COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
HEALTH AND HUMAN SERVICES COMMITTEE
AND JUDICIARY COMMITTEE

Public Hearing re Magellan Mental Health Services

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Stenographic report of public hearing held at Holy Family University, Grant and Frankford Avenues, Philadelphia, Pennsylvania

Wednesday
May 18, 2005
10:00 a.m.

HON. GEORGE KENNEY, CHAIRMAN, HEALTH AND HUMAN SERVICES
HON. DENNIS O'BRIEN, CHAIRMAN, JUDICIARY

MEMBERS OF HOUSE OF REPRESENTATIVES

Hon. John Evans	Hon. Kathy Manderino
Hon. John Fichter	Hon. Doug Reichley
Hon. Tim Hennessey	Hon. Chris Ross
Hon. Thomas Killion	Hon. Kathy Watson

ALSO PRESENT:

Dana Alwine, Esquire, Special Counsel, House Judiciary Committee
Sharon Cole, Research Analyst, Health and Human Services Committee

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CHAIRMAN O'BRIEN: Good morning, everyone. I'm Denny O'Brien, Chair of the House Judiciary Committee. To my right is Chairman George Kenney from Health and Human Services. I would first like to thank Holy Family University for allowing us to use this wonderful facility, and I'd also like to welcome everyone to my legislative district. I'm very proud that this university is part of my legislative district. It serves wonderfully the community. This university is unique in that it offers wonderful educational opportunities for people in this community. They have a wonderful nursing school, they have a new building that is being constructed at the corner of Grant and Frankford Avenue. It's an education building. They have a wonderful business school here. They also offer unique opportunities for individuals who have gone out into the business world or perhaps they are coming back later in life to get their undergraduate or postgraduate degrees. So I have always found Holy Family to be a wonderful asset to this community both in my district and at large, so I want to thank them for that. And I also would like to add that Holy Family is now embracing one of my passions in that the dean of the education department has willingly and very, very energetically embraced the idea of creating what I would think would be the first Master's program for educators in the area of autism, looking towards creating a Ph.D., and for

all the people that are in this discussion, we know what therapeutic support staff is and we're looking at credentialing a program for undergraduate students there. So I want to thank Glenn Sroka for his participation in those discussions.

But the reason that we're here today very simply is to look at issues involving private care for subscriber employer paid MH services. There's a lot of other issues that involve Magellan. Magellan is much more than the issue at hand, so I think it's important that we put a box around the issue that we're going to discuss today. We may go back and look at other boxes in the future, but we're going to stay within this box today.

The issues that we're going to try to deal with today are authorization, credentialing, billing, and administrative issues, and how these issues create barriers to treatment. There are numerous issues. I know there's a lot of interested parties. We have a very ambitious agenda. We're going to try to stick to that agenda. The general rules that we have for these hearings are that I believe that we have panels constructed for efficiency purposes today. We ask that you present your testimony in advance. Copies of that testimony will be available for anyone that's here to audit these hearings. There will be an opportunity for the presenters to make -- to present their testimony, and then

we will open it up to questions.

At this point, I'll recognize my colleague George Kenney for some opening remarks.

CHAIRMAN KENNEY: Thank you, Dennis, and thank you for hosting this public hearing. It is an important public hearing. We on the Health and Human Services Committee, along with our colleagues in the General Assembly, have been working to insure that Pennsylvanians have access to quality health care, and as Chairman O'Brien mentioned, if there are barriers to getting that health care, especially behavioral health, we have found has been a difficulty, we want to knock down those barriers and give people an opportunity to get well. Over the past month, and I'm joined here by Representative Kathy Watson from Bucks County and Representative Tom Killion from Delaware County, we've received numerous e-mails on this issue regarding managed care not allowing consumers to get access to quality health care, and I'll just read a couple lines. One is when you get e-mails like this, it's important we in the General Assembly step in, and I'll just read one.

"It is troubling how managed care companies like Magellan impede and prevent access to the continuity and quality of care that clients deserve." And that's what we're here to find out, if consumers are being impeded from getting quality health care, and I thank the Chairman again and ask

if Representative Watson has any opening remarks.

REPRESENTATIVE WATSON: Thank you, Chairman Kenney and Chairman O'Brien. My remarks are brief. I think my Chairman for Health and Human Services summed it up. We received a number, a large number of e-mails, also several phone calls, and not just from folks who indeed provide care but indeed from patients themselves and families of patients, and that's something that I think we definitely need to hear and see because we don't want any, and the goal certainly of State government is that we get everybody back to where they're a productive person in our society. So thank you very much. I look forward to some interesting comments this morning.

CHAIRMAN O'BRIEN: I would also like to recognize that we have been joined by our friend from Delaware County, Representative Tom Killion.

REPRESENTATIVE KILLION: Thank you, Mr. Chairman. I'll be very brief also. I'm kind of crashing my colleagues' party here. I do not sit on either of these committees, I sit on the Insurance Committee, but as a former chairman of Delaware County Council, we worked with these issues and also received some of the same e-mails. So I want to hear the testimony, and I appreciate you for allowing me to crash their party. Thank you.

CHAIRMAN O'BRIEN: Thank you very much.

At this time we would ask Stacy Mitchell, the Director, Bureau of Managed Care, from the Pennsylvania Department of Health, to come forward.

MS. MITCHELL: Good morning, Chairman Kenney and Chairman O'Brien, members of the committees, and other invited guests. I am Stacy Mitchell, and I am the Director of the Bureau of Managed Care with the Pennsylvania Department of Health. Thank you for inviting me to provide you with information concerning the department's regulatory responsibilities regarding managed care plans in Pennsylvania.

Under Act 68 of 1998, and the HMO Act, the department co-regulates managed care plans along with the Insurance Department. The Insurance Department is responsible for financial matters, including plan solvency, benefit contracts, and premiums. The Department of Health is responsible for most areas of plan operations, including medical management, utilization review, member and provider appeals, quality assurance activities, provider networks, contracts, and credentialing.

The Department of Health issued new managed care regulations effective June 9, 2001, to update the regulations for HMOs and implement Act 68. As you may recall, Act 68 created formal types and levels of enrollee and provider appeals. This includes grievances, which are appeals for

covered services that have been denied as not medically necessary or appropriate, and complaints, which are appeals about anything other than medical necessity and appropriateness, complaints such as contract terms, benefit limits, plan policies and operation. Grievances that reach the third level of review are coordinated by the Bureau of Managed Care and provided by an independent physician or psychologist in the same specialty as the service under review. There were 385 third level grievances in 2004. Planned denials were overturned in 33 percent of the grievances. Complaints that reached the third level are reviewed by the Bureau of Managed Care, and decisions are issued as agency adjudications. There were 95 third level complaints, and the planned denials were overturned in 37 percent of those complaints.

With this general background, I turn to the matter that is the subject of this hearing. As I have said, the department regulates managed care plans and their operations. Many managed care plans that we license have elected to subcontract to others the work they would normally have performed in-house. Subcontracting is not prohibited by law. However, the department holds the managed care plans responsible for the conduct of its subcontractors. The management and provision of behavioral health services is commonly subcontracted to other companies.

In the southeast section of the State, both Aetna and Independence Blue Cross, IBC for short, have been subcontracting behavioral health services to Magellan Behavioral Health for many years. Magellan has two different service centers that support the subcontracted operations. One service center for Aetna is in King of Prussia, and last year the service center that supports IBC was moved from Philadelphia to Alpharetta, Georgia, under a new contract arrangement. There are some functions that Magellan has centralized for both companies and others such as claims processing in Columbia, Maryland. Aetna has elected to discontinue its relationship with Magellan on a national basis and is returning its services to in-house operations effective January 2006.

In early March, the Pennsylvania Psychological Association told us that it was preparing a report concerning problems with Magellan in southeastern Pennsylvania. On April 19, we had a conference call with Representative O'Brien, staff from both committees, and providers from CORA Services to learn more about the concerns about Magellan. It was evident during the call that providers had a very high level of frustration with Magellan, and the department offered to meet with providers directly to gather more insight and information to clarify the areas of concern. Bureau staff also met with representatives from the PPA on

April 20 and received a copy of the PPA report on commercial mental health care in southeastern Pennsylvania that was released that day to the public.

On April 27, we met with Representative O'Brien, staff members from both committees, representatives from the PPA, the Psychiatric Society, the Association of Social Workers, and numerous providers from the southeast. The meeting was hosted by CORA Services and was very helpful in illuminating the operational issues directly affecting and frustrating providers, namely the authorizations process and provider credentialing and recredentialing. Prior to the PPA report and these meetings and conference calls, the department had received no complaints, formal or informal, from providers or enrollees about Magellan's commercial operations. We were presented with documented evidence of operational deficiencies at that meeting, and on the strength of that and the anecdotal information we gathered from the providers, we immediately contacted and mobilized IBC and Aetna to conduct investigations into the providers' allegations regarding their subcontractor, Magellan. Both plans have instituted full-scale investigations including root cause analysis and will be providing to the department a plan of correction that will resolve these operational deficiencies.

We continue to receive documented evidence from the

providers that is supremely useful in investigating the transaction trails that involve both large-scale computer systems and human interactions in multiple States. The issues are complicated, and some solutions will be faster to implement than others, but we believe all the problems that have been presented are fixable and we intend to see that they are in fact corrected. We have pledged to the providers that we will keep them informed of the progress of the investigation and solution implementation, and they have indicated their willingness to assist us with validating the success of the solutions. IBC, Aetna, and Magellan have pledged and demonstrated complete attention and cooperation to the department in this effort.

At this time, I am happy to answer any questions you may have.

CHAIRMAN O'BRIEN: Thank you, Stacy. Perhaps for the members of the panel and those in the audience you can illuminate the relationships between the Department of Health, Department of Welfare, and the Insurance Department. I know that in your testimony you said you received no complaints. Could you also, as part of that discussion, illuminate how providers and clients can access that information as to how to post a complaint and how they would determine whether it's appropriately lodged with the Department of Health, the Insurance Department, or the

Department of Welfare?

MS. MITCHELL: Sure. The Insurance Department generally will get involved in matters that involve contract interpretation, benefit contracts, and the rates and premiums and enrollment transactions. So if someone has been disenrolled or their insurance was cancelled, those types of problems are best brought with the Insurance Department. If people are having problems accessing services, they can't get a referral, they can't get an answer, they can't get a provider within the network, they can't get a return phone call, any types of problems accessing services are best brought to the Health Department if it's commercial issues. The Department of Public Welfare has several arrangements through the Health Choices program, and counties have different service providers. Magellan does some service providing in this section of the State, Community Behavioral Health handles Philadelphia County, Value Options handles other counties. There are several contractors.

If it's an access and availability problem, we can help as well, and we do receive phone calls from enrollees who have been approved for services and can't get access to them, or they can't get approval for services. Some of those issues are appropriate appeals under Act 68 as a complaint or a grievance, depending on the nature of it, and we will get them into the appeal process. Often times we'll do an access

investigation and ask the plan to fulfill the service that's been approved. We have a toll-free telephone number, enrollees contact us directly all the time, we have staff available from 8:00 to 5:00 Monday through Friday, and we can be reached by e-mail as well through the department's Web site.

CHAIRMAN O'BRIEN: There have been several issues that you, that we've discussed both in the conference call and in the subsequent follow-up meeting. Maybe I can start off with the authorization issue. I'll try to keep my question somewhat general so that you can respond. We both heard the conversation. On the authorization issue, it was maintained by providers that, one, authorization has never been denied by Magellan, but there are hurdles, barriers and all kinds of hoops that people have to jump through. And that is a separate issue from the actual eligibility issue. Even after you get all the authorization, it's been suggested that you still might not be paid. But the question is why are we spending all the money on an authorization process that really has no purpose if all the authorizations are going to be approved anyway?

MS. MITCHELL: Well, that's a good question, and whether plans choose to put preauthorization processes in place or not is something that's a business decision on their part. There's no law that prohibits it, there's no law that

requires it. If they are going to put it in place, though, they do have to operate it according to the standards in law, and that requires specific turnaround times, specific notices. The least expensive way to do these types of transactions is to do them electronically. We can do them on the Internet in a secure environment, there's very little human intervention, you don't have to pay benefits to a computer, you don't have to hire, train, and recruit. So most plans generally try to do this as much as possible through electronic transactions. Without getting into a lot of the specifics, what we're seeing is some concern that these electronic transactions are not going as they should be and that there's a very high failure rate of transactions that kick out for human intervention. It's expensive for that to have happen. You have to hire people to do what computers would otherwise do for you. So from what's been happening thus far, we know that there have been people in the provider offices who have been cooperating with us and they've been witnessing the difficulties that the providers have been having and they're already analyzing those problems and beginning to work on solutions to fix them.

If the transactions go the way they're supposed to go, when someone presents CORA Service, the request will be asked and it will be answered immediately, and there won't be any delays for services, but that's not what's happening all

the time right now.

CHAIRMAN O'BRIEN: Do you have any information that you have that you can share with us as to what the nature of the most substantive complaints are? We've heard that the number one, the authorizations are submitted electronically, there has been some representation that some of those authorizations are shredded or dismissed or lost. There's a question of when the clock starts ticking on appeals, and the other issues involve the burden, whether the burden involved or embodied in these authorizations is appropriate, or for one very simple reason, and I'll try to put a humanistic look on this. We're dealing, again, I want to emphasize that we're dealing with the mental health community. It's very difficult for those individuals who are incapacitated due to some level of mental illness to make that first phone call to access treatment. If they are met with a significant level of bureaucracy, then the net result is they're going to walk away. And then the issue is does somebody win, does somebody benefit? And is the authorization process designed to accomplish that end, so that it's a financial issue where we're managing money rather than managing care?

MS. MITCHELL: There's a number of questions all wrapped up in that.

CHAIRMAN O'BRIEN: I told you I would be general.

MS. MITCHELL: Let me try and answer all of them as

best that I can. There's no legal prohibition on doing authorization, so if a company chooses to make a business decision, they do that for business reasons. There is no intent to deny services through an authorization service, but to make sure people get effective and efficient services. And I don't believe what we're seeing is a system that was designed to blockade people and frustrate them and give them and deny them access to services. And in fact, what we're hearing from the providers is that that is not happening because they have been providing services, even without authorization and even without compensation. And we have not received any phone calls from any enrollees who haven't been able to get services.

Having said all that, there was an operational change in the fall of last year that changed the payment terms, and that's partly contributing to some of these transactional difficulties. Up until the fall of last year, providers were capitated, they got paid a per member per month fee. They didn't need to get preauthorizations, they just treated people as they showed up. Last fall they were put on a fee for service basis, which means they have to submit a claim and get an authorization in order to get paid. That puts a lot of transaction now back on the provider that they didn't have to do before, and it also creates a lot of transactions in-house that didn't have to be done before, and

that's a tremendous amount of volume that happens all at once. But we don't believe that any enrollees have been denied any services because of these, at least we have not been made aware of any issues.

CHAIRMAN O'BRIEN: Some of the other specific issues involving authorization surrounds the issue that the administrative, I guess the speculation that after Magellan came out of bankruptcy, that they shifted a huge chunk of the administrative burden to the providers. Also, that the authorization process that they now use is unclear and in fact that it changes from day to day. And there's always been questions as to whether their software communicates appropriately with the other providers that are their subcontractor. We've heard stories that when somebody hits the refresh button, the information that Magellan has will go back five years and the updated information that providers provide is deleted, and then those authorization processes just keep going and the clock never stops. So you may be in the system for an extended period of time, and we all know, I think, how important the clock is in this discussion. And if they do exist, how would providers manifest those problems to the Department of Health, and to other departments if appropriate, and how can we assist you in identifying solutions to those problems?

MS. MITCHELL: We have received a lot of hard copy

evidence from a lot of providers in this process. They are giving us prints of computer screens that show when the services are requested, if they get a default message that the service could not be approved or they've been cancelled out, we're getting that evidence, and then we're getting the information about when the approval is being issued. We can't prohibit them from doing this process, but we can make sure that they do it according to the terms that are set by Act 68, and that's namely to turn one around in two business days or less, two business days at the outset.

The thing that can't be done is to change payment terms and policies on the fly. That's not acceptable, it's not acceptable to not answer people in two business days, but these are transactions that we need to have evidence of, and the provider community has been extremely helpful to us in giving us samples of these transactions. We have in turn been feeding them to IBC and Aetna, and I can't emphasize how critical these transactions are because it allows you to go back through the computer systems to find out switching stations and fingerprints of who touched them and how the systems failed and whether it's the system in one State or a system that's backed up in another State. It's a complicated issue, but the more concrete examples we can be given of this, the better chance that investigators have to go back and find the root cause, and we will go back to get the root

cause of these issues and they will be resolved.

CHAIRMAN O'BRIEN: If you do find that there are substantial issues in the computer issues which would require significant capital investment, will there be a discussion that surrounds Magellan's economic climate and whether they have an ability to respond and upgrade those computers?

MS. MITCHELL: They're accountable to their contractors, they're accountable to IBC and to Aetna, and Aetna and IBC have the obligation to make sure that these services happen in compliance. So we will be holding them responsible. They will have to choose to continue to deal with Magellan or make other decisions and arrangements as they see fit, but these problems will be resolved.

CHAIRMAN O'BRIEN: There's been other issues or complaints that many of us have heard surrounding communication issues when Magellan was housed at Independence Blue Cross. Since they've moved to Georgia, the information that's been funneled to my office dictates that there's been almost no communication. Have you investigated that complaint, and if so, what is the Department of Health's response?

MS. MITCHELL: We have not heard any of those complaints, but I need more information about what type of communication that the providers are looking for that are problematic and we'll be able to--

CHAIRMAN O'BRIEN: I think it relates to the issues of how you go through the authorization process, and they maintain that that process changes day to day and there's no way that they can get what the authorization process is today and how they would facilitate responding to that process.

MS. MITCHELL: It is unacceptable to continue to change operating procedures on the fly. It's unacceptable to change them this week and have a different rule for next week. It's also unacceptable to have providers out there who don't know how to operate within the system. They have a contract, they've signed a contract, they have responsibilities and Magellan has responsibilities, and a large part of this is provider education. And any component of a corrective action plan will include a significant provider education component. Whether that is meetings for office managers or face-to-face meetings and providers to assist them in understanding how to operate the system, there will be absolutely a large provider education component.

CHAIRMAN O'BRIEN: Maybe I can move to the, does anyone else have questions on authorization? Maybe that would be--

(No response.)

Maybe we can move to credentialing. I would just again throw you out one of those general questions that you can respond to, and for I would say 12 years, when Green

Spring was part of Independence Blue Cross, there were credentialing issues that I have been aware of. They certainly have persisted as problematic issues over the last 10 years or so that Magellan has been involved in this process. Over the years I've seen responses, for example, we will double or quadruple the number of providers, but the specific issue that is not addressed is how individuals are credentialed. And one specific issue that I hear time and time and time again is not necessarily that the provider needs credentialed or that there's a new process for that provider to get recredentialed if appropriate, but if you have this network that doubles or grows at four or five times, if you are a network and you're working for provider A and you go to provider B, that credentialing for those individuals to move from one provider to the other is not reciprocal. So you have a system where providers either have to have someone on staff for several months and they're paying them to see nobody, or the individual that they want to bring on board says why do I want to work for a provider like this because they can't get me credentialed? And very simply, if these individuals are licensed through the Department of Health and the Department of State, why is there a superfluous credentialing requirement that is more burdensome and exceeds that level of credentialing that the State already is involved in?

MS. MITCHELL: Well, there's two issues in that.

CHAIRMAN O'BRIEN: I think there's more than that, but you can start with the two that you want to pick first.

MS. MITCHELL: I'm going to pick the two I want to answer, how's that? No, there is actually two central issues. The first is why credential at all?

CHAIRMAN O'BRIEN: I didn't ask that question, but you can respond to that.

MS. MITCHELL: Well, if State licensure is it, why do we put other people through further credentialing processes? Act 68 requires them to credential providers. It has been a staple of NCQA certification since the late '80s. Credentialing was required because managed care plans limited choice. They created a limited network back in the early days, and sometimes they were extremely limited, and you could only receive covered services from those providers and the plans had a responsibility to credential those providers to make sure enrollees were getting covered services that were safe, effective, and efficient. Networks have since grown and expanded, but credentialing still remains a requirement. It's never an easy process, it's one that all licensed professionals go through. It's also not necessarily and doesn't need to be a long, lengthy, and cumbersome process either. The best plans can do it inside of two months to three months maximum from the time they receive a

new application. That's not to say they're doing a lot of the work, often times they're waiting for information to come back in.

For example, if a physician says he has privileges at a hospital, someone at that hospital needs to write a letter and swear that that physician has privileges at that hospital. So often times they're waiting for information to come back in, and that adds to part of the process. But credentialing is extremely important not just in the initial but in the recredentialing. In recredentialing, not only do they make sure that they still have insurance, they check their claims history, but they also incorporate information that they have about their performance and member satisfaction. They're required to do member satisfaction audits, and if providers should no longer be in the network, then they are decredentialed. So we believe it is an important way of ensuring that people are getting access to safe and efficient, effective providers that are going to deliver quality health care services.

Having said that, it does take time. The problem that you're describing about being credentialed at one location and those credentials don't travel to another isn't our understanding of the situation. Although that phenomenon is happening, but it's not happening because of credentialing. Once someone is credentialed by Magellan,

whether they work for provider X or provider Y, they've been credentialed. The problem becomes getting them loaded into the computer in a payment system with the appropriate tax IDs in multiple locations. There are a lot of computer systems here, and so they are in the system with a single name under provider X, they get married, they work for provider Y, the computer doesn't recognize the change in the name, they are loaded with a different name in computer Y, but it's just a complicated provider tracking system. Every health plan has difficulties, this isn't a new phenomenon, providers don't stay put in one place. They move locations, they change jobs, the computer needs to be appropriately coded so that each provider and their tax ID is clearly identified. And we don't know exactly what's going on with this dictionary problem that's happening, but that's what it seems to be. They're recognized in one subset or one database in a particular way, they're not recognized in another, and there doesn't seem to be a good reason for that, other than they need to go through and clean up their provider files. That's the information that we're getting. It's not necessarily, and I won't say that there aren't other issues with credentialing. There are. But once you've been credentialed and you're approved in the network, the fact that you've changed employers shouldn't prohibit you from being operational when you switch jobs.

CHAIRMAN O'BRIEN: Well, if I can just respond to that, and you can't see this, but as I look out at the audience, I see everybody going like this (indicating in the negative.) And if it were, if people were credentialed within two, three months, we could get out of here by 10:45. But that's not, if everybody were credentialed within two or three months, I don't think that we would have a problem. But it's been my personal experience as a board member on several boards that it's always taken longer than six months and that you can never get -- there is no recognition that if someone has been credentialed with provider A that they can move over and go to provider B. And if it were very simple, you know, just to identify that tax information, then we could make this issue go away. That's not been my experience, I can tell you that, and it's not been the experience that I've had in talking with many providers. And so from that standpoint I think that is a very substantial issue that has to be addressed by the Department of Health.

MS. MITCHELL: Well, I understand, and I would just like to say that I can't see everyone behind me, but for those of you who have these experiences--

CHAIRMAN O'BRIEN: We could get a mirror.

MS. MITCHELL: --please, please give us this information, because the two examples that we were given had to do with having bad addresses, they sent the

recredentialing file to the wrong place, or having problems in recognizing their names, and that was causing delays because the recredentialing information was not getting to the location where it should have. So what we've seen is the transactional issues, again, not necessarily the timing or the problems with the process. So I can't say enough, please get us that information and we will chase that down as well. We are looking into the overall process, nonetheless, to make sure that it does happen as smoothly and efficiently as it can be to set that goal and the timeframe of proper recredentialing.

CHAIRMAN O'BRIEN: Maybe as a follow-up to this hearing we can have informational hearings that will bring providers in and drive that conversation to some kind of a resolution. I personally am not satisfied with that response, not from you, I just feel that the system has been broken for over 10 years and I just can't believe that it can be addressed as simply as you stated here today.

As I go through, I don't want to dominate this, I know Representative Watson has some questions and I'll probably have some follow-up questions.

REPRESENTATIVE WATSON: Thank you. Thank you, Mr. Chairman, thank you, Ms. Mitchell, for being here and for going first, because that's never fun in a hearing like this. If someone didn't tell you that, you'll know for the next

time.

My question, if I may refer to your testimony, page 3, in the last paragraph, where you are speaking about IBC and Aetna, and you've asked them to conduct investigations into the provider's allegations regarding the subcontractor Magellan, and I'm reading, both plans have instituted full-scale investigations including root analysis and will provide the department with a plan of correction. So my first question would be, did you give them a date? It always helps if we all have something to shoot for and get things done, and obviously we all love sooner rather than later.

MS. MITCHELL: Absolutely, and our priority is to get this resolved as quickly as possible. We have given them a date of 45 days from the time that we sent them a plan of correction with the evidence that we had in hand, and that would be toward the end of June that they would send us a full formal plan of correction, but we have been in contact with both plans on a weekly basis getting progress reports and updates about the steps that they have taken thus far, and anything, and they have both assured me that anything that can be corrected prior to the due date will be corrected, the transaction problem is a matter of not having sufficient line capacity and service to handle the transactions, that can be resolved very quickly, you just buy additional hardware and you install it. There are other

issues that may take longer than that, but it's important for the providers to continue to send us evidence so that we can continue to feed it to the plans and their investigators. But we believe that most of, they're already on the trail.

REPRESENTATIVE WATSON: All right, and if I may go back to something earlier that Chairman O'Brien was speaking about, if indeed as we looked out when you were saying what you understand to be true and the information provided to you, we saw the heads going no, it's more than this; no, it's more than that. I guess my question is in doing any plan of correction, is there any assurance that you really have a good analysis of all the problems? Because I'm getting the idea that you don't have enough information, nor does Aetna or IBC, to do that. If that's the case, and those heads are going again, so we're going to make that assumption, how do we--

MS. MITCHELL: Let me have a mirror.

REPRESENTATIVE WATSON: That's all right, it's better you don't.

MS. MITCHELL: That's probably true.

(Laughter.)

REPRESENTATIVE WATSON: How do we manage to get all of that other information, detailed anecdotal information, so that we're all on the same page as to what the problems are so that when there is a plan of correction it really corrects

the problems and things move ahead rather than kind of perhaps as they've done before, sideways, if you will? How do we get them, who do we get them to? I'm ready for you to do addresses, phone numbers, e-mails, whatever you want, but these folks have been very good with us and I've spoken to a couple in saying fine, I understand, but I don't have the ability to do it and I may not know what I'm doing. We're going to pinpoint it back to you folks and to IBC and Aetna, but they need to get the information. Can you do that?

MS. MITCHELL: Absolutely. You can reach me directly through my e-mail, it's S as in Sam, T Mitchell, M-I-T-C-H-E-L-L, @state.pa.us. They're all writing, aren't they?

REPRESENTATIVE WATSON: Yes, they are.

MS. MITCHELL: I should put it up on PowerPoint. I'm the Director of the Bureau of Managed Care with the Pennsylvania Department of Health. Our address is room 912, PO Box 90, Harrisburg PA, 17108, and my phone number is 717-787-5193, and I don't know my fax number off the top of my head, but I can get it for you. So you can e-mail them, you can fax them, you can mail it to us. I can't emphasize enough how important this is because you're absolutely right, you need someone to point out the problems so that you know where to look. If you do a credentialing file audit, one of the rules about credentialing is that the committee who

reviews the file needs to look at information that's no older than 180 days. So when you check the practitioner data bank and someone verifies the license and someone verifies the hospital privileges and all of those things, all of that information can't be older than 180 days before that file comes to the committee. So when you look at the files, they'll look perfect. But what you may not see is the five times someone had to fax that information in because it got lost, it got stale dated. Those are the kinds of things that we need so that, and people can tell us where they faxed that information, who they spoke with, because we have a lot of different component pieces being done in different locations and we're very much interested in trying to figure out if we have one particular pocket of problems or if we have something larger, if it's computers, if it's human, we want to find out where this is, and so does IBC and Aetna.

So if you would get us that information, it will help us track down where these problems are. We don't want to send people in to audit and look at perfect files and find out people have been suffering all along because we can't see the stuff that's trying to get in there. We can only see what got in there and what was acted on. We can't see what was unsuccessfully tried and didn't actually land in the right location. So we will be on top of all of this.

REPRESENTATIVE WATSON: Thank you very much.

CHAIRMAN O'BRIEN: Ms. Mitchell, just a question. We're talking about behavioral health issues, and when I listened to the testimony, it sounded like an awful long time goes by before that actual consumer may get the service, whether credentialing or whatever issue. We only regulate managed care organizations. Why don't we just put the Magellans of the world directly under the Department of Health so that we don't have all these steps, so if I complain about Magellan, you tell me to go back to whoever hired Magellan. In the meantime, I'm trying to get help for a consumer, and behavioral health issues are, for the most part, timely issues that you don't have all these barriers and hurdles, would you support regulating the Magellans of the world?

MS. MITCHELL: Well, certainly if that's something that you would like us to do, we need to have legislation that would authorize us to do that. I'm not sure that that solves the problem ultimately because the enrollees and their employers actually sign a contract for services with the IBCs and the Aetnas of the world, and that's who is responsible under that contract for the provision of benefits, whomever they choose to subcontract work to. So, regulating Magellan may give us some additional regulatory horsepower, but at this point in time we don't believe that we need to resolve these problems. We've had full cooperation from Magellan,

we've had full cooperation from Aetna and IBC, and they want these problems resolved. So I never look a gift horse in the mouth when it's giving you extra work.

CHAIRMAN O'BRIEN: Who wants the problems resolved, IBC and--

MS. MITCHELL: IBC, Aetna, and Magellan. They are all--

CHAIRMAN O'BRIEN: Does Magellan not see these problems, or--

MS. MITCHELL: You'll have to ask them.

CHAIRMAN O'BRIEN: You're convinced Magellan wants them resolved?

MS. MITCHELL: I am convinced that Magellan wants them resolved if only because IBC and Aetna want them resolved, but no, they want them resolved as well. And the reason I say that is because any system that requires a lot of human intervention is not necessarily an effective and efficient system, and if what we have going on here bears out to be true, you wouldn't design, if you're designing a system to have electronic claim submission, for example, you'll hear managed care say they want 90-plus percent of their transactions going through electronically. From the time it's entered, you'll see the computers, no human touches it and it comes back paid. That allows them to cut down their administrative costs. If you create a system where 50

percent of your transactions are kicking out for human intervention, you've got some kind of problem. It's not an efficient system. People are costly, you have to hire and train them, maintain them, pay their benefits. It's not the most efficient way to do this. So we believe there's some ingrained systems problems here and we know that Magellan has actually been in provider offices this past week sitting with them watching the transactions, looking at what's going through, what isn't, going screen by screen to see how the transactions are progressing, at what point they are jamming up or being switched to other venues, so we know that they have been in the offices and they are trying to resolve this.

CHAIRMAN O'BRIEN: Thank you.

CHAIRMAN O'BRIEN: Before I pursue some more questions, I would like to recognize that several other legislators have joined us today. We have Representative Hennessey, Representative Manderino, Representative Evans, Representative Fichter, Representative Ross. We will make room at the table here, if you would like to join us.

Following up on Representative Watson's question and my recommendation earlier that perhaps we have an informational meeting that facilitate a conversation between providers between the proper health and specifically identifying the issues surrounding authorization, credentialing, billing, and administrative burden, in

addition to that, I think it would be important to the department to pursue a line of questioning. There has been some suggestion that IBC, Aetna are pulling back in-house credentialing, authorization, and other issues. We would like to be able to share in that information, and we would like to know the Department of Health is pursuing questions surrounding why these companies are withdrawing those processes from Magellan and substantially responding to what Representative Kenney is talking about. How do we get our arms around how we're going to fix this problem? I don't want to be sitting here and being told there are contractual obligations and we can't fix this for another two years, three years, or four years. We are here because we want to make sure that individuals have access to care and that there is no, we eliminate redundancy in the process of authorization, we look at that authorization process and see if it serves a purpose and just doesn't cost a lot of money and it feeds an administrative burden that may be separate from the agenda that we're trying to address here today. Those issues, and also a policy issue I think that has to be addressed, if there are suggestions that Aetna is going to pull its capitation from Magellan, what long-term potential effect is that going to have on the financial stability of that organization and should we as a Commonwealth continue to invest and set our hopes for this quality of care assurance

on a company that may have additional struggles in addition to the bankruptcy that they are coming out of at this point?

I would like to frame further discussion so we can break these issues down so we can have a substantial informational sharing and that this committee, and I hope that the Chairman of health and Human Services, and I'm sure that he will, will reflect that sentiment that we will have ongoing discussions. I don't want to have hearings for time alone, but I do want to get to the bottom of this issue. So are there other individuals that have questions?

(Applause.)

CHAIRMAN O'BRIEN: I did not make a speech. I have been known to have some passion around certain issues on occasion.

Are there any Members that have any other questions? Dana Alwine, who is our counsel to Judiciary.

MS. ALWINE: Stacy, I believe Representative Watson had elicited information from you about when the plans of correction should be done that are going to be generated by IBC and Aetna, and I think you indicated the end of June. At that time will we be able to see copies of that or will we get our information filtered through you?

MS. MITCHELL: The plans of correction, once they are approved and the investigations are complete, would be public information, and so we would be able to share them

with you. I want to emphasize that we did not hear any rumblings about any of these problems and these frustrations, and for that I don't know what the answer is. I know that we're there and we do get phone calls from providers and associations. How or why that happened, I didn't know, but I do know that we did get the information on April 20. On April 27 we did have a meeting in Philadelphia with providers. We had information from them that indicated there were operational deficiencies, there was extreme frustration. It was an exceptionally helpful meeting in giving us information so that we knew where to look, what questions to ask, who to mobilize and how to mobilize them, and we believe that we've done that.

We've been meeting with the senior, very senior, risk management at Aetna and IBC, and they are taking this issue very seriously. They have, since April 27, and we're here now not too much further than that, already begun investigations and root causes analysis and they will get to the bottom of these issues and they will be resolved, and we will be sharing that information. As much as I enjoy coming here to chat with you all, hearings are not necessarily something that we enjoy doing all the time as well either. It's important for us to share our information with you, but we want to get these issues fixed. If it's a credentialing problem, if it's an authorization problem, they are allowed

to do both of those things, but they need to do them according to the rules that have been set up under Act 68, and that's what we're here to enforce, and we believe if we get that course corrected, a lot of these frustrations and these transactional problems are going to disappear.

We have not been informed of anyone who has been denied any services because of these issues, because largely the providers, in their professionalism, have been providing services without authorization or in some uncompensated fashion, and that's not right either. These are services for which people have coverage, but that's been keeping this problem from rising to the surface, and we understand their frustration and we are on top of this and we've been on top of it from the moment that we've been notified, and we will continue to be.

(Applause.)

CHAIRMAN O'BRIEN: Stacy, along that line, there seems to be a disconnect, and I'm not here to beat a dead horse, and I really would suggest for everyone that is in attendance and beyond this room who may hear about these hearings or has an interest in the issue at hand, I'd be interested in drawing a line in the sand and saying from the Department of Health's perspective that we have to move progressively informed. It's very important that the individuals who are affected, both substantially those

individuals who are trying to access care and those that are providing care, that we examine what the root causes are, that there seem to have been substantial complaints surrounding behavioral health, but they've never followed up to the Department of Health. So, drawing a line in the sand, I would suggest that we correct that problem and we address that in the conversations that we're going to have subsequent to this hearing today so that we can access processes for authorization, for credentialing, et cetera, and that we make sure that every provider and clients have access to a clear, a clear definition of what those protocols are. And that they are posted appropriately in the Department of Health, and we'll suggest to the other departments that they post what their responsibilities are and that we make available a consumer-friendly brochure or position paper so that people know how to cut through this. As Representative Kenney articulated, we don't want to be sitting here being turned from one office to another, from one provider to another.

Are there any other questions? Do I see Representative Hennessey moving? I recognize that move from Judiciary. Do you have a question?

REPRESENTATIVE HENNESSEY: No, I'm fine, thank you.

CHAIRMAN O'BRIEN: Okay, thank you, Stacy. We thank you for your testimony at that point.

We would ask the following individuals to come

forward: Dr. Sam Knapp from the Pennsylvania Psychological Association, Lynne Di Caprio from the Delaware County Professional Services, Tom Whiteman, Ph.D., from Life Counseling Services, and Vince Bellowaor from the Association of Springfield Psychologists.

Since there are so many people from Delaware County, maybe Representative Killion should have stayed here.

You can begin whenever you're ready.

DR. KNAPP: I want to thank members of the House Judiciary Committee and the House Health and Human Services Committee for taking time to hear our concerns about the decline in patient care and the waste of resources caused by Magellan in southeastern Pennsylvania. I want to thank the Department of Health for their presentation today and their concerns on this issue.

My name is Samuel Knapp. I'm the Director of Professional Affairs for the Pennsylvania Psychological Association. I wrote the report on the efficiency and quality of commercial mental health care of southeastern Pennsylvania. However, I relied heavily on the input of practicing psychologists such as those who are with me, Dr. Vincent Bellowaor, Ms. Lynne Di Caprio, and Dr. Tom Whiteman. They are the real experts, and I hope you will take advantage of their presence here to ask some questions about the prepared testimony. They know more about what goes on than

Magellan does. Magellan has a theory about how things work. The theory has very little correspondence with reality. We have a little chart there, it's also in your testimony, about the myths and claims of Magellan.

Now, the report focused entirely on Magellan in southeastern Pennsylvania and some areas where Magellan has done an inadequate job such as facilitating psychiatric hospitalizations, and also we know that Magellan has many conscientious employees who appear to be working hard and care in trying to make the system work more friendly. However, there are numerous persistent problems, and these are exacerbated by the fact that Magellan has 99 percent of the commercial mental health care market in southeastern Pennsylvania.

The wide gap between myth and reality, money is being wasted, patients are being harmed, patients are suffering, State laws are being violated, provider dissatisfaction has been growing. We've had a year of promises from Magellan that things are going to get better, so we were happy to hear the reports of the Department of Health, and we're happy to hear that Magellan is concerned about these things, but you're going to have to forgive us if we're a little bit skeptical at this time. We want to see the results.

First, we're going to hear from Dr. Vincent

Bellowaor, who's going to describe problems with the authorization process.

DR. BELLOWAOR: Thank you, good morning. My name is Dr. Vince Bellowaor. I'm a psychologist who runs a group practice in Delaware and Chester Counties. Just to give you a sense of who else I represent, we have with us in my practice 60 psychiatrists, psychologists, and social workers. We also see about a thousand patients a week. Also, I am also a former noncap provider. I never was a capitated provider, so in our practice we always dealt with the authorization issue right from the beginning.

Magellan's authorization process is indeed highly flawed. Theoretically, Magellan allows providers to obtain authorizations through computer, phone, fax, or mail. However, Magellan's Web site often freezes up, faxes are routinely lost, or providers are put on hold for extended periods of time. Once a provider can eventually submit a request for treatment on-line, Magellan responds about 50 percent of the time with a pending message, meaning that the provider will not get an authorization until days or weeks later. Theoretically, providers can get same day authorizations for new patients over the phone. However, the provider can wait 20 minutes on hold before being connected, and even then Magellan's staff only authorizes three patients at a time and then requires the provider to call back and be

put on hold.

The process places a great administrative strain on providers to get the authorizations approved, and even then there is no guarantee that the provider will succeed. Then once a patient is in treatment, providers usually fax or mail in authorization requests. And these are one-page forms that are fairly easy to fill out. But even then there's no proof that the authorization was ever received by Magellan. These hurdles insure that even large group providers like myself who hire specialists in authorizations and billing are hindered from obtaining authorization for treatment for patients and subsequently will be denied payment for treatment services.

I would like to give you one example of the impediments we face. For more than a year, Magellan's claim that its on-line treatment request system is easy, quick and efficient. Also for that year we've been telling them that it is not easy, quick, and efficient. Now, about 10 days ago, Magellan employees came out to my and some other practices to investigate our concerns. As they sat at my computer in my office, these two computer experts realized we were right. The on-line requests that they were trying to process was continually hindered by the freezing up of the Web site. And it wasn't on my end, since we could clearly jump on other Web sites and move around very easily. We know

that they were with us for two hours, in reality it probably took them 40 minutes to process two requests. I do know that later that day they went to another provider and out of 15 requests to get treatment, 15 were pended or failed and they had to wait until that came in the mail at least a few days later.

But the salient issue here is that the authorization process really has absolutely no clinical purpose, does nothing, nothing to improve patient care. That is authorizations are never rejected for clinical reasons, only clerical ones. So these clerical obstacles add substantially to the patient's cost of health care.

Next, I'll have Ms. Lynne Di Caprio, who will now describe problems with the provider file.

MS. DI CAPRIO: Hi, my name is Lynne Di Caprio, and thank you so much for your interest in our concerns, especially the Chairman. Thank you very much.

Vince, do you want to explain what these envelopes are? See these envelopes here, guys?

DR. BELLOWAOR: These are just a week's sampling of the provider authorization requests that do get sent back to us, mostly from us three providers, just to give you a sense of what I see is a blatant waste of money.

MS. DI CAPRIO: So that's one week's worth of what we requested on-line that sometimes gets to us and then we

have to match it, sometimes it doesn't.

CHAIRMAN O'BRIEN: That's one week's worth just from you?

MS. DI CAPRIO: That's one week just from us. And I would like to talk a little bit about the inadequacy of the provider panel, and specifically for psychiatric care. Magellan reports that .2 psychiatrists are available for every thousand covered lives or beneficiaries. However, in reality, the psychiatric network is woefully inadequate. As the director of a large private practice group, I must make certain that all of my patients have access to quality medical management for their psychiatric medication needs.

In 2004, as a large practice director, Magellan provided me, at my request, with a list of 350, 359 actually, psychiatrists who were available and credentialed by Magellan to do medication management in Delaware County, Chester County, and Philadelphia County. I and my staff called each and every one of these doctors. I was looking for additional psychiatric services for my patients. At minimum, we left two messages on everyone's voice mail or with a secretary. I was thoroughly disappointed with the outcome. I ended up, out of the 359 doctors that we originally called, ended up being able to get 14 doctors to actually help with the medical management of my patients. We are a very large practice and see about 1,250 patients a week. The vast

majority of the doctors either flatly refused to take Magellan medication management patients or said that they weren't taking any new patients. It was noted over and over again that many of these doctors actually said that they would only take out-of-pocket patients, which in our business is I won't take your insurance, I'm tired of dealing with it, I'm only going to be paid cash. So the lack of availability of psychiatric services is blatant and particularly disappointing and difficult to deal with with children and adolescents.

I think I am also talking about clean claims. Magellan will claim that 99.2 percent of their clean claims are paid within 30 days. The absolute best response we were able to gather from any group in this area was that 95 percent of clean claims were paid within 53 days. That's the best performance. However, the reality is it's not the clean claims is not an issue. The real issue is that in order to have a clean claim, you have to have an authorization or you can't bill the service. So they may be doing pretty well with clean claims, but with all this (indicating) and timely billing imposed on us, it is very difficult for us to get our claims even evaluated as clean claims because of the obstacles that these authorizations actually provide.

And I would now like to introduce Tom Whiteman, who is the Director of Life Counseling.

DR. WHITEMAN: Thank you, Lynne. My name is Dr. Tom Whiteman. I am the President of Life Counseling Services. I have been asked to address credentialing. I'll deviate from some of the script because a lot of this has already been covered and just add some personal notes. Magellan reports that 99 percent of the providers are credentialed or recredentialed within 30 days. It has been my experience in five years I have probably credentialed or my group has credentialed over 100 therapists. On average it takes three to six months, and comparing other groups, they all would report on average it takes three to six months. The only reason I can come up with such a discrepancy, I know in our group that when we send in an application, and I have somebody who calls every week to find out where is this person's credentialing application, when it reaches the final stage, and that can be six months later, when it reaches the final stage, we are asked to resign and redate the last page. So we do that. We resign and redate the last page and send it in before it goes to final committee. Maybe that's where they get that 99 percent are credentialed or recredentialed within 30 days. But I do know--

(Applause.)

But I do know that it's been my experience that that does not happen. Now, there have been times when it actually has gotten better, and I know that I have been

through probably four different regimes in the Philadelphia office, meaning a whole new leadership team comes and goes, and every new leadership team that comes in, they promise us they're going to fix the credentialing problem, and in eight years of doing this, and Mr. O'Brien, you addressed it, there really has been no significant change. Probably the best it ever was in my experience was when they declared bankruptcy. There was a period of time where everybody had their eyes on what was going on, and that was the best it ever was. Since then it has deteriorated back to the norm of just three to six months.

What's the impact of this? Well, because Magellan is a monopoly in Pennsylvania, in essence you cannot work unless you are Magellan credentialed. There is a lot of, we have a large group, and I would say actually Magellan's mismanagement of this has helped my group. Many of my providers are here today who could go out in private practice but they cannot afford the higher administrative overhead that it takes to do this. So, for example, I have somebody who just calls constantly to check on these credentialing packets which get lost and we have to resend them. So the fact is if you're an independent practitioner in Pennsylvania, you have very little chance of getting credentialed. If you join a large group, you have a better chance and it still takes a lot of time. So in effect, you

are not able to practice and use insurance unless you are Magellan credentialed.

(Applause.)

If somebody changes, and this has already been addressed by the Department of Health, if somebody changes their address or they get married, their name changes, if they switch groups, it can take months to make that switch. In that period of time, as has been pointed out, we continue to see patients, but the problem is we can't bill. And so it's not uncommon for us to call and say, look, this person joined our group, and be told, well, yes, they can see patients because they're credentialed, but you just can't bill for the service. If I hire someone, let's say somebody goes out, recently I had a woman who left because her husband was transferred and she gave me 30 days' notice. I have to then hire someone. And so I put an ad in the paper, that's going to take a couple weeks, we interview and we decide we want to hire this person. I then have to say we would like to offer you this job and in six months you can start. The problem, obviously, what kind of person is going to sit around and wait for six months for me to offer them a job? So the effect I think for the public is you can't, you really can't work and take insurance unless you're credentialed. I know there is very, very few products out there that are not Magellan managed. We have a few unions that are not Magellan

managed, and they by and large will credential people in 2 weeks. And so that's the only comparison I have. Now, that's a very small sampling, but they can do it in 2 weeks.

What's the impact of this mismanagement? Well, you know, there's a lot of providers here, and everyone has a story to tell. They could all tell you stories of what happens about somebody who just for unknown reasons was suddenly decredentialed and told to stop seeing patients. I have a story about, and it's been circulated around, where I have three weeks' worth of authorizations that were just shredded, and that is still being corrected. People are put on hold, told that we can no longer process any more claims today, we're just too busy, the computer is down. The result of all of this is people get frustrated and give up. I tend to be an optimist, and in six years of doing this, I have always said it's going to get better. Six years I keep saying to my staff, it will get better.

And as I said, we've been through several regimes. I've had meetings, individual and group meetings, with the highest levels of Magellan, Aetna, and IBC, and I would tell you that I have, until today, given up. I have given up on the idea that this could ever be better. I do know that sitting down and having people look you in the eye and say we promise we will address your concerns and this will change, I can tell you that that means nothing to me. Because it has

not changed, and it has been far too long. So people like myself and people that work in our group, when they leave, they don't leave to go to another group, they leave to go into private practice and charge people cash. And so when that happens, who wins? Well, people have to pay cash out of pocket to get the service they want. The fastest growing product in our company is cash business. We have people who are managed by Magellan but choose to pay cash. So right now Magellan manages about 90 percent of my business and 10 percent is a growing cash business.

There is a note in here about the utilization for Aetna and IBC Magellan managed product. Utilization is 3.6 percent, and I believe the national average is 5.4, which just illustrates the point that people are not utilizing their benefit. I think people in Pennsylvania seek counseling just as much as anyone else in the country, but they are choosing to go out of network and to pay cash. Obviously, when they do that, Magellan makes money. I don't know what the motive is and people say, well, they really want to do better. I know my interactions with people at Magellan, they are good people, they are competent people, they are caring people. I have good relationships with most of the people at Magellan, and I will tell you individually they are good people, but the system is truly broken. If the system is not working and if you were to pull them aside and

ask them honestly, they will tell you I can't fix your problem. I can't get you credentialed quickly, I can't get these claims fixed, and it can take months and months and months. And one problem with penalties still has not been resolved and it's been two years we are still trying to resolve problems with penalties that were assessed to our group.

The bottom line is we have a chart here, it's estimated, we don't know how much Magellan spends on administration or IBC or Aetna. I know that I read one published study and PPA prepared a study that says almost 50 percent of the outpatient dollar is spent on administration. This is just an example of it. Almost 50 percent of the outpatient dollar is spent on administration. My group alone spends over $100,000 a year just processing these pieces of paper. Testimony has already been given this does absolutely nothing for patient care. All it does is create obstacles for not paying claims.

(Applause.)

I am now very proud and pleased to present Dr. Sam Knapp, who is going to talk about recommendations.

DR. KNAPP: Thank you. In the interest of time, I'm going to just summarize very quickly. We have two major issues, one is how to resolve the current problem, and we hope that the efforts of the Department of Health and the

efforts of the committees will help resolve the current problem, but then we also have the issue of how do we prevent future problems like this from happening again? And I didn't know what the answer is until the dust settles, until we actually get these things settled we might, perhaps the Department of Health needs more regulations, perhaps we need more statutory change. We'll have to wait and see where the dust settles here. But I want to thank you for consideration of these issues, and we'll be happy to answer questions from committee members.

CHAIRMAN O'BRIEN: Maybe I'm oversimplifying this. We've heard all this testimony surrounding authorization issues, the Department of Health doesn't seem to think there are specific problems. If there is, I want to get to the issue of whether this authorization process has a clinical value or whether it's just an undue burden that stands in the way of treatment. One simple issue, maybe you can respond to this, is it an individual is capitated on the number of visits and the authorization process has no clinical value, why don't we just dismiss the authorization process and let these people go through their business?

(Applause.)

DR. BELLOWAOR: There's your answer. I will say that my assumption is that has to be the decision of the insurer, being Aetna and IBC. They have, most recently Aetna

went with sort of an eight review free sessions, so eight unauthorized sessions. Another example of the attempt to make it easier has made it more difficult because if we're going to bill one of those eight unauthorized sessions, we still need to get one of these envelopes from Aetna that has in their patient information and has a code number that if there's ever a claim in question, we have to give them this code number, so it still has to be processed. I will also say that a few insurance companies out there have done away with authorization. One is a managed care company called Cigna, which we've all heard of, they got rid of one about a year ago. I think the big concern with if they get rid of the authorization process is suddenly providers will go wild and seek approval for eight visits a year, and what Cigna actually has shown and has proven is that the utilization when someone utilizes their benefit does not increase one bit. In fact, we have found that what controls how much someone utilizes their benefit is the copay that a patient must pay. And we've all seen our copays rise over the years, and they will continue to rise, that's just what health care is. So I'm not sure why the process is there any longer.

CHAIRMAN O'BRIEN: Let me ask you another question. We've heard perhaps that the authorization credentialing, all these issues are probably maybe appropriate because we want to get a handle on providers. Can you describe for me how

provider networks were comprised years ago and if those provider networks have changed substantially?

Let me just give you a point of reference here. If I am a parent and I want to access a child psychologist, do I get a handbook that tells me what providers have child psychologists? It was my understanding that years ago a provider had to have the comprehensive network, all types of specialties. If I need a child psychologist, is that posted somewhere, what practices have a child psychologist, or do I find myself trying to get into a network and find out that they can't respond to my need? Do I call Georgia? How do I get that information?

DR. WHITEMAN: Currently, you would probably ask your primary care, a lot of services are directed through the primary cares and we get a fair number of referrals there. You can also call Georgia. They tend to just randomly pull up names according to ZIP Codes. I do think I have a bias towards the groups. If you send it to a large group, what we do is we pick out, we know who specializes in a certain area, so they'll have a specific need about a specific child and then we will direct them to that person. However, it is very hard for an individual to get their specialty known within the organization. I know Magellan has collected that data, and specifically to answer that question, I know they have collected that data, but I know that there is a disconnect,

if you call Atlanta, you'll get random names is my understanding.

CHAIRMAN O'BRIEN: Let me ask you another question. The Department of Health has said in my questioning of the Department of Health, I represented that I have heard complaints that they have increased the number of providers, but if you're credentialed with provider A, that is not reciprocal. The Department of Health maintains they've had no complaints. Is that your experience?

MS. DI CAPRIO: I believe that the Department of Health has had no complaints because as provider organizations we just simply take care of our own and pay people as they are providing the service and we wait for months for them to be connected to our groups. So if someone leaves Tom's group and comes to mine, they're not connected to my group for maybe three months, which means I either don't bill for any services and pay them anyway, and I wait and bill the services, and in some specific instances, the authorization actually goes to an individual provider like with Aetna, and if that's the case, I can't get the authorization in time to make that happen. So I'm probably going to eat it.

CHAIRMAN O'BRIEN: Okay. There's one other issue, there has been a well publicized case where a doctor or an individual represented that he is an M.D., U.S. Attorney

prosecuted that case, it's my view that a bad case makes bad law. My concern is that if we try to establish regulations or controls to make sure this don't happen again, that we're going down a bad road. And in fact, it's my experience that this individual has in fact resubmitted his credentials as a doctor and that guy is still going to go back there and do that. Do you have any recommendations on how we can get around that issue, kick that to the curb so we can get to the real substantive issue of how, and again, the credentialing issue, if the Department of State and other departments license individuals, how superfluous is the credentialing requirements that Magellan is imposing on providers at this point?

MS. DI CAPRIO: I don't think the credentialing issue is superfluous. I think there has to be some standard met, and I think Magellan does make an attempt, and other managed care companies make an attempt to meet some standard. Whether it needs to take 180 days to do it or not is really another issue. A lot of this information is on national data banks and it is easy to get on-line. We are all automated and can do that. Some of it probably doesn't need to be done, some of it like your internship. I mean, if you have a license, you've already proved your internship. There are a lot of redundancies.

However, the real issue is Magellan and companies

like Magellan were created because there was a need. Many, many years ago maybe we didn't have the accountability that we do now. We're accountable for our patients, we do understand what we have to do, we do need to answer the phone immediately and meet emergency services. The bottom line is all of this is now unnecessary, and Magellan has taught us well how to do what we do the best, which is to take care of their patients. Our outpatient services are taking care of the people who used to be in somewhere. We need to increase the access to that outpatient care. It is a good thing that they opened up a network. We need to give the patients the availability to go where they need to go to quality people and not go through all of this to get an evaluation. That's what doesn't make any sense.

CHAIRMAN O'BRIEN: I guess what I would be interested in is specific recommendations from you as providers as to how we can create more efficiency in the system so that we can get more of those dollars into appropriate clinical response. It just seems to me, and I don't mean to be overly flamboyant, you have employers are paying more, staff is paying more, and providers getting less. Where does the money go?

DR. BELLOWAOR: I guess you're talking about the three areas of where a recommendation would be, one is credentialing, two is authorizations, and three is claims. I

would say 80 percent of our concerns are around the authorization. As you noted, there is no clinical need for it, there is only a clerical or administrative need, and that need is not on our end. So the simple answer is why do we have authorizations and what do we need to do to get rid of it? The answer regarding credentialing is you need some kind of credentialing. The large groups take care of their own and monitor their own. We have an internal monitoring system, but you certainly need, with all those solo practitioners about there, but again, it doesn't need to be such an onerous system. You can get someone credentialed within a month or two months if you can cut out a lot of the excess there, and a lot of it can be driven if they have a State license and perhaps a visit to their site.

CHAIRMAN O'BRIEN: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

I just wanted to try to summarize this as I'm understanding it. You need, before you can help someone, you have to fax a written authorization to Magellan, and at some point in time, in some timeframe, they call you back and give you an oral authorization over the telephone?

DR. BELLOWAOR: Yes, well--

REPRESENTATIVE HENNESSEY: But as I further understand it, then you can't submit a bill for the services you provide until you get a written authorization sometime

subsequent in the mail?

DR. BELLOWAOR: That's correct.

REPRESENTATIVE HENNESSEY: And you're saying that these are a sampling of what you get in a week's time. If that paperwork doesn't arrive or if you lose it, then they say you don't have a clean claim and you can't get paid for that?

DR. BELLOWAOR: That's right.

REPRESENTATIVE HENNESSEY: Now, from that point, let me--

DR. BELLOWAOR: If I can interrupt one second. Most of our systems are set up that we just hold on to these, there's not even a claim we submit because we have the authorization, so we are sitting at our computer with files of hundreds and hundreds of files waiting to get these authorizations, so you have this gap in payment. These aren't even sent in to get denied, mind you. We only send in claims that already have an authorization attached. So it hasn't reached the claims state yet.

REPRESENTATIVE HENNESSEY: Okay, I guess the issue that brings me here and a lot of others is that we heard from the Department of Health, Ms. Mitchell said that people aren't being harmed, your therapists and psychologists are actually providing the service and then eating the loss, or at least waiting for payment. And Dr. Di Caprio, I think you

said, I think you said patients are being harmed. Help me with that, because either they're harmed or they're not, and it seems to me if they're not being harmed it is because your providers are extending themselves beyond what we would want them to do or expect them to do. But there seems to be a clear divergence of opinion here as to whether patients are actually getting harmed or not.

DR. KNAPP: Yes, I'm glad you brought that up, because just today a psychologist told me that this week he's had two patients who have called and said that they can't come in anymore because their authorizations were limited. Patients apparently get a copy of this and they don't understand what it means, and older patients get very confused by it and they'll say, well, you're authorized for four sessions, for example. Well, they don't understand this, they think this means four sessions for the year or that they only need four sessions and they say if I only get four sessions, I better space them out throughout the year. So we do have patients who do drop out because they misunderstand these authorizations, and providers will do what they can to explain the process, but sometimes we don't always know why patients drop out of treatment.

DR. BELLOWAOR: If I can add to that, the great majority of time we absolutely do try to see patients. However, there are certain times that if I can't get an

authorization, someone has gone into the second month, I am going to have to say to my provider, as long as this patient is not in any immediate harm, you need to tell them they need to wait until they get that authorization. And there are also other practices, other psychologists that will not see somebody until they have that authorization in hand. So we will try as far as possible ethically to continue to see the patient, but after a certain period of time we have to tell them, unless we get an authorization, we can't continue.

DR. WHITEMAN: And one more example I would say for us, for example Keystone 65, which is managed by Magellan, we waited a year to get paid on Keystone 65. So at some point we just said, look, we can't take any more Keystone 65 patients, and I talked to a number of other groups who said, well, we're not taking them either, and so people with Keystone 65 will call and say, I have called 12 providers and nobody will take my insurance, and the reason is we can't figure out how to get paid on that particular product.

DR. BELLOWAOR: And that's consistent with what doctors in my area are writing to me saying that they're waiting for 8, 10, 12 months to get paid for services they have rendered, which is pretty clear it should be an unacceptable practice.

DR. KNAPP: And I also would like to add, this is an issue that Mrs. Di Caprio brought up about the shortage of

psychiatrists in the network. They've dropped out because they're frustrated with the payment process and they will only accept patients who can pay out of pocket. And not all patients can afford that, or if they do afford it, they will often not get all the appointments they need, they just pace out their appointments, and so it does degrade the quality of the provider network, and a lot of, you know, on the survey that we did, we had 215 psychologists respond, 73 were in the Magellan network, 140 were not, and these are people who are very qualified, a lot of them got too frustrated with managed care and just dropped out and a lot of them are very competent, very skilled, and you find a degrading of the quality of the network over time because of the administrative burdens that are involved.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN O'BRIEN: Representative Ross.

REPRESENTATIVE ROSS: Thank you, Mr. Chairman, and I'm certainly going to be interested in hearing the other presenters address some of these kind of issues, but I just personally wanted to state my sense of frustration at how this system is operating right now from all that I've been hearing. And, you know, we did pass Act 68 to try and improve the process by which people appeal, and I'm really becoming persuaded, from what I'm hearing, that I think we need to look hard at some kind of auditing process that will

be done independently that will double-check to make sure that the claims are really being processed properly and that the services are really available and that there are actually providers that are willing to work with the providers or with the networks. And I think we're going to have to really start looking at that. I'm a small government person, I don't like going down that road, but I'm not persuaded that the system is working properly on the private sector, and I think we're going to have to really look at some forms of independent governmental auditing to make sure that that pile of paper doesn't happen in the future.

(Applause.)

CHAIRMAN O'BRIEN: Representative Evans.

REPRESENTATIVE EVANS: Thank you, Mr. Chairman.

Yes, and following up on Representative Ross, bringing in the envelopes I think was a good thing for you to do today. I thought we were in the computer age in 2005, and to see not only the waste of postage, but if we had environmentalists in the crowd here, they might be concerned about the number of trees that died to cause all that paper.

But a couple of quick questions. First, for Ms. Di Caprio, on page 4 of your testimony, you indicated that 350 licensed psychiatrists were contacted, and is the number that you mentioned, 14, that said they were accepting new patients out of 350?

MS. DI CAPRIO: Yes, sir. Out of 359 original doctors that I contacted, 72 of them were duplicates on Magellan's Web site that they gave me, and the rest of them either wouldn't do med management or wouldn't take any Magellan patients.

REPRESENTATIVE EVANS: So I guess the question is, what happens to those patients if it's determined that an individual needs antidepressants, for example, until they can see a doctor to get that prescription, what are you doing with those people now? What's happening to them?

MS. DI CAPRIO: For the most part, what I think all of us do is ask the primary care physician to help out and give the patient some medication until we can get them in to see the psychiatrist. The initial psychiatric evaluations are 45 minutes in length, they have to be, so to have a 45 minute slot open for anybody next week is hard. We have a lot of people who help us out who have inpatient facilities to help us out if we have an emergency. They'll see those folks and get them started on something until we can see them. But more importantly, and I think what's more salient to this whole thing is that I sent my report to Magellan back in June last year and I never had any response from them after I indicated what I thought was a serious lack of adequate psychiatric services.

REPRESENTATIVE EVANS: Thank you.

And Dr. Whiteman, in your testimony on the credentialing aspect, you're indicating that many providers, including your practice, waits three to six months to get a person credentialed to be billable for insurance?

DR. WHITEMAN: Yes, that's correct.

REPRESENTATIVE EVANS: What would your opinion be or what would be the reaction to your group if there were to be legislation drafted to mandate that the insurance company retroactively pay if a person is indeed proven at the back end to be credentialed and to be eligible beyond a certain reasonable time period. They're saying 30 days is when they're trying to be credentialed, or recredentialed, would that be an effective piece of legislation to drive to process or to keep your business going?

DR. WHITEMAN: Absolutely. I am also a believer in small government, I don't like the government to have to intervene. I wish we could sit down and talk out these issues, but I think several of us have made those specifics suggestions and have not been able to accomplish that. But yeah, it would be a big help if I could go ahead and start something, like I need to be able to hire somebody and say, you can start in 30 days, period. When I talk to an M.D. and say I'm not sure when you can start, they don't understand that. And they don't want to hear it. So I need to be a person of my word and say you can start in 30 days, and

whether or not the insurance companies can recognize that person yet, it really needs to be their problem, not my problem.

REPRESENTATIVE EVANS: Thank you, Mr. Chairman.

CHAIRMAN O'BRIEN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman.

I have a specific question, and I apologize, I hope I have the providers right. Dr. Whiteman? Okay, you made a comment that I did not understand. You said something about penalties assessed on groups that are not settled. You made it at the end of, and it kind of came out of the blue for me. Could you explain, I assumed you meant penalties assessed on you, the provider, by Magellan, but you got to give me more background. I didn't understand.

DR. WHITEMAN: It's very complicated. I'll see if I can give you a simple answer. It goes back about two years ago they switched computer systems, and I think this time it was Magellan's computer system, although another time it was IBC's computer system, and during the transition, the two systems did not talk to each other. So I was penalized 20 percent of all my Personal Choice claims during that period of time.

REPRESENTATIVE MANDERINO: Why?

DR. WHITEMAN: Because I didn't have authorization, even though I did. So I had authorization, we put the

authorization number on the claim, the claim was paid, but it was penalized because they said you did not have authorization. We, of course, called our contact person and they said, oh, I see you do have authorization. We sent it to IBC, but IBC did not receive it. And we'll correct that. So IBC, then we waited a couple months, it was not corrected, we called IBC and said, well, we never got the authorizations from Magellan, so you really need to talk to Magellan. So we go back to Magellan and they say, it is not us, it's IBC. IBC says, it's not us, it's Magellan. Two years later, we're still arguing about whose fault it was, but some of those penalties are being corrected one at a time. It started out at $13,000 in $12 penalties. That amount of money, which I'm now going back and still correcting two years later one penalty at a time.

REPRESENTATIVE MANDERINO: Okay. Now, that is a perfect example to my next series of questions. When that happened, you already told me you complained to Magellan. When you didn't get satisfaction there, you complained to their prime contractor, Independence Blue Cross.

DR. WHITEMAN: Correct.

REPRESENTATIVE MANDERINO: When you didn't get satisfaction there, did you file an Act 68 grievance?

DR. WHITEMAN: I didn't know what to do at that point.

REPRESENTATIVE MANDERINO: Okay. So we have a -- one of the flaws, I believe, in Act 68, and I don't know if it's an education flaw, a time flaw, but it kind of leaves it up to individual consumers to file the grievances, and they don't really get much help from their providers. And so for the providers, just because it's more paperwork that you don't have to deal with, aren't helping the consumers with the complaints, or the providers aren't filing the complaints, we kind of have a system breakdown there, if somebody would like to address what's going on there.

DR. KNAPP: I have a psychologist in the audience here, Dr. Mark Wagner, who filed an Act 68 complaint. One week later he was decredentialed by Magellan.

REPRESENTATIVE MANDERINO: Did he file a complaint about the decredentialization?

DR. KNAPP: I don't think he did.

REPRESENTATIVE MANDERINO: I'm just trying to figure out at what level it rises, Representative Ross was talking about audits, somebody else is talking about legislation. So I can put things in place, I'm trying to figure out, again, theoretically, Magellan has these great statistics, but you're telling us the reality is they're not working. Theoretically, we have these great processes in Pennsylvania. I'm trying to figure out why they're not working, where is the level of reporting this kind of

incident so that it can be acted on in an appropriate way, where is it breaking down.

DR. KNAPP: Yeah, I think you're asking the right questions, which is is it that the system is there but it's not being utilized, or is there intrinsic flaws in the system? There is fear, I mean, the question with Dr. Wagner, and most of these providers can give you examples where they complained and then there's some repercussion. We don't know whether this is deliberate or just incidental, because I can identify a number of psychologists who suddenly were decredentialed through clerical error. Is this a random thing? But it leads to a fear of acting, it leads to a fear of wanting to file an Act 68 complaint.

REPRESENTATIVE MANDERINO: Okay, let me just ask one last question. Have any of the prime contractors, the health insurers, Aetna or IBC, who subcontract their behavioral health services to Magellan, have any of them gone out on any routine regular periodic or even occasional basis to survey the actual providers about what your experience is with their subcontractor, what your satisfaction rate is, what any of these kind of concerns that are being addressed here, has anybody from the insurer come out to the providers to check on the satisfaction kinds of issues?

MS. DI CAPRIO: The answer is yes, Independence Blue Cross and Aetna have reached out to the providers on a

number of different occasions. Independence Blue Cross, particularly around Magellan's filing for bankruptcy, was invested enough to ask for a provider to actually be on their oversight committee that meets on a monthly basis, and they in fact included a provider to meet on that committee to serve as kind of a balance. So, yes, there is communication, but ultimately there is an undeclared or declared issue that you have to go to Magellan, you should not be going to the plans. That's sort of the way it is. That's the understanding and that's what we're supposed to do and kind of frightening a little bit when you go to the plan and you usually are reprimanded by Magellan for doing so.

CHAIRMAN O'BRIEN: Representative Fichter.

REPRESENTATIVE FICHTER: Thank you, Mr. Chairman.

I want to go back to what we, all these several hundred envelopes that we have here in front of us. For the record, exactly what are they? Are they rejections of payments or of new members or what, just for the record? Simple language.

DR. WHITEMAN: It is an authorization letter, and the client, the customer, also gets a copy that you have six services authorized. So these are authorization letters.

REPRESENTATIVE FICHTER: You perform the service, you send the proper paperwork to Magellan, Magellan in turn, somebody looks at it and sends it back and it's rejected, is

that it?

DR. WHITEMAN: None of these, no authorization is ever rejected right away.

REPRESENTATIVE FICHTER: Okay, that's what I want to know.

DR. WHITEMAN: We get a piece of paper saying you are approved for six sessions. We probably have already performed three of those, so we go ahead and see the patient whether we have authorization or not. We then get a letter which now means we can generate a bill. Sometimes a letter never comes. These letters are a wonderful thing. I happen to think it can all be done on-line, and since it's routinely authorized, why not just authorize it on a spread sheet and save a lot of paper? But the point being we get an authorization, we never get a letter saying you're not authorized, but we do sometimes send in an authorization and we get nothing back.

REPRESENTATIVE FICHTER: Thank you, Mr. Chairman.

CHAIRMAN O'BRIEN: First, I would like to welcome Representative Doug Reichley, who has joined us.

CHAIRMAN O'BRIEN: Any further questions?

(No response.)

Thank you for your testimony.

DR. YEE: Good morning, and thank you all for your interest. I am Ruiza Yee. I am the President of the

Pennsylvania Psychiatric Society, and with are my colleagues, Fleischer and Gwen Lehman, our Executive Director. Both Dr. Fleischer and I are physicians specializing in the practice of psychiatry. My focus is on adult patients, and Dr. Fleischer is a geriatric and adult psychiatrist providing psychiatric services in the office, nursing homes, and inpatient hospital settings.

First, let me point out that the problems cited by the Pennsylvania Psychological Association in its report are, almost without exception, problems that we cited in our society's lawsuit against Magellan in 1999. It is discouraging to say the least that we are still dealing with the same types of issues today. Because the Psychological Association report deals with outpatient treatment, our focus this morning will be Magellan operations as they apply to the inpatient care. I'd like to discuss these in several categories.

First category, the medical necessity standards. Medical necessity standards are important in two levels. First, what is actually in writing, and second, how they are interpreted by Magellan. Several years ago Magellan's written standard for involuntary inpatient hospitalization was more stringent than Pennsylvania's legal standards for involuntary hospitalization. Before we withdrew our lawsuit, the standards were eased, but they are still too restrictive,

especially the interpretation of these standards.

Not too long ago a patient of mine was brought to the hospital by the police after a suicide attempt and she overdosed. She was hospitalized on a 302, or what's known as an emergency involuntary hospital commitment. These are for up to five days in duration under the law. However, after only three days Magellan, while I was still assessing the patient, insisted that I release this patient, even though if I had done so, I would have been legally liable before he was ready to be discharged. I tried to schedule an appeal, which took two days and five phone calls to set up. It was then scheduled for three days later, and three days after that I was still waiting for the outcome, a process that took over eight days to find out if I could keep the patient for an additional two days. And I still had no answer at that point.

A colleague recently reported that Magellan denied hospital treatment for an 18-year-old with schizophrenia on the grounds that, and I quote, "an individualized treatment plan with 24 hour/day access to psychiatric services in a controlled environment was not required," and further, I quote, "the member's symptoms did not show a clear inference of immediate serious harm to self." In fact, this patient was so psychotic she was walking the streets naked, shouting profanities to passersby. She was so psychotic and

disorganized at the time of administration that she was unable to articulate a coherent sentence.

Second point, frequency of review. Even if Magellan authorizes hospitalization, it is almost always just for one day, no matter how critical the patient's condition is. What happens after that review so frequent, sometimes daily, that it feels like harassment. One of my Philadelphia colleagues recently treated a patient who had made a major suicide attempt by overdose. He was in the intensive care unit on a ventilator for a week and then was transferred to a psychiatric unit once his aspiration pneumonia had been cleared. Magellan only authorized three days on the psychiatric unit and then performed daily reauthorizations, even though his major problem, suicidality, a serious one, was not the kind of one that turns around within 24 hours. Daily review in a case like this is pointless. It is as if reviewers want to wear us down or catch us at a time when you can't return their calls so that we don't have an authorizion for that care.

Authorizations for periods after first five days are almost impossible to get. They are almost always denied, forcing us to go through an appeal process. It's as if there's some unwritten law that no matter what the patient's clinical condition is, all patients should be ready for discharge within five days.

Third point, pressure to change medications. We are often pressured by reviewers during concurrent reviews to change medications, more or less to show them that we're doing something. The reality is medications do not take that quickly to change a dosage or to have effects. It takes time. The reviewers recognize this and if you have discussions with them about that, they will tell you, yes, we understand, but.

Fourth issue, time to obtain authorizations. Our colleagues from the Psychological Association had already discussed this at length, but we echo their frustration and their experience. It often takes inordinate amounts of time to obtain authorizations, either initial or concurrent. One of our members recently reported that it took 1 1/2 hours and 18 phone calls to get a patient admitted. My experience is similar. I, when I want to keep a patient in the hospital beyond the three to five days that they initially authorize, my utilization staff in the hospital is no longer allowed to make the phone calls. Instead, I have to do what's known as a physician-to-physician review. It can take repeated calls, sometimes over a period of days, to reach the person authorized to grant an extension, if I can talk him into that position. All these problems siphon physician time away from patient care and they shift practice resources away from other clinical personnel to administrative personnel.

Now I would like to turn the testimony to Dr. Fleischer, who can speak directly to some of these problems.

DR. FLEISCHER: Thank you, Dr. Yee.

Representative Kenney, Representative O'Brien, and other members of the committee, I want to thank you for the opportunity of appearing before you. I've been practicing psychiatry for about 24 years. I am in private practice and I practice by myself. I also employ, I have employed another psychiatrist and several nurse practitioners, so I'm not a big group as the psychologist that spoke to you last. And dealing with Magellan is almost overwhelming for me, and I can actually afford some administrative staff because I have several people that I employ. But their procedures make it really impossible. I had participated in Magellan in the 1990s. What I am going to address my comments to is one big, first is one big thing that I do is I do nursing home care. And to make that real for you, when you think about psychiatric patients in nursing homes, fully half of demented patients have psychiatric issues such as paranoia, depression, they're yelling, screaming, they're paranoid and they can be treated. Medicare makes it very smooth and easy for a geriatric psychiatrist to help out in that situation. Magellan makes it almost impossible.

And I want to caution you, I don't know what to make of this, but I want to give you these facts, that these

issues that we're talking about have been a problem with Magellan for the whole time they've been an organization. I was President of the Philadelphia Chapter of the Psychiatric Society in the 1990s and I can remember having meetings with Magellan about some of these very same issues, that there are problems with authorizations and not doing it, using codes which I have described here, there are several different codes they'll tell you to use, then when you use them they change the rules immediately and they give you no notice, and then they deny your claims.

(Applause.)

I would caution you, what I have seen with Magellan is when we make complaints, when there's a lawsuit, they change things for a while, for a few months things go well, and then they go back to the same old behavior. In the 1990s, unfortunately I had an administrator leave so I had to actually process some of my claims myself, and I had a group and it was actually a lot of time, and what I discovered with Magellan is they had told us to use one code and I had to use a whole bunch of codes, and we lost about $40,000 that we never recovered. Currently, I have another, you know, so I dropped out of Magellan and several years ago I decided all right, we're going to give them another chance because in nursing homes there is more and more Keystone Care 65, which is a Blue Cross product which Magellan administers, Personal

Choice 65. So these patients previously we would see as infrequently as possible because we would rarely, and we had all these problems and I said let's try this again. Again, I just talked to my administrator before I came here and we again have $47,000 owed to us, $37,000, and I'm one practitioner. That's a lot of money. Much of my money comes from Medicare, that's a lot of money for the amount of claims that we're filing.

And I asked my administrator, what's the problem? And the problem is, if you look, it's in terms of one big problem has to do with what they tell us to use as a code. You know, my administrator will call and they'll say use code 323 for follow-up on nursing homes, which is a CPT code, which is their own unique definition. There is a CPT manual published by the AMA that Medicare and IBC and all insurers follow, and Magellan doesn't. 323 is a code for inpatient care. In fact, there is a code for nursing home care, but they don't use that. But we follow their directions. Then they changed the rule, denied all the claims, told us, no, now you're supposed to use a follow-up consultation code. Okay. We spent the time of taking all of those claims, changing them all, printing all the claims out, mailing them to them. They rejected all of them. And they said, no, I'm sorry, we're not going to pay for those.

We had another issue which had to do with I employ

a clinical nurse specialist who is like a nurse practitioner, clinical nurse specialist, and they are going into nursing homes and doing follow-up visits. Clinical nurse specialists are credentialed under Magellan, and several that I employed were credentialed, but they told us to use again one code, 99262, and then they rejected them all and said no, no, no, no, we made a mistake. You're supposed to use 90087, which is a psychotherapy code because that's the only code we have for these particular providers. So we complied and we did that. And then they said, no, we're not going to pay that because now you're past the filing deadline.

(Applause.)

And we've been going back and forth for a year and this is the kind of thing. So when you hear that psychiatrists don't accept patients, I mean, it's because of this. I am again thinking of dropping out. Why? I don't know that I can do this. I mean, I have recently moved my office practice, I do nursing home work, supervise that. I also have an office practice to the Fort Washington area, met with a primary care doctor yesterday or last week and introducing myself and talking about it and I said, well, you know, I do accept Magellan. I accept Blue Cross products. Oh, nobody accepts that. That's great, we'll send you patients. Well, now that I look at this, I know why. And I also asked them at the time, well, what do you do? He said,

well, quite frankly, what happens is we're capitated and we take care of those patients.

So I wonder about this about why the system doesn't change is actually Blue Cross, I guess, and Magellan is getting free care all over the place. By having this system, and this is what I would testify to you, this has gone on so long and it gets better for a few months and then goes back to it, it really benefits them. That they consistently get patients taken care of without paying for it. And it's not only Magellan but also IBC indirectly seems to get that. I don't know why this is, whether it's analyzed, whether it isn't, but I can tell you that's the effect. And if you do anything, you need to have a plan of following up on this six months to a year or ongoing, because otherwise they are going to improve this for four or five months, because I have seen them do it before and then it will go back to the same thing again.

(Applause.)

CHAIRMAN O'BRIEN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you. Just one question for Dr. Yee. And again, I think there is a lot more behind the statement that you made that I want to get to because I didn't really understand it in the context presented. You're talking about pressure to change medications, often pressured by reviewers to change

medications more or less to show you're doing something. Explain that in a little bit more detail both in terms of the why, what are you trying to get to, are they trying to help you to get you something? Are they trying to figure out to get around their system? And secondly, what are the credentials of a person who is a reviewer, if you know?

DR. YEE: I'm glad you asked those questions, because we have to deal with those issues on a day-to-day basis when we have inpatient patients. When a patient is admitted, for example, one case it's for psychosis, after five days automatically, regardless of how sick the patient is, the case will go to a physician-to-physician reviewer.

REPRESENTATIVE MANDERINO: I'm sorry?

DR. YEE: A physician-to-physician reviewer.

REPRESENTATIVE MANDERINO: So the reviewer is a physician?

DR. YEE: The reviewer is a physician and the reviewer is supposed to be a psychiatrist as well. And they should be a board certified psychiatrist. So when I have a discussion with the psychiatrist, this patient is still psychotic. His medication, this antipsychotic, I just increased the dose. And typically an antipsychotic medication will take at least 14 days, which means it's the time when the medication actually is beginning to take effect. And so we had a discussion about this, that, you

know, the pharmacodynamics of the medication is such that the medication will have to take 14 days before it takes effect, why should I increase the dose? What good would that do? And they'll say, yeah, yeah, we know that, but I can't authorize any further statement because you're really not doing anything for the patient. It's as if the whole inpatient hospital stay is just geared toward medication management. That's not the case. Inpatient hospitalization is a very comprehensive treatment for the patient, they receive individual psychotherapy that I do on a daily basis. They go through group therapy every day. They have the milieu therapy where they interact and are encouraged to interact with other patients in the unit. So they get a very comprehensive care geared towards what it is that precipitated their initial compensation to begin with. So medication is only a part of their comprehensive treatment, and yet when a reviewer looks at their treatment, that's what they focus on.

REPRESENTATIVE MANDERINO: Okay, so if this is a constant conflict about the medication management in the peer-to-peer, physician-to-physician review process at day 5, what is, and at least from your testimony it sounds like this is a regular occurrence, what is the actual and practical end result? Do you discharge the patient? Do you increase the medication so that you can continue the other stuff? Do you

butt heads and then not get paid? I mean, what happens and what happens both from a patient outcome point of view and from a cost to the system point of view?

DR. YEE: Typically, what happens is we butt heads because I stay my ground and still think that the patient's medication should not be increased arbitrarily just because they think it should be and we keep the patient if they are unstable at that point and keep them. Unfortunately, what does happen is an appeals process ensues. And while that appeals process is going on, there is this anxiety, the overwhelming anxiety, on the part of the patient because we have to inform them, unfortunately, your insurance is now declining continued hospital stay, but we're going to fight this on your behalf because you are not ready to be discharged. So the additional emotional burden to the patient, who is already very ill at that point, becomes magnified, and certainly that does not contribute to their recovery.

REPRESENTATIVE MANDERINO: And in the end, what happens from a money point of view? Do they, does the payer end up paying anyway? Does the provider end up eating the cost? Does the patient or the family end up paying out of pocket? Tell me what happens monetarily so we can decide from a cost benefit analysis this is worth all this heartache.

DR. YEE: In my personal experience, what has happened to the cases that I have appealed is that Magellan, say, if I appealed for additional five days, I would probably get authorized two out of the five. So the three additional days will be passed on to the patient -- oh, well, I take that back, I'm sorry. At that time I was still a provider. I'm no longer a provider. At that time as a provider you can't pass on the costs to the patients because that's part of your contract. So you basically eat all those three days.

REPRESENTATIVE MANDERINO: Thank you.

CHAIRMAN O'BRIEN: Representative Watson.

REPRESENTATIVE WATSON: Dr. Yee, just in looking at the first page of your testimony, I guess because I don't necessarily expect at the end they lived happily ever after, but I do like to know what happens here. In my understanding, following up on Representative Manderino's question, under your medical necessity standards, the first case that you cited about the individual hospitalized under the 302 whatever, you then would have to eat that money.

DR. YEE: Correct.

REPRESENTATIVE WATSON: The person, however, the patient did stay inpatient?

DR. YEE: Correct. Correct.

REPRESENTATIVE WATSON: The second one is a colleague reported this to you, and I guess I would really

like the colleague to at least give more information, certainly more to the Department of Health, but we have a picture of a woman, whatever age, walking the streets naked, shouting profanity to passersby, dangerous for herself, certainly seems somewhat dangerous or disturbing at the very least to those around her. What happened to her then if she had somebody who was in the program, they just got her in regardless, or what happens to these poor people?

MS. CHAN: This was the case that actually was reported to me in the Psychiatric Society's office. I believe that the patient was admitted. I don't know exactly how her particular case came out and whether she was paid, but the person who reported this to me, this is one of four examples he sent to me on the same day, none of the patients had been authorized for admission, and he told me that he had never, ever gotten an appeal, won an appeal when he had a denial, and he appealed it to Magellan. Never had they overturned themselves. But on this particular patient, I can't tell you exactly what happened, but I believe she was admitted.

REPRESENTATIVE WATSON: And indeed, going back then to this individual, this poor woman, I am reading the quote that says, "the member's symptoms did not show a clear inference of immediate," which is interesting the word "inference," but never mind, the English teacher, sorry, "of

immediate serious harm to self." This judgment is made by--

DR. YEE: Magellan.

REPRESENTATIVE WATSON: And the person at Magellan who makes this is indeed a board certified psychiatrist?

DR. YEE: No, this is just the initial authorization. So at that point it's a care manager that makes the decision about whether or not the patient warrants admission.

REPRESENTATIVE WATSON: Am I not reading something that would suggest almost if not a diagnosis and evaluation and a medical evaluation?

DR. YEE: Correct.

REPRESENTATIVE WATSON: Am I reading then by someone, then you're suggesting to me made by someone who is like me and does not have a medical degree?

DR. YEE: Correct. And we have pointed that out to Magellan in the past. Like I indicated, that their inpatient criteria is actually more stringent than even the Pennsylvania involuntary commitment laws.

REPRESENTATIVE WATSON: I don't even want to go further. Thank you.

CHAIRMAN KENNEY: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Dr. Yee, going back to your 302 involuntary commitment, the ultimate outcome of that appeal process from

your perspective was that you didn't get paid for the days Magellan would not approve?

DR. YEE: Correct.

REPRESENTATIVE HENNESSEY: What about the institution where the person was admitted?

DR. YEE: They also were not reimbursed.

REPRESENTATIVE HENNESSEY: So then--

DR. YEE: The hospital--

REPRESENTATIVE HENNESSEY: So it ends up being uncompensated care for the hospital that we hear about.

DR. YEE: Correct.

REPRESENTATIVE HENNESSEY: So that's another problem that we have in terms of dealing with our hospitals.

DR. YEE: Correct.

REPRESENTATIVE HENNESSEY: Thank you. Thanks very much.

CHAIRMAN KENNEY: Thank you very much for your time.

DR. YEE: I would like to add a final point, if I may. In terms of the ultimate effect that this does, as frustrated as these things are for us as treating physicians, the real price is really paid by our patients. All these things end up hurting them. The patient whose care is unauthorized despite our appeals are hurt even if we keep them in the hospital, which of course we can do whenever we

can. Some who know that they need to be treated and desperately want to get better are then subjected to terrible anxiety as to whether or not their stays will be approved. Some choose to leave rather than face this anxiety. Others, who because of their illness don't fully recognize the need for treatment, will leave because they see the denial of authorization as proof that they don't really need to be in the hospital.

The indirect effect is ultimately as damaging. The time that physicians and other staff put into getting authorizations, making appeals, and cleaning up problems is enormous. It diverts the time and expertise that would otherwise go into clinical care. Fewer patients can be seen, and much of the expense of doing those administrative tasks could otherwise be diverted to more treatment staff. It has gotten so bad that many of our colleagues refuse to participate with Magellan. As we both indicated earlier, we are no longer participating providers not because of financial issues but because of the policies that Magellan has. I still see patients, Magellan, out of network, which means that the patient is responsible for more of the bill. Attending physicians in the Philadelphia hospitals are not having a difficult time finding a participating provider to refer their very acute patients to for aftercare when the hospital stay is over.

Rather than take part in such a problematic system, most psychiatrists in Philadelphia decline to contract at all. This leaves patients who depend on insurance for the cost of their care out of luck. Many patients with that insurance must pay out of pocket and thereby subsidize their insurer, effectively rewarding Magellan's poor provision of a provider network. If psychiatrists reduce rates or see such patients for free, as many do, they are providing the same sort of subsidy for Magellan.

(Applause.)

CHAIRMAN KENNEY: Thank you.

DR. YEE: Thank you very much.

CHAIRMAN KENNEY: Diane Frankel, President, Pennsylvania Society for Clinical Social Work, and Cynthia Corbin, National Association of Social Workers, Pennsylvania Chapter.

Welcome.

MS. FRANKEL: Chairman Kenney, Chairman O'Brien, and committee members, I'd like to thank you very much for providing an opportunity to hear from social workers, to hear their perspective on these issues. I'm Diane Frankel, and I'm here representing the Pennsylvania Society for Clinical Social Work. I am president of this organization that has over 300 members who are clinical social workers working in the Philadelphia metropolitan area, where as you've heard

already, Magellan has a monopoly. I am also a practicing clinical social worker with a part-time private practice in Philadelphia, a faculty member at Bryn Mawr Graduate School of Social Work and Social Research, and I am a Personal Choice subscriber myself.

Many of the members of PSCSW provide services through Magellan, and we recently asked for their experiences in working within the Magellan system. Our members, who are licensed clinical social workers, as I am, are working in the large practice groups that you've heard from the executive director generally run by psychologists, and some also work in smaller independent practices. Their responses to our requests for information mirrored the problems outlined in the psychologists' report and all of the problems that you have received today. The responses predominantly identified problems in credentialing, authorization, and billing. Reported were problems with the initial credentialing application not being processed in a timely manner so that materials became outdated and needed to be repeatedly submitted, lost claim applications, change in fee schedules and authorization procedures that were not clearly articulated, and very lengthy time frames to try to have these situations corrected. It was also noted that because a provider's availability was not always updated in the system, clients reported that they had to make multiple phone calls,

got frustrated, and often did not access services until they had a crisis, which has certainly been implied in the other testimony today. Many of the clinicians noted that payments were slow or did not come at all, and they had to spend extended hours on the phone and with paperwork in order to get paid for the services provided. These were hours that could not be spent working with clients. In all cases, the clinicians indicated that continuity of care was sometimes threatened and disrupted for the clients.

I just covered this very quickly because I know that Cynthia Corbin from the Pennsylvania NASW will be talking more extensively from that perspective. I would like to share my own experience as a practicing clinician trying to become a Magellan provider. About three to four years ago, when I had expanded hours available at my practice and had many clients who had Personal Choice, I started contacting Magellan Provider Services to get a credentialing packet. Having worked in community mental health for many years and working in the system during the transition to managed care, I was very aware of what managed behavioral health care is about and I understood that credentialing did not necessarily mean contracting, but I was trying to get a credentialing packet. I left numerous messages on the electronic answering service requesting a credentialing packet and never received a response. I was unable to find

any information that told me about who was eligible to be credentialed or what the process was.

In February 2004, I finally spoke to someone, Linda Williams, in person who reluctantly sent me materials to fill out to request the credentialing packet. She did not indicate in any way that they were not taking any new providers, and at that point the rumor was that IBC would be expanding their provider network. I heard that both from my employer, because as I mentioned, I am a Personal Choice subscriber, and I had heard that from among the professional community that they were going to be expanding the network. So, I was optimistic. I filled out the forms, sent them in, no response. After a reasonable length of time, I spoke to Linda Williams on the phone and she said that they were not credentialing any new providers, but that when she sent me the forms, they were. When I had spoken with her previously, she had not indicated that there was a short open window for this process.

I just want to make this point because Magellan does not make requirements of procedures accessible to providers, or as we've heard, to many clients. If I as a Personal Choice subscriber wanted to see a mental health provider, it's my understanding from my own clients' experiences that I would not be able to access a full list of providers with specialties noted as well as addresses so that

I could choose the best fit for my needs. And certainly in my own personal experience I had been a clinician for over 25 years, have areas of specialization, and Magellan never gave me an opportunity to provide them with that information, although at that point they might have been able to say we cannot put you into our provider network for particular reasons, but I was never given that opportunity, and my clients weren't given the opportunity to see a mental health professional who they have chosen to see who may be able to provide their special needs.

There are many consequences for client consumers, including they have difficulty connecting, and this is what I hear from clients and this is what I hear from the members of my organization who are licensed clinical social workers, providing what is probably the majority of the mental health behavioral health care services in the Philadelphia area, they have difficulty connecting with appropriate clinicians in a reasonable timeframe within a reasonable traveling distance. The way the fee schedule is being gradually reduced, fewer experienced Master's level clinicians are agreeing to be Magellan providers, and some are withdrawing from the network provider list.

Master's and doctorate level clinicians provide the same therapeutic services, yet the rates paid to the Master's level clinicians are lower, leading to unequal pay for equal

work, and limited access to services for consumers. Client consumers do not have the opportunity to choose from a range of clinicians, especially those that may have many years of experience and now want to become providers. My point being that because it's so unclear how one can become a network provider, those who are more experienced and now want to join provider lists are not able to access that. And inefficient procedures for reauthorization and payment for services rendered often leads to interruptions and therapeutic services and potentially damaging consequences for the mental health of the client consumers.

Again, I want to thank you for the opportunity to share my perspective with you, and I would be happy to answer any questions after Cynthia Corbin presents.

MS. CORBIN: Thank you. I'm Cynthia Corbin, the President of the Pennsylvania Chapter of the National Association of Social Workers, and I would like to thank Chairman Kenney and Chairman O'Brien for taking this time with their committees to hear testimony from us regarding our concerns about Magellan practices and protocols.

Founded in 1975, the National Association of Social Workers, Pennsylvania Chapter, is the eighth largest chapter of NASW and the world's largest association for professional social workers. NASW-PA is currently comprised of over 6,500 members, a majority of whom are providers of mental health

services. A fact sheet with additional information regarding NASW-PA is attached to my testimony for your review.

As social workers, we are called by our code of ethics to promote and advocate for improved access to mental health services. We are committed to seeking social and economic justice for all who are vulnerable and oppressed, including people with mental health illness, and particularly for those who have difficulty in obtaining and maintaining needed services. It is from this perspective on behalf of the chapter's membership and the consumers we serve with which I am presenting testimony today regarding the practices and procedures of Magellan Behavioral Health that serves as a subcontractor to Independence Blue Cross and Aetna.

Because Magellan administers 99 percent of the HMO and a high percentage of non-HMO behavioral health services in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties, it is vitally important that your committees work with the stakeholder present today to ensure that consumers in this area receive the services they need.

Our testimony focuses on the concerns raised by our members in southeastern Pennsylvania, both anecdotally as well as in response to a recent survey the chapter distributed. In addition, we support the concerns raised by the Pennsylvania Psychological Association both in its recently released study entitled, "The Efficiency and Quality

of Commercial Mental Health Care in Southeastern Pennsylvania," and in their testimony presented earlier this morning.

The chapter has received feedback primarily from its licensed clinical social work members regarding delays in credentialing. One provider's experience was that when she was hired by a private practice to serve as an independent contractor, it took Magellan over 90 days to approve her certification, which was all in order and she had even previously been a Magellan provider in good standing. Because of Magellan's delay, this provider was not able to provide patient care for three months, nor earned income for three months. Her experience is not uncommon and certainly has a negative impact on the provider and on the consumer.

We agree with the Psychological Association that Magellan's authorization process does not benefit patient care. Our members have informed us that authorizations are not denied for reasons of medical necessity but rather on the basis of an administrative or technical error. Therefore, even if Magellan agrees with the medical necessity of ongoing treatment, why should such treatment be interrupted or terminated for reasons such as a certain box on a form that was not checked or the timeframe for authorization is two days expired? Our members believe that consumers should receive the number of outpatient services they are entitled

to by virtue of their insurance contract, and therefore authorizations for outpatient treatment should be eliminated.

(Applause.)

One clinician who has been providing services for 40 years, both as a clinician and a health care administrator, shared with us an experience about Magellan implementing or changing policies without notifying providers in writing. For example, this clinician and others were told by Magellan that starting January 1, 2005, the first eight visits were covered and no initial authorization was required. Several months later, however, some providers were being told by Magellan that an authorization was required after the first visit. Magellan stated that a letter had been sent out to providers. When this particular clinician pressed Magellan to provide the letter with the updated policy, he was informed by the Magellan representative in fact that the letter did not exist. Needless to say, our member never received clarification in writing about Magellan's policy pertaining to authorization.

Other clinicians have told us that even the process of where to send claims, since they were told they needed to bill in order to get the authorization forms for more than eight sessions is unclear. If you don't submit the claim for billing purposes, you don't get the authorization form and you can't get additional authorizations over the eight

sessions. The time spent in seeking authorizations and clarifying what Magellan's practices are takes valuable time away from providing essential services to individuals with mental health needs.

As another example of how Magellan's current authorization process impedes access to care, we had one member who is a high volume provider for Magellan inform us that she has clients come in who tell her that Magellan has authorized them for thirty sessions. But when she checks, as the provider, the Magellan on-line system, the patient's case has been terminated for an unknown reason. Sometimes Magellan places an arbitrary timeframe on when the consumer can access sessions. For an example, they only had six months to complete thirty sessions, and even though the person may not seek treatment right away, they will lose those sessions that were authorized during that timeframe because they didn't use them all at that point. The provider contacted Magellan via phone and was told that the client had been authorized for 30 sessions but it was difficult to resolve the situation in a timely fashion to ensure continuous care for the consumer.

When administrative burdens like this occur, the provider is put in a very difficult situation of having to decide to terminate the client for some period of time until all the paperwork is finalized and approved by Magellan or

continuing treatment without final paperwork approval by Magellan and not getting paid for the services.

Several providers informed us that their problems were working with Magellan's computer system. For example, providers attempted to utilize Magellan's on-line system to send documentation into Magellan, but the computer screen will clear without providing the clinician with any proof or record of what was sent electronically to Magellan. One provider who was working to get more sessions authorized for a client had difficulty with the on-line system. She contacted the Magellan information technology support staff for assistance and was told, "it's working for some and not for others," I quote. The staff told her to complete the form by hand and fax it in. This entire process took over an hour, an hour that the provider spent on administrative hassles versus providing patient care. And this example is only one of many similar experiences that have been shared with the chapter often regarding Magellan. Another provider informed the chapter office that thousands of dollars had been lost due to Magellan's computer system erroneously closing out patient case files and not informing the provider until much later. In addition, we have heard from providers that Magellan's on-line system, in comparison to other insurers, is very tedious. With other insurers who enter the necessary identification number and other information appears

on-line, with Magellan's system, the provider must type in all information every time. This duplicates the effort and takes time away from time that could be spent providing patient care.

The chapter has heard from providers that consumers had difficulty getting approval to utilize their benefits. Magellan's initial reviews are very time-consuming, taking anywhere from 30 minutes to an hour. Because this is an initial review and the consumer has just presented for treatment, the provider only has a little amount of information. Magellan requests more information initially than what should be or could be expected and typically only provides one or two days of approval, if at all. This means that the day after the initial review is approved, the provider must review the case again. Again, Magellan wants a tedious amount of information, including the discharge plan and whether the patient can be discharged today, a day or two after admission. This type of process implies a system that is more interested in keeping patients out of treatment rather than helping them access treatment.

Providers also informed us of concerns about the limited treatment time that is provided or authorized to consumers who needed addiction treatment. In addition, they believe that Magellan's authorization treatment time is typically less than what other insurers pay for according to

our members' experience. As you know, effective January 1, 2005, Magellan increased rates for Ph.D. practitioners 7 percent, while reducing Master's trained therapists by 11 percent down to $62 per session or per hour. The chapter fully supports Magellan's increase for Ph.D. practitioners and would be remiss if we did not inform the committee of our members' real concern about the negative impact of the reduced reimbursement rate for Master's level therapists.

What caused Magellan to reduce payments to Master's level therapists? Research shows that outcomes of therapy are not significantly different based upon education of the clinician. A recent study appearing in the October 2004 edition of Consumer Reports found the following: Respondents who said that therapy was mostly talk and lasted at least 13 sessions had better outcome than those whose therapy was mostly medication. Therapy delivered by psychiatrists and clinical social workers was perceived as effective as that given by psychiatrists. If the therapy is effective, even with the varying degrees of the practitioner, then we simply ask what was the reasoning behind the discrepancy in Magellan's rates?

In addition to the serious concerns our members have regarding the recent decision by Magellan to reduce reimbursement to Master's level therapists, there are also some procedural concerns that impact our providers' ability

to reimburse services. Payments are often delayed, and it can take numerous phone calls to insure that the check has been mailed. For example, one practitioner still has not been paid for services rendered in January without any clear explanation as for the delay. These are vital services that our members are providing and they simply ask that they be paid fairly and in a timely manner for such services.

In closing, I again want to thank you, Chairman Kenney, Chairman O'Brien, and members of the committees, for your interest in protecting both mental health providers as well as the rights of consumer who need these essential services in southeastern Pennsylvania. The Pennsylvania chapter of the National Association of Social Workers offers itself as a resource and looks forward to continuing to work with you on this important issue. Thank you.

CHAIRMAN KENNEY: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you for your testimony. Just one question, and you might not be the appropriate person to answer and I'll save it for later if that's the case, it's just your testimony raised the question in my mind. I am a patient accessing my behavioral health benefits. And if medication is the prescribed therapy as compared to counseling, where does the payment come from? Does it come from my behavioral health benefits or does it come from my medical benefits?

MS. FRANKEL: Seeing the psychiatrist--

REPRESENTATIVE MANDERINO: If somebody says you see a psychiatrist twice and you have meds and you don't go back to the psychiatrist until six months later to renew your medication, the cost of the medication is coming out of my medical plan, am I correct?

MS. FRANKEL: The medication.

REPRESENTATIVE MANDERINO: And the physician, the psychiatric visit is coming out of my behavioral health benefits.

MS. FRANKEL: Yes.

REPRESENTATIVE MANDERINO: If I am seeing a counselor, so my therapy doesn't involve medication, my therapy involves 13, 26 visits to a therapist, the cost of that is coming out of my behavioral health benefits?

MS. FRANKEL: Yes, that's correct.

REPRESENTATIVE MANDERINO: Thank you.

CHAIRMAN KENNEY: Representative Reichley.

REPRESENTATIVE REICHLEY: Hi. I was paging through the Magellan materials here, I'm just curious, when you talked about the problem with the authorization forms, the Magellan material seems to indicate that at least on the TRF, the treatment review form, that they are returned to the providers many times because the member ID or date of birth is missing, and I guess I was curious, do you get trained on

how to enter information into the Magellan system when you're initially signing on as a provider?

MS. CORBIN: Well, I think what we heard from most of our members that there's not confusion about how to fill out a form, that there's often things have been filled out correctly and still there have been denials. So it's really not as complicated to do that, it's just the amount of paperwork that has to be done, and each time all of that information has to be re-entered.

REPRESENTATIVE REICHLEY: Well, at least in one of their materials here they say that on the TRF required bills, at least some of the information is prepopulated once you're in the system and comes back up automatically, but the things that have to be re-entered are various access diagnosis and codes, and when you've been saying it's costing time away from the patients, are you yourself doing this or do you have staff?

MS. CORBIN: Well, it can vary. If we're talking about an independent practitioner who is in their office and they have a private practice, then they're doing their form. They may not have staff to do that. You're talking about a setting, I also happen to work in a hospital and we're trying to obtain coverage, then we might have staff to do that. So it really depends on where the practitioner is because we do practice in a variety of different settings.

REPRESENTATIVE REICHLEY: Okay, but getting back to my first question, is there any kind of training offered once the provider Magellan has the information?

MS. CORBIN: Not that I'm aware of in my years of working.

REPRESENTATIVE REICHLEY: Thank you.

CHAIRMAN KENNEY: Thank you. Thank you for your question.

CHAIRMAN O'BRIEN: For the information of those here, there's been numerous requests for information or copies of testimony. You can receive that if you want to e-mail Elizabeth Yarnell at eyarnell@pahousegop.com. That's eyarnell@pahousegop.com. And Elizabeth has given me permission to give her e-mail out.

We're going to take a 5-minute recess. We ask everyone to come back promptly at five minutes to 1:00.

(Whereupon, the proceedings were recessed at 12:47 p.m., and were reconvened at 1:00 p.m.)

CHAIRMAN O'BRIEN: Sharon Katz.

MS. KATZ: My name is Sharon Katz. I'm an advanced practice psychiatric nurse, marriage and family therapist, and owner of Collaborative Care of Abington. Today I come here before this panel wearing many hats. I have 15 years' experience working with managed mental health, and the last 10 as owner of a mental health group practice. In addition,

I serve on Magellan Behavioral Health's Peer Professional Review Committee, the PPRC, overseeing the credentialing process for the Pennsylvania region. I serve this board as a provider representative and I am not an employee of Magellan. I hope that my testimony today will put into context the issues raised in the report recently published by the Pennsylvania Psychological Association.

My group, Collaborative Care of Abington, subscribes to a holistic approach to mental psychiatry and healing, working collaboratively with medical and psychiatric professionals to provide a comprehensive approach to adaptation. I currently have 11 psychotherapists and 2 psychiatrists working in my office as well as complementary alternative specialists. The psychotherapists working for Collaborative Care represent a full complement of disciplines - psychiatrists, social workers, advance practice nurses, licensed professional counselors, and marriage and family therapists - and all meet licensure standards set by their respective professional boards.

My group does not just provide mental health services to Magellan clients, but we are an in-network provider for most of the larger commercial mental health panels. In hearing my testimony today, I want you to keep in mind the evolution of change. Since 1991, mental health care delivery has evolved considerably. We are currently

demanding open access to mental health providers, a dramatic difference from the capitated or PPO provider groups of just a year ago. If a primary care physician needs to refer a client to a mental health provider, insurance issues should be minimal. The change towards open access has its challenges, but the advantages are already being applauded by consumers.

The evolution of a mental health system requires analysis of the problem, constructive intervention to develop a better system, implementation, provision and reanalysis of the process to current problems. Of all professions, the psychologists should understand the process of change. Personally, I believe the system Magellan is working towards is going to streamline my administrative costs, but requires purchasing more clinician accessible computers, training, and time to work through the flaws in the system.

In developing a clinical group, I found it essential to foster a working relationship with companies like Magellan. A working relationship is a two-way street. The companies provide basic structure dictated by Pennsylvania law and the NCQA for credentialing and quality standards. In exchange, we provide services to their consumers and input to make their system more workable. When there is an issue, it is important to analyze the issue to determine if it is our administrative shortcoming or the

insurance company's, and then make an effort to resolve it. Follow-up to the problems takes a method of organization, problem solving skills, articulation of the problem, level of patience and willingness to accept responsibility. Such challenges are not unique with Magellan. I have experienced significant issues with every insurance company in direct proportion to the amount of business we conduct. I personally shudder to think what would happen if some of the other insurance companies were put in Magellan's shoes.

Psychologists' opposition to HMOs is not new. Of all mental health professional groups, they have been proponents of a private practice model that requires an individual consumer to pay nonparticipating provider fees and submit claims themselves. This is at higher cost to the consumer. I find it ironic, therefore, when many of the stronger voices shifted their perspective in favor of pursuing large capitated provider groups. When they sense that money could be made in management of such clinic style practices, they aligned with managed cared.

The capitation of consumer mental health benefits was the worst system I have ever experienced, providing disincentive to treat chronic illness and aggressive management. Many patients were hastily put on medications that were not needed, were seen infrequently, or by professionals who lacked expertise in their specific issues.

The job of modifying a health care system to accommodate challenges by consumers and IBC is not an enviable position. Over the past two years, all providers witnessed many nonclinical changes in all managed mental health care organizations. This included the advent of HIPAA regulations, movement towards more Internet-based management, and centralization of resources. All appeared to require a large overhaul of computer systems and complex models of tracking individual members in a confidential manner. Magellan has gradually centralized their system, a trend mirrored by other such companies.

During these changes, all mental health professionals and groups were relatively unaware of the full impact that this would have on their daily lives. Providers needed to pay attention to their mail, patterns of rejections, and other indications that the system had changed. Inability to understand the new system resulted in delayed reimbursement, or being dropped off credentialing. My experience was that Magellan had been responsive and able to fix the problem in a timely manner.

We all have been challenged by the increased demand for accountability, privacy regulations, and cost containment for services provided. When working with an HMO-based product, the clinicians and administration need to keep in mind the need for verification of benefits, authorizations,

and follow-up to billing in order to receive payment.

Our clinical practice, Collaborative Care, instructs all new clients to call for their own initial authorization numbers and information regarding their co-pay that they are responsible for before being seen. This increases their participation in the therapeutic and billing process. In addition, psychotherapists at Collaborative Care of Abington are held responsible for maintaining paperwork, authorizations, and collecting co-payments, as they are only paid on services once we receive payment.

Credentialing is a serious process that does take two to four months. When a credentialing packet comes, it needs to be addressed immediately. If a clinician has joined another clinical practice or moved since the last credentialing was performed, their packet risks being sent to the wrong address. Many providers, especially psychiatrists, work for more than one provider group or hospital and have multiple contracts with different companies. This gives the impression that much of the information is redundant and therefore does not require completion.

As credentialing becomes more of a legal liability, it has been my observation that Magellan has taken more responsibility over maintaining a network of providers that follow ethical standards. On the PPRC we review individual providers, groups, and hospitals in an objective manner for

compliance with NCQA standards, lawsuits that might indicate unsafe mental health practices, and ethical violations. All attempts are made to credential in a timely manner, but this is inhibited by incomplete information or the need to research a complaint or malpractice claim.

In conclusion, I strongly believe that Magellan is working towards a more progressive mental health system, providing more efficient provider resources, and working towards an electronic billing and on-line authorization system. Many of the problems detailed in the Pennsylvania Psychological Association report were evidence of an evolving system. Magellan manages care for the largest HMOs in Pennsylvania. The psychologists have to adapt to the system of authorization and credentialing or choose to leave the contract. This is their choice, but the impact is on the clients they serve.

The opening of the IBC system to all Magellan providers has been extremely well received by the consumers that I have spoken to. None of them experienced any denial of care. I believe this will be reflected in consumer and primary care physician satisfaction surveys. The mental health providers need to look at themselves and develop programs that need to meet the need of our society. I am proud to say Collaborative Care of Abington has been doing that for years, working with HMOs, creating innovative

programs needed by our community, and enjoying the emotional growth of our patients. As a result, my clinical practice group has significantly low administration rates to mental health institutions, no incidents of suicide, and good compliance with treatment plans. Our success is through following guidelines put forth by the NCQA, collaboration with physicians, listening to patients' needs, and working with managed mental health care companies such as Magellan. As psychotherapists, we should work to resolve problems through understanding the process and removing obstacles that inhibit them. Thank you.

MR. BURNSTEIN: Good afternoon, and thank you for giving me the opportunity to be here today. My name is Ron Burnstein, and I'm the President and CPO of Foundations Behavioral Health in Doylestown, Pennsylvania. We have been providing mental health services in our central Bucks County community since 1964, and I think we have ridden all the waves that have come and gone our way over the years.

Foundations provides a full range of services for children and adolescents. We are a nonprofit facility contracting with all commercial insurers and all forms of Medical Assistance in the State of Pennsylvania. We also serve New Jersey and other eastern States, as well as providing services for TriCare dependent military children. On any given day, we have slightly over 700 children

receiving services through Foundations.

We are well-versed in dealing with both commercial and Medical Assistance insurances, speaking multiple managed care languages in order to survive today's environment. Six months ago I was asked to be on the national advisory committee for Magellan. I am happy to be doing that. I have spent over 20 years being a strong advocate for mental health benefits and parity, meaning treating mental health benefits on equal footing with medical benefits. This fight has led us across the country and to every statehouse in the country. Magellan has been a very strong positive supporter around this issue.

Managed care obviously gets a lot of bad press and is the brunt of many jokes, but the reality is historically there was a great need for managed care. Lengths of stay in hospital were long, with little discussion as to what level of treatment was actually best for the patient. Discharge planning was often haphazard and an afterthought. Our goal has been and continues to be what is best for the patient? Managed care companies want to provide the best care that is cost effective. These two points of view need not be that far apart. Ongoing dialogs like today bring us a lot closer together.

We seek the least restrictive care using the levels of service that best meet the patient's needs. We believe

that aftercare and discharge planning begins with the first contact with service. We seek the shortest length of stay necessary based on medical necessity, with high quality treatment appropriate for the age and diagnosis. As we provide dynamic treatment approach, psychiatrists leading the team of professionals to address the medical needs, and in the case of children and adolescents, with the expectations that families will become actively involved in treatment and discharge planning. We insure that follow-up aftercare appointments are made prior to discharge. We recognize that patients and families are much more likely to keep appointments when it is made for them and scheduled within a few days of the discharge. These goals have come out of a partnership with managed care organizations such as Magellan.

We strongly believe that the advent of managed care has helped us hone our skills in providing excellent care. We have found and we find that with appropriate checks and balances, all points of view can be expressed and appropriately addressed. In this health care environment, nobody always gets what they want, but we felt that we're able to find common ground to always do what is in the best interests of our patients.

In our eyes, we have found Magellan to be a highly professional organization. Magellan is more accessible than other managed care organizations to answer questions that can

arise in trying to navigate the utilization and current review process for inpatient, residential, and partial hospital levels of care. Supervisory staff is accessible and responsive to working out problems, and is sensitive to the need for prompt communication. Magellan's psychiatrists are more available for peer consultations, taking our scheduling needs into account.

Magellan has made the step-down aftercare process more accessible. For example, by not requiring a peer-to-peer review before pre-certifying partial hospital when medical necessity is clearly evident.

The big, tough questions about insuring the uninsured, slowing down spiraling health care costs, and the long-term problems in Medicare and Medicaid funding are serious problems. We face them as individuals, we face them as employers, in our communities and in our States across the country. We all know there are no easy solutions.

Forums like today are very important to raise the right issues and enable us to work together to develop meaningful solutions to these complex problems. As a kid who grew up in the '60s and was a member of the Peace Corps and a Vista volunteer and has been a strong fighter for mental health benefits for the last 20 years, and a big fan of the Beatles, I can't imagine a company whose tag line, "Getting better all the time," isn't trying to do the right thing.

Thank you very much. Laura came with me to handle all the tough questions.

CHAIRMAN KENNEY: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, thank you for being here and adding a different perspective to the hearings.

There were a number of questions that you, I guess I'm speaking first to Ms. Katz, that you addressed in your testimony addressing some of the criticism, but I'd like a little bit more information. One of the things that you said is that you have other insurers that you deal with other than Magellan, and can you tell me who they are and what percentage of your client makeup is with Magellan versus other insurers? I mean, we've kind of all heard testimony that Magellan has 95 percent of the market in southeastern Pennsylvania. You're a southeastern Pennsylvania provider, so I'd like to kind of have that perspective before I start.

MS. KATZ: We have about 85 percent Magellan. The other groups, the larger group is Cigna Behavioral Health, Value Options, TriCare, which is HealthNet now, and we have EAP organizations, we have several of them that contract with us and send clients our way. We also have a lot of self-pay. We also take Blue Cross/Blue Shield out-of-network from other States, and that seems to be a popular choice for the self-employed.

REPRESENTATIVE MANDERINO: Okay. Thank you.

MS. KATZ: And Medicare. Oh yeah, Medicare. And we have about a 6 percent Medicare population.

REPRESENTATIVE MANDERINO: This wasn't one of my original questions, but when one of the prior testifiers, I forget who it was, was talking about Medicare versus some of the what I thought were kind of Medicare supplementals, Key Pro 65, Keystone 65, 65 Special, I kind of was a little bit floored, this is just my ignorance of how it works, why don't people just bill under Medicare? Does Medicare only cover certain things and then the supplemental kicks in? Or if you have the supplemental, you have to use it? I mean, explain that whole process to me, if people were having problems with the geriatric patients and the 65 plus, why didn't they just say I'll bill this to Medicare?

MS. KATZ: Okay, let me explain to you about Medicare. Medicare has co-pays as well as deductibles, and the supplement you bill Medicare first for everybody and the secondary, and whatever secondary, even if it was Personal Choice, it would to go the Personal Choice secondary to Medicare.

REPRESENTATIVE MANDERINO: So when you say Medicare, 6 percent of your client population, these are people who don't also have a supplemental? These are people who do have a supplemental, so that that 6 percent might also

be their secondary kick into one of these insurance products?

MS. KATZ: The question you asked, what's our primary insurance companies, and these are the primary sites of where we go for our primary level of reimbursement. So don't look at the secondaries as an issue.

REPRESENTATIVE MANDERINO: Well, but to me, see, I'm trying to get to the issue of the marketplace. I'm trying to understand the marketplace, because I think so much of this that we're hearing, and I was getting a different impression from your testimony about the marketplace, both in terms of the prevalence of Magellan as an only or not an only payer.

MS. KATZ: Yes.

REPRESENTATIVE MANDERINO: Okay, so that's what I'm trying to get to understand.

MS. KATZ: My practice does not just use Magellan. We openly advertise, we market ourselves in a very big way. We try to have relationships with physicians. If a patient calls and they say that they have Medicare, I say that's fine.

REPRESENTATIVE MANDERINO: Okay, here's what I'm missing: 85 percent of your clients are Magellan, another 6 percent are Medicare, so that brings us up to 91 percent? So 9 percent of your patients are all other sources of insurance that aren't Magellan or aren't Medicare?

MS. KATZ: Yes.

REPRESENTATIVE MANDERINO: And I'm correct that the 6 percent that are Medicare are Medicare only and aren't kicking into another insurance product that is also managed behavioral health wise by Magellan, or they might be?

MS. KATZ: They might be. But part of, we would-- if somebody had Keystone 65, we wouldn't consider that Medicare, we would consider that a Magellan product.

REPRESENTATIVE MANDERINO: Okay, thanks.

MS. KATZ: Now, you also asked another question about why is my practice different than all of these other practices that have these large percentages of--

REPRESENTATIVE MANDERINO: Well, yours is still pretty large, it's just not 95 percent, it's 85 percent.

MS. KATZ: And 85 percent might be too much of an estimate. The truth is, we do take in other groups. We were not a decapitated provider for Magellan. We're also not a PPO or a Personal Choice provider until recent day. We primarily started with open access in mind.

REPRESENTATIVE MANDERINO: Okay. In your testimony you said, "We are currently demanding open access to mental health providers, a dramatic difference between the capitated PPO provider groups just a year ago." You started to get into that. I am not sure as a layperson I understand the point that you were just trying to take me to and that you

were trying to take me to in this testimony. Could you be a little more explicit about the point you're trying to get us to understand with that statement?

MS. KATZ: In capitated provider groups and PPOs, you used to have to go to, you were given a choice of a preferred provider group or one capitation to go to, and that controlled your reimbursement. If you went outside of that group, you would have to pay out-of-network rates. As far as open access, there were I think there was, I forget the statistics of how many thousand Magellan providers were in the region that were not capitated providers or PPOs. When they opened up access September of last year, it allowed you, who went to your primary care doctor to say, well, I heard Sharon Katz is a really good therapist, can I go see her? That's a great idea, let me make sure, call the number on the back of your card and you can go.

REPRESENTATIVE MANDERINO: Okay, so prior to the opening of this network, we didn't have all this authorization stuff that folks came in with stacks of envelopes about.

MS. KATZ: They didn't have it, we did. I always had authorizations. I always had people call for authorizations to make sure that their health care plan I could get reimbursement from.

REPRESENTATIVE MANDERINO: Okay, so then that takes

me, you're following along perfectly here. "Our clinical practice instructs all new clients to call for their own initial authorization numbers and information regarding their co-pays that they are responsible for before being seen." That was your practice prior to the open network, that is your practice currently?.

MS. KATZ: Um-hum.

REPRESENTATIVE MANDERINO: So your practice always had the patient seeking authorization, not the provider.

MS. KATZ: Right.

REPRESENTATIVE MANDERINO: And so all of those envelopes may be stacking up on all of your patients' desks, they're just not stacking up on yours.

MS. KATZ: We get copies of them too, but we already have the authorization number. The day that they walk in they bring the authorization number with them because they get it over the phone.

REPRESENTATIVE MANDERINO: So they're doing the back and forth with the insurers. That's the difference between your business and some of these other folks' business, whereas these other folks are assuming the responsibility of doing the back and forth with the insurer?

MS. KATZ: Right. I don't know why they do that, but that's their choice.

REPRESENTATIVE MANDERINO: Maybe they were trying

to make it easier for their patients.

MS. KATZ: But, if it was easier for the patients, in order to get an authorization, you need to have a date of birth. I don't have that patient's information before they walk in the door, okay? So HIPAA regulations means that you don't have information about these people that would identify them confidentially. So I don't have their Social Security number, I don't know who their primary insurer is, and I don't know their date of birth. And that is information that's asked over the phone in general when you call for provider authorizations. You don't have that until the first day they walk in.

REPRESENTATIVE MANDERINO: Okay, let me make sure I understand how that works. I'm a potential patient in need of behavioral health services and there's now this open access, so I don't necessarily have to go to my primary care physician and say I have this problem, help me, refer me to somebody. I'm going out there in the marketplace. Now, if I call counselor or psychologist or psychiatrist A and say, I have a problem, can you help me, they might say come in to see me and start this process. If I call your place, what will you tell me? Do you say to me go to your insurer and get all this stuff, and then once you get it come to see me?

MS. KATZ: Okay, when a patient like you would go and say I need help, let me go either to the phone book or

let me go to the Internet or go to a friend and mention who they want, and they might say Jane is a great therapist, but we also have Sharon over here, and you call up Jane and say, hey, I would like to come in, she might or might not take your insurance. Okay. That's up to you. And you can say, do you take my insurance? Oh, yes, what do you have? Okay, come on in. That's fine. She might also then say, well, you have Magellan, I'm on the network for Magellan, but let me see if I can get an authorization, you can't come back next week until I find out about your authorization. Okay, I put it on the onus of the individual. I say, if a patient calls in and they say I would like help from your organization, I would say, well, what insurance do you have? Magellan. Okay. Keystone 65, whatever, Aetna, Blue Cross, fine, Magellan. Okay. What is your needs? Let me assign you the right therapist. Before I end the phone call, and I make sure that that therapist is currently credentialed by Magellan, because there are other people who are only credentialed by other groups too.

REPRESENTATIVE MANDERINO: How does your system handle emergencies?

MS. KATZ: Easily. They call me, they call in either by cell phone or the regular number, we're open from 9:00 o'clock in the morning until 9:00 o'clock at night.

REPRESENTATIVE MANDERINO: And somebody says I'm

going to kill myself, and you say, call your insurer and get an authorization?

MS. KATZ: No, go to the emergency room. We don't have any information about this person. We have nothing.

REPRESENTATIVE MANDERINO: Okay.

MS. KATZ: It's important for them to be evaluated by a psychiatrist in a medical-controlled environment as soon as possible in an off-hours situation. If they're going to say they're going to kill themselves on the phone, that's where they go. If they need to come in and we have the availability to accept them as a client, we would have them come in and talk to a therapist and then have them see a psychiatrist within a certain amount of time. Or admit them. Refer them to one of the major hospitals that admit. We don't take on the responsibility of that client until they become our client.

REPRESENTATIVE MANDERINO: You were very thorough and very good in understanding how the credentialing process works and what it takes to get through it and you figured out how to work through that and others seem to be struggling with that, but two questions kind of came to my mind that seems to be, again, different your experience versus what prior testifiers said. You seem to acknowledge that credentialing should take two to four months, whereas others seem to think that that was too long.

MS. KATZ: Yeah.

REPRESENTATIVE MANDERINO: And so I'd like for you to explain that. And then the second part of credentialing is you seem to know how the whole process should work and seem to tell us that the information was readily available where others didn't. What am I missing here? I mean, do you know this because you sit on Magellan's peer review, or is it on the Internet or a phone call away? Explain to us why there seems to be these two different experiences.

MS. KATZ: I'll address my issues. I do understand credentialing because I started in 1991 working with a company called Psychiatric Care Associates, and I worked very intricately with US HealthCare at that point in time, and so I got a very thorough education at US HealthCare. They sent me to a US HealthCare school for the summer, and so I got a lot of information from the very basics in a very early period of time, so I understood the backbone of the intricacies. One of my jobs was a manager of managed care. So when I left that organization and went out on my own, I understood what it took to become a credentialed member. I also knew how I wanted to become part of a network and if I didn't. And I knew where I wanted to go with my own career. It is available on the Internet. Under the Magellan provider Web site, it does tell about credentialing standards. I also knew about NCQA since it began, so I kind of really

understood what the quality of care issues were.

I do understand the issues that these psychiatrists and professional social workers have brought up about credentialing. There have been so many different changes in the system over the last few years, we even tried a universal credentialing award, a company that actually was credentialing both United Behavioral Health and the Magellan plan, and it failed terribly, and I think that that's part of where their frustration came from why it took a year. And that's where a lot of things were lost. When something was sent to Aperture, even done on-line, I gave them two or three times, I did my own on-line through Aperture. It was redundant. It was hard. It was difficult. I'm glad that they moved away from it.

Now we get this prepopulated credentialing packets from Magellan and they have information already filled in on them. A majority of the credentialing information is really there, including internships, including other things, unless it was dropped from the system because Aperture didn't update them, or if you were updated only with Aperture and then it was transferred over to Magellan's computers. So I think that's where part of the issue was, and I think that as a process of change, as I said, there's a lot of mistakes in the system, but the truth is, there is trial and error.

REPRESENTATIVE MANDERINO: So you think that's, for

the most part, an old problem that has been addressed and we're hearing the old anecdotes, not current anecdotes?

MS. KATZ: Exactly. Because Aperture stopped credentialing Magellan clients in March of last year, 2004, so it's over a year now.

REPRESENTATIVE MANDERINO: Thank you for your indulgence, Mr. Chair. I do have one more question, and it's for Mr. Burnstein. And I apologize, at least I didn't have a copy of your full testimony, I did have your two-page letter on your letterhead which kind of mirrored it somewhat. But one of the things you said was, "Six months ago I was asked to be on the National Advisory Committee." What's the national advisory committee?

MR. BURNSTEIN: Magellan has put together a national advisory committee.

REPRESENTATIVE MANDERINO: Okay, so this is a Magellan national.

MR. BURNSTEIN: Excuse me, I thought I--

REPRESENTATIVE MANDERINO: Okay, fine. And then my last question is, you had made the comment about, and I wrote this down because it wasn't in your written remarks, something to the effect of the peer psychiatric, let me give some background, when Dr. Yee was talking about trying to get additional authorization when somebody was inpatient and her frustration of trying to connect with who she called

reviewers, and I said who are those reviewers, and she said they're peer psychiatric reviewers, so I'm assuming you were talking about the same thing, and you said peer psychiatric consultations or whatever are more available at Magellan than your experience is at other insurers.

MR. BURNSTEIN: Right. Right.

REPRESENTATIVE MANDERINO: Would you explain, A, a little bit more in depth about that, and, B, if you have any experience to address the criticism of what seemed to be an inclination to want changes in medication before the medication could take its due course, so to speak? Could you address that portion of the prior testimony?

MS. NASH: Yes. I'm Laura Nash, Director of Professional Services at Foundations Behavioral Health in Doylestown. We have found Magellan to be very available to our doctors. Treating children with the medications on the market is a very difficult and challenging dilemma because most of the medications that are on the market have been designed with trials for adults. So I think you all recognize that issue. So they have literally gone above and beyond to speak to our doctors about newer drugs, experiences they've had with similar children or populations, bringing research knowledge to us saying there's also something been published recently by Magellan or by the AMA or someone regarding this drug.

We also have found them, because they will appreciate that our doctors are treating children and the whole family system. It's not just the one adult. But the parents and sometimes siblings are involved as well, that they have been very respectful of the need for our doctors to be doing the treatment directly and catching up later if need be. So if a doctor needed to speak with a Aetna or IBC/ Magellan doctor and it didn't happen by 4:00 or 5:00 o'clock that day, they've always been very respectful saying, we'll schedule it tomorrow morning, we'll give you today, we'll work it out tomorrow. We have not been denied care.

REPRESENTATIVE MANDERINO: Okay, so that is within the context of treating children. Can you also or do you not treat--

MR. BURNSTEIN: We only treat children and adolescents.

REPRESENTATIVE MANDERINO: You only treat children and adolescents. So you have not experienced this problem either with disagreement about the medication dosage or significant disagreement about the length of stay needed.

MS. NASH: Regarding the dosage, I would answer, yes, we have had disagreements and they get worked out. The doctors are saying maybe you should up the med, and we're saying child. When we say child, you know, there's physical development issues, et cetera, et cetera, we're not

comfortable, they generally will challenge it but are respectful of that.

Regarding the length of stays, we have the same issue as Dr. Yee brought up regarding the involuntary commitments, the ones we refer to as 302s. They will authorize one or two days, even though the State has granted a five-day stay on any presentation and be very judicious about reviewing with us about trying to get that child out quickly, because medical necessity by Magellan does not equal commitment eligibility through the State, if you will. Those two things have never been in concert, if you will, for children or adults. So we do experience that issue.

REPRESENTATIVE MANDERINO: Thank you.

Thank you, Mr. Chairman.

CHAIRMAN KENNEY: Representative Ross.

REPRESENTATIVE ROSS: Thank you, and I once again recognize how bright my colleague Representative Manderino is, because she asked my best questions. But anyway, I would make it a general observation that this panel compared to some of the earlier panels is either a lot more patient or a lot more tolerant, or the earlier panel was a little bit too impatient or too intolerant, because it seems like there are quite different Magellans that we're hearing about from the respective panels. But I would like to probe a couple of these things a little bit further, if I could, because I'm

still trying to understand them.

Are you saying that the authorizations that are being letter required in your mind are appropriate and necessary elements in the process, or do you agree with the earlier panelist that recommended that we get rid of that process?

MR. BURNSTEIN: First of all, we're an inpatient and residential treatment facility. We don't have problems with the authorization, and I think even the other group mentioned that their understanding was psychiatric hospitals were not experiencing that problem, so--

REPRESENTATIVE ROSS: So you're not in a position to comment on that?

MR. BURNSTEIN: Yeah, we really don't have problems with getting authorization and we admit patients 24 hours a day, 7 days a week.

REPRESENTATIVE ROSS: Okay. Now, let me ask then a little bit more about the credentialing. You're indicating that you thought two to four months was reasonable for credentialing, and I was wondering why it takes that long.

MR. BURNSTEIN: Well, she said that. I didn't say that.

REPRESENTATIVE ROSS: Okay. Then you don't have to answer it.

MR. BURNSTEIN: But that's okay, my answer to that

was I think I heard some good suggestions earlier this morning about paying for payment as long as somebody got credentialed later on down the road to help those guys. The other recommendation I would make is that in all our new hires, we have to get child abuse clearances through the State of Pennsylvania, and if we can get that done in 30, I think there's probably no reason Magellan can't get credentialing done in 30 days. So I think they know they need to do it faster, quicker.

REPRESENTATIVE ROSS: Okay, you're the credentialing expert around here. Was there any reason why two to four months? What's so slow?

MS. KATZ: Actually, I know something else. If you were an M.D. applying for privileges at a hospital to work in the emergency room, it would take you two to four months anyway, even if you were in a sister hospital and all you wanted to do is have credentials there. It is that important to make sure the liability claims are explored independently by the people in that hospital, and in this case Magellan. They're taking on that responsibility and they can get sued if they don't understand what liability that practitioner is to them on their panel. They're endorsing this person. They need to know about these clients, and it's the liability of the organization to make sure that they are thoroughly satisfied they got the information.

REPRESENTATIVE ROSS: If there are no outstanding liability claims and none made against the provider?

MS. KATZ: We've gotten new providers credentialed within two months easily without any secondary questions coming up.

REPRESENTATIVE ROSS: In the day of computer, I would think maybe we can do it faster.

MS. KATZ: Absolutely. I totally agree.

REPRESENTATIVE ROSS: And just one last thing that worries me a little bit here. You seem to be fairly comfortable with the idea of shifting some of this authorization effort onto the client, and I'm trying to imagine the condition of some of the clients, and if it's somebody who is in pretty good shape and has just got a little depression and is basically functioning pretty well, fine, but I know in my own experience from some of the people that have been coming to my office that have been struggling with denials and appeals, that the brightest, the most capable folks with the best support systems get through the appeals and succeed in getting the treatment, and the people that are in the most fragile condition who don't have the support system, often don't have the education, just flat out drop out. And I worry a little bit about your model.

MS. KATZ: We actually have clients who come to us severely, severely debilitated and depressed, and we do help

them in that process by picking up the phone ourselves on the first visit and actually make that phone call with them present.

REPRESENTATIVE ROSS: Okay, because I just think we've got to bear that in mind a little bit as we're going forward here.

MS. KATZ: I have a college student with me who works for me and does that, and she checks the authorizations to make sure they're valid.

REPRESENTATIVE ROSS: Thank you, Mr. Chairman.

CHAIRMAN O'BRIEN: In my opening remarks, I tried to put a box around the Magellan conversation that we're having here today, because in my experience you have the private and public size, and then you almost have Magellans, different stories by different counties. That's been my experience. The parallels that I'm hearing here today on the private side have significant parallels to the problems that I'm hearing on the public side, and I have to tell you honestly, that on the public side Bucks County is much better than many of the other counties, and I'm wondering if that provides some insight as to why we're hearing different stories this morning. This morning we seemed to be in this dark hole, and now Magellan seems to be this blue sky with cumulous clouds.

And without being pejorative, Ms. Katz, you went to

the university of what was that school? I'm being pejorative. Maybe you can help start the University of Magellan instead of US HealthCare and we should bring the Department of Education in.

But Dr. Burnstein, I'm sorry, are you a Dr. Burnstein or president and CEO?

MR. BURNSTEIN: No, I'm president and CEO. I'm not a doctor.

CHAIRMAN O'BRIEN: You're not a doctor?

MR. BURNSTEIN: No.

CHAIRMAN O'BRIEN: Are you an accountant?

MR. BURNSTEIN: No. My Master's degree is in education.

CHAIRMAN O'BRIEN: Okay. The blue sky picture that you painted, have you read the report or the complaints contained in there?

MR. BURNSTEIN: Yes, I have. I don't really think, sir, that I painted a blue sky picture. Health care is a very difficult, tough business and tough area, and I think what I said is we work very hard to advocate for our patients' best interests and we do everything we can to make sure that there's benefits so we can provide care and treatment. We work with Magellan just like we work with every other insurance company to be able to provide those services in Bucks County, and we have found ourselves to be

able to make that happen for our patients. Maybe because some of them are children and adolescents and families get involved, maybe things run a little bit better. I'm not sure. I wouldn't say that I painted a blue sky. It's a tough field and a very trying field.

CHAIRMAN O'BRIEN: The national advisory committee that you referred to, I assume that's Magellan's national advisory committee?

MR. BURNSTEIN: Correct.

CHAIRMAN O'BRIEN: Are you appointed to that, or is there, are you contracted with that?

MR. BURNSTEIN: I was appointed to that. I was contacted--

CHAIRMAN O'BRIEN: Is that specifically and limited to an advisory capacity?

MR. BURNSTEIN: Absolutely. The committee is attempting to tackle the tough issues in the health care business and to make sure that they are hearing all sides of the equation. It is peopled by psychiatrists and mental health leaders from around the country, and everybody is talking about the tough issues and trying to talk about potential solutions to those issues. Many of the issues are the kinds of things that are being talked about here today.

CHAIRMAN O'BRIEN: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Ms. Katz, in your testimony you indicated on page 2 that you believe the system Magellan is working towards is going to streamline administrative costs but requires purchasing more clinician accessible computers. And then a little bit later, back on page 5 in the middle paragraph, you're saying you're starting to believe Magellan is working toward a more progressive health care system providing more efficient provider resources and working toward an electronic billing system. Are we dealing here with a situation where Magellan was simply not equipped at the time to take on the burden of administering all these health firms to actually handle them? It sounds like you're suggesting they just weren't up to speed, but they took it over anyway and now they're trying to work through the problems and maybe they need to upgrade their computer system, maybe they need to add more computer systems. Maybe they need to streamline their authorization and billing.

I mean, the sense I get is that they should have been up and running and able to do that and maybe we wouldn't have had the complaints, because they have been going on for several years now. I mean, is that an unreasonable length of time for them to wait for them to get up to speed?

MS. KATZ: The computerized systems, the computerized authorizations and the computerized electronic billing isn't that old. It has only been about six, eight

months since I started using it. And I don't submit it electronically, I submit paper claims even now to make sure that they're clean claims and also because we had certain needs and we did it that way. It is an evolving system. They have errors, and I just decided not to get frustrated by the errors, so I just did a paper system instead of a computerised system for a while.

REPRESENTATIVE HENNESSEY: Is it evolving for Magellan? Is it Magellan's system which is evolving, or is it the entire health care? It would seem to me if you look at health care generally, it moved from the traditional insurance, the HMO, we can say generally that health care in this country is evolving, but I'm specifically looking at what your testimony suggests, which is that Magellan is up and doing stuff and its computer system hasn't caught up. We have a lot of people out there complaining. Your group isn't complaining, we heard from a lot of people today who were.

MS. KATZ: There are other companies who have the same problems Magellan has. United Behavioral Health is another company we deal with. They have the same problems with authorizations on-line, maybe not, maybe it's just the volume. It's the volume that Magellan handles that we probably see more of those errors. We have to get authorizations from everybody except for Cigna. That was the only company, but they do peer review later on. Everyone has

the same basic system. It's where you get tripped up and what volume are you doing and how are you approaching the problems when you get them? When we get the problems, like the psychologists, they sat here with their envelopes, we have the same problem, yes, but we handle it differently because of our volume and because we can handle it differently. We're patient in the process. We actually know that, okay, let's continue the phone call, let's do this, let's do that, let's fax something. Let's make it Excel spreadsheet and e-mail somebody.

The main problem is you have to figure it out. You have to figure out where the problem is, and a lot of it is our problem. A lot of it is my computer system wasn't putting numbers on things and you just had to figure out where the problem is. The other thing--

REPRESENTATIVE HENNESSEY: And have you had the problem with the down time with Magellan computers that other people testified about?

MS. KATZ: Yes and no. Sometimes it's very efficient and sometimes it isn't, but when it is inefficient, we just do the paper claims. We don't make it such a big deal.

REPRESENTATIVE HENNESSEY: When it's not efficient, you mean when the computer is down?

MS. KATZ: Well, if it's taking too long, we just

fill out the piece of paper and send it in. It takes less time, and that's the paper system. There's a backlog system. It's not denial of care, it's a backlog system, because we have a computerized system and we have a paper system, and we're able to handle the paper system very accurately. We keep our originals. We know when we send something in and we follow it through. It's just the way our system works that's different.

REPRESENTATIVE HENNESSEY: Thank you. Thank you, Mr. Chairman.

CHAIRMAN KENNEY: Sharon, just help me going back as a consumer, I go to my primary care physician, we discuss things and I have some depression, and following up on Representative Manderino, they said go to Collaborative Care of Abington, they do a great job. I walk in as a consumer and I give you, I walk in with my Blue Cross, do you then say to me, before I take you, you go back and call Blue Cross? You wouldn't dare say Magellan, because I wouldn't know, if you said to me as a consumer, if I wasn't on this House committee or in the legislature, nobody that has Blue Cross, if they don't have behavioral health care, doesn't even know what Magellan is and couldn't care less. But so I walk in with my Blue Cross and you say, I mean, just the way you, you're saying to me, go call Blue Cross to see if I could have sessions with a therapist?

Help me. I'm just trying to picture all this, in case it ever happens.

MS. KATZ: Okay, there's no guarantee that your Blue Cross card is connected to Magellan.

CHAIRMAN KENNEY: That's right.

MS. KATZ: I say to you, will you please look at the back of your card and tell me what, under mental health care and substance abuse coverage, who do you have listed? Okay, pull out your cards. Everybody doesn't know even who they have. They might have some other company besides Magellan, in which case I would have to make sure that whoever sees you is credentialed by that company, because not everybody is credentialed by the other companies either. So not everybody, even if you have a Personal Choice card, a lot of it is unionized, it goes through a different kind of -- it doesn't even tap Magellan at all, it taps a managed health care company, which is different.

CHAIRMAN KENNEY: When I walk in with this card, it doesn't say anything in the back. You now say to me--

MS. KATZ: Fine, I'll bill your company then.

CHAIRMAN KENNEY: Oh, you'll take me then?

MS. KATZ: Sure. I take 98 percent of people who call I can take.

CHAIRMAN KENNEY: Now, when does all these problems occur, all the envelopes and all, is when I want -- you say I

need 30, getting authorization from whoever my managed care firm is to okay these sessions?

MS. KATZ: The problem comes in when you're at session 7 and session 8 and session 9, when you've gotten those first eight sessions already authorized and you've already been using them, you're real connected.

CHAIRMAN KENNEY: Wait, wait, wait, stop. You would take them right away and give me my first appointment?

MS. KATZ: Yeah. No problem.

CHAIRMAN KENNEY: Believing they're going to take care of me.

MS. KATZ: Yes, and we have somebody in the office that is authorized to actually take a copy of that card and actually, this is what your primary care doctor does too, call and make sure you actually have benefits, because some people walk around with cards that aren't even valid. But the problem exists is when you get to eight sessions and the therapist forgets to fill out the piece of paper or go to the computer and actually put the information in. That's where the problem exists. We actually have computers in our office, my office manager, when somebody comes in, we know how many authorizations we already have and we know if that session is authorized or not, and there's a bell that goes off, it's like a ding-dong bell about people who have expiring authorizations, and we hand a piece of paper to the

therapist to fill it out or to process at that point in time right away, and we didn't lose the sessions. It's when you have a system that doesn't work in your own office. That's why I said you have to take responsibility to fill out this information on authorizations.

Because indeed, some patients don't need, you know, they get 20 sessions per year authorized, paid for by their insurance plan. Most insurance plans only pay for 20 sessions unless it's parity. So if somebody uses those 20 sessions and they go over and it's not a parity diagnosis of major mental illness, then that patient is going to be responsible for full fee pay of that claim. And then it has to be paid by the patient. The patient actually has to pay whatever that therapist says is the agreed amount to access services. So actually the health care company needs to know how many sessions have been used in that calendar year. And that's how they track the authorizations. That's why authorizations are in existence. And it's to my understanding, and I've asked a few times around, authorizations are not unique to Pennsylvania. Authorizations are national. It's not like if you say no, let's drop the authorization system, I celebrate because, yeah, it's less paperwork, less administrative time and less environmentally taxing, but it's not necessarily going to happen. You know. It's a national policy.

CHAIRMAN KENNEY: Now, in the PPA report on commercial health care, it's your belief that a year from now if they did another report, it will be a totally different picture because you think they're playing catch-up?

MS. KATZ: Yes. A lot of them are in decapitated systems, the 100 people systems, and a lot of people will leave those systems to set up their own private offices, because it is streaming in that direction. I've had people leave my office to set up private offices too. There are some people who need to be more creative about their programming, which is outside of the box too but to create programs for the people, okay? So just part of what you're doing.

Pennsylvania, let me just give you a little moment here in conclusion. Philadelphia was the founding fortress of mental health. The first mental institution was in Philadelphia. A majority of the major theories of psychology came from Philadelphia - cognitive behavioral therapy, even authentic capitis, which is Abelman's theory that has been published widely in psychology from the University of Pennsylvania. A majority of the family therapies came from Philadelphia, came from EPI and Friend's Hospital and a few other hospitals. They were the fortress of it. Where did we go wrong? And I believe it was when they capitated these large systems, and then it got out of hand, and now we have

to downsize again, and this is the shift. This is the evolutionary shift.

CHAIRMAN O'BRIEN: I guess I'm just hearing that you're very good at navigating the waters that nobody else can get through. But I'm still hearing that fax and e-mail, Excel sheets, all contribute to frivolous costs to fix a Magellan process, and the net result is still that there's less care at the end of the day.

Representative Evans.

REPRESENTATIVE EVANS: Thank you, Mr. Chairman.

Just very, very briefly. I may have missed this in the testimony, Ms. Katz, you mentioned at the end that you are a psychotherapist?

MS. KATZ: Yes.

REPRESENTATIVE EVANS: And your credentials here list you as a registered nurse. Are you both?

MS. KATZ: Oh, yeah.

REPRESENTATIVE EVANS: You are a licensed psychologist?

MS. KATZ: No. I'm an advanced practice nurse. I have a Master's degree in psychiatric nursing. I went on to get a marriage and family therapy certification in addition, and I'm certified by the AMFT. I'm an administrator. They mentioned, the psychiatrists mentioned a clinical nurse specialist. I'm a clinical nurse specialist. I could be a

nurse practitioner, but I haven't taken three extra classes, so I don't prescribe medication. But I am nationally credentialed to provide psychotherapy, and one of the disciplines is mind psychotherapy.

REPRESENTATIVE EVANS: Thank you.

Ms. Katz and Mr. Burnstein, are either one of you receiving compensation for your testimony today?

MS. KATZ: No, absolutely not.

MR. BURNSTEIN: No.

REPRESENTATIVE EVANS: It just strikes me as a bit odd because we've heard four hours of testimony this morning and people are having problems with this system, and then this most recent testimony it sounds as though, what are you doing differently or are you that much smarter than the rest of the people to figure this out? We've been here for four hours and the committee is here, so obviously there's a groundswell of people who feel there's a big problem. We don't come here just because we want to.

MR. BURNSTEIN: Well, once again, my response to that is, as the manager of a facility, institution facility, we are not having the same kinds of problems expressed to you by the outpatient psychologists, and I think they have acknowledged that they've heard that those don't seem to be an issue. So maybe a part of the answer is that Magellan's got their act together working with facilities and they need

to get their act together in working with outpatient providers.

And the other thing though, just to mention, because somebody hit on it, just to also put this in a framework and put it in a box, the State of New Hampshire's Blue Cross/Blue Shield plan provides $10,000 a year for mental health benefits. That's the max. So the need to manage care, the need to coordinate is so important between professionals. When you've only got a small pot of money to work with, you want to maximize that. And the States are closing their psychiatric facilities and there is no safety net for lots of these families and patients. The need to maximize and coordinate is really paramount so we can bring to bear the best possible treatment we can for patients within their financial limits.

MS. KATZ: I sat at the same provider meetings that these other providers sat at and I heard the information that they heard. How they took it home to their practices and how I took it home to my practice is two different animals. And I went up to the vice president of Magellan at that point in time and I said, they're not listening. And they said, yeah, I know. They're looking for obstacles, they're not looking for solutions. They're looking at the day-to-day grind of what's happening in the collecting of data to prove the system wrong and instead of working with the system and

complaining and getting that to be worked out, they went to an antagonistic perspective from the very beginning of it. And I sat back and I said, well, at least I can have my own thoughts and have my own feelings, but I'm not a part of the Psychological Association of Pennsylvania. I have read all their material because it comes to my office for the other psychologists and we actively discuss it. It doesn't mean that it serves all perspectives of all providers that are out there. Yes, the providers have problems with authorizations and on paper and this and that, filling things out, but it's not unique. And it is in proportion to the business you do. Also, if you were a large practice of psychologists that are having problems obtaining psychiatry, you absolutely haven't changed me. There's a lot of things going on right now. And, yes, psychiatry is needed more coverage for that.

CHAIRMAN KENNEY: Thank you very much.

CHAIRMAN O'BRIEN: Suzanne Kunis, Dr. Nardozi, Christina Fantilli and Joann M. Albright. Are they all together?

MS. KUNIS: Good afternoon. Thank you, Chairman O'Brien, Chairman Kenney, for inviting us here today. My name is Suzanne Kunis, and I am Magellan's Senior Vice President for all of our health plan customer relationships in the eastern part of the United States. I have been in the health care industry for the last 28 years as a registered

nurse, a senior staff member for a major health insurer, and for the last 14 years as a member of the Magellan team. I am the person responsible for maintaining our very important relationships on a day-to-day basis with our key customers in Pennsylvania, which include Independence Blue Cross, Aetna Health, Inc., Capital Blue Cross, and Highmark. I'm also responsible for the oversight of our relationships with the provider community in this market.

I think you all know that Magellan contracts with these licensed commercial insurers, which are all health maintenance organizations as well, to manage behavioral health benefits for their members. Magellan is a Certified Review Entity authorized by the Department of Health since August of 2000, and as such manages behavioral health benefits for over 6 million individuals in Pennsylvania who are members of these plans. Coincidently, I just want to raise the fact that we refer in this document to customers and clients. They are one in the same. You have heard from providers, they also refer to members as clients. So, for clarity purposes, a customer and a client are one in the same.

We are here today to address concerns raised by some providers related to how we authorize services, credential providers, pay their bills, and communicate with them. I want to emphasize that Magellan has always sought

the input of our provider network in many different ways, including an annual survey sent to every provider who has seen a member covered under a Magellan program. The last survey, conducted in October of 2004, with over 1,400 Pennsylvania providers responding and covering all of 2004 to that date, resulted in overall provider satisfaction levels in excess of 89 percent. We are very proud of those results.

However, the survey conducted by the Pennsylvania Psychological Association in January related specifically to provider experience with Magellan from September of 2004 to January 2005 and showed very different results. Although only 73 of the providers who responded are in our network, we take the results very seriously and we're here today to respond to the providers's concerns and to tell you and them what we're doing about them.

So what happened in September of 2004 that would have driven such a change in some of the providers' view of Magellan? One key change occurred in September of 2004 when we implemented a very significant change in the structure of the network for one of our largest clients. The business decision made by our health plan customer to significantly open access to a broader network of already credentialed providers was driven by member complaints regarding access to care and freedom of choice of providers. Our customers need to respond to these very important member access issues. For

these customers' HMO program prior to September 1, 2004, the provider network in Pennsylvania consisted of 14 provider groups who served over 600,000 HMO members in their capitated financial arrangements. It was basically a closed network. Members could not choose their own providers, they were assigned to a provider group.

Under that arrangement, these group practices did not have to seek authorization for treatment, nor did they have to submit claims for payment. Their fees were pre-paid each month for the members assigned to their groups. Effective September 1, 2004, the reimbursement structure changed to fee for service. Providers now had to submit claims and seek authorizations. Effective November 1, 2004, that network was open to over 2,000 already credentialed providers, about four and a half times the size of the previous network. In January of 2005, the PPO network similarly expanded to almost double its size prior to January. Members had been demanding choice, and our health plan representatives to meet the needs of its members and offer a competitive product in the market.

While we believe that we've worked hard, we worked with and educated providers as to recent changes throughout the spring and summer of 2004 in terms of a much expanded provider network and the change from capitated arrangements to fee-for-service arrangements requiring advance

authorizations, it obviously was not enough. These changes were made to improve service and access for our members to a full array of providers and their services. The Internet functionality for initial authorizations among other activities was rolled out last summer in a deliberate effort to make this transition less cumbersome to providers. Clearly, it didn't meet its goal.

In hindsight, the processes that we had in place for authorizations that had served us and our providers well in the past had not worked well for providers with such large patient populations. We recognize the need to explore how we can fulfill our obligations to our members and to our health plan clients while also fully engaging with the provider community to ensure that we enhance and support their practices. We are absolutely committed to doing that.

In the PPA survey and in subsequent meetings and communications with your committees and the concerned providers, it became clear to us that the following issues are those which require our immediate attention in the view of the providers.

One, the credentialing and recredentialing process. A rigorous provider credentialing and recredentialing process is a requirement of Pennsylvania law and a standard for all managed care networks. It is also a Centers for Medicare and Medicaid Services, CMMS, requirement for payers doing

Medicare business, which Magellan does. We have included Magellan's credentialing criteria in the packet of materials.

Credentialing is also a contractual requirement between Magellan and its customers. It is a requirement of the National Committee on Quality Assurance, NCQA, an accrediting body whose stamp of approval is considered the gold standard of quality for health plans with behavioral managed care organizations alike. NCQA requires that credentialing be completed in 180 days. We have accomplished that goal. In fact, Magellan has been accredited by NCQA based on credentialing and other key performance indicators, and as recent as January 2005, our Georgia operation, which serves over 2 million of our Pennsylvania members, achieved a score of 100 percent by NCQA. That score means that there were no recommendations for improvement. That survey was attended by Department of Health reviewers in the Bureau of Managed Care who participated in the process. We are extremely proud of that achievement.

That said, and in light of the PPA survey results and feedback from key stakeholders, while we want our credentialing process and rosters to be accurate and up to date, we also want it to be easy for providers to navigate, we are therefore taking these actions. An external audit of Magellan's credentialing and recredentialing process by an independent audit firm will be conducted and the firm will be

engaged by one of our largest clients. We will make necessary adjustments to the process based on the audit findings. We will determine what improvements can be made to support Web based functionality. In concert with our customer organizations, we will work to provide on-line access to our provider network for those health plan members who do not have access to provider directories at this time. We will seek input from and partner with network providers to determine other opportunities to streamline the process.

With regard to provider communications, based on the expressed concerns in the PPA survey, Magellan has begun the following:

We have made an organizational commitment to timely and understandable notices to providers in accordance with contractual requirements which will be actively monitored by Magellan's Corporate Compliance Department. We will conduct increased provider forums for training and education as well as to gain feedback on how we're doing. We will publish an ongoing training calendar for 2005 within the next 45 days. Internal training will be conducted to improve knowledge of Pennsylvania network capabilities for our Georgia team over the next 45 days. We will evaluate any data gathered to refine specialty information that will be used for referral purposes. We will actively involve our Georgia leadership team in provider forums to develop regular communication and

open relationships, and we will seek the active involvement of providers to be part of the solution through greater communication and participation.

We fully recognize the importance of resolving these issues and the need to work collaboratively with the providers, the regulatory agencies, and our customers to resolve them in the interest of ensuring high quality services for our members. We are prepared to make the commitment to you today to work side by side addressing the concerns on the issues that have been raised to us.

On a broader scale, I would like to highlight other important initiatives that are currently underway. Magellan technology and provider relations staff visited five key provider groups at their facilities on May 9 and May 10, 2005, to evaluate Internet capabilities related to authorizations from the perspective of the provider and to develop an action plan as a result of the outcome of those visits. We've established an internal cross-functional SWAT team that is investigating each complaint raised in order to identify process improvements and implement them as quickly as possible. We are working with our clients to develop specific action plans in response to Department of Health requests regarding corrective action plans. We will convene by July 1, 2005, a Provider-Magellan's Strategic Council to work through provider concerns, discuss proposed changes to

get provider perspectives, and to jointly identify ways in which we can better work together as partners, focussed on serving the behavioral needs of our members.

We have designated Magellan's Chief Compliance Officer, John DiBernardi, to be the single point of contact for Pennsylvania regulators and legislators to address issues raised with them and to keep key parties informed of the progress made in our efforts to move forward in a positive way. We have worked together with these providers for many years. We value productive, collegial relationships. Our goals are the same, to do the right thing for the members in need of our services. We want to be accountable to providers and to you who have the commitment of our organization to do just that.

I'm happy to take questions from you at the conclusion of the presentation by my colleague, Danna Mezin, and after that I will introduce our other team members.

MS. MEZIN: Thank you, and good afternoon. I join Suzanne and thank you for the opportunity to be here today. My name is Danna Mezin, and I am the Senior Vice President of Operations at Magellan. I am the person at Magellan with overall responsibility for our care management centers and claims processing operations. I have over 25 years' experience in leading call centers and service operations. I joined Magellan nearly three years ago. Upon joining the

organization, my charge was to enhance service delivery and improve our operational efficiency.

Looking at our performance record, I am pleased to report to you that Magellan has improved its service at nearly every delivery point for our members, providers, and customers. In fact, our level of service can rival many service organizations. We have demonstrated improvement in the speed in which we answer our phone calls and pay our claims as well as the accuracy of our claims payment, and now for nearly two years we have consistently achieved our performance goals. Our excellent results in NCQA and URAC accreditation satisfaction surveys, State and client audits, and performance metrics are just a few of the indicators that demonstrate our overall service performance.

Over the past three years Magellan has invested heavily in new technology to enhance our members' and providers' experience with us. We have implemented new self-service tools such as a new Web site and an interactive voice response system. We have upgraded our telephone system to enable us to route callers more effectively to the most qualified associates to meet the caller's service needs. We have better implemented new scheduling and forecasting tools to allow us to better predict call volume and schedule staff more effectively to meet the fluctuating call volumes we experience. We have implemented new reporting tools that

have enhanced our ability to hold ourselves accountable and identified areas for improvement. This is just a small sampling of the changes we have made in a relatively short period of time. We are proud of our track record, but we have not become complacent.

As an organization, we are committed to continuous improvement and welcome input from this panel and our providers. While we believe the PPA survey findings are not necessarily representative of the feedback of the overall network we serve and that the results are a direct response to changes made in order to open greater access to the network for our members, we are here today to listen to the concerns of the provider community and work with them to better facilitate our new working relationship given the changes that have been made.

We have analyzed the survey results, read recent letters by Pennsylvania providers, and made special visits to provider offices, as Suzanne mentioned, all in an effort to better understand the impact of the changes, be able to respond to provider concerns, and where appropriate develop approaches to help mitigate problems.

I would like to respond to the operational concerns that have been put forth. First, call center performance. It has been difficult to address this general concern as the issues expressed have been anecdotal in nature. Looking at

our call center statistics since January 2005, Magellan has achieved or exceeded our goal of answering all calls live in 30 seconds or less on average in each Magellan care management center that supports providers and members in Pennsylvania. Like all call centers, we do have peak periods which can be challenging to predict. We do, however, continuously work to ensure our service levels are achieved consistently regardless of the time of day.

While it had been a practice at Magellan several years ago to limit transactions per call, this practice was discontinued some time ago. Neither our members nor providers, nor Magellan for that matter, were effectively served by this practice. In response to providers recently raising this issue, in the last three weeks we observed over 750 calls to identify any of our associates who are not compliant with our service guidelines of meeting all the needs of a caller in one call. We did not observe a single associate advising a caller that they could not assist with all of the caller's inquiries. As reinforcement to our policy, we did, however, issue a reminder of our first call resolution requirement to our associates.

In response to the concern about consistency of information given by different associates, we acknowledge that this is an area where we have an opportunity for improvement. While all of our associates participate in a

six- to nine-week new hire training program, the nature of our business is very complicated and the learning curve is steep. To this end we have recently more than doubled our service center training staff, are deploying new on-line learning tools, and are creating a new curriculum, which is progress in action. Together these initiatives should allow our new hires to be more effective in servicing our customers.

Next, our authorization process. We have undertaken the following initiatives. In January 2004, Magellan launched a new Web site. The site was designed to both provide enhanced behavioral health content that was available to our members and providers, and to introduce self-service functionality to facilitate interactions with Magellan. Since the site's launch in 2004, we have enhanced the site with periodic updates to make the site more user-friendly and to increase functionality. We are very proud of the progress we've made to date and the increased use of our site by both members and providers. We continue to work on improving our site and appreciate the feedback we regularly receive from members and providers through our provider advisory groups, member advisory groups, e-mails, communications with our provider relations team, and our service centers. We take this feedback very seriously and have made many enhancements to our site in response to these

recommendations.

In response to the more recent and passionate feedback we have received from the southeastern Pennsylvania providers, we are pleased to inform you that we will be accelerating many of the enhancements that were planned for future updates. Over the past several weeks, we have catalogued all the concerns that have been expressed in written correspondence by the southeastern Pennsylvania providers. As Suzanne stated, we have sent Magellan representatives from our technology department to sit side by side with providers to better understand how they are using the site and to understand where they're experiencing challenges in using it. We have used what we learned in these visits to prioritize enhancements that will address and resolve nearly every expressed concern.

The enhancements we will be implementing will address concerns related to excessive data entry, ineffective error responses, access to the system, and timeliness of responses. The objective of our Web site was to provide additional options for working with Magellan which we thought our providers would find of great value. We regret that our site was not embraced in that spirit, and we are committed to getting to that point with the users of the site.

I'm excited about our future plans as they will take the convenience of self-service to the next level for

our providers. Magellan is committed to providing multiple communication options to our members and providers as we are to removing obstacles to provide care to our members. I'd be happy to speak to the details of the upcoming enhancements during the question and answer period.

On the eligibility front, we are working with our clients to access the frequency of eligibility updates and to determine if there are any gaps in our system interfaces which may be impacting our data integrity. We look forward to sharing the results of these efforts with you as this work progresses.

We do acknowledge that there are many procedural variations for providers who work with Magellan because many of our procedures are customized by our clients. This can be very challenging for providers who are servicing members covered by a variety of health plans. Where variations may exist in service delivery within an account, we apologize for that. As previously mentioned, we are currently working to determine where current training is needed for our team members, and where our systems can be enhanced to better support our team members in servicing our customers.

Thank you very much for the opportunity to speak today. The entire Magellan team is committed to providing access to high quality care for our members, achieving high standards for our own performance, and working

collaboratively with providers. We're pleased to answer your questions and to work with you.

Suzanne will now introduce our colleagues, who will help us in responding to your questions. Thank you.

MS. KUNIS: I just want to take a moment to introduce the folks that we have with us today that are members of our team. Sitting next to me is Dr. Lawrence Nardozi. Dr. Nardozi is a board certified geriatric psychiatrist. He completed his residency at Thomas Jefferson University Hospital here in Philadelphia and maintains a clinical faculty appointment at Jefferson Medical College. He is Past President of the Philadelphia Psychiatric Society, and is currently the Eastern Regional Medical Director for Magellan's Health Plan Business.

Sitting next to Dr. Nardozi is Dr. Joann Albright. Dr. Albright is a Ph.D. psychologist licensed in the Commonwealth of Pennsylvania and has over 25 years of behavioral health clinical experience. She is a Senior Vice President of Magellan and leads our Creditation, Quality, and Outcomes Department.

To my left is Christina Fantilli, who is Vice President of Network Field Services for Magellan's eastern region. Christina has over 10 years of network development contracting and provider relations experience, and we asked everybody to be here today to try to be able to provide the

best answers that we can to any questions you might have. Thank you.

CHAIRMAN O'BRIEN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thanks. Thank you all for being here.

I have one technical or explanation needed, Ms. Mezzin. I hope I said that right. I don't know what this means, in your testimony you said, "On the eligibility front, we are working with our clients to assess the frequency of eligibility updates and determine if there are any gaps in our system interfaces that will be impacting our data integrity." Put that in layman's terms for me.

MS. MEZIN: Sure. What it means is that in order to determine whether a member is covered by Magellan, we receive that information from our clients.

REPRESENTATIVE MANDERINO: Your clients meaning the providers or the patient?

MS. MEZIN: IBC or Aetna health plans.

REPRESENTATIVE MANDERINO: The health plans.

MS. MEZIN: So they send us notification of this is who is eligible to receive behavorial health benefits.

REPRESENTATIVE MANDERINO: Yes, Kathy Manderino has a policy with IBC that provides her behavioral health services through you?

MS. MEZIN: Exactly, and they transmit that data,

depending on the client, either it comes electronically or it comes on tape, and we load that data into our computer.

REPRESENTATIVE MANDERINO: And that's the first piece of information that is needed before you even get to the whole authorization issue?

MS. MEZIN: Yes, we verify eligibility to be able to issue an authorization.

REPRESENTATIVE MANDERINO: Okay, and then authorization goes to whether or not the person needs the treatment or is eligible for the treatment. One, you're a covered member, and the second one is you're eligible just for treatment?

MS. MEZIN: Well, if you're a covered member, then you're eligible for the benefits that are defined by your health plan. Does that make sense?

REPRESENTATIVE MANDERINO: I think.

MS. MEZIN: Okay.

REPRESENTATIVE MANDERINO: Here are a couple of things that, and I will just ask the question and you can decide who is the most appropriate person on the panel to answer it. We heard a lot about delays that some of the providers thought were inordinately long, some in the credentialing process and others in the authorization for service process. On the credentialing part, some folks thought it should take 30 days, your statistics seem to

indicate that most of them, the vast majority of them happen within 30 days, and others think that it takes two to four months. Tell us from your perspective what is going on with credentialing, what the result is and if there's any need for improvement in that regard.

DR. ALBRIGHT: I hope I can look at you at the same time and lean over. Thank you for the question. Let me just explain a little bit about our credentialing process and give you some statistics. During the last six months for providers in Pennsylvania, 73 percent of them are credentialed within 90 days, 96 to 99 percent, if you're talking about credentialing and recredentialing, are credentialed within 180 days. So 73 percent within the 90 days. So we were pleased when people said it was taking two to four months, because we certainly want to stay within the 180 days that is the NCQA standard, that is the national standard, but we have been meeting a far more stringent standard and meeting it with 73 percent are met within less than 90 days.

Now, interestingly, in this survey that we do on an annual basis, we ask the question about timeliness, satisfaction with the timeliness of credentialing, and on that question, 76 percent of the people who were surveyed in Pennsylvania last year said they were satisfied with the timeliness of our credentialing. Now, that leaves an

opportunity of 25 percent who said they were not satisfied with it, and that's certainly an opportunity for improvement. But this is why we're very willing to collaborate because that 25 percent seems to be a very vocal group and we want to decrease that. But we have not said that we are hitting that 30 days. Sometimes we hit it at 30, but again, 73 percent of the time we are at 90 days or below.

Now, the question was asked, and I can go on, why can't it be done in 30 days? And I'd be glad to spend time on that if you'd like, but I don't want to go there if that's not your question.

REPRESENTATIVE MANDERINO: Well, you may go there with some of my follow-ups. I think as this hearing goes on we're grasping a lot of concepts, but I suspect we miss the nuances, because this is not our business. We used to have closed networks. Six months ago, or I guess it's been a little more, nine months ago, we opened up the networks. Now all of a sudden you're flooded with lots of new people who want to be credentialized by you in order to provide service?

DR. ALBRIGHT: When we opened the panel, we did expand the number, but they were already credentialed in our network.

REPRESENTATIVE MANDERINO: You didn't expand the number?

DR. ALBRIGHT: The number that were expanded were

already in our network, so they were credentialed people.

REPRESENTATIVE MANDERINO: Okay, so there wasn't--

DR. ALBRIGHT: The floodgate.

REPRESENTATIVE MANDERINO: There wasn't this floodgate of new applicants that could be seen to be slowing down a normally faster process?

DR. ALBRIGHT: That's correct.

REPRESENTATIVE MANDERINO: Okay, credentialing means for the first time I am applying to be, one, a provider within your network; recredentialing means I'm already a provider in your network and I want to renew my, continue and renew my relationship with you.

DR. ALBRIGHT: Exactly.

REPRESENTATIVE MANDERINO: Is there a difference in the timeframe it takes to credential somebody versus what it takes to recredential somebody?

DR. ALBRIGHT: In terms of our statistics, they are about the same, maybe a percentage different, but they're very close to the same. The statistics I gave you were very close. Now, would you like me to explain the process?

REPRESENTATIVE MANDERINO: Yeah, please.

DR. ALBRIGHT: Whether you're new or a recredentialed, we will send a packet to you at 195 days before the expiration of your recredentialing, or if you're new, as soon as we get the application we will send it. So

once we send that out to someone, we then begin to have a clock ticking, our own internal clock to say how many days is it. At 90 days if we do not get a response, if it's self-initiate or if it's recredentialing, we then send out a letter to say we haven't heard from you and we need to move on this. We then at that time we make three outreach calls, because we want to be provider friendly. So we call the people and say, we don't have your packet, we don't have your materials yet. So we make three phone calls between 90 days and 60 days. At 60 days we then send a letter saying we are going to suspend your credentialing if you are already credentialed to say we're concerned about continuity of care for your members, please, please, please send in your materials.

Now, I do know that whether it's a credentialed packet or a recredentialed packet, about 50 percent of our packages that come in from providers are missing materials. We acknowledge that must be a training issue then. We developed a checklist, but even so, we have to follow through and get additional information. Let me just give you a small example of the kinds of things then that we need to follow up on. Not the 15 or 20 things we must do for primary source verification, but for example, a provider will send us the date of their license, which we must have, and you would all want to know that your provider is licensed. But they will

say, Dr. Albright, I got my license, it's going to expire in 2006. But we're required to have the date so that it's the month and the year as well. So we will send back and say, you still didn't give -- we didn't get the month, even though we asked for the month and the year. Those kinds of things will hold up.

I do know that in addition to the 50 percent that we need to send back and just get additional information, that 25 percent of our people do not wait, they do not respond until 90 days, and so we need to be sending this out as a reminder.

Now, in terms of that process, I can certainly explain, we do subscribe to NCQA, we take much pride in the fact that we want to meet the highest standard possible in the industry, and the NCQA scrutinizes our files just as you had a chance to participate in that most recent survey. In that process, they do a random sort of files. They could have chosen any file. We don't have any say, they choose the files, they come and they look at those. So they will look at those elements.

Now, in our preparation, we have to verify many, many factors, and that's called primary source verification. That's a very lengthy process, depending on if the material is on-line or not. We must not only verify you went to the university, we must verify the course at the university. We

must not only verify you have a license, but if you have board certification. If you're a prescriber, we need to know that you've got DEA or controlled substances certification. Then we need to look at do you have the right malpractice insurance, and on and on and on. But that's the kind of checking we do.

REPRESENTATIVE MANDERINO: Okay, so two criticisms that were raised earlier about the credentialing process, please explain either why this has to happen or why it doesn't happen, somebody moves from one provider organization to another provider organization and they were already credentialed by you but now they're kind of sitting there without a job for a couple of months until they're credentialed again with this new provider.

DR. ALBRIGHT: Once you're credentialed, you stay credentialed unless you have allowed your credentialing to lapse. So if Dr. Albright belongs to group A and I decide not to belong to anybody for a while, I am still licensed and still credentialed. The problem becomes that I may, as Dr. Albright, have failed to have notified Magellan that I have moved to group B. Now, we say why can't the group just notify Magellan? Because we need verification from the licensed provider themselves that they have moved to the group. It protects the provider as well.

REPRESENTATIVE MANDERINO: So a licensed provider

who is currently credentialed which hasn't expired who leaves employer A and goes to employer B should not have any waiting period on their recredentialing and their ability to hit the ground running on day one with their new employer and have their billings be covered?

DR. ALBRIGHT: If they've notified us.

MS. KUNIS: Let me just add one thing to that, because this is the challenge. When a provider changes groups or, this is a very transient population of providers, quite honestly, they can work for one group, five groups, seven groups. When a provider is looking to be, say, okay, I'm actually going to work part-time for this provider group, I'm also going to work part-time for these folks, what we need to do then is to basically link up in the system the fact that that provider is associated with two groups now.

REPRESENTATIVE MANDERINO: If you link that up after the fact--

MS. KUNIS: Yes.

REPRESENTATIVE MANDERINO: But there was never a break in their credentialing as far as you're concerned, so there appears to me to be no liability issues outstanding for you.

MS. KUNIS: That's right.

REPRESENTATIVE MANDERINO: Does that claim get paid?

MS. KUNIS: The answer is yes, with a qualifier. The qualifier is this, and I'm hoping that if you were to ask the providers that were here earlier today that they would be able to respond in the same way. When this happens, first of all, the linkage up until the beginning of this year was a totally manual process, so we not only link them up in our system, but we have to notify our client as well. And it was a manual process, and quite honestly, it took a long time. And it was very cumbersome, and quite honestly, I don't fault a provider for being so concerned about that process. We automated the process in January, and again, it's not perfect yet because it still takes a couple of weeks to have this happen. So what is the provider told? You can see these patients, but quite honestly, if you submit a bill before you're linked up, it's not going to get paid because the linkage has to be made between the provider and those groups. So we ask the providers, please see the patient; yes, you can submit the bills, but let us tell you when that linkage is complete so you can get paid. There is no intention on anyone's part to not pay the providers.

REPRESENTATIVE MANDERINO: Okay, either I didn't hear you correctly, and I'm willing to listen again, or you said two different things. I heard you say when I asked if the credentialing delay results in treatment being provided before you made that link-up, do they ultimately get paid?

And first you said yes, but, and then your "but" just basically said, no, they don't get paid if the link-up doesn't happen before they submit the services. So clarify it again.

MS. KUNIS: Okay, first of all it's not a credentialing issue, because they are credentialed.

REPRESENTATIVE MANDERINO: Well, right now I was taking you through the whole scenario for credentialing. Then I was going to take you through the whole scenario -- sorry, Mr. Chairman -- for authorization, because it seems to me they're two different problems that people are complaining about and they're two different areas where payments are being denied.

MS. KUNIS: Okay.

REPRESENTATIVE MANDERINO: So my head is still in credentialing.

MS. KUNIS: That's right. Okay. I am Suzanne Kunis, I am a psychiatrist in a group practice, psychologist, social worker. I decide I want to spend a couple nights a week working for this group practice. I'm already credentialed, so from a Magellan standpoint, I am credentialed and I can see a member.

REPRESENTATIVE MANDERINO: And the reason you're credentialed is you don't want any risk out there--

MS. KUNIS: It's required by Pennsylvania law and

NCQA.

REPRESENTATIVE MANDERINO: And we love that.

MS. KUNIS: So I am now providing service to that group that we just talked about. I am not able to link to provide services in the group but we can here as well, because some of those claims are paid by our customers.

REPRESENTATIVE MANDERINO: Okay, and how long does that linkage take?

MS. KUNIS: The point I was trying to make, on the manual side it used to take -- we have a history that was bad. It could have been months.

REPRESENTATIVE MANDERINO: Okay, and when it was months, and you would say to a provider, you're authorized to provide service, was I hearing them wrong when they said but then you would come back and say for all the services you provided before you were linked up, we're not going to pay you?

MS. KUNIS: No, again, and I'm going to give you my perspective here as Magellan. What we have done is when the provider linkage is made, any service that was provided to those members would be paid for.

REPRESENTATIVE MANDERINO: Prior or post? Prior to the link-up or after the link-up? So long as you said you're authorized to provide the service, you would honor payment for that service?

MS. KUNIS: It has to be linked up before a payment can be made.

REPRESENTATIVE MANDERINO: Yeah, before the check is cut, quote, unquote.

MS. KUNIS: That's correct.

REPRESENTATIVE MANDERINO: But whether the check is cut, if the link-up happened on January 1, and three of the visits happened before January 1 but you said go ahead and do it, once the link-up is made on January 1, you're saying that you would pay.

MS. KUNIS: That we would pay. That's correct.

REPRESENTATIVE MANDERINO: And I very clearly heard them saying they weren't being paid. Okay, so if they weren't, okay, do you keep -- let's go through, that was the credentialing. Maybe it's also the authorizing thing in there too. I mean, maybe part of that was what you authorized, but now I want to go to authorization in the -- I'm very confused. Let me ask it this way. Let's go to the inpatient setting. Some of the criticisms in the inpatient setting were not about -- we were done with credentialing, we were on either authorizing additional days or allowing payment for inpatient stays, and I got the clear impression from some of the testimony that providers felt that they were absorbing costs, meaning not being paid for days, even though Magellan had not disputed the medical necessity of the stay,

but had some other reason like, I don't even know what other administrative reason would be, but it seemed to me there was a distinction about, and I don't know if it was a disagreement about medical necessity, I'm sure in some cases that was it, but I clearly heard folks say that sometimes payment would be denied because of some administrative denial, some administrative reason. Do you have any -- did you hear that the same way I did and do you have any response or clarification?

DR. NARDOZI: I think the issue may have been somewhat complicated in terms of the testimony that I understood when the two representatives were here, Dr. Yee and Dr. Fleischer. I think Dr. Yee was making the point that there may be a patient who is remanded in voluntary evaluation and treatment and Magellan's physician, through one it of its physician advisors, may disagree with that medical necessity of that stay. If I may, I would like to give you a thumbnail sketch of the process. If you feel you understand it completely, then I'll spare you of that.

REPRESENTATIVE MANDERINO: Well, you know what? Maybe that would be helpful, but I don't want to lose my train of thought here, because I'm trying to follow the money and I'm trying to get, at least at this point, to the issue of treatment that nobody disagreed was medically necessary and a covered benefit, but whether or not it's actually being

paid for, or if the -- see, I'll tell you my bias -- not my bias, where I'm coming from. If I thought these were just administrative hassles to the practice of these providers, I don't think we'd be here. I think this is about the money, and I think that they believe that you are saving money on their backs, and that's why we're here. So I'm trying to get you to respond both in the credentialing processes to the concerns they raised and in the authorization process to the concerns they raised in following the money and figuring out whether or not their complaints about basically we're providing medically necessary covered benefits that we're not being paid for because Magellan has whatever, computer problems, snafu problems or administrative problems that they're using as an excuse for us to eat the extra days and extra time for the costs of that provision of services. That's where I'm trying to get.

So when I ask that question about the inpatient, I don't mean to say I don't want to understand how it works, I want to understand the money. I'm trying to understand the money, because I'm thinking that that's what they're complaining about, and it sounds like a legitimate beef to me, so I'd like to give you an opportunity to dissuade me of what I'm thinking.

MS. MEZIN: As I said in my testimony, I have responsibility for claims payment, so since you're interested

in money, let me see if I can help you.

We do not, as a practice, deny claims permanently, if you will, because of an administrative problem. If we receive a claim from a provider, be it an outpatient claim or an inpatient claim, and we do not have all of the information that we need to process that claim, we will possibly deny that claim and send back an explanation as to why it was denied and the provider has the opportunity to correct and provide the appropriate information. It could be that the authorization was given to the mother and the claim was submitted for the child and we can't match the authorization between who it was for. Our systems will say this doesn't match, I'm going to automatically deny this claim and send it back. If the provider then gets the denial letter back with an explanation as to what's wrong and corrects it, we will then process it.

What I heard when they complained about Magellan is trying to save money on our backs here, a message that I heard--

REPRESENTATIVE MANDERINO: Those were my words, I don't think those were anybody else's words.

MS. MEZIN: We picked up on that one. What I heard them saying is that they purposely are denying these claims, and then I have to being back and correct it, there are timely filing requirements where we say if you don't submit

your claim within X amount of days, again, we follow the State regulations for timely filing, if it's not submitted within X number of days, that we then deny the claim. That has happened, I will not say it has not happened, but when it has been brought to our attention, we can see why the claim was denied. And if it comes back in to our service center, we will override the timely filing and we will pay the claim. It happens with some frequency that we override our claim for timely filing. So I believe that's what they were alluding to when they said they put us through this administrative hassle. That would be my interpretation. It's not our intention to do it. I personally, as the guy responsible for the productivity in our claims department, I would assure that rather the claim come in correctly and we handle it one time, we get everything submitted properly and process through the claim and pay it, not that we have to then handle it a second, third, or however many times until it's done correctly.

REPRESENTATIVE MANDERINO: Now, one of the testifiers prior, and I'm not saying this was the only reason, but at least one person seemed to think that the rejection of something based on something being wrong on the claim, not necessarily an identity confusion but a coding confusion, I'd like to hear your response to that. Without any, this is paraphrasing, without any notice Magellan would

change the codes that we were supposed to bill under and so all of the billings that we did under this code were then rejected and we were told use a different code, and respond to that.

MS. MEZIN: We do not change our code with any degree of frequency whatsoever. We follow, for the most part, HIPAA standard codes. As HIPAA has been implemented, and as you all know, there is a graduated tiering in the implementation of HIPAA and the standardization of claims processing. Our codes have gotten more and more standardized. So as a practice, thinking back, I can't think of codes that we have recently changed.

What I will say, if I were to pick a complexity that I scratch my head at, quite frankly, is we do have some codes that are unique to Magellan and the way that we have paid claims, and I can see that a provider who is processing with Magellan for a variety of different health plans might find it challenging to have to know the unique code that's specific to Magellan. Generally, if we use a unique code, it's because one of our clients has requested that we track certain information or they want payment to be a certain way for a certain type of service and we don't have a standard code that allows us to then follow the special rules that they set for claims payment. As a general rule, again, we don't change our codes. I have 400 people I'd have to

retrain too.

REPRESENTATIVE MANDERINO: Could it be an implementation of a unique code that something used to be a standard HIPAA code and now we're using a unique Magellan code and all of a sudden people are getting a lot of rejections? Is that what they could have been referring to?

MS. MEZIN: That would be a stretch for me. Again, we don't change our codes with that degree of frequency that I would think that would be a driver. If we did change our codes, it would be communicated, and that is a standard for us to communicate it. Again, it's not in our interest operationally to try to confuse people that we have to do rework all the time. And again, the codes just don't change with that degree of frequency. When do they change, if they do change? They change when we implement new groups potentially under an existing client, they change with the new year occasionally, but it's not a regular thing. I don't know if any of you guys remember the last time we changed payment codes for either IBC or Aetna?

REPRESENTATIVE MANDERINO: I'm cognizant that I've been monopolizing things and I know other Members have equally important questions. Let me just ask the last concern I have going back to the credentialing process. And I guess there's really two things I'd like you to respond to. I believe it was within the context of the credentialing

process, and let me do it this way. Our Department of Health puts out an annual report on HMOs. And the Keystone Health Plan East statistics, which I assume you administer their behavioral health, stated that 99 percent of applicants were recredentialed within 30 days. Which is even different testimony than what you said is typical. So I'm wondering, what does that 30 days mean, and I'm remembering the testimony of somebody prior who talked about re-signing papers at the end kind of after we waited a couple of months and worked things through, and so could you, I mean, if everyone kind of acknowledged, including the last panelists, that two to four months is not a typical, you're telling us 90 days is the national thing and you're well within that, and then how does one plan come up with 99 percent of the applicants recredentialed in 30 days? Am I mixing apples and oranges? Can you please explain that and explain that whole re-signing thing that people were complaining about?

MS. KUNIS: We believe, again, we're not positive, but we believe that the 99 percent that's reported by the health plan includes every recredentialing activity that takes place for the entire health plan. It's not specific to behavioral health. So the numbers that we provided are specific to our own credentialing.

REPRESENTATIVE MANDERINO: And I don't mean to be extreperous, that's a word my mother used to like to use, but

why would recredentialing be so much more complicated for behavioral health providers than it would be for other medical providers?

MS. FANTILLI: Okay. Again, and I will not profess to know how it was on the medical side, but my understanding of going through this is that, for instance, a cardiologist in any State is going to require the same amount of credentials, licensing boards are the same thing. When you get into behavioral health, social workers, LPCs, marriage and family therapists, the different types of States require different credentials in licensing based on those different licensures we have, and therefore when you get into it, it gets into this licensing board, let's just say in Pennsylvania most of it is electronic, so in other States it's not, where you have paper. So what would happen essentially -- well, I'm sorry, go ahead.

REPRESENTATIVE MANDERINO: Well, I just don't want you to get too far off. I want to hear it, but it seems to me if I'm a cardiologist at Abington and I'm a Pennsylvania board certified cardiologist, you're still checking where I went to school, the same kinds of stuff, do I have any liability claims? I mean--

MS. FANTILLI: It's generally when you get into, again, not knowing, I'm assuming there is more expediency on the medical side of the house when you're checking

credentialing. For example, when you get into I want to go check that board for your license for a social worker in a particular State, I may only be allowed to call up on the phone and ask for three credentials on that paper, so it does take a longer process.

REPRESENTATIVE MANDERINO: But you're credentialing people practicing, if we're talking about in the southeastern Pennsylvania market, practicing in southeastern Pennsylvania.

MS. FANTILLI: Correct.

REPRESENTATIVE MANDERINO: So you're doing credentialing through the same professional organizations that everyone else who is doing credentialing of Pennsylvania providers are doing irrespective of the kind of practice they have.

MS. FANTILLI: And we can check into sort of in that HMO report as to why it wasn't 30 days, because we're not clear, that is not our experience and that we can, we do not credential within 30 days. It does take us between two and four months on average to get that done.

REPRESENTATIVE MANDERINO: Does Magellan provide the behavioral health services under the Highmark?

MS. KUNIS: Yes.

REPRESENTATIVE MANDERINO: You provide them but you do not do their credentialing, is that correct about that?

MS. FANTILLI: That's correct.

REPRESENTATIVE MANDERINO: Well, why?

CHAIRMAN O'BRIEN: Why?

REPRESENTATIVE MANDERINO: Yeah, well why, but more importantly, and maybe the question, and I realize my follow-up question was how long does it take them, whoever does their credentialing to do it, you may not know that.

MS. KUNIS: Each customer decides what functions it's going to delegate to the vendor, and Highmark chose not to delegate credentialing. It's actually their network, it's not even a Magellan network. And I don't know what their turnaround time is on the behavioral health side. But we will follow up specifically on the issue of why does it take longer to do behavioral health recredentialing and let's look at what it should. We would be happy to follow up on that issue.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Mr. Chairman.

CHAIRMAN O'BRIEN: Representative Fichter.

REPRESENTATIVE FICHTER: Thank you, Mr. Chairman.

It's getting to be a long day, but I'm sure we have more questions. This morning I guess we heard eight organizations, people representing organizations or individuals saying that it's very cumbersome, and then we had three individuals come on board and say things are very good and fine, and then we had Danna come on and say that things

are progressing, claims processing is very complicated and you're upgrading your training and your training staff, you're undertaking new initiatives, you launched a new Web site, you enhanced the Web site already, you're working to improve your site and give more feedback, and on and on and on, which is all good. But we talked about the past mostly today and now we're here today, and with all these enhancements, I would assume the people and organizations that were dissatisfied this morning are going to be happier as we go into the future. Is that, give me, can we look at that?

MS. MEZIN: If they're not, then we're working on the wrong enhancements. I listened to a lot of the passion around the concerns about the authorization, which seemed to be tied to our Web site, and you can't help being a customer service person, which is what I did, I started my first job was on the phones as a reservation sales agent, and I care about the service that they're receiving. When you listen, and I think I reflect back on how we deployed our Web site, if you could go hindsight and say, let me kick myself for having made a mistake, I'll kick myself here for our Web site. And what we ended up doing is we launched our Web site, we did not have, prior to January 2004, any self-service capability on the Web. I came from out of the airline industry where you guys probably know you all make

your reservations on the Web these days, you pay $5 to go and call in and you're talking to somebody live to do that, and I came out of a very automated world and have worked for other health care companies in between that time and now, and a lot of other folks were a lot farther along than Magellan was in terms of self-service capabilities, so we tried to catapult ourselves and say we've got to at least get ourselves out there.

So we put capabilities out there that I would say was a step in the right direction but certainly nowhere what people have come to expect on the Web. You expect on the Web you put in your Social Security number and the system, your banking system knows everything about you when you hardly have to key anything in. We put the Web out there and said, gosh, wouldn't it be nice if people could just submit a treatment request form on-line, and I would rather put it out there without it being prepopulated so they can at least submit it on-line, and then part two will be prepopulated. What I'm hearing from the providers today is why doesn't your Web prepopulate? Everybody else's Web prepopulates, and we're getting there. We're just not there, and we've taken the steps and tried to prioritize what do you think would give, you know, the most satisfaction out there in terms of self-service capability, and we've been doing it a step at a time. And what I heard them say today is accelerate it. It

should be there now.

We've spent the past two years like most other health care organizations, investing a lot of money to become HIPAA compliant. We spent millions and millions of dollars and focused on that. When I joined the organization three years ago, we had 36 systems. Today we have 3. And we've spent time collapsing our systems and said we can't put up with functionality, they have to interface with 36 different systems, let's make our priority getting on to common platforms so that we can be one Magellan and provide more common services across all of the clients that we service. Our priorities I guess were someplace else than the Web, and the message we got today is these are the tools, I need to do my job more effectively. Magellan, make this a better tool for me, and we hear that and you will see very immediately there are a lot of changes that we can make that aren't that hard. I think you guys probably all know programming a Web site is a lot easier than rebuilding your legacy systems, which is what we've been doing for the past two years.

So, Representative Fichter, I certainly hope that the things that we're working on, we're doing our best to listen really, really well today and take that seriously and make the right changes.

REPRESENTATIVE FICHTER: I hope so too, but I don't want to be back here in a year and hear the same problems,

because we might not be too nice. But anyhow, having said that, obviously you're aware that you have problems with certain providers. What are you going to do to alleviate that problem? I know you have the Web site, enhancements, and all that, but just like anything else, if you have a problem and you have a ratio of 8 to 3, 8 against and 3 for, then you have a problem. So what is Magellan going to do to alleviate the problem and get rid of the problem? In addition to the enhancements, the Web site enhancements?

MS. MEZIN: I guess if I go back to Stacy's testimony the first thing this morning, they said the first time they heard of problems were in April. We consistently listened, and I would have to honestly say that a lot of the issues that we heard just in the recent weeks have been issues that haven't been as apparent. I had no idea, quite honestly, and shame on me if you want to say that, but up until April, I had no idea that there was such dissatisfaction with our Web site. As a company, we were so excited to have Web application and functionality out there that we never had before. You know, shame on me for not realizing that providers were so distraught with what we put out to get out of the gate. I think we're trying to do a good job, step one is listen and understand, and just as I think you also, hopefully you heard from Stacy this morning as well that there are a lot of places where there's some

things that are set rules, they are what they are and maybe there are ways that we can make them easier. I think for us it's really understanding the problems. How is it that we've been audited so many times, that we just had a 100 percent score on our NCQA survey in our Georgia office and yet there's so much dissatisfaction with what we're doing? The first thing that's most important for all of us is to understand the root cause that's driving a lot of these issues, and then to put an action plan around it.

As Suzanne said in her testimony, we have an outside audit firm coming in to look at a lot of our procedures. Maybe you can't see the forest from the trees sometimes to see what some of those underlying issues are. We're open to outside audit coming in and looking at it. And personally, I would love for some of you guys to come and visit some of our offices and see all the things that we're doing right and the care that our team members have for taking care of the members that we serve and working with the providers. There's a lot of good things going on at Magellan, and we're committed to figuring out what's wrong and putting an action plan in that's very aggressive. And I hope you heard that we tried to identify before walking in the door here today based on what we've learned so far what can we do to be immediate? And we want to show immediate and permanent improvement, even if it's something small. And I

know I said I don't care if you have to change somebody being kicked off our system in 15 minutes, make it a half hour tomorrow. I want to show them that we're committed to making changes. And the things that are easy to do we'll do fast, the things that are harder to do we'll develop a thorough plan so that we're sure that they stick.

I don't want to come back.

REPRESENTATIVE FICHTER: All right, well, thank you very much. You're on the record.

MS. MEZIN: I am happy to be on the record.

REPRESENTATIVE FICHTER: We've heard what you said, what you testified to, and I just hope you follow through and do what you say you're going to do.

Thank you, Mr. Chairman.

CHAIRMAN O'BRIEN: Representative Ross.

REPRESENTATIVE ROSS: It's a long day and I'll be brief. I just wanted to highlight something that particularly bothered me, and that was the occasion where someone filed for reimbursement and then there was a little tweak to it and it was resubmitted and it was announced that it was after the deadline. Following up on Representative Manderino's questions and concerns following the money, the later you pay a claim, the more time you have the use of the money. Now, I'm sure you would say, and I would trust that you would say that this is unintentional and it just happens.

MS. MEZIN: And we do adjust when we're late.

REPRESENTATIVE ROSS: Okay, well, that's encouraging, but I would say that things like that are things that I think you really want to be looking at in terms of your systems. It shouldn't be about, well, there's a little tiny mistake, so we're kicking it out. If there's a little tiny mistake, the goal should be to fix that mistake and for you to cooperate with the provider, or as some of the providers seem to be doing, pushing some of this stuff back down on the client, which worries me as well, that you're showing signs and methods internally within your system to reduce the number of those mistakes that are on there to get these things paid first time quicker. And I know that it is a shared responsibility between you and the provider, obviously, but it does worry us a little bit if we see claims kicked out for minor routine things. And perhaps maybe even the claims forms then wind up being somewhat to blame.

So that's something that I -- and I think we're all going to continue to be observant, I guess is the best way to describe it, on what's going on.

MS. MEZIN: May I respond to that?

REPRESENTATIVE ROSS: Yeah.

MS. MEZIN: We actually have a metric that I track very closely with my team. We call it service requests, internal. And what that is is that's the percent of claims

that come back to us a second time for handling. And on average, and it varies a little bit from platform to platform, and as you may know, some of our clients, Aetna as an example, we do work on their systems as opposed to our system, so we have a slightly different, but across the board we run about 3 percent of our claims come back, if you will, is what we call a service request or rework. Meaning that something happened the first time and the provider is saying I don't think something is right here. And we track that percentage all the time. Our goal is to make that percentage as low as it can possibly be because it's a reflection of rework, and that's a bad thing.

One of the metrics that we have not been tracking that we will be implementing, and that is of the 3 percent that's coming in, how many of those then, one, are only coming back once, how many of them are coming back twice or three times, which would really get people on a bundle that were not correcting their problem? And then second, of that 3 percent, what percent of those are actually ultimately being adjusted for payment? What I do track, because I do follow the money, you know, how much money are we paying in interest? Because when we don't pay within our time of requirements, we do pay interest on that, and that's obviously an expense to Magellan. And I can tell you and be happy to show you a graph, but it looks kind of like this

(indicating) over the last three years, that that number is coming down and down and down. Because when we do make an adjustment ultimately, we pay a penalty for not handling it right the first time.

REPRESENTATIVE ROSS: Do you calculate that from the date of service?

MS. MEZIN: Yes, we do.

REPRESENTATIVE ROSS: Not from the date of the corrected claim? Because that's important.

MS. MEZIN: I believe it's from the date the claim was submitted, but I need to double-check.

REPRESENTATIVE ROSS: It's worth looking at.

MS. MEZIN: I know the answer, but it's one of those times when all of a sudden I don't know, but I'll double-check.

REPRESENTATIVE ROSS: I won't hold you to it.

I just want to make one last comment that was raised earlier in one of the earlier panels also, the sense that some people don't want to work with you any longer, some of the providers, and that's a serious issue as well. And so the discouraged person who stops submitting the claim because they give up is perhaps a factor in there someplace as well that needs to be worried about and the fact that some people don't want to take clients because they would have to work with you is another thing that I think you need to be

obviously worrying about, and we certainly are worrying about, because eventually, whether it's any kind of health care insurance company, we're going to get to a point where even though people are paying for their insurance, they're not getting the services off of that and they're having to pay out of pocket, and that's another way the system kind of comes apart at the seams.

MS. MEZIN: It certainly isn't Magellan's objective to be tolerated. We're a service organization and we support care to patients. It's not our objective and whether we can go back and maybe talk to providers who left the network and understand it, understand why they left and how we tortured them or whatever it was that they're claiming and why they were so distraught with our services, we're not afraid to ask people or encourage people to share with us what's wrong, and that's the only way that we'll fix it.

REPRESENTATIVE ROSS: Thank you.

CHAIRMAN KENNEY: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

All of you heard the testimony from people, and I don't want to get into detail, but we heard about claims being subjected for inconsequential reasons, we heard about suicidal patients, we heard about delays, the letters I've been getting claiming that the delays in payments have gone on for 10, 12 months in time. It's a little hard for me to

understand, first of all, how that would be going on and nobody in Magellan ever heard about it until sometime in the latter part of April of this year. Putting that aside, what I want to do is sort of take you up on your invitation to say come see what we're doing right.

MS. MEZIN: We'd love it.

REPRESENTATIVE HENNESSEY: Tell me, of the people that you heard this morning, do they represent 5 percent of the body of patients out there? Do they represent 2 percent? Are they representing 20 or 30 or 40 percent? Because that's really the issue I think we've got to get at, whether or not there's people who are being denied coverage or having their claims denied, providers having their claims denied at a relatively large scale, or are we talking about something that's very, very insignificant in the overall scheme of things under Magellan's umbrella.

MS. KUNIS: In terms of the providers' response to the survey, they represent about 4 percent of our network in southeastern Pennsylvania. So when we talk, and in your package you'll find some materials from our surveys and some feedback from the total number of folks who have seen patients. So it's just a comparative point.

In terms of the, I'm sorry, I was trying to make sure I answered all your questions. In terms of the patient population that are serviced by these providers, the

providers that spoke today have seen very high volumes of patients, absolutely they do, so I don't want to mislead you and say, you know, even though the responses were a small percentage of the network, they do see a high volume of our members.

REPRESENTATIVE HENNESSEY: But I thought I just heard Danna say that only 3 percent of the bills that you receive or the claims that you receive get reworked.

MS. MEZIN: That's across our whole book of business, not specific to Pennsylvania.

REPRESENTATIVE HENNESSEY: In Pennsylvania then, what percentage is likely to be reworked? Why don't we focus on--

MS. MEZIN: I'll have to get those statistics for you. I'm not sure what it is specific to Pennsylvania. Our guess is that it would be pretty consistent with what our book is, but we'll confirm it for you.

REPRESENTATIVE HENNESSEY: If I could just follow up on a question that Representative Ross had, and I think Representative Manderino before him, when there's a delay in payment, who benefits specifically now? Is it Magellan or is it IBC or Highmark or Aetna or anybody else who contracts with Magellan to pay for those covered services? It would seem to me that as a middle man or as an administrator you could delay payment and IBC could benefit because they don't

have to pay you to pass that money through. If you delay for 90 days, then they can get the interest on that money, and if it's a substantial amount of claims, then it could be a substantial amount of interest they could make, or is it something that Magellan captures? If there is a delay, regardless of whether it's legitimate or not, who makes the money on the interest that's earned while that money is sitting in the bank waiting to get out to a provider?

MS. KUNIS: It depends on the product line. There are certain product lines, PPO products ordinarily are paid through our health plans, so if claims were delayed, the health plan would benefit.

REPRESENTATIVE HENNESSEY: That would be the IBCs, Highmark or Aetna?

MS. KUNIS: That's correct. For the HMO for IBC, for example, if claims are delayed, from a financial perspective Magellan would be the person to benefit by the float or whatever, that would be Magellan's benefit.

REPRESENTATIVE HENNESSEY: Thank you, and I think that was probably more important to Sharon, and I think she understands that a little bit better than I do, but I think it's important that we are clear who does benefit, whether it's Magellan or somebody else.

Two other questions. One again Representative Ross mentioned, there was the concern, somebody said attending

physicians in Philadelphia hospitals have a difficult time finding a participating provider for whom to release a patient because of the dissatisfaction in the southeast with Magellan's practices. Is that, do you dispute that? I mean, is it a problem that we don't have people out there that are treated on an outpatient basis after they are released from the hospital?

DR. NARDOZI: I am going to speak in a general sense from a clinical basis, and then let Christina answer it from the overall network perspective. The process is built so that we encourage discharge planning from day one. In other words, we believe that the least restrictive means of care is the best, and I think that's something that's nationally accepted. You'd rather be home getting care as opposed to the hospital. We initiate the discussion for discharge planning so that we can make sure that there are adequate resources, and we partner or at least collaborate with the facilities, the hospital, to assure that patients are transferred. If we couldn't find somebody in the network, we would go out of network. So from our perspective, in terms of availability and accessibility, we're held to certain standards, and I want people more expert than that to describe it, because they have to do with timeliness and geography.

REPRESENTATIVE HENNESSEY: So essentially then you

would dispute what she's saying that people can't find, or in hospitals doctors can't find doctors to treat on an outpatient basis once they release that patient?

DR. NARDOZI: I would say on a distinct but related issue, because the issue came up about child and adolescent psychiatrists, there is, as I'm sure you well know, a dearth of child and adolescent psychiatrists in the country. It's not that we don't have them in our network, it's that they don't exist. So there will be challenges on occasion to having people seen, because there just aren't enough people, not because they're not in our network, they're just aren't enough people generally.

MS. FANTILLI: I think you covered one of the things I was going to get to. It's not an unknown fact that at times psychiatry and child psychiatrists in particular are a commodity, it's very difficult at times to find them, depending on the location and geography. Particularly you could also have, I think some of the testimony that I heard they're saying, I think, you know, they either opt out of the network or they don't join networks. And that's because of the paucity of child psychiatrists, I can be in a geographic area where I don't have to join a network because people are going to come, so I don't have to join managed care. It's not unique to Magellan as an MPHO, I can set up here and the patients will come and will be private pay.

So to that end, what happens, I'm a member trying to receive care and this problems exists here, we will not, at all of our service centers, we will find an out of network psychiatrist for you. Let's just say there's a situation where that physician can't find somebody or a member can't find somebody in our network. That call comes to us and we will find someone out of network regardless of what the rate of reimbursement is, we will find that for you so someone is not sitting there looking for a psychiatrist.

MS. KUNIS: Just one other point too, one of the things that are very important in the industry, the EDIT numbers, I don't know how familiar you are with EDIT, but it's really we're required with our health plans to report things such as ambulatory follow-up for mental health discharge. And we take that very seriously. The standards require that patients are seen within seven days of discharge from a facility for mental health. And we actually have grappled with this issue over the course of time and to the point where we literally established financial incentives to providers to take these patients within the first seven days of discharge, because we know that the most important thing to the success of somebody coming out of a hospital is that there is that continuation of service. You don't just discharge and go away. There are additional follow-up services. Our goal, as Dr. Nardozi stated, is to keep the

patient in the community as much as possible, so that's why we're trying to get these patients to be seen. Again, if I can reward providers to take these patients, to see them within the first seven days of discharge.

REPRESENTATIVE HENNESSEY: Okay, I appreciate that. I guess I'm just a bit puzzled on how we can have you guys making such a common sense view of the way the policies of Magellan work, and then we hear from the provider community saying this thing is falling apart. I think it becomes more and more important for us to know whether the people who were here testifying and the people who were applauding when they were testifying saying Magellan is way out in left field represent a very small percentage of the southeastern Pennsylvania population of patients and providers, or whether they're a much more significant number, because they were testifying about problems that you guys are here saying really don't exist, or if they exist they're just ancient history and we've made a lot of corrections to our systems. We don't hear many of them say that all the problems have gone away in the last six months.

MS. KUNIS: And we're not saying all the problems have gone away. I mean, first of all, we do acknowledge that our Internet capabilities, we need to spend a lot of time trying to make that more user friendly. Today as a provider, I get a message saying this authorization has been pending.

It doesn't tell me why the authorization is pending. It has a HIPAA compliant message on there that we're required to use. We're looking to say maybe we'll still use those, but then also try to put additional information out there to try to tell the provider at that very point in time what the applicability is and let them fix it right at that point in time. So please don't misunderstand, we're not saying we're perfect. We know we have work to do, and we want to have the providers' feedback, and that's why we're committed to try to sit down together and work through the issues one by one.

CHAIRMAN O'BRIEN: Representative Watson.

REPRESENTATIVE WATSON: Thank you, and thank you for especially that last statement. I guess I'll go back, if I may, Ms. Kunis, page 6 of your testimony, and I think I have a million and a half questions, most of which were asked by my colleague Representative Manderino.

REPRESENTATIVE MANDERINO: Sorry.

REPRESENTATIVE WATSON: No, you did a good job. So I'm trying to consolidate in the essence of time here. On page 6, second bullet point, you established an internal functional SWAT team that's investigating each complaint. Am I to assume from this statement, and based on subsequent statements you've made, that you will get a copy perhaps of everything that's been carefully taken down today and every one of our testifiers that testified prior to you, you're

going to investigate their complaints?

MS. KUNIS: At this point, when we spoke here about the internal cross-functional team, which is basically meaning people who are credentialed in authorized care, trying to make sure the whole picture is looked at together, what we referenced here is that we have received, through the Department of Health, we have the PPA survey results and we have the comments and the specific details that came from the Department of Health.

REPRESENTATIVE WATSON: I'm going to stop you short because we already, our first testifier from the Department of Health admitted in questioning, I think, that she hadn't heard a lot of it. So I guess what I'm asking you to say that you will extend -- a couple things. Would you extend further that you will include and get copies of the testimony that was given today and investigate those claims? That will save me time too so I don't have to ask you about the one doctor who testified that he's got two years worth of going back and forth with you because the system changed two or three times, and I'm hearing you say that if we get that all worked out, he's going to get all of his interest.

MS. MEZIN: I wrote down his $37,000 and his name to go look up his claims.

REPRESENTATIVE WATSON: Okay, well, he's still around and I'm willing to tell him we're going to get it

straightened out for him and he's going to get all of his interest.

MS. MEZIN: We'll research all of his claims.

REPRESENTATIVE HENNESSEY: It was $47,000. Don't cheat him out. And interest.

REPRESENTATIVE WATSON: And I am guessing that we have that all because we have a crack stenographer here, so you can get all that information and be in touch with him and we can do that, and I think that's important.

I appreciate too the opportunity that you gave that we could come and talk to you. Would I assume that you would also extend that opportunity to, and I'm looking at some of the folks who represent specific organizations they testified on behalf of, so I would really like you to be, I'll come and talk to you, but at this point I'm dissatisfied by what, having listened, though I come from Bucks County and as we all know, it is obviously the premiere county for a lot of reasons, and my colleagues in Philadelphia admitted that, we have that too.

(Laughter.)

But very seriously, that would you have them -- I'd like to have folks from the Pennsylvania Psychological Association, the Pennsylvania Psychiatric Association, the Pennsylvania Society for Clinical Social Work. Since those folks came representing their whole group, I would like you

to bring them in, because they're really at the crux of, regardless of how you design or how fast, they can tell you, and I found them to be, their testimony to be somewhat reasonable folks, passionate to be sure, I like that word, but reasonable folks, they want to just get to the bottom of it. We assume we're all in the business of trying in our own way to help people, and that's the bottom line on this one. So I would like to suggest that while it's good to have us come in, you need to have them come in and maybe we can solve a lot of these problems more quickly and also permanently. I felt very sad when I listened to the one doctor who said he was a little bit off, I assume a person in this business is basically a hopeful person for the people they see and they can make a difference, I don't like listening to him say, and I heard it before in this year and in the last six months, and I'm telling you, in a year you'll be back here for the same thing. Representative Fichter said it the best, we don't want to be back here in a year and hearing the same thing. Actually, assuming I'm re-elected at some point, I don't want to be back here in two years hearing the same thing either. Okay? Thank you.

DR. NARDOZI: Representative, if I could, when you were asking some clarification on the issue of medical necessity and the reviews, if I could just clarify that for you, because I saw that look of concern.

REPRESENTATIVE WATSON: That would be fine.

DR. NARDOZI: The issue of medical necessity rests upon use of medical necessity criteria which Magellan, I believe, and you could verify this in an independent form, has the state of the art. These are scientifically based criteria which are really fairly broad and go across all levels of mental health and psychiatric care. They are reviewed by panels of experts annually and updated according to the latest scientific literature. I know because I've participated in this at many levels at different times in the company. Those criteria are used to determine, and again, they're fairly broadly based, not restricted, whether or not our psychiatrists would agree with the need for that level of care, whatever that level of care is, but we're generally talking about higher levels of care. A care manager, a Magellan care manager will take the first level of information in initial review. That person is a clinician, and there are standards for that person's expertise in terms of time that they function as a clinician before they came to Magellan. That person can give an authorization for care but cannot say that care is not going to be authorized, and that I think may have been a misunderstanding in terms of the testimony. As only a board certified psychiatrist, which is what Magellan uses for its physician advisors, who are independent contractors, only that person who would agree or

disagree that medical necessity is met.

Let me tell you also that there are myriad activities in improving the quality of decisions both in terms of documentation and the decisions themselves. In integrated reliability studies, document review, I've participated in them myself and have through various capacities. I am fairly confident that the processes are in place to assure, again, barring human imperfection, that these processes are in place and that they function for the most part very well. And I hope that addresses that issue for you. If it doesn't, I would be happy to answer any questions you may have on it.

REPRESENTATIVE WATSON: Thank you, it does to a point, and I have to say that I recognize that what I was reading and what I heard started with the phrase "a colleague recently reported." I've already said to the individual, can you go back to the colleague, I think we need to get the specifics, which speaks to what I just said to you, that if indeed you would sit down then with the members or the representatives from their association and go over things like this so we wouldn't have that, and maybe there was miscommunication and maybe sometimes stories get a tad, a bit of hyperbole, but at the same time, if there's any essence at all in this, there's something very wrong, and that needs to be addressed. And I guess that's what we're really asking

for, that we are permanently and positively assured that that's not happening, because I have the utmost respect for many of the people, having read what they said and looked who they are, I have respect for them. They wouldn't take the time to be here.

Therefore, and I know that your job and your concern is to see the company does well, you're fine, you've sat through all of this, it wasn't a fun day, I'm sure, for you, but at the same time, the people have to come first, and that's what we want in this.

DR. NARDOZI: We agree. Our job is to see that members receive safe, efficient, and effective care, and in part of the attraction of my coming to Magellan, and again, I've been on both sides of the phone, so to speak. I'm still in practice as a physician. Part of the reason was the vision I think Magellan represents in terms of moving the whole process and structure of managed care to a place where we're talking about what is the value add? And in my own focus, my own supervision of our physician advisors and care managers, and I think the people who are here are dedicated. The issue becomes how does the process become more member centered and more provider centered? How do we develop programs which we could tell you about in great detail that enhanced the well-being of the members and systems in place in an attempt to make it easier for providers? The role of

the physician advisor, because that's how this came up in terms of necessity, is really to function as a colleague to his or her reviewer. It is not to impress or put pressure upon the attending physician to do something that the attending physician does not agree with. But we must acknowledge that in psychiatric care there is a large arena or significant arena in which there can be an honest difference of opinion between two medical professionals. There are processes in place beyond that in terms of appeal checks and balances going all the way up to independent review, and I think you heard statistics from the Department of Health in terms of the process that might reach them. And so we are very much attuned to that, very sensitive to that. We really are dedicated to seeing that members get the care they need in a safe, efficient, and effective manner.

REPRESENTATIVE WATSON: Thank you.

CHAIRMAN O'BRIEN: I'm going to need some help here. I may not -- you may have to help me find some questions of what I'm about to say, because I don't know that I have any questions. I feel like I've been stupefied here, and maybe I'm just the only person that doesn't understand this.

Doctor, your last explanation on medical necessity leaves me somewhat weak in the knees, because over many, many years of dealing with the previous Secretaries of Welfare, I

have had slippery slope definitions of medical necessity formularies where I think I could reach my button and fly from here to California without stopping. I don't know where your national standards come, and I don't mean that in a pejorative sense, but I don't really trust definitions of medical necessity or formularies because I have seen where Mercer in Pennsylvania has taken standards and then they tweaked them and the assumptions don't make any sense and it leaves maybe a $20 million hole in the budget. Maybe that's where a lot of this comes from, there's not enough money in the pot, but I have to say what I'm hearing here is that there's a silent majority of providers out there that we're not hearing from, and there's only a small disgruntled, perhaps distraught, passionate number of providers that are out there. And to me, the vernacular I guess that I can use, that translates into a bunch of whiny cry-babies. That, frankly, I think is the disconnect that many of us are expressing in hearing this kind of schitzophrenic kind of afternoon and morning that we put together here.

And frankly, and I said this to you in private and I said it to the Secretary of Health, the real issue as I see here is that I see us in a debate about how we're going to manage money and not manage care. I hear all this talk about authorizations, and I frankly don't know whether those authorizations are designed to establish a barrier to care,

because the population that we're talking about here today can't get through those barriers, and why are those authorizations so expensive? And we're hearing on the other hand that maybe we don't need them at all. Okay. Why are they, when you look at that one group that came up, I think her name was Sharon Katz, maybe I'm missing something. She said she was a capitated provider. I think half of the providers today were not capitated. No, she's the reverse. Well, same difference. I just really have difficulty understanding how this authorization process, which really hasn't been substantially responded to. The issues that we heard around authorizations, I haven't heard any real curative response as to how we're going to fix that issue or address that issue. I haven't also heard, there's a big disconnect here, and this not only involves stories that I heard. I sit as secretary of a board who for 10 years I can't get anybody credentialed, and I have paperwork out the wazoo and I have to take six months and I have to pay people for six months, and I don't get paid for that job. But if I can't get it done with everybody that I know, I don't know how anybody else is getting through the credentialing mess. I just don't get it. And I think it's unacceptable when you have this population, and that group, you know, maybe we're all missing something. Maybe we should let all the providers stop and let the people fend for themselves. Maybe that's

the deal.

I just have a real problem understanding again where we have 10 years of information, and maybe it's because it was a manual system, and I hear all these little juicy jiggle-jaggles going on here, and maybe over the last 6 months or maybe over 18 months, I don't know, everything's been fixed, everything's great, and these stories that we're hearing here today are beyond when we had open access. I can't correlate this in my own mind. I can't understand that.

The one thing that comes to mind is if I have 10 years' experience where I've had all these problems, why should I believe that it's going to get fixed now? Why should I care? The one thing that I'm driven to is having another conversation. Since we've been invited to come in and put all our problems on the table, I'll ask my co-chairman here from Health and Human Services, why don't we have another hearing for Magellan, and maybe that's not the same people, maybe you'll have another cast of characters come in, but let's bring the public side in. Because I see the same parallels in the hat that I wear on that side of behavioral health as I've seen on this side of behavioral health, and maybe let's bring them all in, serve them up, and say, you know, in my book of business, where is all that success story? Because I frankly don't see it. Is the book

of business successful everywhere else except Pennsylvania? And I'm putting my wingnut hat on now, and I'm not going to apologize for that because this has been my experience, and I know everybody here has heard these stories in their legislative offices. And frankly, this map, this plan that you have doesn't really respond to the substantive issues that I have heard surrounding this issue.

And I would just like to asked Dana Alwine to ask a couple questions, and then if you find some questions in there you want to respond to, I'll welcome that. But there are some significant timeline issues that I would like Dana to inquire about. That's around your bankruptcy issues and maybe some of the other dilatory practices that are related to that issue. And then Sharon Cole.

MS. ALWINE: Suzanne, maybe you can address that. We met with you two weeks ago, I believe, and at that time you discussed the bankruptcy lightly, but you prepared a very comprehensive timeline for us. For the benefit of the members here that were not in that meeting, can you tell us how the bankruptcy overlays on the structural changes, the change to the open access?

MS. KUNIS: Okay, we went through the bankruptcy process. We filed for bankruptcy because of the fact that we had more debt than we could service in our organization. That started because of the fact that in the late 1990s there

was an opportunity where a bunch of companies were bought by Magellan as an organization, and over the course of the years it basically was, those companies were no longer valued at the level that we purchased them for. And so we needed to file for bankruptcy because we couldn't address the debt.

During the course of that process, one of the things that was not an issue was operating capital. We were able to financially, from a day-to-day operational standpoint, were able to fund our business. Our issue from the bankruptcy standpoint was really our debt, and again, debt associated with those acquisitions.

When we, one of the first orders for bankruptcy, one of the things that we wanted to make sure was addressed through the bankruptcy court which was more important to us was to make sure that providers never lost a day of payment, and that was approved the first day. Because we knew it was important during that period of time, to make sure that there was never a concern. A, we wanted to make sure that providers got paid because they're critical to the services we provide here. So we wanted to make sure they got paid, but also to make certain that we kept service and service was improved over time, because if anything went wrong, people would associate that with the bankruptcy, and that was something we were trying to make sure didn't happen.

We came out of bankruptcy successfully, and those

two activities really are unrelated because as we go a little further along--

MS. ALWINE: Can you give us some dates?

MS. KUNIS: March 11 of 2003 went into chapter 11, and January 6, 2004, came out.

MS. ALWINE: Continue.

MS. KUNIS: In the terms of the network change, we actually went through a competitive bidding process to renew a contract with one of our major clients in southeastern Pennsylvania, and all of our peers were out there, peer organizations, looking to take on that business. One of the requirements was that we open the network, it would be an open access network, that it would no longer be a subcapitated network, so that members, instead of being assigned to group practice, that they literally could go to any provider they chose to as long as they were in the network. We were awarded the contract in March, we announced to the providers in April, and then there was a whole string of events after that trying to make certain that we worked with the providers to say there was a big change. Now, these are huge practices, so we knew there would be issues in terms of really turning everything upside down where they never had to seek authorization before, with the subcapitated network, they were going to be like any other provider, they were going to have to get an authorization for this program.

The network that was implemented was an already existing Magellan network. We have a broad access network, and then we had a smaller subcapitated network, which was 14 groups, again, with all of the HMO membership assigned to those groups. That changed to fee-for-service, and again, all these other requirements are in there.

Some of the things that we did before the implementation is we knew that these folks had many, many patients that were in treatment with them already, so rather than saying the day the switch gets turned that you need to start calling for authorizations at that point, we actually dealt with counterdata and automatically loaded over 16,000 authorizations to the system to try to make it easier for the migration.

Also during those first few months we actually had 10 folks at our senior staff level, myself included and some of the others here, to reach out to the top 10 providers on a weekly basis to basically ask, how are things going? Are your claims being paid on time? Because we wanted them to see that we were going to live up to the promise that we made and we would put everything in place that we possibly could to try to make this work.

MS. ALWINE: Of those top 10, were any of them represented here today?

MS. KUNIS: Yes. Absolutely.

MS. ALWINE: Which?

MS. KUNIS: Dr. Whiteman and Dr. Di Caprio.

MS. ALWINE: Two of the people that are complaining about the procedural problems.

MS. KUNIS: That's correct.

MS. ALWINE: All right.

MS. KUNIS: So we automatically loaded authorizations to make it transitionally simpler. We offered cash advances to providers because we said, look, we know you're going from a capitated arrangement to a fee-for-service world. It's going to take a few months for revenues to level off so you're getting a regular cash flow, so we offered a graduated cash advance to be able to make it easier to get through the transition. Unfortunately, we had two providers that were interested in that. The others thought it would be too hard to manage in their own practices to go that route, so we didn't provide cash advances to those providers. We did do executive outreach. We actually tracked with every single report to our customers about what we were hearing from the providers during those outreach efforts. The good news was we had some very positive feedback about, wow, you made my claims turn around in 14 days. You guys are really coming through.

Yes, there are things we needed to work on along the way. One of the concerns was their referral base was

changing. The business now was an open access network, so members can go where they choose to go. We also have known those providers for years as preferred providers in our system, so that when somebody comes in looking for care, the first name that pops up on the screen for authorization are the groups that have been seeing this membership population over the course of time. It will also provide other providers in that service area, but they were always listed first because again, we know these providers, we know the quality of work that they did, and while we're trying to transition and trying to make this a reasonable transition for them and the members, we're trying to do as much as we could to make it easier.

So those are the kinds of things. We implemented the on-line Internet authorization for initial authorizations. Obviously today, that probably wasn't a good idea, and the reason it wasn't a good idea is if I were a provider that had 50 patients a week, I would say this would be very effective for them. These providers have thousands of patients. Between the three of them today, you heard of 3,000 patients a week are being seen. That's a big volume, and that's what we need to address.

MS. ALWINE: So, from April 2004 to April 2005 is when all the new systems have come into play where the providers have a great deal of paperwork and it's more

different paperwork than they've done in the past. Is that a fair assessment?

MS. KUNIS: That's correct.

MS. ALWINE: So you can see where there are complaints, where their complaints appear to be office management complaints, they are actually quality of care complaints, and that's where our concern lies, and that's where we think we're getting too much of a broad stroke from you and not enough of what seems like picayune details, but that is where the problem lies.

For example, when -- I believe Danna is her name -- says that the call center performance complaints are anecdotal in nature, what could they otherwise be? You're talking about people calling up and they're getting a busy signal. How do I chart that and keep a record to complain to you? And anecdotal in this essence is a very pejorative way to paint a very real problem, which is the two hours I spend trying to get on the phone with you are two hours that I'm not providing my quality care to my patients. That's one example. I don't expect an answer to that.

The other question would be, you've got apples and oranges here. You've recently more than doubled service center training staff. You know, quantify that for us. Does that mean you had two, now you have five? When you're talking about the size of your service area, what are the

numbers here? These are things that seem very menial to you perhaps, but it is the essence of the problem they're coming to us with. There are not enough bodies, there are not enough people processing their paperwork, and this is affecting their quality of care. Can you quantify the extension of your new staff? Your Alpharetta, Georgia, staff has expanded from what to what?

MS. MEZIN: Sure. Just in terms of the training staff?

MS. ALWINE: Yes.

MS. MEZIN: We had no training staff in our Alpharetta, Georgia, office. All of the training that was provided for the Alpharetta--

MS. ALWINE: No, call center staff. People answering calls.

MS. MEZIN: There are about 250 people who are in our Alpharetta center. About half of those people are on the phones either being customer service associates and/or clinicians receiving phone calls.

MS. ALWINE: So now it's 125 people?

MS. MEZIN: We added, before bringing business from IBC down to Georgia, we added 150 people to our service center from the April timeframe to September.

MS. ALWINE: But prior to that, you have this increased number of providers and you're making due with less

than half that amount. I'm just trying to make you understand, this is where the complaints came from. This is the point at which we heard them.

MS. MEZIN: I'm sorry, we're not talking about the same thing then. We had previously serviced the IBC business in Pennsylvania, in Philadelphia, and we transitioned that work to Georgia, and we actually increased our staff as we transitioned it from Pennsylvania down to Georgia.

MS. ALWINE: Did we not hear that there was an increase in the number of providers in your network?

MS. MEZIN: No, our network remained the same.

MS. ALWINE: Okay.

MS. MEZIN: So we didn't increase the number of providers in the network, and the membership was the same. So the reasons that we increased is that we were growing the size of our center, we didn't have a dedicated training staff in that center, which we then added three dedicated instructors that are now in that center for 250 people, which we did a benchmark across the country to see what were the appropriate ratios in the type business that we're in for training--

MS. ALWINE: Well, there goes the broad stroke again. You're responding to very specific complaints in a very specific area. I'm not sure the national dynamic means a whole lot to the people who have come here and spoke to us

today.

MS. MEZIN: Well, I look at instructors and what was needed for us to be able to hire the number of people that we needed to have. We had small classes, there were about nine people in a class, so part of our bringing training staff in brought in additional incremental resources above the three that's now on on an ongoing basis. So the training staff that's there now, you know, is working on a day to day basis with all of our front line associates in formal training programs. We also have supervisors that are there to provide coaching on the clinical side, we have one supervisor for every 12 front line employees; on the customer service side, it's about 1 to 18.

MS. ALWINE: But none of this was in place last April, you're saying now it is in place. We're still trying to respond to the backlog that was presented to us today. I'm not being argumentative with you, I'm just trying to make it very clear that the more specific you are in addressing these very specific problems, the happier we'll be and we'll go away.

MS. MEZIN: But let me give you an example of the specific, because we have been trying to understand the issues and find specific ways to determine what's driving the problem. I think it was two days ago we got a complaint that someone tried to reach our provider services line and that

they could not get through, that they were on hold for over 20 minutes. We have a very sophisticated telephone system in our St. Louis office where our provider services line is. We went in and we looked at the four telephone calls that entire day that abandoned, which means somebody dialed in and waited for some specific amount of time before they chose to hang up. Anyone familiar with the Avaya telephone system, it's a very good phone system that we deploy in that center, as we do in our Alpharetta center. We went in and looked at every single phone call, each of those four phone calls to determine how long they held. We had two phone calls that held for six seconds before they hung up. Chances are they realized they dialed the wrong number and hung up the phone. We had another call, I think it was 30 seconds where they waited for 30 seconds until they abandoned, and the worst phone call was 1 minute, 25 seconds.

So when they came to us and said this is the day that I called, I called today and I waited for 20 minutes, we were not able to find a phone call in our system that hung up after waiting 20 minutes. So when we share the statistics that we have, we're trying to use data to understand where are the issues? Why is it that someone waited for 20 minutes? How can I find that problem? Do I have a gap in my staffing in a certain hour of the day that we need to increase our staff? So we are trying to be very specific and

understand the very specific complaints.

Some of the issues we've had a hard time finding out because they haven't been able to say here's the day that I called your staff or here is the person with whom I spoke. Whenever we have specific information, just like we went and looked at every phone call that abandoned that day, we are trying very hard to get to that detail so that we can understand what's driving this complaint. I sat down with our technology folks, I wanted to see every single treatment request form that processed in more than two days. I know the guideline is two days. We sat there and went through reams of paper for those that were submitted on paper, we looked at what came in through our system. We are taking these complaints very, very seriously and trying very hard to understand the interpretation and why is there a gap between what we're hearing from the providers and what we feel we're experiencing ourselves.

Are we measuring the wrong things? Are we looking at something that, and why isn't it reflective of their experience? And honestly, in some cases we have found that there was a problem someplace that caused a delay in a response going out. But I also think there are gaps, and if you don't mind me taking a little bit of liberty here, you know, we all saw the envelopes, The Miracle on 34th Street display of envelopes here, and the first thing I wanted to

say is, do we all understand that it's the State of Pennsylvania that requires us to send those envelopes? There is a requirement that for every authorization that we issue we have to send a letter out. We don't send letters out in every State. If it's not required by State law, we don't send it. So we require that here in Pennsylvania for those letters to be sent. I'm more than happy to have our providers go on-line where they can look up all of their authorizations and never send a letter out. Now, if we can get to a place together where, you know, we hear that they have about these letters and felt it necessary to bring them all here and say this is a bad practice, I sign up. Let's stop sending letters. I'm happy to not have to do that any longer.

So we're not trying to say we disavow ourselves that there are issues. We're trying to understand enough of the detail. I will personally be sitting down and figure out why is there a $37,000 or $47,000 gap or why are there claims that we have a provider who thinks that we've been dragging our feet? That's not our intention, and I would like to understand what causes that to happen. And if he can provide us those specifics, we'd be delighted to look at every piece of minutia to determine what caused that to happen.

MS. ALWINE: I'm sure that particular provider will be happy to provide you with his records from last year.

MS. MEZIN: And we invite him to do that.

MS. ALWINE: And we would like to encourage you to do more of that and a little less data research and a little more provider contact, and I think that's what all the people that were here today were asking, and it's not what they're receiving, and although you've said you haven't received any complaints until 30 days ago or 45 days ago, remember this has been going on in their practices for a long time and they are not in business to spend time on the phone with a subcontractor of a contractor that is supposed to be serving them. You made the business bid to take on this job, you're expected to do it, and if you can be out of sight and out of mind while you're doing it, all the better. They're in business to treat people who are ill; they're not in business to do paperwork.

MS. MEZIN: We certainly understand that. And to the extent that we can mitigate it, we're delighted to reduce the amount of paperwork that's involved. If there's a way that that can happen, we're not opposed to doing that.

MS. ALWINE: Okay, like I said, I didn't need a specific response to every, I think we're trying to wrap up here rather than have specific rather broad stroke responses, and I'd like to turn it back to Representative O'Brien, if I may.

CHAIRMAN O'BRIEN: I've had a sidebar conversation

with the Chairman of Health and Human Services, and we've decided we are going to have a second round of hearings. I'm glad that many of the Members have left so they wouldn't beat me up for intending to put them through this again, but I think it's important to look at the public side of this and see the parallels that exist.

Let me ask you this. We're running right up against another budget deadline. We have the Department of Health out here saying they're going to go look at this, and we're all going to go home for the summer and you guys are going to go out and play with your systems and do all that kind of jiggle-jaggle, and I don't mean that in a pejorative sense, but if I gave you a deadline of June 22, which happens to be my birthday, how would you give me a birthday present? How would you specifically, instead of waiting for the Department of Health or anybody else, how would you tell me right now you're going to involve this provider community that has expressed this interest here today and be honest and say by June 22, how are you going to involve them in a productive discussion, and what weight are you going to give their input?

MS. KUNIS: I will say to you today that we will invite the folks that represented each of the professional associations to sit down with us and literally go through every issue that's been out there and to try to work. One of

the things that was very clear to me as we went through the hearing this morning and hearing people's input is there is a lot of information that could help to clarify simply by providing information to the providers and doing some provider information that would be helpful so that they're not sending applications to the wrong place. Some of the things that I think would be helpful with we will do.

I will commit to you that we will sit down with those providers before June 22 to go through this process and actually start something again, the commitments that we're making, and rather the changes that we're making, but also to make sure that those are the things that are going to meet the need here. And I mean by June 22 we will meet with those professional provider associations and do what we need to do to start and maintain an ongoing dialogue with these issues.

CHAIRMAN O'BRIEN: Very specific issue, we've heard a lot about credentialing here today. What response are you going to bring to the table to put experience around that credentialing process so that we can say confidently that we're not going to have the delays, the reciprocity issues, the delays in credentialing that are going to keep people out of service? I want to hear something substantive. I went through the authorization process. What are you going to do to correct the credentialing issue?

MS. KUNIS: Well, I mentioned earlier--

CHAIRMAN O'BRIEN: I want a birthday present on that one too.

MS. KUNIS: Well, there has been an outside consultant hired to come in and literally look at these functions from front to back, and as a result of that, again, it's not attached to Magellan, this is somebody that's independent, that we would sit down and every recommendation or finding that comes out of that we will have to address an action plan around--

CHAIRMAN O'BRIEN: Action plan. Am I talking six months, a year, two years?

MS. KUNIS: There are things I can do--

CHAIRMAN O'BRIEN: I've heard action plans for 10 years. I'm sorry.

MS. KUNIS: Well, there are things I can do right away based on the things that we've heard and the information we've had shared with us, but we're also going to wind up having a list of recommendations that are going to come out of these audits that we will be implementing, and we will do that.

CHAIRMAN O'BRIEN: Let me ask you one specific thing. We heard, and I'm sure you heard from the Secretary of Health, I heard it, whatever the thing was when we had the meeting about somebody getting all these faxes and they would call back and call back and call back and say, I shredded

them. What did you do about that, when you heard that? Or if you're hearing it today, what would you do to somebody that did that?

MS. MEZIN: They would be fired.

CHAIRMAN O'BRIEN: Was that person fired that shredded those documents? Is that person still on payroll?

MS. MEZIN: We could not identify who it was, if it happened, and who it was.

CHAIRMAN O'BRIEN: So you still believe all this is anecdotal and not substantive?

MS. MEZIN: That's not what I'm suggesting here. What I'm suggesting is that where we're able to receive very specific information and we can go back and find out why something happened, then we're able to take corrective action. So in a case, and we had one provider who followed up and provided us a series of authorizations that he wanted loaded into the system, that was something that we were able to take a very concrete document, assign it to someone and manage it through. Where we don't have something specific, it's very hard for me to go find a shredded document. I'm not sure how I can do that. If you have suggestions, I'm open to it, but I don't--

CHAIRMAN O'BRIEN: I don't think this is funny. I don't think that's funny. I'm not asking you to go out and find shredded documents. I'm not asking you to prove a

negative. What I'm asking you, these are very, very--

MS. MEZIN: But I'm--

CHAIRMAN O'BRIEN: I'm not asking you to go find shredded documents. I'm asking you, there are very serious issues that have been going on here today. I want to know how you're going to respond to that. You've heard testimony. You heard the individual who said his documents were shredded. You heard somebody else who said I have $47,000 I can't collect. Why don't you say I'm going to meet with that person who said his documents are shredded instead of saying, how do I find documents that were shredded?

MS. MEZIN: We have said that we will meet with those providers and we will, and we'll do our best to understand the details of their issues, and where we have processes that can be changed or systems that will be enhanced, we have committed to you that those are the things that we will work on to do. So there's not a question that we want to provide good service to our partners who are providers. We're dependent on them for providing great care to the members that we're responsible for and that we service. So we have every reason to want to work with them and to solve their problems. It's a lot easier to fix those problems than to be here, I assure you of that.

CHAIRMAN O'BRIEN: Well, I don't know about that.

MS. MEZIN: It's not a love.

CHAIRMAN O'BRIEN: I'm sitting here as a legislator, as chairman of this committee, but I also wear other hats when I sit here has the secretary of a board and I'm on several nonprofit organizations and I am telling you, I've sat there with these credentialing issues for the last 12 years, not 10 years, when Independence Blue Cross owned Green Spring, I told you this, we had it for two years before they sold that business to you, and it never got changed. Never got changed. I find it difficult sitting here as Denny O'Brien and saying, you are now going to have this revelation and you want to fix this and you care about quality of care. I don't get it. I don't get it.

MS. MEZIN: Well, Chairman O'Brien--

CHAIRMAN O'BRIEN: Sharon Cole, do you have a question?

MS. COLE: Yeah. I know it's getting late, but succinctly, you agree, Danna and Sue, that prompt appropriate treatment gets people better, right? I mean, prompt appropriate treatment gets people better. Okay. Now, you said if you don't have subspecialists, psychiatrists, psychologist, that you would definitely let them go out of network. Okay, if they go out of network, and this is trying to follow the money, I'm trying to follow the money too, do you grant them a waiver? How long does it take them to get the waiver to go out of network?

MS. KUNIS: There is no waiver, so to speak. What we'll do is we'll find a provider out of network for them, and then we'll talk to the provider about we need you to take care of this patient, we'll be responsible to pay you, so to try to take the patient out of it. The patient doesn't have to do anything, it's really making arrangements with a provider to see that patient. And we'll pay that whatever we can to get that patient in.

MS. COLE: Okay, who's responsible for making certain that there are those specialists in the network?

MS. KUNIS: We are responsible to make sure that we have a broad access network that has a mix of providers with various specialties. There are certain provider types such as child adolescent psychiatry. The demand nationally is five times the availability, so that's a real concern. The second is eating disorder programs that are hard to find. Those type of specialties may not always be in the network, but we need to find them.

MS. COLE: So you're saying you don't need a waiver with Magellan, but you just call and make it all happen and you don't make the patient have to do any of this work. All right. So then if that's the case, how much is covered by the claim? If they go out of network, because you don't have the providers to service that person appropriately, I mean, you might have a psychiatrist who can service someone with

depression or someone that can serve an adult but not a child, so you should be sending them to the specialist so they can get the proper, appropriate care they can get, now how much is that going to be covered by the individual? Are you going to pay the 100 percent that should have been covered if you had the specialist in your program, or are you going to pay 50 percent?

MS. KUNIS: The way it works is if we need to go out of network to find a specialty provider to handle a member's treatment, that we will treat that as though it were in network care. So the member would have no additional liability than they would had they been in network.

MS. COLE: You really think that person who's sick is getting that message, is understanding that? I'm under the impression a lot of people believe that they're going to have to pay 50 percent higher than what they have to pay if they went to that specialist.

MS. KUNIS: My only response basically is that we generally again work this through with the provider so the provider knows ahead of time what they're going to get paid so that in their conversation with the patient they would tell them that they won't have any financial liability.

MS. COLE: How timely is that done?

MS. KUNIS: That happens right at the time when the person is seeking treatment.

MS. COLE: Okay, thank you.

CHAIRMAN O'BRIEN: Dana.

MS. ALWINE: Denny just asked me if I had any follow-up question. I just have a follow-up statement to make just to clarify, and this is not a broad stroke and this is not superficial. From our viewpoint as Representatives and staffers here, we see you, you stand in a service relationship to these providers and to their clients, and we would ask you to be mindful of that as you forge whatever solution you're going to work on on a case-by-case basis, on a person-by-person basis is to remember how that relationship is structured and that if your systems, either your old or your new, are not meshing with their ability to provide what they are being paid to provide, then the give has to come from you. They're doing what they're supposed to be doing. You're a subcontractor working for a contractor, you service them. And we would ask you to be mindful of that structure as you go forward from here, and I know we'll be following up.

Thanks.

MS. KUNIS: Understood.

CHAIRMAN O'BRIEN: Someone just suggested that my using this chairmanship here to solicit birthday presents sounds like reflective of some other problems that are going on in this environment, and that wasn't my intention.

MS. MEZIN: We will be getting copies of the record.

CHAIRMAN O'BRIEN: I believe we have literally exhausted this issue for today, and so this hearing is adjourned.

(Whereupon, the proceedings were concluded at 4:07 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

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ANN-MARIE P. SWEENEY

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