LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP TRANSPARENCY REPORT

FISCAL YEAR 2014

Department of Health and Hospitals

P.O. Box 629

Baton Rouge, LA 70821-0629

Phone: (225) 342-9500

Fax: (225) 342-5568

January 2015

Table of Contents

Executive Summary

The charge of Act 212 of the 2013 Regular Legislative Session was to provide transparency relative to Medicaid managed care programs. Within the Department of Health and Hospitals (DHH), Office of Behavioral Health (OBH), this involves the Louisiana Behavioral Health Partnership (LBHP) and the Coordinated System of Care (CSoC). CSoC is a specialized program for children and youth who have the most complex behavioral health needs and are in or at the most risk of out-of-home placement. To manage the LBHP, inclusive of CSoC, Magellan Health Services of Louisiana, Inc. (Magellan) was selected through a competitive procurement process to administer the program as the statewide management organization (SMO).

This report outlines annual responses to the requests made by the Legislature in Act 212 relative to Magellan's management of care within the LBHP and CSoC. The measures included in this report are used to demonstrate that the following outcomes expressed in the legislation are achieved:

- implementation of CSoC;
- improved access, quality and efficiency of behavioral health services for children not eligible for CSoC and for adults with severe mental illness and/or addictive disorders;
- successful transition from a model of behavioral health care in which service was delivered regionally to one in which human service districts or local governing entities (LGEs) deliver care locally;
- seamless coordination of behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals;
- advancement of resiliency, recovery and a consumer-focused system of person-centered care; and
- implementation of best practices and evidence-based practices that are effective and supported by data collected from measuring outcomes, quality and accountability.

Preface

The LBHP provides a new approach to both delivering and financing behavioral health services for Louisiana's children and adults through a fully integrated system. This service delivery model creates an integrated public behavioral health service system drawing on the strengths of the private, public and non-profit sectors. The goals are to provide enhanced access to a more complete and effective array of evidence-based behavioral health services and supports while also improving individual health outcomes. Ultimately, by enhancing access and offering coordinated care management, the LBHP is expected to yield a reduction in unnecessary hospitalizations, institutionalizations and emergency department visits as well as a higher quality of care for children, adults and their families. To achieve this goal, the LBHP made major strides to expand access to services and in doing so has served approximately 85,000 children and 106,000 adults with serious mental illness, major mental disorders, acute stabilization needs and/or addictive disorders. This exceeds the program objectives of treating at least 50,000 children and 100,000 adults.

Within the LBHP, CSoC offers a comprehensive array of intensive services with the goal of enabling these children to remain in or return to their homes and communities. Wraparound agencies (WAAs) provide individualized care planning and management through child and family teams (CFTs), which are charged with the development of a plan of care for each child or youth. The Department applied for statewide implementation of CSoC with the Centers for Medicare and Medicaid Services (CMS) in state fiscal year (SFY) 2014 and received approval for statewide expansion in September 2014. With statewide expansion, it is anticipated that a total of approximately 2,400 youth who are at greatest risk and have the most complex needs will be enrolled in the program the program – an expansion from the current 1,200 children who are currently being served.

All major transformations present challenges along the way. However, the LBHP continues to improve how Louisiana citizens with behavioral health issues are served and offers the following measures and outcomes as part of this SFY 2014 managed care transparency report. Since implementation, noticeable expansion of services, increased numbers of enrolled members and a dramatic expansion in the provider network have occurred. Further information regarding initiatives and expansion within the LBHP is identified through the data included in this report.

In preparation for the submission of this report, DHH worked with Myers and Stauffer to independently review the Medicaid data submitted by Magellan. The data submitted by Magellan was found to be within a reasonable and expected variance from the review performed. For ease of reference, the information requested within Act 212 has been divided into sections by the matching numerical request in the legislation and attached through appendices to this report.

1 LOCAL GOVERNING ENTITY INFORMATION

Local Governing Entity (LGE) Contact Information	Parishes
Acadiana Human Services District (AAHSD) Brad Farmer, Executive Director 302 Dulles Drive Lafayette, LA 70506 337-262-4190	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion
Capital Area Human Services District (CAHSD) Jan Kasofsky, Ph.D., Executive Director 4615 Government Street Baton Rouge, LA 70806 225-922-2700	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana
Central Louisiana Human Services District (CLSHD) Egan Jones, Executive Director 401 Rainbow Drive, Unit 35 Pineville, LA 71360 318-487-5191	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn
Florida Parishes Human Services Authority (FPHSA) Melanie Watkins, Executive Director 835-B Pride Drive, Hammond, LA 70401 Phone# 985-543-4333	Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington
Imperial Calcasieu Human Services Authority (ImCal) Tanya McGee, Executive Director 3505 5th Avenue, Suite B Lake Charles, LA 70607 337-475-3100	Allen, Beauregard, Calcasieu, Jefferson Davis and Cameron
Jefferson Parish Human Services Authority (JPHSA) Lisa English Rhoden, Executive Director 3616 South I-10 Service Road West, Metairie, LA 70001 504-838-5215	Jefferson
Metropolitan Human Services District (MHSD) Judge Calvin Johnson, Executive Director 1010 Common, Ste. 600, New Orleans, LA 70112 504-568-3130	Orleans, St. Bernard, and Plaquemines
Northeast Delta Human Services Authority (NEDHSA) Monteic Sizer, Ph.D., Executive Director 2513 Ferrand St. Monroe, LA 71201 318-362-3270	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union and West Carroll
Northwest Louisiana Human Services District (NLHSD) Doug Efferson, Executive Director 2924 Knight Street, Suite 350 Shreveport, LA 71105 318-862-3085	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster
South Central Louisiana Human Services Authority (SCLHSA) Lisa Schilling, Executive Director 521 Legion Avenue Houma, Louisiana 70364 985-858-2931	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne

2 PROVIDER INFORMATION

Since implementation of the LBHP, OBH and Magellan have overseen the expansion of the network of providers available to deliver behavioral health care across the state. This provider number is defined by entry point, so a provider is identified by each location where services are provided. This expansion in the provider network includes additional provider types and additional services, including services allowable within the scope of practice and professional license of Licensed Mental Health Professionals, 24-7 crisis triage by telephone, mobile services, community psychiatric support and treatment, psychosocial rehabilitation, additional evidence-based practices, addiction rehabilitation and case conference services, which are scheduled face-to-face meetings between two or more individuals to discuss the beneficiary's treatment. The providers combined offer a total of over 5,000 specialties of service. Current network data indicates the following statewide summary by provider type, credentialing status and specialty:

Provider Type:	**Number of Contracted Providers:**
Facility	3,302
Group	844
Independent Practitioner	902
Credentialing Status:	**Number of Providers:**
Credentialed	5,048
Pending Credentialing	35
Specialty of Service:	**Number of Contracted Providers:**
Applied Behavior Analysis	10
Ambulatory Detox Outpatient	6
ASAM Level I – Outpatient Substance Use	787
ASAM Level II – Intensive Outpatient Substance Use	175
ASAM Level III.1 – Clinically Managed Low-Intensity	44
ASAM Level III.2D – Clinically Managed Social Detox	8
ASAM Level III.3 & III.5 – Clinically Managed Medium-Intensity	61
ASAM Level III.7 – Medically Monitored High-Intensity/Co-Occurring	9
ASAM Level III.7D – Medically Monitored Detox	23
ASAM Level IV – Inpatient Alcohol/Drug Detox	16
Assertive Community Treatment	54
Case Conference	191
Community Support Services (CPST)	481
Crisis Intervention	444
Crisis Stabilization	1
Functional Family Therapy	27
Group Home Substance Use	1

Homebuilders	16
Independent Living/Skills Building	109
Inpatient Electro-Convulsive Therapy	1
Inpatient Psychiatric Hospital	83
Inpatient Substance Use Hospital	18
Laboratory Services	36
Multi-Systemic Therapy	41
Non-Medical Group Home	34
Outpatient Electro-Convulsive Therapy	1
Outpatient Eating Disorder	235
Parent Support and Training	1
Psychiatric Outpatient	1,601
Psychiatric Residential Treatment Facility	7
Psychosocial Rehabilitation	405
Short Term Respite	13
Specialist - Other	87
Wraparound Services	5
Supportive Living Community Residential Crisis Beds	2
Therapeutic Foster Care	12
Therapeutic Group Home	2
Youth Support and Training	1

Please note that many independent practitioners have separate subspecialties of service that are not listed above. The comprehensive list of providers enrolled in the Magellan network, along with their specialties and subspecialties, credentialing date and provider type, can be found at the following link: http://new.dhh.louisiana.gov/index.cfm/page/2094.

3–8 MEMBER INFORMATION

Over one million individuals have become enrolled members in Magellan's health plan. These members now have access to information, education and new services. Details of the following legislative requests can be found in the attached Appendix III through VIII:

Legislative Request Item Number:	Data Book Tab Label:	Statewide Total
SECTION 3:	Appendix III: Medicaid and Non-Medicaid Enrollees	1,406,746
SECTION 4:	Appendix IV: Adult Medicaid Members	52,057
SECTION 5:	Appendix V: Adult Non-Medicaid Members	20,702
SECTION 6:	Appendix VI: CSoC Members	1,783
SECTION 7:	Appendix VII: Non-CSoC Medicaid Youth Members	68,766
SECTION 8:	Appendix VIII: Non-CSoC Non-Medicaid Youth Members	1,784

9 Percentage of Calls Referred to Services

This data element shows the number of calls received by Magellan from clients that identified their parish of residence as well as the number and percentage of those calls referred for services. Clients call Magellan for various reasons and do not always require referral to services, particularly if the call is solely for the purpose of requesting or gathering information. Clients are referred to services upon request and based on an assessment of their behavioral health needs. Persons not requiring referral to services may decide to remain anonymous, which accounts for the number of calls that remain unidentified by parish. Please refer to Appendix IX for additional data details.

10 Average Hours from Call to Authorization

As indicated in the previous data element, while a majority of calls are referred to services, a large minority often do not require a referral. As a result, this metric was difficult to track with accuracy. Instead, the length of time from the call to authorization of services by Magellan is provided below. According to the statewide management organization (SMO) request for proposal (RFP) language, the SMO shall generally provide notice of standard authorization decisions within 14 calendar days following the request for service. The data below reflects that the number of expedited cases is significantly lower than standard inpatient cases. As a result, variances within one or two individual cases have a much more significant impact on the expedited data element. Additionally, the expedited cases tend to be the most complex, needing additional case management to place members who are not already admitted into a specialized inpatient facility.

Level of Care	**Expedited Average Hours from Call to Authorization**	**Standard Average Hours from Call to Authorization**
Inpatient	0.35	0.16
Outpatient	0.70	2.33

11 Percentage of Referrals Considered Immediate, Urgent and Routine

Magellan makes referrals based on the behavioral health needs of the client when presenting, either in person or by calling Magellan. Referrals for service are grouped into the following classifications: a life-threatening emergency requiring immediate attention; an urgent need, which is generally when a member could face severe harm or pain if not expediently linked to services through urgent care, or a routine behavioral health service need. Upon referral, Magellan authorizes services based on the necessary clinical criteria.

Percentage of Referrals Considered Immediate, Urgent and Routine

Parish Name	Emergent	Urgent	Routine
Acadia	1.36%	34.24%	64.41%
Allen	1.05%	39.90%	59.06%
Ascension	1.37%	30.12%	68.51%
Assumption	0.62%	23.02%	76.36%
Avoyelles	1.14%	28.37%	70.50%
Beauregard	2.73%	31.25%	66.02%
Bienville	0.67%	33.44%	65.89%
Bossier	0.99%	32.05%	66.96%
Caddo	0.85%	29.81%	69.35%
Calcasieu	1.80%	30.07%	68.13%
Caldwell	0.22%	21.24%	78.54%
Cameron	0%	25.00%	75.00%
Catahoula	0.55%	26.30%	73.15%
Claiborne	0.76%	34.47%	64.77%
Concordia	0.78%	27.30%	71.92%
De Soto	0.49%	29.60%	69.91%
East Baton Rouge	0.82%	28.58%	70.50%
East Carroll	0.67%	25.17%	74.16%
East Feliciana	1.25%	37.50%	61.25%
Evangeline	2.36%	35.46%	62.17%
Franklin	1.06%	26.50%	72.44%
Grant	0.70%	29.25%	70.04%
Iberia	2.28%	35.80%	61.92%
Iberville	0.71%	36.81%	62.48%
Jackson	3.21%	22.94%	73.85%
Jefferson	0.86%	27.39%	71.75%

Jefferson Davis	0.69%	24.74%	74.57%
La Salle	0.98%	30.29%	68.76%
Lafayette	1.54%	32.14%	66.32%
Lafourche	0.70%	28.66%	70.64%
Lincoln	1.06%	25.31%	73.63%
Livingston	2.55%	36.16%	61.29%
Madison	0.55%	23.61%	71.16%
Morehouse	0.69%	27.30%	72.01%
N/A	1.80%	34.14%	64.06%
Natchitoches	0.73%	29.03%	70.24%
Orleans	0.73%	19.16%	80.11%
Ouachita	0.70%	25.89%	71.40%
Plaquemines	1.40%	33.02%	65.58%
Pointe Coupee	0.95%	23.63%	75.42%
Rapides	0.95%	30.02%	69.03%
Red River	0.45%	22.97%	76.58%
Richland	0.51%	31.81%	67.68%
Sabine	2.00%	27.45%	70.54%
Saint Bernard	0.55%	31.06%	68.39%
Saint Charles	1.78%	29.57%	68.65%
Saint Helena	4.69%	32.81%	62.50%
Saint James	0.87%	27.17%	71.96%
Saint Landry	2.59%	34.43%	69.98%
Saint Martin	1.79%	32.86%	65.35%
Saint Mary	2.05%	32.09%	65.86%
Saint Tammany	0.90%	26.07%	73.03%
Saint John the Baptist	0.99%	24.36%	74.65%
Tangipahoa	1.13%	29.61%	69.26%
Tensas	1.41%	30.23%	68.36%
Terrebonne	1.25%	27.53%	71.22%
Union	1.72%	25.02%	74.26%
Vermilion	1.98%	36.96%	61.06%
Vernon	0.54%	29.55%	69.91%
Washington	1.35%	26.29%	72.36%
Webster	0.30%	29.34%	70.36%
West Baton Rouge	0.88%	33.04%	66.80%
West Carroll	1.20%	28.80%	70.00%
West Feliciana	0%	43.70%	56.30%
Winn	1.13%	28.61%	70.25%

12 CLEAN CLAIMS

Magellan defines a clean claim as one that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim. A provider submits a clean claim by providing the required data elements on the standard claims forms along with any attachments, additional elements or revisions of which the provider has knowledge. Magellan does not typically require attachments or other information in addition to the standard forms.

The requested data includes the percentage of clean claims paid within 30 days for each facility broken out by local governing entity (LGE). Also included in this data element is the average number of days taken to pay clean claims and the average number of days taken to pay all claims at each facility by LGE.

Clean Claims				
Agency	**Provider Type**	**% of Clean Claims Paid within 30 Days**	**Avg. Days to Pay all Clean Claims**	**Avg. Days to Pay all Claims**
AAHSD	Community Mental Health Center (In-State Only)	100.00%	3.40	5.13
AAHSD	Mental Health Clinic	99.78%	4.59	5.20
AAHSD	Substance Abuse And Alcohol Abuse Center	100.00%	2.00	2.00
CAHSD	Community Mental Health Center (In-State Only)	99.84%	6.82	7.28
CAHSD	Mental Health Clinic	99.26%	5.51	6.44
CAHSD	Psychiatric Residential Treatment Facility	100.00%	2.05	2.15
CAHSD	State/Local Entity	90.00%	10.00	10.00
CLHSD	Community Mental Health Center (In-State Only)	100.00%	1.95	7.97
CLHSD	Mental Health Clinic	99.99%	2.61	3.23
CLHSD	State/Local Entity	100.00%	10.00	10.00
FPHSA	Community Mental Health Center (In-State Only)	94.17%	8.01	13.40
FPHSA	Mental Health Clinic	99.84%	4.36	4.42
FPHSA	Psychiatric Residential Treatment Facility	99.99%	3.04	6.18
FPHSA	State/Local Entity	100.00%	7.00	7.00
FPHSA	Substance Abuse And Alcohol Abuse Center	100.00%	7.25	7.25
ImCal	Community Mental Health Center (In-State Only)	96.42%	3.79	10.79
ImCal	Mental Health Clinic	96.82%	4.60	5.42
JPHSA	Agency	100.00%	8.00	8.00
JPHSA	Community Mental Health Center (In-State Only)	100.00%	3.29	3.50
JPHSA	Mental Health Clinic	99.95%	3.08	3.97

MHSD	Community Mental Health Center (In-State Only)	92.76%	13.16	13.39
MHSD	Mental Health Clinic	98.34%	6.18	7.93
MHSD	State/Local Entity	0%	31.00	31.00
NEDHSA	Community Mental Health Center (In-State Only)	98.65%	2.50	7.95
NEDHSA	Mental Health Clinic	99.34%	3.12	3.76
NEDHSA	State/Local Entity	96.21%	13.06	13.06
Non LGE	Agency	97.17%	11.09	11.63
Non LGE	Behavioral Health Rehabilitation Provider Agency	100.00%	4.05	64.93
Non LGE	Clinical Nurse Specialist	100.00%	3.50	3.50
Non LGE	CMHC	91.95%	18.81	19.52
Non LGE	Community Mental Health Center (In-State Only)	99.00%	4.37	4.55
Non LGE	Doctor Of Osteopathy (Do) And Doctors Of Osteopathy, Psychiatry	92.33%	16.04	17.75
Non LGE	Family Support Organization	99.52%	4.86	5.28
Non LGE	Federally Qualified Health Center (In-State Only)	97.04%	9.52	11.45
Non LGE	Foster Care Program	100.00%	15.11	16.76
Non LGE	Freestanding Psych Hospital	67.94%	42.58	42.95
Non LGE	Freestanding Substance Use Treatment Facility	78.39%	28.06	29.46
Non LGE	General Hospital	65.45%	37.80	39.11
Non LGE	Group	75.96%	25.73	26.11
Non LGE	Hospital	85.07%	22.31	23.69
Non LGE	Hospital-Distinct Part Psych Unit (In-State Only)	96.16%	7.40	9.20
Non LGE	Individual	97.03%	8.90	9.97
Non LGE	Lea & School Board (In State Only)	99.59%	2.83	2.89
Non LGE	Licensed Addiction Counselors (LAC)	100.00%	2.95	26.94
Non LGE	Licensed Clinical Social Worker (LCSW)	99.62%	4.39	5.03
Non LGE	Medical Or Licensed Psychologist	99.17%	5.69	6.06
Non LGE	Mental Health Clinic	99.37%	4.35	4.59
Non LGE	Mental Health Hospital (Free-Standing)	89.83%	18.18	19.28
Non LGE	Mental Health Rehabilitation (In-State Only)	99.32%	6.53	6.78
Non LGE	Multi-Systemic Therapy (In-State Only)	99.99%	3.36	3.54
Non LGE	Non-Medical Group Home	97.19%	15.34	16.49
Non LGE	Nurse Practitioner And Nurse Practitioner Group	97.81%	7.42	8.25
Non LGE	Organization, No Setting	89.13%	23.71	24.21
Non LGE	Physician (MD) And Physician (MD) Group	94.40%	12.73	14.76
Non LGE	Psychiatric Residential Treatment Facility	99.43%	3.78	6.06
Non LGE	Residential Treatment Center	66.67%	18.43	19.43
Non LGE	Respite Care (Center Based)- Waiver (In-State Only)	99.65%	4.17	4.62
Non LGE	School Based Clinic	98.72%	7.74	7.82
Non LGE	School District	100.00%	6.66	6.66
Non LGE	School-Based Health Center (In-State Only)	98.25%	8.95	11.02

Non LGE	State Hospital	50.00%	42.25	42.25
Non LGE	Substance Abuse And Alcohol Abuse Center	99.72%	7.70	8.31
Non LGE	Therapeutic Foster Care	98.55%	14.43	15.10
Non LGE	Transition Coordination (Skills Building)	99.65%	4.40	4.90
NWLHSD	Agency	100.00%	10.67	13.67
NWLHSD	Community Mental Health Center (In-State Only)	99.97%	2.40	5.92
NWLHSD	Mental Health Clinic	100.00%	2.37	3.48
SCLHSA	Community Mental Health Center (In-State Only)	99.97%	3.32	3.49
SCLHSA	Mental Health Clinic	100.00%	4.38	4.93
SCLHSA	State/Local Entity	100.00%	8.00	8.00

13 TOTAL CLAIMS DENIED

There have been 589,978 denied claims compared to 2,848,681 paid claims, which means that denials account for 20 percent of all claims. There are multiple reasons a claim may be denied. Most frequently, a claim is denied due to errors in the submission process. Common errors include the provider submitting duplicate claims, the member being ineligible for the service submitted for reimbursement, a lack of documentation, or a lack prior authorization. Duplicate claims submission is the primary reason for claims denial at 21.6 percent), and non-covered diagnosis and patient ineligibility account for another 11.6 percent of denied claims. Please note that this requested list of items is not exhaustive of causes for claims denial.

Total Claims Denied

Denial Type	Denial Type Count	All Denial Count	% of All Denials
Lack of Prior Authorization	149,003	589,978	25.26%
Lack of Documentation	6,905	589,978	1.17%
Non-Covered Service	92,611	589,978	15.70%

14 Percentage of Members Providing Consent for Release of Information to Coordinate with Primary Care Physician

Five metrics are presented to identify the percentage of members who provide consent for the release of information for the coordination of care with the member's primary care physician (PCP) and other healthcare providers from July 1, 2013, through June 30, 2014. Four of these metrics are captured as part of the treatment record review (TRR) process for inpatient, residential substance use, outpatient and the aggregate of these three levels of care. One metric comes from a data report on referrals received from the Bayou Health plans. Below are the results from the treatment record reviews associated with this legislative request.

Percentage of Members Providing Consent for Release of Information to Coordinate with Primary Care Physician	
Total Providers Reviewed	143
Total Records in Compliance	677
Total Records Reviewed	1,376
% of Records with ROI of PCP	49.2%

A total of 143 providers were reviewed from July 2013 through June 2014 as part of TRR process. Of the 1,374 records reviewed, 677 records were in compliance for releases of information with PCPs and other healthcare providers for a total compliance rate of 49.2 percent. Magellan requires providers who score under 80 percent to submit a corrective action plan on how they intend to improve compliance with this element. Barriers to this process that have been previously identified include the lack of certainty among members as to the identity of their PCP, the inability for providers to quickly identify the PCP if the PCP is unknown to the member, the unwillingness or inability of providers to coordinate care and member refusal. The lack of a mechanism to quickly identify the member's assigned PCP was identified as the root cause of noncompliance.

Magellan is actively coordinating with Medicaid and the Bayou Health plans to address this issue. In 2015, the Department of Health and Hospitals (DHH) intends to integrate specialized behavioral healthcare with primary, physical healthcare by incorporating the LBHP into Bayou

Health. With this change, providers will have a single health plan for each Medicaid member to better coordinate care. This is anticipated to improve outcomes and allow for increased coordination of services. Throughout the integration process, Magellan will continue to monitor providers as well as referrals to and from the Bayou Health plans with the goal of increasing the coordination of care.

15 Behavioral Health in Emergency Rooms

Magellan defines unique members presenting in the emergency room (ER) as the number of unduplicated persons that receive services in the ER. Presentations equate to the number of times that these persons enter the ER for care, and the unique member may present to the ER multiple times. Likewise, a provider may submit multiple claims for each presentation for both a professional claim for services and a facility claim for overhead expenses. This explains why the number of claims exceeds the number of presentations and why the number of presentations exceeds the number of unique members as presented in Appendix XIV attached to this report.

Unique Members Presenting in ER	ER Presentations	ER Claims
27,482	32,069	64,162

16 REPORT ON QUALITY MANAGEMENT

Magellan operates the Louisiana Care Management Center (CMC) in Baton Rouge that serves as the hub of its Louisiana operations for the LBHP. Further information on the specific reporting requests made in Act 212 relative to the SMO's performance on quality management can be found in the following attached reports:

- Quality Improvement–Clinical Management (QI/CM) Program Evaluation (3/1/2013 through 2/28/2014) and
- Louisiana CMC Magellan Health Services – Magellan Behavioral Health Utilization Management Program Description for Medicaid Managed Care (3/1/2014 - 2/28/2015).

The Care Management Center resources allocated to the Quality Program are detailed within Appendix B of Magellan's QI/CM Program Evaluation report. The team consists of multiple Louisiana-based and corporate level staff with at least 16 full-time devoted personnel to quality as indicated in the table below. Complete details regarding this information can be found beginning on page 143 of the attached report.

Louisiana CMC Staff	Percent of FTE Allocated to QI
General Manager	25%
Medical Director	25%
Medical Administrator	15%
UM/CM Administrator	25%
Manager Clinical Services	25%
Supervisor Clinical Services (3)	25%
Supervisor Recovery and Resiliency Care Management (1)	25%
Director Member Service	15%
Compliance Officer	25%
Quality Management Administrator	100%
QI Manager	100%
QI Clinical Reviewer (10)	100%
QI Specialist	100%
Member Grievance Coordinator	100%
Trainer (3)	25%
QI Manager Reporting and Analytics	100%
Sr. Data and Reporting Analyst	100%

Louisiana CMC Staff	Percent of FTE Allocated to QI
Ambulatory Follow-up Supervisor	20%
Network Administrator	20%
Manager Area Contracting	15%
Network Coordinators (9)	20%
Senior Account Executive	25%
Corporate Staff	**Percent of FTE Allocated to QI**
Senior Vice President, Outcomes and Research	15%
Vice President Quality Improvement	25%
National Director, Quality Improvement	10%
National Director, Quality and Accreditation	10%
Vice President, Outcomes and Evaluations	20%
Vice President, QI Performance Measurement	10%
Chief Medical Officer – Behavioral Health	10%

The SMO used a quality committee structure for generating input and participation of members, families/caretakers and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes. Specifically, the Member Services Committee and the Family, Member, Advocate and Stakeholder Committee (FMASC) were used. As noted on page 126 of the QI/CM report, efforts were made to improve member/family member involvement in the committees during the second contract year, including member recruitment and restructuring of the FMASC.

In order to demonstrate its compliance with all the federal requirements of 42 CFR 438.240 and the utilization management requirement for the Medicaid program as described in 42 CFR 456, Magellan provided the following:

42 CFR 456:

For the purpose of meeting the mandates of federal regulation 42 CFR 456, Magellan's clinical services department includes personnel responsible for the SMO's utilization management (UM) functions. The UM program is supported at both the corporate and regional levels with designated staff and committees that include a behavioral health practitioner. Each care management center (CMC) has an independent UM committee or standing UM agenda items integrated within its quality improvement committee (QIC) to monitor the UM program for effectiveness and impact on its member population.

Guidelines have been established for density and geographic distribution based on the covered population and statewide service area. These guidelines are used by Magellan to develop and maintain a network of contracted behavioral healthcare providers from individual practitioners to facilities and programs with a wide range of expertise and clinical specialties to support member access to covered behavioral health services. Industry credentialing standards for behavioral health providers are followed, and contracted providers are made aware of the UM program activities conducted by Magellan via the *Magellan Behavioral Health Provider Handbook.*

Further details surrounding the UM program and its outcomes and measures can be found in the attached documents titled *Quality Improvement–Clinical Management (QI/CM) Program Evaluation (3/1/2013 through 2/28/2014)* and *Louisiana CMC Magellan Health Services – Magellan Behavioral Health Utilization Management Program Description for Medicaid Managed Care (3/1/2014 – 2/28/2015).*

42 CFR 438.240:

As per the requirements of 42 CFR 438.240, Magellan's QI department monitors critical performance measures on an ongoing basis to determine if opportunities for improvement can be identified due to underutilization, to assist populations with specialty healthcare needs or other statewide factors. Magellan works to enhance quality through the implementation of performance improvement projects (PIPs). PIPs are required by the Centers for Medicare & Medicaid Services (CMS) and are part of the external quality review (EQR) function of managed care. They are focused initiatives used to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement sustained over time. PIPs are specifically aimed at creating a favorable effect on health outcomes and member satisfaction. Magellan implemented the following three PIPs in the second year of its contract, which spanned SFY 2014:

1. *Improve the Number of Coordinated System of Care (CSoC) Treatment Plans with Service Authorization at First Review*

   One of the goals of CSoC is to ensure that children who are either in an out-of-home placement or at risk of out-of-home placement receive sufficient community-based services to improve their functioning and reduce the risk of future out-of-home placements. Magellan assessed the number of CSoC children with a wraparound agency (WAA) authorization and enrolled for at least 30 days who have an established plan of

care with authorization for additional CSoC services. As per the QI/CM program evaluation, in comparison with the baseline, results for the second year of the project displayed increased rates of service authorizations than in the first year. Magellan met the goal for 95 percent service authorizations at first review while improving from 95.9 percent in the first year to 96.16 percent in the second year. Magellan also more than doubled the percentage of CSoC youth with claims submitted for services from 42.6 percent in the first year to 86.42 percent in the second year (*Section V. Quality Improvement Activities and Performance Improvement Projects*, QI/CM Program Evaluation, page 50). Overall, Magellan has shown marked improvement with this PIP but continues to monitor and work toward ways to improve outcomes for Louisiana, especially to ensure members receive timely services through greater provider accountability.

2. *Improve Member Access to Emergent, Urgent and Routine Appointments*

Avoiding delays in care is essential to preventing further deterioration of a member's condition, so it is important for members to be able to access care within appropriate timeframes based on the urgency of the issue once a need is recognized. Timely access to care also impacts patient satisfaction and clinical outcomes. One of Magellan's primary functions is to ensure that members are able to promptly access behavioral health services based on the presenting issue, and so it is important for the SMO to monitor the speed with which members are able to access emergent, urgent and routine services. The LBHP identified access to care as a priority for formal performance monitoring and improvement as part of the implementation of managed care.

In response to identified barriers with the success of this PIP, Magellan has conducted internal and external trainings to members, providers and staff; implemented surveys to providers for updated information and conducted member service calls and other outreach efforts to improve appointment access and quality of care provided to members of the LBHP.

3. *Improve the Rate of Ambulatory Follow-Up after Hospitalization (AFU) for Mental Illness*

Ambulatory follow-up after inpatient treatment is an important component of care management as it ensures that any recovery or stabilization that occurred during admission is not lost and that further gains may continue in the least restrictive environment possible. In addition to clinical risks, members discharged from inpatient

treatment who fail to have adequate aftercare may be at risk of requiring readmission to inpatient settings, resulting in inappropriate utilization of high-cost, 24-hour facility services and underutilization of appropriate outpatient services. As detailed within the QI/CM program evaluation, there were a total of 15,976 members discharged from an inpatient setting with a mental health diagnosis. Of those members, 4,949 (31 percent) attended a follow-up visit within seven days, and 8,237 members (52 percent) attended a follow-up visit within 30 days (*Section V. Quality Improvement Activities and Performance Improvement Projects*, QI/CM Program Evaluation, page 59). Additional details regarding the successes, identified barriers, and corrective measures for these PIPs and their progress are outlined in the attached QI/CM program evaluation beginning on page 33.

Relative to 42 CFR 438.240's requirement that Magellan have mechanisms in place for utilization management (UM), Magellan has initiated a UM program to ensure that members receive services that are individualized, effective, least restrictive, and medically necessary. One of Magellan's goals is to decrease utilization of higher levels of care and increase appropriate utilization of home- and community-based services. Underutilization of any service could be caused by several factors, including but not limited to barriers to access, lack of member awareness of service availability, UM program issues resulting in service authorization or denial delays. Overutilization of services could indicate a lack of availability of the appropriate alternative services or provider and practitioner issues. For additional information and outcome measures of the UM program, please reference Section VIII, Evaluation of Over/Under Utilization of Services within the QI/CM program evaluation report beginning on page 70.

As per 42 CFR 438.240, Magellan also has mechanisms in place to assess the quality and appropriateness of care furnished to persons with special healthcare needs through its Recovery and Resiliency Care Management (RCM) program, which provides intensive case management to high-risk members, including children/youth who are eligible for CSoC level of care and reside in a community that is not currently a CSoC-implementing region, children age 12 and under who are hospitalized, substance using pregnant women, IV drug users, members with one or more admission for an eating disorder, members who have chronic or severe physical health and mental health co-morbid conditions, and many others. Other important activities completed by the RCM team include the Birth Outcome Initiative, crisis plan development and provider

education. Outcomes from the RCM program have been very positive over the past year as shown in the tables below.

Children	
Improvement in Psychosocial Functioning	80%
Improvement in Physical Health	60%
Improvement in Distress Symptoms	67%
Improvement in Strengths	93%
Decrease in School Missed Days	41%
Improvement in General Health	53%

Adults	
Improvement in Emotional Health	90%
Improvement in Physical Health	57%
Decrease in Work Days Missed	20%
Improvement in Behavioral Symptoms	77%
Improvement in Strengths	87%
Improvement in Provider Relationship	76%
Improvement in Confidence in Treatment	70%
Improvement in General Health	53%

The Care Management team has also made it a priority to continuously improve the care coordination activities and partnership with the Bayou Health plans. To further this objective, the RCM program has assigned multiple care managers to work specifically with the Bayou Health plans to ensure appropriate continuous care to members across systems, especially with regard to members with specialty healthcare concerns. For more information, please reference Sections X & XI of the QI/CM program evaluation regarding behavioral/medical integration activities and coordination of care activities on pages 78-84.

a) The SMO has also documented the implementation and maintenance of a formal outcomes assessment process that is standardized, relatable and valid in accordance with industry standards.

OBH established the Interdepartmental Monitoring Team (IMT) to facilitate monitoring of the LBHP waivers and state plan amendment performance measures outlined for CMS. The

IMT is composed of representatives from other state agencies, Medicaid and different sections of OBH. The IMT meets regularly and has established a schedule for reporting and accountability with Magellan, including monthly, quarterly, semi-annual and annual reporting reviews. The IMT receives reports, reviews and offers analysis and provides feedback to Magellan. This structure was developed in late 2012, and the IMT continues to refine its processes. In addition to the IMT, Magellan's Quality, Outcomes and Research Department works with members and the state to implement its *Outcomes 360* program, which is a comprehensive, integrated approach to clinical measurement and outcomes reporting. It uses quantifiable measures to track progress and identify areas for improvement. The primary components of the Louisiana CMC *Outcomes 360* are as follows:

- Consumer Health Inventory,
- Consumer Health Inventory – Child,
- Telesage Outcomes Measurement System (TOMS), and
- Child and Adolescent Needs and Strengths (CANS) Comprehensive LA.

Additional information and outcomes regarding Outcomes 360 can be found beginning on page 84 of the QI/CM program evaluation in Section XII – Clinical/Functional Outcomes Activities.

17 TOTAL FUNDING PAID FOR CLAIMS TO PROVIDERS, ADMINISTRATIVE COSTS AND PROFIT

a) Please see below for details on payments to providers in answer to part a) of question number 17 from Act 212 relative to the LBHP.

Payment of Claims to Providers	
Month of Service	**Claims Paid Amount**
2013-07	$22,538,692.87
2013-08	$23,836,689.04
2013-09	$23,555,879.93
2013-10	$27,060,742.56
2013-11	$24,866,435.02
2013-12	$24,614,223.92
2014-01	$25,490,876.22
2014-02	$25,362,755.26
2014-03	$27,104,039.68
2014-04	$27,612,589.14
2014-05	$27,787,227.19
2014-06	$25,415,410.29
Annual TOTAL	**$305,245,561.12**

b & c) In answer to requests 17(b) and (c) within Act 212, please reference the attached Merit Health Insurance Company, Schedule B Income Statement 12/31/13 and Merit Health Insurance Company, Schedule B Income Statement 6/30/14, which are semi-annual reports from Magellan's parent company, Merit Health Insurance, and detail its administrative expenses and net profit in Louisiana.

18 EXPLANATION OF PROGRAM CHANGES

a) Changes in standards or processes for submission of claims by behavioral health service providers to the SMO

In 2013, Magellan revamped processes to require that all provider claims for Assertive Community Treatment (ACT) services be submitted via a standard claims-submission process. This was a change from the prior process of accepting an encounter document, which required manual payment. This change in claims submission processes for these services has improved payment controls and reduced the administrative tasks required to process payment.

b) Changes in types of behavioral health services covered through the SMO

Changes to services within the LBHP have been primarily achieved through in lieu of agreements with Medicaid. In lieu of services are authorized under 42 CFR 438.6 and are allowed only for capitated health plans. This allows Magellan's capitated managed care plan, which is only for adults, to provide health-related services under the capitated rate in place of state plan services if it is more cost-efficient or effective. There have been two in lieu of agreements in SFY 2014 including:

1) *Allow 21-year-old members in CSoC to also receive 1915(i) services*: Starting in October of 2013, this approved process change allows youths aged 21 receiving CSoC services who by definition have aged out of early and periodic screening, diagnosis and treatment (EPSDT) services to be eligible for 1915(i) complementary services. Many youths aged 21 can benefit from the community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) services available to Medicaid adult members.
2) *Allow the use of crisis intervention services by all Medicaid adults*: This approved change in May of 2014 allows crisis intervention services to be payable to all Medicaid enrolled adults. Previously, crisis intervention services were only available to 1915(i)-eligible adults. However, crisis intervention has a positive impact on reducing the need for hospitalization. Therefore, the rationale for the change is to reduce the need for emergency room and psychiatric inpatient stays by making 24/7 services available to all adult Medicaid members in need.

a) Changes in reimbursement rates for covered services

In anticipation of contract year three for the LBHP, certain capitation rates were readjusted in order to fall within the actuarially sound rate range as required by the contract. This adjustment was budget-neutral and had no impact on overall funding.

Medicaid Eligibility Group	Actuarially Adjusted Rate 3/1/13-2/28/14	Actuarially Adjusted Rate 3/1/14-2/28/15
Non-Disabled Adult, Ages 21-64	$18.66	$20.05
Disabled Adults, Ages 21-64	$64.23	$63.26
Aged, 65+	$8.92	$8.72

Additionally, in the summer of 2013, Magellan opted to implement two rate increases:

1) *Medication management rate:* Increase in the reimbursement rate to contracted prescribers with the intended outcome of improving access to care and preventing an erosion of the prescriber network. Increases were applied to CPT codes 99211-99215 and amounted to an approximate 70 percent increase in pre-visit reimbursement.
2) *Case conference rate:* Increase in the reimbursement rate to contracted providers eligible to deliver case conference services. Case conference represents a critical component of community-based case management services, and the prior reimbursement was insufficient to incentivize interested providers/agencies. The rate was increased approximately 70 percent for a 30-minute unit of service.

19 ADDITIONAL METRICS/MEASURES

The State has been able to expand the service array with many new service types. With the federal match associated with these services DHH is able to better capitalize on its available state general fund dollars. These services are shifting the behavioral health care landscape with a focus on building a continuum of care. In addition to the expanded service array allowable under Medicaid through the LBHP, new providers are also able to bill for allowable services under the LBHP. Expansion to new providers primarily consisted of licensed mental health professionals (LMHPs) and new facilities/agencies. In addition to the comparative list below, some outpatient facilities are also newly allowed to bill for behavioral health services under the LBHP expansion:

Pre-LBHP Implementation	Post-LBHP Implementation
Psychiatrists	Psychiatrists
Psychologists (limited)	Psychologists (expanded)
Social workers (limited)	Social workers (expanded)
Licensed clinical social workers (limited)	Licensed clinical social workers
Community mental health centers	Community mental health centers
Mental health rehabilitation programs	Mental health rehabilitation programs
Multi-systemic therapy (MST)	Multi-systemic therapy (MST)
	Licensed addiction counselors
	Licensed professional counselors
	License marriage and family therapists
	Functional family therapy providers
	Substance use treatment facilities
	Therapeutic group homes
	Psychiatric residential treatment facilities
	School based health clinics
	Certified addictions counselors, advanced practice registered nurse and other masters therapists (limited)

Some additional highlights on Magellan's functionality within the LBHP are:

- the coordination of care for members, including referral, assistance with eligibility, treatment planning, utilization review, follow-up care, assistance with discharge planning and placement and peer support;
- the provision of a free electronic behavioral health record to all eligible providers that also serves as the State's system for the uninsured;
- the provision of intensive case management for people with special health care needs, such as pregnant women with addiction disorders or women with dependent children with co-occurring disorders;

- the management of dollars spent in the system to focus on community-based care;
- the performance of a quality review of providers and provision of technical assistance to improve care;
- the investigation of complaints of fraud and/or abuse;
- the processing and payment of claims for services for both adult and child populations within Medicaid, as well as those additional services funded through the Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ; and
- the fostering of system transformation with programs that include:
  - cultural competency standards and training;
  - recovery, resiliency and peer support;
  - Magellan Youth Leaders Inspiring Youth Empowerment (MyLIFE) for youth, a peer-based support group;
  - support for families and
  - liaisons specialized to DCFS, OJJ and DOE.

APPENDICES