DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF BEHAVIORAL HEALTH
LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP
EXPERIENCE OF FOUR HUMAN SERVICES DISTRICTS/AUTHORITIES DURING IMPLEMENTATION AND TRANSITION

FINANCIAL AUDIT SERVICES
INFORMATIONAL AUDIT
ISSUED AUGUST 14, 2013

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

August 14, 2013

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 an informational audit of the implementation and transition issues for the Louisiana Behavioral Health Partnership at the Department of Health and Hospitals, Office of Behavioral Health. Our audit consisted primarily of inquiries and the examination of selected financial transactions, records, and other documentation. 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 four human services districts/authorities: Capital Area Human Services District, South Central Louisiana Human Services Authority, Metropolitan Human Services District, and Florida Parishes Human Services Authority. 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, and Florida Parishes Human Services Authority for their assistance.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

WDG:EFS:THC:ch

DHH-LBHP 2013

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Department of Health and Hospitals - Office of Behavioral Health
Louisiana Behavioral Health Partnership
Experience of Four Human Services Districts/Authorities During Implementation and Transition

Informational Audit - August 2013

Audit Control # 80120148

Introduction

The Department of Health and Hospitals (DHH) - Office of Behavioral Health (OBH) has as a goal to manage and deliver services and support necessary to improve the quality of life for citizens with mental illness and addictive disorders. In March 2012, DHH-OBH launched the Louisiana Behavioral Health Partnership (LBHP) using a private contractor, Magellan Health Services (Magellan), as the manager of all state behavioral health programs. When Magellan began providing behavioral health management, all service providers of state behavioral health programs were required to enroll as a Magellan provider and meet Magellan provider requirements. The two-year contract with Magellan terminates on February 28, 2014, and totals approximately $354 million. For the period of March 1, 2012, through February 28, 2013, Magellan was paid approximately $156 million for behavioral health management and services.

This report provides the results of our informational audit of the DHH-OBH transition from its previous service delivery model to the new LBHP model as experienced by four human services districts/authorities. These entities included Capital Area Human Services District (CAHSD) based in Baton Rouge, South Central Louisiana Human Services Authority (SCLHSA) based in Houma, Metropolitan Human Services District (MHSD) based in New Orleans, and Florida Parishes Human Services Authority (FPHSA) based in Amite. We did not review or consider the overall implementation and transition as it relates to any of the other service provider groups that are part of the LBHP. According to OBH management, the LBHP includes approximately 2,000 behavioral health services providers.

Our report is focused on the experience of four districts/authorities during the transition as represented by district/authority management. We did not review the overall efforts or effectiveness of the OBH personnel as part of the implementation and transition.

Our objectives were:

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

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

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

Background

The human services districts/authorities are created as local governmental entities governed by a local board of directors with missions to provide state behavioral health services and services for the developmentally disabled. Currently, there are 10 districts/authorities operating in the state with four districts/authorities beginning operation on July 1, 2013 (see Appendix C). While the districts/authorities are defined as local entities, DHH controls their budgets, has significant influence over their service delivery, and with the exception of Jefferson Parish Human Services District, provides their fiscal services and financial reporting.

Historically, the districts/authorities have been funded through a combination of General Fund appropriations, transfers from DHH, and small amounts of revenue from fees collected for their services. Before LBHP, the districts/authorities were required to provide services for the patients in their service areas using these budgeted funds. Now, with the implementation of LBHP, the districts/authorities file claims with Magellan to earn a fee for each service delivered. Previously, fees for service made up less than two percent of the districts/authorities' total operating budget, but under the new model, fees are as much as 15 percent of the operating budget, so the districts/authorities have a greater reliance on the fees to fund their overall operations.

	Pre-LBHP (As of February 29, 2012)			Post-LBHP (As of February 28, 2013)		
	Total Budget	Total Self-Generated Budgeted (fees)	% to Total	Total Budget	Total Self-Generated Budgeted (fees)	% to Total
CAHSD	$30,579,431	$48,000	0.2%	$32,223,034	$3,207,781	10%
FPHSA	$19,892,352	$95,188	0.5%	$20,600,858	$3,036,181	15%
MHSD	$31,193,137	$548,381	1.8%	$33,215,571	$2,241,030	7%
SCLHSA	$24,918,548	$161,994	0.7%	$24,935,506	$2,050,407	8%

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

District/authority management reported being impacted by the OBH/Magellan transition in several ways:

- Conflicting regulations creating confusion and a possible gap in service for an at-risk population
- Claims payments that are 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 are not being achieved
- Required provider agreements include significant changes in the billing process, such as which district/authority services are billed, who can provide billable services, and how claims are filed. If a service is not listed in the agreement, the district cannot bill for that service.

CONFLICTING REGULATIONS	CAHSD	MHSD	SCLHSA	FPHSA
Conflicting regulations creating confusion and a possible gap in service for an at-risk population. ✓ = Yes	✓	*	✓	✓

* MHSD did not report this issue. MHSD contracts with other providers to deliver substance abuse services.

At the implementation of the LBHP, there were no juvenile facilities in the state that were OBH-certified to treat Medicaid eligible substance abuse patients age 18 to 20, creating a possible gap in service for this at-risk population. Medicaid defines a "child" as up to 21 years old, with the Medicaid state plan providing for substance abuse services to children under 21 years old. However, OBH certifies juvenile facilities for individuals under 18 and adult facilities for individuals 18 and over.

OBH has instructed districts/authorities to treat the Medicaid eligible 18-to-20-year-old population in adult facilities, in possible conflict with Medicaid regulations. One district reported that it was instructed by the DHH Medicaid unit to exclude this population from substance abuse services. Because of the lack of understanding and communication related to this population, it is currently uncertain as to what is required to be in compliance with Medicaid regulations and what the repercussions may be for noncompliance.

DHH-OBH management stated that they were aware of this conflict in regulations when LBHP was implemented. OBH further noted that services for this population were available through

state funding other than Medicaid. However, district/authority management reported confusion and a lack of understanding on how services were to be provided to this population.

CLAIMS PAYMENTS	CAHSD	MHSD	SCLHSA	FPHSA
Claims payments have been problematic and caused extra time and expense to track and reconcile.	✓	✓	✓	✓
Billing dates are expiring, leaving the districts/authorities with no means to collect unbilled services.	✓	*	✓	✓
Patient eligibility is more difficult to determine now than before Magellan.	✓	✓	✓	✓
Reconciliation of Magellan payments has presented significant challenges.	✓	✓	✓	✓
Some proper and accurate claims receive errors because of conflicting information between the claim data and the Magellan system.	✓	✓	✓	✓

* MHSD did not report this issue. A large portion of unbilled claims related to third-party billings that the Magellan electronic health records system could not process. MHSD implemented a separate electronic health records system to bill those third-party claims.

Before the LBHP implementation, Capital Area Human Services District (CAHSD) used a three-person team to bill claims. The salary and related benefits for this function totaled approximately $180,000 per year. After the implementation of LBHP, because of the problems with claims reconciliation and collection, CAHSD hired an experienced practice administrator and a billing manager. It also moved three vacant positions from other duties to claims processing and used nine temporary employees to perform new administrative functions, removing those functions from service delivery personnel. The salary and related benefits costs to the district for these claims and administrative functions under the new system are approximately $450,000 per year, a $270,000 increase since the LBHP implementation.

While other districts/authorities did not detail and quantify their claims and billings process changes, the impact of decreased revenue, increased expense, and decreased productivity was reported. South Central Louisiana Human Services Authority (SCLHSA) estimated the time spent correcting claims and billings errors equated to one full-time staff person for each of its eight clinics. Florida Parishes Human Services Authority (FPHSA) has not been filing any third-party claims, and in response to the loss in revenue, it noted a three-day furlough for all staff, an elimination of seven filled positions and four vacant positions and an average of 30 vacant positions out of its total authorized staffing of 198.

Billing Expiration Dates

Because of the changes in claims billing, fee schedules, and coding issues, numerous district/authority claims have been rejected and denied. The districts/authorities may not be able to collect for these services because they have been unable to file or correct the claims prior to the billing expiration dates.

Eligibility

District/authority management told the auditors that determining eligibility for their patients is an ongoing problem. They noted that the Medicaid eligibility population used by Magellan was different from the eligibility population for DHH Medicaid. After claims were rejected, the districts/authorities received communication from DHH that certain Medicaid populations were excluded from participation in the LBHP.[1] District/authority management informed us they were not adequately educated on these populations. OBH management stated it has now determined proper protocol and is educating providers on how to identify and bill for these populations.

District/authority management noted difficulty with determining eligibility for a new population of patients created by the LBHP, the 1915(i) waiver recipients.[2] At the beginning of the LBHP, this population was provided services without determination of eligibility, and if a recipient was later determined to be ineligible, Magellan would recoup the amount paid for the services. As the LBHP progressed, claims without eligibility determinations were rejected, and because of a backlog of eligibility assessments, many of the recipients have not received an approval or rejection of eligibility. The lack of communication of eligibility results inhibits the appeals process, as both patients and claims join a large pool of errors that is difficult to resolve quickly.

Reconciliations

At implementation, the districts/authorities did not understand the Magellan reports and the explanation of payments (EOP). The districts/authorities noted discrepancies between claims payment reports and the EOP. Magellan includes certain reporting data, called encounter claims, in its EOP that do not represent actual claims filed or paid. The lack of understanding on how to interpret Magellan's documentation and payment processes has contributed to the districts/authorities having difficulty reconciling payments received to patient records, bank deposits, and accounts receivable. In some cases, this led district/authority management to believe that they were not being paid for all claims submitted.

Clinical Advisor

Clinical Advisor is Magellan's electronic health records system. The districts/authorities that had not already fully implemented an electronic health records system were required by DHH-OBH to use Magellan's Clinical Advisor.

[1] LBHP was implemented under the authority of a waiver from CMS with recipient populations defined within the waiver document. Some Medicaid populations are excluded from the LBHP but are still eligible for mental health services under Medicaid, such as adults certified for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Others are excluded because the recipient is not entitled to traditional Medicaid services (e.g., Qualified Medicare Beneficiaries). For cases where Medicaid eligible populations are excluded from the LBHP and the recipient is entitled to mental health services and/or Medicaid payment for his/her claims, claims for payment should be submitted through the normal Medicaid claims process rather than through Magellan.

[2] 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.

CLINICAL ADVISOR (Electronic Health Records System)	CAHSD	MHSD	SCLHSA	FPHSA
Districts/authorities were required to use Clinical Advisor and forfeited money to cancel contracts for other electronic health record systems.	✓	*	✓	✓
Lack of successful training for the use of Clinical Advisor exacerbated the challenges.	✓	✓	✓	✓
Magellan rates are set as default.	✓	*	✓	✓
There are issues with diagnosis codes, procedure codes, and/or coding descriptions.	✓	✓	✓	✓

*Note: MHSD 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. MHSD uses Clinical Advisor only to file Magellan claims.

According to district/authority management, Clinical Advisor was not adequate to meet their needs.

- CAHSD, SCLHSA, and FPHSA, through a request for proposal process, jointly selected an electronic health records system (EHR). Each signed an agreement to buy and implement the new system. Once LBHP was launched, the districts/authorities were required by OBH to use Clinical Advisor. As a result, the districts/authorities terminated the existing EHR contracts. Each district/authority had already paid $84,792 toward the purchase of the system. Collectively, the amount forfeited for canceling the existing contracts totaled $254,376.

- The training provided for Clinical Advisor included webinars and weekly teleconferences, but the districts/authorities reported to us that their staff left the training without the necessary skills to administer the system. In some instances, training manuals explain how to perform tasks, but the districts/authorities indicate that they are unclear as to how to perform such tasks. Based on interviews with the districts/authorities, the lack of successful training required district/authority staff to spend additional hours correcting errors.

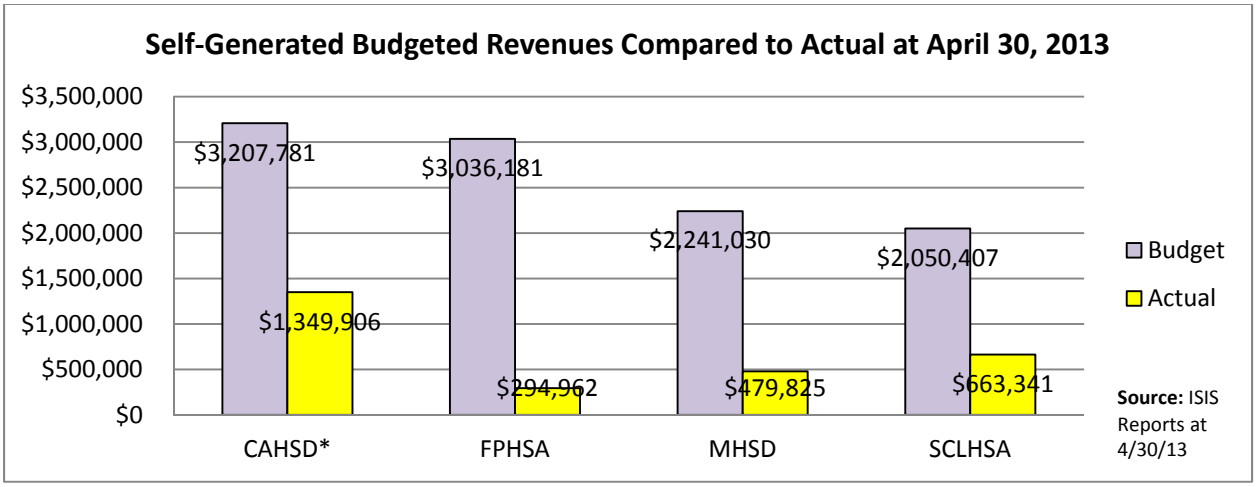
- At implementation, Clinical Advisor was not designed to accommodate third-party payers, including Medicare, private insurance, guarantors, and private pay patients. As enhancements allowing for third-party payers were rolled out, the districts/authorities noted that the rate schedules within Clinical Advisor defaulted to Magellan rates and could not be altered based on the payer. Without the ability to use appropriate rates, the districts/authorities were unable to use Clinical Advisor to bill for third-party payers. Many third-party claims remain unbilled by the districts/authorities because most are manually billed through time-consuming paper claims. As a result, the districts/authorities may not be able to accurately identify and calculate accounts receivable.

- According to district/authority management, Clinical Advisor was not properly programmed to accommodate the use of diagnosis codes, procedure codes, and coding descriptions as required by the districts/authorities and their provider

agreements with Magellan. Issues with diagnosis codes noted by the districts/authorities consist of applicable diagnosis codes omitted from Clinical Advisor and the inability to change diagnosis codes when a patient is treated at a subsequent facility within a district/authority. Several instances were noted where districts/authorities were unable to bill for certain procedure codes that were billable according to their provider agreements. According to DHH-OBH management, Magellan added a programming feature to Clinical Advisor to remedy this issue within six months of implementation and notified the districts/authorities to recycle the claims.

BUDGET	CAHSD	MHSD	SCLHSA	FPHSA
Self-generated revenue budget is overly optimistic.	✓	✓	✓	✓

The estimate of self-generated revenue used in the budgets for the districts/authorities was overly optimistic and is currently not being achieved by the districts/authorities. As of April 30, 2013, the districts and authorities have collected $2,788,034 against a budget of $10,535,399, or 26%, of self-generated revenues. With only two months remaining in the fiscal year, it is highly unlikely that any of the districts/authorities will collect their budgeted amounts. For example, as noted in the chart below, Florida Parishes Human Services Authority (FPHSA) has collected less than 10% of its self-generated budgeted revenues. DHH-OBH management reported to us that the self-generated budget amounts were derived by a DHH-OBH contractor using historical data provided by the districts/authorities.



* CAHSD has not deposited approximately $1.2 million in Magellan payments into the state treasury as of April 30, 2013. The amount used for actual in the chart above was obtained by adding the amount indicated in ISIS to the amount in the local bank account attributed to Magellan payments.

PROVIDER AGREEMENT	CAHSD	MHSD	SCLHSA	FPHSA
Changes to which services are billable, who can deliver billable services, and how claims are filed were not fully explained by OBH.	✓	✓	✓	✓

Prior to the Louisiana Behavioral Health Partnership (LBHP), the districts/authorities managed their service delivery in conjunction with DHH-OBH guidance. After the LBHP, each district/authority was required to enter into a provider agreement with Magellan. District/authority management noted the following:

- Prior to LBHP, the districts/authorities operated state mental health clinics that were paid a flat rate of $100 per visit with a maximum of one visit per day per patient. Under the LBHP, the districts/authorities may bill for more than one service per day, but the billable rates are lower than the $100 flat rate in most cases. A few examples of these lower rates are as follows:

Rate Change Examples for Masters Degree Level Staff	Prior to LBHP	Original LBHP Rates	Subsequent LBHP Rate Change
Psychiatric Diagnostic Interview, CPT 90801	$100.00	$76.97	$75.86
Individual Psychotherapy (20-30 min.), CPT 90804	$100.00	$33.85	$33.36
Individual Psychotherapy (45-50 min.), CPT 90806	$100.00	$47.64	$46.95
Family Psychotherapy with Patient Present, CPT 90847	$100.00	$55.16	$54.37

- Services provided by nurses and some services provided by unlicensed professionals are no longer billable. Prior to the LBHP, billable mental health services were provided by licensed clinicians, including nurses, as well as unlicensed professionals with master's, bachelor's, and associate level degrees, or less. Under the LBHP, billable services are based on staff credentials. The districts/authorities reported that the inability to bill for some services provided by unlicensed social workers has been especially problematic because licensed clinical social workers are difficult to recruit and retain. Nurses and unlicensed professionals are still treating patients, but the services they provide may not be billable.

- Initially, approved addiction services for the districts/authorities did not include intensive outpatient therapy program (IOP) services. At LBHP implementation, DHH-OBH issued certification approval letters to the districts/authorities that indicated to Magellan what services could be provided by each district/authority facility. The letters included addiction services as approved services for the three districts/authorities that provide these services, but did not include IOP services, even though the IOP services were included in the fee schedule provided by Magellan. As a result, the level of care codes related to IOP services were not

coded into Magellan's system for the districts/authorities, causing rejected IOP claims. In February 2013, the districts/authorities were instructed by Magellan to request amended certification approval letters from OBH to include IOP services. The three districts/authorities that were affected by this issue have made that request, and one district/authority reported the resumption of pre-authorizations and claims payments. However, all three reported that they have not been paid for the previously rejected IOP claims.

- Because of the inability of Clinical Advisor to capture and accurately report data, the districts/authorities could not provide the number or dollar amount of rejected IOP claims.

Results: According to district/authority management, the impact of the transition and implementation issues noted previously may impair their ability to deliver needed services. Also, Medicaid eligible individuals between the ages of 18 and 20 may have been excluded from receiving inpatient substance abuse services.

Recommendation: DHH-OBH and Magellan should work closely with the human services districts/authorities to address the continuing transition issues and identify mutually beneficial solutions. If similar issues exist with other LBHP providers, efforts should also be made to address those groups. Since four new districts/authorities began operation on July 1, 2013, efforts should be made to ensure that the transition issues are adequately addressed so their service delivery is not negatively impacted.

Management's Response: DHH-OBH management noted it was aware of the regulations regarding the Medicaid eligible 18-to-20-year-old population and the discrepancy in payment guidelines for this population. Management noted this issue was new and unique to the LBHP since these services were not included prior to implementation. Management again noted that the districts/authorities have been advised to use block grant and state general fund to fund services to this population.

Management acknowledged the frustration of district/authority management and staff in the difficulties noted with Clinical Advisor. They noted intensive efforts by Magellan, with OBH oversight, to implement enhancements to the electronic health records system. Regarding third-party claims, Magellan, as of July 19, 2013, has developed the functionality in Clinical Advisor to accomplish the third-party billings and is currently training and providing technical assistance for third-party billing to be fully implemented by October 2013.

Management noted the districts/authorities follow the state budget process, and DHH does not control or manage the district/authority budgets.

Additional Comments: We agree that the districts/authorities follow the state budget process. However, DHH, by statute, approves the district/authority budgets. Based on our audit experience with DHH and the districts/authorities, the approval is more than administrative. DHH-OBH provided the budget amounts to shift to self-generated revenue based on the work of an OBH contractor. Routinely over the past several years, we have witnessed portions of mid-year budget cuts required of DHH being passed through to the districts/authorities. We believe that DHH does exert significant control over district/authority budgets.

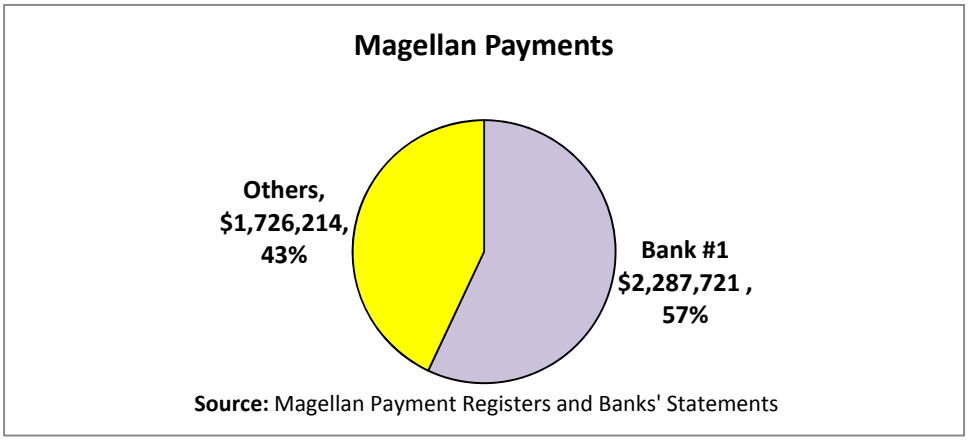
See management's full response at Appendix A.

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

Under the Louisiana Behavioral Health Partnership (LBHP), the districts/authorities are required to file claims with Magellan to receive a payment for each service delivered. These payments are not immediately available to the districts/authorities, but must first be reconciled, classified, and deposited in the state treasury by the DHH Fiscal section before the districts/authorities can access the funds.

For the first year of operation through February 2013, Magellan payments, totaling approximately $4 million, were deposited into 10 different accounts. These deposits had not been reconciled with the Magellan payment registers since the program began. Efforts over several months to reconcile two of these accounts were made by DHH Fiscal, but the reconciliations were incomplete, with up to $840,000 being carried as items it could not identify and account for.

One of the bank accounts used (referred to as Bank #1 in the chart below), with deposits of approximately $2.3 million, did not automatically transfer daily to the state treasury. Instead, the funds in this account were transferred to the state treasury monthly by writing a manual check. The monthly check made payable to the state treasury was mailed to DHH Fiscal and then deposited in the treasury. Each month, this manual process delayed funds available to the districts/authorities by up to 30 additional days. Neither DHH Fiscal nor Magellan were able to provide signed documentation noting that DHH Fiscal had authorized this account to be used in this manner.



Source: Magellan Payment Registers and Banks' Statements

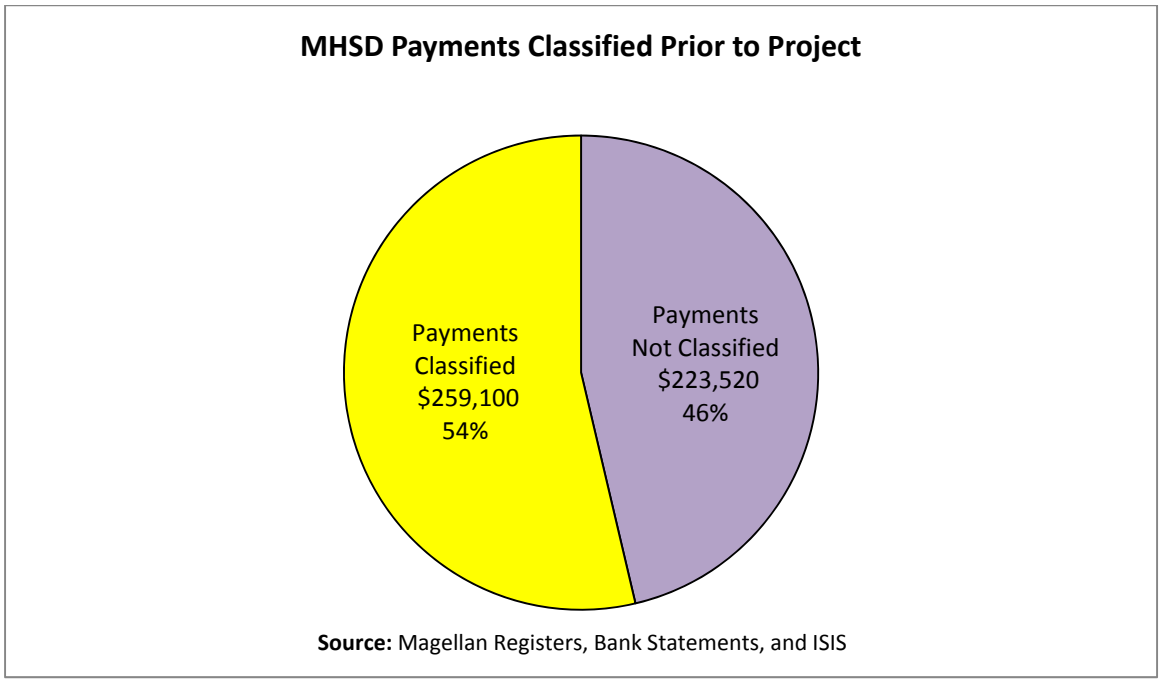
After three weeks of work and inquiry, we obtained valid payment registers and were able to reconcile all amounts paid by Magellan in these 10 accounts. After the complete reconciliation, we were then able to determine what amounts should have been made available to the districts/authorities for their use. The number of days from payment to classification by DHH Fiscal ranged from 23 days to 323 days with some amounts remaining unclassified as of April 30, 2013, as shown on the following page.

Payments - March 2012 to February 2013

	Amount Paid	Classified	Not Classified	Days from Payment to Classification		
FPHSA	$199,765	$199,765		31 days	to	92 days
CAHSD	1,322,729	62,447	$1,260,282*	48 days	to	323 days**
MHSD	482,620	481,730	890	23 days	to	241 days**
SCLHSA	551,264	551,264		31 days	to	99 days
DHH Regions	1,457,557	1,457,557		25 days	to	111 days
	$4,013,935	$2,752,763	$1,261,172			

* CAHSD has not deposited approximately $1.2 million in Magellan payments into the state treasury as of April 30, 2013.
** Days as of April 30, 2013.

Almost half of Metropolitan Human Services District revenues were unclassified when our work for this report began.



Results: 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/authorities could access funds paid by Magellan for their services. As a result, the districts/authorities did not have access to funds which could potentially limit their ability to deliver future services.

Recommendation: DHH Fiscal should gain a better understanding of Magellan practices, payment registers, and coding to ensure that payments can be reconciled routinely to bank statements. DHH Fiscal should review all bank accounts used and arrange for Magellan to make payments directly to district/authority accounts or a state account that is automatically transferred nightly to the state treasury. DHH Fiscal should design and implement adequate fiscal controls to ensure that Magellan payments are identified and classified timely to the proper district/authority so that the district/authority has access to the funds earned.

Management's Response: DHH Fiscal obtained approval from the Cash Management Review Board to establish separate accounts for each district/authority to receive Magellan payments. These accounts will automatically transfer funds nightly to the state treasury. DHH Fiscal is also working with Magellan to develop reports to reconcile Magellan payments made to funds at the state treasury.

See management's full response at Appendix A.

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

Our review noted that certain requirements contained in the Magellan contract were not met regarding implementation planning. In addition, significant technical requirements were not met for the electronic health records system. Our results disclosed the following:

Implementation Planning

- The contract required documentation of all planning meetings, including a list of attendees, topics discussed, decisions recommended, and future action. While auditors did receive planning meeting documentation, the documentation lacked reliable lists of attendees. For the Magellan electronic health records system training forums, no documentation or attendee lists were provided. Without documentation and records of attendance, we were not able to determine if adequate outreach and communication occurred during the planning and implementation as required by the contract.

- The contract required a written project communication plan to keep management and staff aware of information and assigned responsibilities and to keep all system stakeholders proactively informed on the progress of the project. While DHH-OBH provided planning and communication documentation, we did not receive a written project communication plan as required by the contract.

Electronic Health Records System

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

  Once we inquired about it not meeting the March 1, 2013 requirement, we were notified that DHH-OBH was negotiating a contract amendment that would extend the time requirement to meet the required standard. To date, we have not received a signed contract amendment.

  By not using an electronic health records system that meets "meaningful use," the districts/authorities have not used potential federal incentive payments and may be subject to certain penalties in future years.[3] Eligible provider electronic health

[3] Section 1848 of the Social Security Act (as amended by the American Recovery and Reinvestment Act of 2009) notes that covered professional services furnished by an eligible professional during 2015 or any subsequent payment year could be subject to payment adjustments for not using a meaningful use electronic health records system.

records systems that meet meaningful use standards are eligible to receive incentive payments up to $63,750 according to Medicaid provider ID.

- According to technical requirements in the contract, Magellan's information system must support state and federal reporting requirements, including federal block grants. According to DHH-OBH and auditor observations, Clinical Advisor is not capturing the appropriate data to meet federal block grant reporting requirements. Inadequate reporting could result in disallowance of expenditures.

- The contract requires that Clinical Advisor encompass all core functions and reporting provided through the previous DHH-OBH Accounts Receivable System. While DHH-OBH considers these functions complete and delivered, district/authority 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.

- 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. 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. According to DHH-OBH, this project has been delayed because of significant technical challenges with the implementation of Clinical Advisor.

Results: For the contract clauses noted above, DHH-OBH has not adequately monitored the Magellan contract to ensure that all contractual requirements have been met. Although the contract allows DHH-OBH to impose sanctions on Magellan of up to $100 a day when it has been determined that required services are not being provided, no such sanctions have been applied.

Recommendation: DHH-OBH should monitor the Magellan contract to ensure that all contractual requirements are met, especially those technical system requirements that have a possible negative impact on Louisiana Behavioral Health Partnership providers.

Management's Response: DHH-OBH management noted that effective immediately, OBH staff has been advised to obtain documentation of attendance and topics discussed at all relevant meetings for the LBHP.

Management also noted that rather than the written project communication plan required in the contract, Magellan is using the LBHP implementation dashboard to report to OBH. Management contends that the implementation dashboard serves the same purpose as the required written project communication plan.

Regarding the electronic health records system, management is currently developing an amendment to the contract for Clinical Advisor to meet the CMS "meaningful use" requirements and anticipates that Clinical Advisor will meet "meaningful use" standards by 2014.

Management also mentioned that current CMS regulations indicate full funding for the electronic health records incentives will be available for providers that enroll in the program before 2016. Management further noted current Louisiana Medicaid regulations do not assess penalties on providers for noncompliance with the "meaningful use" standards.

Magellan is currently working on system changes to Clinical Advisor that will capture the data elements required for federal block grant reporting by December 2013 and will implement changes that allow Clinical Advisor to interface with LaHIE by March 2014.

Additional Comments: The written project communication plan is required by the contract. We have not reviewed the implementation dashboard to determine if the dashboard meets the same purpose as the written project communication plan.

The contract required that Clinical Advisor meet "meaningful use" standards within one year, which would have been March 2013. While we realize that Louisiana Medicaid does not have provider penalties for electronic health records that do not meet "meaningful use," Medicare does have penalties beginning in 2015.

No sanctions have been imposed on Magellan for not meeting all required contract provisions.

See management's full response at Appendix A.

APPENDIX A: MANAGEMENT'S RESPONSE

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Behavioral Health

July 26, 2013

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 discussions with our office concerning the Louisiana Behavioral Health Partnership (LBHP). The LBHP is a unique approach to behavioral health managed care. Since the initial implementation phase, the Office of Behavioral Health (OBH) continues to evolve in its role as contract monitor and oversight agency for the LBHP. OBH offers the following in response to the issues raised:

Documentation:
As noted in the Informational Audit, the absence of documentation of attendee logs made it difficult for the auditors to ascertain that sufficient outreach and communication to stakeholders had occurred. Effective immediately, OBH staff has been advised to obtain documentation of attendance and topics discussed at all relevant meetings related to the LBHP. Additionally, the audit indicates that a "written project communication plan" was not made available. The purpose of the written project communication plan is to keep management and staff aware of assigned responsibilities and keep stakeholders informed on the progress of the LBHP. Functionally, Magellan is utilizing the LBHP implementation dashboard to report to OBH for this purpose.

Definitional Discrepancies:
Prior to the LBHP, substance abuse services were not reimbursable under the Louisiana Medicaid program in either outpatient or inpatient settings. Within the OBH service delivery model, persons18 years of age and over were recognized as adults; conversely, under the Medicaid program, persons less than 21 years of age are recognized under the regulations governing services/reimbursement to children. This discrepancy in reimbursement guidelines is well known; however, prior to implementation of the LBHP, no specific Medicaid reimbursable services existed unique to the 18 to under 21 age group. As it relates to reimbursement for traditional program model services, OBH has advised the LGEs to continue to use block grant and SGF funding sources.

Billing:
OBH recognizes two issues raised by the Informational Audit: 1) reconciliation of Magellan payments to accounts in the state treasury and 2) inability of nurses to bill for injection services. In response to item one, DHH-Fiscal has obtained approval from the Cash Management Review Board to establish zero balance accounts (ZBA) to receive Magellan payments for each LGE. The balance in these accounts will automatically transfer nightly to the state treasury account. As reported by DHH-Fiscal, it is working with Magellan to identify and develop reports to reconcile Magellan payments to funds received in the state treasury.

With respect to item two, Magellan is actively addressing the issue concerning billing for the provision of services by nursing staff. As reported by Magellan, full resolution of this issue is expected within the next 90

days. This resolution will allow that injections by qualified nursing staff will be reimbursable under the physician's extender code (CPT code 96372).

Electronic Health Records (EHR):
The Informational Audit indicates four primary areas of concern within the Clinical Advisor recordkeeping system. These four areas are: 1) billing of third party payors; 2) meaningful use standards under the EHR Incentive Program; 3) data elements necessary for block grant reporting requirements; and 4) connectivity to the Louisiana Health Information Exchange.

Clinical Advisor was initially designed for Medicaid claims processing and reporting personal health information and a clinical treatment plan of care within a closed information system. The conversion to a comprehensive managed care model within an "open" information system format for all behavioral health services is a labor intensive process. There is no question that this process has been frustrating for staff and LGE management. Intensive effort has been dedicated by Magellan with OBH oversight to implement enhancements to the initial system so that it can be successfully tailored during the first year of implementation to meet a broad array of data reporting, billing, and accounting procedures for the LGE operated behavioral health clinics. Significant technical assistance has been provided through informational bulletins, webinars, and on-site technical assistance as requested by LGEs. These visits and trainings have included one-on-one attention to issues, including use of Clinical Advisor for business practice purposes, health information record keeping, and billing. 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.

With respect to item one, the LGEs are unable to bill for third party claims through the Clinical Advisor system. According to Magellan, as of July 19, 2013, computer enhancements for functionality within Clinical Advisor for third party claims processing is now complete. Magellan is currently in the training and technical assistance phase, and full implementation of third party billing through Clinical Advisor is anticipated for October of 2013.

Relative to item two, the LGE Executive Directors have expressed concern over the loss of potential incentive payments available to their clinical operations due to meaningful use standards not being met by Clinical Advisor. OBH is currently developing an amendment to the contract in order for Clinical Advisor to meet meaningful use requirements. The Federal Medicaid EHR Incentive Program provides incentive payments for up to five years to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology as established by CMS. Current regulations indicate that full funding for all five years will be available for providers that enroll in the program before 2016. Therefore, delayed certification of meaningful use should not impact the LGEs since it is anticipated that Clinical Advisor will meet meaningful use standards in 2014. The LGEs are not subject to financial penalties since Louisiana Medicaid does not assess penalties for noncompliance with EHR meaningful use. OBH staff is available to provide information to the LGE Executive Directors regarding this topic.

Regarding item three, OBH recognizes that certain data reporting inadequacies necessary for the mental health and substance abuse block grant reporting requirements presently exist in Clinical Advisor. OBH is currently working with Magellan to capture the appropriate data elements, and OBH has met with Federal block grant authorities for guidance and is working with Magellan to identify the necessary data elements for inclusion in Clinical Advisor. As advised by Magellan, these changes will have an anticipated implementation date in December of 2013.

With respect to item four, OBH also acknowledges that Clinical Advisor is not connected to the Louisiana Health Information Exchange (LaHIE) network as per the contract's requirements. OBH anticipates that the implementation of features to allow connectivity with LaHIE will be no later than March of 2014.

In summary, while OBH continues to provide technical assistance to the LGEs, the LGEs are separate budget units within DHH schedule 09. The LGEs follow the standard state budget process as outlined in statute with their budgets receiving final approval through the legislature. DHH does not control or manage the LGE budgets or the collection of self-generated revenues. 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,

Anthony H. Speier, Ph.D.
Assistant Secretary

Cc: Kathy Kliebert, Secretary
Courtney Phillips, Deputy Secretary

AS/jk

APPENDIX B: SCOPE AND METHODOLOGY

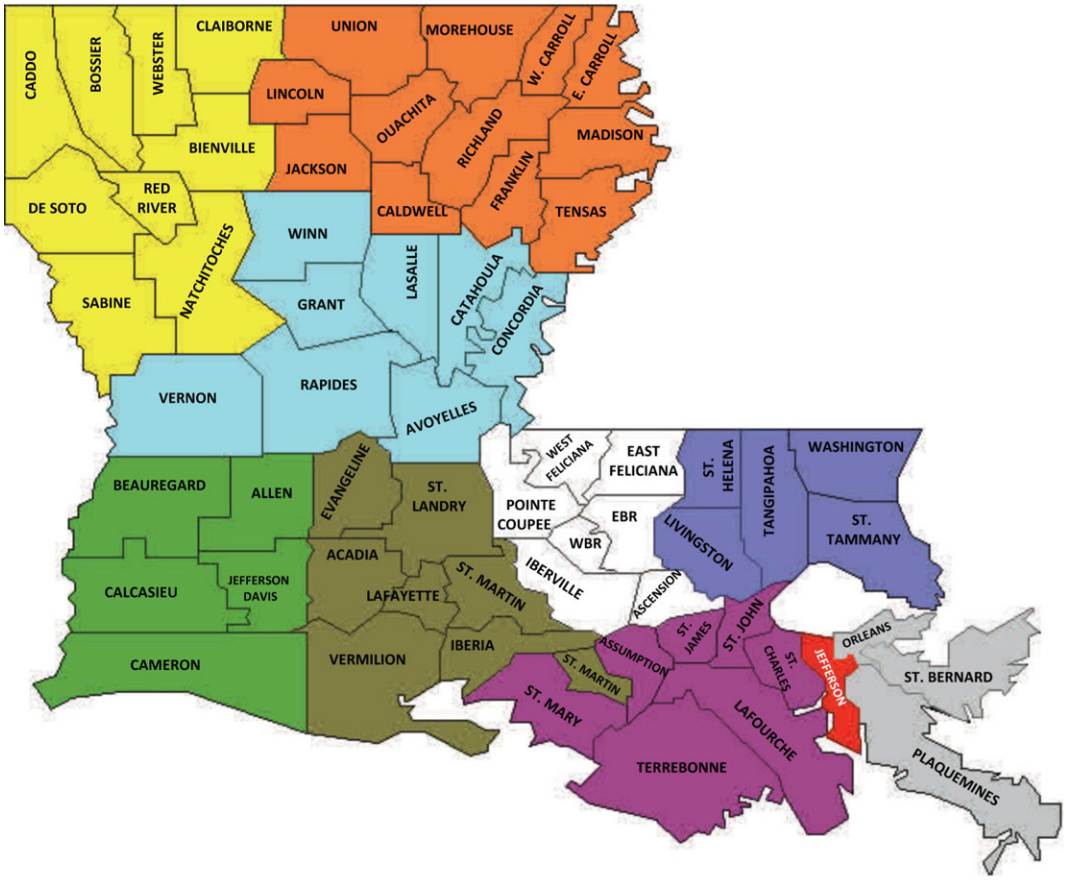
We conducted procedures for this informational audit to provide information to the Legislature on the implementation and transition issues for the Louisiana Behavioral Health Partnership (LBHP) as experienced by four human services districts/authorities. We did not conduct this audit in accordance with governmental auditing standards. Our objectives were:

1. How did the Department of Health and Hospitals - Office of Behavioral Health (DHH-OBH)/Magellan changes and transition issues impact the human services districts/authorities?
2. Did DHH implement adequate fiscal controls to ensure that the human services districts/authorities were paid accurately and timely for services provided?
3. Did DHH-OBH adequately monitor the Magellan contract to ensure that contract requirements were met?

To achieve our objectives, we:

- Interviewed DHH-OBH personnel and performed certain procedures to obtain an understanding of the LBHP service delivery model, Magellan's role as the state managing organization, and the implementation timeline.
- Interviewed Capital Area Human Services District and South Central Louisiana Human Services Authority management to identify transition issues and possible impact on service delivery.
- Conducted certain procedures at DHH-OBH and DHH Fiscal to access internal controls over the Magellan payments processes.
- Performed a detailed reconciliation of Magellan payments to all human services districts/authorities and DHH regions for the first year of LBHP operation.
- Reviewed the Magellan contract and performed certain 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, and Florida Parishes Human Services Authority 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/authorities management.
- Discussed the contents of the report with DHH management.

APPENDIX C: DEPARTMENT OF HEALTH AND HOSPITALS HUMAN SERVICES DISTRICTS/AUTHORITIES (As of July 1, 2013)



- Jefferson Parish Human Services Authority
- Metropolitan Human Services District
- Capital Area Human Services District
- South Central Human Services Authority
- Acadiana Area Human Services District
- Imperial Calcasieu Human Services Authority
- Central Human Services District
- Northwest Louisiana Human Services District
- Northeast Louisiana Human Services District
- Florida Parishes Human Services Authority