



Magellan Healthcare, Inc.
Louisiana Coordinated System of Care
QUALITY IMPROVEMENT PROGRAM EVALUATION

01/01/2018 – 10/31/2018

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Executive Summary

Magellan Health's CSOC Unit conducts an annual evaluation of its Quality Improvement Program to: evaluate outcomes, review effectiveness, assess goal achievement, evaluate the deployment of resources, document and trend input from advisory groups (including consumers, family members and other stakeholders), and identify opportunities for improvement in the ongoing provision of safe and high-quality services to members. The evaluation covers a fully integrated quality program including recovery/resiliency-focused clinical and medical integration programs. This report summarizes the findings from an evaluation of data from 01/01/2018 through 12/31/2018. In addition, this report assesses progress towards the goals and prioritized objectives set forth in the previous year's quality improvement program description, work plan and program evaluation. It also ensures that the spirit of the CSOC Unit's mission was realized.

Program Focus and Prioritized Objectives for 2019

Magellan Health's vision and mission seamlessly reinforce the goals of Louisiana's CSOC Unit, as defined by the Louisiana Department of Health (LDH), which include:

- reducing the State's cost of providing services by leveraging Medicaid and other funding sources; increasing service effectiveness and reducing duplication across agencies;
- reducing out of home placements in the current and future admissions of children and youths with significant behavioral health challenges and co-occurring disorders;
- improving the overall outcomes of children and their caretakers; and
- increasing member and caregiver input and choice in treatment.

In collaboration with the LDH, youths, families, providers and stakeholders, Magellan Health facilitates quality activities that promote CSOC goals and sustains recovery and resiliency for youths and families. We also promote high-quality care, which is characterized as safe, effective, member-centered, timely, efficient and equitable. All quality activities reinforce Magellan Health's goals, and they are organized under the following three themes:

- positively influencing the health and well-being of individuals by improving clinical outcomes, assuring member safety, and adding value through efficiency.
- enhancing service delivery for Members and their families.
- ensuring that all core business processes are innovative, and meet or exceed contract, regulatory, and accreditation guidelines.

Based on a review of:

- progress towards 2017-18 program goals
- lessons learned
- an assessment of the identified opportunities for improvement and their root causes
- an increased understanding of the need for timely identification of critical variables and their root causes (barriers) in order to identify and implement effective interventions
- customer feedback and contractual requirements
- consumer, family member and stakeholder input

Based on this review, **2019 prioritized goals and objectives** for the Louisiana CSoC Unit are:¹

Positively influencing Health and Well-being, Including Member Safety

- Improve the percentage of members showing clinical improvement as assessed by the Child and Adolescent Needs and Strengths (CANS) assessment (initially, and upon discharge) from the 2018 YTD rate of 73.6% to 75% in 2019.
- Develop and begin implementation of an Outcomes-Driven Reimbursement Payment Model with Wraparound Agencies (WAAs). Specific details of the model will be developed in partnership with the WAAs and the LDH, and submitted to the LDH for approval prior to implementation.
- Increase the rate for the [HEDIS] 7-day Follow-up after Hospitalization measure from 56% (MY 2017) to 60% for MY 2019, exceeding the 75th percentile (58%).
- Increase the rate for the [HEDIS] 30-day Follow-up after Hospitalization measure from 72% (MY 2017) to 80% for MY 2019.

Enhance Service and the Experience of Care

- Implement a comprehensive assessment and monitoring plan for Family Support Organizations (FSO) and establish a baseline for adherence to Substance Abuse and Mental Health Service Administration (SAMHSA) Peer Competencies for Peer Workers in Behavioral Health Services. Specific details of the plan will be developed in partnership with the FSO and the LDH, and submitted to the LDH for approval.
- Improve the rate of compliance [with State and Magellan qualifications and training requirements] for unlicensed direct care staff from the 2018 YTD rate of 82.5% to a rate of 90% for 2019.
- Improve provider compliance relative to updating provider demographic information (on Magellan's provider portal, or MagellanProvider.com) from the 2018 YTD rate of 81.9% to a rate of 90% for 2019.
- Improve the number of contracted and credentialed short-term respite providers in Regions 3, 5 and 6, by at least one new provider organization or new provider location, per region.

Meet and Exceed Contractual, Regulatory & Accreditation Requirements

- Timely delivery of 95% of contract deliverables, including reports.
- Achieve three-year Managed Behavioral Healthcare Organization (MBHO) accreditation from the National Committee for Quality Assurance (NCQA) by 11/01/2019.
- Establish and implement a claims submission protocol for WAAs, with all Wraparound Facilitation payments reimbursed through claims by 11/01/2019.
- Establish and implement a data exchange protocol between Magellan and WAAs to support and enhance state and federal reporting requirements.

Acknowledgment and Approval

The 2018 Quality Improvement and Utilization Management Program Evaluation was prepared by the Louisiana CSoC Unit and reviewed and approved by the Quality Improvement Committee during its meeting on [Date], as indicated by the signature(s) below:

¹¹ Louisiana Department of Health SOW 14.2.3.2.4.

Name

Richard Dalton, Medical Director
Co-Chair, Quality Improvement Committee

Date

Name

Wendy Bowlin, Director of Quality and Outcomes
Co-Chair, Quality Improvement Committee

Date

Louisiana Coordinated System of Care Unit
Quality Improvement – Clinical Management Program Evaluation
01/01/2018-10/31/2018

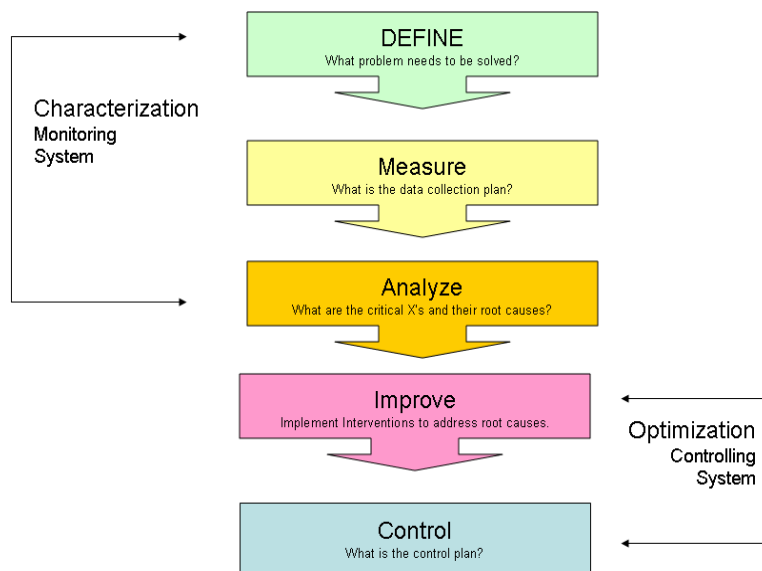
I. Overview

Magellan’s Quality Improvement (QI) Program is member-focused and includes objective and systematic monitoring of quality, recovery and resiliency-focused healthcare and services provided to Louisiana CSoc members. We leverage our extensive national experience managing specialty behavioral health programs, and promoting systems of care (SOC) values, to create an atmosphere where positive outcomes are achievable for Louisiana’s highest-risk youths and families. Magellan fully embraces Wraparound philosophies and recognizes that youth, family, provider, and stakeholder engagement is necessary to ensure that our CSoc goals, objectives and activities align with the members we serve, within the unique culture of Louisiana.

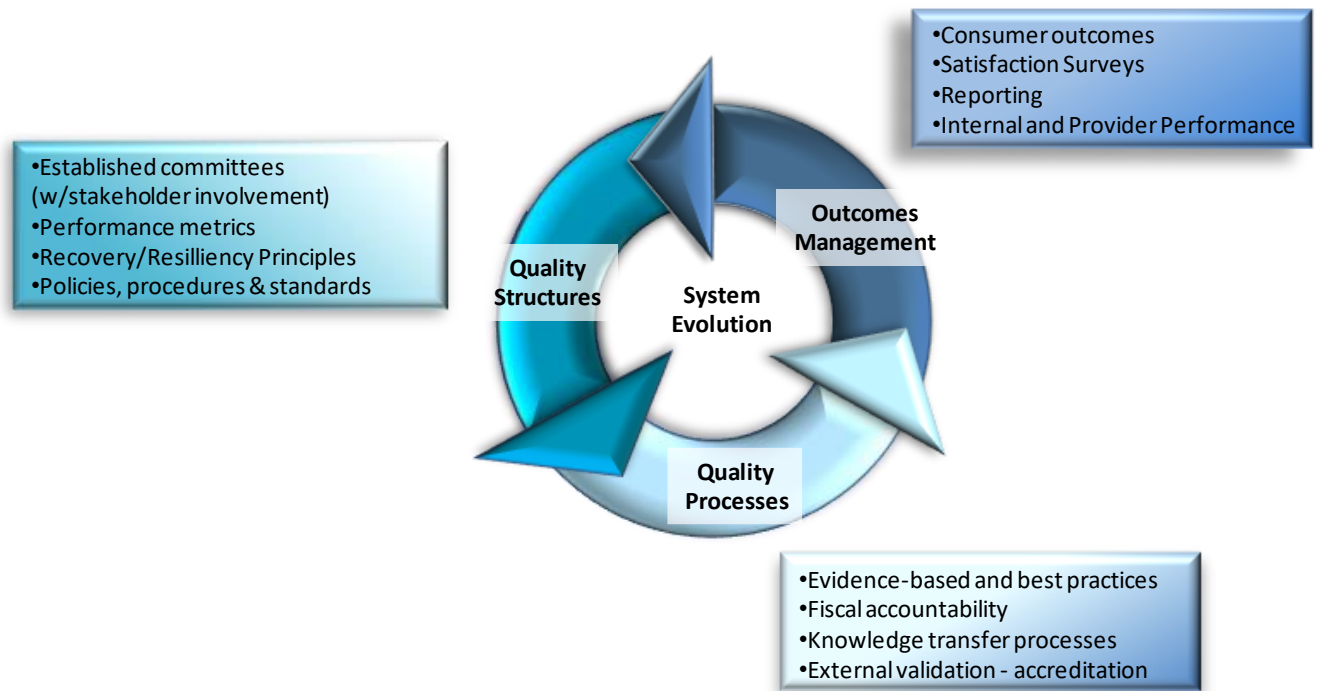
The scope of the QI program includes objectively and systematically monitoring the quality of behavioral health [and related recovery and resiliency] services provided to Magellan’s customers. Our QI Program is the direct responsibility of Louisiana’s CSoc Unit Program Director, Kathleen Coenson. The QI program is managed by the Director of Quality and Outcomes, Wendy Bowlin, who is supported by regional and corporate staff. Local oversight of the QI program is provided by the Louisiana CSoc Quality Improvement Committee (QIC). Corporate oversight of the QI program occurs through a corporate committee structure.

Magellan Health’s Quality Process

Louisiana’s QI program utilizes a Six Sigma Define, Measure, Analyze, Improve & Control (DMAIC) process to insure timely identification of critical variables and their root causes (barriers). DMAIC process outcomes are used to develop measurable interventions that lead to improvement. Our QI committees oversee this process and a spectrum of measures and activities described in the CSoc Quality Improvement Program Description and evaluated in this document.



QI committee oversight is a crucial component of the CSoc Unit's approach to overall systems transformation and evolution. When coupled with other mechanisms, as illustrated below, it results in systems evolution and the development of a culture of quality. Please see Section II of the CSoc Unit's Quality Improvement Program Description for further details regarding our quality improvement committees and related processes.



Oversight includes monitoring a spectrum of quality of care and service measures, including utilization data, member and provider satisfaction survey results, complaints, and other quality monitors. Each of these quality improvement and utilization management activities is described, trended, and analyzed in this evaluation of the overall effectiveness of the QI and UM program.

II. Population Description and Assessment

CSoc is an evidence-based approach to supporting children and youths, ages 5 through 20, with significant behavioral health challenges or co-occurring disorders who are in, or at imminent risk of, out of home placement. CSoc offers an array of Home and Community-Based services (HCBS) to members, in addition to all services available through their Medicaid coverage. The program has a maximum enrollment of 2,400 members, at any given time, within nine regions. Regional Wraparound Agencies (WAAs) and statewide Family Support Organizations (FSOs) support and guide members and their families through the wraparound process. Please see the 2019 Network Development Plan for a complete description and assessment of the population served in 2018, including:

- age, gender and race
- language classification and needs

- translation/interpretation services
- geographic classification
- diagnosis
- involvement in child-serving state agencies
- cultural competency

This report informs the development of Magellan’s 2019 Outcomes Evaluation plan. The plan provides a comprehensive strategy to determine the effectiveness of the CSoC program for various member population groups (e.g., gender, race, age, diagnosis, system involvement, etc.), and the Cultural Competency Program Description. Some of the initiatives for 2019 include:

- enhanced monitoring of cultural competency in Wraparound Practice through clinical Assessment and Plan of Care Review Tools.
- evaluating accessibility and outcomes to identify and address disparities in care by gender, race and age.

III. Accessibility and Availability of Services ²

CSoC is dependent on a diverse, comprehensive and competent network of providers. Magellan works collaboratively with providers to ensure that treatment is accessible, recovery-oriented, person-centered, evidence-based and spans the full spectrum of services. Improving member access to services is a key tenet of the wraparound model. Unlike traditional Medicaid programs, members in CSoC receive support in accessing services through their Wraparound Agency. The Wraparound Facilitator is tasked with assisting members in navigating through the system, ranging from assistance with provider selection to addressing unmet needs. Magellan facilitates the selection process by providing a comprehensive web-based search engine that allows members to search for providers by level of care, those accepting new patients, gender, specialty (e.g., autism, CBT, eating disorder, etc.), ages treated, languages 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’s Network Management Specialists are dedicated to specific Wraparound regions to provide support and technical assistance in accessing services, as well.

Magellan has an established process for monitoring accessibility and availability of services, which drives recruitment efforts. Magellan’s quality committees meet quarterly to review geographic access and appointment availability data, member satisfaction survey results and grievances to identify gaps in the type, density, and location of contracted behavioral health providers. When gaps are identified, the quality committees implement and monitor action plans, including conducting provider surveys and forums, as well as recruitment of out-of-network providers.

Telephonic Accessibility

Magellan has effectively operated a Baton Rouge-based call center for six years, serving Louisiana’s CSoC members and their families. Our call center is fully staffed and provides a full array of services, including crisis response, service referrals, and service authorizations, 24 hours a day, 365 days a year. Our

² Louisiana Department of Health SOW 14.2.3.2.1.

Member Services Department serves as the frontline for children, family members and other caregivers. All Member Service Representatives (MSRs), Licensed Mental Health Professionals (LMHPs), Care Managers and Physician Advisors are Magellan employees. We do not use answering services or external vendors. Our Call Center provides several services including addressing member questions and concerns, recording grievances, as well as facilitating service authorizations, and referrals. Magellan's phone system provides tracking and reporting on call center performance metrics in 30-minute intervals, daily, weekly and monthly.

Telephonic accessibility is monitored on a daily basis to identify staffing needs and ensure that service standards are met. If call volumes and service levels warrant additional resources, CSOC calls are routed to back up agents at other Magellan sites. Performance metrics are monitored by our Supervisors on a daily, weekly and monthly basis and data is reported quarterly to the QIC. **Table 1** shows our average speed of answer (ASA) and abandonment rate performance. **Figures 1** and **2** provide quarterly trending.

Table 1. Call Volume, Average Speed of Answer, and Abandonment Rates

Indicator	2017	2018
Inbound Calls	8362	8044
Answered	8126	7795
Abandoned	236	249
Abandonment Rate	2.82%	3.10%
Average Speed to Answer	14.38	19.59
Handle Time	0:06	0:07

Figure 1. Abandonment Rate

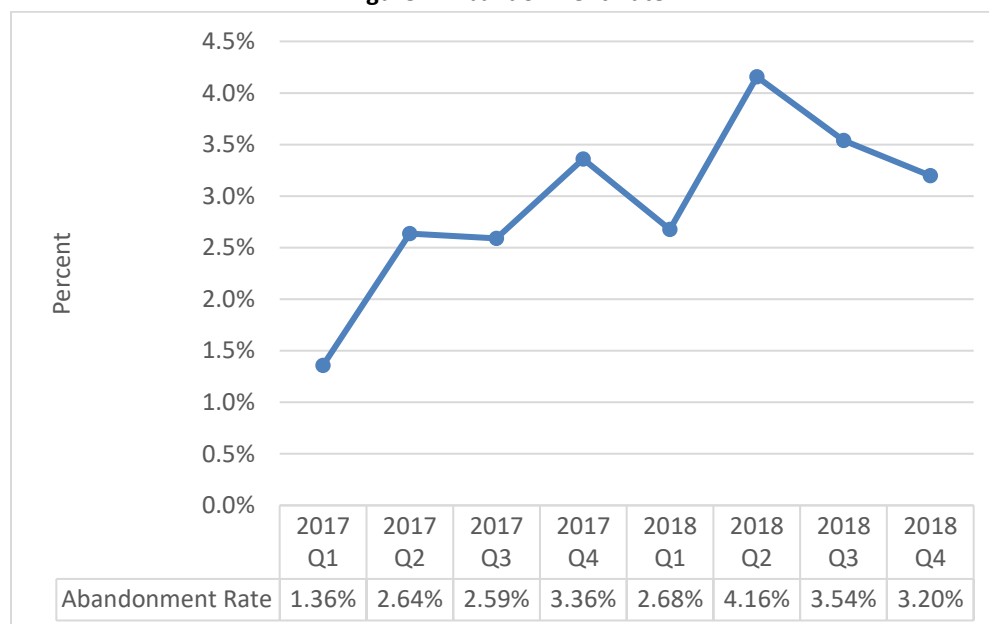
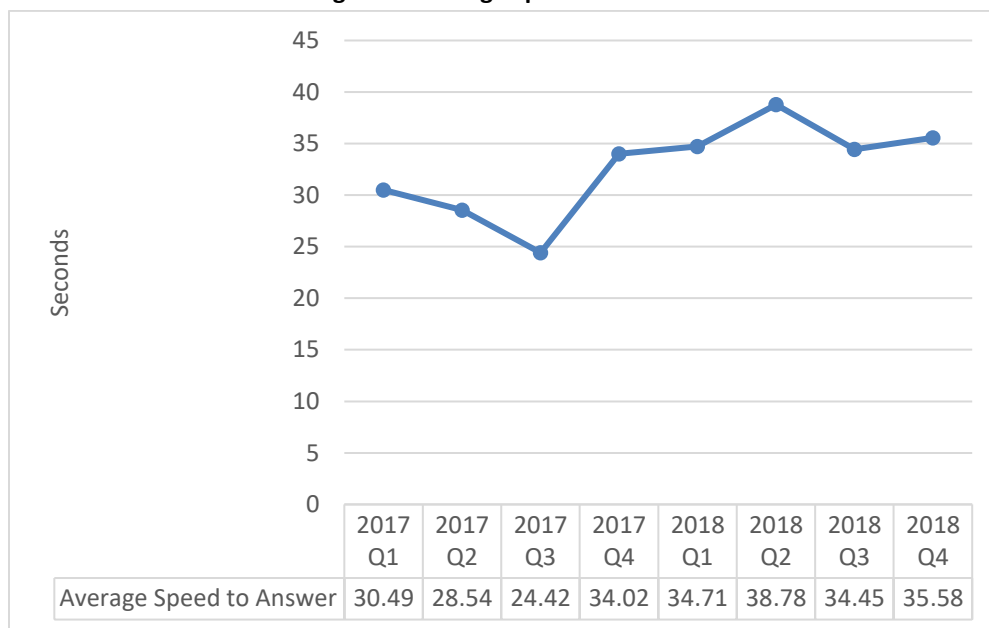


Figure 2. Average Speed of Answer



Practitioner/Provider Availability and Accessibility

Magellan’s comprehensive network of organizations, facilities, and individual service providers establish the foundation for a one-of-a-kind system for CSOC - ensuring direct access to care, collaboration with provider partners, and continual improvement for individualized, well-coordinated health services. Louisiana CSOC is dependent on a diverse, comprehensive, and competent network of providers. We work collaboratively with providers to ensure that treatment is accessible, recovery-oriented, person-centered, evidence-based, and spans the full spectrum of services.

Our current network includes the full array of CSOC-required provider types throughout the State. The network also includes a WAA in each region and a statewide FSO, both of which are certified by the LDH.

Magellan’s network adequacy policies and procedures provide a roadmap for network development that reflects specific standards for access and density to ensure that distance, time, and appointment availability capacity standards are met. Magellan develops a comprehensive, annual Network Development Plan that includes data analyses of the following, which help to identify network gaps and barriers:

- provider demographics
- GeoAccess for prescribers and non-prescribers
- over/under utilization of services
- authorization turnaround times
- appointment availability
- network development
- evidence-based and best practice initiatives
- material changes in the network

Magellan and the State agree that adequacy is achieved when there are no discernible network access difficulties. Through extensive community and stakeholder engagement, use of data analytics, review of member grievances and access to care metrics, as well as our member surveys, Magellan has identified opportunities for network development in crisis response, prescriber, evidence-based practice, Independent Living Skills Building (ILSB), and Short Term Respite (STR) providers. Network development strategies to address these areas include:

- **Focused recruitment:** When gaps in service are identified, Magellan pursues focused recruitment to secure required providers. Focused recruitment continually refines our CSoC provider network to meet the specific needs of our population, including cultural, ethnic, language and geographic characteristics.
- **Telehealth to expand access:** We plan to leverage our existing network to increase capacity in rural areas, support after-care, and meet urgent appointment needs through Telehealth.
- **Expansion of evidence-base services:** We will expand access to evidence-based and evidence-informed practices that meet the unique needs of CSoC members.
- **Stakeholder engagement:** We engage stakeholders, such as OJJ, DCFS, LDH and Managed Care Organizations (MCOs), to identify and support network gaps and unmet community needs.

Please see Magellan's Network Development Plan for a full list of interventions.

III. Quality Work Plan Evaluation: Performance Measures and Quality Improvement Activities³

Magellan analyzes network-related data and tracks performance reporting measures identified in the LDH's Quality Improvement Strategy (QIS). Magellan conducts all required activities, including:

- submitting a Corrective Action Plan (CAP) within 30 calendar days of notification by the LDH, including a timetable for correcting performance deficiencies. Magellan recognizes that the LDH must approve all CAPs, and will monitor our progress towards correcting deficiencies.
- providing the LDH with weekly reports of wraparound referrals and enrollment from the WAAs.
- collecting data from the WAAs including the WAA data spreadsheet, which captures information on client progress and outcomes in domains such as schools and communities (use of natural supports, out-of-home placements, status at discharge, hospitalizations, etc.).
- submitting quantitative reports including a summary table that presents monthly, quarterly, and/or YTD data, as directed by the LDH.
- ensuring that each report meets LDH requirements (e.g., sampling methodology, data source, data validation methods, etc.), required by the LDH.
- adhering to regulatory required technical specifications for all quality reports and performance measures.
- stratification of data reports as requested by the LDH, in response to legislative, media or other external requestors.
- utilization of systems, operations, and performance monitoring tools that are flexible and adaptable to changes in quality measurements required by the LDH.

³ Louisiana Department of Health SOW 14.2.3.2.1.

These performance measures 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. Many of the measures are reported monthly or quarterly, allowing administrators and program directors to have a real-time mechanism to monitor results and implement process improvement initiatives as needed. Measures that are reported annually are generally measures that have shown consistent and high levels of performance across time. **Table 2** shows the complete list of final report submissions that the LDH will receive, accompanied by performance measure results, narratives related to any performance deficiencies, remediation efforts and trend analyses.

Table 2. Performance Measure Final Reports⁴

Report Identifier	Performance Measure	Frequency
AA 01	Number and percentage of participants whose plan of care shows evidence that their setting meets HCBS requirements	Quarterly
AA 02	Number and percentage of CSOC providers who meet HCBS setting rule requirements	Quarterly
CM 02	Standard and Expedited Service Authorizations and Denials	Quarterly
EOB PI 147	Explanation of Benefits Report	Quarterly
FA 01	Number and percentage of paid claims coded according to the services rendered	Quarterly
FA 02	Number and percentage of claims that paid no less than the approved rate contained in the waiver application	Quarterly
GM 01	CSOC Member Grievances	Monthly
GM 02	CSOC Member Appeals Report & State Fair Hearing Report	Monthly
GM0 3	Provider Grievances & Appeals Report	Monthly
HW 01	Number and percentage of incidents involving abuse, neglect, exploitation, and death referred to the appropriate protective service agency for investigation within 24 hours of notification	Quarterly
HW 02	Number and percentage of critical incidents involving licensed/certified providers investigated by the Contractor within the established timeframe	Quarterly
HW 03	Number and percentage of participants who received information about how to report critical incidents, as documented by the participant/authorized representative's signature on the State-approved form	Annually (Waiver Year)
HW 04	Number and percentage of critical incidents which did not involve the use of restraints or seclusion	Quarterly
HW 05	Number and percentage of participants who received coordination and support to resolve health needs identified through case management contacts	Quarterly

⁴ Louisiana Department of Health SOW 14.2.3.2.3.

Report Identifier	Performance Measure	Frequency
	Quality Committee and Sub-committee Documentation	Quarterly
LOC 01	Number and percentage of initial participants who meet level of care requirements prior to receipt of services	Annually (Waiver Year)
LOC 02	Number and percentage of participants whose level of care determination form was completed timely as required by the state	Annually (Waiver Year)
LOC 03	Number and percentage of participants whose level of care determination was made by a qualified evaluator	Annually (Waiver Year)
POC 01	Number and percentage of participants whose plan of care reflects supports and services necessary to address the participant's goals	Annually (Waiver Year)
POC 02	Number and percentage of participants whose plan of care include supports and services consistent with assessed health needs, including risks	Annually (Waiver Year)
POC 03	Number and percentage of participants who participated in the plan of care development, as documented by the participant's and parents/caregiver's signature on the plan of care	Annually (Waiver Year)
POC 04	Number and percentage of participants whose plans of care were updated timely, as specified in the waiver application	Annually (Waiver Year)
POC 05	Number and percentage of participants whose plan of care was updated when the participant's needs changed	Annually (Waiver Year)
POC 06	Number and percentage of participants who received services in the type, amount, duration, and frequency specified in the plan of care	Monthly
POC 07	Number and percentage of participants given a choice among service providers, as documented by the participant/authorized representative's signature on the State-approved form	Annually (Waiver Year)
POC 08	Number and percentage of participants who received information on available HCBS, as documented by the participant/authorized representative's signature on the State-approved form	Annually (Waiver Year)
QM 05	CSoC Demographics	Quarterly
QM 06	Involvement with Child-Serving State Agencies	Quarterly
QM 07	CSoC Length of Stay	Quarterly
QM 08	CANS Outcomes	Quarterly
QM 09	Living Situation at Discharge	Quarterly
QM 10	Improved School Functioning	Quarterly
QM 12	Access to Wraparound	Quarterly
QM 13	Utilization of Natural Supports	Quarterly
QM 14	Utilization of Outpatient Services	Quarterly
QM 17	Performance Improvement Project Outcomes	Annually

Report Identifier	Performance Measure	Frequency
		(3 months following the end of each contract year)
QM 20	CSoC Adverse Incidents Report	Monthly
QP 01	Number and percent of providers meeting licensing and training requirements prior to furnishing waiver services	Quarterly
QP 02	Number and percent of providers continuously meeting licensing and training requirements	Quarterly
QP 03	Number and percent of non-licensed direct care staff of providers that meet State requirements	Quarterly
	Treatment Record Review Summary Report	Quarterly
	Appointment Availability	Quarterly
	Non-waiver Network Monitoring	Quarterly
	Network Status Report (out-of-network and out of state placements)	Monthly

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. These performance measures provides a mechanism to monitor programmatic outcomes to ensure the CSoC program is achieving these goals. Some of the results from 2018 for key performance measures are outlined below.

- **Access to Wraparound Performance Measures.** 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 95.9% of referrals meeting standard in WY2 Q2, which was an increase of 1.4 percentage points from the same quarter of the previous year. Face-to-face contact had a relatively flat trend since 2017 as evidenced by 69.6% of youth meeting timeframes in WY2 Q2, which was only a slight decline (i.e., -1.1 percentage points) from the same quarter of the previous year. Figure 3 shows access to wraparound measures for 01/01/2018 through 12/31/2018.
- **Natural/Informal Support on Plan of Care Performance Measure.** 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 4 shows a steady trend line for this type of involvement, with over 91% of members having natural and informal support involvement in WY2 Q2.
- **Children in Restrictive Settings Performance Measures.** 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 the percent of members required inpatient hospitalization stayed at or below 5% since July 2017. There was also slight decline in the average length of stay (ALOS), which shows an ALOS of only 7.1 days in WY1

Q2 and 6.6 in WY2 Q2. Figure 5 illustrates inpatient utilization measures for 01/01/2018 through 12/31/2018.

- **Discharge Performance Measures.** 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 continue to account for the largest type of discharge and have stabilized to the upper forty percentages for most quarters throughout 2017- 18. Another of the central goals of the program is for enrolled members to discharge into a home and community setting. The data show that over 90% of the children are discharging into the home and community setting, with WY2 Q2 of 94.6%. Figures 6 and 7 display the results for the discharge indicators.
- **Outcome Performance Measures.** 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 program has consistently maintained strong outcomes, with approximately 70% of membership showing improvement in clinical functioning. Figures 8 shows quarterly results since December 2015.

In 2019, Magellan will expand upon this initial CANS analysis to better understand variances in changes identified across CSoC subgroups, including gender, race, age, diagnosis and system involvement and for members receiving different support and services. This effort will utilize the DMAIC (Define, Measure, Analyze, Improve and Control) Model, which is a data-driven framework used to solve complex or multifaceted problems in a logical and systemic manner. Following an evaluation of [subgroup-specific] descriptive data, Magellan will administer statistical tests that account for confounding variables to identify areas of opportunity. We will partner with the LDH, and other providers and stakeholders, to discuss these areas of opportunity and remediation-related goals. Measurable interventions will be developed and implemented to improve our performance. Magellan's CSoC Quality Improvement Committee (QIC), Utilization Management Committee (UMC), Network Strategy Committee (NSC) and Risk, Account and Compliance Committee (ARC) provide oversight of these efforts. Full details of these initiatives can be found in the 2019 Outcome Evaluation Plan.

Along with the historical measures, Magellan's 2019 Quality Work will include more strategic and targeted measures that factor in various stages of member enrollment in wraparound, including:

- **LOS and Transition Phase Management Performance Measures**
 - ❖ Percent of members discharged within ± 30 days of expected discharge reported on the 180-day eligibility POC prior to the discharge.
 - ❖ Percent discharged between 9-18 months of full CSoC enrollment date.
 - ❖ Percent discharged within ± 30 days of expected discharge reported on the 180-day eligibility POC prior to the discharge and between 9-18 months of full CSoC enrollment date.

■ **Inpatient Utilization Performance Measures**

- ❖ Percent of members with full eligibility who had an inpatient hospital admission during each 180-day CSoC eligibility period (i.e., 0-179 days, 180 days-359 days, 360-539 days and ≥ 540 days) during the reporting period.
- ❖ Average length of stay members with full eligibility who had an inpatient hospital admission during each 180-day CSoC eligibility period (i.e., 0-179 days, 180 days-359 days, 360-539 days and ≥ 540 days) during the reporting period.

■ **Natural/Informal Support Monitoring Performance Measures**

- ❖ Percent of members with full eligibility who had at least one (1) natural/informal support (excluding immediate family members) on the CFT during each 180-day CSoC eligibility period (i.e., 0-179 days, 180 days-359 days, 360-539 days and ≥ 540 days) during the reporting period.
- ❖ Percent of members with full eligibility who had a natural/informal support on the CFT that actively participated in the CFT meeting during each 180-day CSoC eligibility period (i.e., 0-179 days, 180 days-359 days, 360-539 days and ≥ 540 days) during the reporting period.

Figure 3: Access to Wraparound

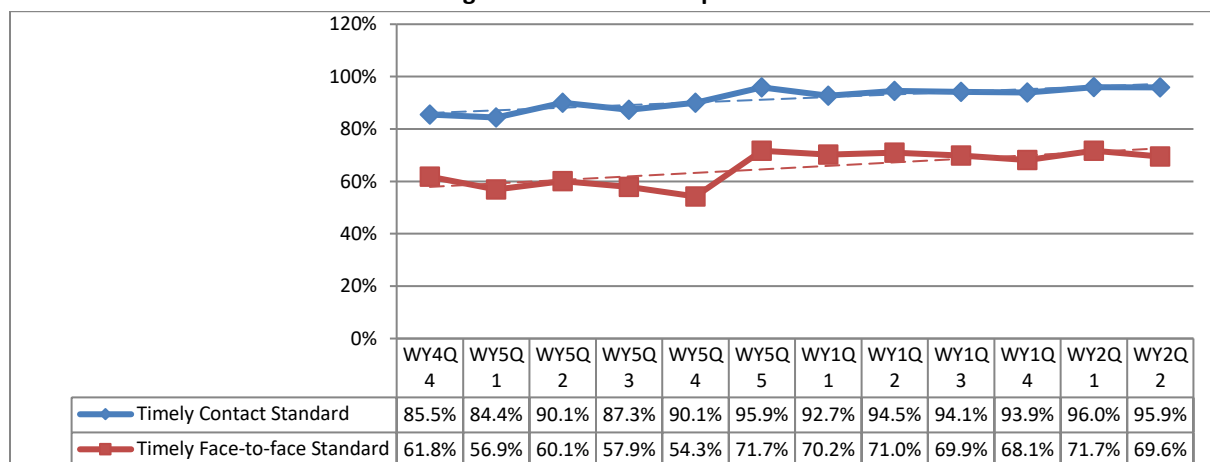


Figure 4: Natural/Informal Support on Plan of Care

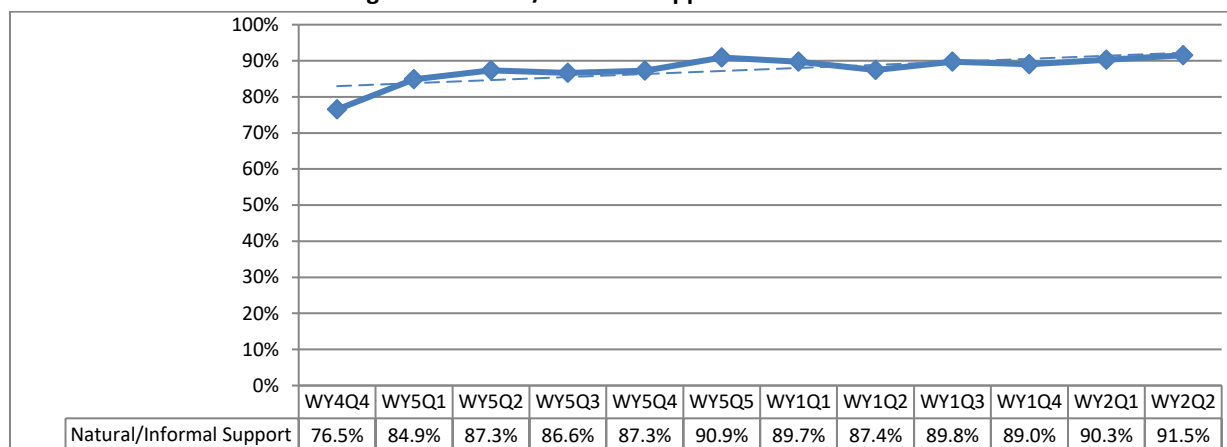


Figure 5. Children in Restrictive Settings

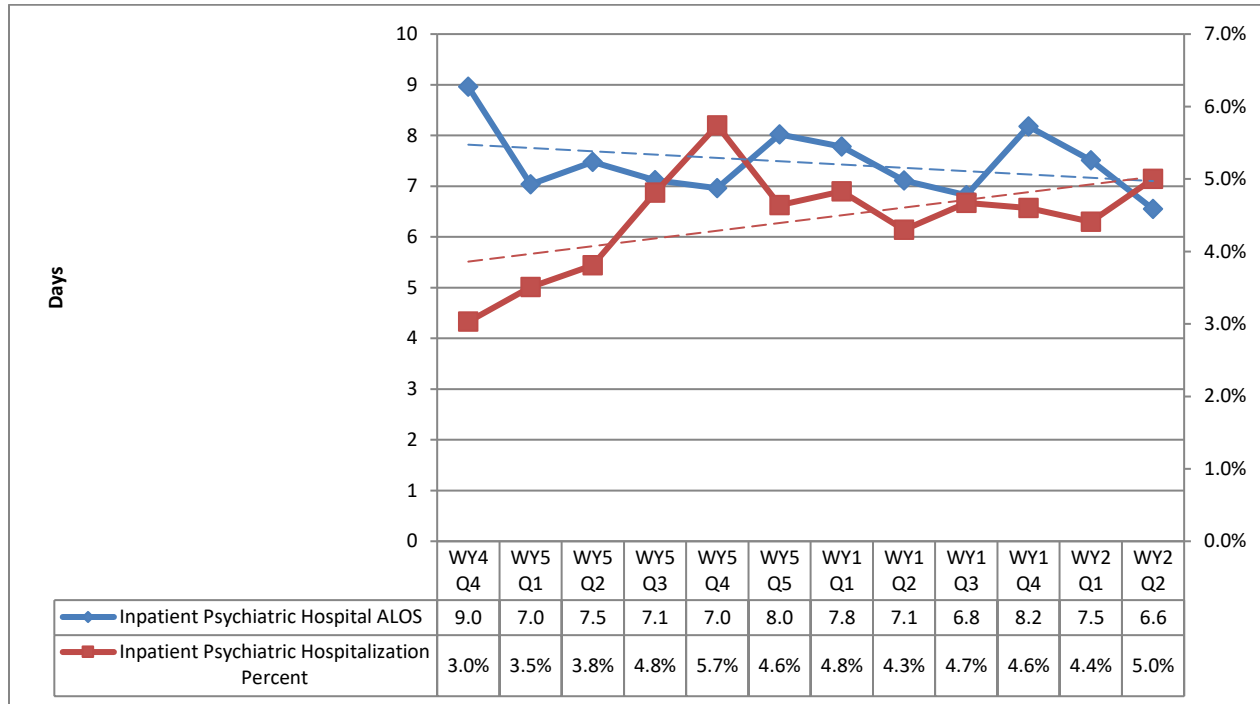


Figure 6: Home and Community Based Setting at Discharge

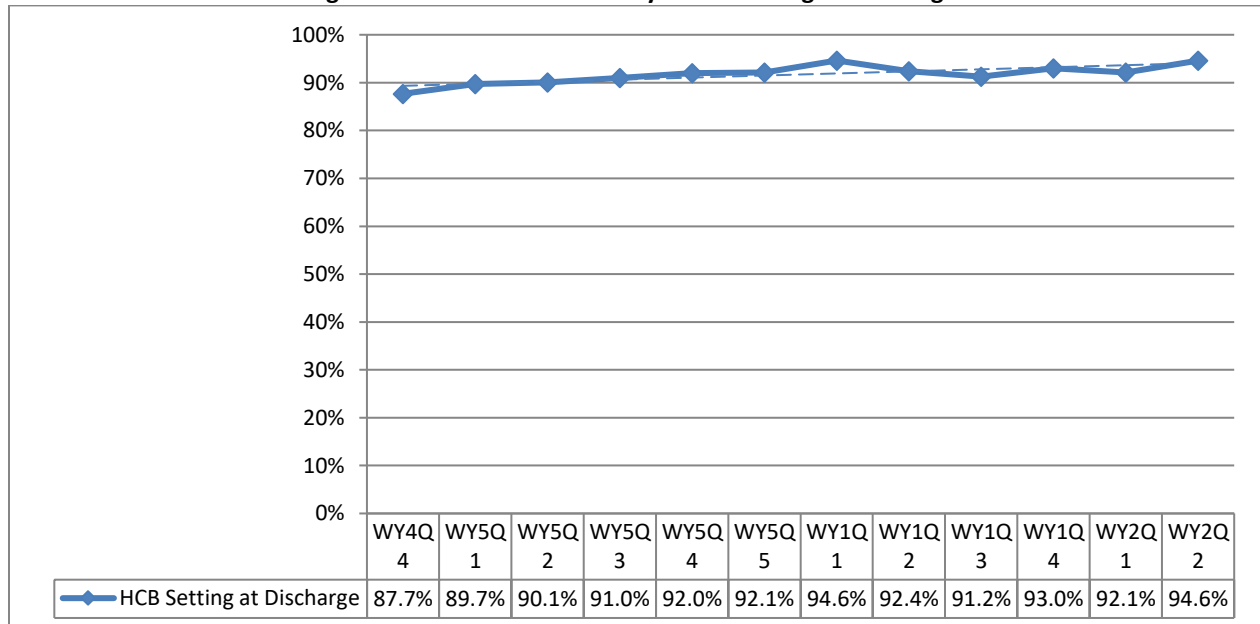


Figure 7: Reasons for Discharge

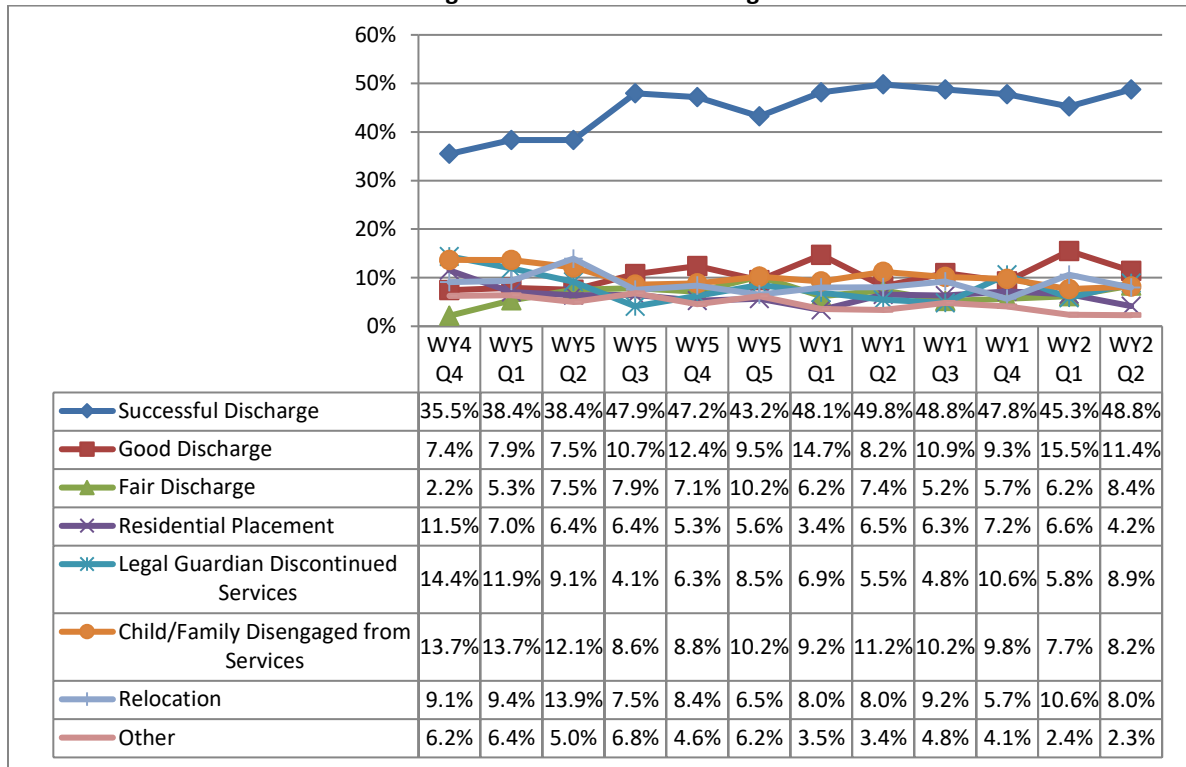
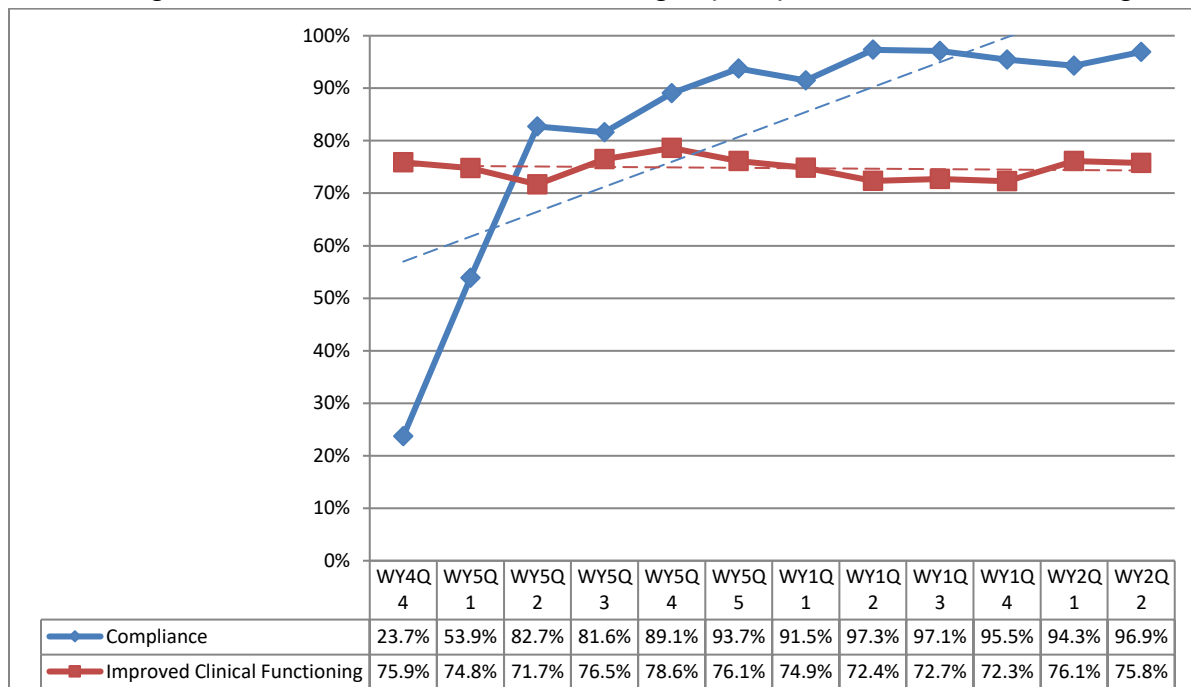


Figure 8: Child and Adolescent Needs and Strengths (CANS) Outcomes: Clinical Functioning



Some of the results of key quality activities that were completed in 2018 and any recommendations for 2019 are documented below.

- **Treatment Record Reviews (TRRs).** The TRR process is a key quality activity involving the collection of data regarding 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. Due to consistently high performance over the past two years (i.e., performance greater than 90%), Magellan proposes a non-random selection process that targets waiver providers and newly contracted providers, which are provider groups that have historically had lower levels of compliance on TRRs.
- **Provider Network Monitoring Reviews.** Magellan conducts onsite annual reviews for specialized waiver providers, as well as a random selection of behavioral health providers to ensure ongoing compliance with LDH, Magellan and state/federal regulations. provider licensing requirements
 - ❖ unlicensed direct care staff qualifications and training requirements:
 - verification of criminal background check, drug testing, and Tuberculosis test on file which indicates the check was conducted prior to employment and the individual is not barred from providing services based on the results of such checks/tests
 - the individual is not barred from providing services
 - verification of staff qualifications, including work, professional, required training and educational experience, as well as NPI
 - verification that unlicensed direct care staff member does not have a negative finding on Louisiana state nurse aide registry and the Louisiana direct service worker registry prior to hire and agency compliance with monitoring every 6 months
 - cultural competency training completed prior to the provision of waiver services, and annually thereafter
 - completed First Aid, CPR and seizure assessment
 - motor vehicle screen, if applicable
 - ❖ appointment availability
 - provision of emergent care and appointment within 1 hour of request
 - urgent appointment availability within 48 hours of a request
 - routine appointment available within 14 days of a request
 - ❖ Home and Community Based Setting (HCBS) Rule adherence

Inconsistent results have been recorded for provider compliance regarding adherence with unlicensed direct care staff for qualification and training requirements as outlined in the **Table 3**.

Table 3. Unlicensed Direct Care Staff Compliance Rates for 2018

Quarter	Waiver Providers				Non-Waiver Providers			
	# of Providers Audited	# of Staff Compliant	# of Staff Audited	% Compliant	# of Providers Audited	# of Staff Compliant	# of Staff Audited	% Compliant
Jan - Mar 2018	7	42	45	93.3%	10	91	97	93.8%
Apr - Jun 2018	7	51	58	87.9%	8	75	77	97.4%

	Waiver Providers				Non-Waiver Providers			
Jul - Sept 2018	10	25	39	64.1%	8	54	71	76.1%
Oct - Dec 2018	3	8	11	72.7%	7	69	69	100.0%
Jan - Dec 2018	27	126	153	82.4%	33	289	314	92.0%

Magellan has been dedicated to ensuring that providers are aware of all requirements for documentation practices and utilizes a comprehensive training approach to ensure awareness of standards, including monitoring completion of required trainings, conducting onsite and desktop provider monitoring, and providing clear guides regarding expectations through the Magellan website, the provider handbook, and email blasts. In order to support continued compliance, Magellan implemented the following remedial and recoupment activities non-complaint staff in 2018:

- ❖ **Remedial Activities:** Provider is given notification of names and areas of non-compliance for unlicensed direct care staff members who do not meet LDH training requirements and qualifications as defined in the Behavioral Health Service Provider Manual (<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf>). The non-compliant staff is instructed to immediately discontinue rendering services. The staff will not be allowed to render services until compliance can be verified by Magellan.
- ❖ **Recoupment Activities:** If staff are determined to be non-compliant for LDH training requirements and qualifications as defined in the Behavioral Health Service Provider Manual, Magellan will recoup claims for services rendered by staff from 02/01/2018 to the date of compliance. Magellan will submit list to LDH as part of quarterly reporting for approval and then to the corporate Cost-Containment Department for recoupment upon LDH approval of report.

Enhancements will be made in 2019 to further support provider compliance. Effective January, 2019, unlicensed staff will be required to submit claims with unique NPI numbers, which will augment our ability to isolate and recoup claims for non-compliant staff. Magellan will also restructure the Network Department to add two dedicated Network Coordinators to increase the scope and scale of these audits. The coordinators will conduct provider outreach and/or training to ensure adherence to provider qualifications and requirements. In addition to the above requirements, the Network Coordinators will also monitor provider data ensuring compliance with the following:

- ❖ Verification of appropriate taxonomy codes
 - ❖ Up to date staff rosters with NPI are on file
 - ❖ Compliance with provider demographic attestations
 - ❖ Annual license is obtained and on file
 - ❖ Accreditation is acquired and maintained
 - ❖ Appointment availability and accessibility
- **Patient Safety/Adverse Incidents.** Adverse incidents are defined as unexpected occurrences in connection with services provided through Magellan or its subsidiaries and affiliates that led to (or

could have led to) serious unintended harm, loss or damage, such as death or serious injury, to an individual receiving services through Magellan or a third party. Types of adverse incidents include:

- ❖ death
- ❖ suicide attempt
- ❖ significant medication error
- ❖ event requiring emergency services (of the fire department or a law enforcement agency)
- ❖ abuse (physical, psychological or sexual abuse, or extortion or exploitation)
- ❖ serious injury or illness
- ❖ missing person
- ❖ seclusion or restraint

Magellan has processes in place to conduct an adverse incident investigation within 12 calendar days of the date of discovery. All necessary corrective actions occur within 30 calendar days of the date of discovery, unless an extension is granted by the LDH. Incidents involving abuse are reported to the appropriate regulatory body and the member's guardian (when a minor is involved) within twenty-four hours of discovery.

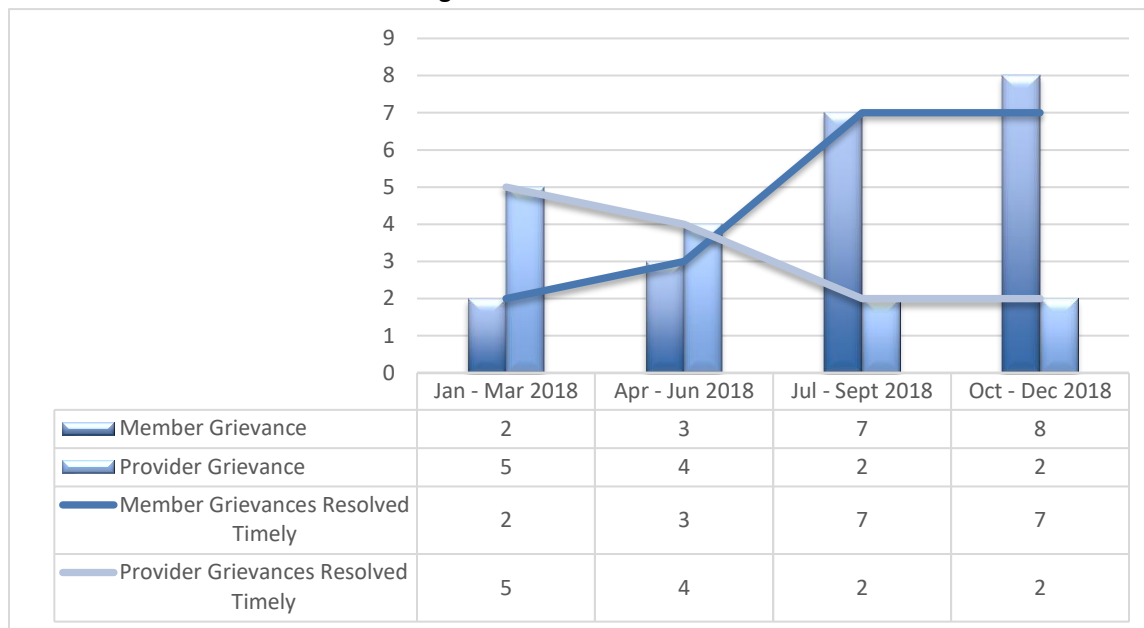
Over the course of 2018, there was one reported incident of suicide and one reported incident of death involving substance use members enrolled in CSOC. Although these incidents did not indicate aberrant patterns in the network, it is believed that enhanced monitoring of members with actionable risk behaviors will facilitate improved ongoing risk assessments, improved implementation of crisis plans, improved coordination of care and improved follow-up care for members who require inpatient psychiatric hospitalization. Patient Safety record reviews will be developed and implemented in 2019.

- **Member and Provider Grievances.** Magellan is committed to providing all impacted parties with support throughout the grievance process any expression of dissatisfaction is acknowledged and addressed as a grievance. Grievances can be initiated by a member, family member, network provider or other involved party or stakeholder. Once received, member and provider grievances are reviewed for clinical urgency and legal implications. If a grievance is urgent (e.g., the member's condition is unstable or emergent), it is deemed clinically urgent and referred to the Medical Director and Clinical Department for expedited processing (within 2 business days of receipt). If the grievance includes a compliance issue, Magellan's Compliance Department is notified. Our Legal Department is engaged, when necessary.

As part of the investigation process, Magellan actively coordinates with the Clinical Director of the member's WAA to ensure that the CFT is involved in the identification of solution-focused interventions aimed at addressing the area of dissatisfaction. This may include coaching or training for the facilitator and/or provider, increased involvement of natural and community supports, adjusting strategies on the POC or assisting the member in selecting a different provider. This high touch, collaborative process ensures that the family's culture is honored throughout the process. Grievance resolutions are provided in writing but we also attempt to contact the grievant by phone to ensure that the resolution is satisfactory. If a provider grievance is determined to be beyond the scope of services provided by Magellan, the provider is directed to the appropriate non-Magellan

party for resolution. **Figure 9** provides details on the number of provider and member grievances that were received and processed during 2018. There was one provider that had an aberrant trend of provider and member grievances as well as poor compliance with network monitoring requirements and quality of care practices since being contracted with Magellan in 2016 (i.e., Faith and Hope Independent, LLC). The provider was presented to the Regional Network Contracting Committee in November 2018 and were voted to be terminated from the network in December 2018. Members were given a 90-day transition period to ensure transition of care to other qualified providers. There are no substantive changes to the grievance policies and procedures are anticipated in 2019.

Figure 9. Member and Provider Grievances



- Appeals.** Magellan supports members and providers in appealing adverse clinical determinations. An appeal is defined as a formal review of a decision about a member's behavioral health services. Our members are provided 60 calendar days from the date of the written notice of adverse benefit determination to request an appeal. The member or a representative acting on the member's behalf, or the provider, acting on behalf of the member and with the member's written consent, may request an appeal either orally or in writing, including online. If the request is not an expedited request, the request must follow the oral filing with a written, signed appeal request. Upon receipt of an oral appeal, an appeal coordinator will send a letter to the grievant reminding them that written confirmation must be received within 15 days of the oral appeal in order to complete appeal request. The member is still afforded the full 60 calendar period to file an appeal if the written, signed appeal is not received following 15 days of the oral appeal. When a request for an expedited resolution is received, our team will work to resolve it within 72 hours. Standard appeal requests are acknowledged within 3 business days of receipt and a determination is made within 30 days of receipt. **Table 4** outlines the type, category, decision and resolution timeliness of appeals received during 2018. There were no notable trends that require intervention in 2019 and no substantive changes are anticipated in the process and procedures for managing appeals.

Table 4. Appeals Received in 2018

		Decision		Category		Type		
Month	Received	Upheld	Withdrawn	Inpatient	Eligibility	Expedited	Standard	Resolved Timely
Jan	4	4	0	4	0	4	0	4
Feb	2	2	0	2	0	2	0	2
Mar	2	2	0	2	0	2	0	2
Apr	4	2	0	2	2	2	2	4
May	0	0	0	0	0	0	0	0
Jun	3	2	0	2	1	2	1	3
Jul	2	2	0	2	0	2	0	2
Aug	1	1	0	1	0	1	0	1
Sep	1	1	0	1	0	1	0	1
Oct	2	1	0	1	1	1	1	2
Nov	2	1	0	1	1	1	1	2
Dec	1	0	0	1	0	0	1	N/A

IV. Performance Improvement Projects (PIPs) ⁵

Magellan implemented an LDH-approved Performance Improvement Plan (PIP). The PIP focused on implementation indicators that monitor best practices in Wraparound and track fidelity to the model. Indicators included frequency of Child and Family Team (CFT) meetings and team composition, specifically natural/informal support participation in these meetings. Magellan monitored indicators for six consecutive months to establish a baseline, and evaluated trends quarterly thereafter.

Since the PIP began in April, 2017, positive improvements have been observed in the frequency of CFT meetings; however, participation of natural/informal supports remained flat despite interventions, with little or no consistent progress and significant variation among regions. The project was closed in November 2018 in order focus new initiatives. In 2019, Magellan's QI department will implement Quality Improvement Activities (QIAs) to address, at minimum, two clinical and non-clinical areas. Magellan will collaborate with the LDH to select a QIA to serve as our PIP. The recommended areas of improvement include:

- improve ambulatory follow-up after inpatient hospitalization measures
- increase overall clinical improvement as measured by the Child and Adolescent Needs and Strengths, CANS (comparing the initial and discharge assessments)
- reduce inpatient admissions for newly enrolled members
- improve adherence to ADHD Clinical Practice Guidelines (CPG) by rendering providers

⁵ Louisiana Department of Health SOW 14.2.3.2.2.

- improve the percent of unlicensed direct care staff that adhere to LDH and Magellan qualifications.
- Improve the percentage of members with a natural/informal support on the CFT who actively participate in the CFT meeting at periods of enrollment in CSoc (including 180 -359 days, 360-539 days and ≥ 540 days).
- improve the percentage of complete and accurate eligibility assessment submissions.

V. Care Management Initiatives⁶

Care Management (CM) is the overall system of medical and psychosocial management encompassing Utilization Management (UM), care coordination, discharge planning, continuity of care and care transitions. CM is a direct and indirect mechanism for monitoring providers to ensure access to and quality of care, CPG adherence and care coordination activities (e.g., scheduling assistance, etc.). This section outlines some of the key activities and initiatives for our 2019 CM and UM programs.

A. Inpatient Admission Management

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 the percent of members required inpatient hospitalization stayed at or below 5% since July 2017. There was also slight decline in the average length of stay (ALOS), which shows an ALOS of 7.1 days in WY1 Q2 and only 6.6 in WY2 Q2. **Figure 10** illustrates inpatient utilization measures for 01/01/2018 through 12/31/2018.

When members are admitted to a hospital, Magellan, the WAA and the hospital work together to ensure that the member is stabilized quickly. The CFT remains engaged and all after-care needs are met. Magellan promotes the development of strong working relationships between our clinical team and providers. To facilitate this, we pair Care Managers within regions, allowing for more efficient management of members requiring hospitalization. This is accomplished through our Mini Team staffing design, which combines clinical, network and quality staff for each of the nine regions. This approach allows Magellan staff to specialize in member and network demographics for each region, increasing rapid detection and resolution of member needs. Key activities and tools to achieve those goals include:

- **Medical Necessity Criteria (MNC).** Magellan has developed a vigorous set of clinical programs to manage children admitted to an IP hospital setting. In 2016, Magellan made critical changes to our MNC, which mandated that all CSoc members 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 continued oversight of our members so that treatment plans can be adjusted quickly. The MNC also includes enhanced criteria requiring active coordination of care with WAAs throughout the course of treatment, including within 24-hours of admission. This high level of coordination allows the hospital to leverage the WAAs' deep knowledge of families to create a comprehensive discharge plan and reduce recidivism.

⁶ Louisiana Department of Health SOW 14.2.3.2.1.

- **Hospital/ER Protocol**
 - ❖ Hospitals are included in CFTs, and at least one CFT meeting is held while the member is hospitalized. If any services are added or increased in frequency, Magellan will immediately issue temporary authorizations for those services until a POC can be submitted.
 - ❖ Magellan notifies members' MCOs of an admission and works with their CSoC liaisons to ensure medications are authorized and available before discharge.
 - ❖ Magellan's CM applies customized CSoC MNC to hospital reviews that require WAA collaboration and enhanced discharge planning.
 - ❖ Magellan's CM bridges any identified gaps, and supports collaboration between WAAs & hospitals.
- **Discharge Protocol**
 - ❖ The CFT meets and updates a POC within 15 days of a member's discharge from an IP hospital; Magellan will review POCs and issue appropriate authorizations.
 - ❖ The updated Crisis Plan that address the reason for the admission.
 - ❖ Magellan's CM team conducts a follow-up call with the guardian within three days of the IP discharge, and again within one week of the first call, to ensure that the member has appropriate follow up appointments and there are no barriers to attending appointments (transportation, scheduling difficulties, medication concerns, etc.).
- **Physician Advisor (PA) Feedback.** Magellan's PAs complete routine assessments of providers, including contractual and quality-related compliance. PAs must document the presence/absence of any quality of care concerns prior to signing off on the Magellan PA documentation forms. A positive response alerts Magellan's quality and network teams of the need for further monitoring and intervention with the provider.
- **Breaking Barriers Round.** Magellan's clinical teams conduct "Breaking Barriers Rounds" to closely monitor and manage higher severity youth such as: youths who have been in an IP level of care more than one time in the past nine months; youths who are IP within thirty days of the CSoC referral date; youths who are IP, and they have been discharged from PRTF within the past nine months (or PRTF is being considered) and youths who are IP and they have recently been in detention. These rounds take place several times per week and evaluate many areas of member functioning, including what has worked for the youth in the past, exploration of the current POC, evaluation of natural supports, assessment of active formal and informal services and identification of diagnosed or potential developmental delays, medical issues, etc. The CM then communicates with the WAA or hospital to assist with treatment planning.
- **Follow-up After Hospitalization Management.** The clinical team actively intervenes at each point during, and following, inpatient admissions to facilitate appropriate follow-up care. Care Managers proactively engage with hospital staff from admission to discharge to monitor the status of discharge plans, promote coordination of care with Wraparound Agencies (WAAs), and ensure that follow-up appointments have been scheduled. Care managers can also provide information to hospitals regarding in-network providers and assist with scheduling appointments, if needed. Care managers also give WAAs the follow-up and discharge information needed to facilitate coordination of care. Magellan also makes follow-up calls to members within 72 hours of discharge to monitor their progress. We also confirm that they've made an outpatient appointment and help address any barriers in getting to the doctor. If the member does not have an appointment, we offer to conference them in with the provider's office to schedule one. To support this initiative, the CSoC Unit monitors the rate for the HEDIS-like Follow-Up After Hospitalization for Mental Illness (FUH) 7-

Day and 30-Day measures which monitor if members admitted to an inpatient psychiatric hospital setting receive follow-up care with a behavioral health provider following discharge. Members seeking timely outpatient services following an inpatient hospitalization can also reduce recidivism and improve outcomes. Because the CSoC program includes specialty peer and support services, Magellan reports on the FUH measures, as well as a variation of those measures (that includes ILSB, STR, Parent Support and Training and Youth Support and Training). These services are critical to CSoC and provide another layer of support to our members following discharge from an inpatient admission. **Table 5** provides the state and regional rates for 7-day and 30-day measures from 01/01/2018 through 12/01/2018 as of 01/21/2019. When compared to 2017 performance, the rates are slightly lower (i.e., 7-day FUH: 55.9% and 66.4% for HEDIS and Modified HEDIS respectively; 30-day FUH rates were 72.6% and 82.3% for HEDIS and Modified HEDIS respectively). The rates should increase slightly as more claims are submitted, with final report being submitted to the state for 2018 MY on 04/15/2019. Magellan recommends that improving FUH rates be considered as a formal PIP topic for 2019.

Figure 10: Children in Restrictive Settings

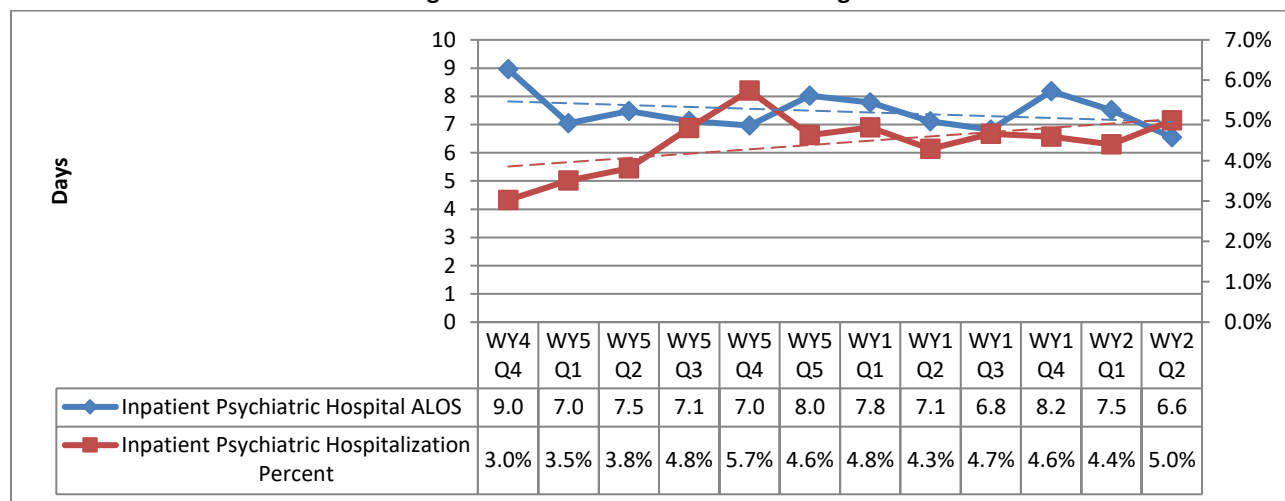


Table 5. FUH Rates for 01/01/2018-12/01/2018

Region	Denominator	National HEDIS Specifications ¹				Modified HEDIS Specifications ²			
		7-Day Numerator	7-Day Percent	30-Day Numerator	30-Day Percent	7-Day Numerator	7-Day Percent	30-Day Numerator	30-Day Percent
Region 1	41	24	58.54%	31	75.61%	29	70.73%	34	82.93%
Region 2	40	16	40.00%	22	55.00%	24	60.00%	32	80.00%
Region 3	66	34	51.52%	47	71.21%	41	62.12%	53	80.30%
Region 4	37	18	48.65%	28	75.68%	19	51.35%	30	81.08%
Region 5	36	21	58.33%	26	72.22%	25	69.44%	30	83.33%
Region 6	44	22	50.00%	29	65.91%	27	61.36%	34	77.27%
Region 7	22	14	63.64%	20	90.91%	15	68.18%	21	95.45%
Region 8	50	27	54.00%	34	68.00%	38	76.00%	43	86.00%
Region 9	23	12	52.17%	19	82.61%	17	73.91%	22	95.65%
Total	359	188	52.37%	256	71.31%	235	65.46%	299	83.29%

¹Includes waiver service CSoC ILSB only

²Adds waiver services CSoC YST, PST, CS, STR

B. Screening Programs

Screening activities incorporate and identify appropriate methods of assessment and referral for members requiring BH services (and linkages to primary medical care services, as needed). These activities include scheduling assistance, monitoring, and follow up for member(s) requiring BH services. Screening activities for 2019 include:

- **Referrals:** Magellan's Care Managers speak to each family seeking CSoC enrollment and begin the referral process by administering a brief CANS to determine if the child meets presumptive eligibility criteria. If the child does not meet the criteria, the CM's honor our commitment to making accurate and consistent clinical determinations by ensuring that the family's appeal rights are clearly explained. They also collaborate with the child's MCO to ensure that immediate treatment needs are met. If the child is presumptively eligible for CSoC, the Care Manager explains to the family how the program works and what can be expected from the WAA and providers. The CM also requests information about the child's PCP (to coordinate care), discusses any health concerns, risks, or special needs and ensures that any immediate treatment needs are met. Magellan's MCO Liaison follows up with the MCO to ensure that ongoing treatment needs are met.
- **Assessment and eligibility:** One of our CM team members is dedicated to making clinical eligibility determinations. This CM, who is also a Licensed Mental Health Professional, has in-depth experience in reviewing the CANS and the Individualized Behavioral Health Assessment. They also review all available clinical information and reach out to WAAs to ensure Magellan has sufficient information to make accurate eligibility determinations. During this process, the child's family is informed of their appeal rights, in the event of any adverse determinations. Our CM is also able to identify concerns about the quality of the assessments that are completed and works with the WAA and the corresponding regional Mini Team. The Mini Team includes representatives from the CM, Quality, and Network departments.

C. Behavioral Continuum and Behavioral/Medical Integration Activities ⁷

Magellan's CM program ensures that clinically appropriate and cost-effective BH services are identified, planned, obtained and monitored for members identified as high risk or those having unique, chronic, or complex needs. The process integrates Child and Family Teams, including the member and their guardian and Care Managers (who review the member's strengths and needs) resulting in a mutually agreed upon, clinically appropriate and cost-effective service plan. CM Program coordination activities functions include, but are not limited to:

- **Plan of Care approval:** The Plan of Care is the core document guiding formal and informal services the child and their family receive. The child's assigned Care Manager uses a Plan of Care Review tool to ensure that Wraparound best practices and waiver requirements are met. Our goals are to help the child and family achieve their goals, support the family and help them keep their child safely at home.
- **Risk identification:** Care Managers monitor CSoC members for changes in conditions that indicate specialized treatment needs, increased risk, or the need for more intensive services. The Care Manager may become aware of a change in condition through collaboration with a provider,

⁷ Louisiana Department of Health SOW 14.2.3.2.1.

through changes in utilization (such as ER visits or IP admissions), through review of an updated CANS or IBHA, or by utilization of the CANS Risk Identification Tool. If there is a change in condition, the Care Manager will collaborate with the WAA to ensure the Plan of Care is adjusted as appropriate to reflect additional needs and services.

- **Care coordination:** There are many avenues by which a Care Manager may become aware of care coordination needs a child may have. These include: the Barriers document in a Plan of Care, information provided in an assessment, through utilization reviews with hospitals, via a WAA interface on Magellan's provider website, through WAA or Treatment Record Reviews, during WAA technical assistance visits, or from speaking with the family of a CSoC member. Magellan has Care Managers, WAA Coordinators, Care Workers, an FSO Coordinator, and MCO and Agency Liaisons who focus on the individual needs of our members and their families. Medical needs, educational challenges, BH treatment and agency involvement are just a few triggers for increased care coordination activities.
- **Coordination with MCOs:** Care Managers and our MCO Liaison coordinate care with the member's MCO to promote overall health and wellness and non-duplicative services. Medical needs are considered during every clinical review and member interaction to ensure that members have appropriate and effective healthcare.

D. Coordination of Care Activities

When a WAA informs Magellan of a Member's discharge from CSoC, the following actions are taken to support a smooth transition of care to the member's MCO:

- The MCO Liaison verifies which MCO the Member is enrolled with.
- The MCO Liaison sends the following to the MCO in advance of a weekly meeting established to ensure continuity of care:
 - ❖ the member's initial, and most recent, CANS assessment
 - ❖ the member's IBHA
 - ❖ the member's most recent POC (which includes a crisis plan)
 - ❖ any other assessments conducted during the member's CSoC enrollment

E. Inter-rater Reliability

Magellan's clinical policies require an annual assessment that gauges if MNC is applied consistently by clinical care management staff, physician advisor consultants and medical directors. The measurement process is designed to conform to NCQA, URAC, and licensing requirements. Our corporate and local clinical teams collaborate to develop MNC scenarios specific to Louisiana. Our CSoC Unit completed the inter-rater reliability measurement using a secure, interactive intranet site accessible to care managers, clinical supervisors, physician advisors, and medical directors. The measurement activity uses clinical case vignettes that represent a cross-section of the types of cases a care manager, physician advisor, or medical director might encounter.

VI. Consumer, Family and Stakeholder Input and Involvement

A true "culture of quality" is based on a solid QI strategy informed by an organization's youths, families, stakeholders and providers. There must be a team approach that promotes shared responsibility for developing, implementing, monitoring and evaluating the QI Program. Design, implementation and

evaluation processes must factor in all team members' perspectives, mandates, and resources. Magellan actively recruits youths, caregivers, family members, WAAs, providers, peers and local stakeholders to ensure that the Quality Committee team member composition is representative of the communities we serve.

Just as the Wraparound model emphasizes collaboration and a team-based approach, our QI committee structure supports input from committee members with diverse backgrounds. The QIC provides a safe environment for the exchange of ideas and its subcommittee members share their unique perspectives and experiences, adding depth and understanding to the evaluation process. This helps us identify and prioritize relevant information and ideas worthy of further design and pursuit.

Stakeholder input helps the committee evaluate and understand quality findings and identify root causes that might not have, otherwise, been considered. To ensure effective participation, Magellan creates a comprehensive committee, workgroup and forum orientation program that contains both training and orientation materials. In 2019, Magellan will implement targeted recruitment efforts to enhance stakeholder involvement in our committee structure.

VII. Accreditation

Magellan is committed to achieving National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Organization (MBHO) Accreditation as soon as possible and we will maintain accreditation for the life of the Contract. Magellan is currently accredited as a Credentialing Verification Organization (CVO) through NCQA. We leverage well-established protocols, policies and procedures built on NCQA standards, and have developed a comprehensive accreditation project plan to guide the preparation and tracking process. Although our accreditation efforts are led by the Quality Team, accreditation is embraced as a collaborative effort supported by all departments. Magellan will not only obtain accreditation, but we will demonstrate and maintain continuous high levels of excellence in service delivery. To support our comprehensive approach to accreditation, the following activities are underway:

- recruitment of an Accreditation Manager to coordinate preparation and monitor our continued readiness for, and compliance with, NCQA standards;
- form a NCQA Operations Project Team, led by the QI Department, which provides oversight and support to Louisiana's accreditation activities.

VIII. Resources

The CSoC Unit's Quality Program is well staffed, and includes both corporate and local resources. Corporate resources include the following departments:

- **Quality, Outcomes and Research** - provides direction on the identification, implementation, and documentation of Quality Improvement Activities and Performance Improvement Projects and QI document templates; implements satisfaction surveys for members, providers, and customer organizations.
- **Analytical Services** - provides data reports on several QI and UM indicators; provides consultation on report definitions and analysis.
- **Network Services** - verifies the accuracy of credentials submitted by providers for inclusion in the network.

- **National Clinical Management** - supports the development of medical necessity criteria and clinical practice guidelines; consults on clinical, medical, and quality issues for all care and condition care management programs.
- **Compliance** - develops policies and standards; monitors HIPPA and related privacy and security practices; oversees Magellan's Fraud, Waste & Abuse efforts.

Magellan's Behavioral Health Quality Improvement Committee (BH-QIC) provides oversight of Louisiana's CSOC QI Program. It is co-chaired by the Chief Medical Officer for Behavioral Health and reports to the Enterprise Quality Committee. The Chief Medical Officer is directly accountable for the QI Program, and oversight of our CSOC Program is provided by the QIC and its subcommittees, including: the Utilization Management Committee (UMC), the Regional Network Credentialing Committee (RNCC), the Network Strategy Committee (NSC) and the Compliance Committee.

IX. Delegation

No CSOC-related functions, for the state of Louisiana, are delegated to a vendor or subcontractor.

X. Regulatory Compliance Monitoring

Magellan implements a comprehensive approach to the prevention and detection of potential fraud, waste and abuse (FWA) and overpayments. In order to meet program goals and adhere to the requirements of the CSOC SOW, our Program Integrity Compliance Officer oversees FWA activities. These activities are based on well-defined programmatic objectives and detailed policies and procedures, including Magellan's Medicaid Compliance Program policies and regulatory guidance. We use a multi-pronged approach that includes proactive and predictive methodologies for faster identification of possible FWA, improved controls, and greater savings through cost avoidance. Our processes include risk analyses, ongoing data analyses, desktop/onsite audits and investigations, retrospective reviews of data and employee vetting and reporting.

- **Risk analyses:** The SIU has established a process for identifying and assessing FWA risks. The process includes an annual risk assessment, which includes an evaluation of the following information: the HHS-OIG Work Plan, internally identified areas of risk, local fraud taskforce meetings, results of data analyses and data mining, state FWA activity reports, risks identified by the FBI or the Federal Office of Personnel Management, published news articles and other sources. The SIU also identifies potential areas of risk through ongoing education, research and monitoring.
- **Ongoing Data Analyses:** The SIU analyzes claims payments and authorization data for potential FWA. On a monthly basis, we look for outliers in utilization and costs using predictive analytics, social network analyses and other algorithms. We prioritize the analyses that are developed and deployed, and we introduce new algorithms on an investigation or customer-specific basis. The SIU shares member treatment patterns with Magellan's clinical and medical staff, which may result in a clinical or medical review. Examples of standard data analysis reports include provider anomalies, unbundling of services, duplicate billing, excessive treatment hours, services rendered on holidays and weekends, professional services provided to members in long-term care facilities and outliers in psychological testing.
- **Audits:** When the SIU identifies questionable patterns, claims audits are conducted. Throughout the course of an investigation, Magellan will actively coordinate efforts with Louisiana's Medicaid Fraud Unit and program integrity, oversight and law enforcement agencies. We plan to expand the

responsibilities of our Program Integrity team to include onsite reviews, which allow direct access to provider records, as needed.

- **Member Verification:** Magellan routinely conducts a “Verification of Services Provided to Members Audit” as part of its FWA process. On a monthly basis, we randomly select paid claims and send a Member Service Verification Questionnaire to our WAA partners. We carefully review each questionnaire and record the results in our Member Service Verification Log (MSVL). If a member indicates that (s) he did not receive a service, our Compliance Officer will contact the member to confirm their response. Once confirmed, the Compliance Officer will forward the case to the SIU and comply with State reporting requirements.
- **Retrospective Review of Data:** All suspicious activity is analyzed by our SIU staff for retrospective review. The SIU Investigator and our Clinical team will determine the methodology for the retrospective record review. Information reviewed includes: treatment record reviews conducted as part of the QI process; member and/or customer complaints; suspicions raised by Magellan personnel; external sources (i.e., PPRC referral, government agencies or other insurers); audits; onsite provider reviews and/or data mining results.

XI. Summary

The Louisiana CSoC Unit’s 2018 achievements and opportunities for improvement, as well as prioritized areas for focus in 2019 are outlined in the Executive Report on page 2. The contents of this report Louisiana CSoC Unit’s on-going QI activities, the trending of measures to assess performance, an analysis of improvements and an overall evaluation of the effectiveness of the QI and UM programs. The Louisiana CSoC Unit remains committed to on-going evaluation and improvement of care and services

