Louisiana Coordinated System of Care: Annual Evaluation of the Quality Program

Magellan in Louisiana
Contracting Period: December 1, 2016-December 31, 2017

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Introduction

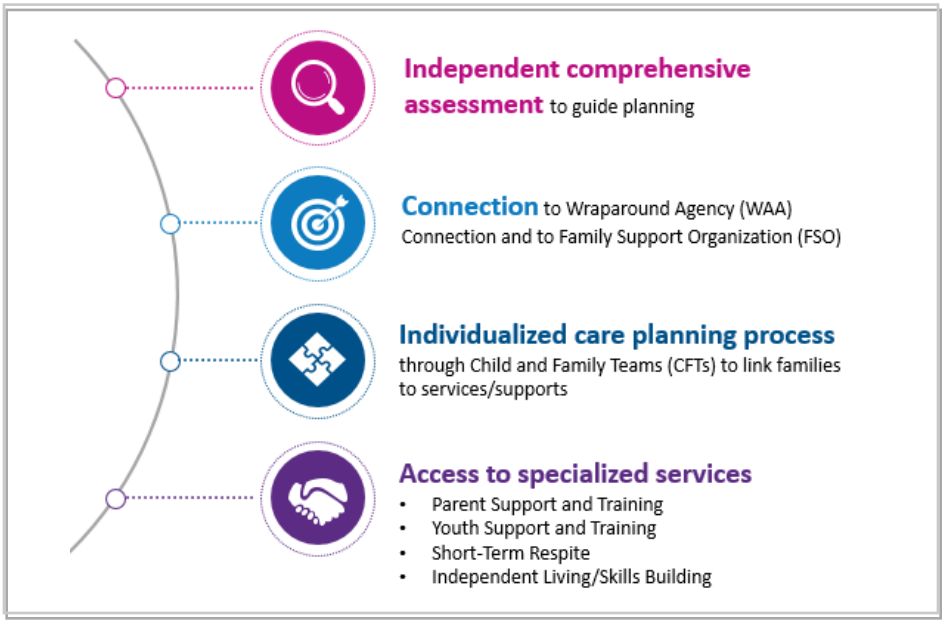
The Coordinated System of Care (CSoC) is an innovative approach to offering behavioral health care services for children/youth and their families in Louisiana that is based on system of care values and wraparound principles. This initiative serves families of children who have complex behavioral health needs and are either in or at risk of being in an out-of-home placement. The family-driven and coordinated approach of CSoC is meant to create and oversee a service delivery system that is better integrated, has enhanced service offerings, and achieves improved outcomes. This is accomplished by ensuring families who have children with severe behavioral health challenges get the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider, to keep or return children home or to their home communities. The goals of the CSoC are as follows:

- To reduce state's cost of providing services by leveraging Medicaid and other funding sources as well as increasing service effectiveness and reducing duplication across agencies,
- To reduce out of home placements in the current number and future admissions of children and youth with significant behavioral health challenges and co-occurring disorders,
- To improve the overall outcomes of children and their caretakers, and
- To increase member and caregiver voice and choice in treatment.

Families enrolled in CSoC receive individualized care planning and management, also known as wraparound, provided by a Wraparound Agency. A Wraparound Facilitator is assigned to each family to engage, support and guide the member through the wraparound process. Under the guidance of the facilitator, the family and child collaborate with a team of people, known as a Child and Family Team (CFT), to develop a single plan that meets the needs of the youth. It is through the process of combining all services into one coordinated plan that there is an opportunity to create better communication and collaboration among families, youth, state agencies, providers, and others who support the family. Children and families enrolled in CSoC are eligible for all of the services available through traditional Medicaid plus specialized treatment planning and services offered through CSoC. Figure 1 provides an illustration of the benefits of CSoC, including access to the following waiver services:

- Parent support & training
- Youth support & training
- Short-term respite
- Independent Living Skills and Skills Building

Figure 1: Benefits of CSoC



Implementation of CSoC in Louisiana was done in two phases, with the state being divided into nine regions. Phase one was initiated in March 2012 and consisted of the implementation of five regions, with a capacity to serve up to 1,200 youth and families. Phase two, which included the implementation of the remaining four regions, was completed in November 2014 and increased the enrollment capacity to 2,400 youth and families. Since 2012, CSoC has served over 11,400 members (duplicated), which represents 6,797 unique member lives (unduplicated). Year over year membership in CSoC grows, with a 10% increase in membership from 12/04/2015 to 12/29/2017, as shown in Table 1.

Table 1: Enrollment at End of the Contract Year

Point in Time	Membership	Percent of Growth from 12/04/2015
12/04/2015	2,030	-
11/25/2016	2,194	8.1%
12/29/2017	2,231	9.9%

Magellan has played a vital role in the implementation and development of CSoC in Louisiana. During initial implementation, Magellan of Louisiana served as the State Management Organization (SMO) responsible for managing and administering Medicaid and non-Medicaid behavioral health services, including CSoC, for children and adults. As the SMO, Magellan's System Transformation Department was dedicated to CSoC operations with the goal of facilitating synergies with both our providers and our customer. The department was responsible for educating and training providers and the community on wraparound principles, ensuring compliance with waiver requirements, fostering provider understanding of managed care principles, and providing technical assistance to ensure the success of the CSoC program. In December 2015, the Healthy Louisiana plans, or Louisiana's Managed Care Organizations, became responsible for managing both physical and behavioral health services under the direction of the Louisiana Department of Health (LDH) and Medicaid; however, due to the complexities of the program, CSoC remained a specialty behavioral health carve-out program. Through an RFP

process, Magellan was named the CSoC Contractor. As the CSoC Contractor, Magellan is committed to serving and empowering our membership as well as supporting LDH in the achievement of CSoC goals and program advancement.

Since 2012, Magellan has been dedicated to maintaining a network of qualified Medicaid behavioral health and waiver service providers in sufficient numbers and locations throughout the state to meet the needs of members enrolled in CSoC to ensure member choice in treatment. This network includes a Wraparound Agency for each region and a statewide Family Support Organization (FSO), both of which are certified by LDH and contracted with Magellan. The FSO is responsible for meeting the Parent Support and Youth Support service needs of all the state's CSoC members. All other waiver and specialized behavioral health service providers are contracted with Magellan. Magellan continuously evaluates the accessibility of services and implements a robust provider-monitoring plan to ensure the delivery of culturally competent, quality services to our membership. Magellan works collaboratively with providers and LDH to identify solutions to improve the quality of service delivery and adherence to federal and state requirements.

This report serves an annual evaluation of the CSoC Quality Improvement (QI) Program to evaluate outcomes, assess goal achievement and to identify opportunities for improvement in the ongoing provision of high-quality care and service to members. This evaluation is an internal practical document used by Magellan of Louisiana to analyze its status compared to performance and program goals, identify barriers or challenges as well as opportunities for improvement, and develop interventions to improve or promote care and service to the populations served. This document is not written for public consumption, rather it is intended to facilitate collaborative initiatives with the state, meet contract requirements, and provide a summary of the prior year's initiatives. This document is not a stand-alone document and includes information referenced in complementary annual reports. The following documents should be referenced to provide additional information as needed: Network Development and Management Plan, Annual Fidelity Review Report, Member Satisfaction Survey Report, Annual Performance Improvement Plan, Provider Performance Report, and Waiver Assurance Reports.

It should be stated that the date parameters referenced in the report are largely 12/01/2016 through 12/31/2017. When possible, comparisons are made to the previous year of 12/01/2015 through 11/30/2016. Please note there were was an adjustment made this year to the reporting periods to align them with the new waiver year quarters (i.e., calendar quarters) beginning on 07/01/2017. Because of this, many of the time periods and labels referenced in the report are nonstandard, including one quarter with four months and a year with five quarters. Table 2 specifies the dates and labels for the waiver year quarters that are referenced in the report.

Table 2: Waiver Year Quarter Date Parameters

Time Period	Label	Date Parameters
Waiver Year 4 Quarter 4	WY4 Q4	12/01/2015-02/29/2016
Waiver Year 5 Quarter 1	WY5 Q1	03/01/2016-05/30/2016
Waiver Year 5 Quarter 2	WY5 Q2	06/01/2016-08/30/2016
Waiver Year 5 Quarter 3	WY5 Q3	09/01/2016-11/30/2016
Waiver Year 5 Quarter 4	WY5 Q4	12/01/2016-03/31/2017
Waiver Year 5 Quarter 5	WY5 Q5	04/01/2017-06/30/2017
Waiver Year 1 Quarter 1	WY1 Q1	07/01/2017-09/30/2017
Waiver Year 1 Quarter 2	WY1 Q2	10/01/2017-12/31/2017

Time Period	Label	Date Parameters
Waiver Year 1 Quarter 3	WY1 Q3	01/01/2018-03/31/2018

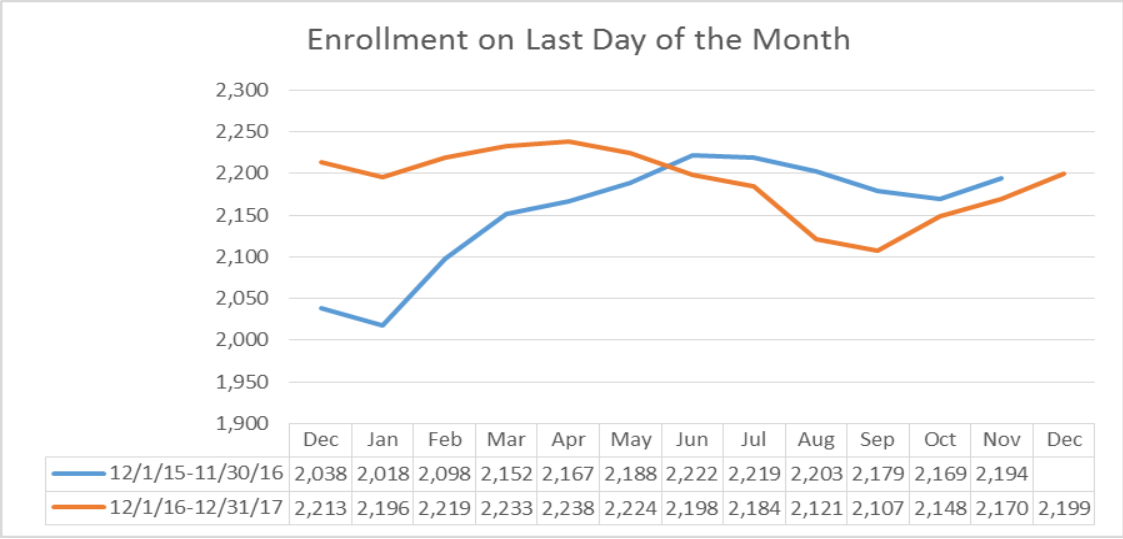
Demographics

Cultural competency in healthcare is described as the capability of providers to effectively render services that meet the cultural, social and linguistic needs of its members. It is believed that when members feel heard and understood by their providers, they are more likely to actively engage and participate in treatment, which can positively impact member outcomes. Awareness of member demographics is essential to ensuring services are delivered in a culturally competent manner. This section evaluates the demographic information for all unique members enrolled in the program from December 1, 2016 through December 31, 2017 as well as how Magellan approaches ensuring the cultural competency of its providers. The primary data source for member demographics is the combination of Medicaid eligibility data and Magellan's internal management system, Integrated Product's (IP), authorization data.

Enrollment

The CSoC program served a total of 4,329 members from 12/01/2016 through 12/31/2017. The average monthly enrollment was 2,154 members during 12/01/2015 through 11/30/2016 and 2,188 members during 12/01/2016 through 12/31/2017, which was an increase of thirty-four members. Regional enrollment is determined by the number of referrals received, and enrollment management must be flexible to adapt to changes in the census. Referrals and enrollment are evaluated by clinical staff on a weekly basis to ensure slot allocation meets the needs of the membership. Of the 4,329 members served in CSoC during this time period, Region 9 had the highest census, which was represented by Region 1 in the previous year. Region 5 represented the lowest enrollment region for the second year in a row. Several factors, including urban-rural classification can impact differences in regional enrollment. Figure 2 and Table 3 illustrate enrollment data.

Figure 2: Enrollment on the Last Day of the Month



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
12/1/15-11/30/16	2,038	2,018	2,098	2,152	2,167	2,188	2,222	2,219	2,203	2,179	2,169	2,194	
12/1/16-12/31/17	2,213	2,196	2,219	2,233	2,238	2,224	2,198	2,184	2,121	2,107	2,148	2,170	2,199

Table 3: Average Annual Enrollment by Region

	12/1/15-11/30/16		12/1/16-12/31/17	
Region	**Number**	**Percent**	**Number**	**Percent**
Region 1	631	15.9%	624	14.4%
Region 2	509	12.8%	475	11.0%
Region 3	492	12.4%	610	14.1%
Region 4	381	9.6%	480	11.1%
Region 5	277	7.0%	280	6.5%
Region 6	282	7.1%	353	8.2%
Region 7	382	9.6%	368	8.5%
Region 8	445	11.2%	449	10.4%
Region 9	563	14.2%	690	15.9%
Total	3962	100%	4329	100%

Age, Gender, and Race

Youth and children between ages five and twenty years are eligible for the CSoC program. The target age group of the CSoC program is youth between the ages thirteen to sixteen. In July 2017, there was a change to the age criteria for eligibility, shifting eligibility from birth through twenty-one years to five through twenty years. This amendment only affected members enrolled after 07/01/2017 and was implemented to better align the program with the target age group intended to be served by wraparound. Members enrolled prior to 07/01/2017 were allowed to continue enrollment until their natural discharge. The largest age group was sixteen year old members (n=432), which aligns with our target. Children ages eight to seventeen represented 80.6% of the membership, which aligns with the programs goals. Children under seven represented approximately 12.2% and eighteen and over represented 7.2%.

A majority of the CSoC members are males, representing 62.4% of the eligible members (n=2,702). The Black/African American race showed the highest percentage of the membership, representing 57.1% (n=2,474). White members were the second highest representation of the membership, denoting 35.9% (n=1,554). This aligns with research citing racial disparities for youth and children that are at high risk for commitment or arrest. Non-Hispanic/Non-Latino ethnicity represented 95.4% of the membership (n=4,128). The demographics of members served in CSoC has been stable the since the program's implementation and no notable trends that require action were dedicated. Tables 4 through 7 illustrate the demographic elements of enrollment.

Table 4: Age of CSoC Members

	12/1/15-11/30/16		12/1/16-12/31/17	
Age	**Number**	**Percent**	**Number**	**Percent**
1	0	0.0%	0	0.0%
2	5	0.1%	3	0.1%
3	20	0.5%	12	0.3%
4	51	1.3%	39	0.9%
5	84	2.1%	110	2.5%
6	119	3.0%	176	4.1%
7	184	4.6%	188	4.3%

	12/1/15-11/30/16		12/1/16-12/31/17	
Age	Number	Percent	Number	Percent
8	214	5.4%	242	5.6%
9	251	6.3%	295	6.8%
10	268	6.8%	337	7.8%
11	278	7.0%	321	7.4%
12	316	8.0%	362	8.4%
13	341	8.6%	380	8.8%
14	401	10.1%	400	9.2%
15	419	10.6%	427	9.9%
16	408	10.3%	432	10.0%
17	304	7.7%	295	6.8%
18	152	3.8%	165	3.8%
19	71	1.8%	75	1.7%
20	41	1.0%	42	1.0%
21	35	0.9%	24	0.6%
22	0	0.0%	4	0.1%
Total	3962	100%	4329	100%

Table 5: Gender of CSoC Members

	12/1/15-11/30/16		12/1/16-12/31/17	
Gender	Number	Percent	Number	Percent
Female	1463	36.9%	1627	37.6%
Male	2499	63.1%	2702	62.4%
Total	3962	100%	4329	100%

Table 6: Race of CSoC Members

	12/1/15-11/30/16		12/1/16-12/31/17	
Race	Number	Percent	Number	Percent
Black/ African American	2294	57.9%	2474	57.1%
White	1416	35.7%	1553	35.9%
Multi-Racial	32	0.8%	54	1.2%
American Indian/Alaskan Native	25	0.6%	43	1.0%
Asian	5	0.1%	6	0.1%
Native Hawaiian/Other Pacific Islander	2	0.1%	1	0.0%
Unknown	188	4.7%	198	4.6%
Total	3962	100%	4329	100%

Table 7: Ethnicity of CSoC Members

	12/1/15-11/30/16		12/1/16-12/31/17	
Ethnicity	Number	Percent	Number	Percent
Non-Hispanic/Non-Latino	3779	95.38%	4128	95.36%
Hispanic/Latino	38	0.96%	53	1.22%
Unknown	145	3.66%	148	3.42%

Ethnicity	12/1/15-11/30/16		12/1/16-12/31/17	
	Number	Percent	Number	Percent
Total	3962	100%	4329	100%

Language Classification

The language classification of members is important factor to monitor to ensure there is a sufficient number and type of service providers to meet the needs of the membership. The primary language for CSoC members is English, representing 99.28% of the CSoC population (n=4,298). Unspecified and Spanish language represented 0.37% and 0.23% of the population respectively. Magellan ensures that we are responsive to all members, not just the majority. If a provider is unable to meet the member's language needs, Magellan ensures that members have access to translation or interpretative services at no cost to the member. Magellan does this through a contract with Global Interpreting Network for translation services. Magellan also makes translated versions of important member documents, such as the member handbook, readily available to members in Spanish and Vietnamese on our website. All our formal notifications inform include instructions for our members on how to request translations as needed. Please see the Network Development Plan for more information on the provider demographics related to language. Table 8 shows details for the primary language of membership.

Table 8: Primary Language

Language	12/1/15-11/30/16		12/1/16-12/31/17	
	Number	Percent	Number	Percent
English	3923	99.00%	4298	99.28%
Spanish	9	0.20%	10	0.23%
Cantonese	0	0.00%	1	0.02%
Vietnamese	0	0.00%	1	0.02%
Not Declared	0	0.00%	3	0.07%
Unspecified	30	0.80%	16	0.37%
Total	3962	100%	4329	100%

Geographic Classification

Where the member resides plays an important role for the member from both a cultural standpoint as well as access to care. Understanding the geographic setting is vital to ensuring each member's needs are evaluated in context of the resources available to them. In the CSoC program, the majority of members, or 71.4% (n=1,644), resided in rural setting, while the remaining 28.6% (n=657) resided in urban settings.

One of the characteristics of rural areas is there can be less access to formal providers. As a result of this, the people in rural settings are entrepreneurial, creative and resourceful in identifying ways to meet their needs. Magellan uses the data to identify areas that require specific network development activities to increase access to care and freedom of choice among providers for rural areas. Magellan also recommends that Wraparound Agencies serving rural areas emphasize training and coaching opportunities to increase natural and informal support engagement as a mechanism to mitigate decreased access to formal service providers for these areas. Table 9 provides the breakdown of rural and urban membership for Louisiana.

Table 9: Geographic Classification on Last Day of the Year

	11/30/16		12/31/17	
Member Group	**Number**	**Percent**	**Number**	**Percent**
Urban/Suburban	765	32%	657	28.6%
Rural	1,624	68%	1,644	71.4%
Total	2,389	100%	2,301	100%

Diagnosis

Understanding the diagnostic prevalence of our membership is essential for the effective management of a healthcare program and allows for the promotion of evidenced based practices for the treatment of the most common seen diagnoses. To support our providers, Magellan adopts, develops and distributes clinical guidelines based on sound scientific evidence, clinical best practices, and member needs. Magellan requires our providers to be familiar with these guidelines, including the following diagnoses and conditions:

- Acute Stress Disorder
- Post-Traumatic Stress Disorder
- ADHD
- Autism
- Bipolar Disorder
- Depression
- Generalized Anxiety Disorder
- Managing Suicidal Patients
- Obsessive-Compulsive Disorder
- Panic Disorder
- Schizophrenia
- Substance Use Disorders

Attention Deficit Hyperactivity Disorder (ADHD), all types, represented the highest diagnostic prevalence rate for the CSoC program, with 37% of membership with an ADHD diagnosis. This is consistent with previous years. Mental Disorder, Not Otherwise Specified and Oppositional Defiant Disorder diagnoses represented second and third highest diagnostic category. Due to the large number of members diagnosed with ADHD, Magellan emphasizes providers' adherence to clinical practice guidelines for the treatment of ADHD and monitors provider compliance through the treatment record review process. This process is describe in detail in the Provider Monitoring section of this report. Table 10 provides the primary diagnostic prevalence for members over the past two years.

Table 10: Primary Diagnosis for CSoC Members

	12/1/16-12/31/17		12/1/15-11/30/16	
Diagnosis	**N**	**%**	**N**	**%**
F90.9: Attention-deficit hyperactivity disorder, unspecified type	705	16.29%	767	19.36%
F90.2: Attention-deficit hyperactivity disorder, combined type	644	14.88%	511	12.90%
F99: Mental disorder, not otherwise specified	442	10.21%	595	15.02%
F91.3: Oppositional defiant disorder	380	8.78%	367	9.26%

	12/1/16-12/31/17		12/1/15-11/30/16	
Diagnosis	**N**	**%**	**N**	**%**
R69: Illness, unspecified	363	8.39%	106	2.68%
F43.20: Adjustment disorder, unspecified	189	4.37%	164	4.14%
F90.1: Attention-deficit hyperactivity disorder, predominantly hyperactive type	155	3.58%	141	3.56%
F32.9: Major depressive disorder, single episode, unspecified	143	3.30%	101	2.55%
F84.0: Autistic disorder	142	3.28%	110	2.78%
F43.25: Adjustment disorder with mixed disturbance of emotions and conduct	104	2.40%	86	2.17%
F43.8: Other reactions to severe stress	86	1.99%	n/a*	
F31.9: Bipolar disorder, unspecified	81	1.87%	71	1.79%
F90.0: Attention-deficit hyperactivity disorder, predominantly inattentive type	77	1.78%	49	1.24%
F43.10: Post-traumatic stress disorder, unspecified	60	1.39%	51	1.29%
F39: Unspecified mood [affective] disorder	57	1.32%	80	2.02%
F91.9: Conduct disorder, unspecified	52	1.20%	94	2.37%
F43.24: Adjustment disorder with disturbance of conduct	50	1.16%	n/a*	
F33.1: Major depressive disorder, recurrent, moderate	35	0.81%	45	1.14%
Other	564	13.03%	541	13.65%
Unspecified	0	0.00%	0	0.00%
Total	4329		3962	

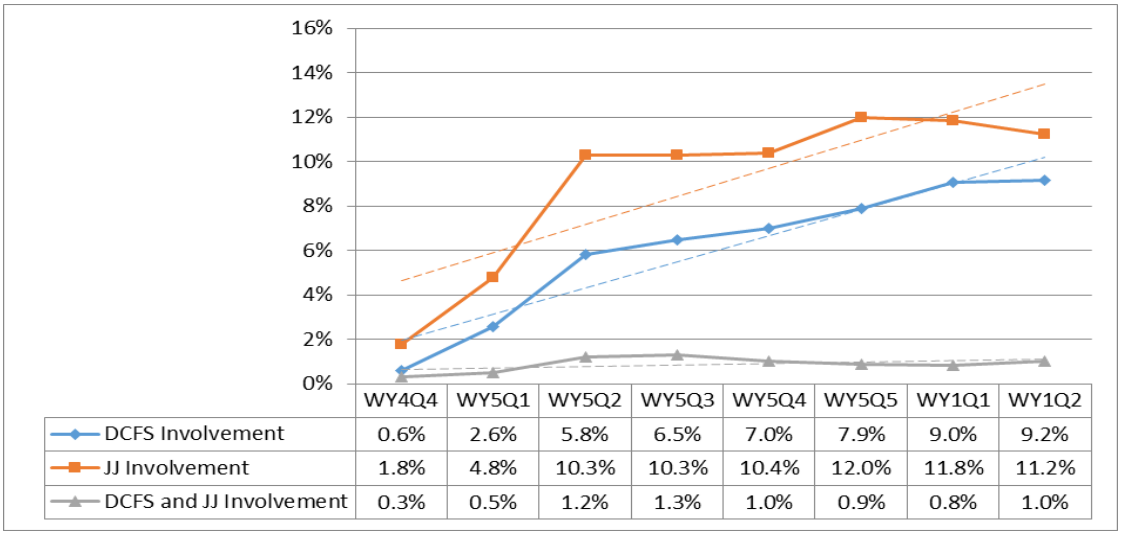
* Diagnosis did not make the top 18 in CY5

Involvement in Child-Serving State Agencies

Members enrolled in CSoC are often involved in one or more of Louisiana's child-serving agencies, including the LDH, Louisiana Department of Education (LDOE), Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ). CSoC provides a mechanism to bring all of these agencies together into one coordinated network to offer our members the right services, at the right time, at the right level of intensity, for the right amount of time, from the right provider. DCFS, LDOE, and OJJ all have representation on the CSoC Governance Board, which has oversight over the program and informs programmatic goals and activities.

In the final quarter of the year (i.e., 10/01/2017-12/31/2017), approximately 21.4% of CSoC members were involved with child-serving agencies. This was an increase from the 18% observed in the final quarter of the previous year. This included 9.2% of members with DCFS involvement, 11.2% with OJJ involvement, and 1.0% with both DCFS and OJJ involvement. Figure 3 provides a depiction of the quarterly trending of members with involvement in child-serving agencies. Magellan uses this data to support outcomes monitoring and relationship building for representation of these state agencies.

Figure 3: Percentage of Members with Child-Serving Agency Involvement



	WY4Q4	WY5Q1	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
DCFS Involvement	0.6%	2.6%	5.8%	6.5%	7.0%	7.9%	9.0%	9.2%
JJ Involvement	1.8%	4.8%	10.3%	10.3%	10.4%	12.0%	11.8%	11.2%
DCFS and JJ Involvement	0.3%	0.5%	1.2%	1.3%	1.0%	0.9%	0.8%	1.0%

Average Length of Stay

Average Length of Stay (LOS) is an important indicator when managing enrollment. Because the CSoC program has a maximum enrollment of 2,400 members, it essential for children to remain in the program for the right length of time to achieve positive outcomes but not too long to impede other eligible members from entering the program. The recommended length of stay for wraparound programs in other states is 18 to 24 months; however, implementation differences, such as program funding sources, the assessment process, and eligibility criteria, could impact this. The 1915(c) waiver governing this program assumes a 9-month average length of stay. The table below provides LOS detail by statewide total and region. Average LOS is impacted by the phased implementation approach for CSoC in which Regions 1, 2, 5, 8, and 9 were implemented in March 2012 and the remaining regions were implemented in November 2014. For 01/01/2017 through 12/31/2017, the statewide average LOS was 365 days, an increase of 34 days from the previous year average (n=331 days), and the median LOS was 326, also an increase from the previous year's median (n=261 days). It is believed this increase is affected by the decreased influence of 2-phased implementation and the increase period of time for the second-phase regions to be fully implemented. Region 1 had the highest average LOS (n=565.67), which was 124 days longer than the second highest region (i.e., Region 4). In 2016, Magellan has implemented more targeted management of members with LOS equal to or greater than 540 days. Members that meet this criteria require a CANS eligibility assessment to be administered once every 90 days, as compared to once every 180 days for those enrolled less than 540 days. This allows Magellan and wraparound facilitators to more closely monitor clinical eligibility as the member moves toward transition out of CSoC.

One of the goals that Magellan set related to LOS is to decrease the percentage of members enrolled in CSoC longer than eighteen months by 10%. As of 12/01/2016, 13.6% of youth enrolled in CSoC had been enrolled for greater than eighteen months and 1.3% (inclusive) had been enrolled more than thirty-six months. As of 01/01/2018, 15.1% of youth enrolled in CSoC had been enrolled for greater than eighteen months and 0.6% (inclusive) had been enrolled for more than thirty-six months. In late 2016, Magellan implemented a plan to address longer lengths of stay of the identified youth, which included

weekly internal staffings that include the CSoC Medical Director, care managers, CSoC coordinators, and clinical leadership to review plans of care and specific youth needs, requiring a CANS eligibility assessment to be completed every ninety days, and active collaboration between Wraparound Agencies and Magellan to address barriers to transition. Early in the intervention, there were improvements in the number of youth enrolled greater than eighteen months (12.97% in February), but those gains were lost during the summer months. However, there were much better results in decreasing the number of youth who were enrolled greater than thirty-six months, with a change from 1.29% of youth to 0.56% of youth representing a 43% decrease in the number of those youth. Table 11 outlines the LOS details for the previous year.

Table 11: Length of Stay of CSoC from 01/01/2017 through 12/31/2017

Region	# of Members Discharged - Previous 12 Months	Average Length of Stay	Median Length of Stay	Minimum Length of Stay	Maximum Length of Stay	Number of Youth Discharged Before 30 Days or Less After Enrollment	Number of Youth Discharged Between 31 and 90 Days After Enrollment	Number of Youth Discharged Between 91 and 180 Days After Enrollment	Number of Youth Discharged Between 181 and 360 Days After Enrollment	Number of Youth Discharged After 360+ Days of Enrollment
1	280	565.67	536.5	25	1,428	2	14	39	46	179
2	271	367.83	346	22	1,153	2	28	68	55	118
3	326	323.21	276	10	927	1	32	110	81	102
4	183	442.07	360	33	900	0	6	40	48	89
5	155	263.39	242	22	694	2	8	56	64	25
6	180	291.72	180	59	995	0	8	84	50	38
7	189	291.20	231	17	1,079	1	11	78	58	41
8	263	291.50	220	27	900	2	31	98	65	67
9	304	382.23	334	40	989	0	20	88	84	112
All Regions	**2151**	**365.21**	**326**	**10**	**1428**	**10**	**158**	**661**	**551**	**771**

Cultural Competency

Magellan is committed to a strong cultural diversity program, including tribal awareness. Magellan recognizes the diversity and specific cultural needs of its members and has developed a comprehensive program that addresses these needs in an effective and respectful manner. The Magellan method for provision of care is compatible with the members' cultural health beliefs and practices and preferred languages. Aspects of this philosophy and approach are embedded throughout the Magellan Cultural Diversity Program. The analysis of race and ethnicity presented above provides a guiding framework for tailoring a cultural competency program for the Louisiana CSoC CMC. Guiding principles for the Magellan Cultural Competency Program include:

- Acknowledging and respecting variance in behaviors, beliefs, and values that influence mental health and incorporating those variables into assessment and treatment.
- Emphasizing member-centered care in the treatment and discharge processes.
- Incorporating natural supports such as family involvement and traditional healing practices when appropriate.

- Encouraging active participation of the member and family in treatment. Incorporating adequate opportunities for feedback from members regarding policies and procedures.
- Monitoring an adequate provider network to ensure services are geographically, psychologically, and culturally accessible to consumers and families.
- Developing a comprehensive program to promote cultural sensitivity and competence.
- Promoting the integration of primary care, mental health care, and substance use services.

Magellan maintains a strong focus on continuous quality improvement. Each department manager or supervisor is accountable for the success of the program through the integration of the principles of cultural competency in all aspects of organizational planning and working to assure cultural competence at each level within the system. The Louisiana CSoC CMC coordinates input from a variety of stakeholders, including administrative staff, front line employees, consumers and community organizations for the development and operation of the Cultural Competency Program. Magellan's Utilization Management Committee and the Quality Improvement Committee are established to ensure the quality management program reviews and analyzes program data to evaluate racial and ethnic disparities in utilization patterns, outcomes, satisfaction, and provider cultural competency. These committees oversee the cultural competency work plan and report to the Quality Improvement Committee (QIC). As referenced above, the QI Program includes indicators to assure equal delivery for all services described in the program description. Indicators include, but are not limited to:

- Member grievances and provider complaints, including monitoring of grievances for issues that are potentially related to culturally insensitive practices.
  - There were no grievances related to cultural issues from 12/1/2015 through 12/31/2017.
- Network access and availability measures including the availability of individual practitioners, organizational providers, and providers who share the members' ethnic or language preference that are within a reasonable distance and timeframe (see Provider Network Demographics in this section).
- Treatment Record Review monitoring.
  - Magellan also monitors providers to ensure services are delivered in a culturally competent manner. Magellan includes two elements in the audit tools that are utilized to monitor for documentation for quality standards. Over the course of the contract year, twenty-four providers participated in Treatment Record Reviews to monitor documentation and record keeping practices. Eighty-three records were reviewed, with all records showing evidence that treatment was being provided in a culturally competent manner for a compliance rate of 100%. No systematic areas of need were identified.
- Satisfaction survey data related to cultural competency.
  - Member perception of the experience of care is an essential component of monitoring the quality of provider service delivery Magellan administered a survey based on the CAHPS Experience of Care and Health Outcomes (ECHO) Survey. There was one question that assessed satisfaction related to cultural competency of service delivery. Results showed improvements compared to 2016 administration and details are in the Table 14.

Table 14: Cultural Competency Satisfaction Survey Detail

Question Details	Number	2017	2016	Change from Previous Administration
In the last 6 months, did the care your child received	1017	93.2%	85.5%	7.7%

Question Details	Number	2017	2016	Change from Previous Administration
meet his or her language, race, religion or cultural needs?				

To support our commitment to ensuring services are provided in a culturally competent manner, Magellan provides our providers with the tools necessary to develop awareness, knowledge, and skills to improve the delivery of culturally appropriate care. Magellan requires providers to have three hours of cultural competency trainings, including tribal awareness, per year. Providers can complete all four of Magellan's training modules or provide evidence of alternate training to fulfill this requirement. The four modules include:

- The Hispanic/Latino Community in Louisiana
- Louisiana Native American Indian Tribes
- Vietnamese in Louisiana
- Why Cross-Cultural Competency

Magellan monitors provider compliance for Cultural Competency training requirements. Please see the Provider Monitoring Activities section for further details on this process.

Program Objectives and Work Plan Evaluation

The purpose and scope of the Louisiana CSoC Quality Work Plan is to set forth all the performance measures and activities for services managed by Magellan as the CSoC Contractor for LDH. It outlines and describes the specific activities to be conducted during 12/01/2016 through 12/31/2017 to meet contract requirements identified in the CSoC Statement of Work (SOW), promote the quality process throughout the organization, and support the objectives of the Quality Program. Please see Appendix A for details on the type and number of Magellan resources allocated to the CSoC Quality Program to ensure compliance with contract deliverables.

With a focus on care and respect for the individual, Louisiana CSoC staff members apply clinical expertise to assist members during challenging times. Magellan provides innovative solutions to our customer and members alike, and collaborates with providers to positively influence the health and well-being of individuals. Magellan consistently endeavors to maintain high-quality clinical care with a focus on patient safety and providing preventive behavioral health services while promoting the goals and values of CSoC, including:

- Family driven
- Youth guided
- Team-based
- Culturally and Linguistically Competent (in a way that the family is comfortable)
- Home and Community based
- Strength-based
- Individualized
- Integrated Across Systems (bringing agencies, schools, and providers together to work with families)
- Connected to Natural Helping Networks
- Data driven and outcomes oriented
- Unconditional Care

Magellan's organizational vision and mission statements align directly with the goals and values of CSoC. They include:

- Vision: Sparking innovation to build healthier and brighter futures.
- Mission: Magellan guides individuals to make better decisions, and live healthier and more fulfilling lives, by improving the overall quality and affordability of healthcare.

In keeping with the vision and mission of Magellan and goals set forth by LDH, Magellan established the following prioritized objectives as part of our Quality Work Plan:

1. Monitor sub-contracted provider activities to ensure compliance with federal and state regulations, waiver requirements, and all other quality management requirements to allow for continued leverage of funding sources as evidenced by:
    - Showing overall network performance above 90% for Treatment Record Reviews (TRRs).
        - **Met Goal:** A total of twenty-four providers from all provider types were selected for review. The provider network mean score showed a performance rate of 91%, which exceeded goal by one percentage point. Please see Provider Monitoring section for more details on this process.

- Increasing compliance with Clinical Practice Guidelines (CPG) as evidenced by ninety percent (90%) or more of the providers reviewed as outlined in TRR plan were consistently in compliance with a performance rate of 80% as outlined in 9.4.7. of the SOW.
  - **Met Goal:** Because of the demographics of CSoC members, ADHD and suicide risk CPGs were selected to be audited as part of the LDH approved TRR plan. No member records reviewed triggered the criteria for the suicide risk CPG module. Ten providers triggered the ADHD CPG audit tool (i.e., member diagnosed with ADHD). Of those providers, the compliance rate was 100% (30/30), which exceeded the goal.

2. Exhibit high level of member and provider satisfaction with Magellan.
   - Show satisfaction at a rate equal to or greater than 80% positive on more individual survey elements in 2017 as compared to the 2016 administration.
     - **Goal Met:** Magellan administered a survey based on the CAHPS Experience of Care and Health Outcomes (ECHO) Survey in 2017. There were a total of thirty-two questions assessing satisfaction in the 2016, with 53.1% of questions equal to or greater than 80% positive. In 2017, there were twenty-five questions assessing satisfaction, with 68% equal to or greater than 80% positive, which achieved our goal. Please see Member Satisfaction section of this report for further information.
   - Exceed 90% in overall provider satisfaction.
     - **Goal Met:** Magellan administered the Magellan Provider Satisfaction Survey questionnaire designed by Magellan's Surveys Department. In 2017, the overall satisfaction with the services provided by Magellan was 95.9%, an increase of 1.2 percentage points from 2016 (n=94.7%). This rate exceeded our goal by 5.9 percentage points. Please see Provider Satisfaction section of this report for further information.
   - Meet and/or exceed national mean scores for youth and caregiver satisfaction with his or her experiences in wraparound as measured by the Wraparound Fidelity Index, Short Form (WFI-EZ).
     - **Goal Met:** The WFI-EZ survey provides essential information on the adherence to fidelity, outcomes and satisfaction. Youth and caregivers reported high satisfaction with their wraparound experiences through this survey. Overall caregiver satisfaction showed high rates, with regions ranging from 83% to 91% and seven regions above the national mean of 79.9%. Youth satisfaction ranged from 77% to 91%, with seven regions scoring above the national mean of 76.7% and one region equal to the national mean. This high level of satisfaction was also reflected when looking at item level details. Both caregivers and youth showed higher rates of satisfied than the seen in the national means for all four items assessed (i.e., process/participation, youth progress, family progress on meeting needs and confidence in the ability to care for youth in own home).

3. Ensure consistent application of high fidelity to the wraparound model by meeting and/or exceeding national mean scores for total fidelity scores as measured by the WFI-EZ.
   - Show improvement in mean scores for items identified as low-scoring items for Caregiver, Youth and Facilitator Surveys.
     - **Met Goal:** Magellan implemented a fidelity monitoring system using the WFI-EZ to confirm the core elements of wraparound facilitation are maintained in accordance with the standards of practice established by the National

Wraparound Initiative (NWI). The measurement of fidelity is meant to support program improvement and identify areas of strengths and opportunities for improvement. Fidelity was evaluated using three WFI-EZ survey types, including youth, caregiver and facilitator. The total fidelity scores in Louisiana for all respondent types were higher than the national mean, particularly the caregiver score at 3.5 percentage points higher than the national mean. There were also improvements for all respondent types in the number of items statistically identified as low scored items, with caregiver respondents showing three items identified in 2016 and no items in 2017. The Annual Fidelity Review Report provides a full analysis of the fidelity monitoring results.

4. Improve the quality of assessments and Plans of Care submitted by Wraparound Agencies, thereby providing youth and families with effective care, as evidenced by improvements in the Louisiana Department of Health (LDH) agreed upon Best Practice indicators to be implemented in contract year two.
    - **Met Goal:** Magellan dedicated to waiver compliance and employs specially trained staff, known as CSoC Coordinators, to monitor and ensure compliance of the Wraparound Agencies with Plan of Care performance measures. The Plan of Care elements monitored through this documentation process showed high levels of compliance, with all measures exceeding the minimum threshold of 90%.
5. Promote post hospital appointment scheduling and other hospital aftercare Best Practice adherence, as evidenced by exceeding the National Committee for Quality Assurance (NCQA) 50th percentile (≥ 46%) for 7-day Follow-Up after Hospitalization (FUH) for Mental Illness rates by four percentage points, or ≥ 50%.
    - **Met Goal:** FUH measures monitor how quickly members attend an outpatient appointment following a discharge from an inpatient hospital admission, with a standard of being seen within 7 and 30 days from discharge. It is believed that integrating members into outpatient services as soon as possible following an inpatient hospitalization can reduce recidivism and improve outcomes for members. The 7-day FUH preliminary rates for 01/01/2017 through 12/01/2017 were 53.7% and 64.4% for HEDIS and Modified HEDIS (i.e., includes peer services) respectively. CSoC achieved the goal of exceeding 50th percentile for 7-day FUH (i.e., 46%) for the standard HEDIS group. This metric is affected by claims-lag for outpatient claims and final results will be reported in April 2018. Please see the Outcomes section for more information on FUH measures.
6. Improve community tenure as evidenced by percentage of children/youth requiring inpatient hospitalization less than or equal to five percent.
    - **Goal Met:** Community Tenure is measured and reported quarterly. In the period of 12/01/2016 through 03/31/2017, 5.5% of enrolled youth experienced an inpatient stay (note, this is a four-month quarter), 4.6% for 04/01/2017 through 06/30/2017, 4.8% for 07/01/2017 through 09/30/2017, and 4.5% for 10/01/2017 through 12/31/2017. This goal was achieved due to the number of youth presenting for hospitalization and not as a result of denials of initial inpatient authorization. Even with these satisfactory outcomes, Magellan is working with the Wraparound Agencies to intervene to minimize avoidable hospitalizations by focusing on utilization of crisis intervention services, improving the quality of crisis plans, and implementing the Wraparound Best Practices document that was disseminated by LDH in January 2018. Please see Accessibility of Care section for more details on inpatient utilization interventions.
7. Decrease the percentage of members enrolled in CSoC longer than 18 months by 10%.

- **Improvement Needed:** As of 12/01/2016, 13.6% of youth enrolled in CSoC had been enrolled for greater than eighteen months and 1.3% (inclusive) had been enrolled more than thirty-six months. As of 01/01/2018, 15.1% of youth enrolled in CSoC had been enrolled for greater than eighteen months and 0.6% (inclusive) had been enrolled for more than thirty-six months. In late 2016, Magellan implemented a plan to address longer lengths of stay of the identified youth, which included weekly internal staffings that include the CSoC Medical Director, care managers, CSoC coordinators, and clinical leadership to review plans of care and specific youth needs, requiring a CANS eligibility assessment to be completed every ninety days, and active collaboration between Wraparound Agencies and Magellan to address barriers to transition. Early in the intervention, there were improvements in the number of youth enrolled greater than eighteen months (12.97% in February), but those gains were lost during the summer months. However, there were much better results in decreasing the number of youth who were enrolled greater than thirty-six months, with a change from 1.29% of youth to 0.56% of youth representing a 43% decrease in the number of those youth.

8. Improve clinical and functional member outcomes as evidenced by statistically significant improvements ($p \leq 0.05$) in the Child and Adolescent Needs and Strengths (CANS) global average scores.
    - **Goal Met:** In August 2017, Magellan conducted a CANS global and domain score median analysis of 2,754 members meeting the defined criteria. The mean length of stay for the sample was 10.2 months. The z-statistic was used to evaluate the median global and domain scores at the initial and discharge assessments to determine if the differences in scores were due to chance. This comprehensive analysis showed strong outcomes, including a seventeen percentage point change from initial to discharge. Both the global and domain scores, with the exception of the acculturation domain, showed strong significant improvement as evidenced by p value of equal to or less than .001. This means that there is confidence that the results are not the result of chance but rather result of the programmatic interventions. The low number of youth that triggered the acculturation item initially explains why this domain did not show statistically significant improvements. Please see the Outcomes Section for a full summary of outcomes data collected this year.
9. Show statistically significant improvement ($p \leq 0.05$) in school functioning as evidenced by improvements in admission and discharge CANS School Module scores.
    - **Goal Met:** The same CANS analysis showed the average school domain score decreased from 7.8 to 4.6, which represented statistically significant improvement in school functioning ($p \leq .001$). This data shows that youth enrolled in CSoC are showing vast improvements in functioning, both clinically and in school, not because of chance but rather because of the programmatic interventions. Please see the Outcomes Section for a full summary of outcomes data collected this year.
10. Increase the provider network of short-term respite and crisis stabilization providers through collaboration with LDH and MCOs.
    - **Goal Met:** Since 2015, CSoC program as seen a steady increase in STR providers, with a 155.6% increase in providers 12/01/2015 to 12/01/2017. This year, Magellan, with the approval of LDH, coordinated meetings with the Healthy Louisiana Plans and LDH to discuss and plan efforts to develop Crisis Stabilization services Magellan was successful in contracting with a Crisis Stabilization provider in April 2017 and is working with LDH to ensure proper application of the service to our members.

11. Detect under and over utilization of services (as defined as μ ± σ) through use of control charts. If a trend of under and over utilization of services is detected, Magellan will implement DMAIC process to address.
    - **Improvement Needed: Inpatient Utilization.** The evaluation of the utilization of inpatient hospitalizations showed an increase in utilization; however, there was only one month (October 2017) where utilization exceeded two standard deviations above the mean. Magellan actively managed this level of care and implemented several interventions to address the specific factors that contributed to the increased utilization and has seen declines in utilization as a result. Please reference the Accessibility of Services section of this report for full details on inpatient utilization
    - **Improvement Needed: Waiver Outpatient Service Utilization.** Although statistical under utilization was not indicated in this category, there were some waiver services, specifically peer support services, which required a formal action plan to address access to care and quality of care concerns. These concerns lead to the termination of the statewide Family Support Organization, which was solely responsible for providing the youth and parent peer services. Magellan proactively collaborated with our partner, LDH, upon identification of concerns and actively participated in and administered remedial activities to foster improvements. Following the termination, Magellan assisted in identifying a new FSO and actively worked with our LDH and wraparound agency partners to ensure transition and implementation plans were implemented effectively. Magellan will actively monitor the FSO implementation plan in the upcoming contracting period to ensure access to care and quality of care standards are met.
    - **Goal Met: Non-waiver Outpatient Utilization.** When evaluating non-waiver HCBS and traditional outpatient services, there were no services that showed under or over utilization of services. Magellan will vigorously continue to monitor these levels of care. Please see the Accessibility of Care Section for complete details regarding utilization data.
12. Ensure that appointment authorization timeliness exceeds 95% for emergent, urgent and routine appointments.
    - **Goals Met:** All three of the appointment authorizations were met. Over the course of 12/01/2016 through 12/31/2017, there were 34,582 routine appointment authorizations requested and authorized timely, a compliance rate of 94.5% (n=32,683). The average time of service authorization of 7.5 days, which was 6.5 days less than the fourteen day requirement. Urgent and emergent appointment authorizations only represented 4.5% and 0.07% respectively of the total authorization requests received (n=36,246). Urgent and emergent authorizations requests were completed timely 99.5% and 100% of the time respectively, with both meeting the 95% goal.

The Louisiana CSoC CMC Quality/UM Work Plan is revised annually with customer, provider, consumer, and family member input and feedback and approved by the CMC Quality Improvement Committee. The Quality/UM Work Plan is then submitted to the Magellan Vice President of Quality for further review and presentation to the Magellan Healthcare Behavioral Health Quality Improvement Committee (BH-QIC). Because the Work Plan is an evolving document, it is updated as necessary and reviewed quarterly as part of the ongoing QI process. The Quality/UM Work Plan is used as a "living document" to monitor progress and apply the QI process as needed. The objectives outlined above demonstrate that Magellan is successfully accomplishing the goals of CSoC. This report provides a more detailed analysis of how many of those objectives were met and discusses opportunities for improvement with a focus on continuously striving for higher levels of achievement.

Quality Work Plan Evaluation

Tables 12 and 13 outline the performance measures and quality activities monitored as part of the CSoC Quality Program. The status for 12/01/2015 through 11/30/2016 and 12/01/2016 through 12/31/2017 are provided as well as any recommended changes planned for the upcoming contract extension period. The unit reporting committee column references the quality committee assigned to oversee and monitor the activity and includes: the Quality Improvement Committee (QIC), the Utilization Management Committee (UMC), and the Regional Networking Credentialing Committee (RNCC). The structure and responsibilities of each committee is fully described in the Quality Improvement Program Description.

Tables 12 and 13: Quality Program Performance Measures and Quality Activities

Quality Performance Measures							
Performance Measure	**Goal**	**Reporting Frequency**	**CSoC Owner**	**CSoC Reporting Committee**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Telephone Access Timeliness (Member Service Associates Lines)							
1. Average Speed of Answer (ASA)	≤ 30 secs.	Monthly	MS Admin.	QIC	22.2 sec	14.4 secs	None
2. Call Abandonment Rate (CAR)	≤ 5%	Monthly	MS Admin.	QIC	5.03%	2.9%	None
Grievances							
3. Member Grievances Received	Monitoring Indicator	Monthly	QM Director	QIC	29	21	None
4. Resolution Responsiveness (Rate resolved w/in turnaround time)	≥ 90%	Monthly	QM Director	QIC	97%	95%	None
Accessibility of Services							
5. Emergent Care	≥ 95%	Quarterly	Clinical Director	UMC	99.6%	100%	None
6. Urgent Care	≥ 95%	Quarterly	Clinical Director	UMC	99.1%	99.5%	None
7. Routine Care	≥ 80%	Quarterly	Clinical Director	UMC	100%	94.5%	None
Ambulatory Follow-Up							
8. 7-Day Rate	≥46%	Calendar Quarter	Clinical Director	UMC	53.4% and 78.65% for HEDIS and Modified HEDIS respectively (final)	53.7% and 64.8% for HEDIS and Modified HEDIS respectively (preliminary)	Final report to be submitted on 4/15.
9. 30-Day Rate	≥65%	Calendar Quarter	Clinical Director	UMC	67.2% and 92.2% for HEDIS and Modified HEDIS respectively	71.0% and 81.6% for HEDIS and Modified HEDIS respectively (preliminary)	Final report to be submitted on 4/15.
Adverse Incident Reporting							

Quality Performance Measures							
Performance Measure	**Goal**	**Reporting Frequency**	**CSoC Owner**	**CSoC Reporting Committee**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
10. Suicides/Homicides (Inpatient & Outpatient)	Monitoring Indicator	Monthly	Med. Director QM Director	QIC	0	0	None
11. Other Adverse Incidents (IP & OP)	Monitoring Indicator	Monthly	Med. Director QM Director	QIC	61	60	None
Member Satisfaction							
12. Member Satisfaction with Magellan	Greater number of questions ≥ 80% from previous administration.	Annual	QM Director MS Admin.	QIC	32 questions assessing satisfaction, with 53.1% of questions equal to or greater than 80%.	25 questions assessing satisfaction, with 68% equal to or greater than 80%.	Please see Member Satisfaction Survey for full action plan and interventions for contract year 2.
Claims Administration							
13. Financial Payment Accuracy	≥97%	Quarterly	MS Admin.	QIC	99.84%	100%	None
14. Procedural Accuracy	≥98%	Quarterly	MS Admin.	QIC	99.75%	100%	None
15. Turn Around w/in 15 days	≥90%	Quarterly	MS Admin.	QIC	99.93%	99.86%	None
16. Turn Around w/in 30 days	≥99%	Quarterly	MS Admin.	QIC	100%	100%	None
17. Turn Around w/in 60 days	100%	Quarterly	MS Admin.	QIC	100%	100%	None
Appeals							
18. Standard	≥98%	Quarterly	Clinical Director	UMC	100%	100%	None
19. Expedited	≥98%	Quarterly	Clinical Director	UMC	100%	100%	None
20. State Fair Hearing (2nd Level of Appeal)	≥98%	Quarterly	Clinical Director	UMC	N/A	N/A	None

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Treatment Record Reviews	Monitor documentation practices against policies/procedures. Results shared with providers and included in re-credentialing review process.	80%	QIC RNCC	QM Director Medical Director	Quarterly	Met Goal	Met Goal	Please see Provider Performance Report.
Clinical Practice Guidelines	Review and implement National CPGs for use w/member population. Assess provider adherence.	90%	QIC RNCC	QM Director Med. Director Clinical Director	Annual	Met Goal	Met Goal	Please see Provider Performance Report.
1915(c) Waiver Assurance Audits	Monitor documentation practices against federal regulations for 1915 (c) waiver assurances to ensure compliance. Monitor remediation action plans for assurances with system performance under 100% or as outlined by LDH.	100% or as indicated by the waiver	QIC UMC Compliance	QM Director Clinical Director Compliance Admin.	Monthly, Quarterly, Semi-annual, Annual	Individual report submissions are submitted as required by LDH. Provider performance reports evaluate many of the report measures as well.	Individual report submissions are submitted as required by LDH. Provider performance reports evaluate many of the report measures as well.	Please see individual report submissions and Provider Performance Report.
1915(c) Waiver Assurance QI Projects	When system performance is less than 90% for any measure, Magellan will conduct further analysis to determine the cause and complete a quality improvement project, subject to the review and approval of LDH-OBH. Each quality improvement project must measure the impact to determine whether the project was effective. If the project is deemed ineffective by LDH-OBH, Magellan will employ other interventions to ensure the needs of members served are addressed and resolved in a systemic manner.		QIC UMC Compliance	QM Director Clinical Director Compliance Admin.	Monthly, Quarterly, Semi-annual, Annual	Individual report submissions are submitted as required by LDH.	Individual report submissions are submitted as required by LDH.	Please see individual report submissions.

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Fidelity Monitoring	Monitor Wraparound providers to ensure adherence to minimum fidelity standards. (See Fidelity Monitoring Plan for full details.)		QIC RNCC	QM Director Medical Director	Annually	Please see Fidelity Review Annual Report.	Please see Fidelity Review Annual Report.	Please see Fidelity Review Annual Report.
Cultural Competency	Monitor provider's provision of care to promote compatibility with the member's cultural health beliefs and practices and preferred language through evaluation of grievances, TRR data, and satisfaction survey data. Monitor compliance with annual training requirement as part of the Onsite Network Monitoring audits and credentialing and recredentialing.		QIC	QM Director Med. Director	Annual	Please see Network Development Plan.	Please see Network Development Plan.	Please see Network Development Plan.
Timeliness of UM Decisions	Monitor through care manager and physician advisor chart audits timeliness of UM decisions based on Magellan standards, accreditation standards and state regulations. (All levels of review- pre-cert to appeals)	Urgent Request: 72 hours Standard Request: 14 days Expedited Appeal: 72 hours Standard Appeal: 30 days	UMC	Clinical Director	Quarterly	Please see Network Development Plan.	Please see Network Development Plan.	Please see Network Development Plan.
Inter-rater Reliability	Demonstrate consistent application of medical necessity criteria by CMs and PAs as evidenced by completing annual evaluation with a passing score.	90%	UM QIC	Med. Director Clinical Director QM Director	Annual	100%	100%	None

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Provider Site Visits	Assess provider record keeping practices and physical location against established standards, policies and procedures as part of credentialing/recredentialing, onsite network waiver audits and/or as a result of receiving grievances, including actions and follow-up, and adherence to Home and Community-Based Services (HCBS) rule as applicable.	100%	RNCC QIC	Network Admin. QM Director	Quarterly	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Data Collection & Integration	Workflows in place to collect and use data sources to improve care and service, including: 1- Outpatient Claims 2- Inpatient Claims 3- Demographic Data 4- Medicaid Eligibility Data collection includes data on race, ethnicity, gender, age, primary language, and geography. (Please see QI Program Description page 26 for full details.)		QIC UMC	QM Director	Annual	Ongoing Activity	Ongoing Activity	None

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Data Integrity	Quality checks used to verify data integrity include comparisons against expected values, domain analysis, and comparisons to standard code sets/values. For reviewing data completeness, quality checks assess whether all data that came into the system was processed. The data quality checks record any data quality exceptions in standard tables to facilitate quality monitoring and reporting. The data warehouse staff conducts regular data quality meetings with the source system and business experts to review data quality reports and initiate appropriate actions (as outlined in Policy: QI.MCD.3.LA Medicaid.Baton Rouge CMC.01Ensuring Timely, Accurate, and Complete Reporting).		QIC	QM Director	Ongoing	Ongoing Activity	Ongoing Activity	None
Outcomes Initiatives and Activities	Develop, implement, and monitor specific clinical assessment (outcomes) measures (i.e., QIS Performance Measures, CANS, Readmission Rates, etc.) through the Quality Committee structure.		QIC UMC	QM Director	Annual	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Performance Improvement Projects	Develop, implement, and monitor quality activities/projects. Monitor contract required PIP: Increase in the Attendance of Behavioral Health Providers at the Child and Family Team Meetings.	50%	QIC UMC	QM Director	Annual	Please see PIP Annual Report.	Please see PIP Annual Report.	Please see PIP Annual Report.
Best and Evidence-based Practices	Implement identified best practices as part of TRR process. Monitor and update status of best practices quarterly.		UMC QIC	Clinical Director QM Director	Quarterly	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Coordination of Care Activities (BH-Medical and BH-BH)	Identify and implement coordination activities with stakeholders. Monitor effectiveness of activities/interventions through Wraparound Agency monitoring and TRR.		UMC	Med. Director Clinical Director	Quarterly	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Consumer, Family/ Member and Provider Input	Obtain member and provider feedback on key quality and UM Program elements through the grievance process, satisfaction surveys, and participation in the quality committee structure.		QIC UMC	All Committee Chairs	Ongoing	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Stakeholder Training	Develop, plan and maintain training log for consumer, family member, and stakeholder training.		QIC	MS Admin.	QIC	Please see Training Plan.	Please see Training Plan.	Please see Training Plan.
Over/Under Utilization Review	Evaluation of utilization and relevant core indicator data to identify patterns of potential inappropriate utilization for both IP and OP data as monitored by control charts using standard deviation from the mean. Measures include: • Inpatient • CPST/PSR • CSoC Services • Other Outpatient Services	$\mu \pm \sigma$ (± 1 Standard Deviation from the Mean)	UM QIC	Med Director QM Director Clinical Director	Annual	Please see Accessibility Section of this report.	Please see Accessibility Section of this report.	Please see Accessibility Section of this report.
Care Management Initiatives	Track and describe Care Management Initiatives as outlined in Section VIII the Program Description		UMC	QM Director Clinical Director	Quarterly	Please see UM Program Description	Please see UM Program Description	Please see UM Program Description
Member and Provider Satisfaction	Obtain member and provider feedback on satisfaction with services provided	≥85%	QIC UMC RNCC	All Comm. Chairs	Ongoing	Please see Member and Provider Satisfaction Reports.	Please see Member Satisfaction Report; and Satisfaction Sections of this Report.	Please see Member and Provider Satisfaction Reports.
2015-16 QM/UM Program Evaluation	Document and trend key QI and clinical indicators, activities and opportunities for improvement, and program effectiveness. Demonstrate member and practitioner input.		UMC QIC	QM Admin	02/28/2017	Com.	This document serves as evaluation, along with reports referenced.	Please see associated reference documents and Contract Year Two work plan.

Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
2015-16 Quality Program Description	Develop plans for QI & UM Program based on 2015 findings and identify opportunities for improvement.		QIC	QM Director	02/28/2017	Completed	Previous approval extended until 10/31/17	See submitted document.
2015-16 Quality Program Work Plan	Develop plan to monitor prioritized QI activities and core performance measures based on QI and UM PD goals. Submit Work Plan update.		QIC	QM Director	02/28/2017	Completed	Previous approval extended until 10/31/17.	See submitted document.
2015-16 UM Program Description	Develop plans for UM Program based on 2015 findings and identify opportunities for improvement.		UMC	QM Director Clinical Director	02/28/2017	Completed	Previous approval extended until 10/31/17,	See submitted document.
Policies & Procedures	Conduct annual policy review. Modify per contract requirements and state regulations. Review and implement corporate P&Ps.		QIC	Med Director Compliance Admin.	Annual	Ongoing Activity	Ongoing Activity	None
Review/ Approve Service Authorization Criteria	Maintain guidelines for level of care/medical necessity determination for contract required criteria (Service Authorization Criteria).		QIC UMC	All Comm. Chairs	Ongoing	Ongoing Activity	Ongoing Activity	None
Network Oversight	Define size, composition, and training needs of the network. Ensure providers are appropriately credentialed and meet State requirements for provision of services rendered. Review provider performance, monitor provider action plans, and perform site visits to ensure compliance.		QIC RNCC	Network Admin.	Quarterly	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Compliance Program Monitoring	Review of local, federal and state laws and regulations relating to the UM Program, including Fraud, Waste and Abuse activities. Please refer to QI Program Description for a full list of activities.		Compliance Committee	Compliance Admin.	Quarterly	Ongoing Activity	Ongoing Activity	None

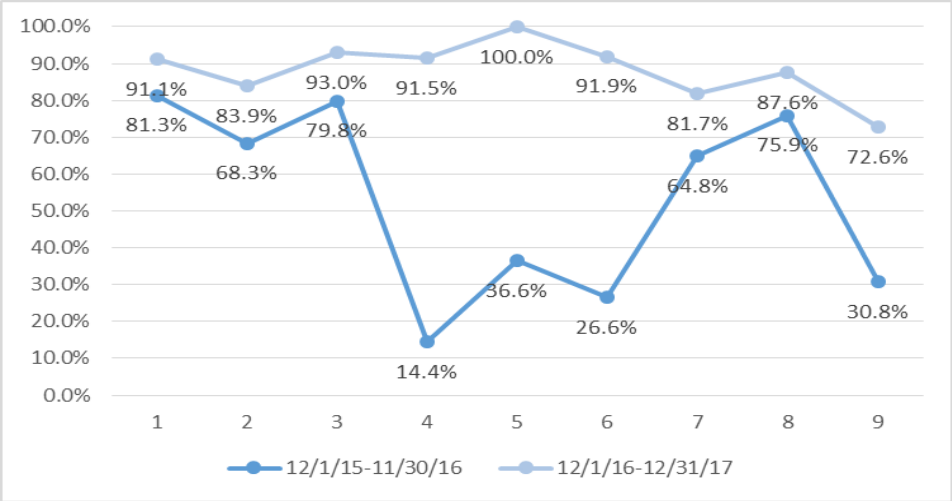
Quality Program Activities								
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**12/1/15-11/30/16 Status**	**12/1/16-12/31/17 Status**	**Recommended Changes**
Staff Training	Develop plan and maintain training log for all Unit staff.		QIC	Training Specialist	Quarterly	Ongoing Activity	Ongoing Activity	None
Confidentiality Checks	Monitor Unit practices against confidentiality requirements.		Compliance Committee	Compliance Admin.	Quarterly	Ongoing Activity	Ongoing Activity	None
Personnel File Review	Maintain current and complete information on UNIT clinical and customer service staff.		QIC	Corporate HR	Annual	Ongoing Activity	Ongoing Activity	None
Grievance Review	Review and implement necessary actions to address issues identified in grievances and grievance-related correspondence.		QIC	QM Director	Quarterly	Please see Provider Performance Report.	Please see Provider Performance Report.	Please see Provider Performance Report.
Minutes Review	Monitor minutes to ensure they are current, signed and dated. Minutes must reflect quality process discussion.		QIC	QM Director	At the minimum Quarterly	Ongoing Activity	Ongoing Activity	None
Annual Reports	Develop Annual Report that includes the following items annually on or before December 1 of the contract year: • A current organization chart containing all positions. The chart must include the person's name, title and telephone number and portion of time allocated to the Louisiana Contractor contract, other contracts, and other lines of business. • A functional organization chart of the key program areas, responsibilities and the areas that report to that position. • A listing of all functions and their locations; and a list of any functions that are performed outside of the state.		QIC	CSoC Program Director	Annual	Ongoing Activity	Ongoing Activity	None

Member Satisfaction

The member satisfaction survey is a vital component of our quality program. Member satisfaction surveys remain the most direct measure of assessing the member's perceptions of quality of provider service delivery and outcome of care. Gathering member input and feedback allows us to continuously improve our processes and enable our provider network to learn the needs of those we serve to improve our member's experience of care. Magellan administered a survey based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care and Health Outcomes (ECHO) Survey. In response to member and Wraparound Agency feedback regarding the usability of the 2016 survey, Magellan, in collaboration with LDH, reduced the number of questions assessing satisfaction from thirty-two to twenty-five, increased the look back period of the questions from three months to six months, and simplified the reading level of questions where possible. Magellan also modified the period of time a member was required to be enrolled to participate in survey from greater to or equal to thirty-one days to three months to ensure adequate engagement in the program prior to survey administration. The content of the questions focused on access to care and quality of care of both the provider network, excluding the Wraparound Agencies, and Magellan. Magellan also conducts an annual fidelity review that should be referenced to evaluate satisfaction with the wraparound model and the Wraparound Agencies.

The methodology of the survey was selected to achieve maximum member participation in order to support the CSOC goal of increasing members' voice and choice in treatment. Magellan collaborated with Wraparound Agencies to administer the survey in person to accomplish higher response rates. There was a sixty day distribution period to ensure that members had adequate time to complete the survey. The administration period began on 10/02/2017 and closed on 12/01/2017. The total number of members sampled was 1,606 (i.e., members enrolled that meet criteria as of report run date of 09/11/2017), with 257 members discharging/disenrolling during the administration period. A total of 1,174 members/guardians completed the survey, for a response rate of 87% (n=1,349). This was a thirty percentage point increase in the response rate from 2016 administration (n=57%) and was the highest response rate achieved as part of any satisfaction survey administered by Magellan Health in Louisiana to date. The number of responses exceeded the statistical requirement of 385 needed meet the contractual requirement of a 95% confidence level with a +/-5% error rate. There was some variation in the response rates by regions, with a high of 100% in Region 5 and a low of 72.6% in Region 4; however, it should be noted the lowest responding region was fifty-eight percentage points greater than the previous year's lowest region (n=14.4%). Figure 3 depicts the response rates by region.

Figure 3: Regional Response Rate Comparison



Magellan set a goal for the 2017 survey to show a higher percentage of elements showing a satisfaction rate of equal to or greater than 80% as compared to the previous administration. There were a total of thirty-two questions assessing satisfaction in 2016, with 53.1% of questions equal to or greater than 80% positive. In 2017, there were twenty-five questions assessing satisfaction, with 68% (n=17) equal to or greater than 80% positive, which achieved our goal. Tables 14 through 17 show notable observations regarding survey results.

Table 14: Comparison of 2016 and 2017 Administration by Question Level

Administration Year	2016		2017	
Question Level	Number	% from Total	Number	% from Total
Equal to or greater than 80% positive	17	53.1%	17	68.0%
Less than 80% positive	15	46.9%	8	32.0%
Total Questions Assessing Satisfaction	32		25	

Table 15: Comparison of 2016 and 2017 Administration by Level of Change

Comparison from 2016 and 2017 Administrations	
Level of Change	Number
Increase of less than 5%	2
Increase of less than 2%	4
Increase of greater than 5%	4
Increase of greater than 10%	1
Decline of less than 5%	2
Decline of less than 2%	11
Decline of equal to or greater than 10%	1
Total Questions Assessing Satisfaction	25

Table 16: Top Scored Satisfaction Items

Question	% POSITIVE		
	2016	2017	Change from Previous Administration
In the last 6 months, did the care your child received meet his or her language, race, religion or cultural needs?	85.5%	93.2%	7.7%
In the last 6 months, were you given information about your child's rights as a patient?	89.2%	90.5%	1.3%
How often did the people your child saw for counseling or treatment show respect for what you had to say?	89.1%	90.2%	1.1%

Table 17: Low Scored Items

Question	% POSITIVE		
	2016	2017	Change from Previous Administration
In general, how would you rate your child's overall mental health now?	58.6%	55.6%	-3.0%
In the last 6 months when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?	71.5%	69.6%	-1.9%
In the last 6 months, if your child was prescribed medicine, were you told what side effects to watch for?	74.0%	70.2%	-3.8%

Top-scored items highlight that members and/or guardians feel confident that services are delivered in a culturally competent manner and they understand their rights as members. This shows alignment with the key wraparound principles of family voice and choice and cultural competency. Low-scored items indicate opportunities for improvement, but it is important to evaluate them in context to the survey. For example, the question rating the child's overall mental health showed only 6.6% of membership indicating poor rating for mental health. Program eligibility criteria should also be considered because members are not eligible for CSoC unless they have acute clinical needs, which should be considered if comparing this to a general managed care population.

Magellan established a Member Satisfaction Workgroup, with representation from clinical, quality, network, executive and LDH leadership, to discuss the results of the survey and identify questions that would benefit from interventions to foster improvement. Magellan also reviewed results of the survey with Wraparound Agency leadership to better understand regional factors contributing to satisfaction. One recommendation made by the Wraparound Agencies and the workgroup included ensuring future surveys clearly define the provider type that should be rated. Most questions reference "counseling and treatment," which are broad terms and make it difficult to apply meaning to the results and delineate barriers to satisfaction. Two questions were identified as the opportunities for improvement and are referenced below, along with interventions in Table 18.

Table 18: Opportunities for Improvement for 2017 Administration

Question	% POSITIVE		
	2016	2017	Change from Previous Administration
In the last 6 months, did anyone your child saw for counseling or treatment share information with others that should have been kept private? No responses shown.	88.8%	78.8%	-10.0%
In the last 6 months, if your child was prescribed medicine, were you told what side effects to watch for?	74.0%	70.2%	-3.8%

Interventions

- One of the key components of wraparound is the Child and Family Team. Team meetings are facilitated by the Wraparound Facilitator. As part of this team, providers and other formal and informal supports are involved with identifying the child/youth's needs and develop strategies to address them. The team design can be difficult for families who are not accustomed to openly sharing their story with other team members. It was also noted that with incidents of abuse, neglect or exploitation, providers are required to report the incidents to the appropriate agencies, which can be perceived as sharing private information. Magellan requested that the Wraparound Agencies share this information as part of coaching with facilitators to improve awareness of members' perceptions related to privacy to ensure that the family feels empowered rather than forced to share vital information with the team.
- One of the roles of youth support and training (YST) specialist, as outlined in the LDH Behavioral Health Services Provider Manual, is to assist the child/youth to regain the ability to make independent choices and take a proactive role in treatment, including discussing questions or concerns with their clinician about medications, diagnoses or treatment. Because of this, Magellan will present the survey data, specifically related to the side effect of medicines, to Family Support Organization for utilization in peer staff training. It is believed informing peer and parent support specialists of members' perceptions of treatment can lead to opportunities to better serve members in this area.
- Magellan will present data summary date to Magellan Provider Network during the June 2018 Provider All-Call to improve provider insight into member's perception of treatment.

Accessibility of Services

Improving member accessibility to services is a key tenet of the wraparound model. Unlike traditional Medicaid programs, members in CSoC are supported in accessing services through their Wraparound Agency. The Wraparound Facilitator is tasked with assisting members in navigating through the system, assisting in the selection of providers and addressing unmet needs. Magellan facilitates the selection process by providing a comprehensive web-based search engine that allows the member to search for a provider by level of care, accepting new patients, gender, specialty (e.g., autism, CBT, eating disorder, etc.), ages treated, language spoken, ethnicity, provider type (e.g., psychiatrist, psychologist, social worker, etc.) and location conditions (e.g., TTD capabilities, public transportation, evening/weekend appointments, and wheelchair accessibility). Magellan also has dedicated a Provider Relations Liaison (PRL) assigned to each Wraparound region that provide support and technical assistance in accessing services.

Magellan has an established process to monitor accessibility and availability of services, which informs recruitment efforts. Magellan quality committees meet quarterly to review geographic access and appointment availability data, the results of member satisfaction surveys, and member/family grievances to identify gaps in the type, density, and location of behavioral health providers in Magellan's network. When gaps are identified, the quality committees implement and monitor action plans to address, including but not limited to developing provider surveys, conducting provider forums and outreaching to out-of-network providers to facilitate recruitment efforts. This section will review authorization, utilization, and member survey related to access to care to identify if there are any areas that require improvement activities for the upcoming contracting period.

Authorization of Services

Magellan monitors the timeliness of authorizations to ensure internal operations do not affect access to care. Magellan categorizes appointments as routine, urgent, and emergent. Timeframes for authorizations for emergent appointments are within one hour of the request, urgent within forty-eight hours/two calendar days, and routine within fourteen calendar days. The routine, emergent and urgent compliance rate goals are set at 95% compliance. Over the course of 12/01/2016 through 12/31/2017, there were 34,582 routine appointment authorizations requested and authorized timely, a compliance rate of 94.5% (n=32,683). The average time of service authorization of 7.5 days, which was 6.5 days less than the fourteen day requirement. Urgent and emergent appointment authorizations only represented 4.5% and 0.07% respectively of the total authorization requests received (n=36,246). Urgent and emergent authorizations requests were completed timely 99.5% and 100% of the time respectively, with both meeting the 95% goal. Table 19 shows authorization details.

Table 19: Authorization Data for 12/01/2016 through 12/31/2017

Risk Level	Time Units	Number of Service Authorizations	Number of Timely Service Authorizations	Percent of Timely Service Authorizations	Average Time of Service Authorizations	Time Units
Routine	14 Days	34,582	32,683	94.51%	7.52	Days
Urgent	3 days	1,638	1,630	99.51%	0.11	Days
Emergent	1 hour	20	20	100%	126.73	Minutes

Utilization of Services

One of the pillars of CSoC is to ensure members receive services that are individualized, effective, provided in the least restrictive setting, and medically necessary. To accomplish this goal, it is imperative that members receive services in the appropriate level of care while not over or under utilizing services in any level of care. The Utilization Management Committee (UMC) monitors trends quarterly, and the QI department conducts an annual analysis to identify trends in over and under utilization of services in Louisiana. This analysis evaluates several metrics across levels of care to obtain a comprehensive understanding of how members are utilizing services. These metrics including but are not limited to:

- Inpatient Hospital Utilization
- Home and Community Based Service (CPST/PSR/CI) Utilization
- Other Outpatient Service Utilization
- FFT and Homebuilders Service Utilization
- CSoC Waiver Service Utilization

The UMC uses control charts to evaluate utilization trends based on standard deviations from the mean to detect statistical over or under utilization. Opportunities for improvement are indicated when over or under utilization, or utilization above or below two standard deviations from the mean, are identified over a period of time. The below graphs show utilization data for twenty four months, beginning in December 2015 and ending in December 2017, to monitor long term trends. When analyzing data, it should be noted that outpatient utilization data is based on claims and can be subject to a claims lag, which means there is a drop in the last three months of data reported because claims have not been submitted by the provider by the time the report was run. Inpatient data are generated through authorization information, which are not affected by a claims submissions.

Inpatient Hospital

One of the goals of CSoC is to reduce the number of current and future admissions to restrictive settings, such as inpatient hospitals. Magellan has a vigorous set of clinical approaches to manage children admitted to an inpatient setting based on our extensive experience with the population and understanding of the goals and principles of wraparound. In 2016, Magellan made critical changes to our Medical Necessity Criteria (MNC), which required all CSoC members to be seen by a physician daily. This standard of care is higher than what is required by the Louisiana licensing board for hospitals and ensures our youth are evaluated daily. This allows the physician to quickly adjust the treatment plan to optimize the time a member is away from their families. The MNC also includes enhanced criteria to require active coordination of care with Wraparound Agencies throughout the course of treatment, including within twenty-four hours of admission. This high level of coordination allows the hospital to leverage the Wraparound Agency's deep knowledge of the family to create a comprehensive discharge plan to reduce recidivism.

Along with our MNC, Magellan enables our clinical staff to develop strong relationships with hospitals and providers by pairing care managers with regions, allowing for more efficient management of those members who require hospitalization. This is done through an approach, known as mini-teams. The mini-team combines a clinical, network and quality staff for each of the nine regions. This team approach provides an avenue for Magellan staff to develop an expertise of member and network demographics of each region and increases our capacity for the rapid detection and resolution of

member needs. Mini-teams consist of the care manager, CSoC coordinator, quality clinical reviewer, PRL, Managed Care Organization (MCO) liaison, and clinical supervisor.

Even with these proactive clinical approaches, there were instances of increased inpatient utilization during the year. Although this increase was not consistent over time, Magellan worked aggressively to address any rises by analyzing and addressing barriers to maintaining community tenure. The root-cause analysis completed by our clinical leadership identified several factors that contributed to increased utilization and the clinical team worked collectively to formulate interventions to address each. The factors and interventions are as follows:

- **Factor:** There was a pattern of hospitalizations that involved members who had issues accessing to pharmaceuticals, which are managed by the Healthy Louisiana Plans, or Louisiana's Medicaid MCOs.
  Intervention: Magellan employs a dedicated MCO liaison that is tasked with working with the MCOs to ensure coordination of care for shared members, with an emphasis on pharmacy and physical/medical needs. Magellan implemented a workgroup in March 2017 with the MCOs to address pharmacy issues specifically. As a result of this work group, initiatives were implemented to improve Magellan's involvement in problems related to accessing pharmaceuticals with the goal of initiating a rapid plan of focused interventions with the MCOs to resolve the issues. Magellan's Clinical Director and MCO liaison conducted face-to-face meetings during April and May 2017 with all Healthy Louisiana Plans to emphasize these initiatives directly.
- **Factor:** Increases in inpatient utilization were partially driven by a small subset of presumptively eligible members with multiple admissions and readmissions upon entry into the CSoC program.
  Interventions: To address the admissions and readmissions, Magellan intervened at the individual youth level and systemically. On an individual level, Magellan's clinical leadership reached out to the Wraparound Agencies serving these youth to review the Plans of Care, crisis plans, and assessments to identify for areas of need that may not have been fully addressed in the treatment plan and to brainstorm strategies for the Child and Family Team to consider. Systemically, Magellan's clinical director met with all Wraparound Agency clinical directors to review their individual region's utilization data across all levels of care so that the agencies can make more informed decisions related to coaching and supervision. Magellan care managers also received additional training and supervision to support inpatient utilization management. As part of the additional supervision, all youth who were admitted to a hospital during their presumptive eligibility period, youth who where readmitted to the hospital within thirty days of previous discharge, youth with lengths of stay greater than seven days, and youth with complex needs were reviewed at least weekly by clinical leadership. Lastly, Magellan closely monitored care coordination activities by hospitals and Wraparound Agencies through utilization management and quality processes.
- **Factor:** There was also a trend noted in frequent hospital utilization by families who desired treatment at the Psychiatric Residential Treatment Facility (PRTF) level of care, a service managed by the Healthy Louisiana plans.
  Intervention: Magellan partnered with the Wraparound Agencies, the Healthy Louisiana plans and families when appropriate, in order to increase our support of these high-need families with the goal of maintaining the youths safely in their homes. In December 2017, Magellan identified twenty four youth with frequent hospitalizations for intervention. It is believed that the inpatient admissions for this group had some association with a desire for PRTF treatment as evidenced by a PRTF request being made to the members' Healthy Louisiana plans for twenty-

two of the twenty-four members. As part of the intervention, Magellan requested member records, including the family story. The regional mini-team then met to review all documentation related to each child, paying particular attention to whether the Plan of Care strategies changed when they were not effective, the strength and relevance of the crisis plan, system and individual gaps in care, potential quality concerns and provider network concerns. After the internal review, Wraparound Agencies and the mini-teams met to collaborate to meet each youth's needs and identify solutions to support members and families.

Along with these interventions, Magellan's clinical teams implemented inpatient youth internal staffings, also known a Breaking Barriers Rounds, to more closely monitor and manage higher severity youth, such as:

- Youth who have been in an inpatient level of care more than one time in the past nine months
- Youth who are in inpatient within thirty days of CSoC referral date
- Youth who are in inpatient who have been discharged from psychiatric residential treatment facility within the past nine months
- Youth who are in inpatient who have been in detention within the past month
- Youth who are in inpatient and PRTF is being explored
- Youth who are in inpatient with complexity

These staffing take place several times a week and evaluate many areas of member functioning, including what has worked for the youth in the past, exploration of the current plan of care, evaluation of natural supports, assessment of active formal and informal services, identification of diagnosed or potential developmental delays, medical issues, etc. The care manager for that region then communicates with the Wraparound Agency or hospital and provides any suggestions or concerns we have regarding the current treatment plan. It is believed these staffings provide a mechanism to stimulate the brainstorming and creative thinking that is essential to effectively apply the ten principles of wraparound for the youth and family. Figures 4 through 7 provide specific utilization data for the inpatient level of care.

Figure 4: Inpatient Admission per Thousand

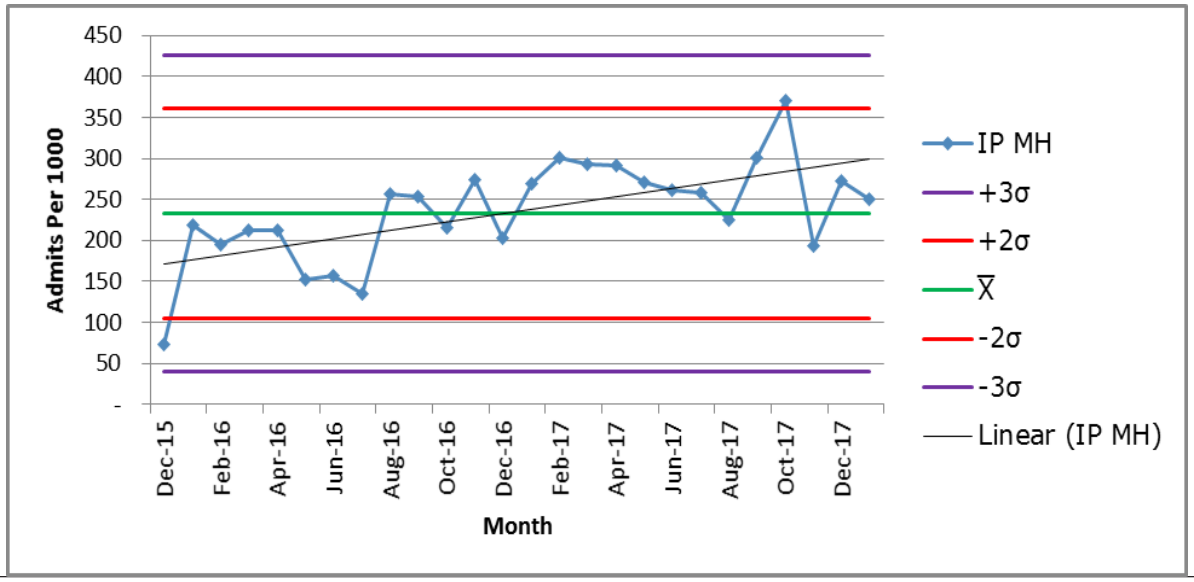


Figure 5: Inpatient Days per Thousand

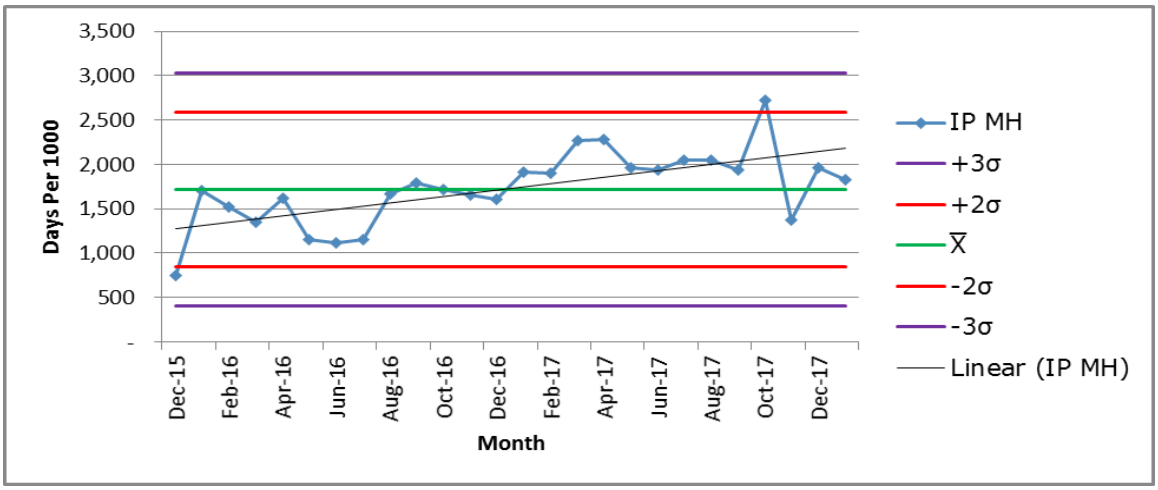


Figure 6: Inpatient Average Length of Stay

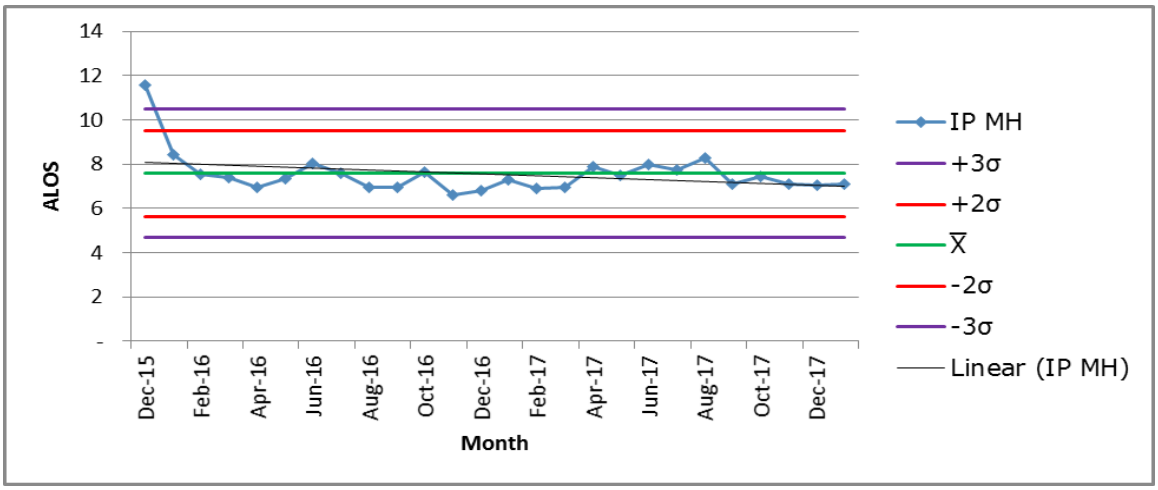
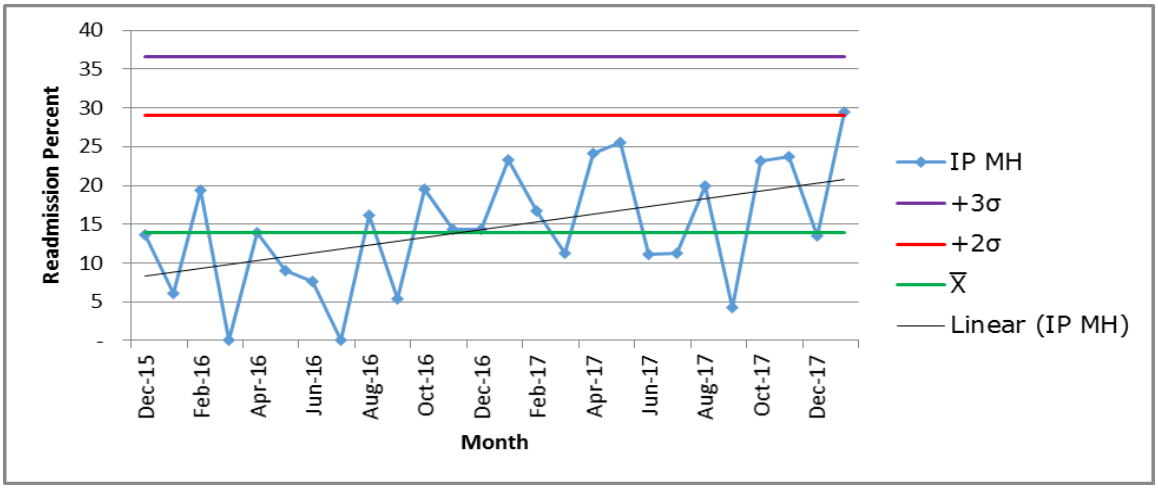


Figure 7: Inpatient Readmission Rate



Home and Community Based and Traditional Outpatient Services

One of the central tenets of CSoC is to ensure members receive the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider. Services delivered in the Home and Community Based Settings (HCBS) are believed to provide an avenue for families to receive necessary services in a manner that aligns with the values inherent to the wraparound process. Magellan actively manages HCBS services, also know as Mental Health Rehabilitation (MHR) services, including CPST, PSR, and CI, through the Plan of Care authorization process. Through this process, each service must address a need identified by the youth and family and be assigned a strategy or strategies. Plans of care require specific detail that addresses the frequency, amount and duration of services required to complete each strategy. The Plans of Care are then independently reviewed by an internal Magellan clinician to ensure the strategies address all identified needs and there are changes over time. Once approved, the services are authorized, with compliance monitored over time. This process allows Magellan to vigorously oversee supports and services for every member enrolled in the program and monitor progress towards meeting members needs.

Figures 8 through 12 illustrate trends in outpatient service utilization. As mentioned previously, outpatient data is impacted by claims lag, which explains the declines seen in the last few months in many of the figures. When evaluating non-waiver HCBS and traditional outpatient services, there were no services that showed under or over utilization of services. Traditional outpatient services in Figure 9 include outpatient therapy, medication management, and assessments. Although traditional outpatient services typically do not require an authorization, these services are also addressed in the Plan of Care and internally monitored. Magellan monitors the quality of care of outpatient services through the Treatment Record Review (TRR) process, which is described in detail in the Provider Performance Report. The TRR process includes:

- Collecting data for the evaluation of quality of care delivered to Magellan members by providers;
- Providing feedback to providers on documentation standards for on-going education; and
- Monitoring provider compliance with Magellan clinical practice guidelines.

In May 2015, Magellan also implemented a targeted review process for outpatient providers with a high percentage of members with inpatient hospitalization utilization. These audits utilized the following criteria to identify outlier outpatient providers with high utilization: greater than twenty percent of members with an inpatient claim, less than five unique members served (low numbers of members can skew percentages); and the provider is not a hospital or physician. The reviews monitor the outpatient provider coordination with the Wraparound Agency and hospitals, the quality of service delivery, the provider's participation in CFTs and utilization of crisis interventions to divert inpatient admissions when possible. All the processes and interventions described in this section also apply to evidenced-based and CSoC waiver services described in the next subsections.

Figure 8: All Outpatient Combined Members Served

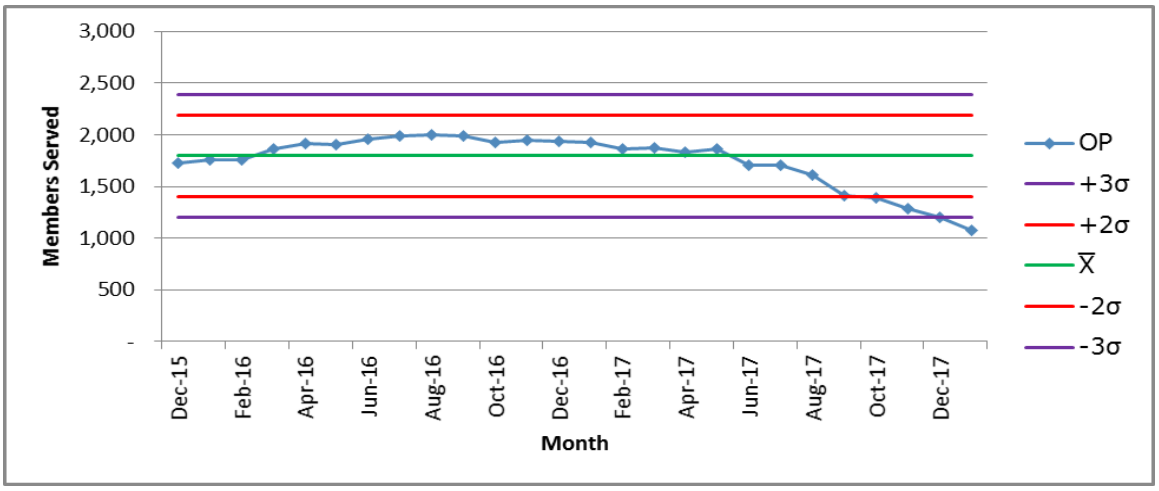


Figure 9: Traditional Outpatient Members Served

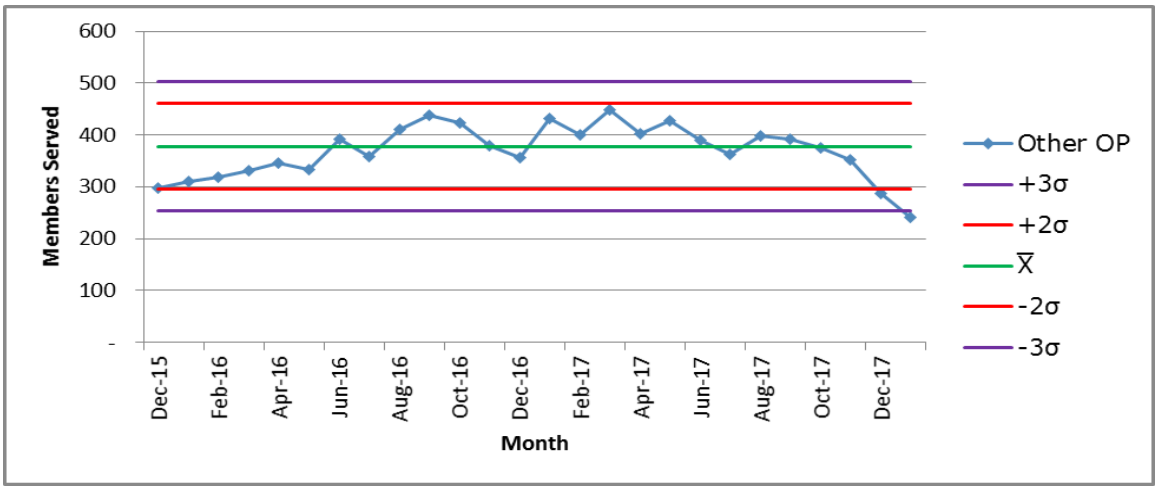


Figure 10: CPST Members Served

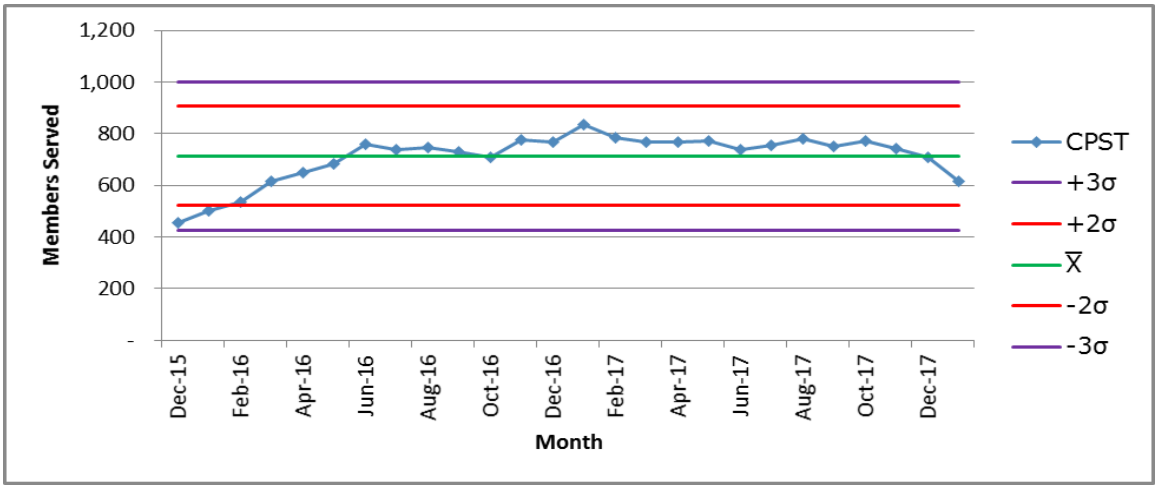


Figure 11: PSR Members Served

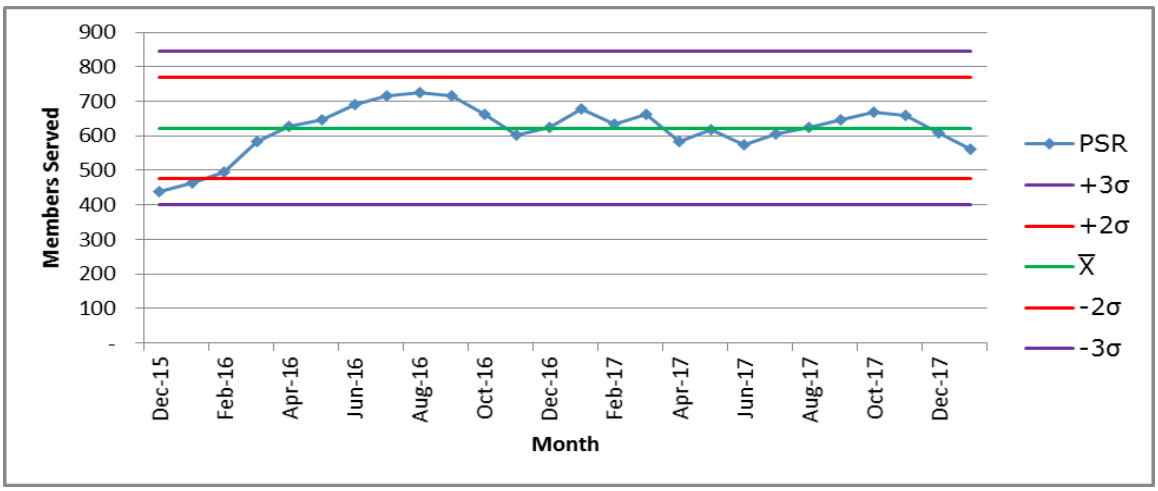
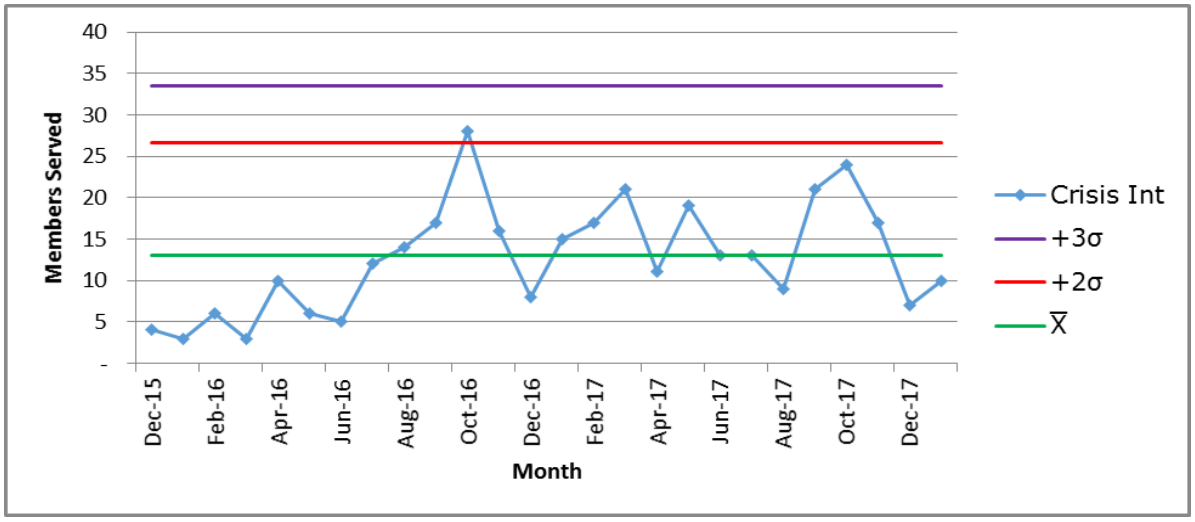


Figure 12: Crisis Intervention Members Served



Evidence-Based Practices

The Louisiana CSoC network includes access to evidence-based practices (EBP) for children, including Homebuilders and Functional Family Therapy (FFT). EBPs are essential to serve the demographic and diagnostic needs of CSoC members. Homebuilders is an intensive, in-home evidence-based program utilizing research-based strategies (e.g., motivational Interviewing, cognitive and behavioral interventions, relapse prevention, skills training, etc.) for families with children (birth to 18 years) at imminent risk of out of home placement, or being reunified from placement. Functional Family Therapy (FFT) is an evidence-based family intervention targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Utilization of FFT has continued to grow in 2017. Homebuilders' utilization remained lower than anticipated. It is believed that guidance from the Institute of Family Development, the organization responsible for training, certifying and monitor Homebuilders providers, instructed their providers to only serve families who were referred by a child-placing agency or entity to ensure fidelity to the model. As noted in the demographic section of this report, less than ten percent of youth in CSoC have involvement with the Department of Children and Family Services (DCFS). This programmatic decision and the low number of youth with DCFS involvement are likely to contribute to the lower utilization of this service seen since 2015. Figures 13 and 14 illustrate utilization of EBP services.

Figure 13: Family Functional Therapy Members Served

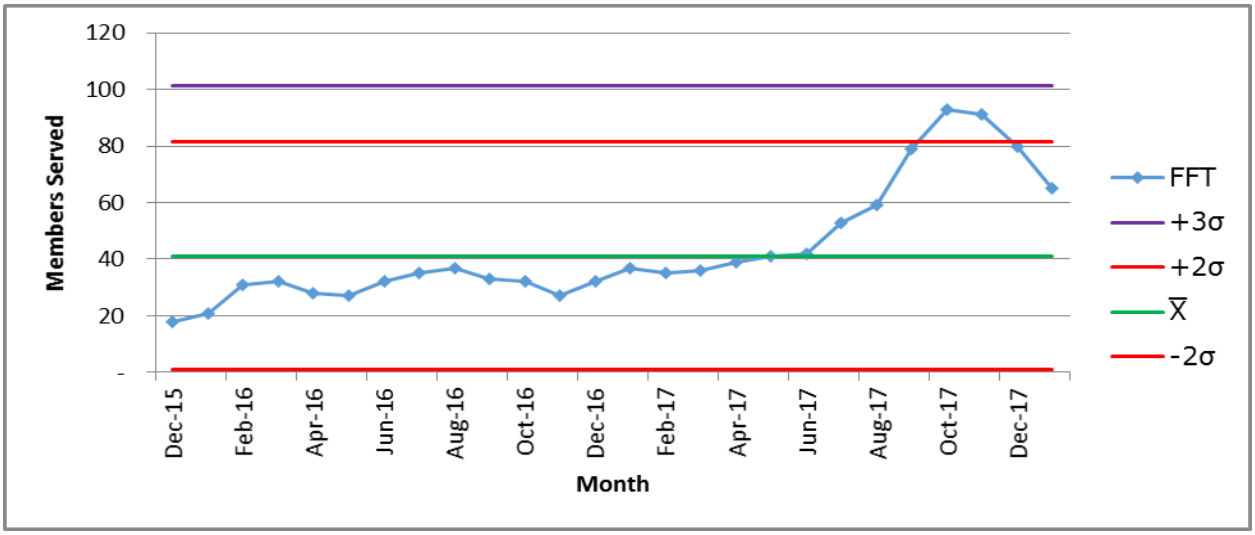
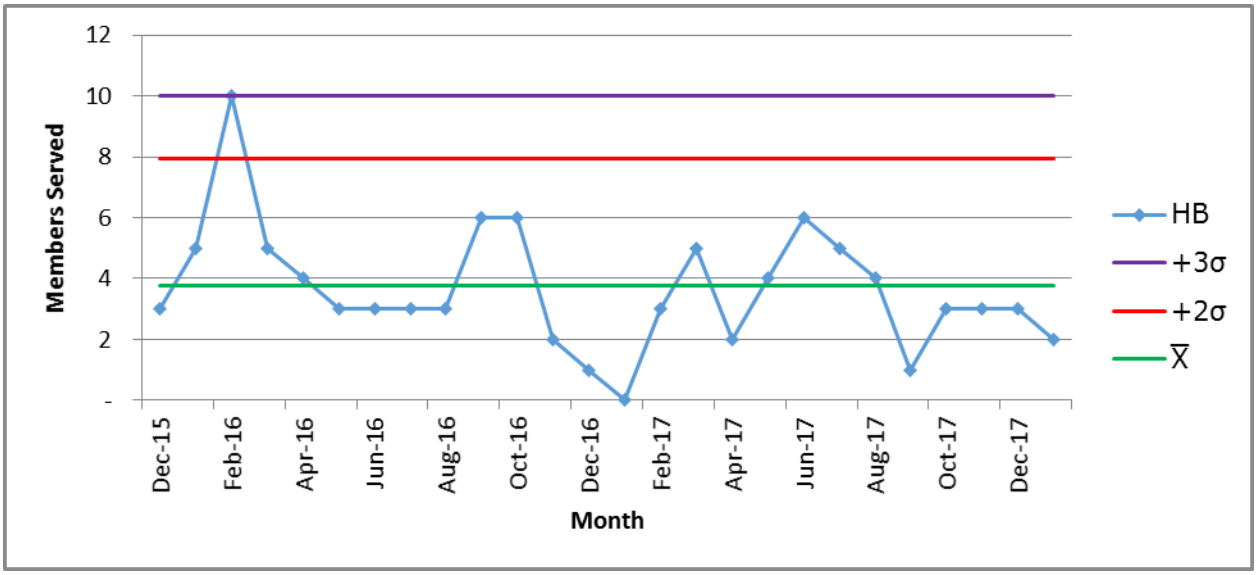


Figure 14: Homebuilders Members Served



CSoC Waiver Services

Magellan monitors utilization of the four specialized CSoC services. In CSoC, the Family Support Organization (FSO) is certified and contracted to deliver two of the four waiver services, parent support and training (PST) and youth support and training (YST). In August 2017, Ekhaya Youth Project was terminated from the Magellan network due to quality of care and access to care issues. This explains the drop in utilization of these two services in the later half of 2017 as illustrated in Figure 18 and 19. In response to the termination, Magellan implemented and enacted a member transition plan to ensure that strategies assigned to the FSO were transitioned to natural/informal supports or other formal providers. LDH also released a Request for Information to recruit qualified providers to join the network. As of January 2018, one provider has been certified by LDH, contracted by Magellan, and

began accepting referrals. The provider implementation plan emphasizes recruitment and training to ensure service delivery meets best practice standards for peer support services. During the next year, Magellan will continue to recruit providers in collaboration with a Request for Information process managed by LDH to ensure adequate access to care, quality of care and freedom of choice in providers.

Independent Living Skills Building (ILSB) is a service intended to help transition-aged youth to develop skills for independence and self-sufficiency. Since 2016, Magellan has increased oversight of youth receiving services to more closely monitor medical necessity criteria. This explains the decline in utilization beginning in December 2015, as depicted Figure 20. It is believed that the decline that is depicted is not the result of current underutilization of the service but rather previous overutilization. There were positive trend in utilization for Short-term Respite (STR), which is most likely the outcome of increases to the number of STR providers. Continued growth of this provider type is needed and is discussed further in the Network Development section. Figures 20 and 21 show trends in ILSB and STR utilization.

Figure 15: Parent Support & Training Members Served

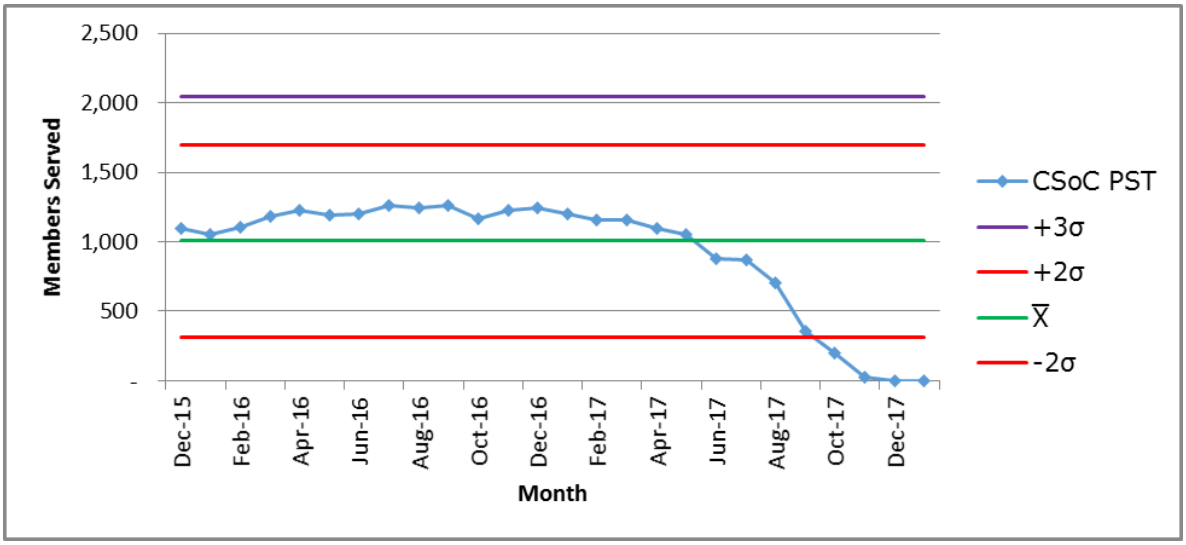


Figure 16: Youth Support & Training Members Served

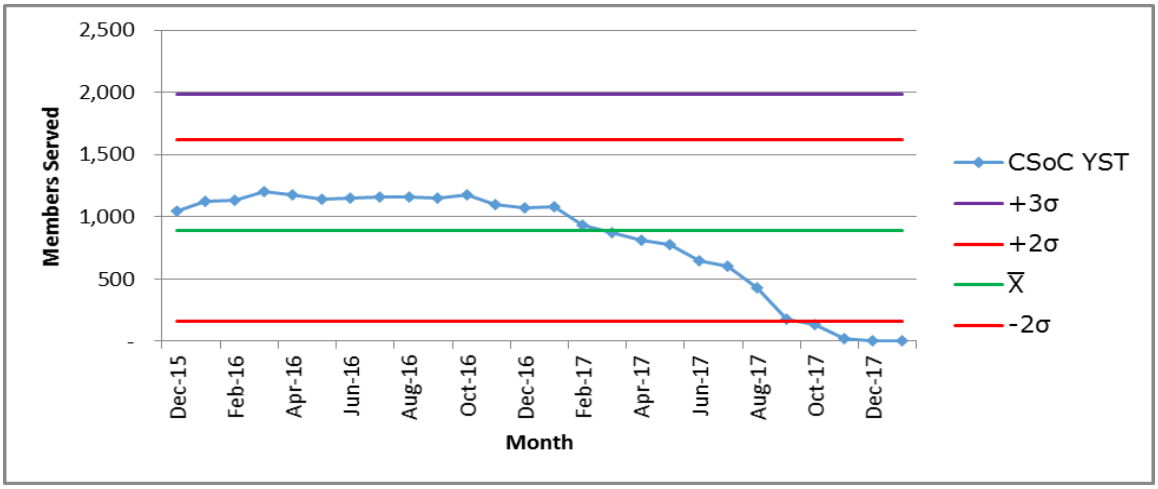


Figure 17: Independent Living Skills Building Members Served

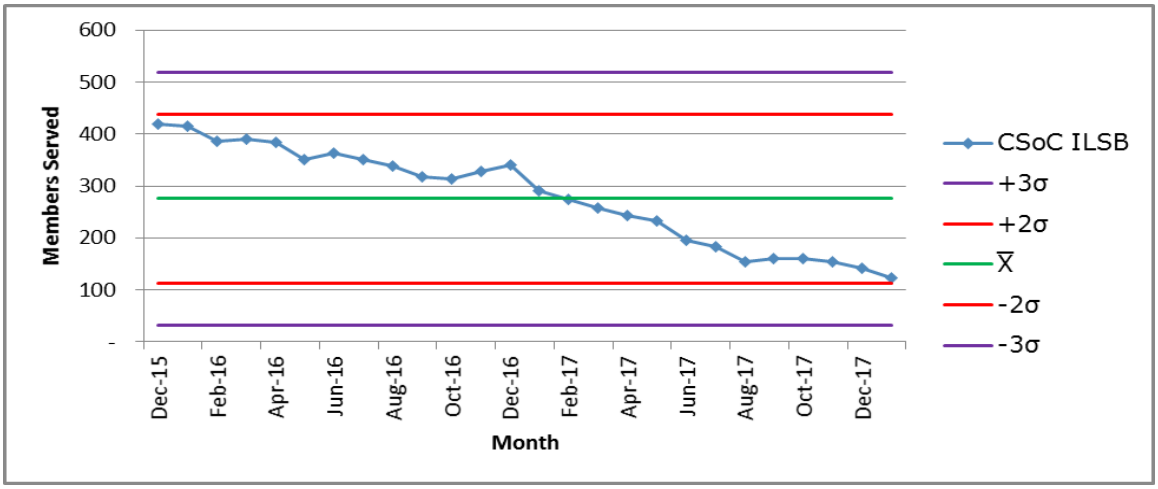
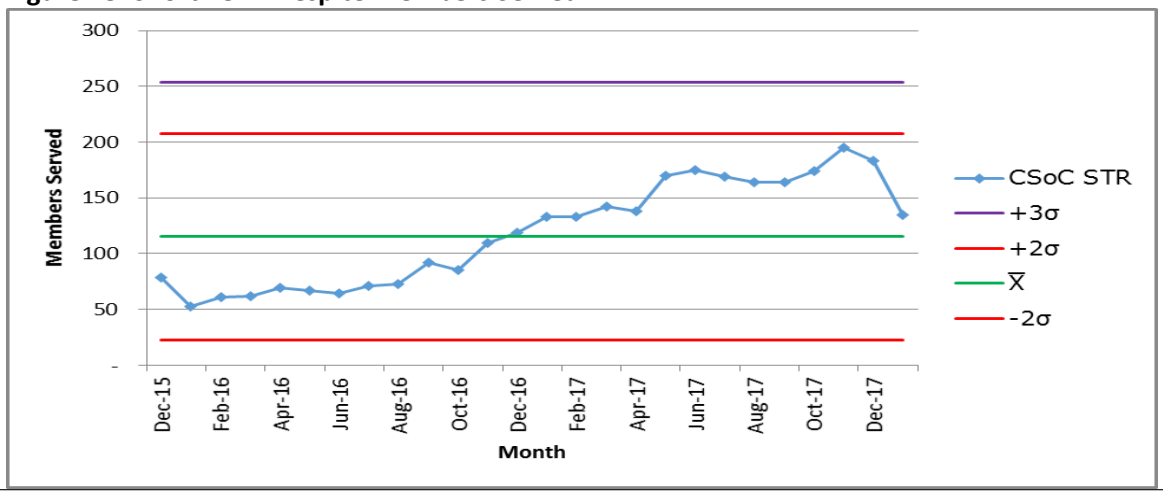


Figure 18: Short Term Respite Members Served



Member Survey

Although utilization data is beneficial to monitor access to care, members' perception of access to care is also highly valued in informing network development initiatives. Because of this, Magellan collects member survey data to assess access to care through a monthly verbal survey. In this process, Wraparound Facilitators are responsible for contacting members at least monthly to survey if they are receiving services in the type, amount, duration, and frequency specified in the Plan of Care. Individual remediation is offered to every member to ensure he/she receives services in the type, amount, duration, and frequency specified in the Plan of Care in the future if there is a negative response. The remediation is determined in context to the member's choice and voice. They include:

- Option 1: I did not need those services this month. (No Action needed).
- Option 2: I have a provider, but they are not meeting my needs for services this month. (Action Plan: Wraparound Facilitator contacts provider as part of care coordination).
- Option 3: I have a provider, but they are not meeting my needs for services this month. (Action Plan: Wraparound Facilitator helps member pick another provider).
- Option 4: There are no providers available for the service I need. (Action Plan: Wraparound Facilitator submits CSoC Needs Reporting Form to Magellan Health).
- Option 5: Member indicated multiple providers are not meeting services needs and appropriate action plan was implemented for each provider as required.

Overall Compliance

The overall compliance rate for this measure is calculated by looking at members that respond they are receiving services to meet their needs and those members reporting they did not receive but did not need services to meet their needs. The overall compliance rate has increased steadily since August 2017 and peaked in December 2017 with 94.76% of members reporting they are receiving the services that they need. It is believed that the termination of the FSO and implementation of the FSO member transition plan was the largest contributor to the increase in compliance for this measure. This also affected the pattern of options selected when members' needs were not met. Changes to the process that influenced this are described next. Tables 20 and 21 and Figures 19 and 20 outline the details and trends of data collected since 2015 for POC 06.

Table 20: POC 06 Overall Statewide Compliance Rate

Month Year	Numerator	Denominator	Compliance Rate
Dec 2015	1726	2037	84.73%
Jan 2016	1716	2018	85.03%
Feb 2016	1761	2031	86.71%
Mar 2016	1793	2114	84.82%
Apr 2106	1796	2176	82.54%
May 2016	1852	2202	84.11%
June 2016	1883	2219	84.86%
July 2016	1976	2261	87.39%
Aug 2016	1964	2204	89.11%
Sept 2016	1962	2201	89.14%

Month Year	Numerator	Denominator	Compliance Rate
Oct 2016	1934	2171	89.08%
Nov 2016	1885	2191	86.03%
Dec 2016	1891	2207	85.68%
Jan 2017	1956	2255	86.74%
Feb 2017	1903	2210	86.11%
Mar 2017	1886	2232	84.50%
Apr 2017	1888	2319	81.41%
May 2017	1778	2307	77.07%
June 2017	1667	2260	73.76%
July 2017	1523	2247	67.78%
Aug 2017	1706	2224	76.71%
Sept 2017	1901	2163	87.89%
Oct 2017	2051	2192	93.57%
Nov 2017	2075	2209	93.93%
Dec 2017	2134	2252	94.76%

Table 21: POC 06 Option Selection Trending (Members who reported they were not getting all of the services on their Plan of Care)

Month	Option 1	Option 2	Option 3	Option 4	Option 5
Dec 2015	13.50%	67.80%	5.50%	7.20%	5.20%
Jan 2016	21.85%	60.41%	5.40%	4.88%	6.94%
Feb 2016	31.70%	52.90%	3.30%	8.10%	4.10%
Mar 2016	27.30%	52.00%	5.70%	10.20%	4.80%
Apr 2106	22.50%	62.00%	2.10%	10.40%	2.70%
May 2016	26.80%	57.50%	1.70%	13.00%	1.00%
June 2016	25.50%	59.90%	0.90%	13.50%	0.20%
July 2016	30.80%	64.60%	1.90%	10.90%	1.50%
Aug 2016	33.30%	50.00%	2.80%	12.50%	1.40%
Sept 2016	28.70%	56.10%	3.90%	10.70%	0.60%
Oct 2016	32.90%	50.10%	4.50%	10.80%	1.70%
Nov 2016	24.70%	58.00%	2.70%	13.30%	1.20%
Dec 2016	27.40%	56.80%	7.40%	9.90%	2.20%
Jan 2017	33.41%	53.49%	3.28%	8.73%	1.09%
Feb 2017	27.42%	61.94%	3.31%	5.20%	2.13%
Mar 2017	24.62%	66.67%	1.09%	6.10%	1.53%
Apr 2017	19.23%	60.44%	5.31%	14.29%	0.73%
May 2017	19.60%	38.45%	3.80%	37.54%	0.61%
June 2017	17.87%	21.05%	5.26%	55.12%	0.69%
July 2017	16.88%	18.25%	3.10%	61.77%	0.00%
Aug 2017	23.71%	14.43%	5.01%	56.41%	0.44%

Month	Option 1	Option 2	Option 3	Option 4	Option 5
Sept 2017	32.30%	20.67%	11.11%	35.92%	0.00%
Oct 2017	48.16%	29.41%	9.56%	12.13%	0.74%
Nov 2017	51.84%	34.56%	13.60%	0.00%	0.00%
Dec 2017	47.56%	41.78%	10.67%	0.00%	0.00%

Figure 19: POC 06 Overall Compliance Rate

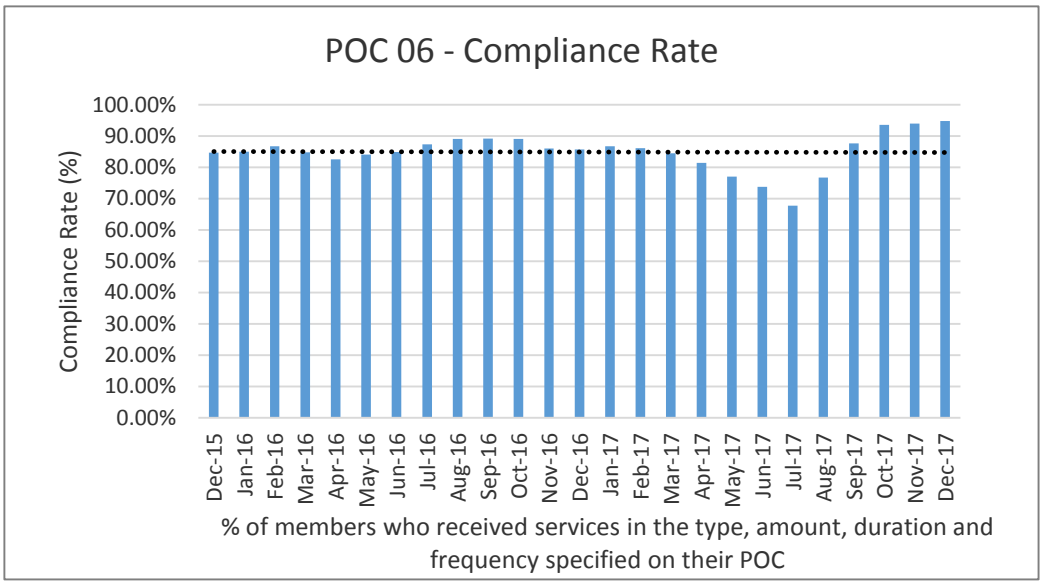
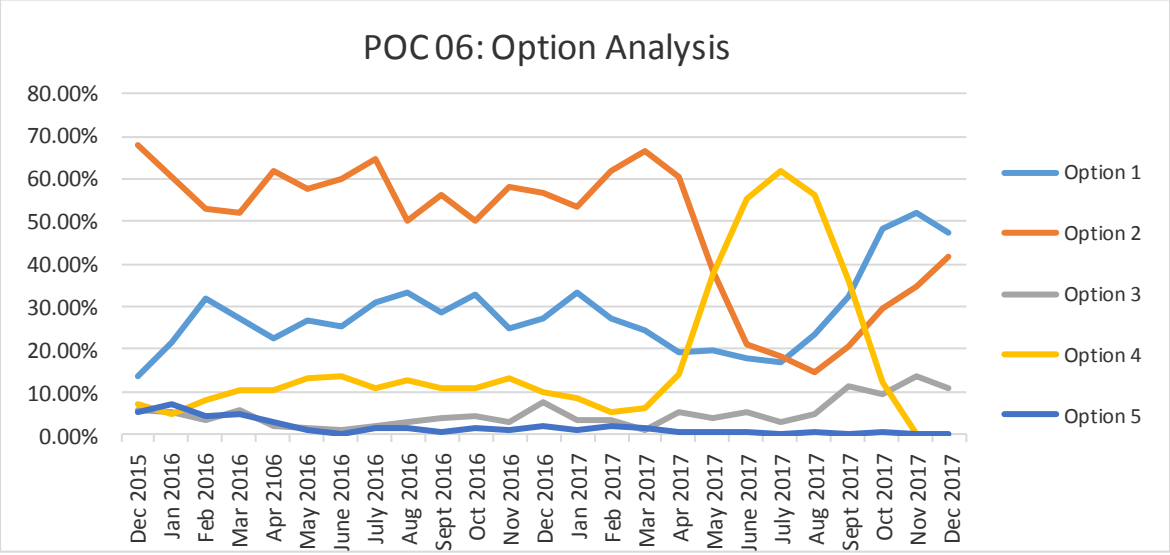


Figure 20: POC 06 Option Analysis



Option 4 and Needs Reporting Forms

As noted above Option 4 is selected if a need is identified for several months in a row. It is the only remedial activity that included member level detail and provider detail through the submission of a NRF, which allowed Magellan to work directly with providers to address barriers. Of the 2381 NRF reports received from March 2016 to December 2017, 2307 were either for Youth or Parent Support Services delivered by the FSO, representing 96.9% of reports received. It should be noted that in order to simplify the reporting process as a result of ongoing and growing access issues for FSO services, Option 2 was eliminated as an option for FSO services in June 2017. Facilitators were instructed to select Option 4 for members having issues accessing FSO services. If a Wraparound Facilitator selected Option 4 due to access issues with the FSO, a Needs Reporting Form (NRF) was no longer required to be submitted. This can explain the increase in Option 4 reports received beginning in June 2017. This process change will be discontinued in 2018. Table 24 represents regional and total NRF data from March 2016 (when the process was initially implemented) to December 2017.

Table 22: Needs Reporting Forms Received from December 2015 to December 2017

Month	Provider Type	R1	R2	R3	R4	R5	R6	R7	R8	R9	Monthly Total by Type	Monthly Total Received	Monthly % of FSO Reports
Mar-16	FSO	2	2	32	0	0	0	4	0	0	40	49	81.6%
	Other	3	0	3	0	0	0	3	0	0	9		
Apr-16	FSO	8	10	32	0	0	0	0	0	0	50	51	98.0%
	Other	1	0	0	0	0	0	0	0	0	1		
May-16	FSO	8	12	38	0	0	3	0	0	0	61	63	96.8%
	Other	1	1	0	0	0	0	0	0	0	2		
Jun-16	FSO	9	10	35	0	0	2	3	0	0	59	68	86.8%
	Other	0	8	0	0	0	0	1	0	0	9		
Jul-16	FSO	1	3	9	0	0	0	0	0	0	13	21	61.9%
	Other	0	8	0	0	0	0	0	0	0	8		
Aug-16	FSO	8	3	22	0	0	1	3	0	0	37	47	78.7%
	Other	0	8	1	0	0	0	1	0	0	10		
Sep-16	FSO	8	1	17	0	0	2	0	0	0	28	36	77.8%
	Other	0	7	0	0	0	0	1	0	0	8		
Oct-16	FSO	10	0	15	0	0	4	6	0	0	35	38	92.1%
	Other	0	3	0	0	0	0	0	0	0	3		
Nov-16	FSO	8	0	35	0	0	2	6	0	0	51	54	94.4%
	Other	0	3	0	0	0	0	0	0	0	3		
Dec-16	FSO	4	4	29	0	0	2	0	0	0	39	40	97.5%
	Other	0	1	0	0	0	0	0	0	0	1		
Jan-17	FSO	2	0	32	0	0	0	6	0	0	40	40	100%
	Other	0	0	0	0	0	0	0	0	0	0		
Feb-17	FSO	6	0	0	0	0	0	16	0	0	22	24	91.7%
	Other	0	0	0	0	0	0	2	0	0	2		
Mar-17	FSO	18	6	0	0	0	0	5	0	0	29	30	96.7%
	Other	0	1	0	0	0	0	0	0	0	1		
Apr-17	FSO	24	0	0	0	4	0	49	0	0	77	78	98.7%
	Other	1	0	0	0	0	0	0	0	0	1		
May-17	FSO	76	7	0	76	6	7	55	0	20	247	248	99.6%
	Other	1	0	0	0	0	0	0	0	0	1		

Month	Provider Type	R1	R2	R3	R4	R5	R6	R7	R8	R9	Monthly Total by Type	Monthly Total Received	Monthly % of FSO Reports
Jun-17	FSO	118	64	0	75	4	22	58	0	52	393	401	98.0%
	Other	2	1	0	0	0	0	5	0	0	8		
Jul-17	FSO	146	81	0	122	5	16	67	1	94	532	538	98.9%
	Other	0	0	0	0	0	5	1	0	0	6		
Aug-17	FSO	102	82	0	102	0	4	9	0	83	382	383	99.7%
	Other	0	0	0	0	0	1	0	0	0	1		
Sept-17	FSO	5	19	0	63	0	2	2	0	48	139	139	100.0%
	Other	0	0	0	0	0	0	0	0	0	0		
Oct-17	FSO	1	0	0	19	0	0	1	0	12	33	33	100.0%
	Other	0	0	0	0	0	0	0	0	0	0		
Nov-17	FSO	0	0	0	0	0	0	0	0	0	0	0	
	Other	0	0	0	0	0	0	0	0	0	0		
Dec-17	Other	0	0	0	0	0	0	0	0	0	0	0	
	FSO	0	0	0	0	0	0	0	0	0	0		
Total FSO		564	304	296	457	19	67	290	1	309	2307		
Total Received		573	345	300	457	19	73	304	1	309	2381		
% FSO Reports		98.4%	88.1%	98.7%	100.0%	100.0%	91.8%	95.4%	100.0%	100.0%	96.9%		

FSO Access Issues

Throughout the year, Magellan worked with Medicaid and LDH to proactively address growing concerns related to access to FSO services, including initiating a solution-focused work group in February 2017. Unfortunately due to escalating issues, the FSO (i.e., Ekhaya Youth Project) was terminated from the Magellan network on 08/08/2017 as a result of Board of Director resignations, historical quality and access issues, failure to meet staff payroll, and ongoing grievances and complaints. A ninety day member transition plan was implemented on 08/08/2017 and closed on 11/06/2017 to ensure FSO strategies were transitioned to natural/informal supports and/or other formal providers as appropriate. In August 2017, LDH released a Request for Information in order to recruit qualified providers to join the network. As of January 2018, one provider has been certifed by LDH, contracted by Magellan and began accepting referrals in January 2018. The provider implementation plan emphasizes recruitment and training to ensure service delivery meets best practice standards for peer support services. During the next year, Magellan will continue to recruit providers in collaboration with a Request for Information process managed by LDH to ensure adequate access to care, quality of care and freedom of choice in providers.

Next Steps

In March 2018, Magellan will make enhancements to the POC 06 process to enhance our analytic processes to identify and monitor members who have consecutive months reporting they are not receiving services. Magellan has developed management tools for the Wraparound Agencies to ensure the swift identification of members that require intensive interventions.

Network Development

Magellan monitors the provider network, utilization, and quality data to ensure compliance with contract requirements and to inform network development activities. Our network development strategy is both adaptable and collaborative to ensure network composition meets the needs of our membership. Contract requirements include:

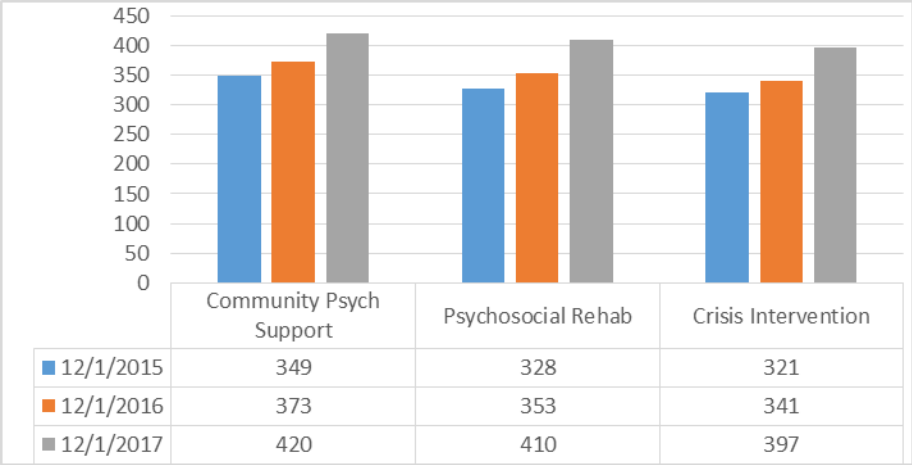
- Maintain a network with a sufficient number of providers of specialized CSoC services including Youth Support and Training (YST), Parent Support and Training (PST), Independent Living/Skills Building (ILSB), and Short Term Respite (STR).
- Contract with at least one Federally Qualified Health Center (FQHC) in each CSoC region of the state if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications. Magellan will notify Louisiana Department of Health (LDH) if there are any barriers or issues with contracting with FQHCs.
- Continue analysis of network composition through review of ad hoc reporting and GEO Access.
- Track data that identify gaps in the provider network regarding levels of care *and/or* specialty services that correspond to members' needs in a particular geographic region.
- Ensure its provider network offers an appropriate range of specialty behavioral health services that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements.
- Assure that the network has a sufficient number of prescribers and other qualified service providers to deliver services during evenings and weekends for members or their families/caregivers who are unavailable for appointments during regular business hours.
- Monitor and report to LDH the number and type of out-of-network subcontracts for treatment by provider type and region.
- Monitor and report monthly on the number of out of state placements for treatment services by type of placement, the location of placement, and evidence of what efforts are being made to return these youth to the state and their homes.
- Enter into Ad hoc or Single Case Agreements for out-of-network or out-of-state providers to provide services for members when medically appropriate for continuity of care.

As stated in the Accessibility of Services section, Magellan has an established process to monitor accessibility and availability of services, which informs recruitment efforts. Workgroups review the geographic network access and appointment availability data, the results of member satisfaction surveys, and member/family grievances to identify gaps in the type, density, and location of behavioral health providers in Magellan's network. Access issues are also monitored via the Needs Reporting Form. The NRF spreadsheet includes member level detail and provider detail, allowing Magellan to work directly with providers to address barriers. It is imperative that we work closely with our service providers on access issues and rely on them to report unmet needs. When gaps are identified, the Network Services Department develops provider surveys, email blasts, provider forums, *and/or* provider outreach to determine interest. This workgroup reports to the QIC if opportunities for improvement are identified.

Specialized Behavioral Health Services

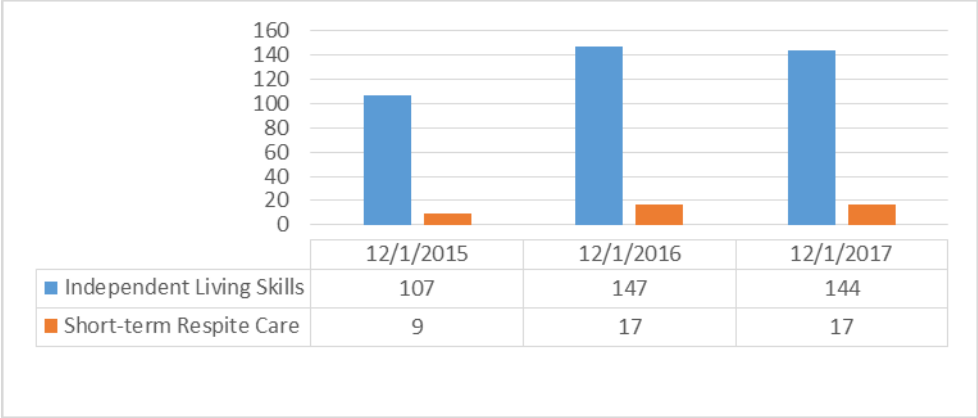
From 12/01/2016 to 12/31/2017, there was a 65% decline in the overall composition of the network that was largely due to the robust efforts of our network and quality departments, in collaboration with LDH, Health Standards Section (HSS), and Medicaid's Program Integrity to evaluate and maintain contracted providers who provide quality care, actively participated in the network and were compliant with contractual requirements. Recruitment efforts in contract year two resulted in the continued expansion of HCBS services, such as CPST, PSR, CI, as well as waiver services, including ILSB and STR. Since 2015, the CSoC program has seen a steady increase in STR providers, with a 155.6% increase in providers 12/01/2015 to 12/01/2017. Interventions to facilitate network development included leveraging provider calls, direct provider outreach, the partnership with Wraparound Agencies, and Network Strategy Workgroup sessions to inform the provider community to support recruitment of additional Waiver and HCBS providers. Figures 21 and 22 depict increases in the HCBS and STR providers in our network since 2015.

Figure 21: Growth in Home and Community Based Service Providers



	Community Psych Support	Psychosocial Rehab	Crisis Intervention
12/1/2015	349	328	321
12/1/2016	373	353	341
12/1/2017	420	410	397

Figure 22: Growth in Waiver Service Providers



	12/1/2015	12/1/2016	12/1/2017
Independent Living Skills	107	147	144
Short-term Respite Care	9	17	17

Family Support Organization

In CSoC, the Family Support Organization (FSO) is certified and contracted to deliver two of the four waiver services, parent support & training (PST) and youth support & training (YST). Initially when the program was implemented in 2012, there were five FSOs certified and contracted to deliver these two services; however, in 2014, through an RFI process, Louisiana Department of Health (LDH) shifted the model to a single, statewide FSO model for the CSoC program. At that time, Ekhaya Youth Project (Ekhaya) was designated to serve as Louisiana's FSO. In August 2017, Ekhaya Youth Project was terminated from the Magellan network and LDH released a Request for Information to recruit qualified providers to join the network. As of January 2018, one provider has been certified by LDH and contracted by Magellan and began accepting referrals in January 2018. The provider implementation plan emphasizes recruitment and training to ensure service delivery meets best practice standards for peer support services. During the next year, Magellan will continue to recruit providers in collaboration with a Request for Information process managed by LDH to ensure adequate access to care, quality of care and freedom of choice in providers.

Prescribers and Other Qualified Service Providers

Having a sufficient number of prescribers and other qualified service providers is also key to the successful service delivery of our membership. Magellan is notified of gaps via the POC 06 needs reporting forms or grievances from members/families or providers. Ad hoc, or single case agreements, for out-of-network or out-of-state providers, are entered into when medically appropriate and/or needed to ensure continuity of care. While the table below indicates shortages for some provider types, there were no out-of-state Ad hoc agreements in 2017 related to issues with access to services. Magellan entered into twenty single case agreements in contract year two to maintain continuity of care or to provide specialty services. Nineteen of the twenty providers with a single case agreement joined the network. Magellan remains committed to ensuring the network maintains the appropriate number of providers to meet members' needs. Tables 23 and 24 provide details on the GEO access standings as of 12/01/2017. Table 24 is based on the reporting template provided by LDH and does not include FSO, ILSB and crisis stabilization providers.

Table 23: GEO Access for Prescribers

	Urban	Rural
Total Members	657	1,644
Members with Desired Access	657	1,639
Members without Desired Access	0	5
Percent with Desired Access	100.0%	99.7%
Average miles to Prescriber 1	1.9	12.1

Table 24: Specialized Behavioral Health Network Adequacy and GEO Access

Provider Type	CSoC R1	CSoC R2	CSoC R3	CSoC R4	CSoC R5	CSoC R6	CSoC R7	CSoC R8	CSoC R9	Statewide
Advanced Practice Registered Nurse	2	4	7	2	8	3	2	0	1	28
Behavioral Health Rehab Provider Agency (opened after 3.1.12)	63	37	17	4	13	4	10	26	17	170
Distinct Part Psychiatric Unit	4	2	3	1	6	2	0	7	2	26
Doctor of Osteopathic Medicine	2	0	0	0	0	0	0	0	0	2
Family Functional Therapy	2	1	0	1	4	1	1	3	5	18
Federally Qualified Health Center	17	11	10	9	3	0	1	3	5	59
Free Standing Psychiatric Hospital	5	6	2	1	3	3	4	2	2	27
Homebuilders	0	2	0	1	0	0	0	2	2	7
Licensed Addiction Counselor	1	1	2	0	0	0	0	0	1	5
Licensed Clinical Social Worker	57	31	32	5	14	10	5	9	5	164
Licensed Marriage and Family Therapist	7	2	3	1	0	7	2	3	2	24
Licensed Professional Counselor	56	20	21	10	18	20	9	37	18	203
Mental Health Clinic (LGE Clinics)	7	8	8	4	1	3	1	0	0	32
Mental Health Rehabilitation Agency (Legacy MHR)	14	11	0	3	3	2	4	9	10	51
Psychiatrist	60	32	10	2	9	7	3	10	3	127
Psychologist - Clinical	37	5	9	0	3	1	3	3	0	56
Respite Care Services Agency/Center Based Respite	1	3	2	2	0	1	3	2	3	14
Rural Health Clinic	0	0	0	0	0	0	0	0	2	2
School Based Health Center	1	0	0	1	1	5	1	1	4	14
Substance Abuse and Alcohol Abuse Center (Outpatient)	15	13	10	5	7	5	4	8	11	76
Wraparound Facilitation (CSoC)	1	1	1	1	1	1	1	1	1	9
Total	334	173	124	43	83	64	48	110	73	1114

Crisis Stabilization Development

Since 2015, the CSoC program has seen a steady increase in STR providers, with a 155.6% increase in providers 12/01/2015 to 12/01/2017. This year, Magellan, with the approval of LDH, coordinated meetings with the Healthy Louisiana Plans and LDH to discuss respective efforts in developing Crisis

Stabilization services and share barriers to development. Licensing rules and rates remain as notable barriers to the development of this service, as well as, lack of utilization data that would inform needs. The meetings ended with Magellan encouraging the implementation of structured collaborative interventions to leverage resources from all managed care organizations to better develop Crisis Stabilization services for Louisiana's Medicaid population. Magellan was successful in contracting with a Crisis Stabilization provider in April 2017 and is working with LDH to ensure proper application of the service to our members.

Provider Monitoring

The treatment record review (TRR) process is a key quality activity to collect data on the quality of services delivered by providers. It is a process in which documentation and record keeping processes are reviewed to ensure compliance with quality standards and federal/state guidelines. Treatment record reviews are conducted to:

- Collect data for the evaluation of the quality of care delivered to Magellan members by providers;
- Provide feedback to providers on documentation standards for on-going education;
- Monitor provider compliance with Magellan clinical practice guidelines (CPGs);
- Monitor provider compliance with Medicaid waiver assurance performance measures;
- Verify that treatment record keeping practices meet Magellan standards;
- Investigate quality concerns and reported deficiencies of providers, which may indicate that a provider does not meet Magellan standards;
- Investigate grievances related to the clinical or administrative practices of providers, as determined on a case-by-case basis;
- Meet specific requirements of customer organizations; and
- Meet requirements of various accreditation standards that are adhered to by Magellan.

TRR results are reviewed by the QIC and the RNCC for the purpose of identifying opportunities for improvement for network treatment record documentation and adherence to clinical practice guidelines. The results of reviews are also considered by the RNCC before making decisions about credentialing, re-credentialing, corrective or disciplinary action, or termination from Magellan's provider network. The TRR Plan includes all the specific activities related to the process. Magellan has two processes to monitor network providers' records, including:

- **Standard TRR process** to monitor specialized behavioral health and waiver service providers, including monitoring of CPGs for ADHD and Suicide Risk for applicable members. Magellan sets a minimum performance threshold of 80% compliance and a goal of 90% for overall network compliance.
- **Wraparound Monitoring Reviews** to monitor Wraparound Agencies for compliance with waiver assurances and documentation requirements. LDH sets a minimum performance threshold of 90% compliance and a goal of 100% for waiver assurances. Magellan establishes a minimum performance threshold of 80% compliance and a goal of 90% for overall network compliance.

The following section provides the results of monitoring activities from 12/01/2016 through 12/31/2017.

Standard Treatment Record Review

Twenty-four providers were reviewed for standard TRR. Providers from all levels of care were randomly selected for audit, including twelve home and community-based providers, eleven waiver providers, and the Family Support Organization. Twelve of the providers were identified as high-volume providers and were audited onsite. Twelve of the providers were classified as low-volume providers and were audited

remotely through a desktop review. The provider network showed a high level of compliance with the standards monitored. The network compliance rate for the core quality standards was 91%, or 2,775.5 of 3,045 elements met. This was eleven percentage points higher than the established minimum performance threshold of 80% compliance and one point over our goal of 90%. This was slightly lower than the 94% score from the previous year; however, this is not believed to indicate systematic concerns. Table 25 provides section scores for TRR elements.

Table 25: Results of Standard TRR

Sections	Total Elements Reviewed	Elements Meeting Compliance	Compliance Rate (%)
Standard			
General	332	325	98%
Member Rights & Confidentiality	358	262.5	73%
Initial Evaluation	777	733	94%
Individualized Treatment Plan	259	245	95%
Ongoing Treatment	754	723	96%
Coordination of Care	297	260	88%
Medication Management	74	74	100%
Discharge	N/A	N/A	N/A
Restraints/Seclusions	N/A	N/A	N/A
CSoC	164	123	75%
Adverse Incident	N/A	N/A	N/A
Total	3045	2775.5	91%
Clinical Practice Guidelines			
CPG: ADHD	30	30	100%
CPG: Suicide Risk	N/A	N/A	N/A

Despite the high level of overall network performance, Magellan continues to focus efforts on improving care. All providers receive technical assistance throughout the process and are informed of educational resources available to them on the Magellan of Louisiana website to facilitate process improvement activities. High-volume providers receive feedback at the time of audit and are educated on interventions to improve compliance. Each provider receives a formal results letter identifying any items that scored below the 80% performance measurement threshold. Along with results letter and technical assistance, Magellan requires providers who score below a certain level to submit a Performance Improvement Plan (PIP) on intervention to address deficiencies. There are two levels of PIP, including:

- **Informal PIPs**
  - Required for providers with an aggregate score between 70%-79%
  - Includes a written corrective action plan that specifies the provider's activities to modify processes and procedures to address deficiencies
- **Formal PIPs**
  - Required for providers with an aggregate score below 70%

- Includes a written corrective action plan that specifies the provider's activities to modify processes and procedures to address deficiencies and a follow-up audit to monitor progress

Of the twenty-four providers reviewed in contract year two, only two providers were placed on Formal PIPs, with six being placed on Informal PIPs. The two providers placed on formal PIPs were home and community-based providers that were contracted with Magellan after 12/01/2015 and had not yet participated in a formal TRR review. As part of the Formal PIP process, the providers are scheduled to be re-audited during the April to June waiver quarter to ensure improvements are evidenced in the documentation. Results will be reported as part of standard TRR quarterly reporting.

Opportunities for Improvement

TRR data is used to identify when systematic process improvement interventions are needed. Although the overall and sectional scores were above 80%, three sections fell below 90% compliance and offer areas for possible intervention to promote improved service delivery. Opportunities for improvement include:

- Member Rights and Confidentiality
  - Release for communication with Wrap Around Agency
  - Release(s) for communication w/PCP, other providers, and involved parties are signed or patient refusal documented, informed consent for treatment
- Coordination of Care
  - Evidence of provider request of the consumer for authorization for PCP communication
  - Treatment Record reflects continuity and coordination of care between primary behavioral health clinician, psychiatrist, treatment programs/institutions, other behavioral health providers, and ancillary providers
- CSoC
  - IBHA included in the record.

Many of the elements identified as opportunities for improvement are related to coordination of care in some capacity. Coordination among systems, including behavioral health providers, is central to promote the principles of the wraparound model and is done as part of the Child and Family Team (CFT). The CFT meets at a minimum monthly and discusses the member's progress on the Plan of Care. Magellan has worked systematically with providers to improve formal behavioral health provider participation in CFTs as part of a statewide PIP, with a goal of advancing coordination of care. Magellan has also educated both the Wraparound Agencies and providers on the importance of sharing the appropriate release forms, assessments and treatment planning documents. Coordination with Primary Care Physicians (PCPs) continues to be an important initiative for the managed care industry. Magellan provides annual training on PCP coordination to promote this best practice and makes the training available to providers on the Magellan of Louisiana website. In January 2018, Magellan disseminated the updated Louisiana CSoC Standard Operating Procedures manual that included specific guidance and time parameters for the wraparound agencies to share documentation and notify providers of CFT's meetings. This is anticipated to help support improved documentation sharing between and providers. Magellan will continue to provide education to the both the Wraparound Agencies and providers to promote improved coordination of care during treatment.

Wraparound Agency Monitoring Reviews

The CSoC waiver authority requires the CSoC Contractor to have systems in place to measure and improve its performance in meeting the waiver requirements. The record review of WAAs is a data source for multiple CSoC waiver performance measures, such as Level of Care, Service Plans/Plan of Care, Home and Community-Based Setting, and Participant Health and Welfare. Magellan also monitors other documentation requirements that support contract requirements and quality initiatives through this process. All review elements under the record review must be scored as met or not met to maintain the correct evidentiary sample size and reporting requirements. A score of met indicates there is no evidence of non-compliance for the measure. Inter-rater reliability assessments are conducted annually to ensure the consistency in clinical management decision-making. Magellan selects a representative, random sample of members for review and adheres to sample size standards that require a sufficient size to ensure a confidence level of 95%, with a confidence interval of plus or minus 5% (i.e., sample size equal to or greater than 385 records). Magellan exceeded the sample size requirement by reviewing a total of 401 records for waiver requirements. The additional documentation requirements scored varied depending on if the question was applicable to the member record. Table 26 outlines the results of Wraparound Agency monitoring activities.

Table 26: Wraparound Agency Monitoring Activities

Question	Numerator	Denominator	Compliance Rate
Documentation Requirements			
1A Member Handbook, including rights and responsibilities was disseminated to member as evidenced by signed Freedom of Choice Form.	401	401	100
2A Psych advance directives or refusal documented (applicable to adults only)	20	29	68.97
1B D/C planning/linkage to alternative tx (level of care) leading to D/C occurring	401	401	100
1C Evidence of provider request of consumer for authorization for PCP communication	369	400	92.25
2C PCP communication after initial assessment/evaluation	398	401	99.25
3C Evidence of PCP communication at other significant points in treatment.	54	54	100
4C Treatment Record reflects continuity and coordination of care between primary behavioral health clinician and (note all that apply under comments): psychiatrist, treatment programs/institutions, other behavioral health providers, ancillary providers	391	397	98.49
1D Evidence of timely notification of Behavioral Health Providers of CFT meeting	276	399	69.17
Waiver Assurances			
1F Member's level of care determination was made by a qualified evaluator	400	401	99.75
1G Plan of care reflects supports and services necessary to address the member's goals	401	401	100

Question	Numerator	Denominator	Compliance Rate
2G Plan of care includes supports and services consistent with assessed health needs, including risks	401	401	100
3G Member participated in the plan of care development, as documented by the member's/authorized representative's signature on the plan of care	400	401	99.75
4G Plan of care updated timely, as specified in the waiver application	401	401	100
5G Plan of care was updated when the member's needs changed	400	401	99.75
6G Member was given a choice among service providers, as documented by the member/authorized representative's signature on the State-approved form	401	401	100
7G Member received information on available HCBS, as documented by the member/authorized representative's signature on the State-approved form	401	401	100
1H Member received information about how to report critical incidents, as documented by the member/authorized representative's signature on the State-approved form	401	401	100
2H Member received coordination and support to resolve health needs identified through case management contacts	401	401	100

As the Table 26 indicates, Wraparound Agencies showed very high compliance with waiver and contract requirements. After each audit, onsite debriefings are held with Wraparound Agency leadership to review results, and immediate feedback is provided along with education on areas of improvement needed. Additionally, corrective action plans are required for waiver assurance measures not meeting 100% compliance standards and documentation measures that scored below the 80% compliance standard threshold.

There were two waiver assurance Plan of Care items that did not meet the 100% compliance standard. In quarter one, there was one member record from Region 8 which was non-compliant for the Plan of Care being updated when the member's needs changed. In quarter two, Region 8 also had a member record that scored non-compliant for the member participating in the Plan of Care development as documented by a signature. Region 8 received a request for a corrective action plan to address deficiencies and remedial activities were effected as evidence by all records showing 100% in quarters three and four.

There were two documentation requirements that showed compliance rates below 90%, including advanced psychiatric directives and timely notification of CFT. These are the same two measures identified as opportunities for improvement last year; although, it should be noted that there was 35.6 percentage point improvement for the advance psychiatric directives item. One of the factors influencing the lower compliance rate for the advanced psychiatric directive element was the lower number of records audited. This is because this element is only applicable for members eighteen years and older, which represented twenty nine of the records reviewed. Magellan provided Wraparound Agencies with specific guidance on expectations on how to meet requirements for advance psychiatric directives and the performance measure has improved over time, with the measure scoring at 100% at the final quarterly audit for the year.

Several interventions have been implemented to address the compliance rate for the CFT notification element. This includes implementing a standardized protocol for how Wraparound Agencies notify providers of a CFT meeting. The following two changes were also made in the scoring procedure during the previous year to address barriers reported by Wraparound Agencies:

- The notification requirement decreased from ten days to seven days.
- If a provider attends a CFT and the next CFT is scheduled with the provider present, this would be considered timely notification.

As referenced in the TRR section, there was also revised version of the Louisiana CSoC Standard Operating Procedures (SOP) effective in January 2018, which requires the Wraparound Agencies to provide an electronic copy of the current Plan of Care to all formal providers listed on the CFT via secure email within five business days of each CFT meeting. Because the Plan of Care generally includes the next scheduled CFT meeting, this intervention should also have a positive impact on compliance for this element.

Provider Satisfaction Survey

Similar to member satisfaction surveys, provider satisfaction surveys serve as the most direct measure of assessing the practitioner's satisfaction with features and services provided by a managed care organization. Magellan conducts a survey of its participating network providers at least annually to obtain their perceptions of the service they received through Magellan. Feedback is collected using the Magellan Provider Satisfaction Survey questionnaire designed and administered by Magellan's corporate Survey Operations teams. The survey assesses satisfaction in the following areas: case management, utilization management, services, claims payment and reimbursement, communication, provider website, PCP communications, and overall experience.

All participating providers who received at least one authorization or submitted a claim for a service between 01/01/2017 and 06/30/2017 were selected to be surveyed. The questionnaires were distributed in July 2017 by e-mail or fax with an option to return them by fax and instructions for online completion. The survey department did multiple distributions and provider outreach to support our corporate and customer response rate goals. The survey was closed in November 2017. The survey data presented provides the second year of data for Magellan as the CSoC Contractor.

Of the 285 surveys delivered, 103 providers responded for a response rate of 36.1%, which was an increase of 10.8 percentage points from previous administration. The overall satisfaction with the services provided by Magellan was 95.9%, an increase of 1.2 percentage points from 2016 (n=94.7%). This is the highest overall satisfaction achieved in Magellan's history of serving Louisiana Medicaid members. Tables 27 and 28 outline the top and low-scored elements.

Table 27: Top Scored Satisfaction Items

	% POSITIVE		
Question	**2016**	**2017**	**Change from Previous Administration**
How satisfied are you with www.MagellanHealth.com/provider?	95.0%	96.9%	1.9%
During the past 12 months, how satisfied are you with Magellan publications (i.e., provider handbook, Provider Focus newsletter)?	91.7%	96.7%	5.0%
During the past 12 months, how satisfied are you with Magellan's provider support for our online self-service tools?	97.1%	95.8%	-1.3%
If you spoke to a utilization management clinical reviewer, please rate your satisfaction with the professionalism of the clinical reviewer(s)	86.2%	94.5%	8.3%

Table 28: Low Scored Items

Question	% POSITIVE		
	2016	2017	Change from Previous Administration
If you have filed a formal administrative complaint during the last 12 months, how satisfied were you with the timeliness of the resolution?	92.3%	78.6%	-13.7%
During the past 12 months, how satisfied are you with Magellan's authorization process	84.1%	76.1%	-8.0%
Do you know that you can file a formal administrative complaint via the provider website, by phone, or by mail?	70.0%	74.7%	4.7%

Top-scored items highlight providers' satisfaction with services provided by Magellan's network department, including web-based electronic supports. Low-scored items are used to inform process improvement activities for the upcoming contract year. The following discussion and actions are scheduled for these low-scoring items:

- It is believed the decreased satisfaction rate in authorization decision timeliness is influenced by the planning process that is associated with wraparound. One of the primary components of wraparound is the development, implementation and monitoring of a comprehensive plan that guides the family's treatment and service authorizations. Because of this, authorizations for CSoC members are not directly requested from Magellan, which can add steps to the traditional managed care authorization process. Additional steps include writing of the plan of care, which requires time for the facilitator to ensure that it address all areas of need, and review and approval by the facilitator's supervisor. The plan then requires oversight by Magellan, which can include collaboration with Wraparound Agency and amendments in the plan to ensure that it meets all of the member's needs as assessed in the IBHA and CANS assessments prior to acceptance. It should be noted there are generally very few denials of outpatient service requests for members as part of this process. Once the plan is accepted, Magellan is required to maintain a fourteen day time frame to create authorizations. Authorization data are available through Magellan's provider website and is updated daily to minimize any delays in providing services once the authorization is created. Magellan's Provider Relation Liaisons continue to provide education and assistance on requesting authorizations to the provider network to support this process. Another intervention that has been implemented is a change to the CSoC Standard Operating Procedures (SOP) document. The new criteria requires Wraparound Agencies to disseminate Plans of Care to providers electronically within five business days of the CFT. Magellan will continue to focus attention on provider education. It is also believed that some larger systemic issues related to Medicaid and LDH's mental health rehabilitation reform initiatives that affected the authorization process for outpatient providers and could have influenced the provider network's satisfaction with requesting authorizations systemically.
- Provider complaints serve as an invaluable means to evaluate a provider's relationship to other providers and stakeholders as well as members. Information on how to file a grievance is found on the Magellan website and available in the Provider Handbook. Magellan's website was redesigned in January 2018 to make it more user friendly and meet federal communication

regulations. Magellan will be developing a training to inform the provider network of the new design and will highlight the capacity to submit complaints online. Resolution timeliness is defined by industry and accreditation standards and is established at thirty days following receipt of complaint. As part of the acknowledgement process, complainants receive a written communication acknowledging receipt of complaint, which includes the time frame for which the complaint will be resolved. As part of the resolution processes, complainants are generally contacted telephonically by a clinical reviewer to further discuss content of complaints. Magellan will inform the complainant of the thirty day resolution timeframe to improve expectations related to resolution period. Magellan will make instructions on filing complaints and the timeframes for resolving complaints as a standing agenda announcement for all Provider All Calls to increase the scale and scope of provider reach.

Outcomes

Two of the main goals of the CSoC program are to reduce current and future out of home placement admissions and improve the overall outcomes of youth enrolled and their caretakers. Magellan's QI department is tasked with monitoring programmatic outcomes to ensure the CSoC program is achieving these goals. Similar to the approach Magellan takes with provider monitoring, outcomes are examined using a multidimensional approach. This section provides details on the two major mechanisms utilized by Magellan to monitor outcomes, the Child and Adolescent Needs and Strengths (CANS) assessment and Quality Improvement Strategy (QIS) performance measures.

Child and Adolescent Needs and Strengths (CANS)

The CANS Comprehensive Multisystem Assessment is a multi-purpose tool developed for children's services to support decision making, including eligibility and service planning, facilitating quality improvement initiatives, and monitoring of outcomes of services. The CANS is completed based on a face-to-face interview with the child and guardian(s) when possible as well as additional supporting information. The Louisiana CANS was developed with Dr. John Lyons to meet the unique needs of the state at the initiation of the CSoC program in 2012. It utilizes a localized algorithm to determine the child/youth's level of care, including psychiatric inpatient, nursing facility, treatment foster care, residential treatment, intensive community services, supportive and traditional outpatient care, which was developed to be sensitive to Louisiana's service delivery system and culture.

Unlike other psychometric tools, the CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans. The CANS measures not only member and caregiver needs but also strengths, aligning it with the principles of CSoC, such as strength-based, individualized, youth guided, family driven, data-driven and outcomes oriented. The CANS is used in practice to link the assessment process to individualized service plan to ensure the needs and strengths identified by the family and youth are addressed in the plan.
The CANS Comprehensive Multisystem Tool is flexible and has the capacity to expand depending upon the needs of youth and the family. There are a set of basic core items that are rated for all youth and unpaid caregivers as well as extension modules, which are triggered when key core questions are scored a one or higher. The extension modules allow the assessor to conduct a deeper dive into important needs, including juvenile justice, trauma, and substance use.

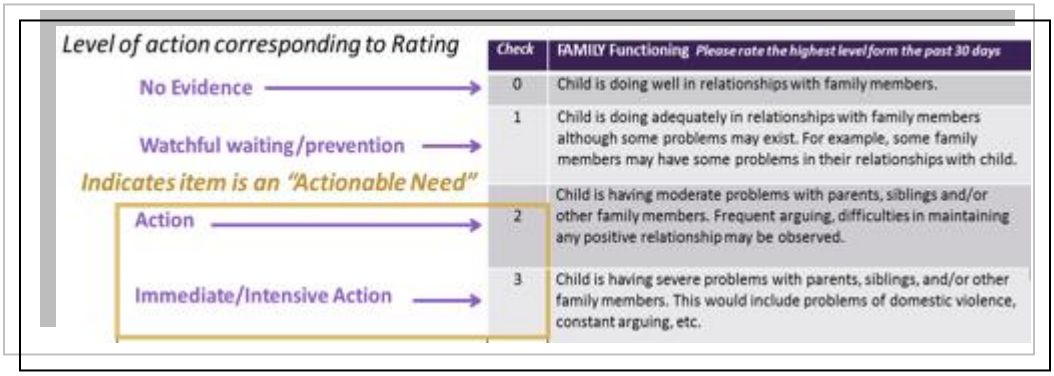
Rating Scale

The CANS measures individual needs and strengths using a 4-point scale to rate the highest level of the member/caregiver for the past 30 days. The scales for needs and strengths are as shown in Table 29. A rating of two or three on a CANS needs suggests that the area must be addressed in the plan. A rating of a zero or one identifies a strength that can be used for strength-based planning and a rating of two or three identifies a strength that should be the focus on strength-building activities. The CANS assesses the child in the following areas: problem behavioral/emotional needs, child risk behaviors, life domain functioning, caregiver strengths and needs, youth strengths, and acculturation. It also measures problem presentations, such as oppositional, attention/impulsivity, depression, and anxiety. Figure 23 illustrates the rating guidance for one of the elements assessed in the CANS.

Table 29: CANS Rating Scale

Rating	Needs Description	Strengths Descriptions
0	No evidence	Centerpiece strength
1	Watchful waiting/prevention	Strength that you can use in planning
2	Action	Identified-strength-must be built
3	Immediate/Intensive Action	No strength identified

Figure 23: Rating Scale for Family Functioning Element in the CANS



Psychometric Properties

The CANS is widely used across the nation to support similar programs, with versions in fifty states to support child welfare, mental health, juvenile justice, and early intervention applications. According to the Praed Foundation, the CANS has demonstrated reliability and validity. The average reliability of the CANS is 0.75 with vignettes, 0.84 with case records, and can be above 0.90 with live cases.

Data Integrity

To further support reliability and validity, Magellan performs input validation (e.g., identifying and investigating outlier scores, duplicates, etc.) to ensure the integrity of data. This includes monitoring the compliance rates quarterly to ensure that discharged members have both an initial and discharge CANS submitted electronically, which allows for the member to be included in current and future analytic activities. Positive impacts have been seen since 2016 as a result of establishing requirements for electronic submissions, with peaking in WY1 Q2 with a compliance rate of 97%. One of the interventions utilized by Magellan to support improved compliance rates was the removal of the sequencing rules for the LA CANS in MagellanProvider.com. Specifically, the requirement for an initial assessment to be electronically submitted before a reassessment or discharge. This requirement solved the immediate issue allowing for paper surveys to be uploaded out of sequence; however, it created new challenges, including the entry of initials, reassessments, and discharges assessments out of order and decreased timeliness of assessment entry. In April 2018, Magellan will restore the original sequencing rules to return reliability to the CANS submission process. Magellan will work with WAAs in February and March 2018 to ensure all initial CANS have been entered before restoring the submission sequencing rules.

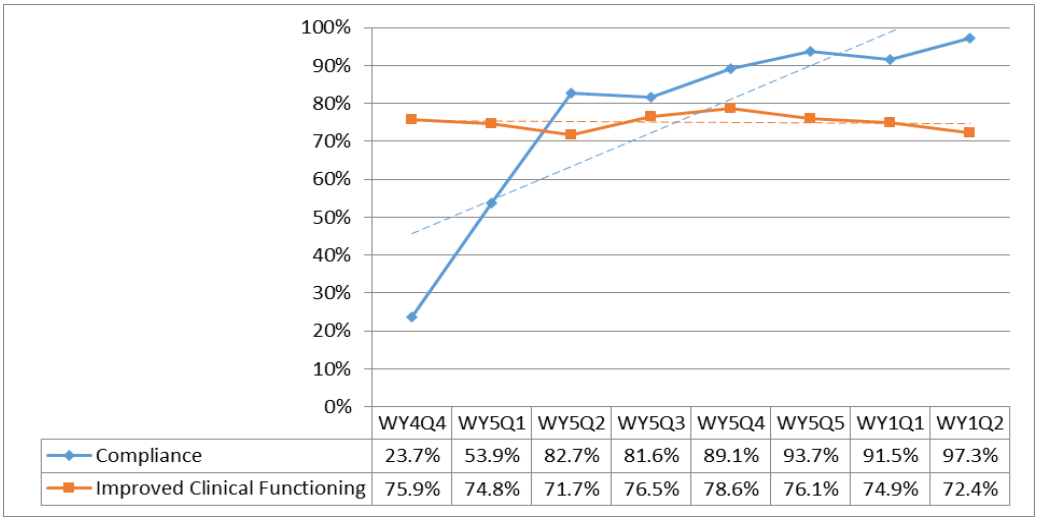
Outcomes Monitoring

Outcomes monitoring using the CANS can be accomplished in two ways, from the individual level and the system level. From an individual perspective, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). The individual's global score, or the sum of all items that measure outcomes, and domain scores, or the sum of all items in a domain that measures outcomes, can be generated by summing items within each of the dimensions (e.g., problems, risk behaviors, functioning, etc.). These scores can be compared over the course of treatment to indicate progress. To monitor outcomes systemically, the average global and domain scores of CSoC members can be tracked over time, specifically at enrollment and discharge from the program. The ability to monitor outcomes at a system level requires the CANS to be submitted electronically and has been supported by Magellan through the creation of interfaces that allow for the seamless collection of this data through MagellanProvider.com. Please see Data Integrity for more details on how Magellan supports compliance rates.

Quarterly CANS Outcomes

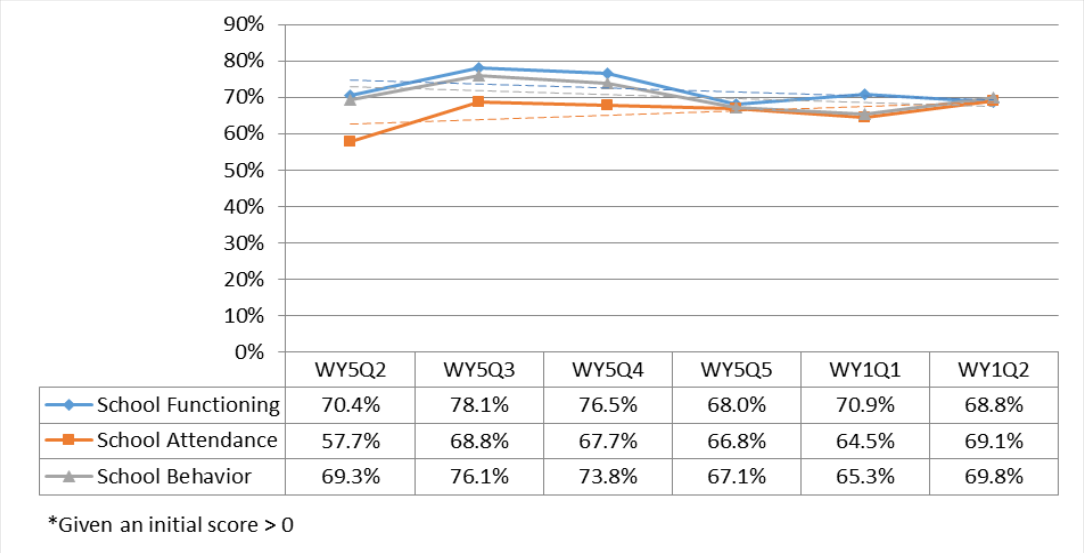
Magellan monitors CANS outcomes quarterly to meet contract requirements for performance measure reporting. This type of monitoring allows LDH, Magellan and WAA program directors to have a real-time mechanism to evaluate outcomes. Magellan monitors clinical functioning and school functioning on a quarterly basis using the CANS. Improved clinical functioning is defined as the percentage of members with a decrease of five points or more in the global scores from the initial and discharge assessments. School functioning is defined as the sum of the four items in the school module, and improvement is represented by a decrease of one point from initial to discharge CANS administrations. Individual items for school behavior and school attendance are also tracked. The program has consistently maintained strong outcomes, with approximately 70% of membership showing improvement in clinical and school functioning. Figures 24 and 25 display the quarterly results since December 2015.

Figure 24: CANS Global Score Quarterly Results



	WY4Q4	WY5Q1	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
Compliance	23.7%	53.9%	82.7%	81.6%	89.1%	93.7%	91.5%	97.3%
Improved Clinical Functioning	75.9%	74.8%	71.7%	76.5%	78.6%	76.1%	74.9%	72.4%

Figure 25: CANS School Module Quarterly Results



	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
School Functioning	70.4%	78.1%	76.5%	68.0%	70.9%	68.8%
School Attendance	57.7%	68.8%	67.7%	66.8%	64.5%	69.1%
School Behavior	69.3%	76.1%	73.8%	67.1%	65.3%	69.8%

*Given an initial score > 0

Comprehensive Analysis

Over the course of the year, Magellan also conducted multiple levels of analytics outside of our contracted reporting requirements. The first level of analysis completed was similar to the analysis done for the quarterly reporting. In this analysis, Magellan evaluated the global score at the initial and discharge assessment; however, this analysis included a larger a sample population of all discharged members with an electronic initial and discharge from 03/01/2012 through 07/10/2017. Although quarterly monitoring has value, it is also important to look at data over a longer period of time. This stabilizes the data by allowing for more members to be included, but it also provides an opportunity to conduct a statistical analysis of the data to ensure differences are not the result of confounding variables, such as seasonality, natural disasters, etc.

In August 2017, Magellan conducted a global and domain median analysis of 2,754 members meeting the defined criteria. The mean length of stay for the sample was 10.2 months. The z-statistic was used to evaluate the median global and domain scores at the initial and discharge assessments to determine if the differences in scores were due to chance. This comprehensive analysis showed strong outcomes, including a seventeen percentage point change from initial to discharge. Both the global and domain scores, with the exception of the acculturation domain, showed strong significant improvement as evidenced by p value of equal to or less than .001. This means that there is confidence that the results are not the result of chance but rather result of the programmatic interventions. The low number of youth that triggered the acculturation item initially explains why this domain did not show statistically significant improvements. Table 30 shows the details of the statistical analysis and Figures 26 through 28 illustrate the results of the global, domain and problem presentation comparison. The results of this comprehensive analysis are powerful, showing consistency in member outcomes across time and providing evidence that children are improving as a result of participation in CSoC.

Table 30: Z Statistic Results for CANS Analysis

Domain	Initial Median	DC Median	P-value	Z Statistic
Life Domain Functioning	13	8	0.000	-35.153
Child Strengths	19	14	0.000	-35.094
Acculturation	0	0	0.000	-5.358
Caregiver Strengths & Needs	11	8	0.000	-23.657
Child Behavioral/Emotional Needs	10	7	0.000	-33.730
Child Risk Behaviors	5	3	0.000	-29.238
School Behavior	8	4	0.000	-32.603
Global Score	58	40	0.000	-37.232

Figure 26: Comprehensive Global Score Analysis

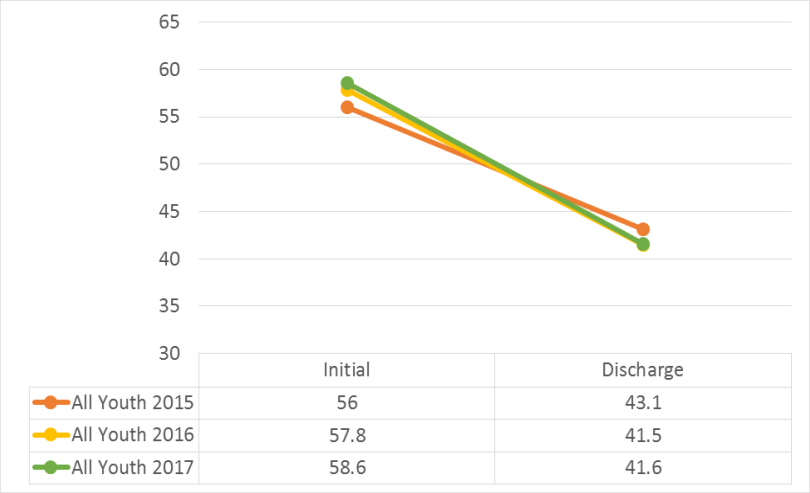


Figure 27: Comprehensive Domain Score Analysis

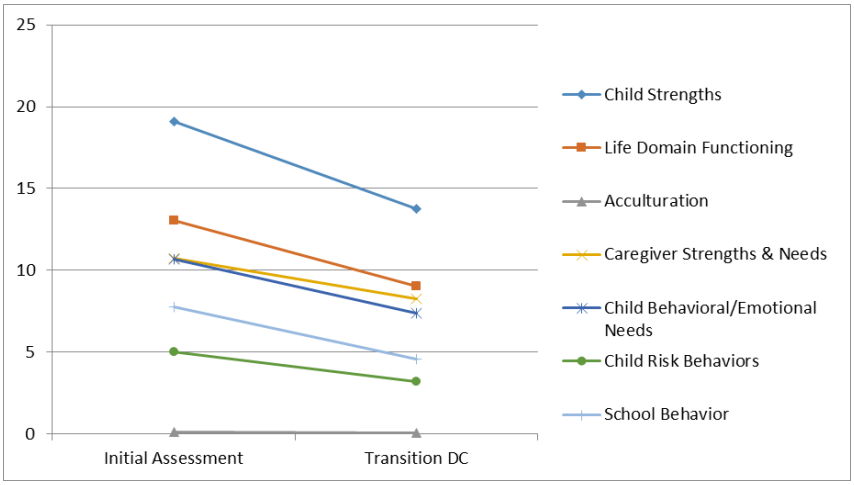
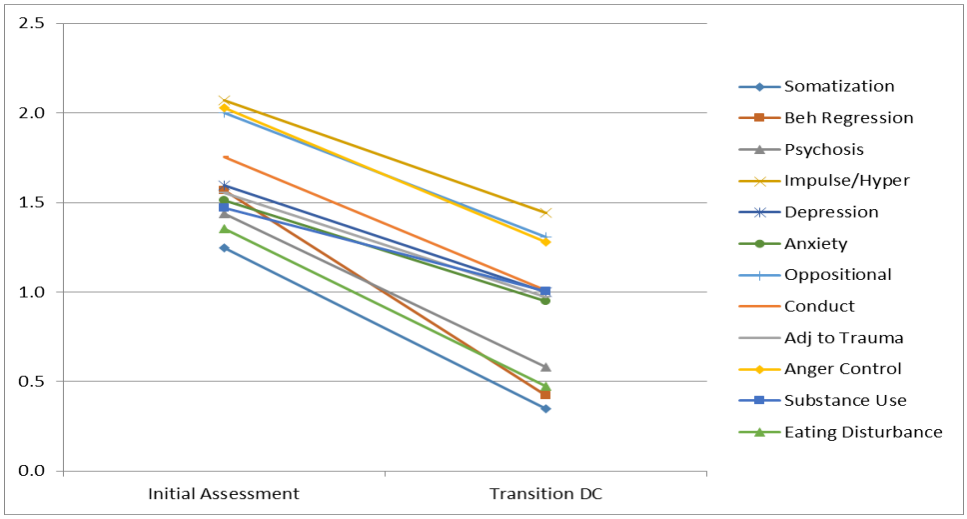


Figure 28: Comprehensive Problem Presentation Analysis



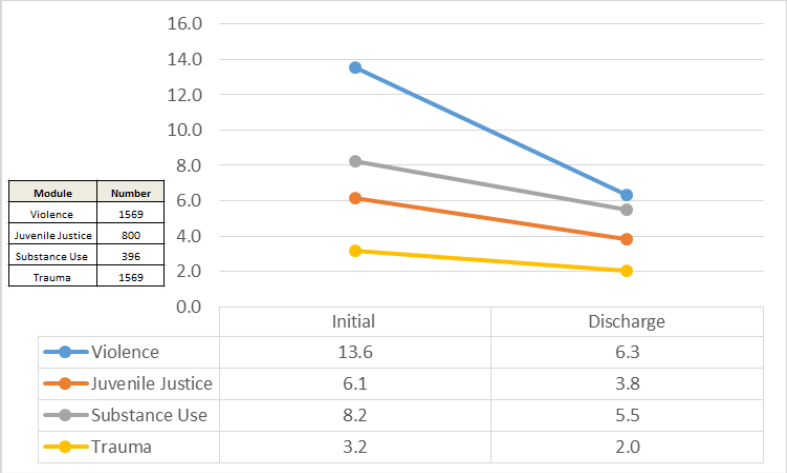
Population Differences

Magellan also uses the CANS to evaluate specific populations that are served through CSoC, such as children involved in child-serving agencies or members that trigger (i.e., score one or higher) extension modules. Magellan conducted an analysis using data gathered through Wraparound Agency self-report data spreadsheets, which allows for the collection of unique member characteristics, such as the Department of Children and Family Services (DCFS) and Office of Juvenile Justice (OJJ). The examination looked at members with an initial to discharge CANS from 01/2016 to 12/2017 and evaluated the average global sum change scores among individuals involved with DCFS, OJJ or members that trigger the juvenile justice module at the initial CANS assessment. The results are outlined in Table 31 and show improvements across all groups, with the greatest improvement in members triggering the juvenile justice model (i.e., change score of -19.13). As part of the comprehensive analysis referenced above, there was an examination of the domain scores for notable extension modules, including violence, juvenile justice, substance use and trauma. As Figure 29 shows there were decreases for all of the modules, with the largest decrease in the violence module.

Table 31: CANS Outcomes for Members Involved in Child-Serving Agencies

Involvement in Child-Serving Agency	Number	Avg Change Sum Score from Initial to Discharge
DCFS Involvement	192	-15.82
OJJ Involvement	351	-13.33
Triggered Juvenile Justice Module	999	-19.13
Overall	1,580	-16.87

Figure 29: Notable Extension Modules



Actionable Needs Analysis

Another area of analysis included evaluating the number of actionable items at the initial and discharge assessment. An actionable item is defined as an item with a score of a two or three. Actionable items are of particular significance for the CSoC program because they must be addressed on the plan of care according to waiver requirement, meaning there is a specific intervention assigned to the need to elicit improvement. In order for a need to be defined as met, the item must be scored as a zero or one at the reassessment administration. Figures 30 through 34 outlined the results of this analysis. The results show strong outcomes with a median of nine met actionable needs from the initial to discharge assessment. Other notable observations include only one gained actionable need and forty stayed non-actionable needs from initial to discharge as illustrated in Figure 33 and 35. This is of value because it provides evidence that members are not improving some areas while decompensating in other areas.

As referenced earlier, the CANS measures functionality across many domains and problem presentations. This evaluation did not just look at the change in the number of actionable items but also the type of items that were being resolved. Figure 35 provides details regarding the top ten actionable items resolved. As the figure indicates, high-risk needs, such as suicide and self-harm that would likely result in future out-of-home placements, were among the largest type of needs met.

Figure 30: Change in Net Actionable Needs from Initial to Discharge Assessments

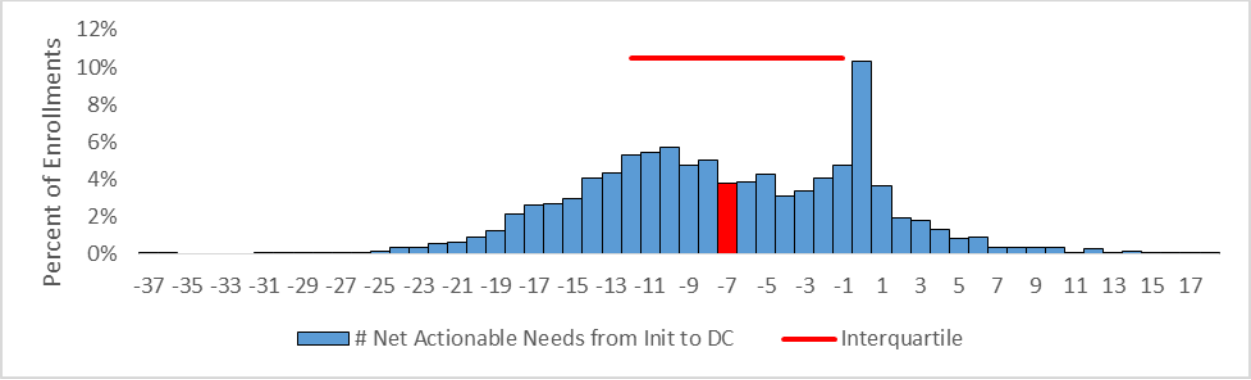


Figure 31: Change in Met Actionable Needs from Initial to Discharge Assessments

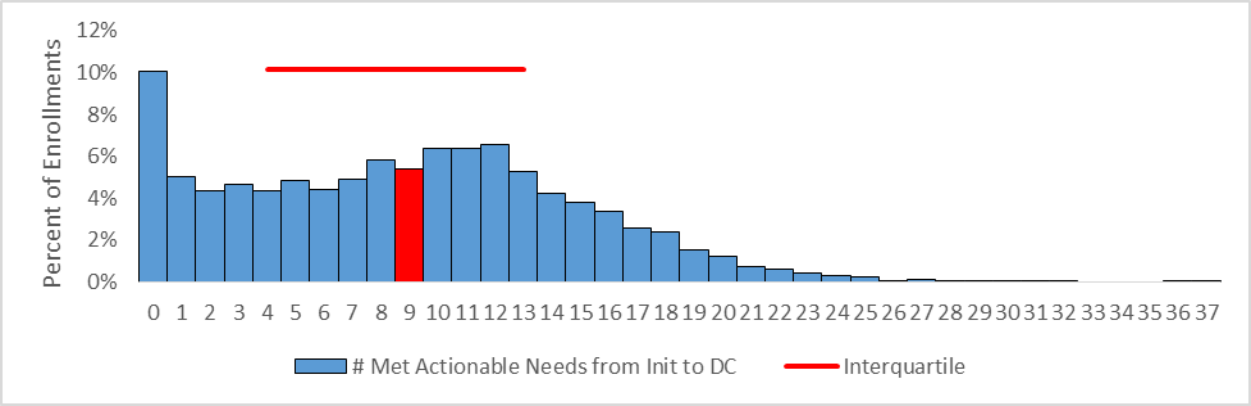


Figure 32: Change in Stayed Actionable Needs from Initial to Discharge Assessments

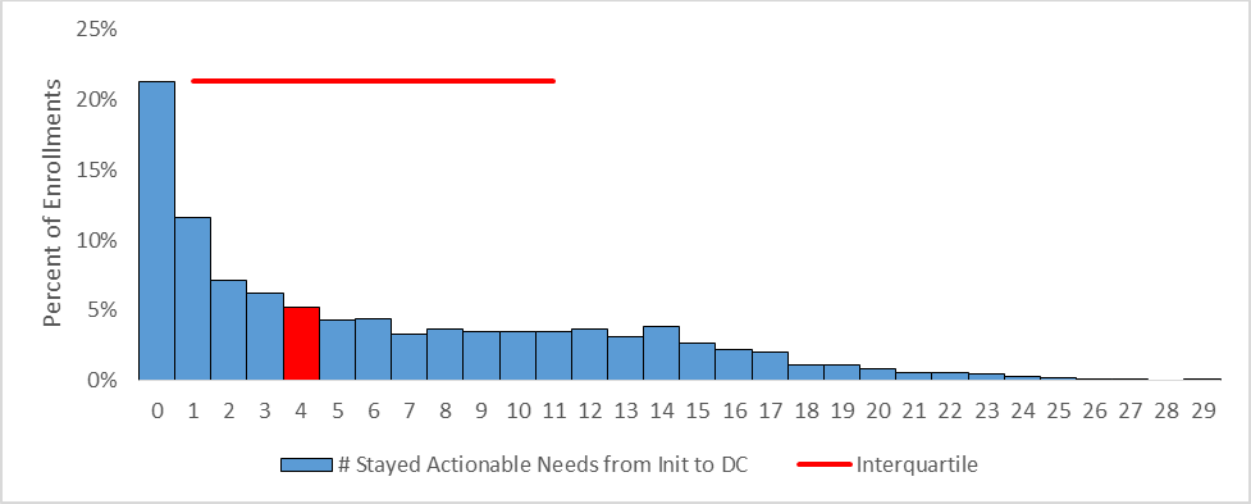


Figure 33: Change in Non-Actionable Needs from Initial to Discharge Assessments

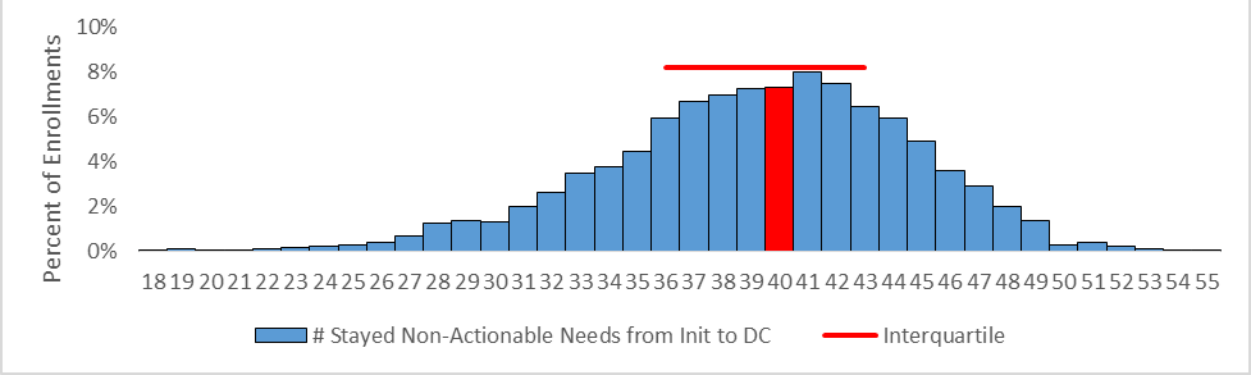


Figure 34: Change in Gained Actionable Needs from Initial to Discharge Assessments

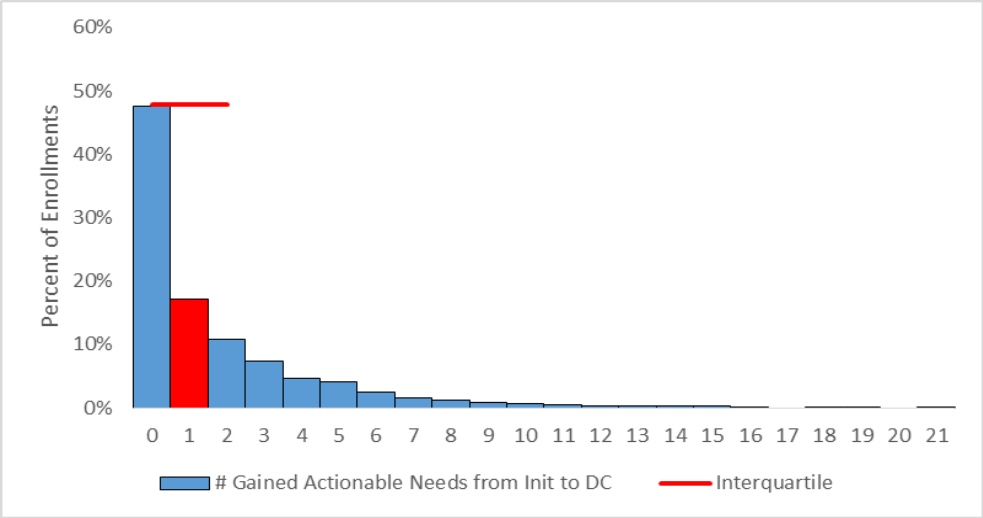
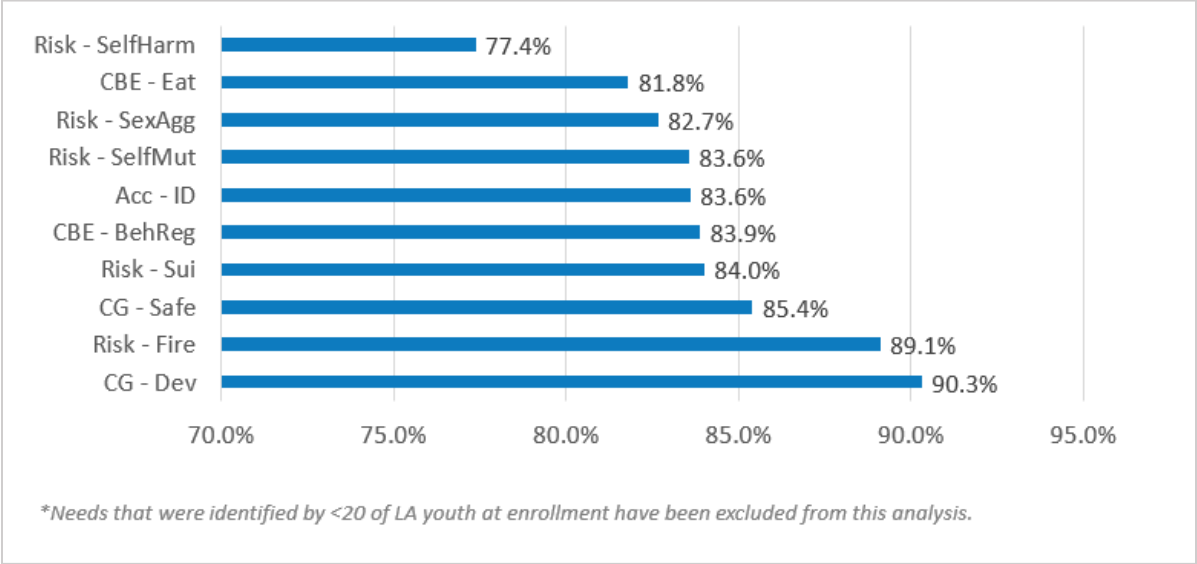


Figure 35: Top Ten Actionable Needs Met



WERT Data Sharing

In 2015, Magellan and LDH began sharing CANS data with the University of Washington's Wraparound Research and Evaluation Team (WERT). This was done in order to better understand how the CANS is being used in wraparound programs across the nation with the goal to provide guidance for program and system-level CANS usage, including:

- What are the typical strengths and needs of Wraparound-enrolled youth and families?
- How much change can programs and systems can expect to see in CANS scores over time?
- How do CANS scores vary across states and sites?

Due to programmatic differences, the research was only able to compare programs at the initial and six month reassessment. The results did provide important information regarding how our initial enrollment compared to other similar programs. It showed that the typical Louisiana youth had three more actionable needs as compared to similar programs, indicating higher level of acuity at enrollment. This is important because our eligibility criteria should target and identify the children and youth at high risk of out of home placement. Figure 36 shows the initial distribution of actionable needs for Louisiana as compared to the other sites involved in the research. This is also illustrated in Figure 37, which shows how Louisiana compared to the other sites for five of the most commonly prevalent actionable needs at baseline. Unfortunately WERT will no longer be able to pursue this level of research due to funding issues; however, Magellan will continue to be open, with the approval of LDH, to continued opportunities for collaboration with external entities to promote CANS and wraparound.

Figure 36: Number of Actionable Needs at Initial Assessment for Louisiana Compared to Other Sites

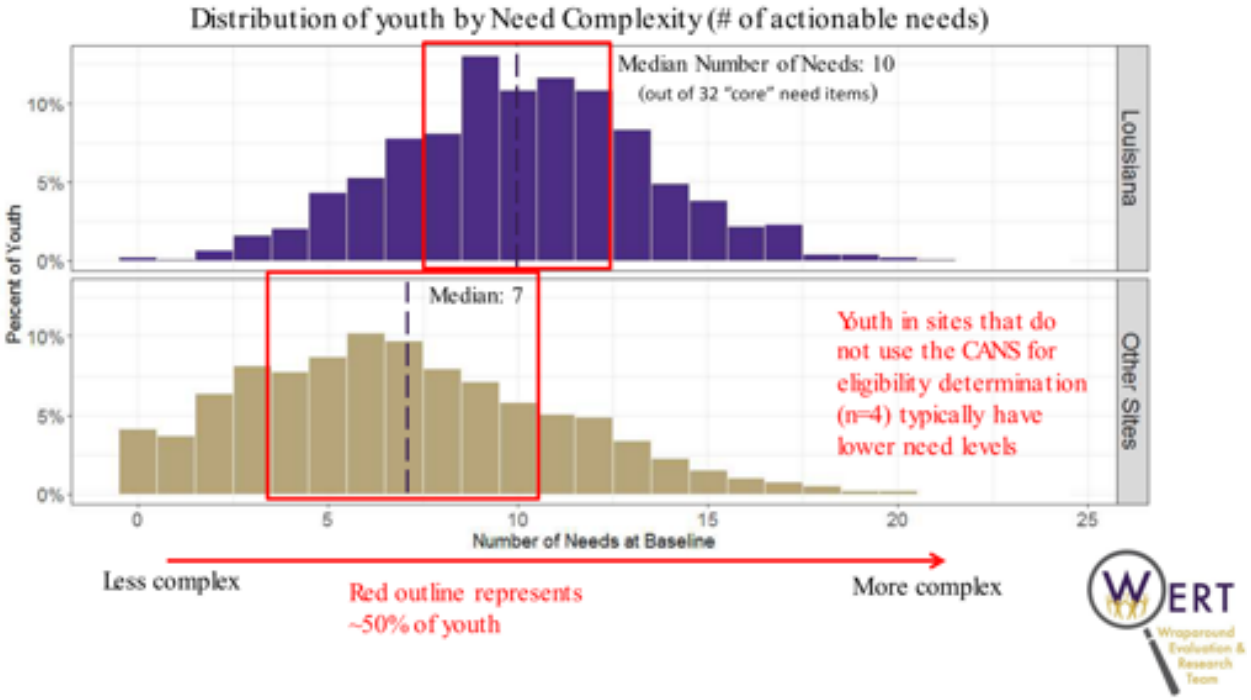
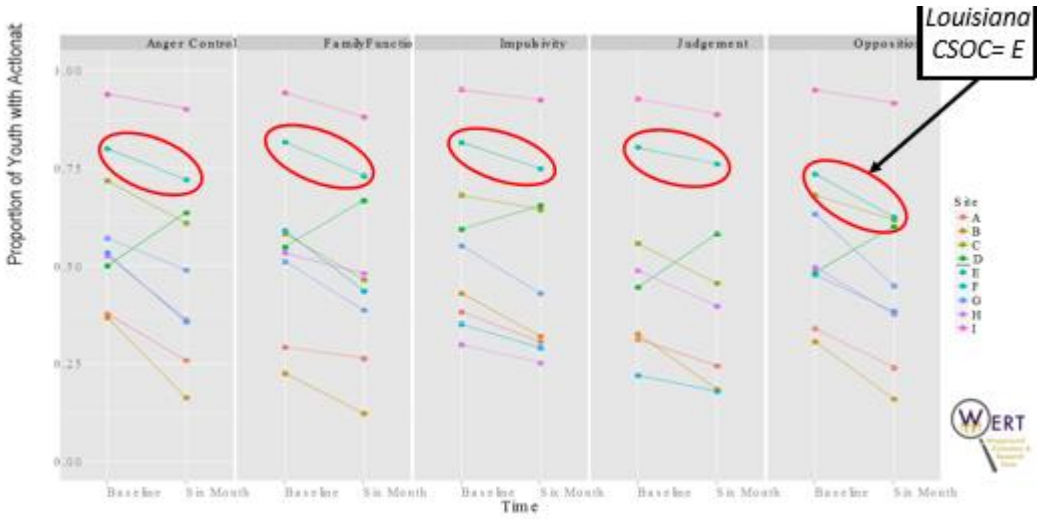


Figure 37: Ratings of Top Five Most Commonly Prevalent Actionable Needs at Baseline by Site



Next Steps

Magellan is committed to advancing our understanding of CSoC program dynamics through CANS data. During the upcoming contracting extension period, Magellan is pursuing advanced analytics to identify key factors contributing to successful discharges. Magellan anticipates the initial findings of this analysis to be presented in the second quarter of the year. Another project related to the CANS that Magellan will pursue further is the examination of reliability and validity of the CANS assessment. This research will focus on outlier CANS assessments as identified through statistical analysis. As part of this project, Magellan will take a deeper dive into regional and assessor issues in the hopes of identifying specific training initiatives to increase reliability and validity outside of the annual certification process conducted by the Praed foundation.

Quality Improvement Strategy Performance Measures

QIS performance measures were established by LDH to ensure compliance with waiver requirements and program goals. The measures evaluate factors that are important at different stages of enrollment and provide a comprehensive outlook on outcomes. Like quarterly CANS monitoring, these measures are monitored quarterly, allowing administrators and program directors to have a real-time mechanism to monitor results and implement process improvement initiatives as needed.

Access to wraparound measures are indicators that look at the Wraparound Agencies' ability to engage families at the time of referral. It is believed families should be engaged as quickly as possible to facilitate full enrollment in the program. Access to wraparound evaluates the timeliness of initial contact, which establishes a minimum threshold of 48 hours, and timeliness of first face-to-face contact, which is expected to take place within seven days. Initial contact has trended upward with 94.5% of referrals meeting standard in WY1 Q2. There has also been a positive trend in the face-to-face contact with 71.0% of youth meeting timeframes in WY1 Q2. Magellan engaged Wraparound Agencies to better understand barriers to face-to-face engagement. Wraparound Agencies identify that factors influencing meeting these timeframes included the day of the week the referral is received and member unavailability. Magellan is dedicated to facilitating engagement with members. Because of this,

Magellan has included specific information to families at the time of the referral regarding specific details regarding the engagement process to assist the Wraparound Agencies. Figure 38 shows access to wraparound measures for 12/01/2016 through 12/31/2017.

Inpatient hospitalizations are sometimes unavoidable due to the severity of the membership served in CSoC; however, the goal is to have the least amount of members as possible require that level of intervention. Additionally, if a member does require an inpatient hospital, the goal is for the member be away from his or her community setting for as few days as possible. Despite serving these highest risk youth population, only 4.3% of members required inpatient hospitalization in WY1 Q2. There was also slight decline in the overall average length of stay (ALOS), which shows an ALOS of only six days in WY1 Q2. Figure 39 illustrates inpatient utilization measures for 12/01/2016 through 12/31/2017.

Follow-Up after Hospitalization (FUH) for Mental Illness HEDIS measures are industry standard performance measures used to monitor if members admitted to an inpatient psychiatric hospital setting receive necessary follow-up care within seven and thirty days from discharge. It is believed that integrating members into outpatient services as soon as possible following an inpatient hospitalization can reduce recidivism and improve outcomes for members. Because of the unique aspects of the CSoC program, Magellan looks at both a standard measure, using NCQA HEDIS specifications, and a modified measure. The modified measures follows HEDIS specifications but also includes peer delivered services. It is believed that peer services are an integral part of the CSoC model and should be considered when evaluating the data for this program. The 7-day FUH preliminary rates for 01/01/2017 through 12/01/2017 were 53.7% and 64.4% for HEDIS and modified HEDIS (e.g., includes peer services) respectively. CSoC achieved its goal of exceeding the 50th percentile for 7-day FUH (i.e., 46%) for the standard HEDIS group. The 30-day FUH rates are currently 70.96% and 81.64% for HEDIS and Modified HEDIS respectively. These metrics are affected by claims-lag for outpatient claims so final results and comparison to previous year will be reported in April 2018. It is anticipated there will be a decrease in the modified HEDIS metrics when comparing years due the termination of the FSO in August. Table 32 provides the 01/01/2017 through 12/01/2017 as of 01/21/2018.

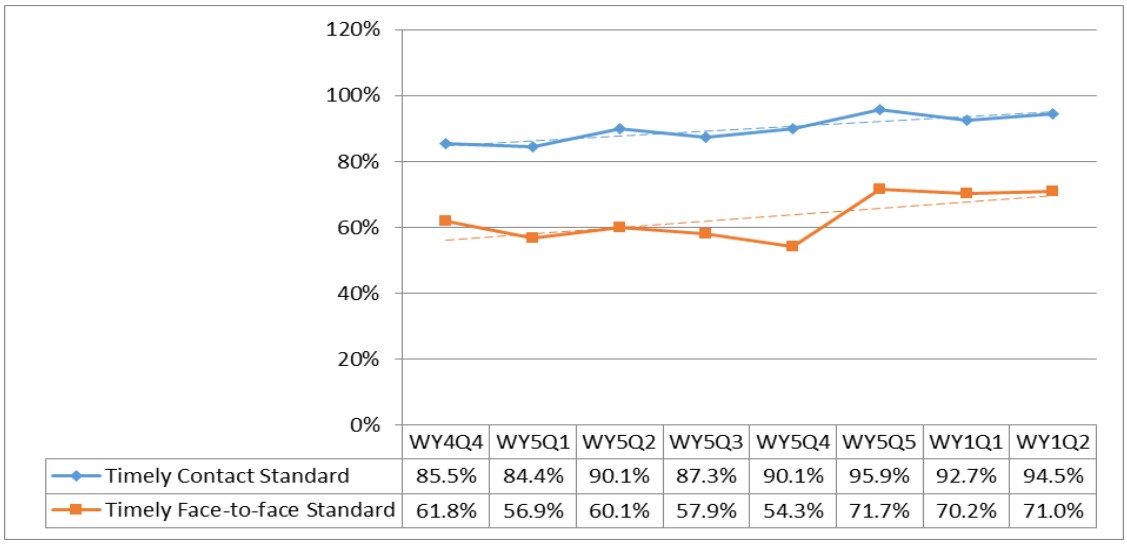
Involvement of natural and informal supports is not only a central value of wraparound, but it is also believed to be a key factor in sustaining improvements following discharge. Figure 40 shows a steady trend line for this type of involvement, with over 87.4% of members having natural and informal support involvement in WY1 Q2. Magellan supported increased monitoring of natural support involvement throughout treatment by adding a field in the CSoC spreadsheet to track natural and/or informal support in ongoing Child and Family Team meetings. Please reference Annual Performance Improvement Plan Report for additional supporting documentation for the need for this enhancement.

A principal goal of CSoC is for members to discharge successfully from the program, or discharge with 80% to 100% of goals met. Successful discharges account for the largest type of discharge and have stabilized to the upper forty percentages for most quarters. Another of the central goals of the program is for enrolled members to discharge into a home and community setting. The data show that approximately 90% of the children are discharging into the home and community setting, with a peak quarter in WY1 Q1 of 94.6%. Figures 41 and 42 display the results for the discharge indicators.

Magellan promotes continuous quality improvement for these performance measures and other important indicators for the CSoC Program through a balanced quarterly scorecard. The scorecard provides statewide and regional data for four consecutive quarters and shows the change in percentage points for the previous two quarters. In November 2017, Magellan initiated quarterly calls with the

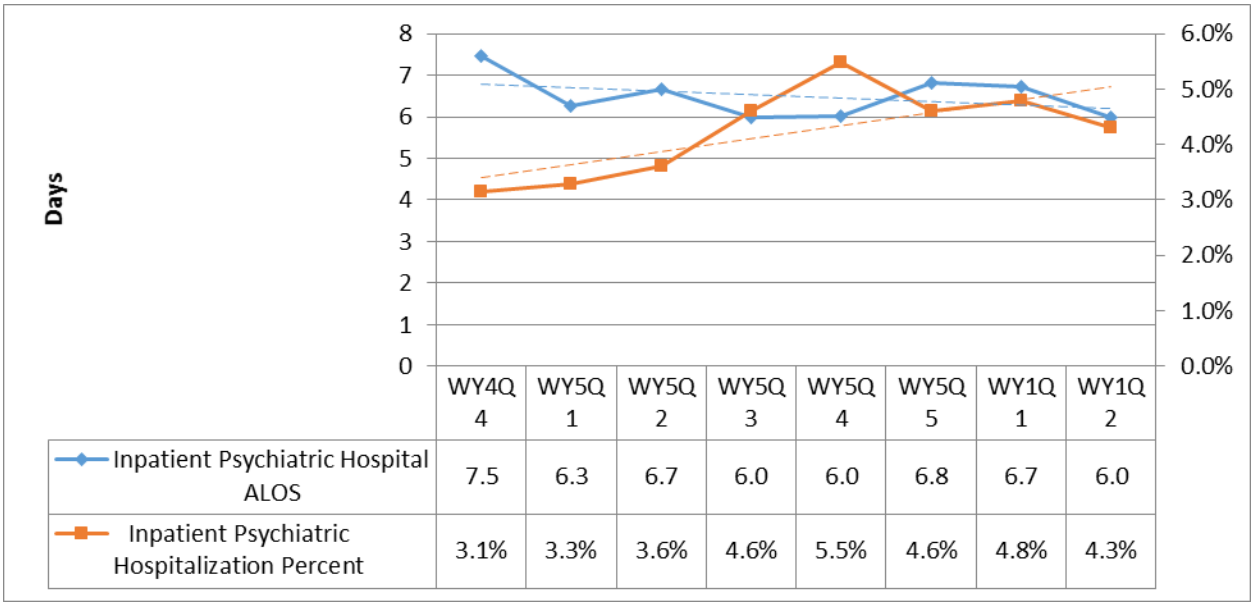
Wraparound Agencies to focus on utilizing this data to inform internal process improvement initiatives, with a focus on significant increases or declines over quarter to better understand regional factors influencing measures. Figure 43 depicts the format of the scorecard.

Figure 38: Access to Wraparound



	WY4Q4	WY5Q1	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
Timely Contact Standard	85.5%	84.4%	90.1%	87.3%	90.1%	95.9%	92.7%	94.5%
Timely Face-to-face Standard	61.8%	56.9%	60.1%	57.9%	54.3%	71.7%	70.2%	71.0%

Figure 39: Children in Restrictive Settings



	WY4Q 4	WY5Q 1	WY5Q 2	WY5Q 3	WY5Q 4	WY5Q 5	WY1Q 1	WY1Q 2
Inpatient Psychiatric Hospital ALOS	7.5	6.3	6.7	6.0	6.0	6.8	6.7	6.0
Inpatient Psychiatric Hospitalization Percent	3.1%	3.3%	3.6%	4.6%	5.5%	4.6%	4.8%	4.3%

Table 32: Follow-up after Hospitalization for Mental Illness Report

		National HEDIS Specifications[1]				Modified HEDIS Specifications[2]			
Region	Denominator	7-Day Numerator	7-Day Percent	30-Day Numerator	30-Day Percent	7-Day Alt Numerator	7-Day Alt Percent	30-Day Alt Numerator	30-Day Alt Percent
Region 1	44	19	43.18%	28	63.64%	24	54.55%	32	72.73%
Region 2	33	15	45.45%	23	69.70%	19	57.58%	30	90.91%
Region 3	73	44	60.27%	54	73.97%	48	65.75%	57	78.08%
Region 4	38	19	50.00%	28	73.68%	21	55.26%	30	78.95%
Region 5	37	23	62.16%	30	81.08%	30	81.08%	34	91.89%
Region 6	43	15	34.88%	24	55.81%	20	46.51%	32	74.42%
Region 7	29	12	41.38%	17	58.62%	18	62.07%	22	75.86%
Region 8	45	32	71.11%	37	82.22%	37	82.22%	42	93.33%
Region 9	23	17	73.91%	18	78.26%	18	78.26%	19	82.61%
Total	365	196	53.70%	259	70.96%	235	64.38%	298	81.64%

[1]Includes waiver service CSoC ILSB only
[2]Adds waiver services CSoC YST, PST, CS, and STR

Figure 40: Natural/Informal Support on Plan of Care

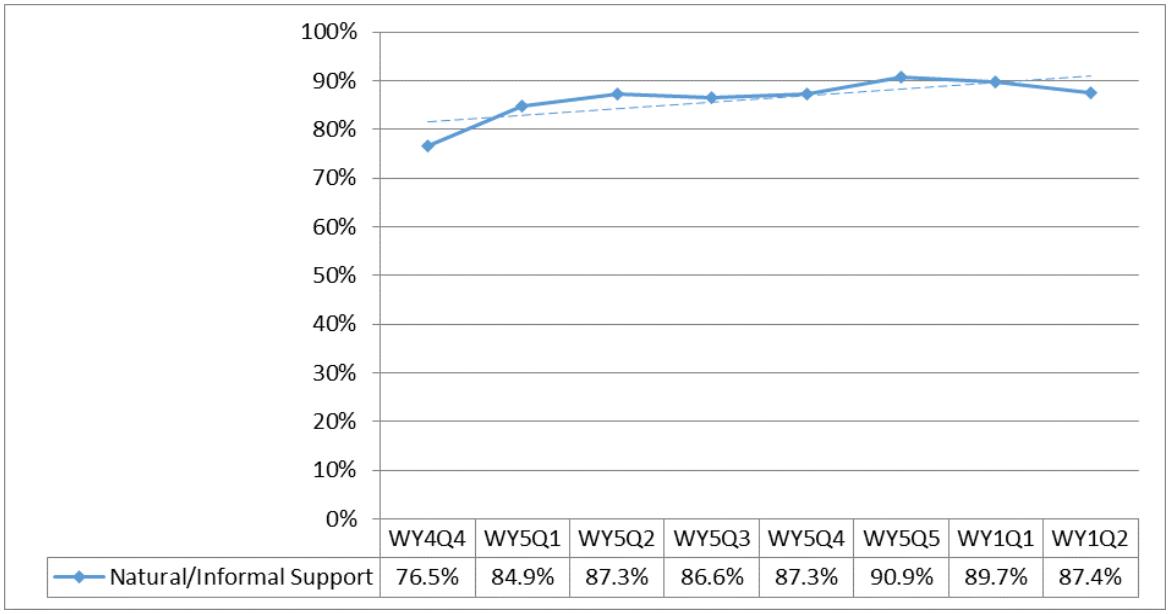
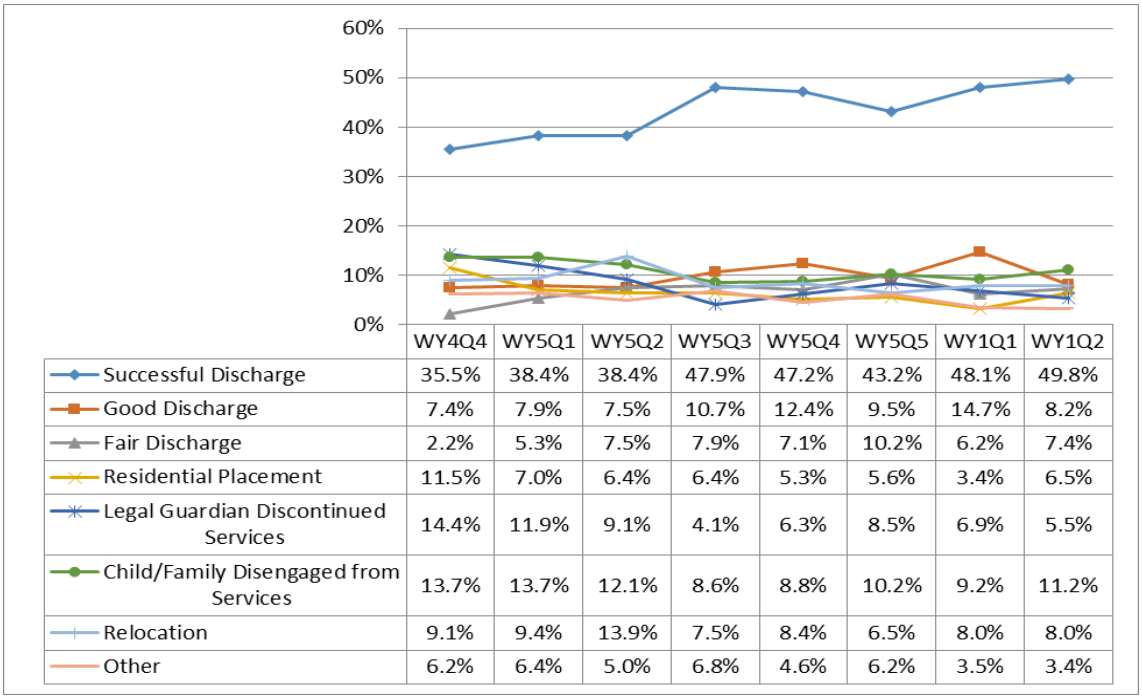
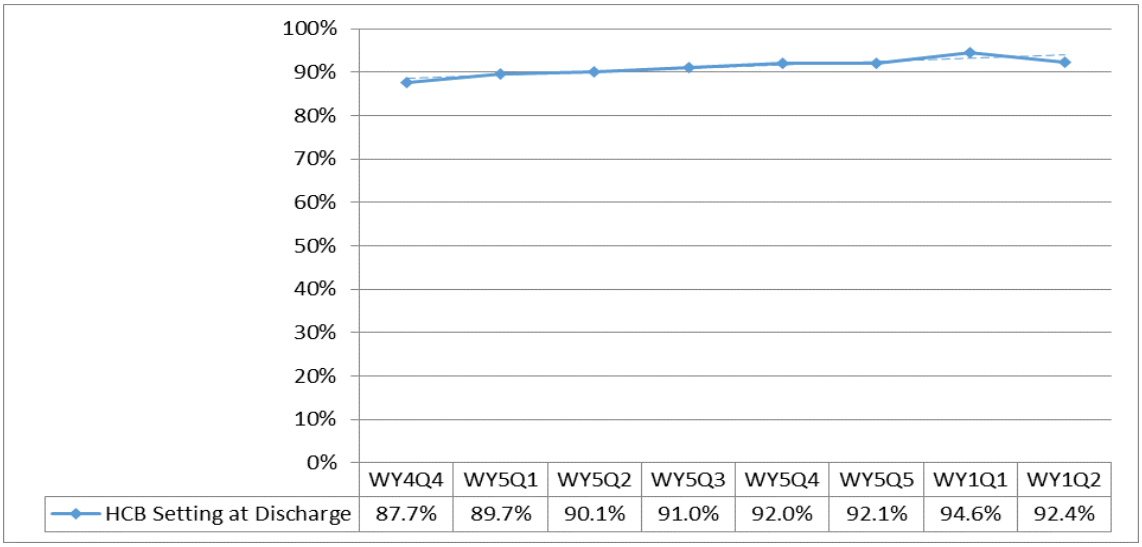


Figure 41: Reasons for Discharge



	WY4Q4	WY5Q1	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
Successful Discharge	35.5%	38.4%	38.4%	47.9%	47.2%	43.2%	48.1%	49.8%
Good Discharge	7.4%	7.9%	7.5%	10.7%	12.4%	9.5%	14.7%	8.2%
Fair Discharge	2.2%	5.3%	7.5%	7.9%	7.1%	10.2%	6.2%	7.4%
Residential Placement	11.5%	7.0%	6.4%	6.4%	5.3%	5.6%	3.4%	6.5%
Legal Guardian Discontinued Services	14.4%	11.9%	9.1%	4.1%	6.3%	8.5%	6.9%	5.5%
Child/Family Disengaged from Services	13.7%	13.7%	12.1%	8.6%	8.8%	10.2%	9.2%	11.2%
Relocation	9.1%	9.4%	13.9%	7.5%	8.4%	6.5%	8.0%	8.0%
Other	6.2%	6.4%	5.0%	6.8%	4.6%	6.2%	3.5%	3.4%

Figure 42: Home and Community Based Setting at Discharge



	WY4Q4	WY5Q1	WY5Q2	WY5Q3	WY5Q4	WY5Q5	WY1Q1	WY1Q2
HCB Setting at Discharge	87.7%	89.7%	90.1%	91.0%	92.0%	92.1%	94.6%	92.4%

Figure 43: Wraparound Quarterly Scorecard

WAA Scorecard WY1Q2

Oct 2017 - Dec 2017

% of Members with at Least 1 Natural/Informal Support on CFT					Change in Units from One Quarter to the Next (black = increase; red = decrease)	
Less than 80%	80% - 89.9%		90% or Greater			
Region	WY5Q4	WY5Q5*	WY1Q1*	WY1Q2*	WY5Q5* to WY1Q1*	WY1Q1* to WY1Q2*
Region 1	91.06%	91.69%	92.11%	90.50%	0.4	1.6
Region 2	85.71%	91.15%	90.50%	88.13%	0.7	2.4
Region 3	85.47%	96.38%	81.85%	87.54%	14.5	5.7
Region 4	79.38%	80.94%	84.00%	81.61%	3.1	2.4
Region 5	94.61%	94.96%	91.97%	89.68%	3.0	2.3
Region 6	89.42%	95.08%	91.26%	91.84%	3.8	0.6
Region 7	98.69%	96.22%	96.41%	97.86%	0.2	1.5
Region 8	88.97%	90.35%	98.31%	96.52%	8.0	1.8
Region 9	80.73%	87.41%	87.21%	88.18%	0.2	1.0
Aggregate	87.25%	90.85%	89.70%	89.54%	1.1	0.2

* Denominator is members with any CFT meeting in report period

% of Members Whose Living Situation at Discharge is HCB					Change in Units from One Quarter to the Next (black = increase; red = decrease)	
Less than 80%	80% - 89.9%		90% or Greater			
Region	WY5Q4	WY5Q5	WY1Q1	WY1Q2	WY5Q5 to WY1Q1	WY1Q1 to WY1Q2
Region 1	89.89%	86.15%	94.29%	95.16%	8.1	0.9
Region 2	94.25%	91.55%	96.88%	95.24%	5.3	1.6
Region 3	84.04%	88.06%	94.25%	91.30%	6.2	2.9
Region 4	87.27%	95.92%	90.91%	90.24%	5.0	0.7
Region 5	95.74%	89.66%	89.58%	96.97%	0.1	7.4
Region 6	95.83%	89.13%	87.80%	88.00%	1.3	0.2
Region 7	95.77%	93.33%	97.56%	91.43%	4.2	6.1
Region 8	93.94%	95.52%	100.00%	94.74%	4.5	5.3
Region 9	94.94%	98.55%	96.67%	89.47%	1.9	7.2
Aggregate	91.98%	92.13%	94.62%	92.38%	2.5	2.2

Summary

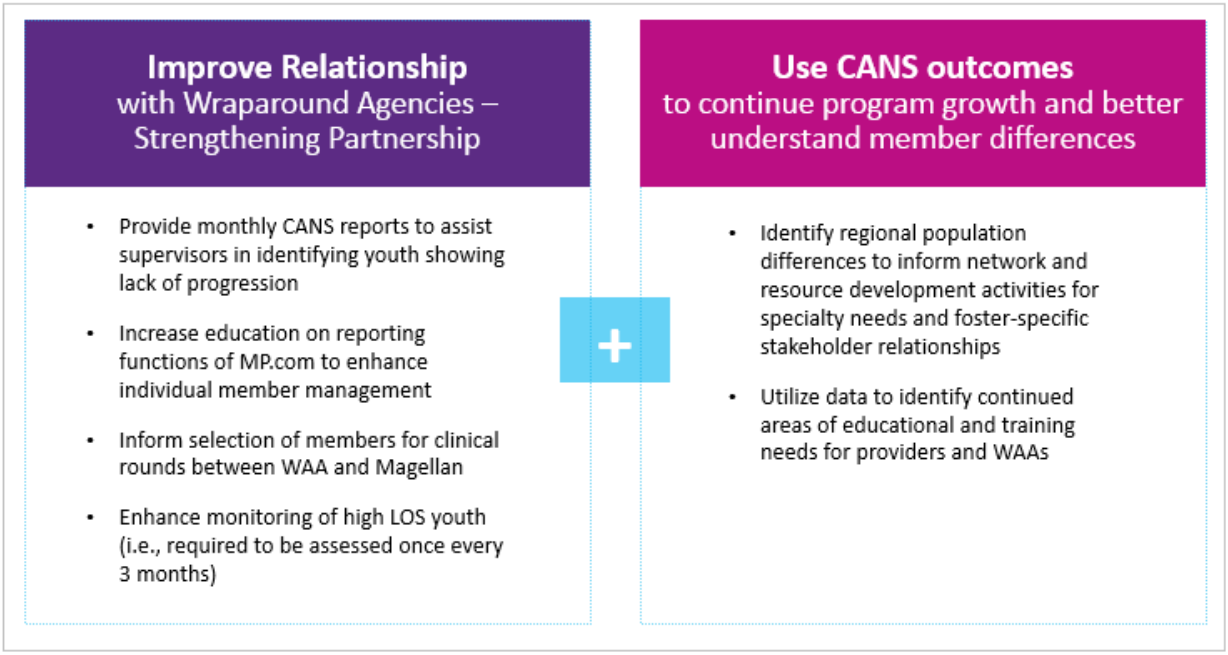
This report provides a comprehensive analysis of the performance of Magellan's provider network, including Wraparound Agencies, waiver providers, and specialized behavioral health providers. The report describes how CSoC is achieving its goal of keeping Louisiana's highest risk youth in the community and it is helping them achieve improvements in all areas of their functioning. It is believed these positive outcomes can be attributed to the hard work of LDH, the entire provider network, and Magellan. The report provided details on the high level of provider performance in multiple areas and provided specific interventions when opportunities for improvement are identified.

CSoC has demonstrated positive outcomes for members and Magellan is committed to supporting and facilitating the achievement of even higher levels of success. Magellan is focused on developing new and innovative approaches to sustain and improve the already positive outcomes achieved. Some of the key activities that are planned for the upcoming contracting period:

- Magellan's quality committees will continue to oversee and monitor quality work plan prioritized objectives, performance measures and activities to ensure compliance with contract deliverables and achievement of the established minimum performance thresholds and/or goals as applicable.
- Magellan's network department will continue to promote and spearhead crisis stabilization network development opportunities with our LDH and Healthy Louisiana Plan partners.
- Magellan's clinical teams will continue implementation of inpatient youth internal clinical rounds to more closely monitor and manage higher severity youth and decrease unnecessary inpatient admissions or readmissions when possible.
- Magellan will continue training initiatives to improve operational understanding of important managed care process, such as authorizing services and filing complaints.

The quality department will focus its efforts on the promotion of data driven quality improvement activities to inform wraparound practice in key areas, such as coaching and training. This will be done through our active participation in the Louisiana Coaches Learning Community, lead by LDH, and attendance at national conferences for CANS and wraparound. This will also include pursuing advancements in CANS data analytics as well as strengthening Magellan's relationship with the Wraparound Agencies. Figure 44 outlines some of the recommended next steps for the utilization CANS data for the upcoming contract extension period. Magellan will also enhance its monitoring activities and increase remedial activities as directed by Medicaid and LDH to support network reform initiatives.

Figure 44: Recommended Next Steps of CANS Data Utilization



Appendix A

Resources Allocated to Louisiana CSoC Quality Program

Regional Staff	Percent of FTE Allocated to QI
Director, Quality Improvement (1)	100%
Clinical Reviewer, Quality Improvement (1)	100%
Project Manger, Quality Improvement (1)	100%
Clinical Director (1)	25%
Appeals and Grievance Coordinator (1)	100%
Network Director (1)	15%
Program Director (1)	15%
Medical Director (1)	10%
Manager, Clinical Services (1)	25%
Report Analyst (2)	50%
CSoC Coordinators (6)	25%

Corporate Staff	Percent of FTE Allocated to QI
Chief Quality Officer	15%
Associate Medical Director	10%
Vice President, Quality Improvement	20%
Vice President, Clinical Services	10%
Director, Outcomes & Evaluations	10%
Project Director, Quality Improvement	10%

Technical Resources
Clinical Information System Claims System Eligibility/Authorization System Other Technical Resources

Analytical Resources
Staff backgrounds in: ○ Computer programming ○ Healthcare data analysis ○ Research methodology ○ Healthcare data analysis
Commercial Statistical Analysis Programs ○ *Access* ○ *Excel* ○ *GeoNetworks®* ○ *SAS* ○ *SPSS* Customized Programs Available Ambulatory Follow-up Report Compliments, Complaints, Grievances HEDIS 3.0 Member Satisfaction Survey System Monthly IUR Summary Report Practitioner Profiling Report Practitioner Satisfaction Survey System Readmission Report