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

Magellan in Louisiana
Contract Year One (December 1, 2015-November 30, 2016)

Contents

Introduction 3

Demographics 5

Program Objectives and Work Plan Evaluation 9

Member Satisfaction 24

Accessibility of Services 26

Network Development 39

Provider Monitoring 42

Provider Satisfaction Survey 46

Outcomes 48

Summary 59

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 a 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, known as wraparound, as well as traditional and non-traditional behavioral health services. A Wraparound Facilitator (WF) supports and guides the member through the wraparound process. Under the guidance of the WF, 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 the opportunity is created for 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. In particular, these families will be able to receive the following waiver services:

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

Implementation of CSoC was a two-phase process, with the state being divided into nine regions. In March 2012, phase one was the implementation of five regions, with a capacity to serve up to 1,200 youth and families. Phase two implementation of the remaining four regions was completed in November 2014 and increased the capacity to serve up to 2,400 youth and families. Since 2012, CSoC has served over 9,300 (duplicated) members and the program continues to grow year after year. In just one year, members fully enrolled in CSoC grew from 2,030 members on 12/04/2015 to 2,194 on 11/25/2016, a growth of eight percent. Based on past enrollment, it is projected that the program could meet the maximum capacity of 2,400 members in the near future.

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 the Medicaid carve-out 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 to facilitate synergies with both providers and our customer. It 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, LDH and Medicaid ended the behavioral health carve-out, and the health plans became responsible for managing behavioral health services; however, due to the complexities of the program, CSoC remained a specialty carve-out program. Through an RFI process, Magellan was named the CSoC Contractor. As the CSoC Contractor, Magellan is committed to serving and empowering our membership and supporting LDH in the achievement of CSoC goals and program advancement.

Since 2012, Magellan has successfully maintained 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 of providers. 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 Family Support Organization (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 providers are contracted with Magellan. Magellan evaluates the accessibility of services of this network and implements a robust provider-monitoring plan to ensure the delivery of culturally competent, quality services to our membership. Magellan works collaboratively with providers 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 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, but to facilitate collaborative initiatives with our customer and across the contracted populations. The Program Evaluation supports requirements outlined in the LDH's Quality Improvement Strategy and provides a summary of the prior year's initiatives. This document is not a stand-alone document and includes information referenced in previously submitted 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.

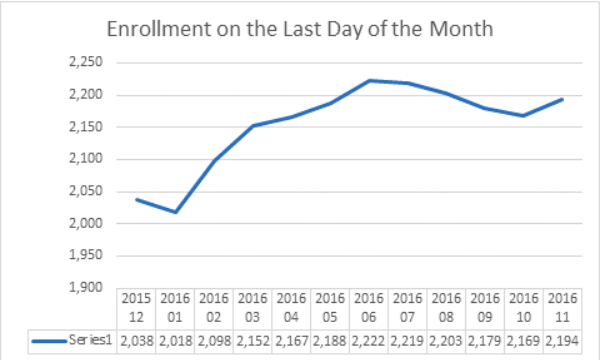
Demographics

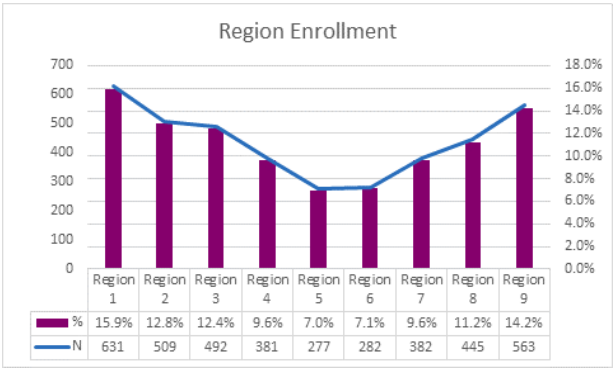
Before outcomes are discussed, it is important to understand the demographics of the membership served in CSoC. The eligibility criteria of the program targets the highest risk youth in the state. This section evaluates information for all unique members enrolled in the program from December 1, 2015, through November 31, 2016 (n=3,962). The primary data source for member demographics is the combination of Medicaid eligibility feed and Magellan's internal management system, Integrated Product's (IP), authorization data.

Enrollment

A total of 3,962 members were served in the CSoC program during contract year one. There has been a steady increase in the monthly enrollment over the course of a year, although growth flattened towards the end of the year. The average monthly enrollment was 2,153 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 3,962 members served in CSoC in contract year one, there was the highest dispersion of members in Region 1 and 9, with Regions 5 and 6 representing the lowest enrollment regions. The differences in enrollment can be impacted by several factors, including urban-rural classification and phase one versus phase two implementation. Figures 1 and 2 illustrate enrollment data.

Figure 1 and 2: Monthly Enrollment and Average Annual Enrollment by Region



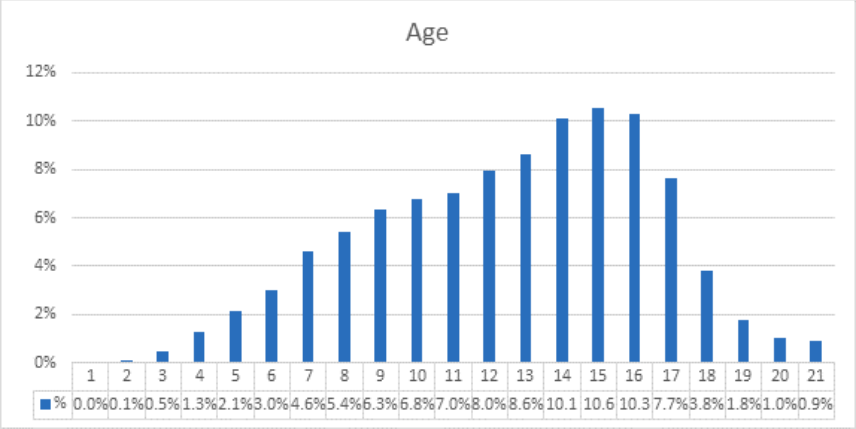


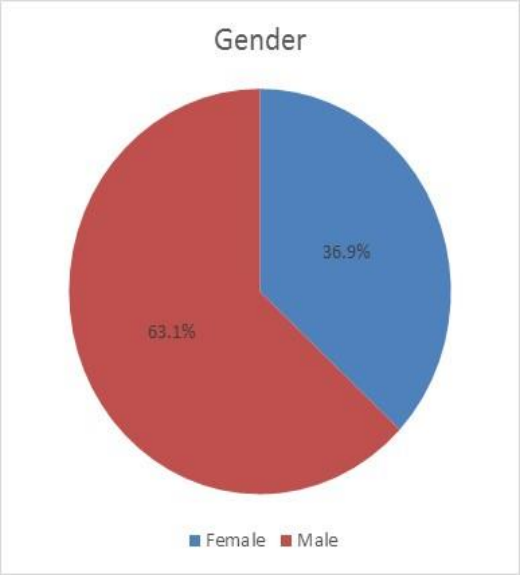
Age, Gender, and Race

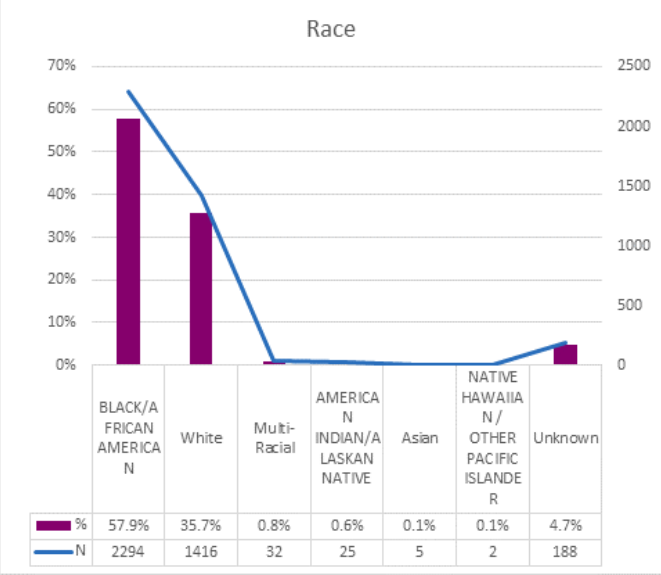
The target age group of the CSoC program is youth ages thirteen to sixteen; however, all children under twenty-two are eligible for the program if they meet clinical and financial criteria. Forty percent of the membership fell within the 13 to 16 age group. The largest age group was fifteen-year-old members (n=419). Children ages eight to seventeen represented 80.7% of the membership, with children under seven representing approximately 11.7% and eighteen and over representing 7.5%. A majority of the CSoC membership are males, representing 63% of the eligible members. The Black/African American race showed the highest percent of the membership, representing 58%. White members were the

second highest percent of the membership, representing 36%. This is also consistent with the membership served since the program's implementation. This is also aligned with what is seen in similar programs throughout the nation serving children at risk of being placed out of the home.

Figure 3, 4, and 5: Age, Gender, and Race of CSoC Members







Language and Geographic Classification

Language and geographic classification of members are important to monitor to ensure there is a sufficient number and type of service providers to meet the needs of the CSoC membership. The primary language for CSoC members is English, representing 99% of the CSoC population. Unspecified and Spanish language represented 0.8% and 0.2% of the population respectively. The majority of members, or 68%, reside in rural setting with the remaining 32% reside in urban settings (Geographic classification was reported from Waiver Year 5 Quarter 3 Network Quarterly Report data submitted in December 2016). Please see the Network Development Plan for more information on the provider demographics and GEO access.

Table 1: Primary Language

Language	Number	Percent
English	3923	99.0%
Spanish	9	0.2%
Unspecified	30	0.8%
Total	3962	100%

Table 2: Geographic Classification

Member Group	Member	Percentage
Urban/Suburban	765	32%
Rural	1624	68%
Total	2389	100%

Diagnosis

Attention Deficit Hyperactivity Disorder (ADHD) represents the highest diagnostic prevalence rate for the CSoC program, with 37% of membership with an ADHD diagnosis. Unknown and Oppositional Defiant Disorder/Conduct Disorder diagnoses represent second and third diagnostic prevalence. 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.

Table 3: Primary Diagnosis for CSoC Members

Diagnosis	N	%
F90.9: Attention-deficit hyperactivity disorder, unspecified type	767	19.4%
F99: Mental disorder, not otherwise specified	595	15.0%
F90.2: Attention-deficit hyperactivity disorder, combined type	511	12.9%
F91.3: Oppositional defiant disorder	367	9.3%
F43.20: Adjustment disorder, unspecified	164	4.1%
F90.1: Attention-deficit hyperactivity disorder, predominantly hyperactive type	141	3.6%
F84.0: Autistic disorder	110	2.8%
R69: Illness, unspecified	106	2.7%
F32.9: Major depressive disorder, single episode, unspecified	101	2.5%
F91.9: Conduct disorder, unspecified	94	2.4%
F43.25: Adjustment disorder with mixed disturbance of emotions and conduct	86	2.2%
F39: Unspecified mood [affective] disorder	80	2.0%
F31.9: Bipolar disorder, unspecified	71	1.8%
F43.10: Post-traumatic stress disorder, unspecified	51	1.3%
F90.0: Attention-deficit hyperactivity disorder, predominantly inattentive type	49	1.2%
F63.81: Intermittent explosive disorder	48	1.2%
F33.1: Major depressive disorder, recurrent, moderate	45	1.1%
F33.9: Major depressive disorder, recurrent, unspecified	35	0.9%

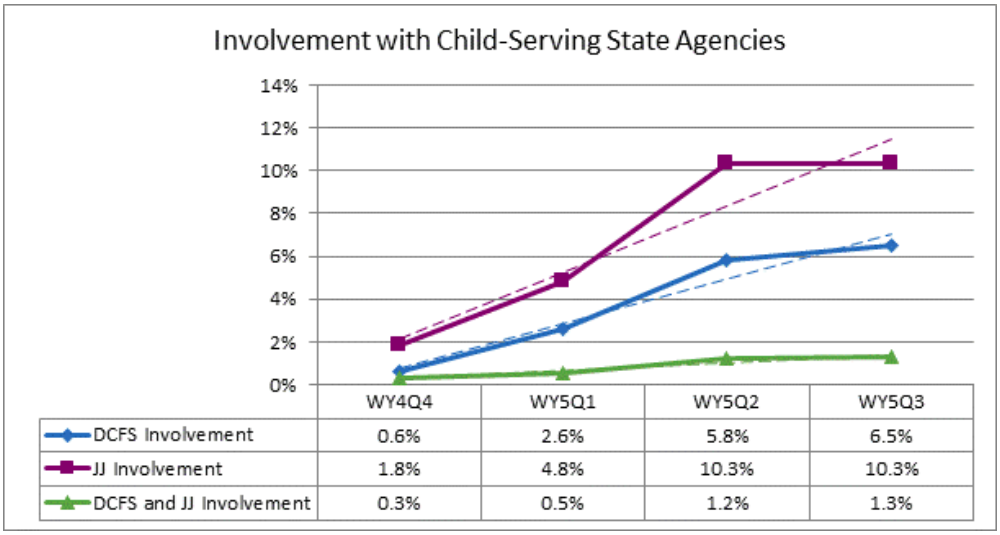
Diagnosis	N	%
Other	541	13.7%
Unspecified	0	0.0%
Total	3962	

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, Department of Education (DOE), 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 the right services at the right time at the right level of intensity. DCFS, DOE, and OJJ all have representation on the CSoC Governance Board, which has oversight over the program and informs programmatic goals and activities.

In waiver year five quarter three (09/01/2016-11/30/2016), approximately 18% of CSoC members were involved with child-serving agencies. This included 6.5% of members with DCFS involvement, 10.3% with OJJ involvement, and 1.3% with both DCFS and OJJ involvement. The increase seen in quarter two was due to a change in the methodology for this measure and not an actual increase in members' involvement with state agencies. The original methodology measured involvement at enrollment only. The new methodology measures any involvement during the reporting period and is believed to be more representative of involvement for CSoC members.

Figure 6: Percentage of Child-Serving Agency Involvement



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
DCFS Involvement	0.6%	2.6%	5.8%	6.5%
JJ Involvement	1.8%	4.8%	10.3%	10.3%
DCFS and JJ Involvement	0.3%	0.5%	1.2%	1.3%

Program Objectives and Work Plan Evaluation

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.

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, preventive behavioral health services, and serving members while promoting the 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

In keeping with the vision and mission of Magellan and goals set forth by LDH, Magellan established prioritized objectives as part of our Quality Work Plan. The 2015-16 objectives are outlined below with a brief summary of contract year one activities.

- 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 80% for Treatment Record Reviews (TRRs).
        - **Met Goal:** A total of 32 providers from all provider types were selected for review. The provider network mean score showed a performance rate of 93.9%, which exceeded goal by 13.9 percentage points. 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 consistently in compliance with a performance rate of 80%.
        - **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. Six providers triggered the ADHD CPG section of the TRR audit tool (i.e., member diagnosed with ADHD). Of those providers, the compliance rate was 100% (36/36). Eight providers triggered the Suicide Risk CPG section of the TRR audit

tool (e.g., member recent or active suicide risk). Of those providers, the compliance rate was 88% (87/95). Both CPG exceeded the compliance rate goal established in 9.4.7. of the SOW.

- Exhibit high level of member and provider satisfaction with Magellan as evidenced by overall satisfaction exceeding 85% in annual surveys.
    - **Goal Met:** Magellan administered the CAHPS Experience of Care and Health Outcomes (ECHO) Survey as required by the LDH. A response rate of 57% (n=998/1749) was achieved. The ECHO does not measure overall satisfaction; however, high levels of satisfaction were achieved for questions that measured member voice and choice. For more information, please see Member Satisfaction section of this report for further information.
    - **Goal Met:** Magellan administered the Magellan Provider Satisfaction Survey questionnaire designed by Magellan's Surveys Department. A response rate of 25% (n=52/206) was achieved, with an overall provider satisfaction rate of 94.7%. Magellan exceeded our goal of 85% by 9.7 percentage points. Please see Provider Satisfaction section of this report for further information.
- Ensure consistent application of and high fidelity to the wraparound model by meeting and/or exceeding national mean scores for total fidelity scores as measured by the Wraparound Fidelity Index, Short Form (WFI-EZ).
    - **Met Goal:** Magellan implemented a fidelity monitoring system to ensure that the WAA Wraparound Facilitator adheres to evidence-informed practices to ensure the core elements of wraparound facilitation are maintained in accordance with the standards of practice established by the National Wraparound Initiative (NWI). Measurement of fidelity is meant to support program improvement and identify areas of strength and opportunities for improvement. Fidelity was evaluated using three WFI-EZ survey types: Youth, Caregiver and Facilitator. The total fidelity scores in Louisiana for all three survey types were higher than what was seen in the national comparison sample. The youth total fidelity scores showed the highest level above the national mean, with a score 5.1 percentage points higher than the national mean. Overall, the 2016 total fidelity scores showed improvement from the previous fidelity review conducted in 2014. In the interim report that was completed by Dr. Eric Bruns for LDH in November 2014, youth and caregiver scores were equal to or close to the mean and the facilitator score was about four and a half percentage points lower than this national average. The Annual Fidelity Review Report provides a full analysis of the fidelity monitoring results.
- Meet *and/or* exceed national mean scores for youth and caregiver satisfaction with his or her experiences in wraparound as measured by the WIFI-EZ.
    - **Goal Met:** The WFI-EZ survey not only monitors adherence to fidelity, it also collects data on youth and caregiver satisfaction. Youth and caregivers reported high satisfaction with their wraparound experiences. Overall caregiver satisfaction varied by region from 77.9% to 88.8%, with six regions scoring above the national mean of 79.9%. Youth satisfaction ranged from 78.5% to 88.8%, with all nine regions scoring above the national mean.
- Ensure members' plans of care reflect supports and services necessary to address the members' goals and their assessed health needs, including risk, as evidenced by provider performance rates exceeding 90% in Plan of Care (POC) monitoring activities.
    - **Met Goal:** Magellan dedicates staff, called CSoC Coordinators, to monitor and ensure compliance with POC performance measures. Magellan consistently attained 100% compliance for Plan of Care Performance Measures (i.e., POC1, POC2, POC3, and POC5)

throughout contract year one.

- Exceed the National Committee for Quality Assurance (NCQA) 50th percentile for 7-day Follow-Up after Hospitalization (FUH) for Mental Illness rates.
    - **Met Goal:** FUH measures monitor how quickly members attend an outpatient appointment following a discharge from an inpatient hospital admission, with a goal of 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 contract year one were 46.4% and 73.3% for HEDIS and Modified HEDIS (e.g., includes peer services) respectively. CSoC achieved the goal of exceeding 50th percentile for 7-day FUH (i.e., 46%) for the standard HEDIS group. The modified HEDIS group was just above the 90th percentile for 7-day FUH (i.e., 70%). Final results will be reported in April 2017. Please see the Outcomes section for more information on FUH measures.
- Improve clinical and functional member outcomes as evidenced by statistically significant improvements ($p < 0.05$) in the Child and Adolescent Needs and Strengths (CANS) global average scores.
    - **Goal Met:** 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. Magellan conducted a CANS Outcomes Analysis that included 1278 members in the CSoC program from 03/01/2012 to 10/16/2016 with both an initial and discharge CANS submitted electronically. The average global score decreased from 57.8 to 41.5, which represented statistically significant improvement in clinical functioning ($p \leq .001$). Please see Outcomes Section of this report for more information on this topic.
- Show statistically significant improvement ($p < 0.05$) 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.
- Solicit feedback and recommendations from key stakeholders, subcontractors, members, member families/caregivers, and providers through the Quality Improvement Committee (QIC) structure and grievance and appeals system. Use the feedback and recommendations to improve performance.
    - **Goal Met:** Member grievances are especially meaningful to CSoC because it provides a mechanism for members to express their voice and choice, a fundamental principle of CSoC. Magellan received 29 member grievances in contract year one, with 96% being resolved within 30 days. Data was used to inform improvement activities with individual providers and systematically. Please see the Provider Performance Report for full details on the results of grievance monitoring.
- Exceed the goal of 50% for provider involvement in the Child and Family Team (CFT) as measured by the participation of behavioral health providers in monthly meetings in person or by phone.
    - **Met Goal:** The CFT develops and monitors the POC, which includes informal and formal supports. The CFT membership is determined by the member and the family and

typically includes, at a minimum, the member, guardian, the Wraparound Facilitator, service providers listed on the POC, and any other natural/informal supports requested by the member. After the initial plan is developed, the team continues to meet, at a minimum, monthly to monitor progress of the POC. Research shows that consistent involvement by team members, including formal service providers, is essential to supporting the goals of CSoC. Behavioral health provider involvement in CFT meetings was 63% in November, which exceeded the goal by 13 percentage points. The preferred participation type, or In-Person Participation, showed the highest level of participation when compared to other participation types and trended at the goal of 50% throughout the year. The annual Performance Improvement Plan report outlines detailed results for this project.

- Ensure travel distance to providers of CSoC services and behavioral health specialists and to psychiatrists for members living in urban parishes does not exceed 30 miles and members living in rural parishes does not exceed 60 miles for 90% of members.
    - Although the major categories of provider type showed 100% compliance, drill down by specific provider types showed opportunities for improvement in some areas. Similar to most states, Louisiana has a shortage of some provider types, primarily psychiatrists and psychologist in rural areas. Magellan uses a multidimensional approach, including monitoring geoaccess reports, member survey data, and member and provider grievances, to ensure there are no negative impacts to our members. Ad hoc or Single Case Agreements are created if gaps are identified. There were no complaints or out-of-state ad hoc agreements in 2016 related to issues with access to these provider types. The department works closely with the clinical team and LDH to address barriers and determine recruitment opportunities. Although no access issues or excessive travel time issues were reported, the Network Department is committed to ensuring we maintain the appropriate number of providers to meet member's needs.
- Detect under and over utilization of services (as defined as the mean plus or minus two standard deviations or $\mu \pm 2\sigma$) through use of control charts. If a trend of under and over utilization of services is detected, Magellan will implement DMAIC process to address.
    - **Met Goal:** The evaluation of utilization of inpatient or outpatient services showed no over utilization of services. Even more, high cost inpatient utilization has consistently declined since 2012.
    - **Improvement Needed:** Outpatient utilization normalized this contract year following increases seen related to the system changing to an integrated model of this contract. Although under utilization was not indicated, there are two services, Short-term Respite and Crisis Stabilization, which require network development. Please see the Network Development section for more details on upcoming activities.
    - **Improvement Needed:** Although utilization data is beneficial to monitor access to care, members' perception of access to care is also highly valued in informing network development. Because of this, Magellan collects member survey data to assess access to care through a monthly verbal survey. During contract year one, the overall compliance rate has trended around 86% of members reporting they are receiving the services that they need. Members that report issues are addressed individually to ensure needs are met in the future. Although compliance with this measure is high, it is still not meeting 90% minimum performance threshold. Peer services provided by FSO are service types identified most often by members as not being provided in a manner that meets their needs. In response, Magellan proactively developed a formal review of FSO utilization and quality data for LDH with recommended action plan for implementation in contract

year two.

- Ensure that appointment access timeliness standards are met for emergent (95%), urgent (95%) and routine (80%) appointments.
    - **Goal Met:** Over the course of contract year one, there were 46,632 routine appointment authorizations for a compliance rate of 99.6% authorized timely. Urgent and emergent appointment requests and authorizations only represent 1.4% of the total authorization requests received (n=47,317), and both showed high compliance with timeliness standards.

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

The following tables outline the performance measures and quality activities monitored as part of the CSoC Quality Program. Contract year one status is provided as well as any recommended changes planned for contract year two.

Table 4 and 5: Quality Program Performance Measures and Quality Activities

Quality Activities						
Performance Measure	**Goal**	**Reporting Frequency**	**CMC Owner**	**CMC Reporting Committee**	**Contract Year 1 Status**	**Recommended Changes**
Telephone Access Timeliness (Member Service Associates Lines)						
1. Average Speed of Answer (ASA)	≤ 30 secs.	Monthly	MS Admin.	QIC	22.2seconds	None
2. Call Abandonment Rate (CAR)	≤ 5%	Monthly	MS Admin.	QIC	5.03%	Adjust staffing patterns to account for staffing during optimal intervals and PTO.
Grievances						
3. Member Grievances Received	Monitoring Indicator	Monthly	QM Director	QIC	29	None
4. Resolution Responsiveness (Rate resolved w/in turnaround time)	≥ 90%	Monthly	QM Director	QIC	97%	None
Accessibility of Services						
5. Emergent Care	≥ 95%	Monthly	Clinical Director	UMC	99.6%	None
6. Urgent Care	≥ 95%	Monthly	Clinical Director	UMC	99.1%	None
7. Routine Care	≥ 80%	Monthly	Clinical Director	UMC	100%	None
Readmission Rates						
8. 30-day Mental Health	<12%	Monthly	Med. Director;	UMC	15%	The CY1 goal was set based on the LBHP goal, which included a

Quality Activities						
Performance Measure	**Goal**	**Reporting Frequency**	**CMC Owner**	**CMC Reporting Committee**	**Contract Year 1 Status**	**Recommended Changes**
			Clinical Director			larger volume of members and inpatient admissions. It is believed the readmission rate showed variability due to lower number of admissions (e.g., 1/2 is 50% vs. 1/10 is 10%). The IP admission rate was equal or less than 5% for CY2. When taking IP volume into account, the readmission rate did not appear to signify issues. Magellan will utilize the WAA Scorecard to monitor regional trends and address opportunities for improvement related to readmission when noted.
Ambulatory Follow-Up						
9. 7-Day Rate	≥46%	Calendar Quarter	Clinical Director	UMC	46.4% and 73.3% for HEDIS and Modified HEDIS respectively	Final report to be submitted on 4/15.
10. 30-Day Rate	≥65%	Calendar Quarter	Clinical Director	UMC	60.6% and 87.3% for HEDIS and Modified HEDIS respectively	Final report to be submitted on 4/15.
Adverse Incident Reporting						
11. Suicides/Homicides (Inpatient & Outpatient)	Monitoring Indicator	Monthly	Med. Director QM Director	QIC	0	None
12. Other Adverse Incidents (IP & OP)	Monitoring Indicator	Monthly	Med. Director QM Director	QIC	60	none
Member Satisfaction						
13. Overall Satisfaction with Magellan	≥ 85%	Annual	QM Director MS Admin.	QIC	Overall satisfaction is not evaluated in ECHO survey.	Please see Member Satisfaction Survey for full action plan and interventions for contract year 2.
Claims Administration						

Quality Activities						
Performance Measure	**Goal**	**Reporting Frequency**	**CMC Owner**	**CMC Reporting Committee**	**Contract Year 1 Status**	**Recommended Changes**
21. Financial Payment Accuracy	≥97%	Quarterly	MS Admin.	QIC	99.84%	none
22. Procedural Accuracy	≥98%	Quarterly	MS Admin.	QIC	99.75%	none
23. Turn Around w/in 15 days	≥90%	Quarterly	MS Admin.	QIC	99.93%	none
24. Turn Around w/in 30 days	≥99%	Quarterly	MS Admin.	QIC	100%	none
25. Turn Around w/in 60 days	100%	Quarterly	MS Admin.	QIC	100%	none
Appeals						
Standard	≥98%	Quarterly	Clinical Director	UMC	100%	none
Expedited	≥98%	Quarterly	Clinical Director	UMC	100%	none
State Fair Hearing (2nd Level of Appeal)	≥98%	Quarterly	Clinical Director	UMC	N/A	none

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 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	Please see Provider Performance Report.	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	Please see Provider Performance Report.	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.	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.	Please see individual report submissions.

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 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	Quarterly	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.
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.
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%	None

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 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.
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	None

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 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	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.
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.

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 Status**	**Recommended Changes**
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.
Coordination of Care Activities (BH-Medical and BH-BH)	Identify and implement coordination activities with stakeholders. Monitor effectiveness of activities/interventions through WAA monitoring and TRR.		UMC	Med. Director Clinical Director	Quarterly	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.
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.
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.
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

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 Status**	**Recommended Changes**
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 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	This document serves as evaluation, along with reports referenced.	Please see associated reference documents and Contract Year Two work plan.
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	New version submitted to LDH on 02/28/17.	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	New version submitted to LDH on 02/28/17.	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	New version submitted to LDH on 02/28/17.	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	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	None

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 Status**	**Recommended Changes**
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.
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	None
Staff Training	Develop plan and maintain training log for all Unit staff.		QIC	Training Specialist	Quarterly	Ongoing Activity	None
Confidentiality Checks	Monitor Unit practices against confidentiality requirements.		Compliance Committee	Compliance Admin.	Quarterly	Ongoing Activity	None
Personnel File Review	Maintain current and complete information on UNIT clinical and customer service staff.		QIC	Corporate HR	Annual	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.
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	None

Quality Program Activities							
Activity/ Project	**Objective**	**Goal**	**CMC Reporting Committee**	**CMC Owner**	**Review Cycle**	**Contract Year 1 Status**	**Recommended Changes**
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	None

Member Satisfaction

The member satisfaction survey is a key 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 provider network to become more effective as well as to learn the needs of those we serve to improve the member experience of care.

Magellan administered the CAHPS Experience of Care and Health Outcomes (ECHO) Survey as required by the LDH. Magellan selected all members enrolled for at least 31 days at a point in time (i.e., 07/28/2016). Because member voice and choice is a central principle of CSoC and wraparound philosophy, Magellan collaborated with Wraparound Agencies (WAAs) to administer the survey in person to achieve higher response rates. The initial distribution of the survey was 08/24/2016, with a close date on 10/21/2016.

Contract Year One survey results represent baseline data. Although previous satisfaction survey data was collected as part of the SMO contract (3/1/12-11/30/15), information was not specific to the CSoC population. A total of 998 members/guardians participated for a response rate of 57% (n=1,749). This was the highest response rate achieved as part of any satisfaction survey administered by Magellan in Louisiana and exceeded the statistical requirement of 385 to 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 81% in Region 1 and a low of 14% in Region 4. Magellan reviewed data with several WAA directors to better understand factors contributing to response rates. Several directors stated members reported that length and readability of the ECHO survey influenced member completion of the survey.

Magellan establishes a Member Satisfaction Workgroup, with UM, QI, network, and medical representatives, to discuss the results of the survey and establish interventions to foster improved member satisfaction. The workgroup established an individual element threshold goal of 80%. Each element result was based on the top two responses of "Strongly Agree" and "Agree". It was noted that the elements measured counseling or treatment in general and should not be considered a direct measure of satisfaction with the Wraparound model or the WAAs. Magellan conducts an annual fidelity review that should be referenced to evaluate satisfaction for those elements of the program. Tables 6 and 7 show the top-scored and lowest-scored items.

Table 6: Top-Scored Satisfaction Items

Question Number	Question Detail	Number of Responses	% Positive
Q18	In the last 3 months, were the goals of your child's counseling or treatment discussed completely with you?	785	92.5%
Q12	How often did the people your child saw for counseling or treatment explain things in a way you could understand?	798	90.9%
Q36	If you were unhappy with your child's counseling or treatment, did you feel free to complain?	834	90.2%

Table 7: Lowest-Scored Items

Question Number	Question Detail	Number of Responses	% Positive
Q30	In general, how would you rate your child's overall mental health now?	849	58.6%
Q32	Compared to 3 months ago, how would you rate your child's ability to deal with social situations now?	857	59.0%
Q35	Compared to 3 months ago, how would you rate how well your child is getting along with family?	866	59.7%

Top-scored items highlight that members *and/or* guardians feel confident in understanding their goals for treatment and their ability express dissatisfaction. This shows alignment with the key Wraparound principle of family voice and choice. Low-scored items indicate opportunities for improvement, but it is important to evaluate them in context to the survey. For example, unlike most other measures, the outcomes measures used a five-point scale with a neutral response option. When positive and neutral response were combined, satisfaction for Q32 and Q35 was above 90%. Survey results indicated the need for interventions to address multiple areas, including Access to Care, Member Voice, and Choice, Outcomes, Access to Treatment. A formal action plan is included in the Member Satisfaction Survey Report. A sample of interventions for contract year two include:

- Review data with WAAs to get feedback regarding member perception. Discuss if WAAs have a mechanism for tracking satisfaction. If so, explore if this data aligns with their data and if not, discuss possible reasons for the disparity.
- Present data to FSO for utilization in staff training. It is believed informing peer and parent support specialists of members' perceptions of treatment can lead to opportunities to better serve as member advocates and empowering members to express feelings to providers.
- Present data to Magellan Provider Network during 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 network department. Unlike traditional Medicaid programs, members in CSoC are supported in accessing services through their WAA. The WF assists the members in navigating through the system and helps them in selecting 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.), by ages treated, language, 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 Provider Relations Liaisons (PRLs) assigned to each WAA 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. Work groups review the network 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 Network Services Department develops provider surveys, email blasts, provider forums, *and/or* provider outreach to determine interest. This work group reports to the Quality Improvement Committee if opportunities for improvement are identified. 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 contract year two.

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 emergent access are within one hour of the request, urgent access within 48 hours /two calendar days, and routine access within 14 calendar days. The routine appointment access goal is set at 80%, and emergent and urgent goals are set at 95%. Over the course of contract year one, there were 46,632 routine appointment authorizations for a compliance rate of 99.6% authorized timely. Urgent and emergent appointment requests and authorizations only represent 1.4% of the total authorization requests received (n=47,317), and both showed high compliance with timeliness standards. Magellan sustained high compliance for all appointment categories in contract year one and no systematic improvements are needed for contract year two.

Table 8: Authorization Data for Contract Year One

Risk Level	Time Units	Number of Service Authorizations	Number of Timely Service Authorizations	Percent of Timely Service Authorizations
Routine	14 Days	46,632	46,455	99.6%
Urgent	3 days	668	662	99.1%
Emergent	1 hour	17	17	100.0%

Utilization of Services

One of the pillars of Magellan 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. To obtain a comprehensive understanding of how members are utilizing services, Magellan monitors and evaluates several metrics across levels of care, including but not limited to:

- Inpatient Hospital Utilization
    - Admissions per thousand, days per thousand, average length of stay, and readmission rate
- Home and Community Based Services (CPST/PSR/CI), Crisis Stabilization and traditional Outpatient
    - Members served and average number of units
- Substance Use Disorder IOP
    - Members served
- FFT & Homebuilders
    - Members served
- CSoC Waiver Services – Parent Support & Training, Youth Support & Training, Independent Living Skills Building, Short Term Respite,
    - Members served and average number of units

The UMC uses control charts to evaluate utilization trends based on standard deviations from the mean to identify statistical over or under utilization detected. Opportunities for improvement are indicated when over/under utilization or utilization above or below two standard deviations from the mean, are detected over a period. The below graphs show utilization data for 27 months, beginning in October 2014 and ending in December 2016 to monitor long term trends. Note that outpatient utilization reporting is impacted by claims lag, which means that there is generally a drop in the most recent data attributed to all claims not being submitted at the time the report was run. Inpatient data are generated through authorization information and are not impacted by claims lag.

Inpatient Hospital

One of the goals of CSoC is to reduce the number of current and future admissions to restrictive settings. Because of our extensive experience and understanding of the goals and principles of CSoC, Magellan has applied innovative clinical approaches to managing children admitted to an inpatient setting that has had a positive impact on the utilization of this level of care. First, Magellan made vital changes to our Medical Necessity Criteria. Magellan now requires all CSoC members to be seen by physician daily, which is a higher standard than is required by the Louisiana licensing board. This ensures that youth are being evaluated daily and allows physicians to quickly adjust the treatment plan to optimize the time they are away from their family. We also enhanced criteria to require 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 WAA's deep knowledge of the family and cumulates in the creation of a comprehensive discharge plan that will reduce recidivism.

Magellan also promotes the clinical staff to develop strong relationships with hospitals and providers, which allows for a more efficient management of members who require hospitalization. This is done through an approach, known as mini-teams. A mini-team combines a clinical, network and quality staff for each of the nine regions. It provides an avenue for Magellan staff to develop an expertise of the region's demographics, a special understanding of the providers and the members served in each region and allows for quick detection and resolution of needs. Figures 7 through 10 outline the steady decreases in inpatient utilization that has resulted from these management efforts.

Figure 7: Inpatient Admission per Thousand

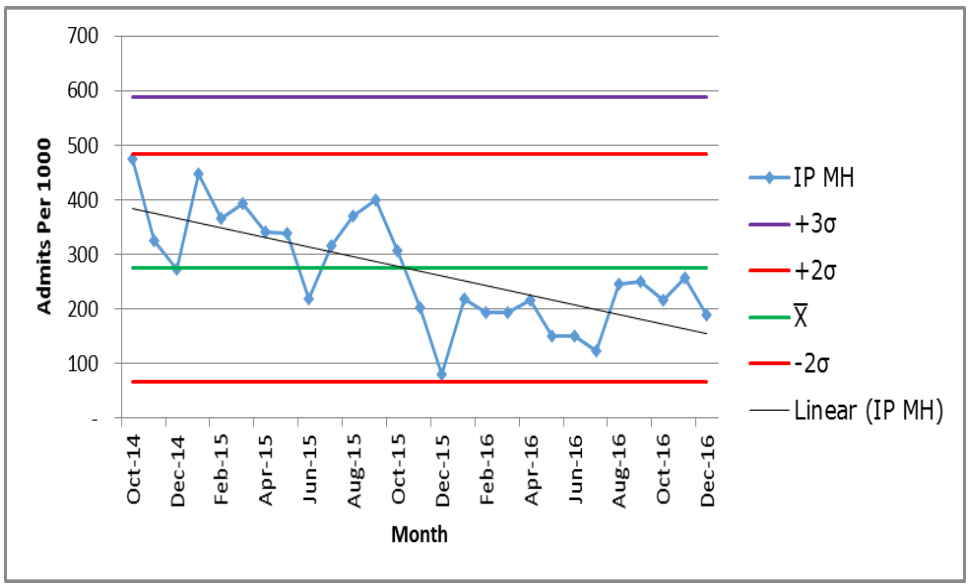


Figure 8: Inpatient Days per Thousand

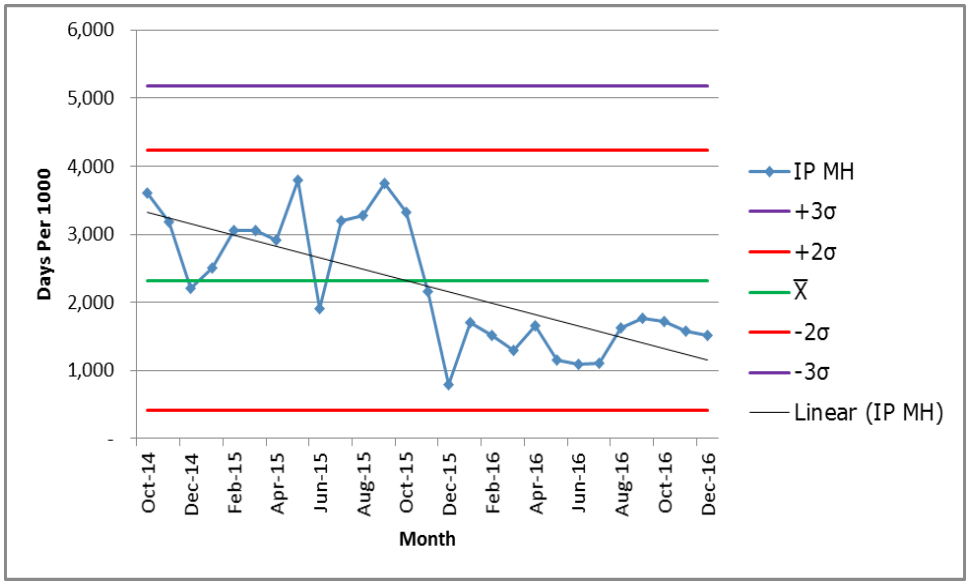


Figure 9: Inpatient Average Length of Stay

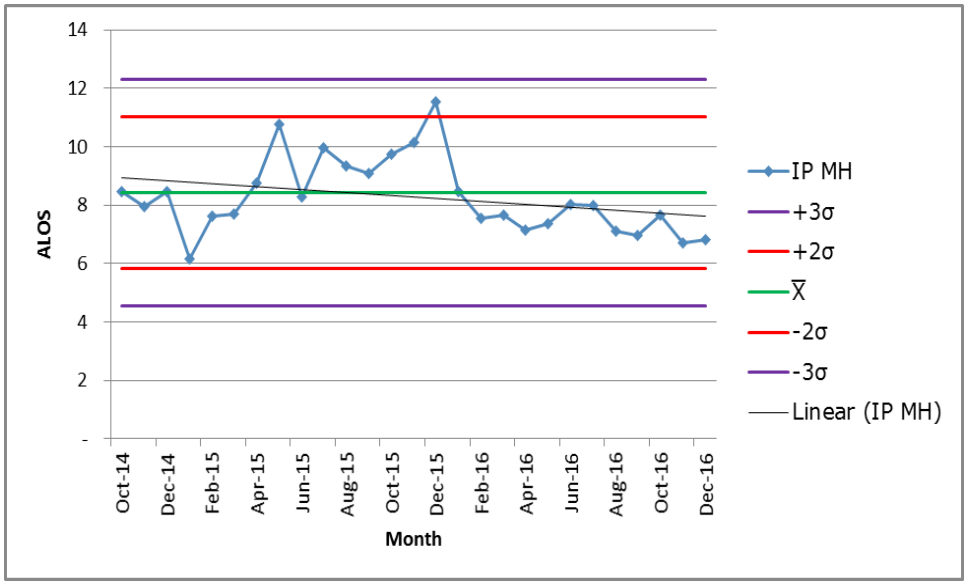
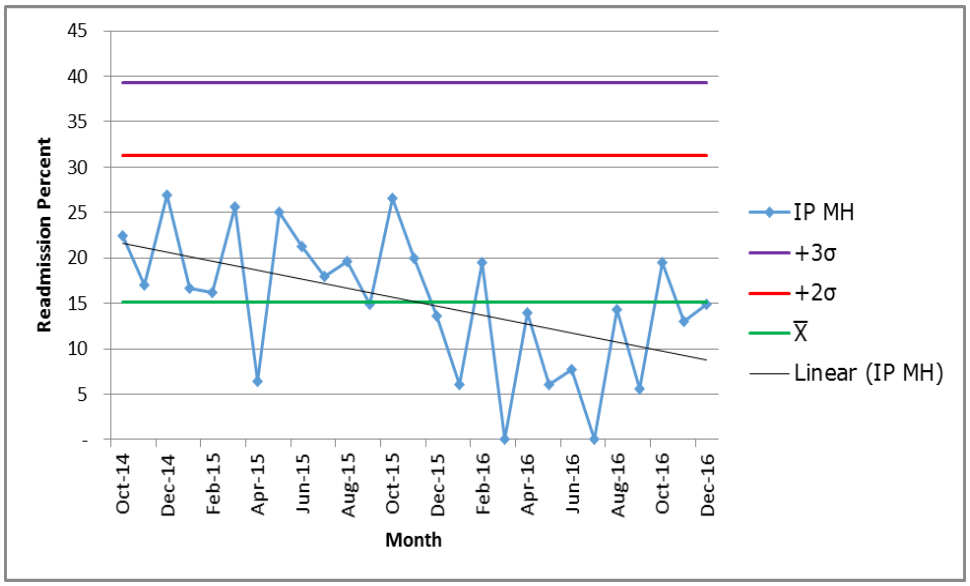


Figure 10: Inpatient Readmission Rate



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 Setting (HCBS) are believed to provide an avenue for families to receive necessary services in a manner that aligns with the values of CSoC. When evaluating non-waiver HCBS and traditional outpatient services, there were no services that showed under or over utilization of services. The figures below indicate that there was a decline in utilization in December 2015. This was the result of changes to Medicaid health care management, specifically the culmination

of the behavioral health carve-out and transition of management of behavioral health to the health plans. It is believed the trend line from December to current is more representative of utilization. Other trends include the decrease of office-based services while utilization of home and community based services has increased. Figures 11 through 14 illustrate trends in outpatient service utilization. As mentioned previously, outpatient data is impacted by claims lag, which explains the drops seen in the last few months. Traditional outpatient services in Figure 12 include outpatient therapy, medication management, and assessments.

Figure 11: All Outpatient Combined Members Served

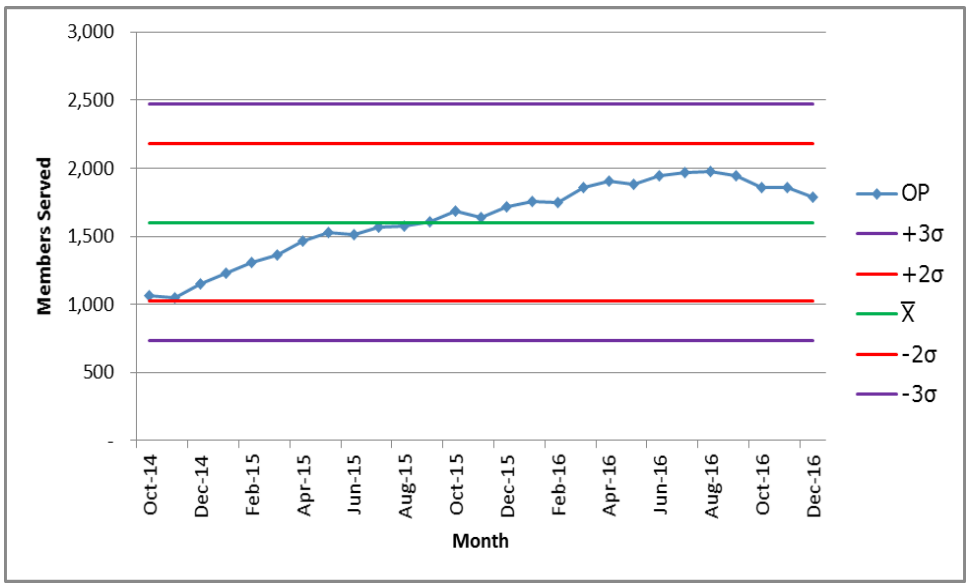


Figure 12: Traditional Outpatient Members Served

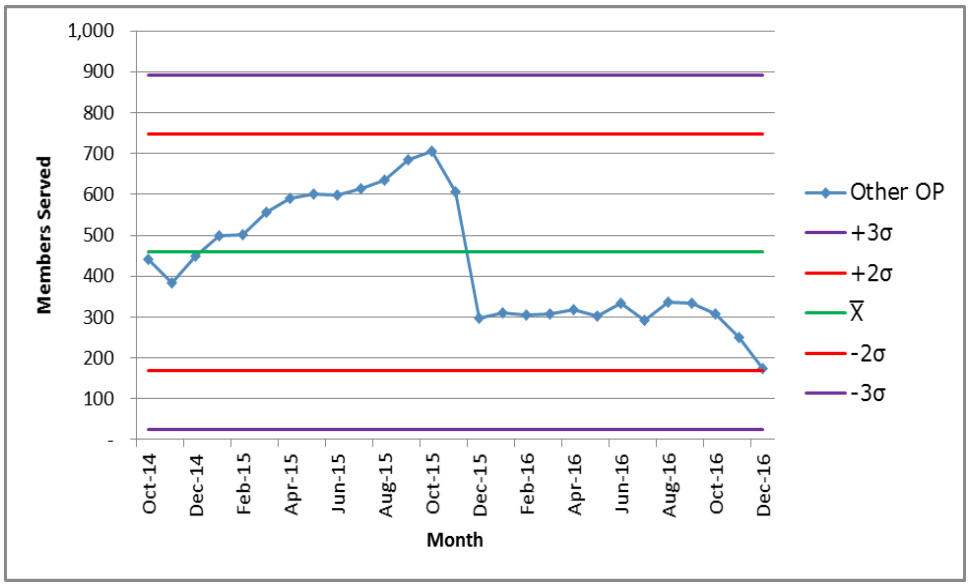


Figure 13: CPST Members Served

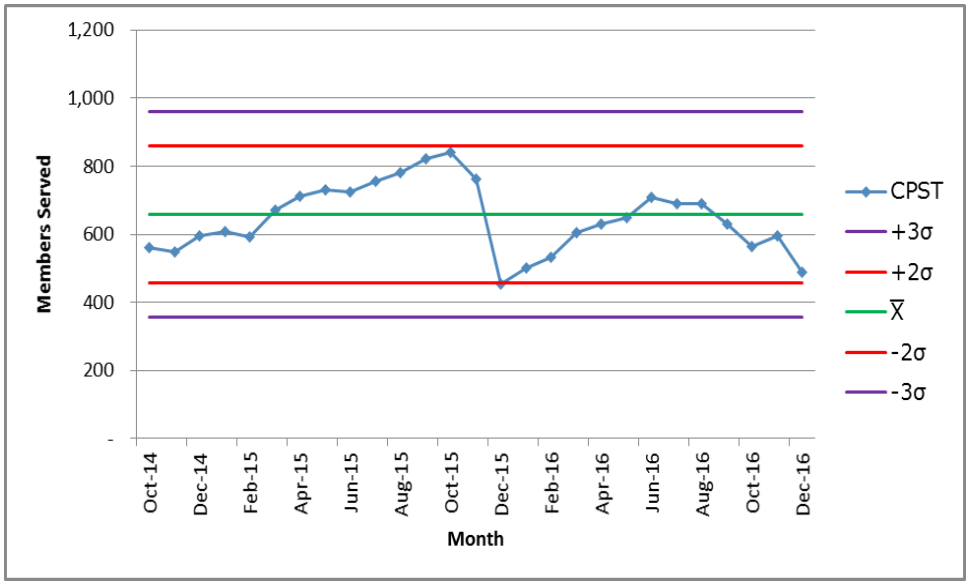
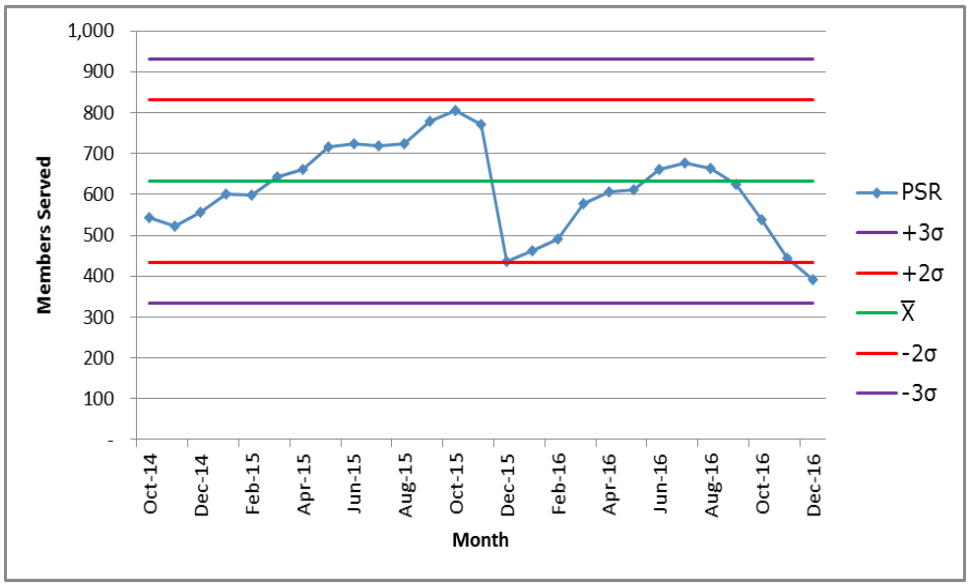


Figure 14: PSR Members Served



CSoC Waiver Services

Children and families enrolled in CSoC are eligible for all of the services available through traditional Medicaid behavioral health services described above as well as specialized services funded through the CSoC waiver. Waiver services include parent support & training (PST), youth support & training (YST), Independent Living and Skills Building (ILSB) and short-term respite (STR).. These services are meant to augment traditional services and provide additional supports to families enrolled in CSoC. These services were not available before 2012, and Magellan's network department was responsible for building the network of providers from the ground up. The statewide Family Support Organization (FSO) as certified by LDH provides two of the services, PST and YST. Magellan collaborates with the FSO to ensure they meet member needs and support operations by providing technical assistance when needed, including claims and encounter, quality, and clinical support. As enrollment has grown, the utilization of PST and YST has increased steadily over time. The next section evaluates access to care for these peer services in more detail. There were increases in the number of rendering STR providers during the contract year, which positively increased utilization. Continued growth of this provider type is needed and is discussed further in the Network Development section. ILSB is a service to help transition aged youth to develop skills for self-sufficiency. Magellan increased oversight of youth receiving services to ensure the delivery was done in accordance with the CSoC waiver, which is why there was a decline beginning in December 2015 in Figure 15.

Figure 15: Parent Support & Training Members Served

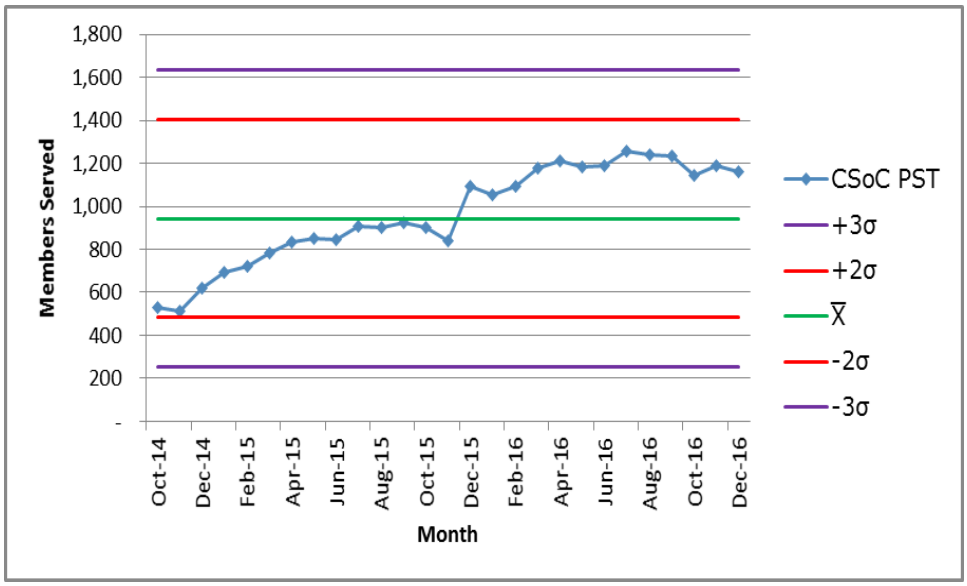


Figure 16: Youth Support & Training Members Served

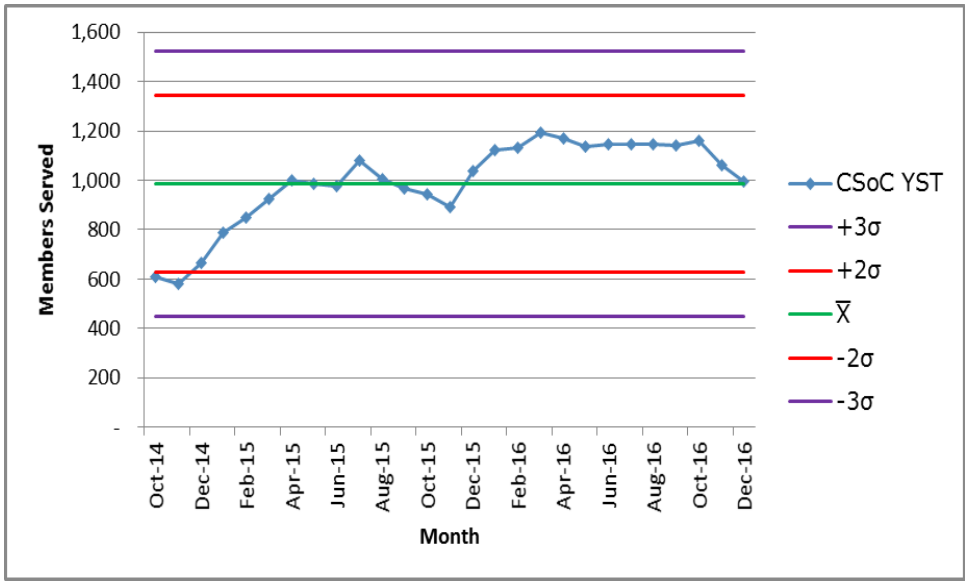


Figure 17: Independent Living Skills Building Members Served

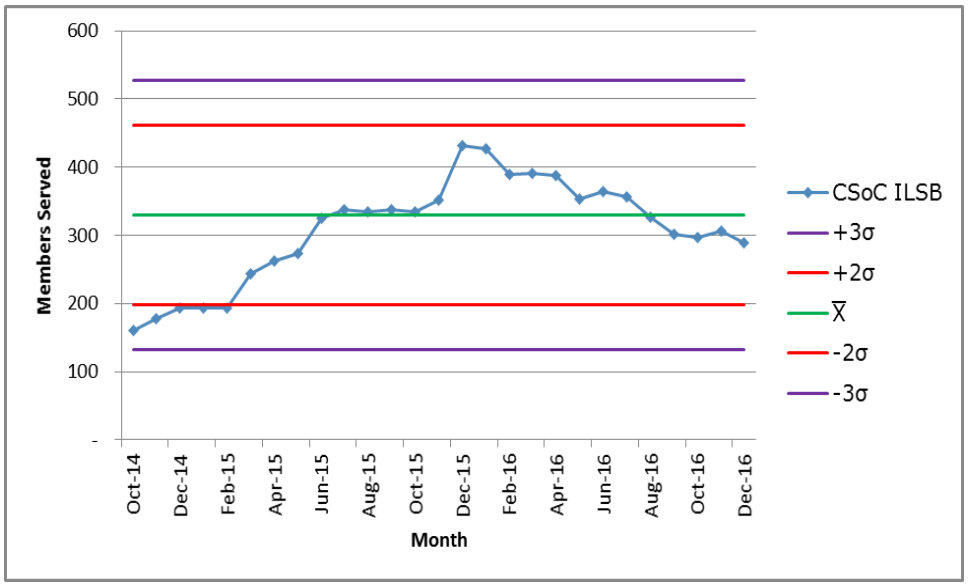
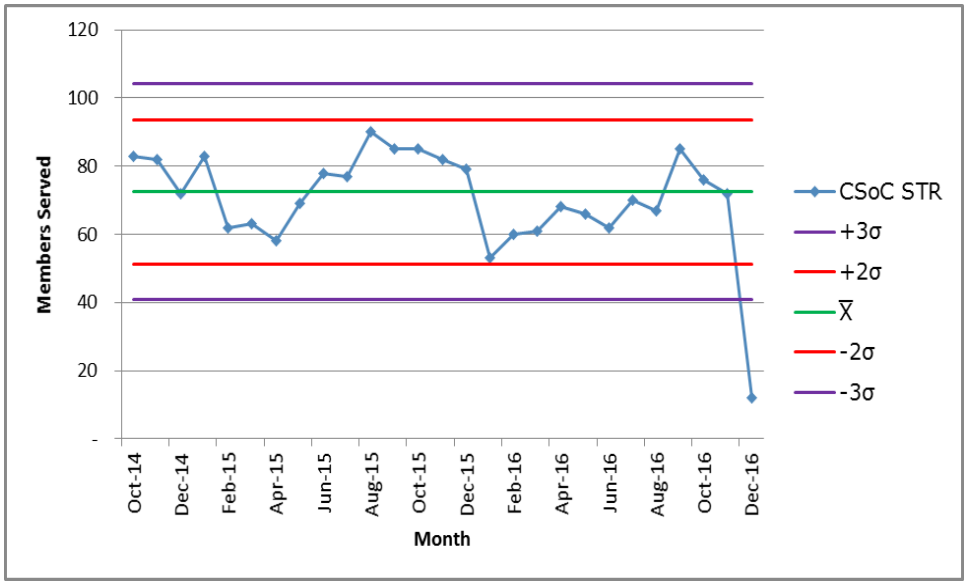


Figure 18: Short Term Respite Members Served



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. Because of this, Magellan collects member survey data to assess access to care through a monthly verbal survey. In this process, Wraparound Facilitators (WFs) 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 (POC). Individual remediation is offered to every member to ensure he/she receives services in the type, amount, duration, and frequency specified in the POC in the future if they have 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.

Table 9 and Figures 19 and 20 outline the details and trends of data collected during contract year one for POC 06.

Table 9: POC 06 Member Survey Details and Compliance Rates

	Percentage of Total				Percentage of "No" Responses with Corresponding Individual Remedial Activities				
Month	Total	19	POC 06 Compliance Rate (Yes + Option 1)	No	Option 1	Option 2	Option 3	Option 4	Option 5
Dec-15	2037	1674	1723	363	49	246	20	26	19
	%	82.2%	84.6%	17.8%	13.5%	67.8%	5.5%	7.2%	5.2%
Jan-16	2018	1629	1714	389	85	235	21	19	27
	%	80.72%	84.9%	19.28%	21.85%	60.41%	5.40%	4.88%	6.94%
Feb-16	2031	1636	1761	395	125	209	13	32	16
	%	80.6%	86.7%	19.5%	31.7%	52.9%	3.3%	8.1%	4.1%
Mar-16	2124	1684	1804	440	120	229	25	45	21
	%	79.3%	84.9%	20.7%	27.3%	52.0%	5.7%	10.2%	4.8%
Apr-16	2176	1697	1805	479	108	297	10	50	13
	%	78.0%	83.0%	22.0%	22.5%	62.0%	2.1%	10.4%	2.7%
May-16	2202	1724	1852	478	128	275	8	62	5
		78.3%	84.1%	21.7%	26.8%	57.5%	1.7%	13.0%	1.0%
Jun-16	2219	1768	1883	451	115	270	4	61	1
	%	79.7%	84.9%	20.3%	25.5%	59.9%	0.9%	13.5%	0.2%
Jul-16	2260	1848	1975	412	127	266	8	45	6
	%	81.8%	87.4%	18.2%	30.8%	64.6%	1.9%	10.9%	1.5%
Aug-16	2204	1844	1964	360	120	180	10	45	5
	%	83.7%	89.1%	16.3%	33.3%	50.0%	2.8%	12.5%	1.4%
Sep-16	2201	1866	1962	335	96	188	13	36	2
	%	84.8%	89.1%	15.2%	28.7%	56.1%	3.9%	10.7%	0.6%
Oct-16	2171	1818	1934	353	116	177	16	38	6
	%	83.7%	89.1%	16.3%	32.9%	50.1%	4.5%	10.8%	1.7%
Nov-16	2179	1774	1874	405	100	235	11	54	5
	%	81.4%	86.0%	18.6%	24.7%	58.0%	2.7%	13.3%	1.2%

Figure 19: POC 06 Overall Compliance Rate

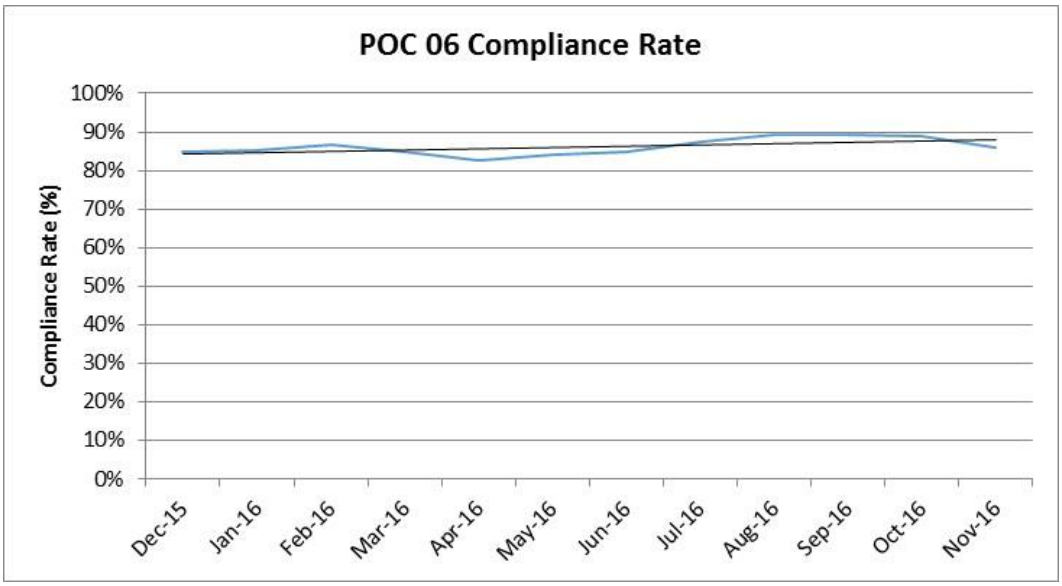
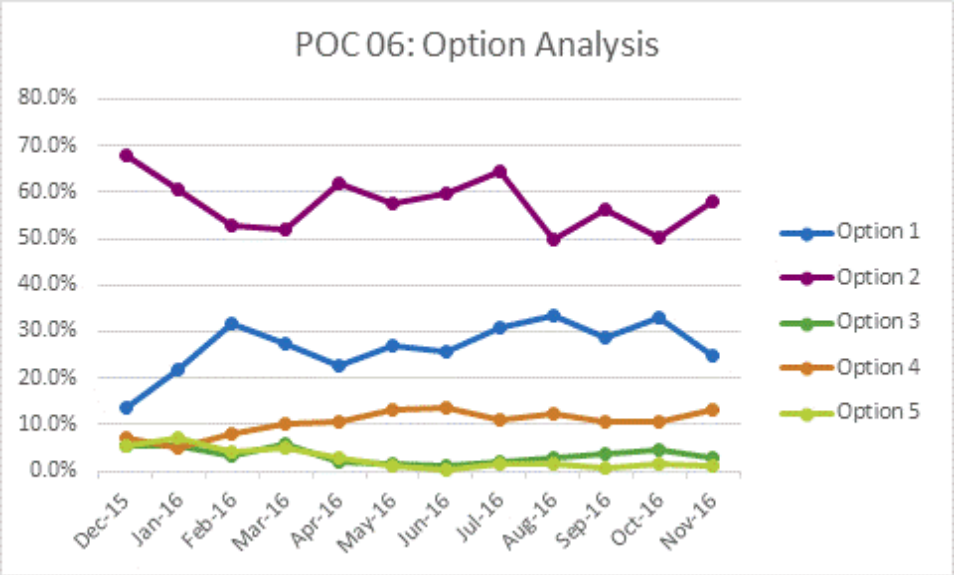


Figure 20: POC 06 Option Analysis



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 trended around 86% of members reporting they are receiving the services that they need. Of those who report they are not receiving services to meet their needs, Option 2 [i.e., 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)] is selected the most often. WFs are instructed to select Option 2 when a need is first identified and address any issues directly with the provider through care coordination. If care coordination is not effective over a period, then the WF selects Option 3 or 4. Option 3 requires a provider change when a provider is available and accounted for approximately 2% of the no responses. Option 4 is selected when care coordination is not effective in meeting the member's needs, and there are no other providers available, such as in the instance of the FSO. The remedial activity for Option 4 requires the WAAs to submit a Needs Reporting Form (NRF) spreadsheet. The NRF spreadsheet includes member level detail and provider detail, allowing Magellan to work directly with providers to address barriers. Table 10 represents regional and total NRF data from March 2016 (when the process was initially implemented) to November 2016.

Table 10: Needs Reporting Forms Received for Contract Year 1

Month	Provider Type	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Monthly Total by Type	Monthly Total Received	Monthly % of FSO Reports
March	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		
April	FSO	8	10	32	0	0	0	0	0	0	50	51	98.0%

Month	Provider Type	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Monthly Total by Type	Monthly Total Received	Monthly % of FSO Reports
	Other	1	0	0	0	0	0	0	0	0	1		
May	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		
June	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		
July	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		
August	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		
September	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		
October	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		
November	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		
Annual Total FSO		62	41	235	0	0	14	22	0	0	374		
Annual Total Received		67	79	239	0	0	14	28	0	0	427		
Annual % FSO Reports		92.5%	51.9%	98.3%	N/A	N/A	100.0%	78.6%	N/A	N/A	87.6%		

Of the 427 NRF reports received from March to October 2016, 374 were either for Youth or Parent Support Services delivered by the FSO, representing 87.6% of reports received. Data was received from five of the nine regions. Region 3 consistently had the largest number of reports submitted. Magellan conducts monthly meetings with FSO upper management to review barriers and discuss interventions for individual members identified on the spreadsheet. The FSO also submits action steps for each to ensure member needs are met and monthly staff roster reports. These reports are submitted to LDH on a monthly basis via Performance Measure POC 06 Report. When comparing Member Survey data to the claims data presented in the Members Served section, it is believed that this number is an underrepresentation of access issues in regions that have not submitted reports. Although Magellan has received feedback from WAAs that this process poses administrative difficulties, the process allows Magellan to intervene with providers at the individual member level. Magellan will address directly with non-reporting regions and encourage utilization of the process in the future.

Magellan proactively developed an FSO Annual Report that provides a comprehensive review of utilization and quality data and recommendations for contract year two. Short-term respite was also identified as a service area that requires further network development. Please see Network Development section of this report for further details regarding contract year two activities.

In contract year two, Magellan plans to make enhancements to the POC 06 process. Magellan will implement enhanced analysis regarding members who consecutively report they are not receiving services. Magellan will use this to create management tools for WAAs and providers. It should be noted

again that only Option 4 allows for member and provider drill down. Magellan will also promote the submission of NRFs when necessary as the process allows Magellan to intervene with providers at the individual member level. Magellan will address directly with non-reporting regions and encourage utilization of the process in the future.

Network Development

Magellan monitors 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:

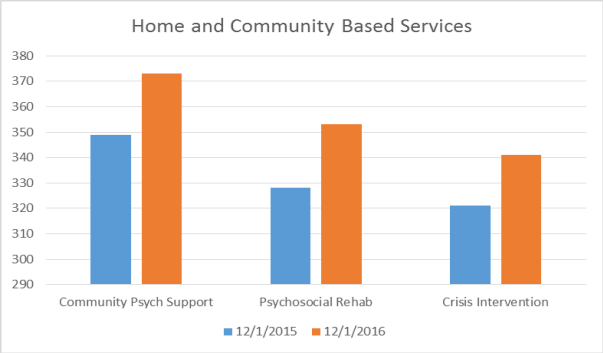
- Maintain a network with a sufficient number of providers of specialized CSoC services including Youth Support and Training (YST), Parent Support and Training (PST), and Independent Living/Skills Building (ILSB).
- Contract with at least one Federally Qualified Health Center (FQHC) in each CSoC region 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.

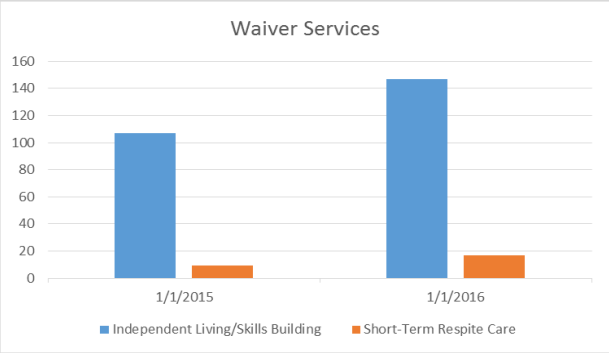
As stated in the Accessibility of Services section, Magellan has an established process to monitor accessibility and availability of services, which informs recruitment efforts. Work groups review the network geographic access and appointment availability data, the results of member satisfaction surveys, and member/family grievances to identify gaps in the type, density, and location of behavioral health providers in Magellan's network. 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 work group reports to the Quality Improvement Committee if opportunities for improvement are identified.

Specialized Behavioral Health Services

Much of the recruitment efforts in contract year one were directed towards the expansion of home and community-based services - CPST, PSR and Crisis Intervention, as well as, CSoC services – PST, YST, ILSB, Short-Term Respite and Crisis Stabilization. Magellan leveraged provider calls, provider newsletters, surveys, and assistance from Wraparound Agencies, through the Network Strategy Workgroup sessions, throughout contract year one, to inform the provider community of the need for additional Waiver and HCB service providers. Through these efforts, we were able to increase the capacity from 998 service locations to 1,067 locations for HCBS and increased ILSB providers by nearly 30%. Short-term Respite providers nearly doubled in contract year one. This growth is attributed to increased outreach efforts and a change in 2016, which allowed Therapeutic Foster Care (TFC) providers to deliver Short-term Respite care.

Figure 21 and 22: Growth in HCBS and Waiver Service Providers





Notable barriers to the development of Crisis Stabilization and Short-term Respite providers were primarily related to licensing rules, rates and a finite number of referrals for Crisis Stabilization. In September 2016, the Centers for Medicare and Medicaid Services (CMS) approved the removal of Crisis Stabilization from the 1915(c) waiver and added it to the Children's Behavioral Health Services' State Plan Amendment (SPA). This service is no longer limited to youth enrolled in the Coordinated System of Care. Magellan believes that the expansion of Crisis Stabilization to a larger member population and the addition of the TFC provider type for Crisis Stabilization and Short-term Respite will contribute greatly to continued development and growth efforts in 2017. Magellan will continue to credential and contract with Short-Term Respite and Crisis Stabilization providers and will continue to work with Wraparound Agencies, providers and LDH-OBH to address the known barriers that hinder the development of Crisis Stabilization and Short-Term Respite.

Family Support Organization

In CSoC, the Family Support Organization is certified and contracted to deliver two of the four waiver services, PST and YST. LDH maintains responsibility for certification of the FSO, while Magellan is responsible for credentialing. Ekhaya Youth Project (Ekhaya) is the designated FSO for Louisiana. As the statewide FSO, Ekhaya is responsible for meeting the PST and YST service needs of all the state's CSoC members. Ekhaya must be flexible and adaptable to ensure there are enough qualified Parent Support Specialists (PSS) and Youth Support Specialists (YSS) to meet the needs of the growing membership

throughout the nine regions. As of 01/06/2017, Ekhaya staff members served 3727 unique members. Although the FSO has been a valued partner of Magellan and the CSoC program, there are some access to care issues that have been identified. A full review of the FSO is in process and will be presented to LDH in early 2017. This report will serve as notification of access barriers related to the certification of the FSO in accordance with Section 8.7.1 of the CSoC Contractor Statement of Work (SOW).

Prescribers and Other Qualified Service Providers

Having a sufficient number of prescribers and other qualified service providers is also key to our successful service delivery. Magellan is notified of gaps via the NRF or complaints from members 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* for continuity of care. While the table below indicates shortages for some provider types, there were no complaints or out-of-state Ad hoc agreements in 2016 related to issues with access to services. One out-of-network Ad hoc agreement was entered into in December of 2016 to allow for continuity of care while the provider was in the process of contracting and credentialing. Although no access issues were reported, Magellan is committed to ensuring the Network maintains the appropriate number of providers to meet member's needs.

Table 11: GEO Access for Practitioners

Member Group	Average Distance to Provider (Miles)	Members with Desired Access	Members Without Desired Access	Total Members	Compliance Rate (% With Access)
PRACTITIONERS - All					
All Practitioners: Urban/Suburban	1	807	0	807	100.0
All Practitioners: Rural	5.8	1744	0	1744	100.0
PRACTITIONERS - Prescribers					
All Prescribers: Urban/Suburban	1.9	807	0	807	100.0
All Prescribers: Rural	11	1744	0	1744	100.0
PRACTITIONERS - Non-Prescribers					
Non-Prescribers: Urban/Suburban	1.1	807	0	807	100.0
Non-Prescribers: Rural	6.2	1744	0	1744	100.0

Provider Monitoring

Magellan has a comprehensive strategy to monitor providers to ensure service delivery adheres to our high standard of care. This strategy includes monitoring adverse incidents, quality of care concerns, member and provider grievance, record reviews and onsite monitoring activities. The data is collected and evaluated to identify patient safety issues and inform continuous process improvement. The treatment record review (TRR) process is one of the key quality activities utilized to collect data on the quality of services delivered by providers. It is a process in which documentation and record keeping process are reviewed to ensure compliance with quality standards and federal/state guidelines. Treatment record reviews are conducted to:

- Collect data for the evaluation of 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;
- 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 RNCC for the purpose of identifying opportunities for improvement for network treatment record documentation and adherence to clinical practice guidelines. Results of reviews are also reviewed by an 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** to monitor specialized behavioral health and waiver service providers, including monitoring of Clinical Practice Guidelines (CPGs) for ADHD and Suicide Risk for applicable members.
- **Wraparound Monitoring Reviews** to monitor Wraparound Agencies for compliance with waiver assurances.

The following section provides the results of contract year one activity.

Standard Treatment Record Review

In contract year one, 32 providers were audited for standard TRR. Providers from all levels of care were randomly selected for audit, including 17 home and community based providers, 8 waiver providers, 6 inpatient hospitals and the Family Support Organization. Seventeen of the providers were identified as high-volume providers and reviews were conducted onsite. Fifteen of the providers classified as low-volume providers were audited remotely. The provider network proved to have a high level of compliance with standards. The network compliance rate for the core quality standards was 94% (3,783 of 4,030 elements met), which was 14 percentage points higher than the established minimum

performance threshold of 80% compliance. Table 12 provides section scores for TRR elements. Despite this high level of 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.

Table 12: Results of Standard TRR

Sections	Elements Meeting Compliance	Elements Items	Compliance Rate (%)
General	459	464	99%
Member Rights & Confidentiality	399	494	81%
Initial Evaluation	716	722	99%
Individualized Treatment Plan	513	541	95%
Ongoing Treatment	921	956	96%
Coordination of Care	354	402	88%
Medication Management	132	135	98%
Discharge	130	130	100%
Restraints/Seclusions	N/A	N/A	N/A
CSoC	123	150	82%
Adverse Incident	N/A	N/A	N/A
Total	**3783**	**4030**	**94%**
Clinical Practice Guidelines	**Elements Meeting Compliance**	**Elements Items**	**Compliance Rate (%)**
CPG: ADHD	36	36	100%
CPG: Suicide Risk	85	97	88%

Wraparound Agency (WAA) Monitoring Reviews

The CSoC waiver authority requires the 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. This contract year, Magellan augmented the onsite record review of WAAs to include other documentation requirements that support contract requirements and quality initiatives. All review elements under the record review must be scored as Met or Not Met to maintain the correct evidentiary sample size. A score of Met indicates there is no evidence of non-compliance for the measure. Inter-rater reliability assessments are conducted annually to ensure consistency in clinical management decision-making. Magellan selects a representative, random sample, which adheres to a confidence level of 95% with a confidence interval of + or – 5% (i.e., sample size ≥ 385 records).

Magellan exceeded this sample size by reviewing a total of 436 records for waiver requirements. The additional documentation requirements scored varied depending on if the question applied to the member. Table 13 outlines the results of WAA monitoring activities.

Table 13: WAA 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.	345	345	100
2A Psych advance directives or refusal documented (applicable to adults only)	1	3	33.33
1B D/C planning/linkage to alternative tx (level of care) leading to D/C occurring	345	345	100
1C Evidence of provider request of consumer for authorization for PCP communication	334	345	96.81
2C PCP communication after initial assessment/evaluation	326	331	98.49
3C Evidence of PCP communication at other significant points in treatment.	259	261	99.23
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	339	341	99.41
1D Evidence of timely notification of Behavioral Health Providers of CFT meeting	299.5	330	90.76
Waiver Assurances			
1F Member's level of care determination was made by a qualified evaluator	436	436	100
1G Plan of care reflects supports and services necessary to address the member's goals	436	436	100
2G Plan of care includes supports and services consistent with assessed health needs, including risks	436	436	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	436	436	100
4G Plan of care updated timely, as specified in the waiver application	436	436	100
5G Plan of care was updated when the member's needs changed	436	436	100
6G Member was given a choice among service providers, as documented by the member/authorized representative's signature on the State-approved form	436	436	100
7G Member received information on available HCBS, as documented by the member/authorized representative's signature on the State-approved form	436	436	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	435	436	99.77
2H Member received coordination and support to resolve health needs identified through case management contacts	436	436	100

As the table indicates, WAAs showed very high compliance with waiver and contract requirements. After each audit, onsite debriefings are held with WAA 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. In aggregate, all

items, except advanced psychiatric directives, showed very high compliance with rates above 90%. The advanced psychiatric directive element was only scored for members 18 years or older, which represented only three of the records reviewed. Magellan provided WAAs with specific guidance on expectations on how to meet requirements for Advanced Psychiatric Directives in August 2016, which is expected to improve compliance for applicable members. Another element that provided an opportunity for improvement was "Evidence of timely notification of Behavioral Health Providers of CFT meetings." Auditors noted that inconsistent documentation of notification is the largest barrier to compliance. Please reference the Annual Performance Improvement Report for a complete report on improvement activities related to behavioral health provider participation in CFT meetings.

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 Magellan Health Services. Magellan surveys its participating network providers at least annually to obtain their perceptions of the service they received in collaboration with 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 and 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 service between January 1 and June 30, 2016 were selected to be surveyed. The questionnaires were distributed in September 2016 by e-mail or fax with an option to return them by fax and instructions for completion online. The survey department did multiple distributions and provider outreach to support our corporate and customer response rate goals. The survey was closed in November 2016. The survey data presented provides baseline data for Magellan as the CSoC Contractor. It is believed that the data can not be compared to the Louisiana Behavioral Health Partnership (LBHP) data because of the substantial changes made to the management of Louisiana's Medicaid program, which changed to an integrated medical model versus a carved out behavioral health model in December 2015.

Of the 206 surveys delivered, 52 providers responded for a response rate of 25.2%. This is similar to response rates achieved corporately and in previous LBHP administrations. The overall satisfaction with the services provided by Magellan was 94.7%. This is the highest overall satisfaction achieved in Magellan's history of serving Louisiana Medicaid members. Only two items fell below the 80% minimum performance threshold. Tables 14 and 15 outline the top and low-scored elements.

Table 14: Top-Scored Satisfaction Items

Question Number	Question Detail	Number of Responses	% Positive
Q23	Magellan's language assistance services (i.e., interpretation, translation services)	49	100.0%
Q24	Magellan's provider support for our online self-service tools	48	97.1%
Q19	Services Satisfaction with Magellan`s Claims appeal process	49	96.8%
Q20	Services Satisfaction with Magellan`s Claims appeal timeliness	49	96.8%

Table 15: Lowest-Scored Items

Question Number	Question Detail	Number of Responses	% Positive
Q8	Timeliness of communicating authorization decisions to you	51	82.2%
Q25	What are the barriers if any, for you or your staff, to updating your demographic information and appointment availability for Magellan?	48	77.1%
Q14	Do you know that you can file a formal administrative complaint via the provider website, by phone, or by mail?	30	70.0%

Top-scored items highlight providers' satisfaction with services provided by Magellan's network department. Magellan's network department placed a special emphasis on supporting providers in navigating new eligibility and claims processes associated with integration. High rates of satisfaction in claims services elements support the effectiveness of these actions. 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 that lower satisfaction in authorization decision timeliness has been impacted by changes associated with integration. Authorizations for CSoC members are not directly requested from Magellan, but rather they are requested through Plans of Care documents managed by WAAs. This process was new to many of the providers that worked with Magellan as part of the LBHP network. Magellan provided education and assistance on requesting authorizations to the provider network. Authorization data is also available through Magellan's provider website and is updated daily. Magellan will continue to focus attention on provider education. Magellan will also collaborate with WAAs as part of the WAA Summit to be held in March 2017 to discuss barriers to timely communication of authorizations to inform future interventions.
- Accurate provider information facilitates improved communication and provider monitoring. Although 77% of providers reported no barrier to updating their provider information, 12.5% of providers reported not remembering to update is a barrier. This was the largest reported barrier, with other representing 8.3%. Magellan conducts provider outreach via provider communications and Provider All-Calls to improve awareness of the need to update information.
- Provider grievances 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 will also develop a provider communication outlining how grievances can be filed to improve awareness.

Outcomes

Two of the main goals of the CSoC program are to reduce current and future out of home placements 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, mainly through Child and Adolescent Needs and Strengths (CANS) data and Quality Improvement Strategy (QIS) performance measures. This section reviews the outcomes accomplished by the CSoC members and providers. Data presented in this section uses waiver year rather than a contract year. Waiver year is used because many of the performance measures reported must align with the CMS waiver application. The waiver year begins in March and ends in February as compared to the contract year, which begins in December and ends in November. The quarters represent the same arrangement of months but are labeled differently. For example, contract year one quarter one is equivalent to waiver year four quarter four.

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) and additional supporting information. Currently, there are versions of the CANS used in 50 states in child welfare, mental health, juvenile justice, and early intervention applications. 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.

Unlike other psychometric tools, the CANS measures not only member needs but also member strengths. This aligns the tool with the principles of CSoC, such as strength-based, individualized, youth guided, family driven, and data driven and outcomes oriented. The CANS is used in practice to link the assessment process to the design of individualized service plans to ensure the needs and strengths identified by the family and youth are the focus of the plan. Needs and strengths are measured using a 4-point scale to rate the highest level of the member from the past 30 days. The following is the scale for needs and strengths:

Needs

0. No evidence
1. Watchful waiting/prevention
2. Action
3. Immediate/Intensive Action

Strengths

0. Centerpiece strength
1. Strength that you can use in planning
2. Identified-strength-must be built
3. No strength identified

A rating of '2' or '3' on a CANS needs suggests that the area must be addressed in the plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a rating of '2' or '3' 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 & needs, youth strengths, and acculturation. It also measures problem

presentations, such as oppositional, attention/impulsivity, depression, and anxiety. Another component of the CANS is that it further assesses areas important to the member, such as school functioning, trauma, juvenile justice, violence, to ensure these needs are identified and addressed as part of the plan of care development.

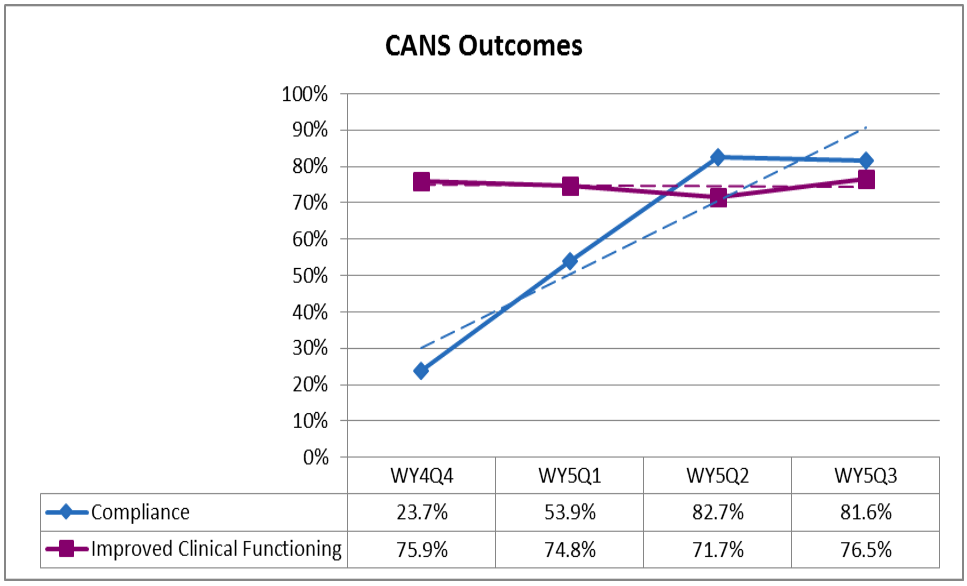
According to the Praed Foundation, the CANS has demonstrated reliability and validity. The average reliability of the CANS is 0.75 with vignettes, 0.84 with case records, and can be above 0.90 with live cases. To further support reliability and validity, Magellan performs input validation (e.g., identifying and investigating outlier scores, duplicates, etc.) to ensure the integrity of data. Statistical significance is referenced during this section. This concept means that the outcome being reported is the result of a relationship between specific factors versus merely the result of chance. It is measured using a p-value, with anything equal or less than 0.05 considered statistically significant. The lower the p-value the more likely the outcome is not due to chance.

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 (sum of all items that measure outcomes) and domain scores can also 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 overall 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 for the collection of this data through MagellanProvider.com. Magellan made electronic submissions a requirement for WAAs in June 2016 and tracks CANS compliance of discharging members to ensure each members information can be included for analysis. Magellan monitors CANS data quarterly as well as conducts an annual comprehensive analysis of outcomes for the program.

Quarterly CANS Outcomes

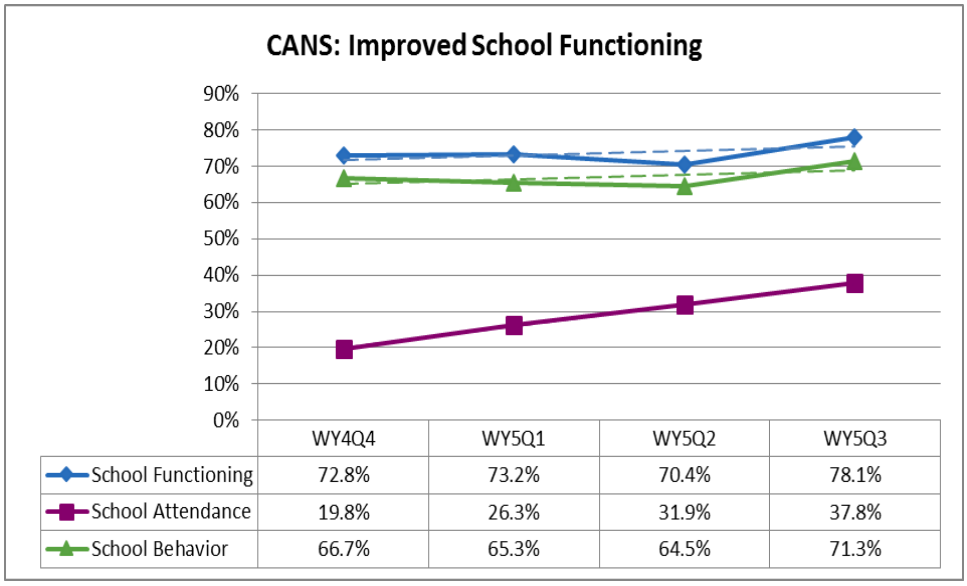
Quarterly monitoring is important because it allows administrators and program directors to have a real-time mechanism to monitor outcomes. This allows for the quick detection of changes in overall outcomes that need to be addressed as well as allows process improvement interventions to be monitored for effectiveness. Clinical functioning and school functioning are the two indicators selected to be monitored. The reports include members that are discharged during the quarter with both an electronic initial and discharge assessment. The global CANS score is used to monitor clinical functioning and improvement is defined as the percentage of members with a decrease of five points or more in the global scores from the initial and discharge CANS. School functioning is 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. Figures 23 and 24 display quarterly data for contract year one.

Figure 23: CANS Global Score Quarterly Results



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
Compliance	23.7%	53.9%	82.7%	81.6%
Improved Clinical Functioning	75.9%	74.8%	71.7%	76.5%

Figure 24: CANS Global Score Quarterly Results



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
School Functioning	72.8%	73.2%	70.4%	78.1%
School Attendance	19.8%	26.3%	31.9%	37.8%
School Behavior	66.7%	65.3%	64.5%	71.3%

The compliance rate indicator shows the number of children with both an initial and discharge CANS. Positive impacts were seen over the course of the year as a result of establishing requirements for submissions as evidenced by an improvement of 57.9 percentage points from the first to fourth quarter. The average trend line for contract year one showed just under 75% of discharging members are showing improved clinical functioning. This is especially impactful since eligible members are at high risk of out of home placement. School CANS data show improvements are achieved in both functioning and behavior for over 70% of discharging children. Interestingly, school attendance did not show the desired level of improvement. Magellan met with regional WAAs to discuss factors that could be contributing to the lack of progress. The WAAs reported that many members do not have problems with school attendance when they enroll in the program. A frequency analysis was done to identify the number of

children who scored '0' on the school attendance item at the initial administration to see if this could be impacting the percent of youth showing improvement. This is important because children who score '0' cannot show improvement as defined by the measure, a decline of one point. Table 14 represents the results of this conditional analysis.

Table 16: Conditional Analysis of the School Module

School Module Item	Original Methodology Percent Improved By 1	Percent of Members who had a Score of 0 on the Initial CANS	New Methodology Percent Improved by 1 Given at Least 1 on Initial
Attendance	37.78%	45.09%	68.81%
Behavior	71.28%	6.30%	76.08%
Achievement	60.45%	9.07%	66.48%
Relations	58.44%	16.12%	69.67%

Definitions for table columns are:

- **Original Methodology**: This number includes all members that scored either a 0, 1, 2, or 3 on the Initial CANS.
- **Percent of Members who had a Score of 0 on the Initial CANS:** This number shows you the percentage of members that scored a 0 on the initial CANS. Of the school module items, school attendance has the largest percent of members scoring 0 at the initial CANS.
- **New Methodology:** This methodology includes only members that scored a 1, 2, or 3 on the Initial CANS. In other words, it removes members who scored 0 from the denominator because those scores can't "improve" or decrease further than 0.

As the data reflects, the percentages of improvement are higher using the new methodology. The results confirm that compared to other items measured in the school module, more youth, or 45% of youth, do not identify school attendance as a need for the initial CANS compared to other items. Clinical and school functioning measures are not as impacted by methodology because both include the average of several items, unlike attendance and behavior, which are stand-alone measures. Magellan recommends that both conditions are reported on future reports to show a more accurate representation of improvement of this measure.

Comprehensive Analysis

Although quarterly monitoring has value, it is also important to look at data over a longer period. It not only stabilizes the data by allowing for more members, but it also provides an opportunity to conduct a statistical analysis of the data and ensures that confounding variables, such as seasonality, natural disasters, etc., do not impact results. In October 2016, Magellan conducted a comprehensive analysis of 1278 members with an initial and discharge CANS from 3/1/2012 to 10/16/2016. There are two cohorts that were evaluated in the analysis, All Population (n= 1278) and the Most Severe, or Top 25% of the All Population group, (n=332). The mean length of stay was 11.2 months for the All Population group and 11.1 months for the Most Severe group. Figures 5 through 10 provide global, domain, and problem presentation scores for each subset. The results of this comprehensive analysis are powerful and supports that children are improving as a result of participation in CSoC.

Figure 25: Global Scores for All Population and Most Severe

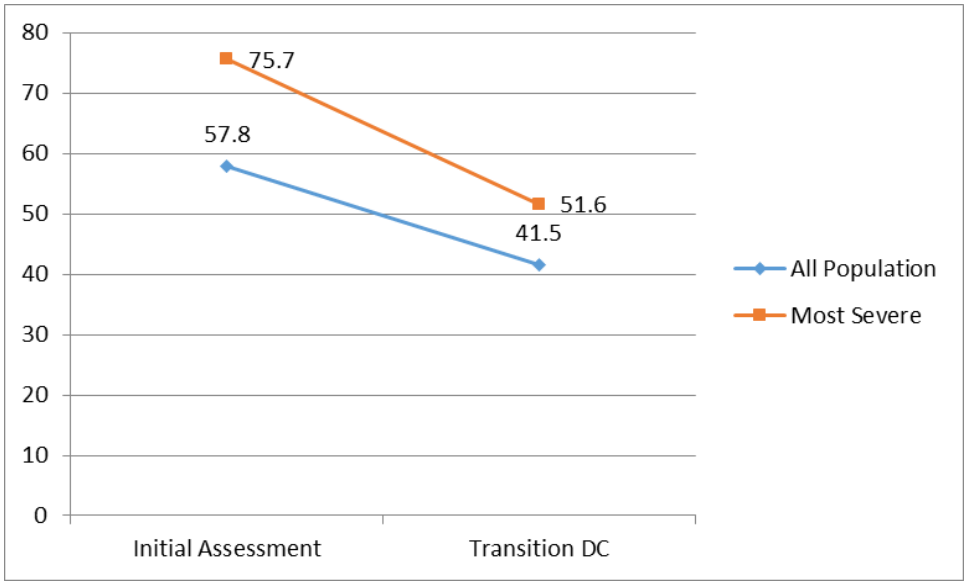


Figure 26: All Population Domain Scores

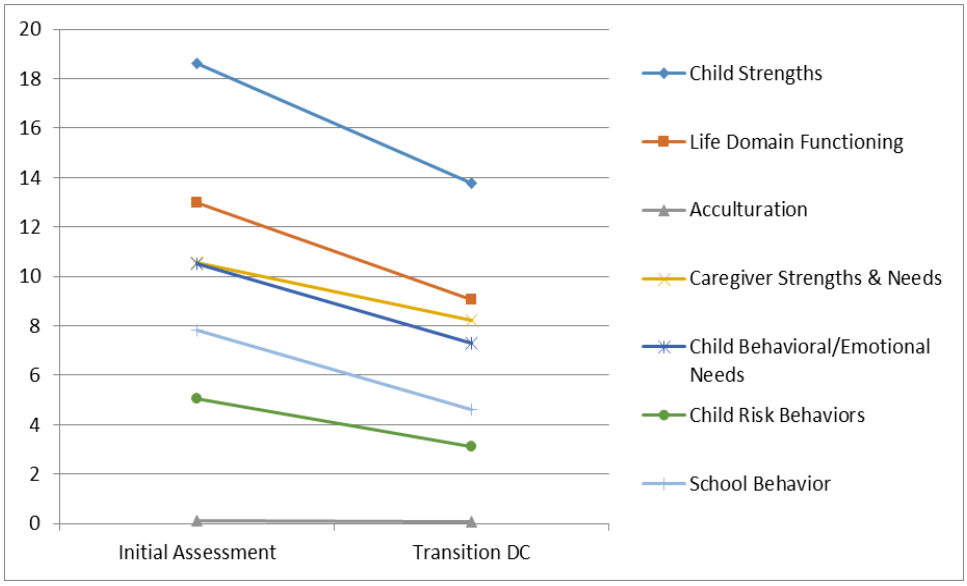


Figure 27: Most Severe Domain Scores

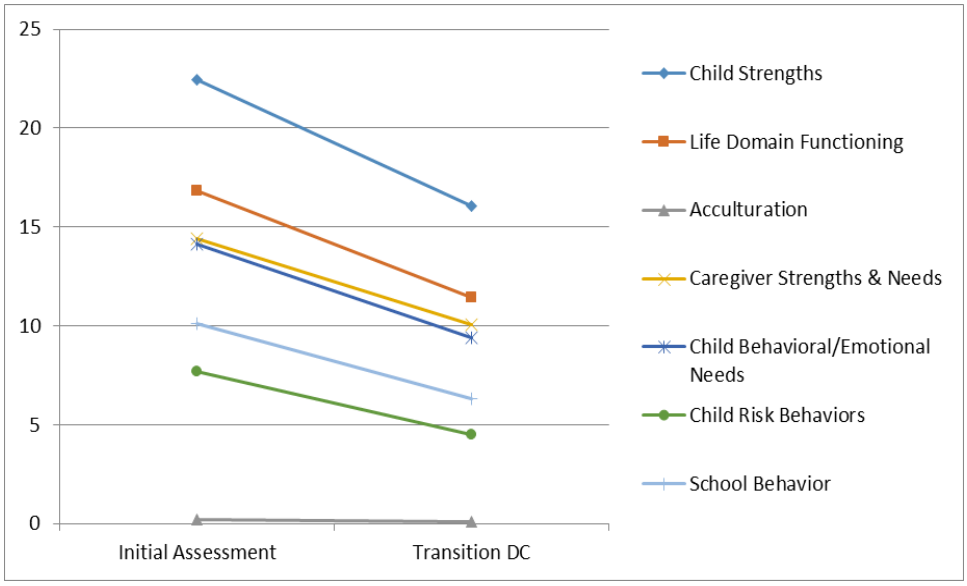


Figure 28: All Population Problem Presentation

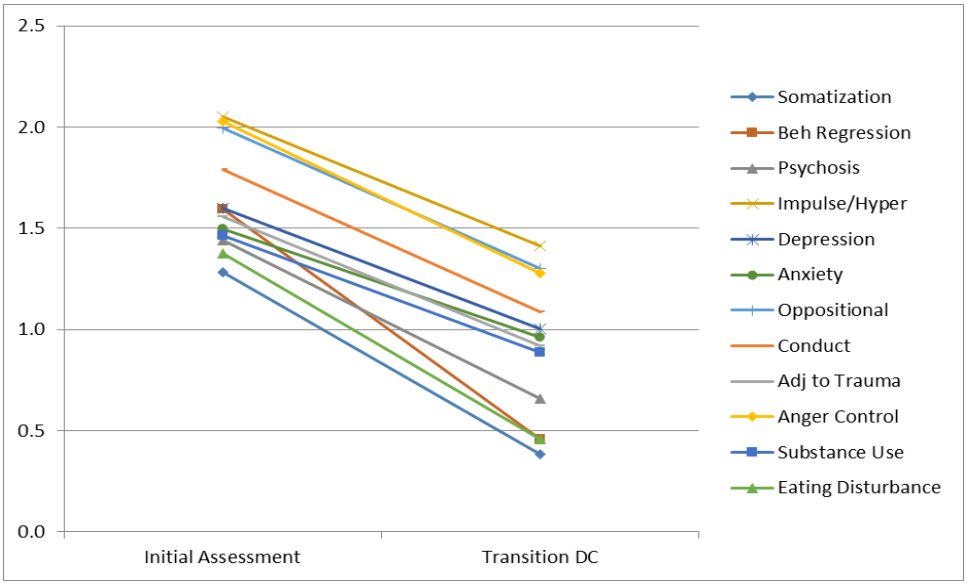


Figure 29: Most Severe Problem Presentation

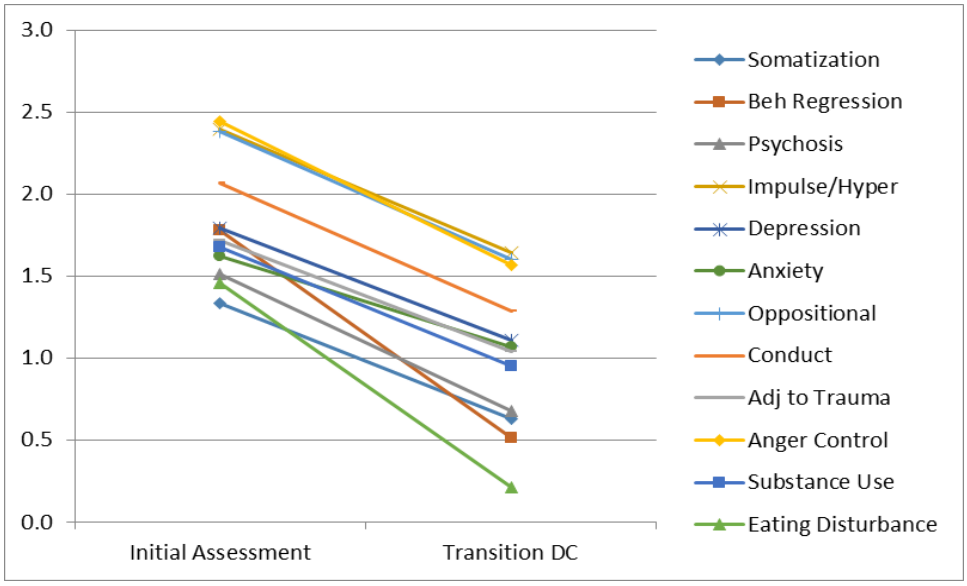
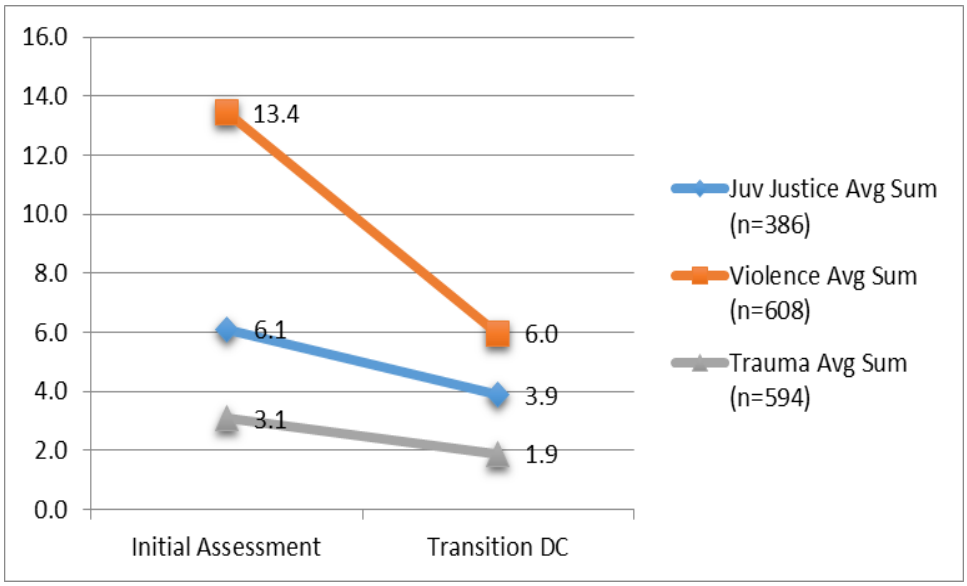


Figure 30: Notable Module Scores



**Includes all outcomes elements associated with the module.*

All figures represent a statistically significant improvement, except the Acculturation Domain Score, as evidenced by p≤.001. This means that there is confidence that the results are not the result of chance but a result of the program. Few youth showed needs in acculturation, which is why this domain did not show statistically significant improvements. Global scores indicate significant improvements in the overall clinical functioning in children enrolled in CSoC. The All Population group showed a decline of 16 points from initial to discharge CANS administrations, with Most Severe Group showing improvements of 24 points. Results indicate that these improvements are seen consistently across all areas assessed by the tool. Improvements are also noted in children involved in juvenile justice or with a history of violence and trauma.

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 WAAs 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 is occurring within timeframes for almost 90% of the youth; however, less than 60% of members have face-to-face contact within timeframes. Magellan engaged WAAs to better understand barriers to face-to-face engagement. WAAs identify that factors influencing meeting these timeframes include the day of the week referral is received and member unavailability. Figure 11 shows access to wraparound measures for contract year one.

Because of the severity of the membership served in CSoC, sometimes inpatient hospitalizations are unavoidable; however, the goal is to have the least amount of members 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 the highest risk youth for placement in restrictive setting, less than 5% of members required inpatient hospitalization in contract year one, with only 3.1% having a hospitalization in waiver year quarter four. Positive trends are also seen in the average length of stay (ALOS), which shows an ALOS of only six days in waiver year five quarter three. Figure 12 illustrates inpatient utilization measures for contract year one.

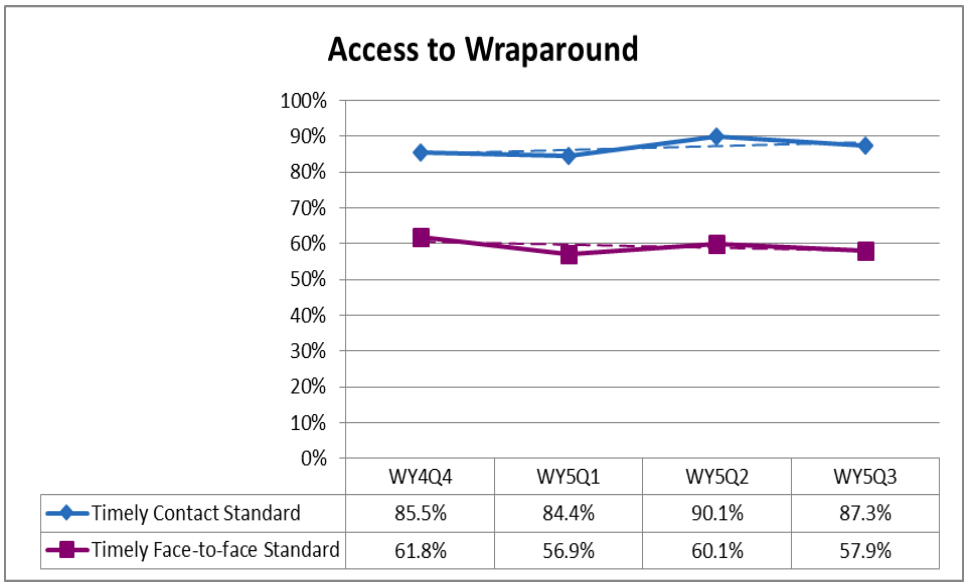
Follow-Up after Hospitalization for Mental Illness HEDIS measures are industry standard performance measures used to monitor if members admitted to an inpatient psychiatric hospital setting receives necessary follow-up care within 7 and 30 days from discharge. It is believed that integrating members into outpatient services as soon as possible following an inpatient hospitalization can reduce recidivism and improve outcomes for members. Because of the unique aspects of the CSoC program, Magellan looks at both a standard measure and a modified measure. Standard HEDIS specifications do not include peer delivered services; however, it is believed that this service type is integral to the CSoC model and should be considered when evaluating the data. These services are included in the modified measure. In contract year one, 7-day FUH rates were 46.4% and 73.3% for HEDIS and Modified HEDIS respectively. The 30-day FUH rates are currently 60.6% and 87.3% for HEDIS and Modified HEDIS respectively. Magellan met the 50th percentile for 7-day FUH (i.e., 46%) for the standard HEDIS group and exceeded the 90th percentile for 7-day FUH (i.e., 70%) for Medicaid programs. This means the CSoC program achieved rates for 7-day FUH higher than 90% of other Medicaid programs when including peer services.

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 13 shows there is a positive trend line for this type of involvement, with over 85% of members having natural and informal support involvement. Magellan feels there are opportunities for improvement for this measure and hopes to implement a new mechanism to monitor involvement throughout treatment not just

documented on the plan of care with the approval of LDH. Please reference the Annual Fidelity Review Report and Annual Performance Improvement Plan Report for additional supporting documentation for the need for this enhancement.

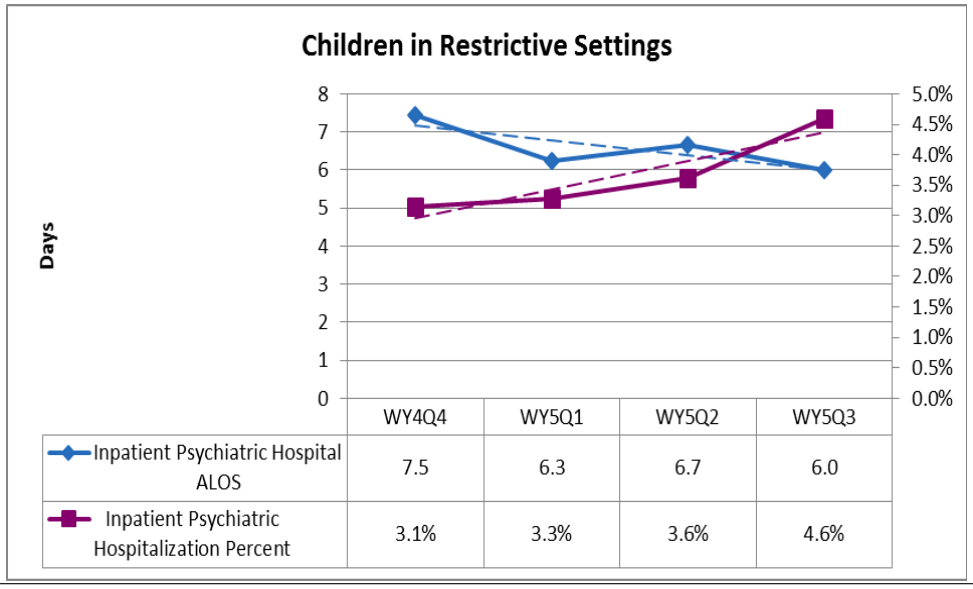
A principal goal of CSoC is for members to discharge successfully from the program, or discharge with 80% to 100% of goals met. Successful discharges account for the largest type of discharge and positive improvements for this measure where seen, with percentages surging from under 40% for most of the year to 50% in the final quarter. Another of the central goals 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. Figures 31 and 32 display results for the discharge indicators.

Figure 31: Access to Wraparound



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
Timely Contact Standard	85.5%	84.4%	90.1%	87.3%
Timely Face-to-face Standard	61.8%	56.9%	60.1%	57.9%

Figure 32: Children in Restrictive Settings



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
Inpatient Psychiatric Hospital ALOS	7.5	6.3	6.7	6.0
Inpatient Psychiatric Hospitalization Percent	3.1%	3.3%	3.6%	4.6%

Table 17: 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	47	21	44.68%	27	57.45%	34	72.34%	40	85.11%
Region 2	48	22	45.83%	28	58.33%	36	75.00%	45	93.75%
Region 3	39	20	51.28%	27	69.23%	27	69.23%	32	82.05%
Region 4	21	8	38.10%	10	47.62%	12	57.14%	14	66.67%
Region 5	22	10	45.45%	16	72.73%	19	86.36%	22	100.00%
Region 6	34	12	35.29%	15	44.12%	18	52.94%	25	73.53%
Region 7	28	18	64.29%	21	75.00%	23	82.14%	26	92.86%
Region 8	59	27	45.76%	35	59.32%	50	84.75%	54	91.53%
Region 9	17	8	47.06%	12	70.59%	12	70.59%	17	100.00%
Total	315	146	46.35%	191	60.63%	231	73.33%	275	87.30%

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

Figure 33: Natural/Informal Support on Plan of Care

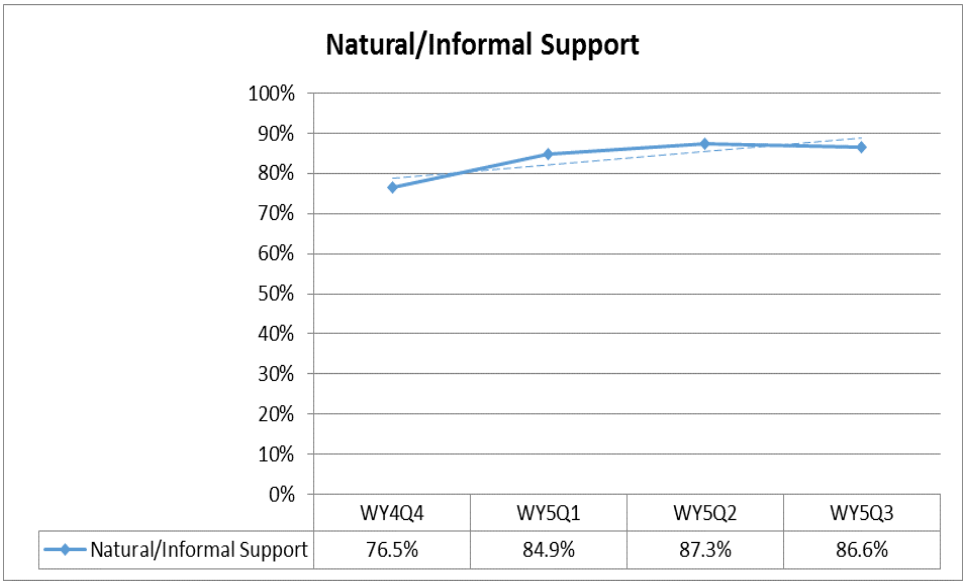
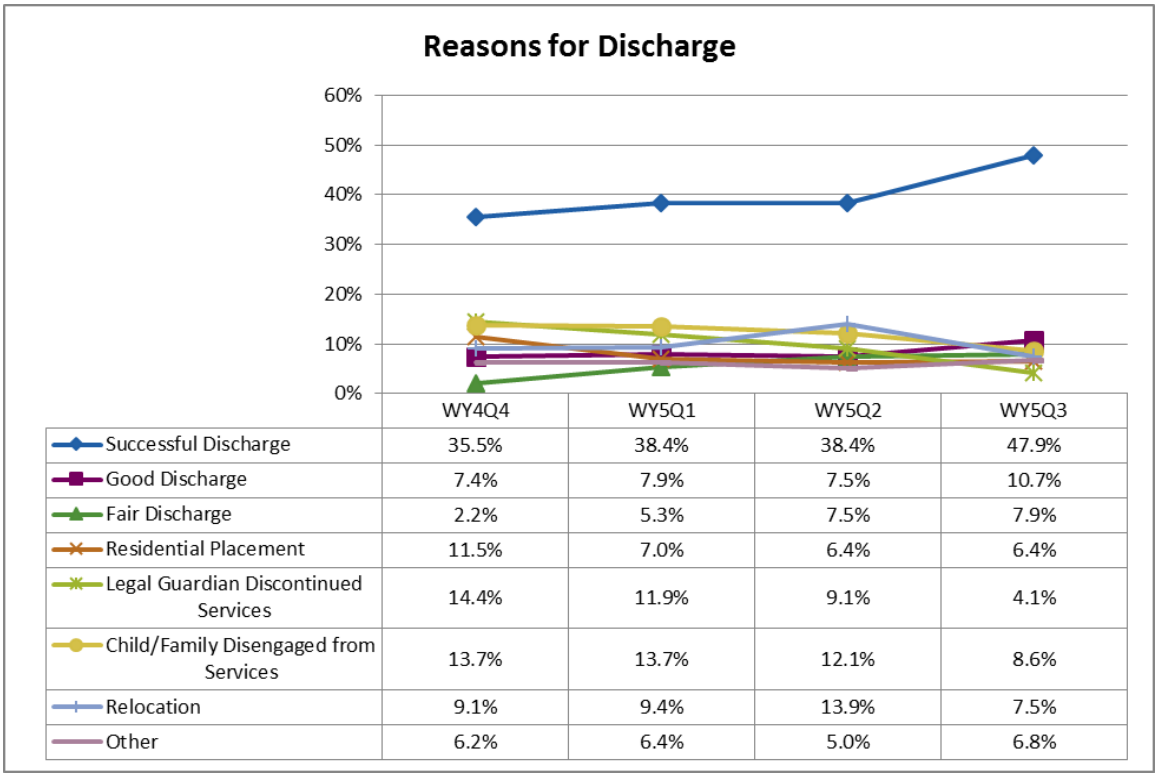
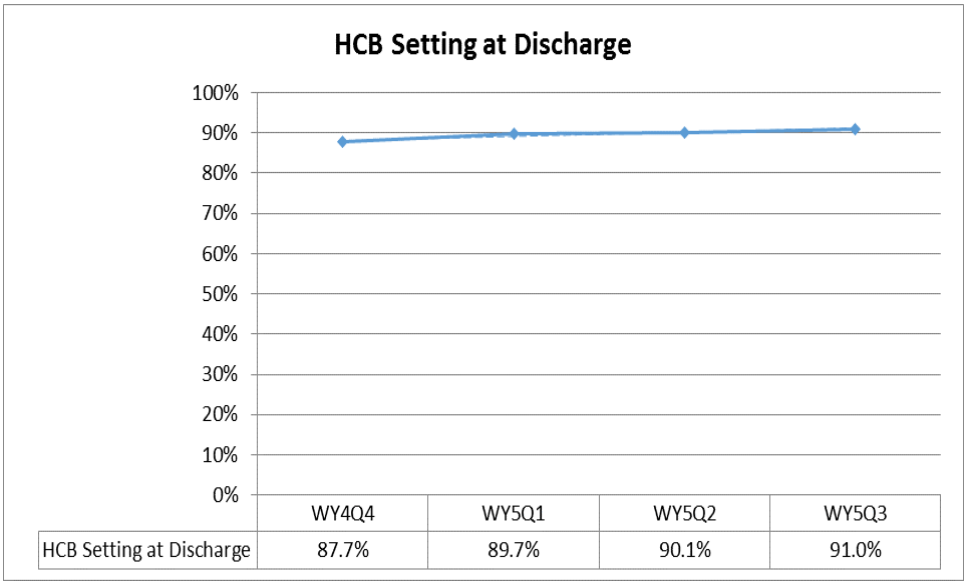


Figure 34: Reasons for Discharge



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
Successful Discharge	35.5%	38.4%	38.4%	47.9%
Good Discharge	7.4%	7.9%	7.5%	10.7%
Fair Discharge	2.2%	5.3%	7.5%	7.9%
Residential Placement	11.5%	7.0%	6.4%	6.4%
Legal Guardian Discontinued Services	14.4%	11.9%	9.1%	4.1%
Child/Family Disengaged from Services	13.7%	13.7%	12.1%	8.6%
Relocation	9.1%	9.4%	13.9%	7.5%
Other	6.2%	6.4%	5.0%	6.8%

Figure 35: Home and Community Based Setting at Discharge



	WY4Q4	WY5Q1	WY5Q2	WY5Q3
HCB Setting at Discharge	87.7%	89.7%	90.1%	91.0%

Summary

The report serves as a summary document to outline how Magellan is supporting LDH, through the administration of the CSoC program, in achieving the goal of keeping Louisiana's highest risk youth in the community and 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. Please refer to the following documents for a full narrative of contract one deliverables and activities: Provider Performance Report, Network Development and Management Plan, Annual Fidelity Review Report, Member Satisfaction Survey Report, and the Annual Performance Improvement Plan.

Although the program has demonstrated positive outcomes for members, Magellan plans to continue to support and facilitate 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. This includes advancements in data analytics and supporting efforts to establish national benchmarking. The CSoC data spreadsheet is the data source for many performance measures. Magellan is in the process of importing past submissions of spreadsheets into our internal data warehouse. This conversion will allow for more advanced statistical analysis to understand better the population differences among the membership. The analysis will evaluate indicators to understand better why some members achieve positive outcomes *and/or* discharge successfully. It is believed the more we understand factors contributing to member success in the program, the more we can tailor our interventions, process improvement activities, training, and coaching to facilitate positive outcomes. It will also focus on factors, such as DCFS/OJJ involvement, FSO involvement, and if the youth has an IEP, etc.

National benchmarking is important to monitor how a program compares to other similar programs. Until now, little information has been available to compare Louisiana outcomes to other wraparound initiatives across the country. University of Washington's Wraparound Evaluation and Research Team (WERT) is actively researching CANS data across multiple states' programs. Magellan, with the approval of LDH, has a data sharing agreement with WERT to facilitate the establishment of national benchmarking for outcomes monitoring. Research by WERT presented at the 2016 CANS conference held in November presented data on eight programs, including Louisiana, and provided meaningful first steps in better understanding how Louisiana's CSoC program compares to other wraparound initiatives. Currently, WERT has identified that factors attributed to implementation differences, such as program funding sources, the assessment process, and eligibility criteria, must first be evaluated before comparisons in data across states can occur. In contract year two, a corporate Magellan CANS subject matter expert will present this information to LDH and discuss implications to our program.