Louisiana CMC

MAGELLAN HEALTH SERVICES –

MAGELLAN HEALTH

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION FOR MEDICAID MANAGED CARE

MARCH 1, 2014 – FEBRUARY 28, 2015

Magellan Behavioral Health 2014 UM Program Description

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Magellan Behavioral Health 2014 UM Program Description

Section I: Overview of Program

Introduction

This document outlines the scope, structure and activities of Magellan Health Utilization Management (UM) program. Detail standards of the UM program are in policies which are referenced throughout this document.

The term "recipient/enrollee/member" is used to represent an individual who is the subscriber or dependent of plan healthcare benefits. Staff titles noted are current at the time this document was approved.

Magellan Health UM 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's 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 Magellan Health Utilization Management program's purpose is to support optimal use of behavioral health services for the evaluation and treatment of primary behavioral health disorders. To facilitate achieving its purpose the Utilization Management program it is based upon core tenets of a *patient centric* model intended to assist recipient/enrollees with attaining the highest degree of value through identification and treatment engagement to sustain positive treatments.

- Δ Consideration of the individual's clinical situation, cultural characteristics, safety and preferences.
- Δ An available and accessible care delivery system through active development and maintenance of a behavioral health provider network.
- Δ Proactive assessment and development of guidelines and predictors of new or updated BH care services and support resources.
- Δ A recovery and resiliency approach allowing the individual to [1] participate fully in their lives within a community setting through reduction or complete remission of symptoms; and [2] enable positive internal qualities (e.g. optimism and problem-solving) and social skills that foster positive support from social circles (e.g. family, friends and community).

Scope

The UM program contains 3 major components:
[1] Certification of benefit (covered service).
[2] Adjunct benefit management services, ranging from coordination of care, also referred to as case management to intensive care management for clinical complex high risk individuals.
[3]Interface with the QI program through retrospective auditing of UM data for quality and utilization trends and outliers.

Magellan does not reward, financially or through other mechanisms, employed or contracted personnel who perform certification for benefit determination and appeal of unfavorable benefit determination that would deliberately result in inappropriate utilization of services. Employees and contracted personnel are made aware of this upon hire or initial contracting. This position is also communicated to providers and recipient/enrollees, as allowed by customer plan contract.

As a benefit management vendor, Magellan Health does not delegate benefit certification determination and formal recipient/enrollee appeal activities. In the unlikely event that this would occur the delegate applicant would be evaluated before executing a formal delegation agreement delineating: responsibilities of each entity including the delegate reporting performance to Magellan Health; 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.

Magellan Health has in place developed or adopted evidence based criteria, guidelines or protocols to manage a wide variety of covered BH services. Services covered in the UM program are dependent on the coverage offered

to the recipient/enrollee by the agency or managed care plan and delegated to Magellan Health for management. The following grid represents common BH covered services.

Setting	Intensity Level	Types
Inpatient *(care rendered at least 24 hrs per day)*	Acute inpatient	Acute care units in a general or psychiatric hospital.
	Non-acute or sub-acute inpatient	BH residential treatment. Residential rehabilitation for alcohol substance use disorder (SUD) treatment;
Ambulatory *(care rendered any segment of time less than 24 hrs per day)*	Acute ambulatory	Emergency room/department. Outpatient crisis unit, may include mobile unit.
	Intermediate ambulatory	Intensive Outpatient (IOP).
	Routine ambulatory	Outpatient location including the individual's home, or via telehealth for treatment and monitoring of BH disorder.

Medicaid managed care coverage may also include community services such as Assertive Community Treatment (ACT) or targeted case management (may be a version of Tiered Care Management, resource coordination, or blended case management); and/or peer support services.

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

Recipient/enrollee 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 program PHI is removed when specific case information is used in proceedings, records, writings, data, or reports for committee review.

UM Program Goals for 2014

Goals are in place to support the objective of our UM program, optimal BH service utilization and are annually evaluated and updated as needed.

–Sustain follow up after hospitalization 7 day rates at 28% or higher and 30 day rates at 48% or higher.

Promote early identification and intervention of behavioral health needs and early identification of at-risk children (e.g., EPSDT screening, CANS).

Reduction in the current number and future admissions of adults and youths with significant behavioral health challenges in restrictive settings outside their home through the increased use of in-home and community services.

Section II: Structure & Resources

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

Corporate UM Program Support

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

The UM Program is under the leadership and direction of senior level BH practitioners, the Chief Medical Officer and Care Management/Utilization Review Administrator. These two areas work together to develop and maintain core UM policies and documents. The Compliance department provides regulatory guidance for core and customized UM 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 program training for CMC Medical Directors and Physician Advisor.

Corporate Committee Oversight

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 recipient/enrollees of contracted customers. The Board of Directors designates the Magellan Enterprise QIC to have broad oversight of the Magellan quality improvement program.

Magellan Health Quality Improvement Committee (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 membership of the BH-QIC which meets at least 4 time a year is fully described in the *Magellan Behavioral Health Quality Improvement Program Description.* This committee is led by the Magellan Health Chief Medical Officer. Listed below are the BH-QIC functions associated with the UM program.

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

Care Management Center (CMC) UM Program Support

The CMC Chief Operations Officer has oversight responsibilities for all day-to-day operations including UM program activities. As senior level BH practitioners, the CMC Care Management/Utilization Review Administrator and Medical Director (Chief Medical Officer) are responsible for the implementation of UM program at the CMC in adherence with federal and applicable state regulations as well as any contractual customer account requirements. Medical Directors are licensed psychiatrists and the CMC Care Management/Utilization Review Administrator is at least a master's level behavioral health practitioner and 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 program activities.

Staff to perform UM program activities are allocated and configured to best meet the UM program needs of the CMC's recipient/enrollee population and to comply with contract or state law.

Member Services Representatives - MSRs perform administrative and recipient/enrollee 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.

Section II: Structure & Resources

Follow Up Specialist – These specialists provide UM program support such as various coordination of care assistance including outreach to providers for scheduling and verification of post hospital discharge follow-up plan adherence.

Care Manager (CM) – CMs perform initial clinical review and case management 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 for benefit determinations of authorization (approval) or unfavorable. 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 program for effectiveness and effect on its recipient/enrollee 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.
- Implement at least two clinical practice guidelines adopted by Magellan.
- Review findings, trends and interventions of QI Work Plan performance monitoring of the UM program.
- Evaluate the CMC UM 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, recipient/enrollee characteristics, behavioral healthcare delivery network characteristics and customer requirements.
- Solicit input from providers and recipient/enrollees, 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 committee functions annually. Standing members should included at least the CMC Care Management/Utilization Review Administrator and/or Medical Director, QI/Compliance lead and GM. The committee chair or designee maintains approved meeting minutes.

Section III: UM Program Activities

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 Health has developed and maintains a proprietary clinical criteria, *Magellan Behavioral Health Medical Necessity Criteria,* which is based on sound scientific evidence for recognized settings of behavioral health services used to decide the medical necessity and clinical appropriateness of services.
Customer account contract requirements and/or state law may mandate the use of an alternative clinical criteria or a modified version of *Magellan Behavioral Health Medical Necessity Criteria.* This is the case for the State of Louisiana contract. Service Authorization Criteria have been developed by the State of Louisiana Office of Behavioral Health in coordination with Louisiana Medicaid. The Service Authorization Criteria have replaced Magellan's medical necessity criteria for this contract.

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 staff. In addition, Magellan furnishes recipient/enrollees 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:	*UM General Guidelines* *CPG Development and Maintenance* *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 recipient/enrollee or a recipient/enrollee's authorized representative such as the ordering/rendering provider may request authorization or appeal.

Recipient/enrollees assessed with a clinical urgency level of emergent or urgent are actively assisted with obtaining services with a provider within the established timeframes.

For non-crisis recipient/enrollee inquiries, MSR with appropriate experience, knowledge, and supervision, may link recipient/enrollees to preferred network providers by providing names and locations of one or more those providers.

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

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

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

Certification of Coverage

The clinical urgency of the recipient/enrollee at the time of the request determines whether the certification of coverage will be conducted within an expedited or standard timeframe. Magellan also has established an expeditious process for certification if continued inpatient days.

Conducting a late certification request (after service has been rendered) is determined by Magellan policy, customer account contract and state regulation.

Approved clinical criteria are used to decide the medical necessity of an eligible coverage and render a coverage determination.

When coverage for a behavioral health service is requested per the prior authorization provision, pre-screening information maybe collected by a MSR or system algorithm based on explicit scripting which includes verifying the recipient/enrollee's eligibility.

Initial clinical review is preformed by a CM who applies the clinical criteria against the clinical features of the individual as reported by a recipient/enrollee or ordering/rendering provider. If the CM cannot authorize the coverage 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 also determines the necessity of a peer-to-peer conversation with the ordering/rendering provider. The peer clinical review results in a medical necessity decision for the basis of a favorable or unfavorable coverage determination.

A coverage determination can be approved (favorable) or a non authorization (unfavorable) called an action, whether its clinically based on a *medical necessity decision* or administrative (recipient/enrollee is not eligible for the benefit or request administratively closed due to lack of information to make a medical necessity decision within required timeframe).

Timeliness and notification requirements for rendering and issuing a benefit determination to appropriate parties are dictated by Magellan policy.

Recipient/Enrollee Action Appeal Rights and Review Process

Recipient/enrollees are provided with formal appeal rights to appeal an action (unfavorable coverage determination). An ordering/rendering provider may invoke the action appeal rights on behalf of the recipient/enrollee as the recipient/enrollee's authorized representative. The clinical urgency of the situation at the time of the appeal request determines whether the appeal will be conducted using the expedited or standard timeframe.

An action appeal decision can be either to uphold or overturn (whole or partially) the action. Timeliness 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 (IRO) of an appeal is provided to recipient/enrollees by each state.

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Policies:	*Medicaid Service Authorization* *Medicaid Action Appeal*

Coordination of Care Assistance (Case Management)

Follow-up After Hospitalization (FAH) This activity promotes behavioral health treatment engagement along the behavioral health care continuum. Discharge planning is initiated when an inpatient episode begins so that when discharge occurs, authorization(s) are in place allowing an uninterrupted transition from inpatient. Magellan staff assist the hospital staff to establish a scheduled service, verify FAH adherence and perform outreach as needed.

Recovery/Resiliency Care Management Each CMC establishes an RCM (Tiered Care Management) Program to maximize positive clinical outcomes for identified cases to facilitate a well integrated, proactive care management

plan. RCM may incorporate a variety of care management mechanisms including field care management programs.

Medical Integration Magellan promotes the integration of behavioral health with general medical services in keeping with the needs of our recipient/enrollees, our 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. The CMC has well-structured program of interaction with the Bayou Health Plans for referral and co-management of care for members with complex medical/behavioral needs.

Coordination of Recipient/enrollee's Care Transition due to Provider Termination from the Network Timely assistance is provided to recipient/enrollees in securing a transfer to an appropriately credentialed ambulatory provider. An extended transition period is offered to recipient/enrollees when an active course of treatment has been identified. The care management team works collaboratively with the departing provider to develop a clinically appropriate transition plan and identification of a new provider. Recipient/enrollees may be referred to the ICM program, if their clinical condition warrants, in an effort to provide support and stability during the transition.

Coordination of Service Support for Recipient/enrollees New to Magellan Standards are in place describing the transition of care support for recipient/enrollees new to Magellan that promote continuity of care and minimize needed BH service disruption for recipient/enrollees in treatment.

Policies:	*Discharge Planning and FAH Adherence* *Integration of Behavioral Healthcare with General Medical Care* *Intensive Care Management* *Transition of Care Support for Recipient/enrollees New to Magellan* *Transition of Care Support for Recipient/enrollees When their Practitioner's Network Participation Ends*

Section IV: Interface with the QI Program

QI Work Plan

The measures to monitor and assess performance are based upon retrospective auditing of process and UM activity event information for quality and utilization trends and outliers. UM program goals have QI objectives and indicators that are dynamic and fully consider the membership'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 activities which are collected by staff at the CMC level. 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 activities and processes as well as achievement of UM program goals.

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

Core Monitoring Activities

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

- Δ Evaluation of Behavioral Health 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.
- Δ 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.
- Δ Case management documentation review based on Magellan standards and CMC specific standards based on customer account or state requirements
- Δ Patient safety is reviewed analysis of complaints, adverse incidents and coordination of care data. Taxonomy of patient safety activities is maintained by the corporate Quality and Outcomes Department. Those employed by the CMC include:
  - ⇨ Improving recipient/enrollee knowledge about their condition and treatment through recipient/enrollee 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 identify clinical practice barriers that may be related to care management processes.

Other:	*QI Work Plan*

Annual Evaluation of UM/QI Program

The Corporate BH-QIC has authority over the *Magellan Health UM/QI 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 Program are met.
- Identify opportunities to improve the effect and effectiveness of UM 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 audit conducted by customer accounts, accreditations and regulatory agencies.