to develop or adopt and renew evidence based clinical practice guidelines from recognized sources. Review, update as needed or re-adoption based on published scientific evidence-based advancements in the field of behavioral health is done at least every two years. Clinical practice guidelines are intended to provide guidance for the evaluation and treatment of acute and chronic behavioral health conditions. Developed or adopted CPGs are made available to network providers and UM/CM staff. Magellan may furnish insured individuals with consumer-relevant information based on the adopted practice guideline, as allowed by contract.

In addition to clinical criteria and CPGs, Magellan staff may access determinations of Magellan's Technology Assessment Committee (TAC) as the result of the assessment of new or new applications of diagnostic, evaluation and treatments relevant to behavioral healthcare.

Policies:	*Benefit Certification & Appeal General Guidelines* *Clinical Practice Guidelines Development & Review* *New Technology Assessment*

Benefit/Covered Service Certification
Magellan is accessible 24 hours a day, seven days a week, throughout the entire year. Performance standards are established for telephonic access. Guidelines describing communications protocols for UM are also in place. The insured individual or their authorized representative such as the ordering/rendering provider may request certification of a benefit/coverage or appeal of adverse benefit/coverage determination.

Insured individuals assessed with a clinical urgency level of emergent or urgent are actively assisted with obtaining an appointment for services with a network provider within the established timeframes.

For non-crisis inquiries by members or their parent/guardian, CSAs with appropriate experience, knowledge, and supervision, may link insured individuals to preferred network providers by providing names and locations of one or more providers. Such referrals are conducted in coordination with the UM/CM team.

When a member is not eligible for benefits requested per their contract, the CSA informs the caller, documents the absence of coverage and refers the insured individual to a CM or appropriate person(s) within the customer account for further assistance. If a member's BH benefits have been exhausted or the member's provider has terminated from the network, the member is assessed for appropriate actions as determined by the member's clinical needs and available BH service resources.

Potential quality of care issues may also be identified during prior authorization and are forwarded to a PA for review.

All decisions regarding the actual delivery of care to the insured individual are made by the treating clinician, who is expected to make these decisions in the insured individual's best interest.

Certification/Authorization Process

Authorization of benefit or coverage before emergency service delivery is waived in the event of an emergency clinical situation that requires immediate medical attention.

Post-stabilization services are services to maintain, improve or resolve the member's emergency medical condition. In most cases the emergency physician treating the insured is responsible for determining when the individual is sufficiently stabilized for transfer or discharge.

The clinical urgency of the member at the time of the coverage request determines whether the authorization process will be conducted within an expedited or standard timeframe. An expeditious process is conducted for coverage review of continued inpatient days.

Conducting the authorization process for a late request (after service has been rendered, but before a standard claim (1500 or UB format) for payment has been submitted) is determined by Magellan policy, contract and state regulation.

Initial clinical review is performed by a CM who applies the clinical criteria against the clinical features of the individual as reported in almost all cases by the ordering/rendering provider. If the CM cannot authorize the benefit based upon medical necessity the request is forwarded to a PA for a peer clinical review. The PA applies the clinical criteria using their clinical knowledge and experience. Other clinical review decision support tools may also be referred to during the peer clinical review and the PA determines the need for a peer-to-peer conversation with the ordering/rendering provider. The peer clinical review results in a medical necessity decision for the basis of an approval (certified benefit request) or adverse coverage/ determination, action.

A *coverage determination* can be approved or adverse (an action) whether it is clinically based on *medical necessity* after applying clinical criteria or administrative (e.g.: member is not eligible for the benefit or the request is administratively closed due to lack of information to make a medical necessity decision within time-to-process requirements or failure to preauthorize when required). Time-to-process and notification requirements for rendering and issuing a coverage determination to appropriate parties are dictated by Magellan policy.

Insured Rights to Appeal

Insured individuals are provided with formal appeal rights to appeal an adverse benefit determination (an action). An ordering/rendering provider may initiate the appeal on behalf of the insured individual when they are acting as the insured individual's authorized representative. The clinical urgency of the situation at the time of the appeal request determines whether the appeal will be processed using the expedited or standard time-to-process.

An appeal decision outcome can be to uphold or overturn (whole or in part) the adverse coverage determination (an action). Appeal review time-to-process and notification requirements for rendering and issuing an appeal decision to appropriate parties are dictated by Magellan policy.

An external independent review by an independent review organization (E/IRO) of an appeal is provided to insured individuals. Ordering/rendering provider may be allowed to appeal an adverse determination on their own behalf for payment which is different than and does not replace the insured appeal rights. This is referred to as a provider-on-behalf-of provider dispute of coverage.

Adjunct Benefit Management Activities

Extra Contractual Benefits Eligibility and Management (ECB) Management of extra contractual benefits or flexing benefits allows the care management team to provide specialized planning for behavioral health care treatment on a case-by-case basis to meet the unique clinical and cultural needs of insured individuals. The intention is to maximize available BH service benefits as made available by the customer account contract and the insured individual's consent.

Benefit Management and Transition Support for Insured individuals New to Magellan Standards are in place describing the transition of service support for insured individuals new to Magellan that promote continuity of care and minimize needed BH service disruption for insured individuals in treatment.

Policies:	*Accessibility of Service and Care* *Benefit Certification & Appeal General Guidelines* *UM General Guidelines: BH Supplement* *Provider Dispute of Benefit Determination* *Medicaid: Service Authorization* *Medicaid: Action Appeal* *Transition of Care Support for Insured individuals New to Magellan* *Exchange of Contractual Benefits Eligibility and Management*

Coordination of Care Assistance Case Management

Post Hospital Transition This activity promotes BH treatment engagement along the BH care continuum. Discharge planning is initiated when an inpatient episode begins so that when discharge occurs, any authorization(s) needed are in place allowing an uninterrupted transition from inpatient services. Magellan staff assists the hospital staff to establish a discharge plan in coordination with the Wraparound Agency with a scheduled service and perform outreach as needed. Unlike hospitalization for a physical condition, psychiatric disorders continue to have significant stigma. Individuals discharged after psychiatric stays have expressed feelings of shame and fear about returning home.

Medical Integration Magellan promotes the integration of behavioral health with general medical services in keeping with the needs of our insured individuals and customer accounts within the context of the benefit contracts under administration. BH-medical integration core elements include timely communication with primary care practitioners; review of BH related pharmacy benefits and formularies; and collaboration with medical providers to increase appropriate use of psychotropic drugs. Magellan conducts regular and ongoing clinical staffing

with associated MCOs to ensure appropriate integration of medical and behavior services and facilitate smooth transitions upon disenrollment from the program.

Transition of Services for Insured individuals when their Benefits are Exhausted Care Managers work closely with Wraparound Agencies and network providers in order to be prepared for a situation where benefit limits have been maximized and hence, reimbursement is no longer available. In accordance with accepted professional guidelines and standards for clinical practice, insured individuals in active treatment are never abandoned. Rather, appropriate policies are in place to support the safe transition of each insured individual from one provider to another under a different benefit plan, private pay or publicly funded arrangement.

Transition of Services for Insured individuals due to Provider Termination from the Network Timely assistance is provided in consultation with Wraparound Agencies to insured individuals in securing a transfer to an appropriately credentialed ambulatory provider. An extended transition period is offered to insured individuals when an active course of treatment has been identified. The care management team works collaboratively with the Wraparound Agency, member, and departing provider to develop a clinically appropriate transition plan and identification of a new provider.

Extra Contractual Benefits Eligibility and Management (ECB) Management of extra contractual benefits or flexing benefits allows the care management team to provide specialized planning for behavioral health care treatment on a case-by-case basis with approval of Louisiana Department of Health (Medicaid and Office of Behavioral Health) to meet the unique clinical and cultural needs of insured individuals. The intention is to maximize available BH service benefits as made available by the customer account contract and the insured individual's consent.

Service Support for Insured individuals New to Magellan Standards are in place describing the transition of care support for insured individuals new to Magellan that promote continuity of care and minimize needed BH service disruption for insured individuals in treatment. Processes are in place to assist the Wraparound Agency in identifying members' current and previous service providers so that they can quickly be included in the Child and Family Team.

Policies:	*Care Coordination When Benefits are Exhausted* *Discharge Planning and FAH Adherence* *Continuity and Integration of Behavioral Healthcare with General Medical Care* *Intensive Care Management* *Transition of Care Support for Insured individuals When their Practitioner's Network Participation Ends*

QI Work Plan

The measures to monitor and assess performance are based upon retrospective auditing of process and UM/CM activity event information for quality and utilization trends and outliers. UM/CM program goals have QI objectives and indicators that are dynamic and fully consider the insured individual's clinical, safety and cultural characteristics/needs as well as historic performance and customer requirements. QI Work Plan is based on measures and objectives that are approved by the BH QIC.

Core Performance Indicators

Core Performance Indicator (CPI) component of the QI Work Plan include indicators for UM/CM activities which are collected by staff at the CMC level, such as benefit certification processing time, readmission (REM) within 30 days and HEDIS FUH. CPI results are reported at established frequencies but no less than annually by each CMC to corporate QI Outcomes & Research department for distribution to corporate committees. The Corporate BH QIC reviews results of CPIs and makes recommendations to support CMC improvements as applicable.

CPI data are used at both the corporate and CMC level in evaluating the effectiveness of UM/CM activities and processes as well as achievement of UM/CM program goals.

The CMC may have additional performance measures to assess additional aspects of UM/CM activities based on insured individual characteristics, regulatory, and/or contractual requirements.

Core Monitoring Activities

In addition to the CPIs, the QI Work Plan also contains annual monitoring of UM/CM processes and outcomes by the CMC.

- Evaluation of BH resource utilization is conducted via the systematic analysis of pertinent quantitative and qualitative measures against relevant CMC approved internal or external thresholds to identify outliers (under and over utilization). The characteristics of the CMC's managed population; region; provider network; and customer account are considered as part of the analysis.
- CMC analyzes collected data to evaluate at least 2 measures of care processes (sometimes referred to as aspect of care) relevant to one or both of the clinical practice guidelines adopted by the CMC.
- Evaluation of the consistency with which clinical reviewers (CMs and PAs) apply the clinical criteria, referred to as inter-rater reliability. Methods of collecting data for this activity may include peer and/or supervisor audits of selected cases and/or audit of clinical documentation related to medical necessity decisions by the CMC Medical Director.
- Case management documentation review based on Magellan standards and CMC specific standards based on customer account or state requirements.
- Patient safety activities focused on:
  - Improving insured individual knowledge about their condition and treatment through insured individual relevant clinical practice guideline information, compliance with aftercare reminders and outreach.
  - Enhancing provider awareness of better practices through sharing provider level process and outcome data, distributing clinical practice guideline information and identifying clinical practice barriers that may be related to care management processes.

Policies:	*Evaluation of Health Service Utilization* *Preventive Behavioral Healthcare*
Other:	*QI Work Plan*

Section IV: Interface with the QI Program

Annual Evaluation of UM/CM Program

The Corporate BH-QIC has authority over the *Magellan Behavioral Health UM/CM Program Description* which is reviewed and evaluated on an annual basis for overall program effectiveness through CMC analysis and findings in order to:

- Critically evaluate the degree to which the goals and objectives of the UM/CM Program are met.
- Identify opportunities to improve the effect and effectiveness of UM/CM program processes.
- Identify "better practices" for universal implementation.

The formal evaluation is documented within the annual QI Program Evaluation and includes findings and results obtained through the QI Work Plan, internal audits conducted by the Compliance Department and external audits conducted by customer accounts, accreditations and regulatory agencies.

Review of the annual evaluation as well as approval of the UM/CM Program description is reflected in the appropriate committee minutes.