MAGELLAN HEALTH SERVICES

QUALITY IMPROVEMENT – CLINICAL MANAGEMENT

PROGRAM EVALUATION

FOR

Louisiana Care Management Center
March 1, 2013-February 28, 2014

APPROVED BY LOUISIANA CMC QUALITY IMPROVEMENT COMMITTEE ON AUGUST 14, 2014

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EXECUTIVE SUMMARY

The Magellan Louisiana Care Management Center conducts an annual evaluation of its Quality Improvement Program to evaluate outcomes; review effectiveness; assess goal achievement; evaluate the deployment of resources; document and trend input from advisory groups, including members, family members and other stakeholder; and to identify opportunities for improvement in the ongoing provision of safe high-quality care and service to members. The evaluation covers a fully integrated quality program including recovery/resiliency-focused clinical and medical integration programs. This report summarizes the evaluation findings from the Louisiana Care Management Center data from March 1, 2013 through February 28, 2014. In addition, this report assesses progress towards the goals and prioritized objectives set forth in the previous year's Louisiana CMC quality improvement program description, work plan and program evaluation while insuring that the spirit of the Louisiana CMC's mission was realized.

The Program Evaluation is an internal practical document used by Magellan of Louisiana to analyze its current status compared to performance and program goals, identify barriers or challenges as well as opportunities for improvement, and then to 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 State's Quality Improvement Strategy as well as those found on pages 88-92 of the Louisiana Behavioral Health Partnership Request for Proposal, and provides a summary of the prior year's initiatives.

Key Accomplishments

Key accomplishments during the previous year identified as a result of the development of this evaluation include:

- Served 150,791 unduplicated members during the second contract year, an increase of 5.5% from the first contract year (142,923)
- Increased unduplicated practitioner provider network 325% since implementation on March 1, 2012 (3/2012: n=571; 3/2014=2,428)
- Received full URAC accreditation, effective to January 1, 2017
- Met goals for all Performance Guarantees for telephone responsiveness, claims administration, clinical, and satisfaction outcomes
- Answered 99,578 calls with a 17-second average speed of answer (ASA) and a 2.57% abandonment rate, meeting contractual performance guarantee goals for telephonic responsiveness
- Improved both member and provider satisfaction. Member satisfaction increased from 82.5% for contract year one to 84.5% in contract year two. Provider satisfaction improved from 80.2% to 87.6%

- Attained penetration rate of 11.16%, for minor members (21 or younger), which is 4.4 percentage points higher than the SAMHSA Medicaid average penetration rate of 6.7% for children receiving behavioral health services
- Increased current enrollment in the Coordinated Systems of Care (CSoC) by 48.6% when comparing end of contract year data
- Expanded Coordinated System of Care (CSoC) services providers by 26% since the beginning of the partnership; the remaining four regions are scheduled for implementation in 2014.
- Reduced readmission rate by 23% for 6 high-volume facilities
- High-utilizer rounds resulted in 58% fewer bed days for top 30 identified bed day members Realigned both internal and external processes and procedures to meet federal waiver requirements, including launch of initial Independent Assessment/Community Based Care Management (IA/CBCM) phase and completion of all required reporting
- Increased utilization of Assertive Community Treatment by 66.79%, with 2305 unique members receiving services
- Processed more than 900 Permanent Supportive Housing Independent Assessments and helped move a total of 250 members to Medicaid 1915i eligibility while actively managing the authorizations of all 2,878 members in PSH.
- Partnered with LSU Health Sciences Center and Tulane departments of psychiatry to provide trainings in Child-Parent Psychotherapy (CPP-LSU) and Parent Management Training (PMT-Tulane) to improve clinical program for our 0 – 6-year-old members
- Increased the total number of contracted prescribers by 27% and the number of contracted psychiatrists by 27.8% since implementation
- Recognized by the Attorney General (AG) of Louisiana for best practices in reporting Fraud, Waste, and Abuse (FWA); increased number of FWA reports submitted to the AG (12 in contract year one and 36 in contract year two) by 200%, with 15 reports being actively pursued by the AG
- Received a total of 960 members referrals from the Bayou Health Plans as a result of the implementation of a standardized referral process
- Implemented Consumer Health Inventory (CHI) pilot with providers to promote utilization of valid and reliable outcomes tools.

Program Focus and Prioritized Objectives for 2014-15

Based on a review of:

- Progress towards 2013-14 program goals,
- Lessons learned,
- An assessment of the identified opportunities for improvement and their root causes,
- An increased understanding of the need for timely identification of critical variables and their root causes (barriers) in order to identify and implement effective interventions,

- Customer feedback and contractual requirements, and
- Member, family member and stakeholder input

The following lists include the **prioritized goals and objectives**[1] for the Louisiana CMC for contract year 2014-15.

1. **Positively influencing Health and Well being, including patient safety**
   - To foster individualized adult, youth and family-driven behavioral health services through increased access to a full array of evidence-based in-home and community services that promote hope, recovery and resiliency.
   - Improve member functioning, daily living and social skills and reduction in symptom severity.
   - Reduction in the current number and future admissions of adults and youths with significant behavioral health challenges to restrictive settings outside their home through the increased use of in-home and community services.

2. **Enhancing Service and the Experience of Care**
   - Improve quality of care by establishing and measuring outcomes.
   - Promote use of culturally competent, holistic approaches to people's lives
   - Increase provider accountability.

3. **Meeting and exceeding contractual, regulatory and accreditation requirements**
   - Manage the state's cost of providing services by using resources in the most effective manner possible.
   - Increase provider compliance with federal waiver and state plan amendment requirements
   - Maintain adherence to URAC accreditation standards.

To accomplish these goals, the following **prioritized objectives** were determined by the Louisiana CMC.

1. Provide evidence-based and best practice models by engaging providers to improve clinical outcomes through models/programs, such as Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Family Functional Therapy (FFT), Homebuilders®, and Hi-Fidelity Wraparound
2. Improve follow up after hospitalization 7-day rates greater than 28% and 30-day rates greater than 48%.
3. Promote early identification and intervention of behavioral health needs and early identification of at-risk children (e.g., EPSDT screening, CANS).

[1] NCQA 2014 MBHO QI 1 Element A #6; URAC UM Version 7.0 Core; URAC CM Version 4.1 Core 20

4. Increase member access to peer support and crisis services.
5. Preserve member experience of care at greater than or equal to 83%.
6. Advance cultural competency initiatives for provider network through increased trainings and provider monitoring.
7. Establish reporting processes for ongoing oversight and outcomes monitoring of highly utilized services.
8. Expand performance-based provider initiatives to increase provider accountability for outcomes.
9. Provide ongoing oversight and compliance monitoring of Home and Community Based Service (HCBS) providers.
10. Maintain or improve all performance measures; no decrease in current measurement results.

ACKNOWLEDGMENT AND APPROVAL

The 2013-14 Quality Improvement and Utilization Management Program Evaluation was prepared by the LA CMC and reviewed and approved by the Quality Improvement Committee during its meeting on August 14, 2014 as indicated by the signature(s) below:

Name	Date
Richard Dalton, MD Chief Medical Officer Co-Chair, Quality Improvement Committee	

Name	Date
Wendy Bowlin, MS, LPC, MBA Quality Management Administrator Co-Chair, Quality Improvement Committee	

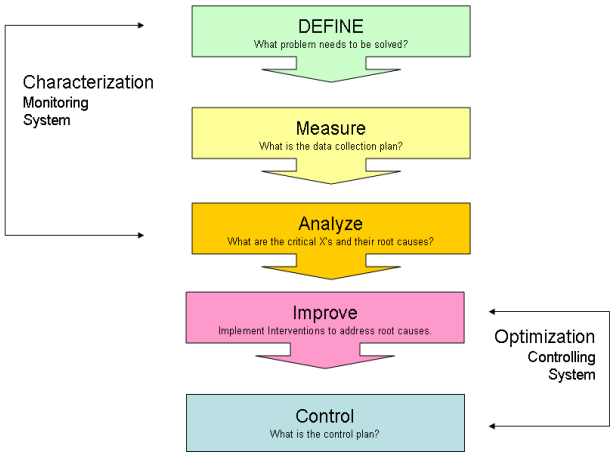
I. OVERVIEW

The Magellan Health Services (Magellan) LA CMC manages recovery and resiliency, mental health/substance use services in a variety of settings delivered by providers from several disciplines. The lines of business served by the Magellan LA CMC include Medicaid coverage and populations identified as part of the Louisiana Behavioral Health Partnership (LBHP). The LBHP includes the Office of Behavioral Health (OBH), the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ), and the Department of Education (DOE). The LA CMC's quality program is comprehensive and covers the following product lines: Behavioral Care Management and Recovery and Resiliency Care Management. In addition, the LA CMC manages the Permanent Supportive Housing and Coordinated System of Care programs for eligible members.

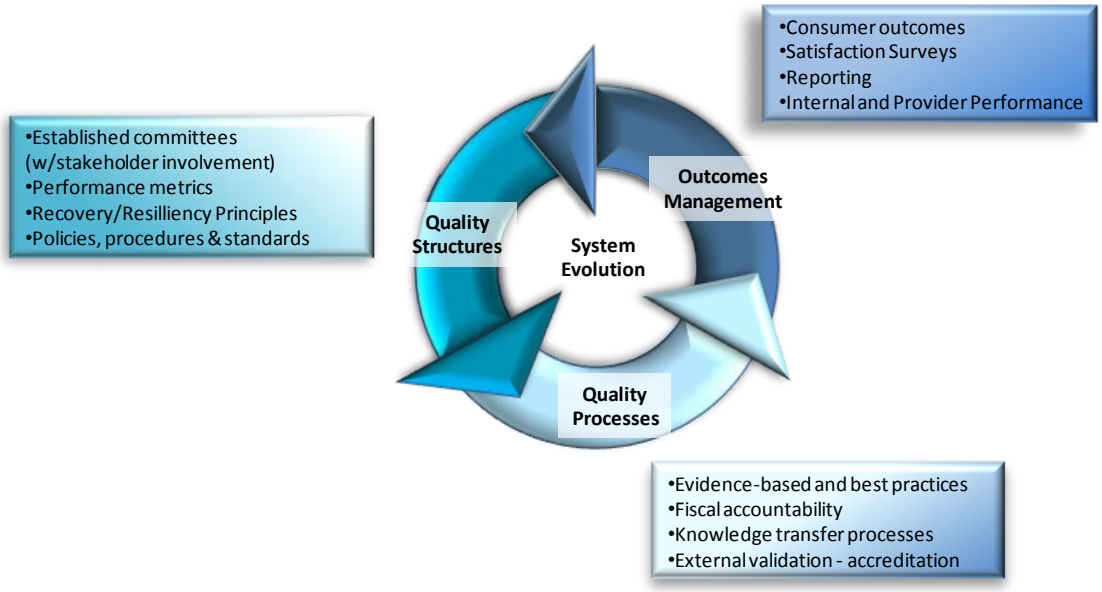
The scope of the Quality Improvement (QI) program includes the objective and systematic monitoring of the quality of behavioral health and related recovery and resiliency services provided to the members of the customer organizations served by Magellan. The LA CMC QI Program is the direct responsibility of the LA CMC Chief Executive Officer. The QI program is managed by the Quality Management Administrator who is supported by regional and corporate staff. Local oversight of the QI program is provided by the LA CMC Quality Improvement Committee (QIC). Corporate oversight of the QI program occurs through a corporate committee structure.

Quality Process at the Louisiana Care Management Center

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



QI committee oversight is a crucial component of the LA CMC approach to overall systems transformation and evolution. When coupled with other mechanisms, as illustrated below, it results in systems evolution and the development of a *culture of quality.* Please see Section II of the LA CMC Quality Improvement Program Description for further description of the quality improvement committees and processes in place at the LA CMC.



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

II. Population Description: Demographics, Cultural Competency Assessment and Diagnostic Prevalence

Magellan conducts an annual population assessment to provide an expansive review of the LBHP members in order to enable the Louisiana Care Management Center (LA CMC) to make informed improvements and/or enhancements to ongoing and planned quality and service initiatives and programs. As part of the overall goal to maintain and enhance the quality of service provided to the LA CMC members, the Quality Improvement Department amasses data from a variety of sources to develop a comprehensive enrollee population assessment each year. The specific purpose of this assessment is twofold. First, it serves as a tool to determine appropriate quality improvement (QI)

initiatives for the coming year. Second, the findings enable the LA CMC to make informed and effective improvements to ongoing QI activities.

The data presented provides a summary of the demographic analysis of the members served by the LA CMC. Because a majority of the members served are funded through Medicaid, the Medicaid eligible population was used as a comparison group to determine if the members being served by the LA CMC were representative of the full population. This approach provides as complete a demographic profile as possible with the intent to understand LA CMC members' characteristics. All data is provided via the Medicaid feed. The following is a list of the demographic variables analyzed by source:
Data reviewed in this report are:

- Population
- Race/Ethnicity
- Age
- Gender
- Language
- Geo-Access Reports
- Information from Translation Service
- Top mental health diagnoses for age groups
- Member Satisfaction survey responses
- Armed Forces managed care members

The LA CMC served a total of 150,791 unique members (unduplicated members with at least one claims received) during the period from March 1, 2013 to February 28, 2014. This is a 5.5% increase over the number of members served in the first contract year (n=142,923). This equates to a penetration rate of 12.76% of the Medicaid eligible population (n=1,181,746). The penetration rate for minor members (21 or younger) was 11.16% and adults over 21 had a penetration rate of 16.67%. In 2008, SAMHSA stated the national penetration rate for the Medicaid child population that received behavioral health care, including mental health and/or substance use disorder (SUD) services and/or psychotropic medications, was 9.6%. When children who only received psychotropic medications were removed, the rate decreased from 9.6% to 6.7%. In comparison, the current data demonstrates the LA CMC is serving the Medicaid population at a rate higher than that seen across the national standards. Please see Section VIII Evaluation of Over/Under Utilization of Services for a more detailed analysis of utilization.

It is vital for the LA CMC to evaluate demographic information of the members served to make informed improvements and/or enhancements to ongoing and planned quality and service initiatives and programs. As part of the overall goal to maintain and enhance the quality of service provided to the LA CMC members, the Quality Improvement Department amasses data from a variety of sources to develop a comprehensive enrollee population assessment each year. The specific purpose of this

assessment is twofold. First, it serves as a tool to determine appropriate quality improvement (QI) initiatives for the coming year. Second, the findings enable the LA CMC to make informed and effective improvements to ongoing QI activities. Demographics for Age, Gender, Veterans Status, Regions, Diagnostic Prevalence, Race, and Ethnicity are included in the evaluation to provide insight into the members served by the LA CMC. The metrics are based on claims data from March 1, 2013 to February 28, 2014. The report was run on May 30, 2014 to account for claims lag.

The tables below present summary demographic information for the LA Medicaid population.

Age

AGE	MED_ELIG	% OF MDC ELIG	SERVED	% OF SERVED
0 - 5	316,733	26.80%	5,520	3.66%
6 - 12	282,587	23.91%	32,112	21.30%
13 - 17	174,697	14.78%	31,508	20.90%
18 - 21	64,916	5.49%	24,495	16.24%
22 - 64	282,552	23.91%	51,876	34.40%
65+	60,261	5.10%	5,280	3.50%
Total	1,181,746		150,791	

The age categories for the members served can be considered relatively representative of the Medicaid eligible population. The 13-17 and 22-64 age categories show some elevation in representation in the members served; however, Magellan has implemented interventions, such as Coordinated Systems of Care and Independent Assessors/Community Based Care Managers, to ensure members with Severe and Persistent Mental Illness and Severe Emotional Disturbance have access to services. Please refer to **Section XVIII Behavioral Continuum (System Transformation)** for more information on these interventions. The group with the greatest disparity between those eligible and served is the children 0-5 group. This group represents 3.66% of the members served despite representing 23.91% of the Medicaid eligible population. Although national prevalence rates are not specific to this age group, many diagnoses outside of neurodevelopmental disorders cannot be made until at least the age of 3. This may explain the lower number of members served. Magellan does recognize the importance of ensuring providers have the necessary training to treat this unique, vulnerable population. Magellan has partnered with local universities to provided special training on two evidence-based practices, Child-Parent Psychotherapy (CPP), and Parent Management Training, to ensure providers have the required skills to treat this age group. More details on this initiative can be found in **Section XVII Evidence- and Best Practice Initiatives.**

Gender

GENDER	Medicaid Eligible	% OF MDC ELIG	SERVED	% OF SERVED
Female	669,464	56.65%	74,716	49.55%
Male	511,915	43.32%	71,377	47.34%
Unknown	367	0.03%	3,428	2.04%
Missing	0	0%	1,270	0.75%
Total	1,181,746		150,791	

	Contract Year 1		Contract Year 2	
Gender	**Frequency**	**Percent**	**Frequency**	**Percent**
Female	61829	48.3%	74,716	49.55%
Male	59384	46.4%	71,377	47.34%
Other	2	0.0%	0	0.0%
Unknown	5792	4.5%	3,428	2.04%
Missing	896	0.7%	1,270	0.75%
Total	127903	100.0%	109,229	100.0%

Females represent 56.65% of the Medicaid eligible population and 49.55% of the members served population, which is a slight underrepresentation. Males represent 43.32% of the Medicaid eligible population and 47.34% of the members served population, which is a slight overrepresentation. Unlike the Medicaid eligible population, there are approximately 3% of missing or unknown data that could skew this variable. Percentage of utilization of behavioral health services showed a slight increase by both the male and female gender between the two contract years. There was also a reduction of unknown and missing data of 2.4 percentage points. Magellan will continue to monitor into contract year 3 to determine if this is an opportunity for improvement that requires interventions to improve accessibility to the female gender population.

Veteran Status

VETERAN_STATUS	MED_ELIG	% OF MDC ELIG	SERVED	% OF SERVED
Unknown	1,134,141	95.97%	102,913	68.25%
No	47,277	4.00%	47,369	31.41%
Yes-No Active Duty	193	0.02%	339	0.22%
Yes-Active Duty Unknown	113	0.01%	139	0.09%
Yes	16	0.00%	19	0.01%
Yes -Active Duty	6	0.00%	12	0.01%
Total	1,181,746		150,791	

Data for veteran status is skewed since 68.25% of data regarding veteran status is 'unknown'. There is even less known data for the Medicaid eligible population as 95.97% is 'unknown'. The United States Census listed Louisiana's estimated population in 2013 at 4,625,470. The National Center for Veterans Analysis and Statistics reported that Louisiana had a total of 315,342 veterans as of September 30, 2013. This represents 6.82% of the population. Although the unknown data distorts this variable, it is believed that veterans are underrepresented in the Medicaid population because they are served through other avenues (e.g., Veterans Administration providers).

Data by Region

REGION	MED_ELIG	% OF MDC ELIG	SERVED	% OF SERVED
Capitol Area Human Service District	154,720	13.09%	19,488	12.92%
Metropolitan Human Service District	120,231	10.17%	18,671	12.38%
Florida Parishes Human Service Authority	126,294	10.69%	16,671	11.06%
South Central Louisiana Human Service Authority	100,021	8.46%	15,810	10.48%
Acadiana Human Services District	155,648	13.17%	15,705	10.42%
Northwest Louisiana Human Services District	142,228	12.04%	14,264	9.46%
Jefferson Parish Human Service Authority	102,176	8.65%	13,920	9.23%
Northeast Delta Human Services District	103,719	8.78%	13,878	9.20%
Central Louisiana Human Services District	83,203	7.04%	9,788	6.49%
Imperial Calcasieu Human Service Authority	73,309	6.20%	9,547	6.33%
UNKNOWN	20,197	1.71%	3,049	2.02%
Total	1,181,746		150,791	

Regional data supports that most of the regions are adequately represented in the members served population. Acadiana and Northwest Louisiana Human Services Districts do show slight underrepresentation. These are both considered to provide services to mainly rural areas, which could impact utilization. Magellan actively works through its network development strategy to recruit providers in these areas to ensure penetration and utilization of services for rural members.

Diagnostic Prevalence

The LA CMC evaluates diagnostic prevalence for inpatient and outpatient levels of care. Because inpatient level of care provides care for higher acuity levels, it is believed that level of care is a confounding variable that could extraneously affect the data and thus should be evaluated separately.

Top Ten Inpatient Diagnostic Categories (Minor/Adult Populations)

Value	DIAGNOSIS	Population	Members Served	% of Top 10 Diagnosis	% of Population
0-17					
0 - 17	311-Depressive disorder, not elsewhere classified	774,017	1,717	24.44%	0.22%
0 - 17	296.90-Unspecified episodic mood disorder	774,017	1,522	21.66%	0.20%
0 - 17	296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	774,017	867	12.34%	0.11%
0 - 17	296.20-Major depressive affective disorder, single episode, unspecified	774,017	759	10.80%	0.10%
0 - 17	312.30-Impulse control disorder, unspecified	774,017	524	7.46%	0.07%
0 - 17	296.23-Major depressive affective disorder, single episode, severe, without mention of psychotic behavior	774,017	456	6.49%	0.06%
0 - 17	296.80-Bipolar disorder, unspecified	774,017	383	5.45%	0.05%
0 - 17	298.9-Unspecified psychosis	774,017	326	4.64%	0.04%
0 - 17	312.34-Intermittent explosive disorder	774,017	267	3.80%	0.03%
0 - 17	314.9-Unspecified hyperkinetic syndrome	774,017	205	2.92%	0.03%
18+					
18+	296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	407,729	2,175	16.64%	0.53%
18+	295.70-Schizoaffective disorder, unspecified	407,729	2,014	15.40%	0.49%
18+	298.9-Unspecified psychosis	407,729	1,348	10.31%	0.33%
18+	295.34-Paranoid type schizophrenia, chronic with acute exacerbation	407,729	1,205	9.22%	0.30%
18+	295.74-Schizoaffective disorder, chronic with acute exacerbation	407,729	1,182	9.04%	0.29%
18+	311-Depressive disorder, not elsewhere classified	407,729	1,181	9.03%	0.29%
18+	296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	407,729	1,129	8.64%	0.28%
18+	295.30-Paranoid type schizophrenia, unspecified	407,729	1,083	8.28%	0.27%
18+	296.20-Major depressive affective disorder, single episode, unspecified	407,729	908	6.95%	0.22%
18+	295.32-Paranoid type schizophrenia, chronic	407,729	849	6.49%	0.21%

Depressive disorders account for 54% of the 0-17 population in the inpatient setting. Eighty-one percent of the diagnoses fall into the category of Mood Disorders. Only 14.18% of the 0-17 population had a primary diagnosis of Impulse Control Disorder, Intermittent Explosive Disorder, and unspecified hyperkinetic syndrome, which will account for a majority of the diagnoses at the outpatient level of care. Schizophrenia spectrum and other psychotic disorders account for 58.74% of the disorders for 18+ members. Depressive disorders account for 41.26%. The LA CMC monitors Clinical Practice

Guidelines (CPGs) for Schizophrenia, Depressive Disorders, ADHD, and Suicide Risk while conducting Treatment Record Reviews to ensure compliance with best treatment practices for these diagnoses.

Top Ten Outpatient Diagnostic Categories (Minor/Adult Populations

Value	DIAGNOSIS	Population	Members Served	% of Top 10 Diagnosis	% of Population
0 - 17					
0 - 17	314.01-Attention deficit disorder with hyperactivity	774,017	27,044	46.96%	3.49%
0 - 17	313.81-Oppositional defiant disorder	774,017	7,254	12.60%	0.94%
0 - 17	311-Depressive disorder, not elsewhere classified	774,017	5,096	8.85%	0.66%
0 - 17	296.90-Unspecified episodic mood disorder	774,017	3,395	5.90%	0.44%
0 - 17	314.00-Attention deficit disorder without mention of hyperactivity	774,017	3,254	5.65%	0.42%
0 - 17	312.9-Unspecified disturbance of conduct	774,017	3,029	5.26%	0.39%
0 - 17	300.00-Anxiety state, unspecified	774,017	2,519	4.37%	0.33%
0 - 17	309.9-Unspecified adjustment reaction	774,017	2,286	3.97%	0.30%
0 - 17	314.9-Unspecified hyperkinetic syndrome	774,017	1,881	3.27%	0.24%
0 - 17	309.4-Adjustment disorder with mixed disturbance of emotions and conduct	774,017	1,829	3.18%	0.24%
18+					
18+	311-Depressive disorder, not elsewhere classified	407,729	4,700	14.00%	1.15%
18+	295.70-Schizoaffective disorder, unspecified	407,729	4,167	12.42%	1.02%
18+	300.00-Anxiety state, unspecified	407,729	4,079	12.15%	1.00%
18+	295.30-Paranoid type schizophrenia, unspecified	407,729	3,608	10.75%	0.88%
18+	296.33-Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	407,729	3,401	10.13%	0.83%
18+	296.80-Bipolar disorder, unspecified	407,729	3,183	9.48%	0.78%
18+	298.9-Unspecified psychosis	407,729	2,960	8.82%	0.73%
18+	296.32-Major depressive affective disorder, recurrent episode, moderate	407,729	2,726	8.12%	0.67%
18+	295.90-Unspecified schizophrenia, unspecified	407,729	2,503	7.46%	0.61%
18+	296.34-Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior	407,729	2,237	6.66%	0.55%

Attention Deficit Disorders accounts for more that half of the diagnoses for the 0 – 17 population in the outpatient levels of care (55.88%). Disruptive, impulse-control, and conduct disorders account for 17.86% and Mood Disorders account for 19.12%. Approximately 7% of the diagnoses are for Adjustment Disorders. Schizophrenia spectrum and other psychotic disorders account for 39.45% of the disorders for 18+ members in the outpatient setting. Mood disorders account for 60.54% with 38.91%

represented by Depressive disorders. As stated previously, the LA CMC monitors Clinical Practice Guidelines (CPGs) for Schizophrenia, Depressive Disorders, ADHD, and Suicide Risk while conducting Treatment Record Reviews to ensure compliance with best treatment practices for these diagnoses. Diagnostic prevalence was also analyzed by gender and race but there were no notable differences in the top 10 diagnoses.

Race and Ethnicity

Racial and ethnic diversity within the LA CMC member population is another important consideration in an effective managed care initiative. Standards have been established to promote the availability of behavioral health care practitioners and providers based on the assessed needs and preferences of its enrollee population. It is important there be sufficient numbers and types of behavioral health care practitioners and providers conveniently located to serve the assessed needs and preferences of the covered population. In other words, the mix of practitioners and providers should be logically related to the known demographic characteristics of the covered population.

RACE	Medicaid Eligible	% OF MDC ELIG	SERVED	% OF SERVED
BLACK/AFRICAN AMERICAN	613,037	51.88%	62,677	41.57%
WHITE	449,003	37.99%	57,382	38.05%
UNKNOWN	98,195	8.31%	26,580	17.63%
Unidentified	14	0.00%	2,566	1.70%
AMERICAN INDIAN/ALASKAN NATIVE	4,196	0.36%	520	0.34%
Multi-Racial	3,698	0.31%	439	0.29%
ASIAN	12,683	1.07%	378	0.25%
OTHER SINGLE RACE	216	0.02%	201	0.13%
NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER	704	0.06%	48	0.03%
Total	1,181,746		150,791	

ETHNICITY	MED_ELIG	% OF MDC ELIG	SERVED	% OF SERVED
NON-HISPANIC OR NON-LATINO	1,085,144	91.83%	119,755	79.42%
UNKNOWN	53,959	4.57%	29,162	19.34%
HISPANIC OR LATINO	42,643	3.61%	1,874	1.24%
Total	1,181,746		150,791	

Unknown and unidentified data plays a significant role when analyzing race and ethnicity. Unknown data accounts for 17.63% of the race data and 19.34% of ethnicity data. It is difficult to determine if underrepresented populations (e.g., Black/African American, Hispanic or Latino) are truly

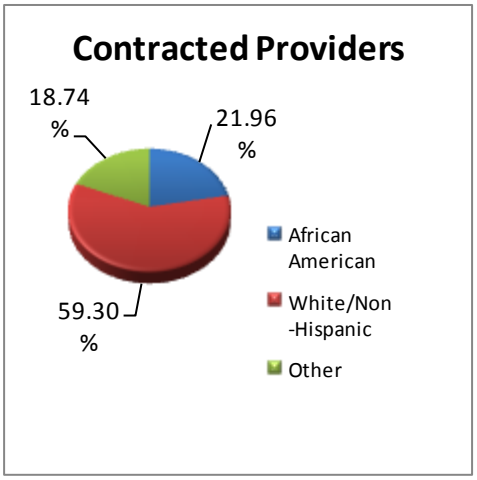
underrepresented with such large amounts of unknown data skewing the results. Because of this, the LA CMC looks at number of factors, including the consumers' perceptions of the "cultural competence" of the network. Analyses of satisfaction surveys of enrollees who have accessed mental health services as well as analysis of comment/complaint data and use of translation services are used to measure these issues. There was no member grievances received from March 1, 2013-February 28, 2014 related to ethnic/cultural or linguistic issues as perceived and reported by the enrollee.

Provider Network Demographics

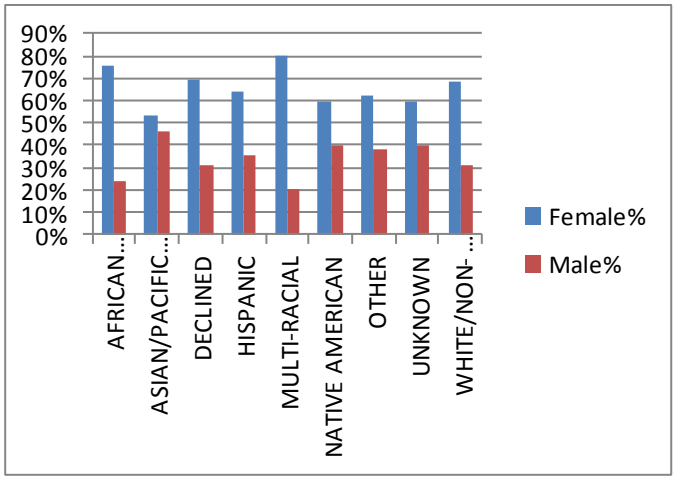
A comparable ratio of staff to diversity in the community can positively impact members. It not only broadens the provider's understanding of the community they work with, it also helps bridge possible mistrust or historical trauma experienced by diverse populations.

The following are graphical representations of contracted practitioners by race and gender (includes self reported data provided by practitioners).

Providers by Race



Providers by Race & Gender



African Americans comprise over half of the members served; however, African American practitioners consisted of less than 22% of the practitioners. Magellan implements a comprehensive program to educate providers on the cultural differences to better ensure services are delivered in a culturally competent manner. Also it was noted that many of the members served by the LBHP receive services via facilities rather than practitioners, which is not reflected in the above data. It is believed that including facility roster staff data will improve reporting capabilities to measure the ratio more accurately. In contract year three, Magellan will create fields for race/ethnicity, gender, and language preference when collecting demographic information for facility roster staff. Magellan will conduct

provider outreach to ensure providers input data. This intervention will allow Magellan for more accurate analysis of the ratio of staff to diversity in the community.

Language Needs

As the state's population continues to grow (2.0% growth from 4/1/10 to 4/1/13) we will see an increase of members whose preferred language may not be English. Magellan monitors its practitioner network and tracks the languages spoken in order to meet identified member needs whenever possible. There are 117,240 people in Louisiana who speak Spanish at home. Of those who speak Spanish at home 43% indicated they speak English less than "very well." Members whose preferred language is not English may have a difficult time describing their challenges with practitioners. It is essential to have staff that can accommodate the members' needs.

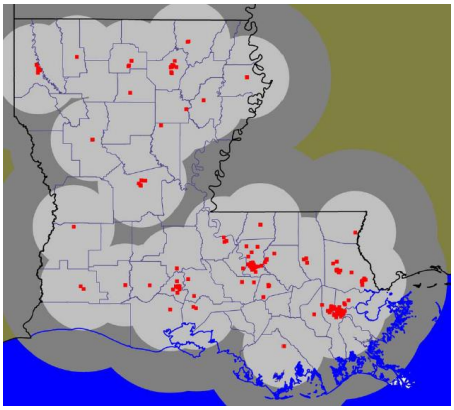
Magellan providers offer 16 language services. Spanish is the second most spoken language used by members other than English. The Geo Map below represents Spanish language services by LBHP providers available to members across the state. The dark gray spheres indicate the 60 mile radius of coverage.

Translation/Interpretation Services

Magellan ensures that members have access to translation or interpretative services at no cost to the member. Magellan contracts with Global Interpreting Network for translation services. In 2013 Global reported 93 appointments for American Sign Language (ASL) interpretation services and 59 appointments for Spanish language interpretation services.

Geo Map – Spanish Language Providers

There are 42 providers at 62 locations who offer Spanish language services. The following picture shows the geoaccess map for providers offer Spanish language services.



Although not everyone as access to a provider offering Spanish language services, Magellan does offer Translation/Interpretation Services to all members. As referenced above, there were only 59 requests for Spanish translation during contract year two. Magellan also tracks member grievances to identify if there are issues related to language. Magellan did not receive any grievances regarding this in contract year two.

Satisfaction Survey Results

Quality of care is a key ingredient in managing health plan costs and keeping members satisfied with health plan services and outcomes. Member satisfaction surveys remain the most practical way to assess consumer perceptions of quality and outcome of care. Such surveys are a major component in the managed care industry's determination of performance and are also of practical importance in planning, administration and evaluation of health services. Magellan measures member satisfaction annually through its Member Satisfaction Survey. The objectives of the satisfaction survey are to:

- Measure and assess trends in member perceptions of mental health and substance use care and service delivery as provided by Magellan and members of the participating provider network;
- Identify the areas most favorably rated, as well as opportunities for improvement; and
- Gather information on key features using a valid standardized instrument for ongoing comparison and quality improvement activities. The tool obtains the members' evaluations on specific features of care with respect to:
  - Access to care
  - Accuracy and effectiveness of communication between and therapist
  - Sensitivity to
  - Confidentiality
  - Interpersonal care
  - Outcomes of care

Evaluations are also made on Magellan's managed care delivery and administration of services, such as access to services, availability and convenience. General satisfaction measures cover members' opinions on overall quality of care. In 2013, the survey sample size consisted of 2,500 adults and 2,500 minor clients who requested treatment between 07/01/2013 and 09/30/2013.

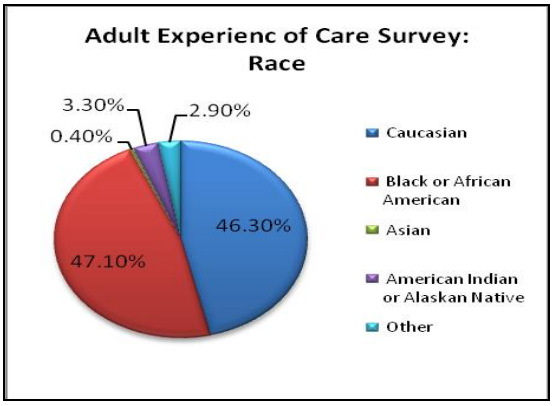
For the second contract year, the response rate was 12.6%. For the question, "If you contacted Magellan, how satisfied are you with the help you got to connect with the services you received? 82.4% of respondents were satisfied, which met the goal of 80%. Also, the overall satisfaction was 84.5%. This was two percentage points higher than contract year 1.

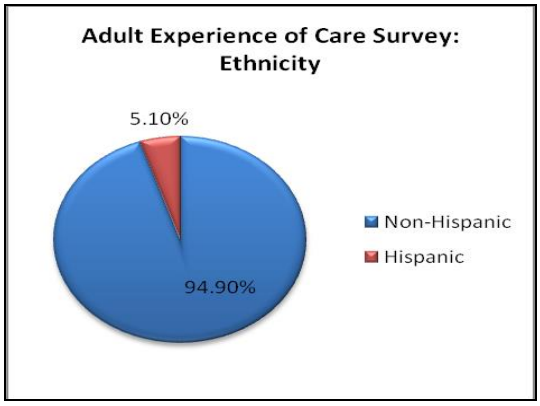
The questions listed below related to access of service, did not meet the 80% goal:

- Member was able to see a psychiatrist when he/she wanted to. (Q13)
- I was able to get all the services I thought I needed. (Q12)

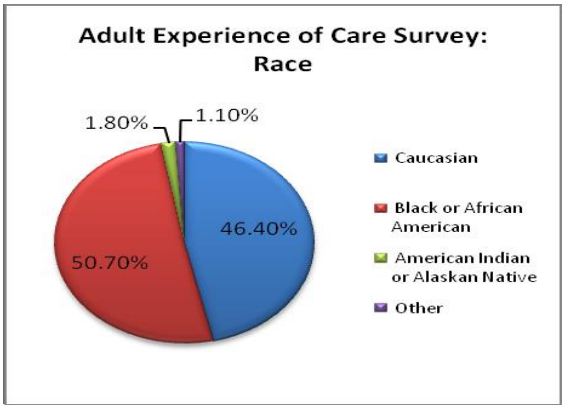
Although there is a known national shortage of psychiatrists in both the public and private sectors of healthcare, Magellan has increased the prescribers by 27% from March 1, 2012 to February 28, 2014. The LA CMC is actively recruiting physician extenders to continue to expand the network of providers with prescribing privileges. Magellan will continue to monitor network adequacy for this provider type on an ongoing basis.

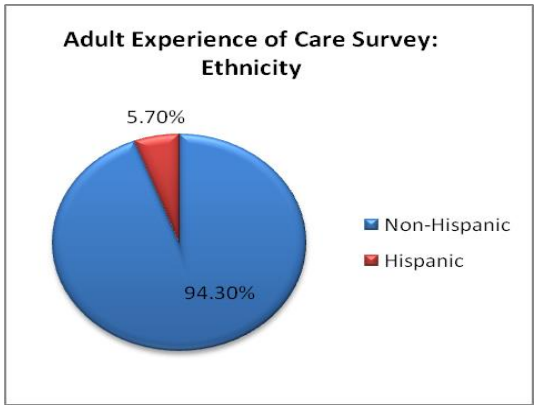
The demographic breakdown of respondents included for Louisiana Adults: 46.3% Caucasian, 47.1% African American, 0.4% Asian, 0% Native Hawaiian/other Pacific Islander, 3.3% American Indian or Alaskan Native, 2.9% Other, 94.9% Non-Hispanic, and 5.1% Hispanic.





Louisiana Minor respondent demographics consisted of 46.4% Caucasian, 50.7% African American, 0% Asian, 0% Native Hawaiian/other Pacific Islander, 1.8% American Indian or Alaskan Native, 1.1% Other, 94.3% Non-Hispanic, and 5.7% Hispanic.





The Louisiana population served by the LA CMC represents a diverse culture and Magellan has implemented services to address the language needs of minority members served, include staff access to translation services for members who require translation for other languages. Magellan has also implemented a Cultural Diversity Toolkit to support both staff and providers in working with members. Cultural competency training is also included as part of the orientation and training provided by the CMC to its staff and provider networks. Opportunities for improvement identified as part of the Member Satisfaction Survey are noted and tracked using the satisfaction survey action plan which is developed based on the annual survey results. More information regarding satisfaction surveys is found in **Section XX Satisfaction Surveys and Grievances.**

Cultural Competency Program

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

Guiding Principles for the Magellan Cultural Competency Program include:

- Acknowledging and respecting variance in behaviors, beliefs and values that influence mental health and incorporating those variables into assessment and treatment.
- Emphasizing member-centered care in the treatment and discharge processes.
- Incorporating natural supports such as family involvement and traditional healing practices when appropriate.
- Encouraging active participation of the member and family in treatment. Incorporating adequate opportunities for feedback from members regarding policies and procedures.
- Developing an adequate provider network so that services are geographically, psychologically, and culturally accessible to consumers and families.
- Developing a comprehensive program to promote cultural sensitivity and competence.
- Promoting the integration of primary care, mental health care, and substance abuse services.

Magellan maintains a strong focus on continuous quality improvement. Each CMC department manager or supervisor is accountable for the success of the program through integration of the principles of cultural competency in all aspects of organizational planning and working to assure cultural competence at each level within the system. The CMC coordinates input from a variety of stakeholders, including

administrative staff, front line employees, consumers and community organizations for the development and operation of the Cultural Competency Program. All policies and procedures related to cultural competency, related program correspondence and quality improvement documents – including this program evaluation – are subject to regular review through the Quality Improvement Program and structures. The QI Program includes indicators to assure equal delivery for all services described in the program description. Indicators include, but are not limited to:

- Grievances and compliments, including monitoring of grievances for issues that are potentially related to culturally insensitive practices.
  - There were no grievances related to cultural issues in contract year two.
- Network access and availability measures including availability of individual practitioners, organizational providers, and providers who share the members' ethnic or language preference that are within a reasonable distance and timeframe.
- Satisfaction survey data related to cultural competency. Contract year one and two comparisons provided below:

Population	Element	CY2: Mar 2013-Feb 2014	CY 1: Mar 2012-Feb 2013	Change (↑,↓, =)
Adult Survey (n=278)	Staff members were sensitive to my cultural background (race, religion, language, customs, etc.)	85.8%	82.4%	↑
	My cultural preferences and race/ethic background were included in planning services I received.	72.3%	69.6%	↑
Minor Survey (n=278)	Staff members were sensitive to my cultural background (race, religion, language, customs, etc.)	89.0%	87.2%	↑
	My cultural preferences and race/ethic background were included in planning services I received.	72.5%	74.6%	↓

Magellan has dedicated one full time equivalent to cultural competency. The Race and Equity Administrator's main role is to promote cultural competency around Louisiana. This is mainly achieved through cultural competency trainings to afford providers and community's opportunities for strengthening cultural awareness skills in delivering culturally appropriate services. Race and Equity Committee (REC) reviews and analyzes program data to evaluate racial and ethnic disparities in utilization patterns, outcomes, satisfaction, and provider cultural competency and oversees the cultural competency work plan and reports to the Quality Improvement Committee (QIC). For example, satisfaction data indicated that there were opportunities for improvement related to perceived satisfaction related to cultural preferences and race/ethic background being included in planning services received. Magellan responded in 2013 by facilitating Regional Provider Cultural Competency trainings for Magellan contracted providers in four different regions of the state as well as with community coalitions. Post training evaluations received from participants of the four Regional Provider

Cultural Competency trainings were positive with an average score of 4.91 out of a possible 5. Agencies that received Magellan facilitated cultural competency trainings in 2013 were:

- Department of Health & Hospital, Office of Behavioral Health
- Alexandria Office of Juvenile Justice
- Louisiana Rehabilitation Service
- National Association for Mental Illness (NAMI) Louisiana Statewide Conference

Magellan will continue to promote cultural competency across its service areas. The goals of the Magellan Cultural Competency Program for the third contract year include:

- Increase education in the importance of cultural impact/influence on life experience.
- Participation in conferences, seminars, forums, committees etc., which address cultural competency topics and reducing health disparities.
- Development, production, and delivery of Cultural Competency Trainings to include CLAS Standards.
- Pursue partnership efforts with external agencies to ensure collaboration with diverse programs and initiatives in order to enhance services.
- Collaborate with Magellan's Quality Improvement (QI) Department to facilitate monitoring and reporting regarding cultural competency through the addition of the following cultural competency elements on the treatment record review tool:
    - Evidence of treatment being provided in a culturally competent manner
    - Cultural, language, religious, racial, ethnic, and sexual issues were assessed.
- Host quarterly Cultural Competency meetings with contracted providers to discuss needs and emerging trends related to CC in Louisiana.
- Collaborate with marketing efforts to ensure the development and dissemination of culturally sensitive healthcare promotional material.
- Generation of recommendations based on data and reports received from all areas to the Race and Equity Committee for the appropriate implementation of CLAS.
- Identify methods to monitor internal compliance of CLAS Standards and make recommendations.

III. Accessibility and Availability of Services

Accessibility and availability of services is evaluated through several avenues, including telephone responsiveness standards, appointment access standards, and geo-access and density standards. This section describes each of the metrics in greater detail.

A. Telephonic Accessibility

Telephonic accessibility is monitored on a daily basis to identify staffing needs and ensure members have adequate access to customer service representatives. In addition, results are reviewed quarterly in the Member Services Committee to identify any trends that need to be addressed.

The following table presents the call volume, ASA (Average Speed Answer), and abandonment rates from March 1, 2013 to February 28, 2014. The goal for abandoned calls is 3% or fewer, and the goal for ASA is 30 seconds or less. Over the year, 99,578 calls were answered with a 17-second ASA and a 2.57% abandonment rate, meeting contractual performance guarantee goals for telephonic responsiveness. There was a slight increase in the abandonment rate and ASA in contract year two; however, all goals were met. The increase is attributed to better management of resources to support other aspects of the CMC while still maintaining telephone responsiveness standards.

Telephone responsiveness	Contract Year 1	Contract Year 2
Numerator (number of abandoned inbound calls)	1,703	2,637
Denominator (Total number of inbound calls)	124,976	102,600
Call Abandonment Rate (Goal: 3%)	1.39%	2.57%
Average Speed to Answer (ASA) in seconds (Goal: 30 seconds)	7.4	16.58

B. Appointment Access

Magellan categorizes appointments as routine, urgent, and emergent. Please refer to Section V (Quality Improvement Activities and Performance Improvement Projects) for full report on this metric.

C. Geo-Access & Density Accessibility

Magellan maintains a behavioral health services provider network consisting of psychiatrists, psychologists, social workers, licensed professional counselors and other service providers. Members have access to qualified providers who have experience with multiple special populations, including children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities. Efforts are made to recruit, retain and develop a diverse provider network. Recruitment may include the assistance of local member advocacy and other community-based groups. Please see **Section V: Quality Improvement Activities and Performance Improvement Projects** for detailed interventions implemented for Improving Member Access to Emergent, Urgent, and Routine Appointments Performance Improvement Project.

Magellan has established processes that address network definition and recruitment. Work groups review the network geographic access and appointment availability data, the results of member satisfaction surveys, and member/family complaints to identify gaps in the type, density, and location of behavioral health providers in Magellan's network. The work group also monitors gaps in services and other culture specific provider service needs. When gaps are identified, the Network Services Department develops a provider recruitment plan and monitors its effectiveness in filling the gaps. This work group reports to the Network Strategy Committee that reports to the Quality Improvement Committee if opportunities for improvement are identified.

The NSC monitors geographic access is to ensure that contracted practitioners and facilities are available in the communities in which members reside. Magellan evaluates access using a standard of a 30-mile radius for members living in urban or suburban areas and 60 miles for those living in rural areas. The average compliance rate for all provider types (see chart below) is 87.9%. Although all provider types do not meet the 100% compliance threshold, this data highlight opportunities for improvement that Magellan has prioritized as most important for the state. During contract year two, the committee identified gaps in out of home placements and the crisis continuum. Magellan is currently working collaboratively with OBH to reduce licensing barriers for providers as well as to expand eligibility for crisis and peer support services to the Adult Medicaid population. This expansion will allow providers to have a larger membership base in order build sustainable business models. Magellan has also targeted national providers with currently providing some LOC to s to increase out of home placements, including Psychiatric Residential Treatment Facility, Therapeutic Group Home, Therapeutic Foster Care, Crisis Stabilization, and Short-term Respite Level of Care. Details regarding network development of CSoC providers are discussed in further detail in **Section XVIII Behavioral Continuum (System Transformation).**

Item	Member Group	Access Standard: One Provider in	Average Distance to Provider (miles)	Members with Desired Access	Members without Desired Access	Total Members	Compliance Rate (%)
Outpatient	Urban/Suburban	- 30 miles	3.5	419,804	13,629	433,433	96.9%
Outpatient	Rural	- 60 miles	13.7	795,599	15,495	811,094	98.1%
Inpatient	Urban/Suburban	- 30 miles	7.6	370,896	62,537	433,433	85.6%
Inpatient	Rural	- 60 miles	21.7	707,053	104,041	811,094	87.2%
Non Prescribers	Urban/Suburban	- 30 miles	2.0	433,433	-	433,433	100.0%
Non Prescribers	Rural	- 60 miles	11.2	810,707	387	811,094	100.0%
Prescribers	Prescribers:	- 30 miles	1.3	433,433	-	433,433	100.0%

	Urban/Suburban						
Prescribers	Prescribers: Rural	- 60 miles	7.5	810,605	489	811,094	99.9%
Mental Health Rehab	Urban/Suburban	- 30 miles	5.0	416,146	17,287	433,433	96.0%
Mental Health Rehab	Rural	- 60 miles	18.2	773,831	37,263	811,094	95.4%
CSOC	Urban/Suburban	- 30 miles	9.7	310,854	83,561	433,433	71.7%
CSOC	Rural	- 60 miles	19.9	406,105	169,733	811,094	50.1%
Residential	Urban/Suburban	- 30 miles	16.3	333,240	100,196	433,433	76.9%
Residential	Rural	- 60 miles	39.7	610,067	201,027	811,094	75.2%

Although continued development is needed, Magellan has made significant progress since implementation. There has been a 325.22% increase in providers from March 1, 2012 to February 28, 2014 as seen in the following chart.

Overall Network Development since Implementation in March 2012

Date	Facilities	Facilities Staff (Not Included in Total)	Groups	Group Staff (Not Included in Total)	Independent Practitioner	Total Practitioners (All Classes) Unduplicated
3/1/2012	143	358	87	141	164	571
4/1/2012	143	359	87	141	163	573
5/1/2012	180	406	99	166	181	649
6/1/2012	206	614	105	192	218	898
7/1/2012	234	688	119	210	238	999
8/1/2012	285	808	131	227	258	1,141
9/1/2012	440	990	141	248	276	1,353
10/1/2012	501	1,116	145	259	282	1,487
11/1/2012	480	1,038	151	275	291	1,423
12/1/2012	533	1,188	159	291	301	1,605
1/1/2013	564	1,236	179	318	308	1,680
2/1/2013	580	1,258	184	340	323	1,730
3/1/2013	587	1,274	184	351	328	1,762
4/1/2013	610	1,302	191	373	333	1,813
5/1/2013	624	1,335	202	383	349	1,866
6/1/2013	636	1,356	209	395	350	1,898
7/1/2013	661	1,434	211	397	357	1,989
8/1/2013	671	1,585	212	408	366	2,151
9/1/2013	680	1,585	213	408	366	2,186
10/1/2013	687	1,645	220	426	371	2,236

11/1/2013	703	1,668	228	443	383	2,280
12/1/2013	705	1,721	236	450	392	2,357
1/1/2014	705	1,691	236	443	398	2,326
2/1/2014	720	1,725	246	475	405	2,376
3/1/2014	708	1,768	252	483	412	2,428

The following highlights some of the accomplishments in the network development:

- The number of psychiatric beds has seen a 122% increase in bed capacity since implementation.
- Eight Therapeutic Group Home (TGH) beds have been added in the Baton Rouge area with an additional 8 beds to be added in Alexandria.
- At present, there are 16 TGH beds licensed in the state. Recruitment efforts continue with existing providers.
- Network for Coordinated System of Care (CSoC) services has grown by 26% since the beginning of the partnership. The remaining four regions are scheduled for implementation in 2014.
- There has been a 27% increase in the number of total prescribers and 27.8% increase in the number of psychiatrists since implementation (see chart below).

Growth of Prescribers since Implementation in March 2012

Month	APRN	Medical Psychologist	Psychiatrist	Grand Total
20130101	39	10	284	333
20130201	41	10	299	350
20130301	42	11	295	348
20130401	43	12	305	360
20130501	42	12	315	369
20130601	43	12	311	366
20130701	43	12	321	376
20130801	42	12	342	396
20130901	45	12	336	393
20131001	45	13	344	402
20131101	47	14	356	417
20131201	48	14	356	418
20140101	49	14	355	418
20140201	49	14	361	424
20140301	49	14	360	423

Magellan continues to actively monitor member accessibility through many avenues. Provider surveys and e-mail blasts are used as means of obtaining information regarding next available urgent and routine appointment openings. In addition to obtaining provider appointment access data, these mechanisms offer the further benefit of reinforcing access standards with providers. Magellan also has implemented internal tracking for staff to document if appointments are not available or there are unmet needs identified through a provider queue. Each reported incident is individually addressed through the appropriate Provider Relations Liaison. The data are also aggregated and monitored to determine if there are regional or provider trends. In the third contract year, the Magellan national QI department will also be implementing a member survey about provider accessibility that will enhance ability to analyze access to care standards.

The network department also works closely with the clinical department to ensure the clinical team has a thorough understanding of access types, access standards and appropriate documentation for tracking and trending. Additionally, our member services department educates our members on access standards via customer service calls and reinforces with the member that Magellan is available to assist.

IV. Quality Work Plan Evaluation: Enterprise / Customer Performance Measures

The Magellan Health Services Louisiana CMC Quality/Clinical Work Plan for Louisiana Behavioral Health Partnership sets forth all the performance measures and activities for services managed by the Louisiana CMC. In addition, it outlines and describes the specific activities to be conducted during the year to promote the quality process throughout the organization and support the objectives of the Quality Program. Some key performance measures are discussed in this section, including Performance Guarantees and Interdepartmental Monitoring Team Measures.

A. Performance Guarantees

Performance Guarantees are performance measures that are subject to financial penalties if the goals are not achieved. The LA CMC met all Performance Guarantees for the second contract year as outlined in the below chart.

Performance Guarantees	2013/2014 Goal	Met / Not-Met (Year to Date)	Actions to Address
Claims administration			
Financial payment (dollar) accuracy-97% of audited claim dollars paid accurately	97%	99.47%	Continue to Monitor
Claims Accuracy	98%	99.77%	Continue to Monitor
TAT – 95% of clean claims paid to all providers within 30 days	95%	97.11%	Continue to Monitor

TAT – 99% of all provider claims paid within 45 days	99%	99.54%**	Continue to Monitor
Telephone responsiveness			
Call Abandonment Rate - Member/ Provider Services Line(s) 5% percent or less for Year 1 and less than 3% for year 2	>3%	2.57%	Continue to Monitor
Average Speed to Answer (ASA) – Member/Provider Services Line(s) all calls (pooled) answered within an average of 30 seconds	30 seconds	16.58 seconds	Continue to Monitor
Clinical			
Ambulatory follow up within 7 days of discharge from 24-hour facility	28%	28.75%	Although this metric met the internal goal, the LA CMC has a long term goal of meeting the HEDIS goal of 46%. A formal Performance Improvement Project has been implemented to advance improvement.
Ambulatory follow up within 30 days of discharge from 24-hour facility	48%	48.66%	Although this metric met the internal goal, the LA CMC has a long term goal of meeting the HEDIS goal of 65%. A formal QIA has been implemented to advance improvement.
Readmission Rate – 15% or less of Members readmitted within 30 days to same acute level of care for Year 1; less than 12 percent of Members readmitted within 30 days to same acute level of care in Year 2	<12%	8.78%	Continue to Monitor
Percent of adult high service users (two or more IP admissions or four ER visits in a year) enrolled in an assertive community treatment program or psychosocial rehab. Source: Schizophrenia PORT, 1998, McEwan & Goldner 2002; APA, 1999.(Year to Date)	15%	25.74%	Continue to Monitor
Satisfaction			
Annual Member Satisfaction Survey:	83%	84.50%	Although goal was met, an Action Plan implemented for measures below 80% in an effort for CQI
Annual Provider Satisfaction Survey:	80%	87.60%	Although goal was met, an Action Plan implemented for measures below 80% in an effort for CQI

B. Interdepartmental Monitoring Team (IMT) Performance Measures

The OBH has established an Inter-Departmental Monitoring Team (IMT), comprised of separate Youth and Adult committees, for the purpose of:

- Developing, overseeing and monitoring the LBHP quality assurance/quality improvement initiatives and activities;
- Ensuring compliance with the 1915(b) waiver, 1915(c) waiver, and 1915(i) State Plan Amendment requirements by collecting and analyzing data and information on all delineated performance measures;
- Ensuring compliance with the SMO contract by collecting, reviewing and analyzing data and information for assigned deliverables and performance guarantees;
- Providing oversight and monitoring of corrective action plans (CAPS);
- Providing guidance, oversight and monitoring of performance improvement projects; and
- Implementing the Quality Improvement Strategy (QIS).

Each IMT committee meets monthly and is composed of staff from OBH, DHH Bureau of Health Services Financing (Medicaid), Magellan, as well as consumer representatives. In addition, the Youth committee includes membership from LBHP partnering state agencies including the Department of Children and Family Services (DCFS), Department of Education (DOE) and the Office of Juvenile Justice (OJJ). The IMT reviews 119 performance measures that are reported on either a monthly, quarterly, semi-annual or annual basis. The performance measures look at metrics that assess Access, Administrative Compliance, Survey Data, Eligibility, Enrollee Rights, Grievance, Outcomes, Quality, Reporting, Treatment Planning and Utilization. The performance measures are monitored by the IMT to ensure upward trends and improvements are seen. Fifty of the metrics have strict 100% compliance standards in order to meet federal regulations. Of those, 21 are currently meeting the 100% compliance standard. The metrics that are in compliance are related to the 1915(c) and 1915(b3) waivers that fund the Coordinated Systems of Care program for children with Severe and Persistent Mental Illness (SPMI). Of the metrics that do not meet compliance, most are related to the 1915(i) State Plan Amendment that funds Home and Community Based Services for the adult population. The measures that are currently not meeting compliance are related to Access, Enrollee Rights, Reporting, and Treatment Planning. Magellan is currently implementing an Independent Assessment/Community-based Care Management action plan to improve compliance with these metrics. This includes the implementation of standardized forms that will allow providers to consistently document required elements related to Enrollee Rights and Reporting. Please see **Section XVIII Behavioral Continuum (System Transformation)** for full details on the action plan. The following charts represent interventions implemented to improve compliance related to Treatment Planning, Access, and Grievances. Magellan will work collaboratively with the IMT to monitor effectiveness of interventions throughout the third contract year.

Treatment Planning Interventions:

Category	Intervention	Responsible Party	Start and End Date
Treatment Record Reviews	Magellan's Quality Improvement Department's (QI) Clinical Reviewers conduct treatment record reviews (TRRs) to ensure that documentation and record keeping standards are in compliance with federal, state, and Magellan quality standards for treatment planning.	QI Clinical Reviewers	March 2012-ongoing
	Magellan standards require individualized treatment plans to be developed and does not allow authorization forms to be used as a treatment plan. Magellan Clinical Reviewers received training that any provider using authorization forms as treatment plans should be scored not in compliance.	QI Clinical Reviewers	Completed July 2014
	A random selection of providers is selected monthly from all level of cares to be reviewed or providers are chosen as a result of quality of care concerns reported. At a minimum 10 records are reviewed per provider utilizing Magellan's Treatment Record Review Auditing Tool. Providers that serve the 1915(i) State Plan Amendment and the 1915(c)(b3) populations are simultaneously audited using the Waiver Auditing Tool that monitors federal waiver performance measures. High volume providers (i.e., those serving 50 or more members) are reviewed at a minimum once every three years.	QI Clinical Reviewers	March 2012-ongoing
	If a provider does not meet minimum standards (i.e., under 80% for the Magellan TRR tool, under 100% for the Waiver Audit Tool), the provider will be required to submit a corrective action plan explaining how they will address deficiencies. Providers that score under 70% on the TRR Tool will be re-audited within 180 days to ensure that deficiencies have been addressed. Providers that continue to not meet minimum standards will be referred to Magellan's Regional Network Credentialing Committee and the provider's status in the network could be affected.	QI Clinical Reviewers	March 2012-ongoing
	TRR and Waiver Performance Measure data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	QI Clinical Reviewers	March 2012-ongoing
Provider Trainings	Provided resource documents on the Magellan of Louisiana website outlining best practices and tips for writing treatment plans. Resources offer providers guidelines on best practices in writing treatment plans and provide education of treatment plan writing techniques (e.g., SMART). These resources have been promoted during provider trainings as well as during onsite treatment record reviews. Resources can be located at: http://magellanoflouisiana.com/for-providers-la-en/quality-improvement-and-outcomes.aspx.	QM Administrator	March 2014-ongoing
	Conducted educational training on development of treatment plan during the monthly provider call. Providers were given direct guidance that authorizations forms would not meet federal, state, and Magellan standards and would be scored not in compliance during audits.	QM Administrator	Completed August 2014

Independent Assessment/ Community Based Care Management (IA/CBCM)	Implemented a four phased rollout of a new Independent Assessment/ Community Based Care Management (IA/CBCM) Plan of Care procedure that replaced the old authorization process for members eligible for the 1915(i) State Plan Amendment. The 1915(i) State Plan Amendment provides expanded home and community based services as determined by clinical and financial eligibility (e.g., adult members with Severe and Persistent Mental Illness). The Independent Assessor/ Community-Based Care Manager serves as the independent conflict-free LMHP who will: • Assess member eligibility and needs; • Develop a plan of care (POC) that addresses needs identified in the assessment; and • Coordinate the overall delivery of home and community based services to the member. The new process brings Magellan into compliance with federal and state waiver performance measures that were validated by IPRO during this review. The POC is a service plan that will be used to inform the treating home and community based provider's treatment plan.	Adult Systems Administrator	June 2014-October 2014
	A random selection of high volume providers is chosen quarterly for review in the process outlined in the TRR intervention. A sample of 385 members is reviewed annually in an onsite provider review. Providers who do not meet 100% compliance with waiver performance measures are required to submit a CAP.	QI Manager	August 2013
	Waiver Performance Measure data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan, in collaboration with the IMT Committee, will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	QI Manager	August 2013
	Magellan implemented quarterly internal quality audits of paperwork submitted at time of 1915(i) eligibility evaluation. Magellan will monitor compliance with treatment planning/Plan of Care elements. Magellan will provide feedback to IA/CBCMs when compliance is not detected and request a written response on how they will correct deficiencies.	QI Manager	October 2014

Access to Care Global Initiatives

Category	Interventions	Responsible Party	Intervention Timeframe
Grievance	Monitor member grievances or provider complaints as they are received. Each grievance/complaint is acknowledged and addressed individually. Magellan tracks and trends to identify if multiple grievances are submitted for a provider or region. Magellan's network department reviews data to determine if network development is needed to improve access for an area/region/service type or if a specific provider requires a corrective action plan to ensure compliance with access standards.	QI and Network	March 2012 and ongoing

	Internal training of Magellan staff on identifying member dissatisfaction (grievances), including those related to access, and reporting grievances in the CART tracking system. Once grievances increase to a level deemed appropriate to the CMC, an initiative will be formed to decrease the level of grievances.	Grievance Coordinator	July 2013
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	Grievance Coordinator/Network	July 2013 and ongoing
Provider	Educate providers through network contacts, provider focus groups, and member service contacts to ensure the providers understand and are able to meet the contractual expectations for appointment standards.	Network/Member Service/Clinical Staff	June 2013 and ongoing
	E-mail blast reminding all providers of the contractual obligation to access standards and educating them on keeping their practice information updated via the provider website.	Network Administrator	November 2013
	Initiated quarterly survey of a sample of providers to monitor availability of emergent, urgent, & routine appointments. This survey will be administered by the Member Service Representatives who will call on behalf of Magellan using a planned script to inquire regarding availability of appointments related to access type. If survey finds provider does not meet established access standards, a follow-up letter is sent to provider discussing expectations and requesting planned actions to comply with appointment access standards.	Member Service Supervisor/QI Manager	June 2013 and ongoing
	Network conducted a survey to providers (non-inpatient) requesting information about their specialties and availability; the network department updated provider records and provider search to ensure accurate provider availability is documented.	Network Administrator	December 2013
Member	Member Services Representatives will assist members that contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in secure appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	Member Service Staff/Care Manager	June 2013 and ongoing
	Educate members on access standards via member service calls; as part of discussion, reinforce with member that Magellan is available to assist and member should call back if unable to obtain timely appointment.	Member Service Staff/Supervisor	July 2013 and ongoing

Access to Care Level of Care Specific

Level of Care	Interventions	Responsible Party	Estimated End Date
Crisis Stabilization (Adults)	• Recruitment efforts included educating interested providers on the Facility Needs Review and licensing requirements to increase awareness of needs and understanding. • Magellan currently partnered with several providers to develop Crisis Stabilization units for children and adults for Q1 2015.	Network Administrator	Q1 2015
Short-Term Respite (CSoC)	• There are 11 providers in the active CSOC Regions. A provider is engaged in discussion to join the network for CSoC Regions 2 by Q1 2015 and another provider anticipated to open in region 7 by the end of Q4 2014. • There are 3 providers are already available in the new CSoC Regions. Based on enrollment, the goal is to have 1 provider in each new region with an option to expand based on number of enrolled children.	Network Administrator	Q1 2015
Crisis Stabilization (CSoC)	• Magellan is partnering with OBH to propose licensing changes that will decrease barriers for new providers to join the network. Based on the outcome of the proposal, 10 new providers would be immediately	Network Administrator	Q1 2015

	added to this level of care in the network. Final analysis expected in Q4 2014. • Partnering with several providers to develop Crisis Stabilization units for children and adults for Q1 2015.		
TGH	• Actively engaged with a provider that is anticipated to open an 8 bed facility in Alexandria by Q4 2014. • Working closely with a large provider to develop a financially viable model for adding several TGH's across the state through a build-out of homes clustered in regions. This provider would meet the current need of 155 beds identified DCFS and OJJ.	Network Administrator	Q4 2014

*Quarters represent calendar year quarters.

Grievances

Category	Intervention	Responsible Party	Start and End Date
Grievance Reporting	Implemented CART (Complaints and Resolution Tracking) system that provides a standardized mechanism to enter and track complaints and grievances for all Magellan staff.	QM Administrator	Completed October 2012
	Implemented internal trainings to reiterate waiver timeliness standards (14 day resolution timeframe). Established internal monitoring for grievances for waiver members to ensure timeliness is met.	QM Administrator	Completed June 2014

V. Quality Improvement Activities and Performance Improvement Projects

The QI department monitors critical performance measures on an ongoing basis to determine if opportunities for improvement are identified. The LA CMC also works with contract monitors to determine if statewide improvements are needed. The Louisiana CMC conducted 3 main Performance Improvement Projects (PIP's) during the second contract year. All Projects used the Six Sigma DMAIC framework by identifying metrics and barriers and implementing solutions. Statistical analysis using the Six Sigma analyzes the number of defects in a process compared to baseline results to show statistical improvement. The sigma levels range from 0 to 6 with any increase showing statistical improvement. The 3 formal PIPs for year 2 were: Improve Member Access to Emergent, Urgent, and Routine Appointments; Improve the Number of CSoC Treatment Plans (Plans of Care) with Service Authorization at First Review; and Improve the Rate of Ambulatory Follow-Up After Hospitalization for Mental Illness.

A. Improve Member Access to Emergent, Urgent, and Routine Appointments

As part of the implementation of managed care, the Louisiana Behavioral Health Partnership identified access to care as a priority for formal performance monitoring and improvement as part of the contract requirements for the first year. This topic was described in the Louisiana Request for Proposal (RFP).

It is important for members to be able to access care within appropriate timeframes once a need is recognized and based on the urgency of the issue. Avoiding delays in care is essential to prevent further

deterioration of the member's condition. One of Magellan's primary functions is to ensure that members are able to promptly access behavioral healthcare services based on the presenting issue. Timely access to care impacts satisfaction and potentially clinical outcomes; therefore, it is important for the Louisiana Care Management Center (LA CMC) to monitor the promptness with which members are able to access emergent, urgent, and routine services.

The aim of the Improve Member Access to Emergent, Urgent, and Routine Appointments Performance Improvement Plan (Appointment Access PIP) is to ensure members receive access to services based on their needs and to improve member access to emergent, urgent, and routine appointments when deficiencies are identified. Based on Magellan national standards, the following performance appointment access goals were established and approved by the Quality Improvement Committee (QIC).

- Emergent – 95%
- Urgent – 95%
- Routine – 70%

Magellan will also monitor members' perception of their appointment access through member grievances, provider complaints and satisfaction survey data to ensure a comprehensive picture of appointment access is evaluated.

The following details the project's methodology, barriers, interventions, results, and next steps.

Methodology

1. Performance Indicators

The appointment access standards established for Medicaid members in the State of Louisiana are:

- Emergent – 1 hour
- Urgent – 48 hours/2 calendar days
- Routine – 14 calendar days

Magellan evaluated multiple measures to monitor member appointment access and members' perception of their appointment access.
Five measures were identified as meaningful for the Appointment Access PIP:

1. Time from request for service to authorization of service (N = Total member population classified as urgent, emergent, or routine)
2. Time from request for service to member accessing service (N = Total member population classified as urgent, emergent, or routine)

3. Member satisfaction with access to care – Minors (N = Total youth member population ages 21 and under)
4. Member satisfaction with access to care – Adults (N= Total adult member population ages 22 and older)
5. Member grievances and provider complaints regarding access to care (N = Total members or providers who reported a grievance related to access)

Baseline results of each of these access measures are presented below.

Measurement #1: Percent of members who are authorized for service within required timeframes (defined as the time a member or provider requests service authorization to the time an organizational determination is made). Quarterly results (contract year quarters) are shown below.

Date	Num	Denom	Emergent	Num	Denom	Urgent	Num	Denom	Routine
Q1*	3381	4394	**76.95%**	2951	2959	**99.73%**	41135	41157	**99.95%**
Q2	2314	2326	**99.48%**	2987	2993	**99.80%**	18325	18337	**99.93%**
Q3	2612	2633	**99.20%**	3377	3382	**99.85%**	20540	20553	**99.94%**
Q4	4702	4720	**99.61%**	3329	3331	**99.94%**	18906	18918	**99.94%**

* Q1 has 4 months due to startup in middle of quarter.

Findings: With the exception of Q1 emergent access, all other quarters exceeded the established decision determination timeliness standard of 95% or above. Q1 emergent data was affected from barriers related to the implementation of the contract. Due to high compliance rates, this measure was not identified as an opportunity for improvement and was not addressed in the PIP.

Measurement #2 – The percent of members attending an appointment within time standards defined as date of request for service and date of first claim post request for service.

Annual (3/1/12 – 2/28/13) appointment access results provided in the table below are based on claims data with run out through May 2013.

Access Type	Performance Goal	Num	Denom	3/1/2012 – 2/28/3013	Sigma Level
Emergent	95% ≤ 1 hour	1,920	2,053	**93.5%**	**3.02**
Urgent	95% ≤ 48 hours/2 calendar days	16,175	22,718	**71.2%**	**2.06**
Routine	70% ≤ 14 calendar days	45,896	61,441	**74.7%**	**2.17**

Findings: Emergent appointment access measured 1.5 percentage points below the established goal of 95%. When evaluating emergent access standards, it is important to note that Magellan identified

requests for authorizations for emergent appointment access generally take place when members are already in a secure environment (e.g., an emergency room or a provider's office). When a member is not in one of these locations, the delay in access is most likely related to getting the member from the current location to a safe environment. The rural landscape of the state is a barrier to accessing care within the established one-hour goal.

The urgent appointment access result (i.e., date of request to date of service) is 23.8 percentage points lower than established goal. Barriers affecting appointment access are discussed in further detail in the barrier analysis section.

The routine appointment access measure exceeds the threshold goal and is 4.7 percentage points above the established goal of 70%. Routine access was not identified as an opportunity for improvement.

Measure #3 – 2013 Member satisfaction with access to care – Minors

	Question	Number Responded	% Positive
Q08	Staff was willing to see my child as often as I felt was necessary.	262	**87.0%**
Q09	Staff returned our call(s) in 24 hours.	266	**83.0%**
Q10	Services were available at times that were good for us.	264	**84.0%**
Q11	The time my child waited between appointments was acceptable.	265	**81.5%**
Q12	My family got as much help as we needed for my child.	270	**81.1%**
Q13	My child was able to see a psychiatrist when he/she wanted to.	251	**72.9%**

Findings: The youth survey was comprised of 44 items and was mailed to 2500 youths randomly selected with the option to respond via mail, fax, or online. The survey was sent to a random selection of members who received at least one service from January 1, 2013 to March 31, 2013. Three weeks following the initial mailing, a second survey was sent to those members not responding. Review of satisfaction results above demonstrates the majority of the parents of minors are satisfied with their ability to access providers. With the exception of Q13 related to *Access to psychiatrist when wanted*, all satisfaction survey results exceed the threshold goal of 80% or above. Although the results are above the goal, access to providers remains an opportunity for improvement, especially as it relates to accessing psychiatrists. This finding is further supported by the results of the Adult survey provided below.

Measure #4 – 2013 Member satisfaction with access to care – Adults

	Question	Number Responded	% Positive
Q8	Staff members were willing to see me as often as I felt was necessary.	276	**79.7%**
Q9	Staff members returned my call(s) in 24 hours.	269	**71.4%**
Q10	Services were available at times that were good for me.	285	**83.5%**
Q11	The time I waited between appointments was acceptable.	285	**79.7%**
Q12	Helped you connect to the services you needed.	277	**79.4%**
Q13	I was able to see a psychiatrist when I wanted to.	281	**76.1%**

Findings: The adult survey contained 40 items and the sample was randomly selected and disseminated in the same way as the youth survey with 2500 surveys mailed to adult members. Adult members indicated lower satisfaction levels with access than did parents of minors. This finding is consistent with findings seen across the Medicaid populations served by Magellan's public sector CMC's. Adult members tend to have lower satisfaction levels in general. The results above are close to threshold hold goal of 80%, but only Q10 *Services were available at times that were good for me* exceeded the established threshold. These findings reinforce the need to monitor access and member satisfaction with access and identify interventions to potentially improve satisfaction levels.

Measure #5 –Member grievances and provider complaints related to access

1st Qtr 2012	2nd Qtr 2012	3rd Qtr 2012	4th Qtr 2013	Total
0	1	2	4	7

Findings: The number of member grievances and provider complaints received from 3/1/2012 – 2/28/2013 related to access to care totaled 7. Magellan believes this number is low and may not be representative of the members' perception. Based on current data, it does not appear most members are dissatisfied with their ability to access appointments, but it is difficult to draw any firm conclusion. The number of grievance indicates Magellan may need to reinforce previously conducted trainings regarding the grievance process to ensure all grievances and complaints are being adequately captured.

Summary of Measures

The data indicates that Magellan's authorization process adheres to Magellan standards for ensuring members are authorized to attend appointments in a timely manner. Member access from time of call to date of service when reviewed in conjunction with satisfaction survey results offers an opportunity

for further improvement. The appointment access measure with the largest discrepancy between date of request and service date relates to urgent appointment access, which is 23.8 percentage points lower than established goal.

Procedures for Data Collection

Measure #1: Data collected from Magellan utilization management system (IP) using the Date of Request to Date of Decision fields

Measure #2: Data collected from Magellan utilization management system (IP) and claims system (CAPS) fields for Date of Request to Date of Claim for first service after request

Measures #3 & #4: Member Satisfaction surveys conducted by Magellan Survey and Outcomes Department using standard Magellan methodology. Survey sent to all clients who requested treatment between 1/1/13 and 3/31/13.

Measure #5: Data collected through Magellan complaint and grievance tracking system (CART) when a member and/or family member makes an expression of dissatisfaction regarding appointment access to provider.

Project Goals for Measures

Measure #1: Decision Timeliness: 95% of all requests meet established decision timeliness standards

Measure #2: Appointment Access

- Emergent: 95%
- Urgent: 95%
- Routine: 70%

Measures #3 & #4: 80% satisfaction with each element

Measure #5: Initially the goal will be to increase grievances and complaints as Magellan is concerned that the current number is not an accurate representation of grievances and complaints in the network. Once a baseline is established and data stabilizes, Magellan will establish a goal to reduce the number of grievances and complaints.

Project Timeline

Data is monitored quarterly. Baseline data was collected in the first contract year (3/1/12-2/28/13). Re-measurement data was collected for the second contract year (3/1/13-3/28/14).

Measure #1: Due to 100% compliance with decision timeliness over the last 3 quarters, it is recommended this measure be maintained as a monitoring indicator and removed as a measure under this PIP.

Measure #2: It is recommended monitoring of appointment access via claims data be continued into Year 2, with focus on increasing the percent of urgent appointments kept within the established time goal (48 hours/2 calendar days). Due to the barriers which can affect members complying with accessing urgent care, Magellan proposes establishing an intermediate Year 2 goal of 80%, an increase of 8.8 percentage points. It is recommended further interventions are implemented and a second re-measurement is taken for the third contract year (3/1/14-2/28/15) for this measure.

Measures #3 & #4: These measures provide a method to obtain member perception of access to care most closely associated with routine appointment access. Magellan recommends continuing to monitor metrics in the third contract year (3/1/14-2/28/15) as part of this PIP to ensure member perception of appointment access is adequately monitored.

Measure #5: Tracking and trending of member complaints related to access also supports analysis of findings related to other metrics. It is recommended monitoring continue as part of this PIP in the third contract year (3/1/14-2/28/15).

Event	Timeframe
Baseline Measurement Period	3/1/2012 through 2/28/2013
Interim Measurement Period	Quarterly 3/1/2013 through 2/28/2014
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2013 through 2/28/2014
Intervention Implementation	See dates below in Interventions Planned and Implemented
Analysis of Project Data	Quarterly 3/1/2013 through 2/28/2014
Submission of Final Report	5/31/2014

Interventions/Changes for Improvement

Barrier Analyses

Barriers affecting appointment access include:

Member

- Member decides not to attend scheduled appointment
- Member makes appointment outside of standards based on their convenience
- Member decides appointment is no longer urgent
- Member lives in a rural area that does not have access to all levels of service

Provider

- Provider perception that appointment is not emergent/urgent
- Provider does not have available appointment within required standards
- Provider does not disclose changes in availability to Magellan resulting in inaccurate information in the Magellan provider database
- Provider does not adhere to contractual standards for emergent, urgent, and routine access.
- Provider unaware of required access standards

Magellan

- Magellan staff incorrectly classifies appointment need.
- Magellan staff does not enter complete data when completing authorizations.
- Magellan does not obtain information from providers regarding current availability.
- There is not a sufficient network for all levels of care for all areas in the state.

Interventions Planned and Implemented

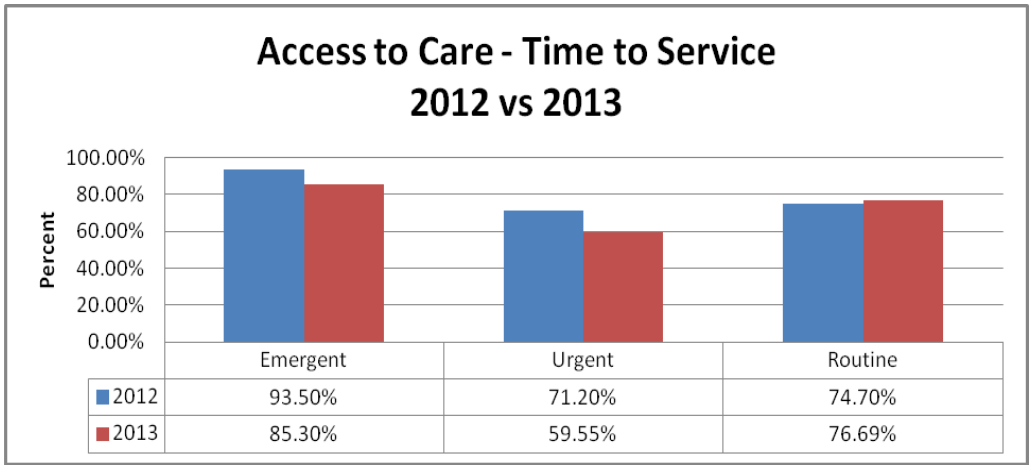
Category	Interventions	Responsible Party	Intervention Timeframe
Grievance	Monitor member grievances or provider complaints as they are received. Each grievance/complaint is acknowledged and addressed individually. Magellan tracks and trends to identify if multiple grievances are submitted for a provider or region. Magellan's network department reviews data to determine if network development is needed to improve access for an area/region/service type or if a specific provider requires a corrective action plan to ensure compliance with access standards.	QI and Network	March 2012 and ongoing
	Internal training of Magellan staff on identifying member dissatisfaction (grievances), including those related to access, and reporting grievances in the CART tracking system. Once grievances increase to a level deemed appropriate to the CMC, an initiative will be formed to decrease the level of grievances.	Grievance Coordinator	July 2013
	Contact providers and discuss appointment access standards when member grievance regarding access to care is received.	Grievance Coordinator/Network	July 2013 and ongoing
Provider	Educate providers through network contacts, provider focus groups, and member service contacts to ensure the providers understand and are able to meet the contractual expectations for appointment standards.	Network/Member Service/Clinical Staff	June 2013 and ongoing
	E-mail blast reminding all providers of the contractual obligation to access standards and educating them on keeping their practice information updated via the provider website.	Network Administrator	November 2013
	Initiated quarterly survey of a sample of providers to monitor availability of	Member Service	June 2013

	emergent, urgent, & routine appointments. This survey will be administered by the Member Service Representatives who will call on behalf of Magellan using a planned script to inquire regarding availability of appointments related to access type. If survey finds provider does not meet established access standards, a follow-up letter is sent to provider discussing expectations and requesting planned actions to comply with appointment access standards.	Supervisor/QI Manager	and ongoing
	Network conducted a survey to providers (non-inpatient) requesting information about their specialties and availability; the network department updated provider records and provider search to ensure accurate provider availability is documented.	Network Administrator	December 2013
Member	Member Services Representatives will assist members that contact Magellan seeking assistance in obtaining appointment; outpatient support specialists and/or care managers will assist member in secure appointment within established timeframes depending on need (e.g., emergent, urgent, routine).	Member Service Staff/Care Manager	June 2013 and ongoing
	Educate members on access standards via member service calls; as part of discussion, reinforce with member that Magellan is available to assist and member should call back if unable to obtain timely appointment.	Member Service Staff/Supervisor	July 2013 and ongoing

Results

Measure #2

Quarters	Q1			Q2			Q3			Q4		
Metrics	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level	Volume	Percent	Sigma Level
Emergent	446	93.95%	3.05	482	84.65%	2.52	441	80.27%	2.35	243	79.84%	2.34
Urgent	9679	58.65%	1.72	11394	60.17%	1.76	11320	57.07%	1.68	7846	63.32%	1.84
Routine	5748	80.20%	2.35	13762	76.97%	2.24	19640	73.47%	2.13	20415	78.62%	2.29



Measure #3: 2013 Member satisfaction with access to care – Minors

	Question	% POSITIVE		
		Mar 2013-Feb 2014	Mar 2012-Feb 2013	Change (↑,↓, =)
Q08	Staff was willing to see my child as often as I felt was necessary.	89.1%	87.0%	↑
Q09	Staff returned our call(s) in 24 hours.	86.3%	83.0%	↑
Q10	Services were available at times that were good for us.	85.5%	84.0%	↑
Q11	The time my child waited between appointments was acceptable.	84.4%	81.5%	↑
Q12	My family got as much help as we needed for my child.	77.6%	81.1%	↓
Q13	My child was able to see a psychiatrist when he/she wanted to.	75.6%	72.9%	↑

Measure #4: 2013 Member satisfaction with access to care – Adults

	Question	% POSITIVE		
		Mar 2013-Feb 2014	Mar 2012-Feb 2013	Change (↑,↓, =)
Q08	Staff members were willing to see me as often as I felt it was necessary.	82.6%	79.7%	↑
Q09	Staff members returned my call(s) in 24 hours.	80.9%	71.4%	↑
Q10	Services were available at times that were good for me.	84.2%	83.5%	↑
Q11	The time I waited between appointments was acceptable.	79.3%	79.7%	↓
Q12	I was able to get all the services I thought I needed.	78.7%	79.4%	↓
Q13	I was able to see a psychiatrist when I wanted to.	76.7%	76.1%	↑

Measure #5: Member Grievances and Provider Grievances Related to Access

Contact Year	Q1	Q2	Q3	Q4	Total
1	0	0	1	2	7
2	5	2	7	21	35

Discussion

Discussion of Results

Measure #2:

As the table above shows, urgent and emergent showed decreases from contract year 1. Emergent appointment access decreased during 4th quarter and was 15 percentage points below the established goal of 95%. Urgent appointment access was 35.5 percentage points below the established goal of 95%. A chart audit was conducted to determine root cause for deficiencies. The root cause of not meeting emergent and urgent access standards was identified as routine community based service appointments (paper based authorizations) that were being classified as urgent and emergent. These specific services require prior authorization from providers as well as the submission of eligibility and/or authorization paperwork to determine if service were medically necessary. Outpatient urgent and emergent appointments would be considered pass through services that would not require this level of review. The Magellan IT system will not allow these appointments to be reclassified; however, it was determined that urgent appointment access would increase to 82% compliance with correct classifications. Administrative staff of the Utilization Management department is now receiving a weekly report to review all outpatient services that were classified as emergent or urgent to address deficiencies in a timely manner and better shape Magellan staff behavior. Magellan is confident that contract year 2015 will display higher percentages in these services due to the implementation of this intervention.

Routine appointment access measure increased from Q2 and Q3 with results displaying 78.6% in Q4. This result 8.6 percentage points above the established goal of 70%.

Measure #3 and #4:

Magellan's National Survey Department mailed 2500 surveys to minors in January-March 2013 for contract year 1 and 2500 surveys in July-September 2013 for contract year 2. The response rate for each was 13.2% and 12.5% respectively. The overall satisfaction increased from 85.4% in contract year 1 to 86.2% in contract year 2, which exceeded the goal of 80%. The results displays that for contract year 2014, all questions related to access went up except for "Q12: My family got as much help as we needed for my child". Even though the majority of the metrics increased, Q12 is recognized as an opportunity for improvement by the CMC.

Magellan's National Survey Department also mailed out 2500 survey's to adults in the same time frame as minors. The response rate was 13.4% for Jan-March 2013 and 12.6% for July-September 2013. The overall satisfaction rate increased from 79.7% for the first contract year to 82.7% for the second contract year, which exceeded the 80% satisfaction goal.

There are six questions in the Minor and Adult survey to measure satisfaction related to access to care. Nine of the twelve questions demonstrated increases in satisfaction. Two of the three questions demonstrating decreased in satisfaction were from the adult survey and each decreased by less than one percentage point from contract year one to two. The final question that showed decrease was from

the minor survey. This question was related to a family feeling satisfied with receiving as much help as was needed for their child and decreased by 3.5 percentage points from contract year one to two. All three of the questions demonstrating decreases were not considered statistically significant declines. The chart below outlines the questions and the satisfaction rates.

Type	Question #	Question	% Positive CY1: 3/1/12-2/28/13	% Positive CY2: 3/1/13- 2/28/14
Minor	Q12	My family got as much help as we needed for my child.	**81.1%**	**77.6%**
Adult	Q11	The time I waited between appointments was acceptable.	**79.7%**	**79.3%**
Adult	Q12	Helped you connect to the services you needed.	**79.4%**	**78.7%**

Although performance thresholds were met in both the adult and minor surveys, it is believed satisfaction survey data provides a meaningful perspective regarding the voice of members regarding access to care. Magellan recommends the two metrics continue to be monitored as part of the PIP. Magellan will develop a corrective action plan related to survey data that will be monitored as part of the Magellan Satisfaction Survey Work Group.

Measure #5:

The number of member grievances and provider complaints related to access received for Q4 2013 was 21. There were a total of 35 grievance regarding access in CY2. Magellan attributes this increased to successful implementation of interventions to identify and track grievances and complaints. Grievances and complaints continued to be handled individually and track and trended to identify network or provider deficiencies.

Limitations

A limitation to this PIP is related to the number of grievances and complaints in contract year 1. Magellan was uncertain if the low volume was due to lack of dissatisfaction by members, member/providers not understanding how to file a grievance/complaint, or lack of Magellan capturing grievances/complaints. Magellan did implement training interventions which lead to a 214% increase in grievances in contract year 2 and will continue to monitor in contract year 3. Another limitation of the PIP is related to the relative newness of the data. It is believed that data will mature and normalize over time which will then allow for improved identification of opportunities for improvement.

Next Steps

Lessons Learned

When evaluating deficiencies in urgent and emergent appointment, Magellan conducted root cause analysis. It was identified the root cause of most of the deficiencies was the misclassification of paper

based authorizations as urgent or emergent by Utilization Management staff. As a result, Magellan has recognized the importance of increased monitoring of the Utilization Management department and implemented interventions to address.

System-level Changes Made and/or Planned

Magellan continues to facilitate member access to emergent, urgent, and routine appointments within appropriate timelines based on the identified need. In the third contract year, the network department will implement several tracking mechanisms to capture non-grievance inquiries related to access to ensure all opportunities for improvement are identified (not just those reported by members). Interventions will also be implemented to improve the accuracy of the Magellan Provider Database (IPD) to ensure the system is up to date regarding provider availability. Magellan continues to strategize on network development for regions or service types that are not adequately represented. Magellan will focus interventions on improving access of crisis intervention and crisis stabilization through network recruitment and development (see May 2014 interventions). It is believed that this will positively impact urgent appointment access. Weekly monitoring of appointment classification is also anticipated to have a positive impact on results.

Conclusion

The CMC has identified many barriers and instituted interventions to improve appointment accessibility; although positive results are noted, many metrics have not met the established minimum performance goals. In the third contract year, the network department will implement several tracking mechanisms to capture non-grievance inquiries related to access to ensure all opportunities for improvement are identified (not just those reported by members). Interventions will also be implemented to improve the accuracy of the Magellan Provider Database (IPD) to ensure the system is up to date regarding provider availability. Magellan continues to strategize on network development for regions or service types that are not adequately represented. Magellan will focus interventions on improving access to crisis intervention and crisis stabilization through network recruitment and development (see May 2014 interventions). It is believed that this will positively impact urgent appointment access. Weekly monitoring of appointment classification is also anticipated to have a positive impact on results. Magellan recommends this PIP continue into contract year 3.

B. Improve the Number of CSoC Treatment Plans (Plans of Care) with Service Authorization at First Review

Magellan was contractually required to implement a predetermined clinical Performance Improvement Project (PIP) during the first contract year. The clinical PIP was identified in the Request for Proposal (RFP) as “The number of Coordinated System of Care treatment plans with service authorization at first

review." (**Note:** from this point forward, this PIP will be using the term Plan of Care as the appropriate language for the CSoC Program.)

One of the goals of the Coordinated System of Care (CSoC) is to ensure children who are either in an out-of-home placement or at risk of out-of-home placement receive sufficient community-based services to reduce the risk of future out-of-home placements. Evidence supports the concept that children receiving services in the home or community have a lower risk of out-of-home placement than those who receive services in more restrictive settings. Ensuring appropriate authorization of community-based services at the time the plan of care is developed helps ensure members have access to these services.

One of the goals of the CSoC is to ensure that children who are already in out-of-home placement or at imminent risk for out-of-home placement receive sufficient home and community-based services to reduce their risk of future out-of-home placement. This topic was selected as one method to monitor the use of home and community-based services (HCBS) for these at risk children.

The aim of the PIP is to ensure that members who are enrolled into the CSoC program have authorizations and receive services prior to the first review. As part of this project, Magellan will monitor both authorization data and claims data. Authorization data will be used to monitor Magellan's internal processes to ensure authorizations are made within 30 days of enrollment. Magellan will also monitor claims to determine if the services were received prior to the first review. Metrics that do not meet standards will be analyzed in order to identify opportunities for improvement.

Methodology

Performance Indicators

During the baseline period, there were 969 unduplicated children that were enrolled for wraparound services and remained enrolled for at least 30 days from date of enrollment. Review of records indicates all 969 children had a 30 day review of their Plan of Care. Of the 969 unduplicated children, 929 (95.9%) received authorizations for a CSoC service. An additional 4 children received authorizations for non-CSoC services totaling 933 members. Thus, 96.3% of CSoC children received some form of service authorization (CSoC + other).

To further evaluate, Magellan then examined the percentage of these children who had claims filed on their behalf for the service authorizations. The analysis revealed that 42.6% of these children (397/933) had claims filed during this period. The majority of these claims were filed within 90 days [360 of the 397 (90.7%) children had claims filed within 90 days].

Youth Support & Training accounted for 32.5% (150 of 461) of the paid claims, and Parent Support & Training accounted for 67.5% (311 of 461) of the claims. Forty nine percent of the claims (n=461) were filed for CSoC services, indicating approximately half of the claims were filed for non-CSoC services (e.g., CPST, PSR, med. mgt.). Specific to CSoC services, a total of 365 CSoC children received Youth Support & Training, Parent Support & Training, or both.

Procedures

WAA roster data were matched against the Magellan data system (IP) to identify all CSoC children who received authorization for services. The Magellan data system records all CSoC treatment authorizations as well as the specific service level authorized. The WAA roster data were further matched against claims data to determine the percentage of children who had claims filed for authorized services. The data collection timeframe was 3/1/2012 through 2/28/2013 with the requirement that all CSoC children included in the measurement period had been enrolled in a WAA for at least 30 days.

Project Timeline

Data is monitored quarterly. Baseline data was collected in the first contract year (3/1/12-2/28/13). Re-measurement data was collected for the second contract year (3/1/13-3/28/14). It is recommended further interventions are implemented and a second re-measurement is taken for the third contract year (3/1/14-2/28/15).

Event	Timeframe
Baseline Measurement Period	3/1/2012 through 2/28/2013
Interim Measurement Period	Quarterly 3/1/2013 through 2/28/2014
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly 3/1/2013 through 2/28/2014
Intervention Implementation	See Interventions below
Analysis of Project Data	Quarterly 3/1/2013 through 2/28/2014
Submission of Final Report	5/31/2014

Interventions/Barriers

Barriers are numbered and the interventions are identified.

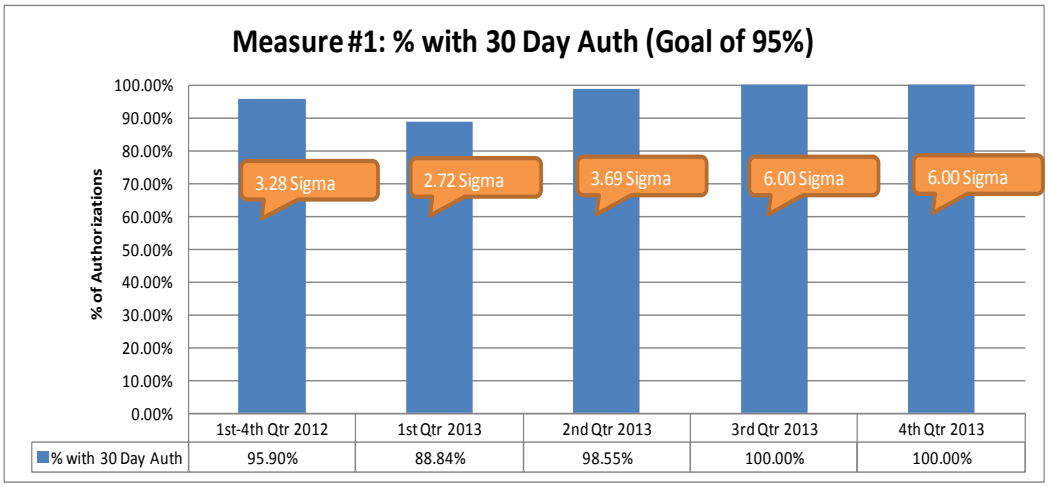
Description of intervention	Intervention Timeframe
General Providers:	

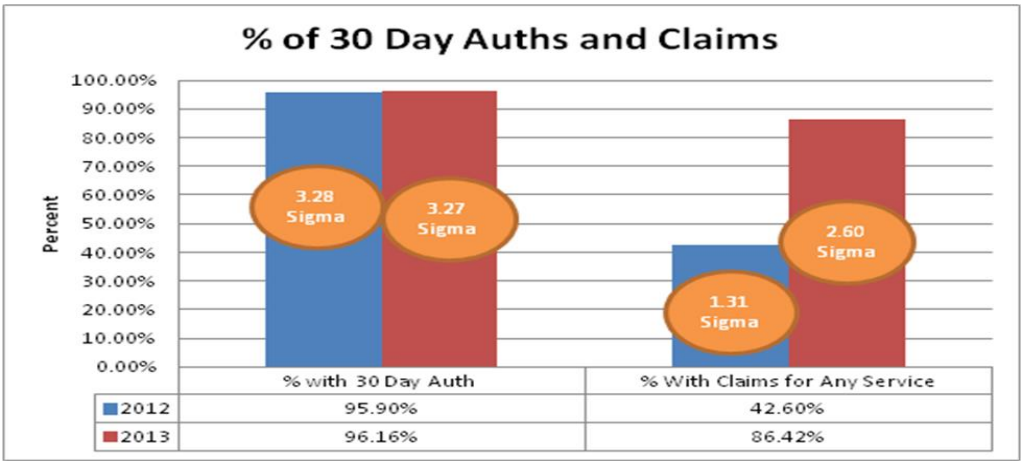
1. Providers are not aware of need to refer to community based services. If aware, providers may not understand the value of referring members to community resources.	
a. The Magellan CSoC team is working to encourage WAA's and FSO to increase referrals to community based services as identified by:	1a. 1/2013 and ongoing
1) CSoC Wraparound Coaches and Care Managers speak with clinical directors or program directors weekly to provide education on the different provider types and services available to the enrolled members.	1) 1/2013 and ongoing (occurs weekly)
2) A formal Affinity call occurs every other Wednesday between WAA Executive Directors (Clinical directors and Program Directors), Magellan DOE liaison, Magellan CSoC Team Members, and FSO Executive Director to identify systemic and/or process barriers that may hinder utilization of services and then bring issues to resolution.	2) 1/2013 and ongoing (occurs bi-monthly)
Magellan Internal:	
2. Need to analyze claims information to determine if member actually utilized services.	
a. Develop routine query of claims information for each of the 5 CSoC services; report should allow for 90 day claims run out.	2a. 5/2013 and ongoing
WAA's/FSO Providers:	
3. Insufficient network access for members to receive required one CSoC services per month**.**	
a. Network is currently recruiting licensed Home and Community Based Services-Center Based Respite providers as potential Crisis Stabilization and Short Term Respite providers.	3a. 04/2012 and ongoing
b. Network Administrator and managers participate in the WAA Affinity call in order to address provider issues in the following areas:	3b. 1/2013 and ongoing (occurs bi-monthly)
1) Insufficient network access	
2) Barriers to network sufficiency	
3) Identification of specific issues/cases that have occurred that requires assistance from Magellan.	3c. 7/2013 – 12/2013
c. The FSO (a major source of CSoC services across the state) was placed on a Corrective Action Plan to address deficiencies in access to care and quality of care concerns. Magellan monitored the CAP weekly through an interdepartmental work group, including the FSO, network, UM, QI, and CSoC. Recommendations from work group were submitted to the OBH following the work group's completion. OBH is currently reviewing status of FSO to determine next steps.	3d. 10/2013 and ongoing
d. Network is working with OBH and Health Standards to allow Crisis Stabilization and Short-term Respite providers to become licensed under the Home and Community Based Services-Substitute Family Care Module, which would allow providers that are currently contracted with Magellan as a Therapeutic Foster Care provider, the ability to become a STR and CS provider as well.	

4. Providers do not have clear understanding of CSoC services or 1915 (c) waiver requirements.	
a. An element was added to the 1915 (c) onsite Waiver Audit tool. WAA's that do not meet the minimum performance threshold of 100% compliance are placed on a Corrective Action Plan and are required to submit a written response on how they intend to address the deficiencies.	4a. 8/2013 (Quarterly)
b. Magellan will disseminate a Plan of Care form that meets waiver requirements. It will require WAA's to clearly identify the type, frequency and duration recommended for each service type, which will improve our ability to capture HCBS utilization (actually provide a check and balance between what was recommended and our claims verifying what was received)	4b. 01/2014 and ongoing
c. Increase education to WAA providers of the CSoC services available to improve referral and utilization of services through use of scheduled onsite reviews.	4c. 1/2014 and ongoing (bi-monthly)
5. Providers do not have a sufficient mechanism to track service delivery to ensure that CSoC members receive at least one CSoC servicer per month.	
a. FSO developed tracking spreadsheet to monitor service utilization of members, including a metric to monitor that each active member is receiving at the minimum one service per month.	5a. 11/2013 and ongoing
b. Magellan implemented a web based WAA's QI Data Spreadsheet that includes drop down data entry to improve data integrity, which will provide increased data tracking and monitoring of WAA's for this element. Metric will be added to the spreadsheet to track if member receives at least one CSoC service per month.	5b. 12/2013, updated 3/2013, and ongoing. Reviewed quarterly

Results

Time Period	Denominator	Numerator	% with 30 Day Auth	Sigma Level	Numerator	% With Claims for Any Service	Sigma Level
Contract Year 1	933	895	95.9%	3.28	397	42.6%	1.31
1st Qtr 2013	448	398	88.8%	2.72	374	83.5%	2.47
2nd Qtr 2013	415	409	98.6%	3.69	372	89.6%	2.76
3rd Qtr 2013	346	346	100%	6.00	299	86.4%	2.60
4th Qtr 2013-14	249	249	100%	6.00	215	86.4%	2.60





Discussion

Discussion of Results

Results for 2013 displayed higher percentage rates than in 2012 and met the goal for 95% authorizations and 55% for claims. The results for 2013 displayed statistical difference over 2012 with positive results. The Six Sigma approach is used to indicate statistically significant improvement by measuring defects per number of opportunities available.

Measure 1: Percent with 30 Day Auth displayed 100% compliance for 2 consecutive quarters and reached a perfect 6.00 sigma level. Measure 2: Percent of Claims for Any Service displayed an increase of 44% over 2013 with 86.42% compliance. The metric also displayed a higher sigma level of 2.60, almost doubling the 2012 sigma level. Both metrics displayed true statistical improvement from 2012 to 2013.

Limitations

Although there have been increases in both metrics, the limitations to the PIP could be in looking at the utilization of CSoC services specifically. In order to be compliant with the 1915c and (b3) waivers, members enrolled in wraparound services must receive at least one CSoC service per month. It would be meaningful to monitor both non-CSoC and CSoC services to monitor compliance.

Next Steps

Lessons Learned

The lesson learned from the PIP is the opportunity to improve provider (e.g., FSO, WAA, etc.) accountability to ensure members receive services timely. Increased accountability will require providers to improve oversight to ensure that member needs are being met. Magellan will also use lessons learned to improve the implementation plan of the CSoC program as it is expanded into the remaining 4 regions of the state.

System-level Changes Made and/or Planned

It is recommended to discontinue measure 1: % with 30 Day Authorizations due to 100% compliance over 2 quarters and perfect 6.00 sigma level in contract year 2. It is recommended that Magellan focus on measure 2: % with Claims for any Service for contract year 3. Magellan recommends that the goal for measure 2 for the third contract year be 85%. Magellan believes this is a reasonable goal as it is anticipated that newly implementing regions will run into barriers related to implementation and development of a network of CSoC providers. Magellan conducted a CSoC Summit with both local and national Magellan representation to conduct root cause analysis and identify interventions for improvement in February 2014. An opportunity for improvement identified was the need for greater accountability by WAA's. Interventions that will be implemented in the third contract year will include a WAA Scorecard to improve WAA's quality management programs and a contract addendum that requires WAA's to ensure members to receive at least one CSoC service per month. It is recommended that Magellan monitors if members receive at least one CSoC service per month in contract year 3.

C. Transitional Care PIP

Project Topic

1. Describe Project Topic

Industry and national behavioral health care standards place a high priority on the assurance of continuity of care for all members, and particularly high risk members, when they transition from inpatient to ambulatory care (HEDIS®, AMBHA; NCQA; AAHC/URAC). The Louisiana Care Management Center (CMC) senior clinical management and the Quality Improvement Committee, in collaboration with Office of Behavioral Health (OBH) for the State of Louisiana, identified improving follow-up after inpatient treatment as a clinical priority. It was determined that members who are discharged from an inpatient level of care represent a high-risk group in terms of severity of impairment and risk of harm to self or others. This is supported by the Surgeon General's report on a national strategy for suicide prevention notes, which cites there is strong evidence for the fact that discontinuities and fragmentation in care following an inpatient admission to a psychiatric facility can increase the risk for suicide (Surgeon General's report, 2012). Continuity of care is a key factor in preventing suicide, and it is noted in the report that death by suicide is more frequent after discharge from an inpatient psychiatric facility than at any other time in treatment (Surgeon General's report, 2012).

Ambulatory follow-up after inpatient treatment is also an important component of care management as it ensures that any recovery or stabilization that occurred during hospitalization is not lost and that further gains may continue in the least possible restrictive environment. Risks for returning to inpatient care are the greatest in the immediate period following discharge, but gradually flatten out over time (Appleby, Desai, Luchins, Gibbons, & Hedeker 1993; Schoenbaum, Cookson, & Stelovich, 1995). 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 treatment, resulting in inappropriate utilization of high-cost inpatient services and under-utilization of appropriate outpatient services (Kruse & Roland, 2002 and Fernando et al., 1990).

2. Rationale for Topic Selection

During contract year one, Magellan gathered baseline data, which identified opportunities for improvement regarding critical performance indicators. Ambulatory follow-up results from March through December 2012 showed a 7-day follow-up after hospitalization for mental illness result of 28% and 30 Day follow-up after hospitalization for mental illness result of 48%. These results were 16 percentage points less than the 7-day goal of 45% and 17 percentage points less than the goal of 65% for 30-day follow-up for members discharged with a mental health diagnosis. These results indicate a significant opportunity for improvement. Based on these findings, in collaboration with OBH for the State of Louisiana, follow-up after hospitalization for members discharged with a mental health diagnosis was identified as a clinical priority.

3. Aim Statement

The aim of this PIP is to increase the number of patients receiving follow-up visits following discharge from an inpatient facility as a means to improve patient safety and meet HEDIS national Medicaid averages for 7 and 30-day FUH.

Methodology

1. Performance Indicators

There were a total of 11,113 members discharged from an inpatient setting with a mental health diagnosis. Of those members, 3,131 (28%) attended a follow-up visit within 7-days and 5,295 (48%) members attended as follow-up visit within 30 days. Using the Six Sigma level calculation approach to baseline metrics and improvements, the 7-day FUH displayed a 0.92 sigma level. The 30 Day FUH is showed a 1.44 sigma level. Baseline 7 and 30-day FUH rates identify opportunities for improvement and sigma levels will be calculated for quarterly measurements to monitor statistical improvement. Jan-March 2013 and April-June 2013 both produced a 31% 7-day FUH rate and a 51% FUH rate in the re-measurements using HEDIS/Claims only data. This percentage increased the sigma level to 0.99 sigma for 7-day FUH and 1.51 sigma for 30-day FUH.

2. Procedures

Data were collected by Magellan internal Enterprise 41A report that meets HEDIS reporting requirements. Magellan internal Enterprise Report 28a was also used for measuring throughout the PIP for claims and supplemental benchmarks. Sigma level statistical calculations were determined by comparing the number of defects (total cases minus exclusions) to opportunities (total cases).

3. Project Timeline

Event	Timeframe
Baseline Measurement Period	March 2012 – December 2012
Interim Measurement Period	Quarterly January 2013 – December 2013
Submission of Interim Report (if applicable)	N/A
Re-measurement Period	Quarterly January 2013 – December 2013
Intervention Implementation	March 2013-February 2014
Analysis of Project Data	Quarterly January 2013 – December 2013
Submission of Final Report	May 31

Interventions/Changes for Improvement

1. Barrier Analyses

A multi-departmental group analyzed data to determine opportunities for improvement and conduct root cause analysis to indentify barriers to access to care. The following barriers were identified:

Practitioner and Facility Barriers

- Failure of facilities to discuss, refer and/or schedule follow-up appointments for/with members.
- Lack of facility staff and/or practitioner understanding of ambulatory follow-up standards.
- Lack of coordination of care across the behavioral health continuum, specifically communication between facilities and patients, mental health providers and/or Magellan staff regarding patients' discharge plans.
- Lack of provider availability within the appointment timeliness standards (possibly related to the low number of providers in some areas or possibly related to provider dissatisfaction with the fee schedules).
- Lack of provider communication with Magellan Staff regarding confirmation of members' post-discharge status and/or confirmation of ambulatory follow-up appointments.
- Provider changes appointment to an appointment outside the 7-day standard.
- Lack of incentive and reported high cost for facilities to invest in discharge planning.

Patient-Specific Barriers

- Refusal by patients to accept ambulatory follow-up appointments (often due to denial concerning their behavioral healthcare needs or to lack of insight into their illness).
- Lack of transportation to ambulatory follow-up appointments.
- Inability to locate an MD for required follow-up with an appointment within the timeliness standards.

Internal Magellan Barriers

- Members are hospitalized for a medical condition and have a co-existing BH diagnosis but are never referred to Magellan for aftercare.

2. Interventions Implemented

Category	Intervention	Barrier	Responsible Party	Start and End Date
Monitoring of Discharge Components via Treatment Record Reviews	Magellan's Quality Improvement Department's (QI) Clinical Reviewers conduct treatment record reviews (TRRs) to ensure that documentation and record keeping standards are in compliance with federal, state, and Magellan quality standards for	Access; Practitioner and Facility Barriers	QI Clinical Reviewers	March 2012-ongoing

	discharge planning and Clinical Practice Guidelines for treatment of Substance Use Disorders (CPG SUD).			
	A random selection of providers is selected monthly the inpatient level of care to be reviewed or providers are chosen as a result of quality of care concerns reported. Records are reviewed utilizing Magellan's Treatment Record Review Auditing Tool. High volume providers (i.e., those serving 50 or more members) are reviewed at a minimum once every three years.	Access;	QI Clinical Reviewers	March 2012-ongoing
	If a provider does not meet minimum standards (i.e., under 80% for the Magellan TRR), the provider will be required to submit a corrective action plan explaining how they will address deficiencies. Providers that score under 70% on the TRR Tool will be re-audited within 180 days to ensure that deficiencies have been addressed. Providers that continue to not meet minimum standards will be referred to Magellan's Regional Network Credentialing Committee and the provider's status in the network could be affected.	Practitioner and Facility Barriers	QI Clinical Reviewers	March 2012-ongoing
	TRR data are reviewed quarterly by Magellan's Quality Improvement Committee (QIC) and the Department of Health and Hospital's Interdepartmental Monitoring Team to determine if systemic opportunities for improvement are identified. If so, Magellan will utilize the DMAIC (Define Measure Analysis Improve Control) model to conduct barrier analysis and develop interventions. Data is reviewed quarterly to determine effectiveness of interventions and determine next steps.	Access;	QI Clinical Reviewers	March 2012-ongoing
High Utilizer Rounds	The top 50 inpatient psychiatric bed day utilizers are chosen quarterly from the most recent running year for inclusion in the group. Rounds are conducted weekly and include several participants across the care management center, including the CMO/Medical Administrator, follow-up team, ICC, Inpatient, Outpatient and Residential Care Managers and Peer Specialists. Cases are prioritized according to inpatient admission status and reviewed by the team for history of inpatient presentation, primary symptomotology, diagnostic category, medical issues, outpatient treatment engagement, and	Practitioner and Facility Barriers: Patient-Specific Barriers	UM/CM Care Managers/ Follow Up Specialist	June 2013 Ongoing Quarterly

	eligibility. Care managers identified specialized needs and implement interventions to address. Interventions include but are not limited to: • Linking members to Independent Assessors for the purpose of establishing 1915(i) eligibility • Assigning members to RCM • Linking members to and coordinating care with community-based service providers • Referring members with medical comorbidities to Bayou Health Plans • Regularly involving Physician Advisors in members' clinical reviews • Using Peer Specialists to help bridge the connection with hard-to-engage members.			
UM Follow Up Team	Within a few days of discharge from a psychiatric hospitalization, members will receive a call from Magellan to verify the aftercare appointment was scheduled within 7 days of discharge and to inquire if the member plans on attending. If the member indicates no aftercare appointment was scheduled or there exists some barrier to attending, Follow Up Specialist will assist the member to reduce barriers (e.g., set up transportation, find provider who can see patient within timeframe).	Access; Practitioner and Facility Barriers: Patient-Specific Barriers	Follow-Up Specialist	March 2012
	Aligned Follow-Up Specialist (FUS) with CM to assist in discharge planning.	Access	Follow-Up Specialist	March 2013 and ongoing
	Running daily reports to monitor if process and procedures are being followed properly	Access	Follow-Up Specialist	March 2013 and ongoing
	Setting monthly Individual and Team goals in Follow-up for 7 and 30-day FUH rates and providing incentives for achieving goals.	Access	Follow-Up Specialist	May 2013 and ongoing
	Identify high risk members (i.e., members currently in hospital and receiving ACT services) to better identify members needing support of follow-up services.	Patient-Specific Barriers	Follow-Up Specialist	May 2013 and ongoing
Provider	Educate providers through network contacts, provider focus groups, and member service contacts to ensure the providers understand and are able to meet the contractual expectations for appointment standards.	Access; Practitioner and Facility Barriers	Network/Member Service/Clinical Staff	June 2013 and ongoing
	E-mail blast reminding all providers of the	Access;	Network	November

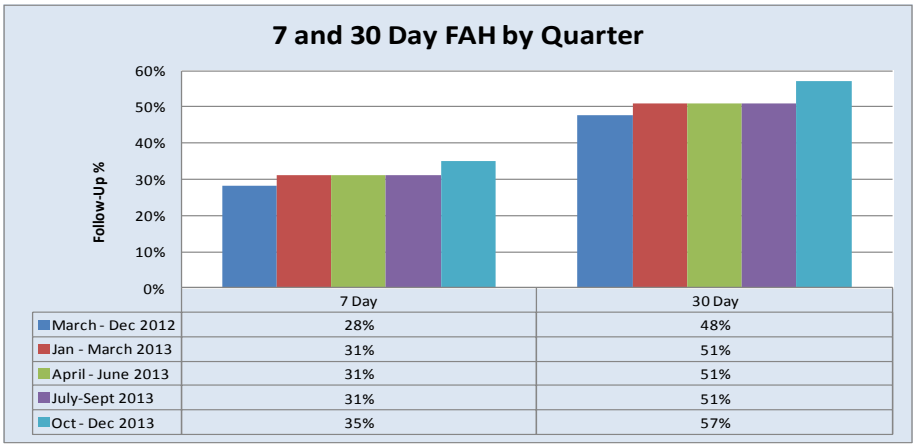
	contractual obligation to access standards and educating them on keeping their practice information updated via the provider website.	Practitioner and Facility Barriers	Administrator	2013
	Initiated quarterly survey of a sample of providers to monitor availability of emergent, urgent, & routine appointments. This survey will be administered by the Member Service Representatives who will call on behalf of Magellan using a planned script to inquire regarding availability of appointments related to access type. If survey finds provider does not meet established access standards, a follow-up letter is sent to provider discussing expectations and requesting planned actions to comply with appointment access standards.	Access; Practitioner and Facility Barriers	Member Service Supervisor/QI Manager	June 2013 and ongoing
	Network conducted a survey to providers (non-inpatient) requesting information about their specialties and availability; the network department updated provider records and provider search to ensure accurate provider availability is documented.	Access; Practitioner and Facility Barriers	Network Administrator	December 2013
Independent Assessment/ Community Based Care Management (IA/CBCM) for Adults	The Independent Assessor/ Community-Based Care Management and Wraparound Agencies serves as independent conflict-free services to ensure members with Severe and Persistent Mental Illness who qualify clinically and financially have access to Home and Community Based Services to increase community tenure and reduce institutionalization. This services is responsible for: • Assessing member eligibility and needs; • Developing a plan of care (POC) that addresses needs identified in the assessment; and • Coordinating the overall delivery of home and community based services to the member. Magellan is required to monitor performance measures to ensure compliance with federal and state waiver regulations. The POC is a service plan that is used to inform home and community based providers' treatment plans. This service is established to ensure that members are connected to the optimum services needed to meet their needs and goals.	Access, Internal Plan System, Transportation	Adult Systems Administrator	IA/CBCM: July 2013-October 2014
Cell Phone (Safe Link)	Provide cell phones (safe link) to members who meet criteria to enhance ability to	Access; Patient-	Systems Transformation	September 2013 and

Distribution	communicate with members who need services.	Specific Barriers	Administrator	ongoing
Provider Queue Tracking	When a Member Service Representatives or Follow Up Specialist identifies a provider who is unable to schedule appointments timely, they are inputted into a provider queue database. Provider Relations Liaisons to follow up on each incident to determine barriers to compliance and reaffirm contractual expectations.	Access; Practitioner and Facility Barriers	Member Service Representatives, Follow Up Specialist, Provider Relations Liaisons	December 2013 and ongoing

Results

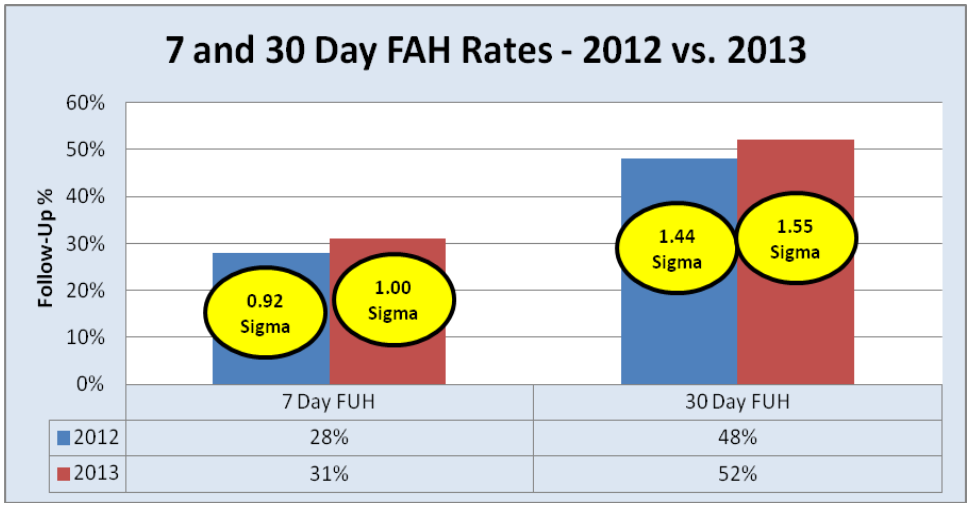
The below results represent the claims with supplemental and HEDIS measurements along with a comparison of 2012 vs. 2013 to display against baseline results.

Claims and Supplemental Results (Enterprise Report 28a)



	7 Day	30 Day
March - Dec 2012	28%	48%
Jan - March 2013	31%	51%
April - June 2013	31%	51%
July-Sept 2013	31%	51%
Oct - Dec 2013	35%	57%

Claims and Supplemental 2012 vs. 2013



Analysis Child vs. Adult FUH Rates

January - December Rates - 2013-(Adult and Child)					
Total Cases	24835	7-day	Sigma Level	30 Day	Sigma Level
Exclusions	8859	4949	-	8237	-
Total FU Cases	15976	15976	-	15976	-
		31%	1.00 Sigma	52%	1.55 Sigma

January - December Rates - 2013-(Child)			
Total Cases	7638	7-day	30 Day
Exclusions	1359	2632	4183
Total FU Cases	6279	6279	6279
		42%	67%

January - December Rates - 2013-(Adult)			
Total Cases	17197	7-day	30 Day
Exclusions	7500	2318	4056
Total FU Cases	9697	9697	9697
		24%	42%

Facility Analysis

Facility	Sum of Cases	Follow Up 7 Rate	Follow Up 30 Rate
BRENTWOOD HOSPITAL SHREVEPORT	2993	35.46%	56.91%
LONGLEAF HOSPITAL	1378	38.80%	60.61%
ACADIA VERMILION HOSPITAL	1204	24.87%	45.36%
RIV OAKS HOSPITAL	1030	34.48%	55.89%
CHILD HOSPITAL NEW ORLEANS	981	47.23%	71.56%
LAKE CHARLES MEMORIAL HOSPITAL	871	27.49%	45.82%
MBH OF LA NORTHLAKE	811	26.32%	46.08%
LIBERTY HEALTHCARE SYSTEMS BASTROP	754	52.61%	73.36%
GREENBRIER HOSPITAL LLC	657	31.94%	53.86%
COMMUNITY CARE HOSPITAL	655	20.16%	40.62%
OUR LADY OF THE LAKE HOSPITAL	556	32.30%	52.37%
LSUHSC SHREVEPORT HOSPITAL	546	29.96%	45.69%
EASTERN LA MENTAL HEALTH SYSTEMS	501	12.92%	30.30%
SAVOY MEDICAL CENTER NEW HORIZONS	465	25.98%	44.98%
GLENWOOD REGIONAL MEDICAL CENTER	465	14.72%	27.92%
WILLIS KNIGHTON SOUTH	444	18.82%	35.37%
OPTIMA SPECIALTY HOSPITAL	443	23.29%	42.92%
SOUTH CAMERON MEMORIAL HOSPITAL	439	23.45%	49.43%
LAFAYETTE GENERAL MEDICAL CENTER INC	423	4.05%	14.29%
CHRISTUS ST PATRICK HOSPITAL	412	13.45%	33.01%
OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER	408	24.94%	44.14%
LSU BEHAVIORAL HEALTH SERVICES DEPAUL CAMPUS	404	52.89%	93.90%
E A CONWAY MEDICAL CENTER	341	22.59%	40.36%
LEONARD J CHABERT MEDICAL	318	60.99%	102.55%
AMERICAN LEGION PAULINE FAULK CENTER	314	11.94%	30.97%
OCEANS BEHAVIORAL HOSPITAL OF LAFAYETTE	312	1.94%	12.26%
SEASIDE BEHAVIORAL CENTER	307	15.84%	28.38%
TECHE REGIONAL MEDICAL CENTER	297	23.55%	43.34%
SEASIDE HEALTH SYSTEMS	292	28.57%	45.99%
ALLEN PARISH HOSPITAL	290	25.44%	51.57%
BATON ROUGE GENERAL MEDICAL CENTER	286	32.14%	51.07%
ST CHARLES PARISH HOSPITAL	279	25.72%	41.67%
SERENITY SPRINGS SPECIALTY HOSPITAL	274	34.83%	55.06%
WEST JEFFERSON MEDICAL CENTER	272	29.85%	48.88%
APOLLO BEHAVIORAL HEALTH HOSPITAL LLC MAINSITE	271	25.56%	52.26%
OPELOUSAS GENERAL HOSPITAL AUTHORITY	258	27.17%	45.67%
LSU BEHAVIORAL HEALTH IP ACUTE	255	14.62%	31.62%
BEACON BEHAVIORAL NEW ORLEANS	238	14.35%	27.00%
BEACON BEHAVIORAL HEALTH MAIN SITE	227	14.35%	36.77%
OCEANS BEHAVIORAL HOSPITAL KENNER	222	1.35%	6.31%

WOODLANDS BEHAVIORAL CENTER	215	0.47%	10.23%
ST FRANCIS MEDICAL CENTER INC	209	28.16%	45.15%
ABROM KAPLAN MEMORIAL HOSPITAL	204	24.63%	43.84%
OCEANS BEHAVIORAL HOSPITAL OF BATON ROUGE	183	1.65%	11.54%
EAST JEFFERSON GENERAL HOSPITAL	175	22.99%	44.83%
ST JAMES BEHAVIORAL HEALTH HOSPITAL	166	127.04%	154.09%
ABBEVILLE GENERAL HOSP BEHAVIORAL MEDICINE CTR	159	17.72%	42.41%
OCHSNER ST ANNE GENERAL HOSPITAL	147	27.40%	51.37%
GENESIS BEHAVIORAL HEALTH INC MAINSITE	140	33.58%	54.74%
LSU HPL MEDICAL CENTER	135	18.52%	43.70%
ACADIA ST LANDRY HOSPITAL	130	13.18%	39.53%
WESTEND HOSPITAL	129	30.16%	44.44%
RED RIV BEHAVIORAL CENTER LLC	125	0.00%	4.00%
OCEANS BEHAVIORAL HOSPITAL ALEXANDRIA	114	0.88%	11.50%
OCEANS BEHAVIORAL HOSPITAL OF OPELOUSAS	103	0.00%	6.86%
PHOENIX BEHAVIORAL HOSPITAL OF EUNICE	97	23.16%	43.16%
DEQUINCY MEMORIAL HOSPITAL INC	97	15.96%	28.72%
MERIDIAN PSYCHIATRIC HOSPITAL	77	15.58%	29.87%
BATON ROUGE BEHAVIORAL HOSPITAL	68	19.30%	40.35%
OCHSNER FOUNDATION HOSPITAL	56	25.45%	47.27%
OCEANS BEHAVIORAL HOSPITAL OF DERIDDER	49	0.00%	12.24%
PHYSICIANS BEHAVIORAL HOSPITAL	47	24.44%	40.00%
NATCHITOCHES REGION MEDICAL CENTER	42	14.63%	34.15%
OCEANS BEHAVIORAL HOSPITAL OF LAKE CHARLES	41	4.88%	14.63%
COMPASS BEHAVIORAL CENTER LLC	38	45.95%	72.97%
OCEANS BEHAVIORAL HOSPITAL OF KENTWOOD	32	3.13%	3.13%
MEDICAL CENTER OF LA	30	20.00%	46.67%
BUNKIE GENERAL HOSPITAL	29	7.14%	25.00%
AMERICAN LEGION HOSPITAL ADMINISTRATION SITE	24	12.50%	29.17%
OPELOUSAS GENERAL HOSPITAL	24	4.17%	33.33%
MAGNOLIA BEHAVIORAL HEALTHCARE LLC	21	14.29%	19.05%
SE LA HOSPITAL	21	19.05%	47.62%
ALLEGIANCE BHC OF RUSTON LLC	20	15.00%	30.00%
HARDTNER MEDICAL CENTER	18	5.88%	17.65%
SPRINGHILL MEDICAL CENTER	12	8.33%	25.00%
CENTRAL LA STATE HOSPITAL	12	0.00%	0.00%
DAUTERIVE HOSPITAL	9	22.22%	44.44%
WASH ST TAMMANY MEDICAL CENTER	5	20.00%	40.00%
HOMER MEMORIAL HOSPITAL	4	0.00%	0.00%
MEMORIAL HOSPITAL AT GULFPORT	3	33.33%	33.33%
SOUTH CAMERON MEMORIAL CALCASIEU OAKS	3	0.00%	0.00%
EAST LA STATE HOSPITAL HBP	3	0.00%	0.00%

VIDANT BEAUFORT HOSPITAL	2	50.00%	50.00%
MEMORIAL HERMANN BAPT BEAUMONT HOSPITAL	2	0.00%	0.00%
CAROLINAS MEDICAL CENTER	2	0.00%	0.00%
PROMISE HOSPITAL OF LA INC	2	50.00%	50.00%
VICKSBURG MEDICAL CENTER	2	0.00%	0.00%
WHITE MEMORIAL MEDICAL CENTER	2	0.00%	0.00%
CHILD HOSPITAL PHYSICIANS BILLING	2	0.00%	50.00%
JOHN PETER SMITH HOSPITAL	2	0.00%	0.00%
WASHINGTON HOSPITAL CENTER	2	0.00%	0.00%
WILLIS KNIGHTON MEDICAL CENTER	1	0.00%	0.00%
THIBODAUX REGIONAL MEDICAL CENTER	1	100.00%	100.00%
GENESIS BEHAVIORAL HOSPITAL INC	1	0.00%	0.00%
LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER	1	0.00%	0.00%
UNIVERSITY HOSPITAL CASE MEDICAL CENTER	1	0.00%	0.00%
EAST TEXAS MEDICAL CENTER UNIVERSITY BLVD	1	0.00%	0.00%
ACADIANA RECOVERY CENTER	1	0.00%	0.00%
MEDICAL COLLEGE OF VIRGINIA HOSPITAL	1	0.00%	0.00%
METRO HOSPITAL CENTER	1	0.00%	0.00%
OUR LADY OF THE LAKE PHYSICIANS GROUP LLC	1	100.00%	100.00%
TIMBERLAWN MENTAL HEALTH SYSTEMS MAIN SITE	1	0.00%	0.00%
ST ANTHONYS HOSPITAL	1	0.00%	0.00%
VICKSBURG HEALTHCARE LLC	1	0.00%	0.00%
SACRED HEART HOSPITAL	1	0.00%	100.00%
LAUREL RIDGE TREATMENT CENTER	1	0.00%	0.00%
ST FRANCIS HOSPITAL	1	0.00%	0.00%
HOUSTON HOSPITAL INC	1	0.00%	0.00%
NY PRESBYTERIAN HOSPITAL WESTCHESTER	1	0.00%	0.00%
NORTHPORT MEDICAL CENTER	1	0.00%	0.00%
BAYPOINTE HOSPITAL MOBILE AL	1	0.00%	0.00%
APOLLO BEHAVIORAL HEALTH HOSPITAL LLC	1	0.00%	0.00%
KINDRED HOSPITAL OF NEW ORLEANS	1	0.00%	0.00%
GREEN OAKS HOSPITAL	1	0.00%	0.00%
MARY WASHINGTON HOSPITAL INC	1	100.00%	100.00%
FT WALTON BEACH MEDICAL CENTER	1	0.00%	100.00%

Discussion

1. Discussion of Results

The rate for 7-day FUH 3 increased percentage points and 30-day FUH increased 4 percentage points between 2012 and 2013 (Enterprise Report 41a: Claims only). This displayed a 0.10 increase in sigma level for 7-day FUH and a 0.11 increase for 30 day FUH. There was 4 percent point increase over 2012 for 7 and 30-day FUH when analyzing data from the Claims and Supplemental data (Enterprise Report

28A. Claims and Supplemental results increased over 2013 with a 7 and 9 point increase for 7 and 30-day FUH respectively from the first to the fourth quarter. These results display a positive trend compared to baseline results.

When analyzing adult vs. child data, it is apparent that children have a much higher 7 and 30-day FUH rate than the adult population. When analyzing data from a facility level, no trends are evident to mention.

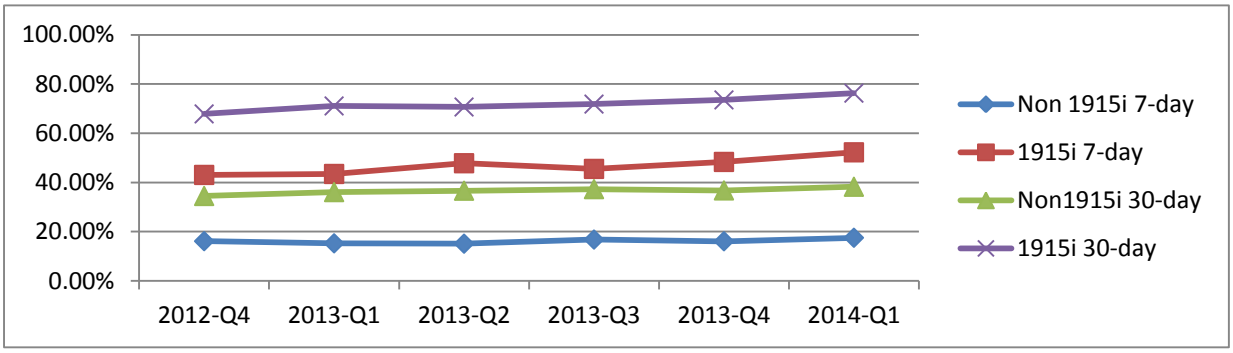
2. Limitations

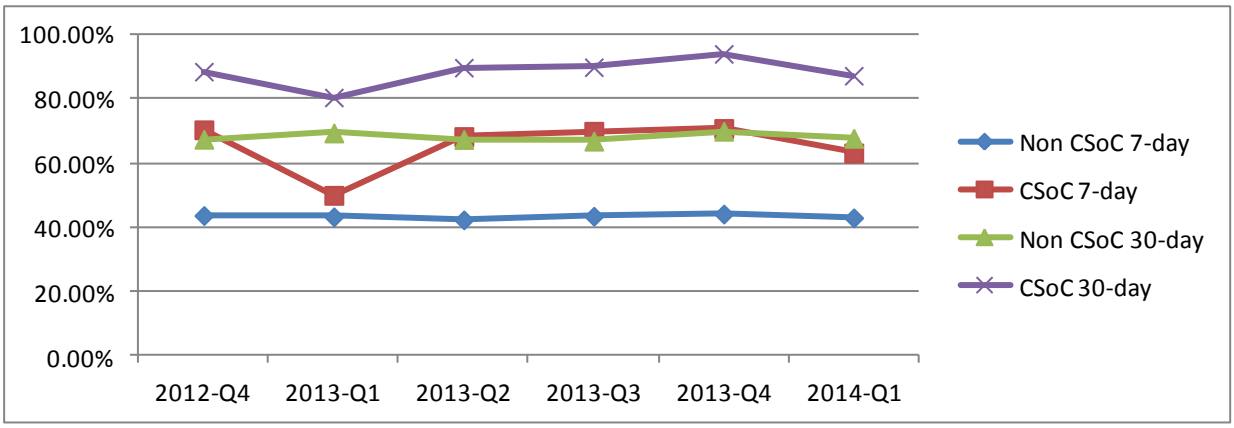
The biggest barrier that the Follow-Up team has found is inability to reach members upon discharge of hospitalization. This prevents the follow-up team from prompting and encouraging the member to adhere the appointment standards.

Next Steps

1. Lessons Learned

The largest barrier learned are patients having problems attending follow-up appointments after hospitalizations and contacting members upon discharge from inpatient facilities. We have learned that bridge appointments have worked in various other areas of the country and it will be implemented in beginning of 2014. It was also determined that evaluating population specific data to identify key drivers and barriers to meeting FUH rate goals would be beneficial. In May 2014, a data report was run to show a breakdown of FUH by populations to identify if there were in notable trends that should be addressed. The following charts show 1915(i) adults, non-1915(i) adults, CSoC children, and non-CSoC children for 7 and 30-day FUH:





As the chart indicates, adult population overall has lower FUH rates than the child population. It also indicates that members enrolled in CSoC or who have 1915(i) eligibility have significantly higher rates for both 7 and 30-day FUH. Both of these programs allow members to have increased access to home and community based services above what is available to the traditional Medicaid population. This drill down provides invaluable information to inform interventions for the third contract year. First, it shows the success of Magellan's efforts to link outpatient and inpatient providers for members already receiving behavioral health services and supports that this should be continued in the future. Secondly, it identifies that interventions should be focused on members who are not enrolled in these higher levels of outpatient services. As noted it is believed bridge appointments will improve the connection between inpatient and outpatient treatment. Magellan will also increase its efforts to develop collaborative relationships between inpatient hospitals and IA/CBCM's. It is believed that if members can receive an eligibility evaluation or independent assessment while they are hospitalized, there will be a greater chance that the member can obtain eligibility and gain access to these community based service providers once discharged.

2. System-level Changes Made and/or Planned

Magellan has implemented an Admissions Team to assist in discharge planning/FUH for (Louisiana Web-Case Logix) with facilities and CM, along with notifying outpatient providers (CPST/PSR, ACT, etc) when member is hospitalized. The bridge appointment initiative will also be implemented for high volume inpatient hospitals. Pilot is anticipated to begin in Brentwood Hospital (located in NW LA) in 6/2014 to implement intervention. Based on volume of members seen at Brentwood, this intervention is expected to drastically increase follow-up rates over the year 2014. Magellan is also in negotiations with River Oaks (located in SE LA) hospital on bridge appointments.

Transitional care (from hospital to home) is a critical component of care in behavioral health settings and begins with the discharge facility. Magellan identified that enhancements to the PIP would be

beneficial to more comprehensively monitor transitional care. In contract year three, Magellan will monitor four indicators for transitional care in order to measure improvement: components of discharge management planning, ambulatory follow up rates for mental health and substance abuse facilities, readmission rates for mental health and substance use disorders, and bridge of discharge program metrics. Magellan will evaluate indicators by population and eligibility categories when appropriate to target interventions to low performing groups.

D. Other PIPs

As part of the CQI, Magellan looks for opportunities to improve both internal and external processes. Improve Average Speed of Answer (ASA) and Call Abandonment Rate (CAR) for Care Management Intake/Authorization Contacts was implemented in contract year one to address opportunities for improvement related to internal telephone responsiveness in the UM department. Significant improvements were made and the QIC voted to discontinue this project as a formal PIP in January 2014. Magellan implemented a PIP to reduce rates of readmission to inpatient psychiatric hospitals, which is described in detail in Section VI Care Management Initiatives

VI. Care Management Initiatives

In 2013, the LA CMC noted a trend in rising readmission rates to acute inpatient settings for adult members. In June 2013, a solution-focused work group was established with the overall goal of identifying, developing and implementing strategies that would result in an overall reduction in readmission rates. As a result, a two-pronged approach was taken:

1. Intervene with facilities with highest readmission rates; and
2. Intervene with members who have highest hospital utilization.

A. Readmission Work group

The group identified the drivers of readmission by identifying and analyzing facilities that consistently had the highest days per thousand (days/1000) rate and the highest readmission rates. The readmission rates were trended for a 5-month period between April and September 2013 to establish a baseline for each identified facility. As a result, six outlier inpatient facilities were identified. The overall readmission rate for these facilities was 25.3%.

Analysis of readmission drivers resulted in several interventions. Interventions included working with hospitals to address the following initiatives:

- Gain support of facility leadership
- Identify barriers to follow up/discharge planning
- Initiation of follow-up planning prior to discharge and submission of Quality of Care Concerns to Magellan's Quality Improvement department when discharge planning was inadequate
- Engage with Assertive Community Treatment (ACT) Leadership for discussion of barriers/opportunities

Because of the collaboration between the providers and Magellan, at the end of the intervention period in December 2013, the readmission rate for these facilities had fallen to 19.5%, a reduction of 5.8% percentage points. Magellan will continue to monitor these outlier providers to ensure continued improvement.

B. High Utilizer Work group

A target member group of the top 100 members with highest inpatient utilization was identified. The 100 members were divided into two groups and the top 50 members for June to August 2013 became the primary focus of interventions. The bottom 50 members continued to receive standard care management attention but did not receive the enhanced interventions, and served as the control group. The intervention and measurement period lasted for 3 months.

Key interventions of the High Utilizer Work group included identification of members when admitted to inpatient hospital through Magellan's Integrated Product authorization system, conducting high utilizer rounds twice per week, enhanced Physician Advisor involvement, automatic enrollment in RCM (with an opt-out option), active involvement of peer specialists and care coordination with health plans, developmental disability services, housing, etc.

High utilizer rounds provided the primary forum for reviewing cases, planning, and reporting on actions taken. Key participants included the Chief Medical Officer, Medical Administrator, Care Management Teams (RCM, Residential Substance Use, and Inpatient), Follow-Up Specialists, and Peer Support Specialists. Areas of emphasis included historic and current reason for admission, symptoms and progress, co-occurring substance use disorder, developmental disability or medical condition, eligibility for and participation in enhanced home and community based services, accessibility of medications, and any other factors contributing to utilization. Efforts were also made to have the same physician advisor to conduct peer-to-peer reviews to establish consistency and draw from ongoing experience with the identified member. This allowed for improved shaping of complex cases.

The Recovery and Resiliency Care Management (RCM) team was integral in implementation of the tasks that emerged from the High Utilizer Rounds. All identified members were enrolled in RCM. If the

member was unwilling to formally enroll, a care manager would still be assigned to assist. The RCM Care Manager would complete tasks such as:

- Reach out to Certified Providers for 1915(i) eligibility assessment and assisting with setting up appointment for assessment (preferably while member is still in the hospital);
- Coordinate care with health plans, developmental disabilities services, etc.;
- Refer and connect members with appropriate home and community based services;
- If member has a current home and community based provider, notify them the member is in an inpatient hospital; and
- Authorize any services that were necessary for the member, outside of customary procedures for authorization.

The Peer Specialists tasks include:

- Provide a voice for the member's definition of recovery;
- Give insight into available network and community resources;
- Engage in face–to-face and telephone contact with members to answer questions;
- Explain service options to members;
- Bridge connections with providers;
- Conduct ongoing "wellness checks" with members who have discharged from inpatient; and
- Identify members who have not been hospitalized.

The follow-up team tasks interventions included:

- Manage data and reporting;
- Assist with appointment access; and
- Verify follow-up appointments.

The Inpatient Concurrent Care Management team provided the following interventions:

- Communicate work group interventions with hospital utilization review staff as appropriate;
- Share the identification of primary care physicians and vital health information;
- Shape providers to get proper prior authorization for medications from the appropriate health plan before discharge;
- Work with hospital staff to allow certified providers and other involved providers (ACT, other home and community based services) access to the member while hospitalized;
- Involve identified physician advisors (PA) early on in hospital stay;
- Attempt to schedule reviews with an identified PA to improve consistency; and

- Authorize days in accordance with Service Authorization Criteria while being mindful of maximizing benefit and coordinating with home and community based or substance use providers.

At the end of the 3-month intervention period, the outcomes for the high utilizers 1-30 and 70-100 are measured. The following chart outlines the results of the intervention.

Timeframe	Pre-Intervention Bed Day Utilization		Post-Intervention Bed Day Utilization	
Q3 2013	Tx Group	1033	444	57% reduction
	Control Group	90	187	107% increase
Q1 2014	Tx Group	1051	394	63% reduction
	Control Group	0	120	120% increase
Q2 2014	Tx Group	1549	481	69% reduction
	Control Group	299	236	21% decrease

Due to the success of the interventions, Magellan analyzes data quarterly to identify a new set of high utilizers in which to target interventions each quarter.

VII. Recovery and Resiliency Care Management

The population of focus for RCM includes members who meet the following criteria:

- Children/youth who are eligible for CSoC level of care and reside in a community that is not currently a CSoC implementing region
- Member with two (2) or more admissions to an acute inpatient or residential level of care within 60 days with a diagnosis of Schizophrenia, Bipolar Disorder or Major Depression
- Children age 12 and under who are hospitalized
- Pregnant women who use substances
- Members age 21 and under who are discharged from a state psychiatric inpatient program followed by one or more admission/hospitalization
- Members who use IV drugs
- Members with one or more admission for an eating disorder
- Members who have chronic or severe physical health and mental health co-morbid conditions
- Members identified as high risk based on predictive modeling results
- Members identified by treatment planners, such as WAAs, Local Governance Entities (LGEs), or other providers as needing Intensive Case Management.

The RCM program provides intensive case management to these high-risk members. The RCM Program currently consists of 9 FTE Care Managers and 1 FTE Care Worker. In the second contract year, 1,585 members were referred to RCM, 871 of which chose to enroll in RCM. The CHI and CHI-C tools for measuring members' experience of improvement in their health showed very positive results.

CHI-C (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%

CHI (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%

Other important activities completed by the RCM team include the Birth Outcome Initiative, crisis plan development and provider education. Four (4) RCM Care Managers are assigned to work with the five Bayou Health plans. The RCM unit has established a Birth Outcome Initiative in line with the state's Birth Outcomes Initiative that connects substance using expectant mothers to appropriate services. Care Managers complete crisis safety plans with members and attach the plan to each member's file through the Magellan system. Also, RCM provides education to emergency departments and providers about the existence and role of the RCM program.

In the first contract year, Magellan identified one barrier to connecting with members was members not having access to telephones. A free cell phone program, in partnership with TracPhone and Voxiva was implemented in 2013. In addition to direct outreach to members by TracPhone, care managers and other Magellan staff were able to refer members to TracPhone. This service allows unlimited calls by the member to Magellan and a set number of minutes and texts for members' other use.

RCM Care Managers, in partnership with the other clinical teams and peer specialists, were integral in the success of the High Utilizer Work group detailed under the Care Management Initiatives.

RCM Care Management/Clinical Goals for 2013 included:

- Reach enrollment capacity of a minimum of 60 members per FTE RCM Care Manager.
  - This goal was achieved and this standard will remain in place in 2014.
- Complete CHI with 80% of RCM participants.
  - This goal was not achieved. 131 CHI assessments were completed
  - Enhanced reporting capabilities, an incentive program for members who complete the CHI and ongoing process improvements will be implemented in 2014 to address this.
- Ensure compliance with established workflows.
  - This goal was achieved. Reviews of individual care manager performance and process audits demonstrate consistent application of policies and following of workflows.
- Develop proposal and justification for adding more Peer Support Specialists to the program.
  - This goal was partially achieved. While additional Peer Support Specialists were not added to Magellan staff, their role and contribution to the overall clinical program were enhanced. In contract year three, Magellan will work with the Office of Behavioral Health and Medicaid to make Peer Support services a reimbursable service for adult members.
- Initiate the RCM Care Manager Certification process for relevant staff.
  - This goal was discontinued due to the reorganization of the RCM program into Tiered Care Management that will guide RCM in 2014.

In 2014, in addition to those above, RCM goals for 2014 include:

- Continue to use “opt-out” model of RCM engagement for identified high utilizers discussed in Care Management Initiatives section.
- Show improved outcomes and decreased utilization of 24-hour levels of care for members during and after involvement with RCM.

VIII. Evaluation of Over/Under Utilization of Services

Magellan is committed to providing quality services to the members served. 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. In order to accomplish this goal, it is imperative that members receive services at the appropriate level of care while not over or under utilizing services in

other levels of care. The QI department conducts an annual analysis to identify trends in over or under utilization of services in Louisiana. Under utilization of services could be impacted by barriers to access, lack of member awareness of availability, UM program issues resulting in delays in obtaining authorization or denials of service that are appropriate for the member's needs. Over utilization of services could indicate the lack of availability of the appropriate alternative services and provider and practitioner issues. One of Magellan's goals is to decrease utilization of higher levels of care and improve community tenure through the increased utilization of home and community based services. This section looks at several utilization management metrics, including EPSDT utilization, to provide a comprehensive view of utilization.

To obtain a comprehensive understanding of how members are utilizing services, Magellan evaluates several metrics, including but not limited to:

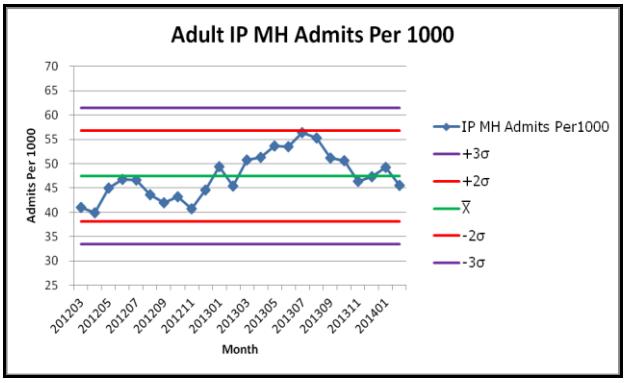
- Inpatient Hospitalization (IP) Mental Health (MH)Admits Per Thousand
- IP MH Average Length of Stay (ALOS)
- IP Substance Abuse (SA) Admits Per Thousand
- IP SA ALOS
- Residential SA Admits Per Thousand
- Residential SA ALOS
- Halfway House SA Admits Per Thousand
- Halfway House SA ALOS
- Community Psychiatric Supportive Treatment (CPST) Average Number of Units (ANOU)
- Psychosocial Rehabilitative Services (PSR) ANOU
- Other Outpatient ANOU
- MST ANOU
- FFT ANOU
- Homebuilders ANOU

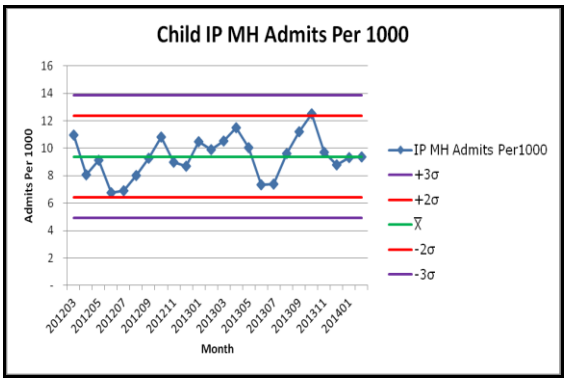
Magellan currently evaluates these metrics for several population groups where appropriate, including adult, adult 1915(i), child, child 1915(c) waiver, and child 1915(b3) waiver. Enhancements to monitoring of over/under utilization for these metrics were made during the contract year two through the inclusion of control charts. Control charts allow Magellan to evaluate utilization trends using statistical analysis. It evaluates utilization based on standard deviations from the mean to identify if there is statistical over or under utilization detected.

IP Admits, IP ALOS, SA Residential Admits, SA Residential ALOS, and outpatient ANOU provide valuable information when analyzing over/under utilization. When evaluating the metrics, it is important to consider that trends will become more stable as the data matures. There is also some degree of variability that is expected due to the size of the population (e.g., lower populations have higher

variability). Opportunities for improvement are indicated where over/under utilization is detected over a period of time. The date parameters for the report are March 1, 2012 to February 28, 2014.

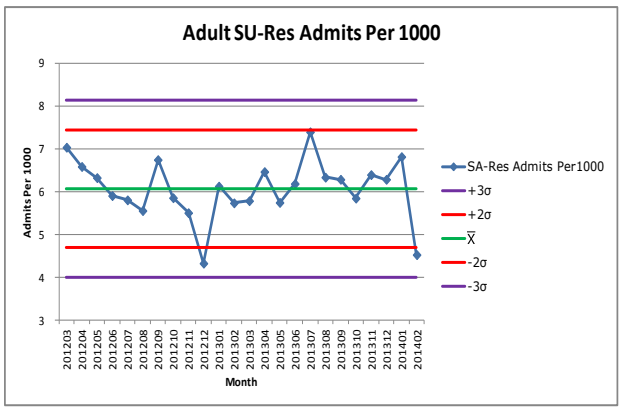
Admits/1000 Inpatient Hospitalization Mental Health

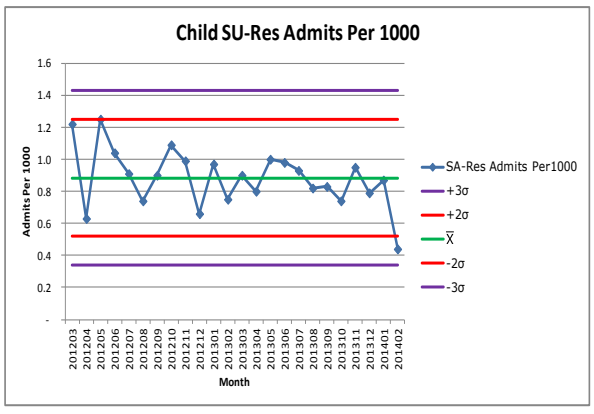




Although variation is noted, adult IP MH admits have remained within two standard deviations from the mean since implementation in March 2012. Admits have increased from 40.97 in March 2012 to 45.59 in February 2014. The metric does appear to have stabilized around the mean (47.47) over the past quarter. Adult admits per 1000 is higher than the Kaiser national aggregate data (30.1). It is believed that this number is skewed lower due to the inclusion of minors in the Kaiser data, which have a lower number of admits per 1000. The data indicate that child admits per 1000 also appears to have stabilized around the mean towards the end of contract year 2. The mean rate of child admissions (8.32) is lower than the adult admits (47.47). It is believed that this is explained due to the acuity level generally seen in adults with Medicaid, which tend to be higher than that of the child population. This is related to the eligibility criteria (e.g., poverty, homelessness, etc.) that place the adult population at higher risk for behavioral health problems.

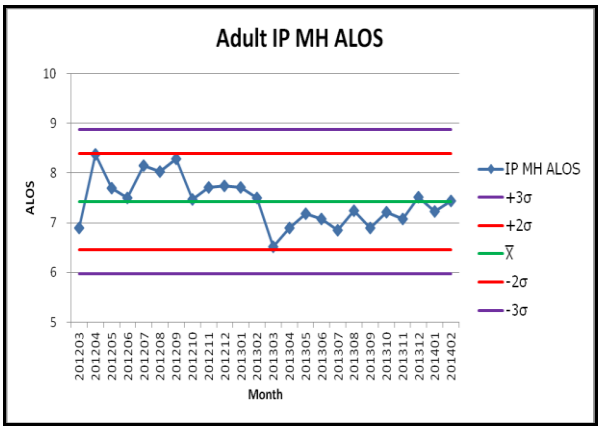
Admits/1000 Substance Use Residential (SU)

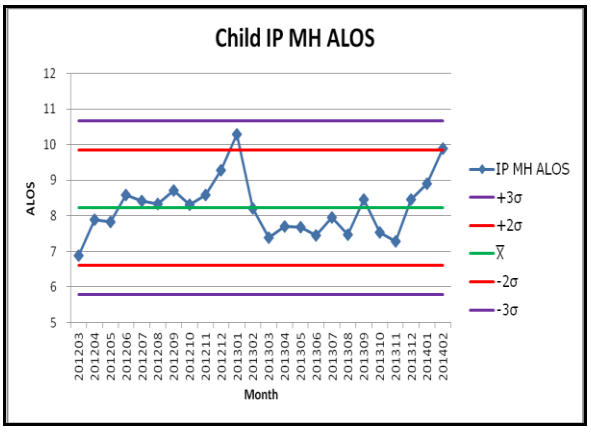




The mean number of admits for Adult Substance Use (SU) Residential is 2.75 and the mean for Child SU residential is 0.03. Because of the low numbers represented in these metrics, small shifts can appear to be significant. Both metrics were below the two standard deviation threshold in February 2014 and Magellan will monitor to determine if this is a trend that should be identified as an opportunity for improvement.

ALOS IP MH

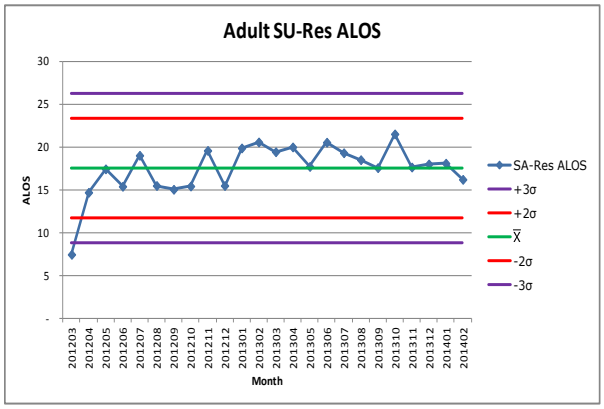


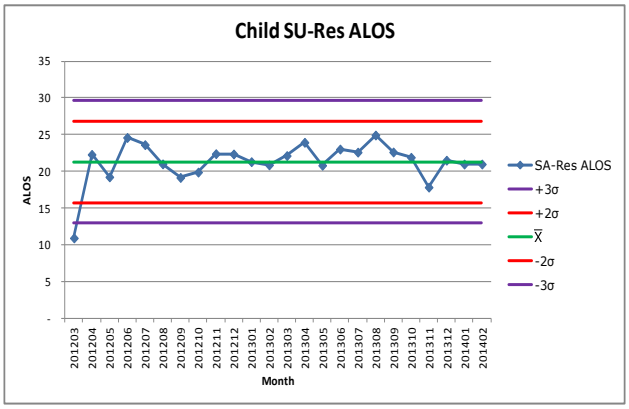


ALOS for IP MH for adults trended below the mean of 7.43 in the beginning of the second contract year, but has since had a steady trend upward towards the mean. This can be attributed to the efforts of the Utilization Management department. There has been significant shaping at this level of care to ensure members are able to discharge to the appropriate lower level of care when medical necessity criteria for IP are not met. The Child IP ALOS mean is 8.23. The chart does show some peak times where ALOS goes above two standard deviations indicating potential overutilization. Seasonality is an extraneous variable that could confound this element. Magellan continues to monitor to ensure that the ALOS returns closer to the mean. In contract year three, Magellan will conduct onsite provider visits with providers with high ALOS to collaborate on solutions to reduce ALOS.

ALOS SU Residential

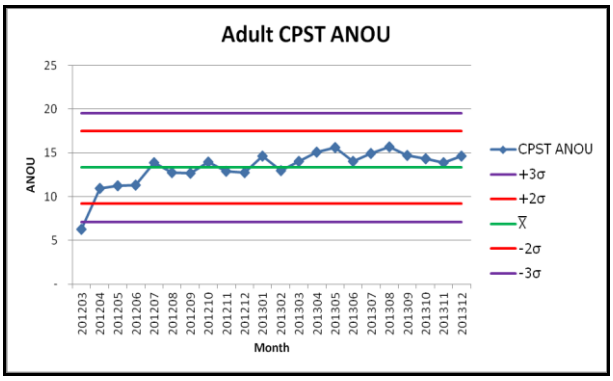
The mean ALOS for Adult SA is 17.49 days. The Child SU ALOS mean is a little higher at 21.28 days. The data is trending around the mean for both populations. Magellan Care Managers actively work with providers to shift utilization from programmatic (e.g., 28 days) to individualized treatment models to ensure utilization meets the member's needs.

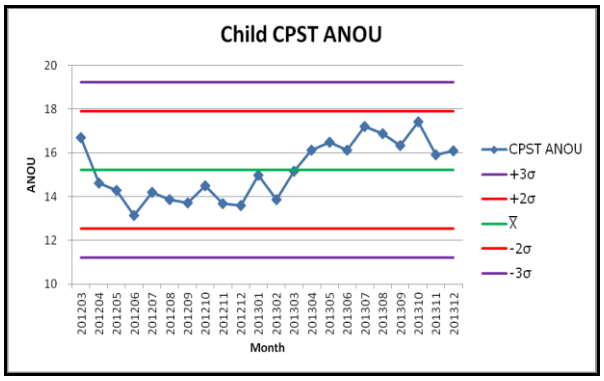


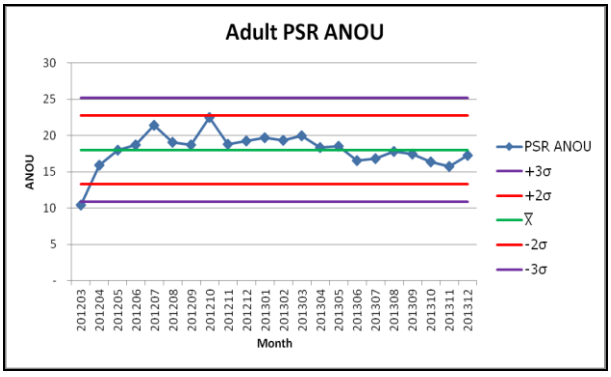


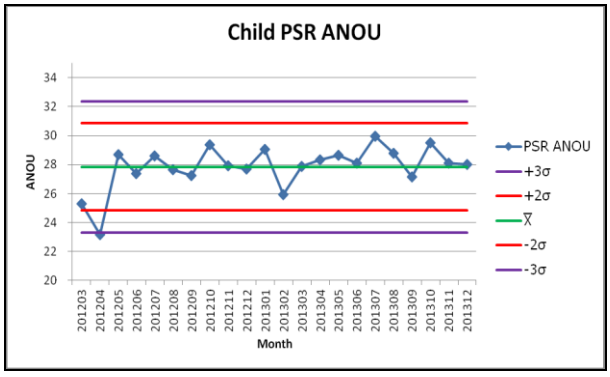
Outpatient Average Number of Units (ANOU)

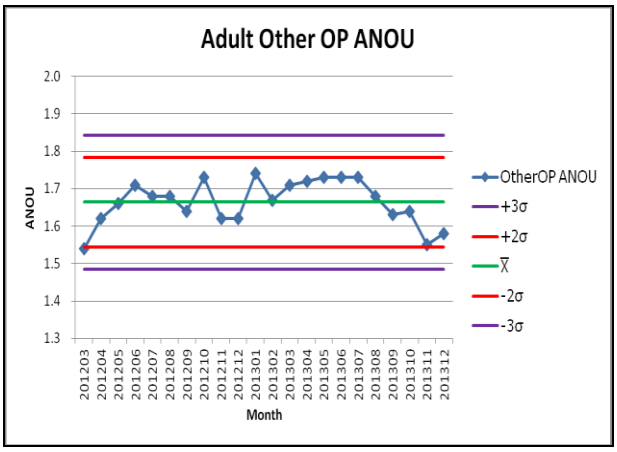
Graphs for Adult and Child CPST, PSR, and other outpatient services are provided below. CPST data for adults and children is trending upward. PSR and other outpatient services remained within two standard deviations from the mean. Magellan continues to monitor outpatient data in context of inpatient and residential utilization with the goal of decreasing utilization at these higher levels of care.

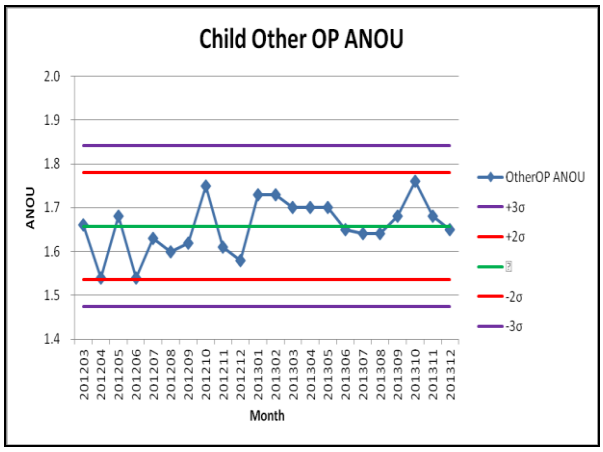












EPSDT Utilization

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a Medicaid initiative that provides comprehensive and preventive health care services, including mental health, for children. It is essential to ensuring that children and adolescents receive appropriate mental health and developmental services. Since March 1, 2012, the state of Louisiana has contracted the management of its behavioral health services, including the EPSDT program, to Magellan Health Services. As part of this contract, Magellan is responsible for ensuring penetration and utilization of mental health services to show compliance with the EPSDT program.

To evaluate EPSDT utilization, the LA CMC QI department analyzed aggregate claims data for all clients age twenty-one years or younger who received behavioral health services from March 1, 2012 until August 31, 2013. Data is limited, as claims history is only available back to March 2012. Continued analysis of data is recommended on a quarterly basis in order to control for short-term variability in the data that could be attributed to extraneous events. The data was analyzed using two groups: an implementation group (March to August 2012) and a re-measurement group (March to August 2013). Data was evaluated using the average number of outpatient visits per member per month for the entire Medicaid child population for these two groups. Data comparison was also done for the Medicaid child population and SPMI child population [1915(c) and (b3) waivers] since implementation. Results were then analyzed using the t test: paired two samples for means.

Comparison of utilization data for the implementation and re-measurement groups indicated there was a significant increase in the average number of outpatient services per member per month from the implementation phase to the re-measurement phase for the Medicaid child population (α=.05, P (T<=t) one-tail: < .001) (see Figure 1). The utilization data also indicated there was a significant increase in the average number of outpatient visits per member per month for the SPMI child population [1915(c) and

(b3) waivers] as compared to the entire Medicaid child population (α=.05, P (T<=t) one-tail: < .001) (see Figure 2).

Figure 1

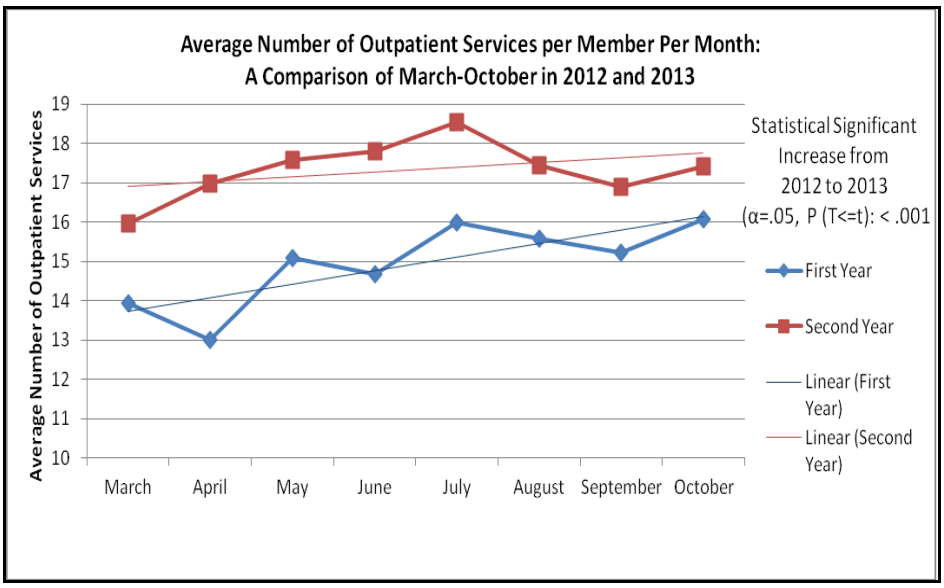
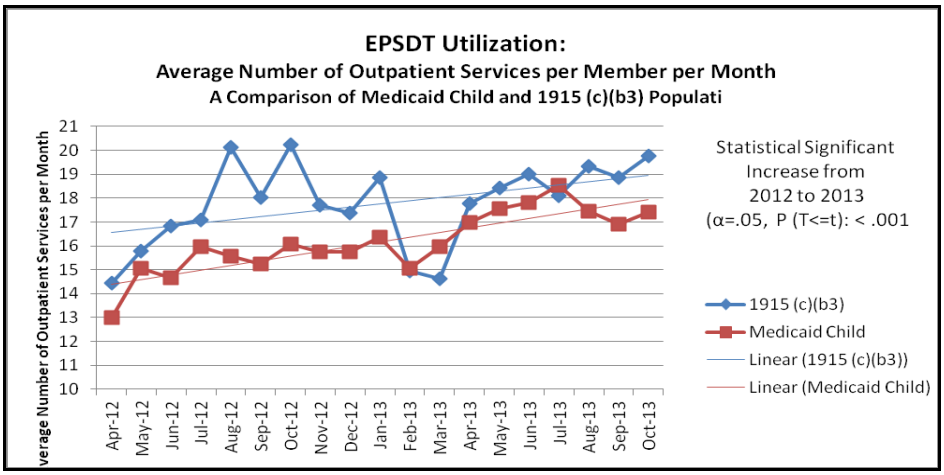


Figure 2



Utilization data demonstrated there was a significant increase in the average number of services for the Medicaid child population when comparing the implementation and the re-measurement phases. There was also a statistically significant increase in the average number of services per member per month between the SPMI child population and the entire Medicaid child population since implementation. Although utilization data showed significant increases in service utilization, there are still opportunities for improvement. The national prevalence rate for mental health problems for children is approximately 21%. As previously discussed in the demographic section, the penetration

rate for minor members (21 or younger) was 11.16%, which is higher than the SAMHSA national average of 6.7% for those receiving behavioral health services, but lower than national prevalence rates would indicate. Since many children are seen in their PCP offices for less severe behavioral health needs, Magellan continues to coordinate with physical health plans to ensure youth are receiving appropriate services, particularly in the form of the appropriate use of psychotropic drugs. Magellan continues to monitor these metrics to ensure continued upward trends in utilization.

IX. Screening Program Activities

The LA CMC QI program develops and demonstrates ongoing implementation screening programs to identify members that would benefit from behavioral health services. Magellan utilizes the Child and Adolescent Needs and Strengths Assessment (CANS) Comprehensive for minor populations to determine eligibility for the CSoC program. The Level of Care Utilization System (LOCUS) is used as part of the 1915(i) State Plan Amendment eligibility determination process for the adult population. If members are determined to be eligible for these programs, they have access to expanded home and community based services not available to the general Medicaid population. Magellan has identified that there are opportunities to improve penetration among the adult population. In the third contract year, Magellan will implement a new Independent Assessment process. Magellan has contracted with a statewide provider to conduct Independent Assessments. Please refer to Section XVIII Behavioral Continuum (System Transformation) for more details.

Magellan will refer members identified with Serious and Persistent Mental Illness (SPMI) for evaluations to improve programmatic participation. Magellan has also identified an opportunity to increase penetration among the EPSDT population as discussed in the previous section. In the third contract year, Magellan will partner with the Department of Education and primary care physicians to promote the use of the Pediatric Symptom Checklist-17 (PSC-17) to identify minors who may benefit from a formal assessment.

Magellan also promotes screening tools on its website. Members have access to a depression and an alcohol use screening tool on the Magellan of Louisiana website:

- **Depression Self-Assessment**: CES-D Scale (Center for Epidemiological Studies-Depression Scale)
- **Alcohol Use Self Assessment:** Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization and tested in a worldwide trial.

Providers have access to the assessment tools to administer to members, or members can access them online. Members are instructed that the screening should not be taken as an accurate diagnosis regardless of the results. Members are informed that if they are having thoughts of suicide, homicide or are functionally impaired, they should contact Magellan immediately and contact information is provided on the webpage.

X. Behavioral / Medical Integration Activities

The Care Management team has made it a priority to continuously improve the care coordination activities and partnership with the Bayou Health plans. The Louisiana CMC Care Management team has ongoing monthly meetings with the five health plans that comprise the Bayou Health Plans, which are AmeriGroup, Community Health Solutions, Amerihealth Caritas, Louisiana Healthcare Connections, and United Healthcare Community Plan. These monthly meetings allow the health plans and the Louisiana CMC to exchange information, discuss the needs of members who are jointly managed and to strategize and implement interventions to manage difficult and complex cases.

Four Recovery and Resiliency Care Management (RCM) care managers are assigned to work with the five Bayou Health Plans to ensure continuous care is provided to members. Additionally, a Health Plan Liaison position has been added to the Louisiana CMC. The liaison is a registered nurse who coordinates activities with the health plans and ensures that members with very complex medical and behavioral needs have those needs met. The Louisiana CMC care managers, health plan liaison, medical administrator, and chief medical officer (CMO) attend rounds with the plans. The CMO is also available for further consultation, when needed.

Magellan also has one Recovery and Resiliency care manager assigned to work with pregnant women with behavioral or substance use disorders. This care manager works closely with state-wide OB/GYN professional groups, local health units, hospitals, residential treatment facilities, behavioral health providers and health plans to coordinate care for these members at high risk of negative outcomes. These members are assigned to the highest level of the Tiered Care Management model.

Rounds are conducted with each Bayou Health Plan at least twice monthly. A shared documentation system is in place with each health plan, whereby information is exchanged at least twice each week on all members currently being co-managed. Additional telephone contact allows the health plan care manager and the Magellan care manager to work together to coordinate care.

These care coordination activities have been folded into the RCM Tiered Care Management system. Members who are lower risk and only require connections to outpatient services and minimal follow-up are assigned to Tier 1. Members more at risk or who have complex medical needs are assigned to Tier 2. Examples of situations that would trigger assignment to Tier 2 include:

- Unstable mental status due to pharmacy issues
- Unstable medical status with a behavioral component

- Behavioral issues when etiology is not clear. Possible etiology may be due to a mental illness, a neurological/cognitive issue (TBI, CVA, Dementia, Hypoxemic event), or developmental disability (MR, autism)
- Frequent medical emergency department utilization due to a psychiatric issues that may mimic medical issues, or medical issues that may mimic psychiatric issues.
- Non- compliance with medical treatment due to mental illness, or non compliance with mental health treatment due to a medical illness
- Unstable eating disorders
- Pregnant members who are medically or psychiatrically unstable and/or unwilling/unable to seek treatment

To improve collaboration as well as coordination activities, Care Management staff receive ongoing training on Bayou Health benefits and the referral process. Triggers for a referral from the health plans to the Louisiana CMC include:

- The number of inpatient admissions
- A child under the age of 12 admitted inpatient
- A pregnant woman who is also a substance user
- A child of any age with one inpatient admission and a diagnosis of autism spectrum disorder
- A member with 2 or more inpatient psychiatric stays within a rolling 12-month period
- A referral from a care manager as a result of a targeted risk assessment
- Referrals for partners in the Louisiana Behavioral Health Partnership (e.g., DCFS, OJJ, etc.)

When a Bayou Health Plan member has been identified as being in possible need of behavioral health services, the Care Management unit works to identify services to which the member's primary care physician can then refer him/her or the primary care physician relays the phone number for the member to contact the Louisiana CMC. Cold calls are never made to these members, unless after careful research, the individual is found to have already contacted Magellan or utilized services authorized by Magellan.

The table below presents the referrals received to and from the Bayou Health Plans:

Time Period	Referrals to Magellan	Referrals to Health Plans
2013-Q1	70	0
2013-Q2	220	2
2013-Q3	370	109
2013-Q4	117	14
Totals	777	125

Because behavioral health is a specialty service, it is anticipated that there will be more referrals from the Bayou Health Plans to Magellan because of the large volume of members served by these plans. This collaboration has enabled the Louisiana CMC to monitor the care of its members across the health care delivery spectrum and helped to improve the quality of care members receive.

Coordination of Care with Primary Care Physicians

Magellan requires that providers communicate and collaborate with a member's PCP. This is especially important in situations where the member presents with a complex co-morbid diagnosis and where the medical and behavioral health issues can impact the member's ability to participate and benefit from treatment services. Magellan is responsible for facilitating this communication and the provision of support and tools to providers to ensure this communication occurs.

Magellan network providers are required to ascertain whether the member is being seen by a PCP as part of the assessment and treatment planning process. For members with a clear indication of a physical health issue, such as cardiovascular disease, diabetes, or hypertension, the provider must identify, obtain information on the PCP, and seek the member's written permission to contact and communicate with the PCP. In such cases, the provider works with the PCP to discuss the treatment plan, medication management, ongoing service needs, and other issues that impact the member's treatment and well-being. As appropriate, compliance with a medical regimen can be incorporated in the member's behavioral health treatment plan. The PCP is included as part of the member's treatment team and works collaboratively with the provider to manage an integrated Plan of Care (POC).

Ensuring Appropriate Care Coordination with the PCP

There are multiple processes through which we ensure that appropriate care coordination occurs between the behavioral health provider and the PCP:

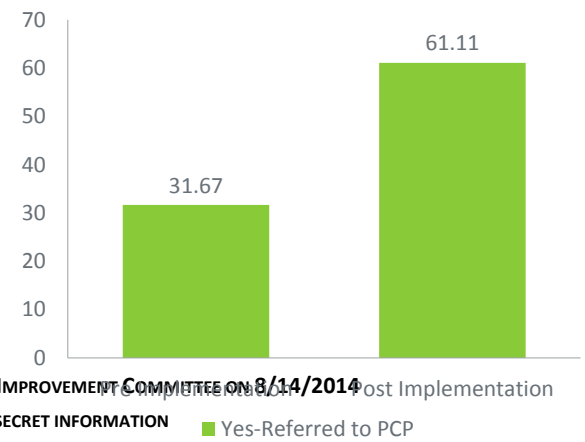
- Care Managers review and ensure that such care coordination exists as part of their **utilization management** functions. If a deficiency is identified, they will notify the provider and, as needed, work with the provider to facilitate such communication. Magellan contacts the Bayou Health Plan care mangers to refer members with medical needs without an identified PCP. Coordination of care with the PCP is an integral part of the services we provide for members with complex needs enrolled in RCM. For these members, we use the joint treatment planning process as one of the primary ways we ensure there is communication and coordination of care between multiple providers and systems of care.
- The quality management team reviews for this type of collaboration as part of our treatment record reviews. Where a deficiency is noted, the provider is offered additional feedback and training or, in

cases of continued problems, is placed on a corrective action plan. Providers are also expected to provide the PCP with information about the member's ongoing needs, especially where a member is hospitalized or requires complex services. We use our grievance process as a means of identifying any issues related to communication with PCPs. When we receive a grievance regarding lack of participation between the PCP and BH provider, our quality management or provider network staff reach out to the provider to address the issue. If a trend is noted in the lack of communication, we will implement a focused process to address the issue. There were no grievances regarding PCP coordination in contract year two.

- Magellan also conducts regular provider trainings, provider manual, provider newsletters, and other provider and facility communication to highlight and emphasize the importance of collaboration between the BH provider and PCP and ways through which providers can augment this type of coordination of care. For example, in one training with providers in Louisiana, we specifically addressed the following requirement that is highlighted in our policies and procedures: "Through this policy, it is our expectation that, with written authorization from the member, you will communicate key clinical information in a timely manner to all other health care providers participating in a member's care, including the member's primary care physician (PCP)."

- **Continuity of Care Documents** –Nitor Group's HISPDirect is our current avenue for disseminating Continuity of Care Documents. Magellan's Clinical Advisor (the EHR used across the State of Louisiana by providers contracted to the LBHP) can send CCDs as requested to participating providers and other HISPDirect enabled entities. Providers may choose to register with HISPDirect to receive updates within Magellan's EHR. In the future, Magellan will be coordinate with LaHIE provided LaHIE's readiness and availability.

In a recent program, we provided education and training to the medical staff of five large Louisiana hospitals on the importance of PCP referrals and provided detailed information on the process for making such referrals. As noted in figure below, the pre- and post training results showed an increase of nearly 30 percentage points in PCP referrals from before to after the training, demonstrating the importance of this type of communication and training.



XI. Coordination of Care Activities

Coordination of Care for members across multiple levels of care, treatment episodes and transition periods has been a priority of the LA CMC. The LA CMC has focused on key activities that include:

- Enhanced involvement of follow-up specialists with members who are receiving treatment in inpatient settings;
- Implementation of a standardized (waiver-compliant) plan of care for children enrolled in CSoC;
- Care manager-generated plans for care for adults with 1915i eligibility;
- Implementation of the new 1915i model utilizing a state-wide Independent Assessment Community Based Care Management agency; and
- Preliminary implementation of bridge appointments.

Care Managers and Follow-Up Specialists have been teamed together to work with particular hospitals. With increased individual accountability, follow-up rates have improved over time. Also, Follow-Up Specialists have taken the lead in identifying outpatient providers who may not be meeting their appointment access standard obligations and coordinating efforts with the network department to address those deficiencies.

The Follow-Up team implemented an admission strategy in early 2014. This intervention includes the following steps to help improve coordination of care for those members admitted to an inpatient provider.

- Researching claims to identify if members admitted to IP have received outpatient services. They then create notes to ensure UM/CM staff have the necessary information to coordinate care (e.g., previous IP admissions, demographics, current outpatient providers etc.) to help assist the care managers as well as the UR dept/discharge planners from the hospitals as it pertains to follow up care.
- Contact ACT providers to notify them if any members currently enrolled in ACT were admitted to inpatient level of care.
- Assisting ACT providers in locating “missing” members. (If an ACT provider has not been able to locate a client they will call in and notify them if they have been hospitalized.)
- Contact outpatient providers to notify them when their clients, who have current authorizations with Magellan, have been admitted to IP care.
- Schedule 1915(i) Independent Assessments as needed for clients to ensure they have access to HCBS if they meet clinical criteria. Referrals to RCM as needed.

The LA CMC has worked collaboratively with one high utilization psychiatric inpatient hospital to develop a bridge on discharge program. This is a step down outpatient service meant to immediately ‘bridge’ gaps between inpatient and ambulatory care and is not a substitute for the community provider

of choice. A bridge session is considered part of discharge planning which is begun during inpatient admission with information obtained during inpatient benefit certifications including the insured's community tenure risk factors. During the inpatient continued stay benefit certification(s) any barriers to community tenure are updated as needed to maintain or re-design the discharge plan. MBH requires that a discharge plan MUST include a provider name with a date and time. It has been shown that a person with a scheduled service is more likely keep the appointment.
The Bridge session must be with a LMHP provider such as a social worker, and occur after the insured has been discharged (discharge orders written by the attending) to a non-inpatient setting, but before the insured, leaves the facility. Bridge sessions take place in the facility's outpatient service area or an office designated by the facility for bridge session, never at bedside. During the bridge session the LMHP provider is to solidify the discharge plan by:

- Confirm demographic information with the patient and their family. Please obtain a current address and working phone number.
- Review Discharge Plan and answer any questions.
- Discuss the importance of follow-up and how engagement in aftercare can reduce the chance of readmission.
- Discuss the importance of taking medication as prescribed. Give suggestions that can assist with remembering medication such as a medication organizer, alarm, connecting with daily routine, etc.
- Discuss possible barriers for keeping the appointments so that Magellan staff can work with the patient on working out this issue (examples: transportation, money for medication, medication until next appointment, comfort level with scheduled provider, etc.).

Bridge on Discharge forms are completed by clinician and faxed to Magellan daily. Magellan reviews form to identify if discharge plan meets specifications. If not, follow up specialists will contact clinician about deficiency. In contract year three, the BOD program and admissions team intervention will be monitored via the Transitional PIP.

Another mechanism to coordinate care is through Wraparound Agencies (WAAs). WAAs are providers that work with members in the Coordinated System of Care (CSoC) program. The WAA is tasked with coordinating care, ensuring member needs are met and monitoring the implementation of the member's plan of care. Since the implementation of a standardized plan of care in the second contract year for children enrolled in CSoC, dramatic increases in utilization of home and community based services and waiver services were observed.

Service	March 2013	February 2014
Current Enrollment (2/28)	724	1067
Youth Support & Training	873 units	10,581 units
Parent Support & Training	1,126 units	8,303 units

CPST	4,116 units	7,134 units

For adults, during contract year 2, the LA CMC implemented both short-term and long-term interventions to move toward full compliance with the 1915(i) State Plan Amendment (SPA) that governs home and community based services for adult members. Internally, care managers collaborated with newly eligible for 1915(i) member and treating providers to construct a plan of care to meet the member's needs as a short-term solution. Simultaneously, a long-term intervention was being implemented to resource a provider to develop and monitor the plan of care. A Request for Information was issued to solicit an Independent Assessor Community Based Care Management agency. This agency was intended to be Magellan's preferred provider of independent assessments and plan of care development and help bring members conflict-free case management as required by the 1915(i) SPA. A cross-departmental work group was established to choose the provider (Pathways) and implement the program. A phased rollout is planned for the remainder of 2014. This program is described fully in Section XVIII Behavioral Continuum (System Transformation).

XII. Clinical/Functional Outcomes Activities

Magellan's Quality, Outcomes and Research Department (QOR) has worked extensively and successfully with members and customers to identify a range of appropriate member-reported and other assessment tools, which together form the foundation of the Magellan *Outcomes360* program—a comprehensive, integrated approach to clinical measurement and outcomes reporting. Designed to address the recovery and resiliency process, Outcomes 360 relies on quantifiable measures to track progress and identify areas for continued improvement. In designing the Magellan *Outcomes 360 suite*, Magellan drew from industry standards for effective measurement tools and collaborated with industry leaders, including former SAMHSA administrator, Charles Curie, who led the development of the National Outcome Measures (NOMs) at a federal level, to develop scientifically sound and clinically useful measurement instruments. QOR incorporated input from members, family members and providers. The end result is reliable data reflecting mental and physical functional health status of individuals and geared towards measurement of the NOMs domains, with a strong recovery and resiliency orientation. The primary components of the Louisiana CMC *Outcomes 360* include the following:

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

A. Consumer Health Inventory (CHI) and Consumer Health Inventory – Child (CHI-C)

The CHI surveys are self-administered via computers, paper, paper fax form or email link and take clients about 5-7 minutes to complete. The CHI-C is for parents/caregivers with the same administration methods and timeframe. An immediate, actionable outcome report in a PDF is available for the member and the provider to use immediately in treatment. Re-assessments within 210 days are connected and show treatment over time. Overnight, the provider's PDF is saved into the provider's mp.com account and the raw data is sent to Magellan for reporting, including the Provider on-demand web-report and a Magellan daily report. The CHI/CHI-C systems also provide aggregate reports of client outcomes by clinician MIS#, clinic MIS#, and account. The CHI is for ages 14+ and the CHI-C for up to age 17. The CHI and CHI-C can both be used for youth ages 14-17 for youth and parent voice. The surveys cover outcomes both for symptoms and functioning. Survey results are aggregated for all initials, reassessments, third+ assessments and most recent assessment. Paired outcomes reports are defined as the initial assessment to most recent assessment. The outcomes are reported by actual score, improvement, clinically significant improvement and symptom set improvements.

The Louisiana CMC uses the CHI assessment as part of the RCM program to evaluate outcomes. Since implementation, there were 438 RCM CHI assessments administered. Twenty-eight of these members have had more than 3 CHI administrations. There are both emotional and physical health scales to measure symptom reduction. On the emotional scale, 52% showed any improvement with 36% showing statistically significant improvement. Fifty-two percent of members also showed any improvement on the physical health scale with 37% showing statistically significant improvement. The CHI also indicated that 43% of the members reported progress in strengths and coping skills, 28% reported progress in provider relationship, and 20% reported progress in confidence in treatment.

In January 2014, Magellan implemented a CHI pilot program with 9 home and community based providers. The pilot focused on adult members that were new members to the providers. Magellan's National Director of Program Innovation and Outcomes conducted a four-part series of webinars to improve understanding on the clinical and programmatic uses of the CHI. Magellan also tracked CHI utilization on a bimonthly basis to shape the providers and promote utilization. In May 2014, 7 of the 9 providers were actively utilizing the CHI. A total of 178 initial CHIs were completed with 69% of those occurring after March 17th. There were 28 members with a paired CHI. In contract year 3, Magellan will discuss with the state that the CHI may be a valuable resource in collecting National Outcomes Measures (NOMS) data as well as statewide clinical outcomes as we continue the partnership.

B. TeleSage Outcomes Measurement System (TOMS)

The Office of Behavioral Health (OBH) is currently contracted with Telesage to assist in the collection of NOMS, which are required to be reported by the state in order to receive federal block grant funding.

Telesage uses the Telesage Outcomes Measurement System (TOMS) surveys to measure treatment outcomes for both adults and children. TOMS surveys are completely self-administered via touch-screen computers and take clients only 6-12 minutes to complete. An immediate, actionable outcome report is produced and is sent to the clinician for use in treatment sessions with the client. The TOMS system also provides aggregate reports of client outcomes by clinician, clinic, region/ Local Governing Entities (LGE), and state. LGE clinics are required to administer using the following guidelines:

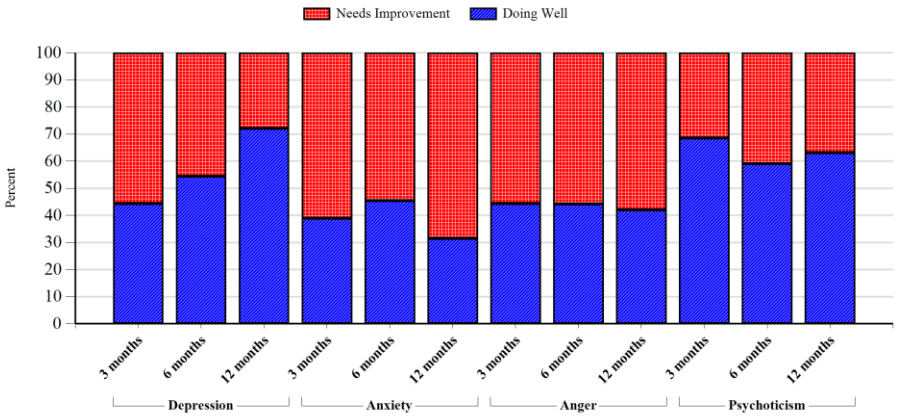
- TOMS survey is administered within 30 days of admission.
- Treatment plan addresses the "Needs Improvement" items of the TOMS survey adequately.
- During the first year, TOMS survey is administered every 3 months from date of initial.
- Following the first year, TOMS survey is administered every 6 months thereafter.

Although Magellan does not receive the raw data, it does have access to outcomes reports through Telesage. The reports are done on a quarterly, calendar schedule and fiscal year. The evaluation looks at data from the first quarter (Q1) of the calendar year (January-March) for 2014. Comparison in administration data is based on Q1 of 2013. The data is divided into two categories: new clients (those who have been in treatment less than one year) and existing clients (those who have been in treatment longer than one year). Graphs are provided by the Louisiana TOMS Aggregate Outcomes Summary Report Card.

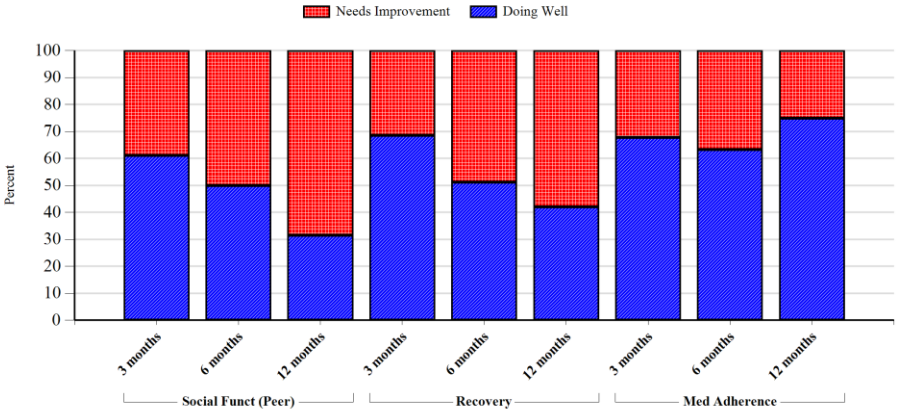
New Clients

New clients are expected to have the TOMS administered within the first 30-days of admission and every three months of the first year. On average, 35 new clients responded to questions on the TOMS during the 3-month administration, 41 for the 6-month administration, and 17 for the 12-month administration in 2014. This represents a 327.2% increase from the 3-month administration for Q1 of 2013 (average n=11). It is believed that this increase is due to elements added to Treatment Record Review to monitor TOMS utilization in August 2014. LGE clinics are required to administer the TOMS as part of federal block grant funding, and are placed on Performance Improvement Plan if deficiencies in administration are detected. Three of the four symptoms metrics (anxiety, anger, and psychoticism) showed increases in “needs improvement” from the 3 and 12-month administrations. The symptom measure for depression showed an upward trend of “doing well” between the 3 and 12-month administrations. Functional measures for medication adherence and binge drinking showed improvement; however, the remaining seven metrics showed downward trends or remained the same.

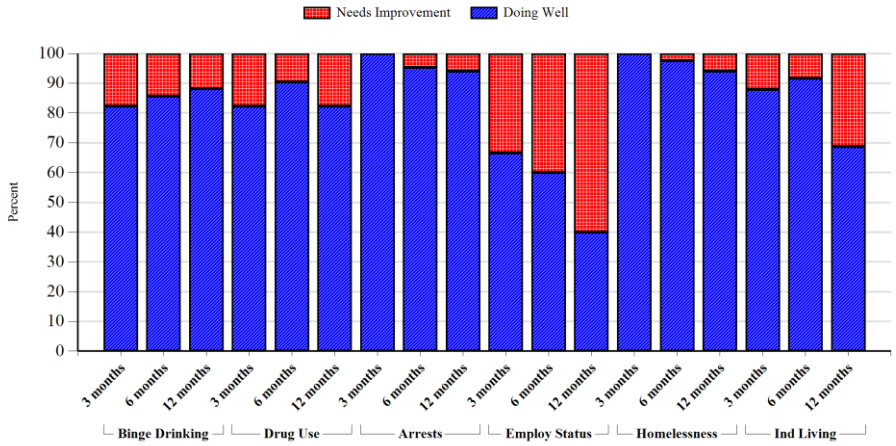
New Clients: Symptoms



New Clients: Functioning



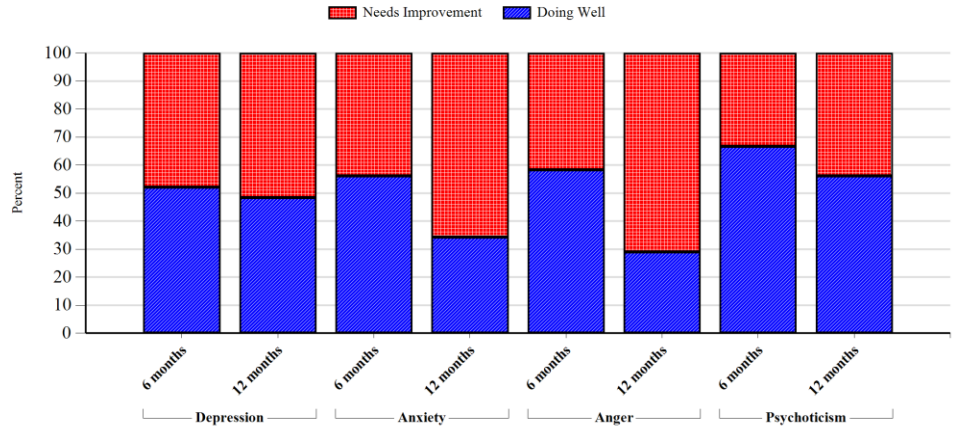
New Clients: Functioning



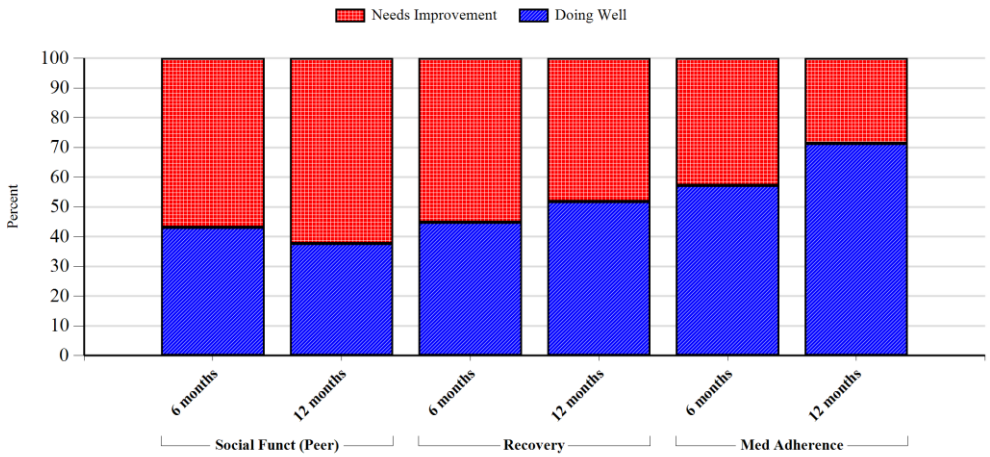
Existing Clients

According to OBH, existing clients are expected to have the TOMS administered every six months. On average, 200 existing clients responded to questions on the TOMS during the 6-month administration and 52 for the 12-month administration during Q1 of 2014. This represents a 325.5% increase from the 6-month administration in Q1 of 2014 (average n=47). As stated previously, it is believed TRR monitoring attributed to improved utilization. Three of the four symptoms metrics (anxiety, anger, and psychoticism) showed increases in "needs improvement" from the 6 and 12-month administrations. The functional measure for homelessness for existing clients indicates 100% doing well at both administrations. Seven of the nine metrics for functioning show slight improvements from the 6 and 12-month administrations, with social recovery and arrests showing slight declines.

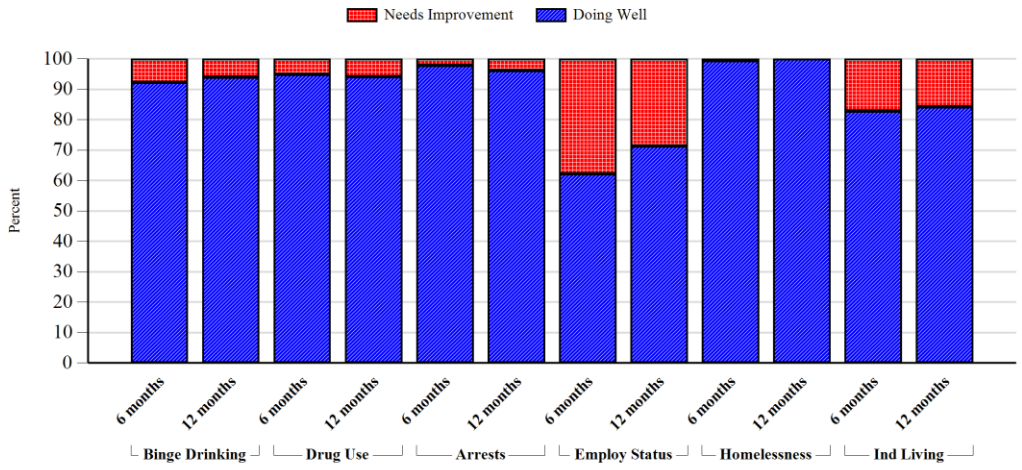
Existing Clients: Symptoms



Existing Clients: Functioning



Existing Clients: Functioning



C. Child and Adolescent Needs and Strengths Assessment (CANS):

Magellan has used CANS assessment tools for more than a decade partnering with providers to understand how best to use the information obtained from the CANS tool for assessment, treatment planning and measuring outcomes. Magellan created a CANS MH system integrating training, certification, individual reports and provider web reports – all available to network providers free of charge. The CANS provides state-of-the-art support through the MH provider portal, continuing education-qualified online training and certification system, learning collaborative in-person and by webinar, and access to CANS creator, John Lyons, PhD, through a consulting agreement. Magellan added a CANS Comprehensive (2012) version to the assessment portal. The CANS Comprehensive was created specifically to assess the needs and strengths of the population served in Louisiana. It measures the following metrics:

- Life Domain Functioning
- Youth Strengths
- Acculturation
- Caregiver Needs and Strengths
- Youth Behavior/Emotional Needs
- Youth Risk Behaviors
- Includes additional modules for school, developmental needs, substance use, trauma, violence, etc.

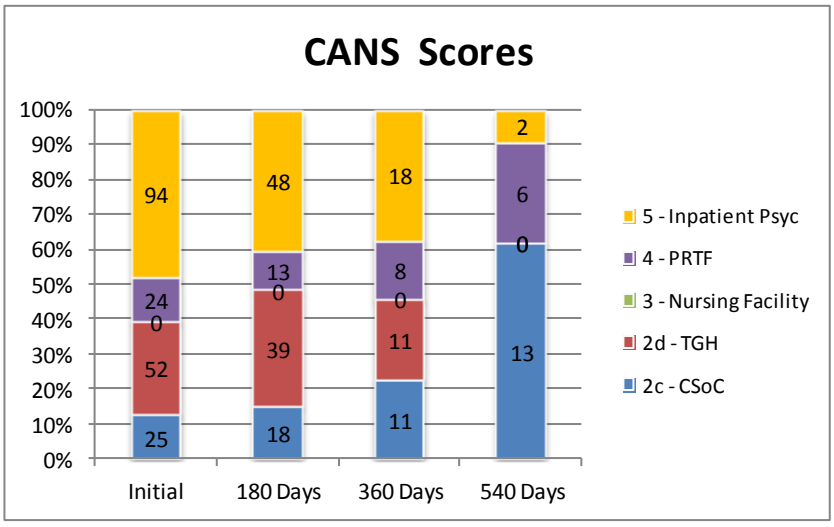
The CANS Comprehensive serves as both an eligibility tool and an outcomes measure for the CSoC population. The CANS is completed by a Licensed Mental Health Professional (LMHP) certified in CANS through the Praed Foundation. In order to receive certification, providers must score a CANS vignette on canstraining.com and pass at a .70 reliability or higher. The Praed Foundation website (canstraining.com) has the complete CANS LA training (e.g., 6 key characteristics of CANS, education videos by domains and items, action level key explanations, glossary items, etc.) as well as additional resources for CANS education (e.g., Total Clinical Outcomes Management education, access to a Praed Foundation Trainer). Completed CANS, along with the Independent Behavioral Health Assessment (IBHA), are submitted to Magellan's care management team to be reviewed by Licensed Care Manager. The Licensed Care Manager reviews the IBHA and CANS to ensure reliability of the CANS ratings and scores CANS to determine eligibility for CSoC waivers. Scoring is based on the following four algorithms that indicate the acuity of the member's need (Level of Need/LON) and risk for services (Level of Care/LOC):

- Inpatient (IP): LON 5
- Psychiatric Residential Treatment Facility (PRTF): LON 4
- Therapeutic Group Home (TGH): LON 2d
- Coordinated System of Care (CSoC): LON 2c

A score of 2c or higher indicate the youth meets eligibility for CSoC. CANS Assessments are then used in the clinical review and approval of CSoC Plan of Care Services. CANS Assessments are completed at the initial assessment and every 180 days thereafter. Overall member scores that decrease from a higher to a lower level of need are considered to show improvement.

Outcomes Data

A weighted sample by CSoC region enrollment of 200 members that were enrolled in CSoC in the second contract year was selected. CANS data were pulled from the member case file for initial CANS, 180-day CANS, etc. (depending on how long the member has been in CSoC). The data shows a decrease in the number of members represented in each administration period due to attrition; however, a decrease in the percentage requiring the highest level of need (IP) was observed in each administration.



The following provides an outline of the 2014-15 goals as related to the CANS:

- Automate the CANS Algorithms for improved outcomes tracking.
    - A request has been submitted to Magellan's IT department to upload the most recent inpatient (IP) algorithm and the electronic version of the Independent Behavioral Health Assessment (IBHA) into Magellan Provider (mp.com).
    - Trainings will be scheduled with Wraparound Agencies and Certified Providers to train on submitting IBHA and CANS into mp.com.
    - Once IBHA and algorithm uploaded, only online submissions will be accepted.
- Improve reliability of CANS ratings identified when different providers score the initial and subsequent CANS
    - Quarterly CANS trainings with Certified Providers and Wraparound agencies
    - Weekly to biweekly meetings with Operations Care Manager reviewing CANS and IBHA to discuss ongoing concerns with CANS ratings
    - 1:1 phone coaching offered to providers that need assistance with rating the CANS and to answer any CANS questions
    - Increasing continuity and consistency with CANS within the Wraparound agencies and the Certified Providers
    - Ongoing CANS education with the Office of Behavioral Health (OBH) CSoC team and the Wraparound Agencies
    - Increased utilization of CANS to inform the Plan of Care (POC) and Child and Family Team Meetings
- Implement CANS train the trainer with John Lyons.
    - Training CANS champions – defining supporting roles

  - Creating CANS regular team meetings
  - Defining inter-departmental responsibilities
  - Improving the functionality of canstraining.com
- Consider outcomes model to improve the validity of reporting CANS outcomes.
  - Consulting with subject matter expert on utilizing CANS to report outcomes and how to best report outcomes
  - Exploring CANS by domain (e.g., Life Domain Functioning, Youth Risk Behaviors, Youth's Strengths)
  - Consider the possibility of implementing 30 days CANS vs. using the Initial Eligibility CANS in reporting outcomes with the 30 day "treatment CANS" offering a more accurate identification of youth's needs and strengths in treatment.

XIII. Patient Safety

Magellan in Louisiana has an ongoing process for monitoring patient safety through customer comments, member grievances, accessibility measures, quality of care concerns and adverse incident reports. The ongoing monitoring of these measures individually and in aggregate allows the CMC to identify trends, which may require adjustment to the network, CMC staffing, or other processes in order to better meet the needs of members. This section will focus on adverse incidents, quality of care concerns, and the patient safety survey. Please see **Section III Accessibility and Availability of Services** and **Section XX Satisfaction Surveys and Grievances** for information on accessibility measures and grievances.

A. Adverse Incidents

Adverse incidents are defined as an unexpected occurrence in connection with services provided through Magellan, its subsidiaries and affiliates (Magellan), that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to an individual receiving services through Magellan or a third party that becomes known to Magellan staff. Types of incidents can include:

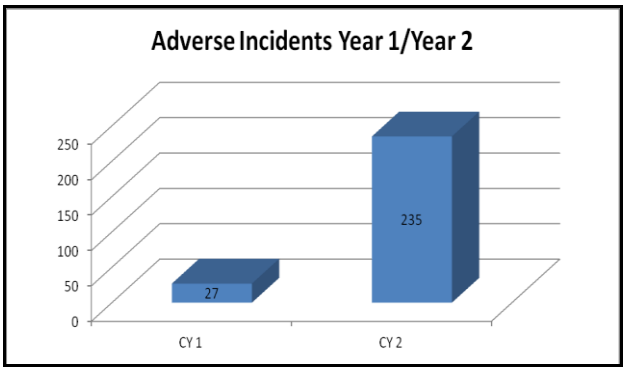
- Death
- Suicide Attempt
- Significant Medication Error
- Event Requiring Emergency Services (of the fire department or a law enforcement agency)
- Abuse (Physical Abuse, Psychological Abuse, Sexual Abuse, or Exploitation)
- Serious Injury or Illness
- Missing Person
- Seclusion or Restraint

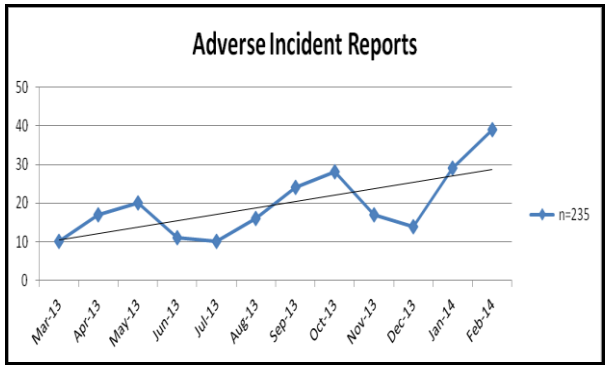
When an adverse incident is identified, whether by a phone call or reference from a member, provider, caregiver, etc., the Magellan representative completes a standard form and forwards it the QM department for entry into the database and investigation. If a member is reporting the concern, the member's primary contact will support and guide the member through the process. These member-facing roles receive training in first-call resolution and active listening techniques allowing them to focus on the caller, listen for key information, key feelings, and clarify their understanding while speaking with the Member. The QM department reviews the incident to assess the level of severity to ensure the safety and well-being of the individual involved for all reported QOC concerns and AI's.

All incidents involving abuse are reported to the appropriate regulatory and to the guardian when the involved member is a minor. The CMO or medical representative addresses any urgent clinical issues with the provider to ensure member safety. The QOC work group, a multidisciplinary team including the CMO and representatives from the UM, QI and Network departments, then reviews concerns to determine next steps, including identifying whether or not a provider performance inquiry and review are necessary. If so, the review is conducted according to the Provider Performance Inquiry and Review Policy with a report outlining the results of the review being sent to Magellan's Peer Review Committee, the Regional Network Credentialing Committee (RNCC). The RNCC will the results of the review to determine if action steps (e.g., provider's status in network is affected) are required. If no review is needed, the QOC work group will continue efforts to resolve any issues or problems and track and trend results. If the Grievance Coordinator notes more than three grievances for the same provider, the issue is escalated to the QOC team and reported to the RNCC.

AI data are analyzed for patterns and trends, such as a disproportionate number of a type or category of concern or a high or increasing number of concerns related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the RNCC conducts a root cause analysis and recommends interventions. This information is disseminated to the QIC to quickly identify where to focus improvement efforts. Magellan reviews this information continuously, so improvements to the system can be made on an ongoing basis. A summary of contract year two data and how that data are used to inform quality improvement activities is provided below.

Number of Incidents Reported

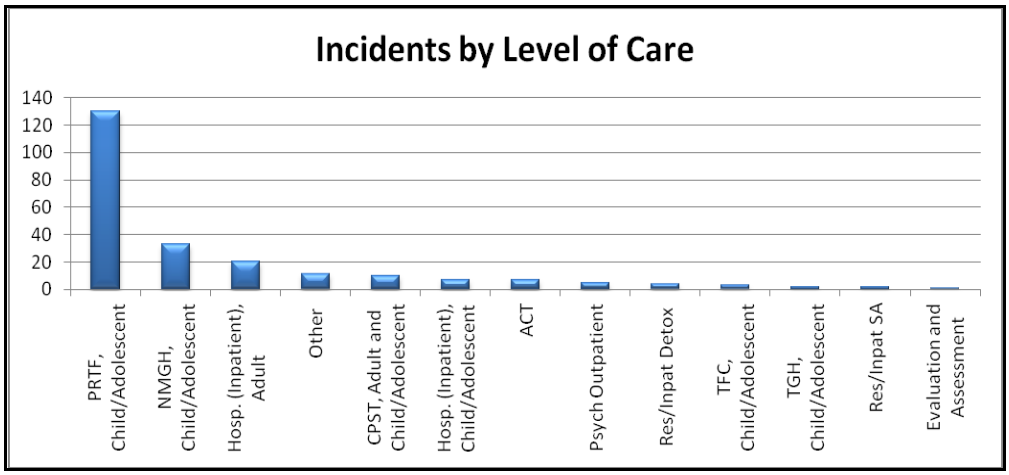




In contract year one, Magellan received 27 incident reports. Magellan believed that this number was an underrepresentation of adverse incidents occurring in the network and conducted root cause analysis to identify barriers to reporting. The major barrier identified was the lack of a standardized reporting form for the Louisiana CMC. Magellan worked collaboratively with DHH-OBH to implement a standardized critical incident reporting form and procedures for providers to submit incidents to us. As a result The Louisiana CMC received a total of 235 adverse incident reports in contract year two, which was a 770% increase in incident reporting.

Incidents by Type and LOC Reporting

Incident Type	Total
Missing Person/Elopements	86
Injury/Illness	41
Abuse	35
Death	29
Other	23
Suicide Attempt	8
Emergency Services Required	6
Neglect	6
Significant Medication Error	1
Grand Total	235



During the 2014 annual analysis of adverse incidents, it was also identified that 55% of all incidents occurred at the Psychiatric Residential Treatment Facility (PRTF) level of care. A facility was identified as an outlier in the overutilization of restraints and seclusions as well as missing persons/elopements. Magellan's CMO and quality team conducted an onsite quality and environmental site review. Magellan worked collaboratively with the facility to implement interventions aimed at reducing restraint and seclusion utilization including:

- Introduced a more rigorous screening process for youth to ensure level of acuity was adequately supervised
- Performed staff training on the use of proactive measures to de-escalate situations that could result in restraint/seclusion use
- Modified documentation to include the means by which staff felt they could have prevented the situation or prevent future occurrences.

As a result of these interventions, a downward trend in restraints and seclusions for the network was observed.

Although Magellan has seen an increase in adverse incident reporting, the data indicate that all LOCs are not reporting as required. Magellan will work with DHH-OBH to implement a contract year three performance improvement project to improving adverse incident reporting. Interventions for this project will be focused on improving provider awareness of reporting protocols and increasing accountability through augmented monitoring. It is believed that through this PIP there will be statistically significant improvement in reporting and a true baseline for critical incidents can be established. Once this baseline is established, Magellan will have the data to more efficiently and effectively target interventions to improve care for Members.

B. Quality of Care Concerns

Quality of Care (QOC) concerns are concerns related to the appropriateness of care or treatment/service delivery that are inconsistent with the standards of best practice. Magellan's approach to quality of care (QOC) concerns aligns with the Triple Aim goals by focusing on improving the Member experience of care as related to quality. Magellan has a comprehensive process to track, review, and investigate critical incidents and other QOC concerns. Magellan provides a standardized mechanism for external Members, providers, stakeholders, agencies, and the State as well as internal Magellan staff to report critical incidents and QOC concerns in order to ensure every voice is heard. This integrated workflow allows the QM program to place great emphasis on critical incident and QOC concern data to identify both individual provider issues and potential systemic concerns. Our integrated, Member-centric approach quickly engages the treating provider(s) to make sure the Member is receiving the appropriate care and services needed to address the issue and to focus the individual's whole health needs.

Magellan investigates and resolves apparent quality of care concerns using the following strategy:

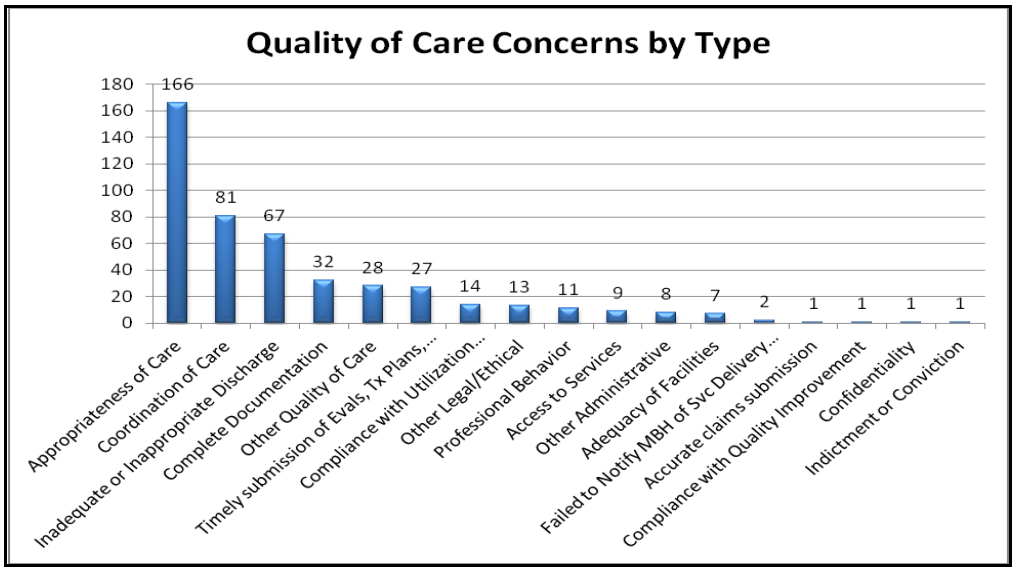
1. **Process and Resolve the Concern:** Magellan engages the Member or provider by expressing compassion for the concern and explaining the grievance process. This allows us to obtain vital information to conduct better investigations. We identify the Member or provider's expectation for the concern and discuss next steps and answer any questions. The case is then referred to a Quality Management Specialist for review and input into the database.
2. **Ensure Appropriate Care – Engage Care Coordination:** This is accomplished by calling the care provider to explain the Member's issue and request they contact the Member to schedule an appointment. We then follow up with the Member to verify the appointment is scheduled and ask if he/she would like someone to accompany him/her. We explain that the case will be reviewed as part of the QM process and encourage the Member to call with any future questions or concerns.
3. **Address Quality of Care Concern:** Magellan assesses **t**he level of severity to ensure Member safety, conducts the QOC investigation and gathers relevant documentation including medical records. PIPs are requested as needed and monitored for implementation and progress. Magellan's peer review committee oversees QOCs and tracks and trends data to identify systemic QOC.

When a QOC concern is identified, whether by a phone call or reference from a Member, provider, caregiver, etc., the Magellan representative completes a standard form and forwards it the QM department for entry into the database and investigation. If a Member is reporting the concern, the Member's primary contact will support and guide the Member through the process. These Member-facing roles receive training in first-call resolution and active listening techniques allowing them to focus

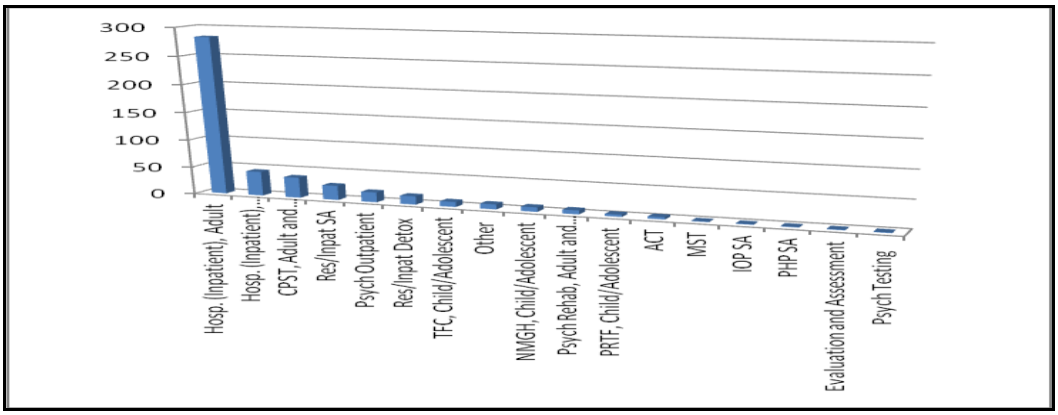
on the caller, listen for key information, key feelings, and clarify their understanding while speaking with the Member.

The QM department reviews the concern to assess the level of severity to ensure the safety and well-being of the individual involved. The CMO or medical representative addresses any urgent clinical issues with the provider to ensure Member safety. The QOC work group, a multidisciplinary team including the CMO and representatives from the UM, QI and Network departments, then reviews concerns to determine next steps, including identifying whether or not a provider performance inquiry and review are necessary. If so, the review is conducted according to the Provider Performance Inquiry and Review Policy with a report outlining the results of the review being sent to Magellan's Peer Review Committee, the Regional Network Credentialing Committee (RNCC). If no review is needed, the QOC work group will continue efforts to resolve any issues or problems and track and trend results. If the Grievance Coordinator notes more than three grievances for the same provider, the issue is escalated to the QOC team and reported to the RNCC. To complete the cycle, we contact the Member to determine if he/she is satisfied with the handling of the concern.

QOC reports are analyzed for patterns and trends, such as a disproportionate number of a type or category of concern or a high or increasing number of concerns related to a particular provider or a particular set of circumstances. When an aberrant pattern or trend is identified, the RNCC conducts a root cause analysis and recommends interventions. This information is disseminated to the QIC to quickly identify where to focus improvement efforts. We review this information continuously, so improvements to the system can be made on an ongoing basis. The following represents data for contract year two by type and LOC.



Level of Care Associated with QOC Concerns



Magellan's care and utilization management staff play an integral role in shaping the quality of our acute inpatient providers through the QOC process. In contract one, a total of 165 reports were submitted. By contract year two, 469 QOC concerns submitted, which represents an increase of 184.2%. It is believed this increase can be attributed to increased efforts by the Care Management staff to shape provider behavior at the inpatient psychiatric hospitalization level of care and improve reporting processes.

Magellan also analyzes trends in the type and level of care associated with the incidents. The largest categories of concerns reported are related to appropriateness of care and inadequate discharge planning. Although Magellan addresses each concern at the Member and provider level, these data are used to inform interventions and initiatives to improve quality of care. Interventions include developing and fostering relationships with the Bayou Health (medical) Plans to coordinate care for members with comorbid medical and psychiatric conditions, conducting clinical rounds for members with serious psychiatric conditions, referring high need members to the Recovery and Resiliency Care Management team for intensive case management and shaping provider behavior through Physician Advisors and quality monitoring. Magellan will continue to monitor Quality of Care Concerns to identify further opportunities for improvement.

C. Patient Safety Survey

Magellan's National QI Department created and conducts an annual survey of patient safety programs and practices currently in place for inpatient facilities and prescribers in the network. The survey, based on industry and accreditation standards, asks facilities about the areas covered by their patient safety programs, with a specific focus on behavioral health, including whether there are policies and protocols for:

- Reporting routine and non-routine safety events

- Using seclusion and restraint procedures safely
- Reducing the likelihood of medication errors, especially when a patient takes more than one medication prescribed by more than one doctor
- Reducing delays in evaluation, testing, and treatment for inpatients
- Using materials, furniture and building designs that foster safety
- Monitoring psychiatric units for materials and practices that, if present, could result in physical harm to inpatients, visitors or staff

Magellan's National QI department identified the following measures as the focus of a Corporate Quality Improvement Activity (QIA) that the LA CMC participates in. The QIA focuses on the following metrics and questions:

- Response Rate
- Send patient discharge summary and labs to patient's PCP
- Discuss history of adverse medication reactions with patient's PCP
- Have safeguards in place to prevent their overuse
- Review profile with provider at time of transition of care
- Review profile with patient at time of transition of care

Survey results are disseminated by the national survey department and evaluated by the Patient Safety Survey work group to determine opportunities for improvement. The work group includes representation from Quality Improvement, Network, Utilization Management, Follow-up and the Chief Medical Officer. The following metrics were identified as areas of interest for the LA CMC measure.

Coordination/Transition of Care		2012		2013		# N/A	Change (↑,↓, =)
		Number of Responses	% Positive	Number of Responses	% Positive		
2a	Send patient discharge summary and labs to patient's PCP?	32	68.8%	116	49.0%	16	↓
2d	Discuss history of adverse medication reactions with patient's PCP?	33	48.5%	117	23.6%	11	↓
Seclusion and Restraints (Facilities Only)							
4b	Have safeguards in place to prevent their overuse?	30	100.0%	110	96.7%	–	↓
Medication Management							
6e	Review profile with provider at time of transition of care?	28	82.1%	118	89.0%	18	↑
6f	Review profile with patient at time of transition of care?	29	96.6%	118	93.3%	14	↓
7a	Perform weight/waist circumference/lab tests at start of	32	75.0%	117	76.5%	19	↑

	medication?						

Baseline response rate data for 2012 was 41%. In 2013, the response rate increased 7.6 percentage points to 48%. It should be noted that the 2013 survey was sent to a larger sample of facilities and physicians (n=245) than 2012 (n=53). This is due to increase in the provider network between the two years. The metrics identified in the chart as opportunities for improvement. The following interventions will be implemented in the third contract year to address opportunities for improvement:

- Send reminder letters to non-responding providers.
- Conduct Coordination of Care (CoC) presentation with providers to educate and promote importance of coordination of care between behavioral health providers and PCP, upload presentation to website to reach global provider network and send provider wide communication to providers with links to presentation.
- Develop and disseminate algorithm to assist providers in understand protocol for identifying PCP from each Medicaid Health Plan.
- QI will conduct TRR reviews of inpatient facilities to monitor compliance. Providers who do not meet minimum fidelity standards will be required to submit PIP.
- Survey results will be disseminated to providers to inform them of opportunities for improvement
- Contact Bayou Health Plans to obtain their procedures on how to request lab tests. Provide algorithms to providers on protocol for requesting labs for each Bayou Health plan.

Opportunities for improvement were also identified for communication with PCPs. Please see **Section X Behavioral/Medical Integration Activities** for information on Magellan's interventions to ensuring appropriate care coordination with PCPs.

XIV. Treatment Record Reviews

The Treatment Record Review (TRR) process is one of the key activities of Magellan's Quality Assurance program**.** The purpose of TRRs is to monitor treatment record documentation and record keeping practices for providers in the LBHP. Significant changes were made in the TRR process and procedures during the 2013-14 contract year to improve efficiencies and reporting capabilities. Beginning in March 2013, a work group was formed to identify barriers to efficiencies and conduct root cause analysis. Process improvements were identified and interventions were implemented based on analysis of data. Interventions included moving to a single audit tool with level of care addendums rather than using separate tools for each level of care. In September 2013, QI initiated the utilization of a single audit tool that enhanced reporting capabilities across the network and improved identification of macro-opportunities for improvement. Magellan also adopted a procedure that allowed for clinical reviewers

to request Performance Improvement Plans (PIPs) for providers that had sufficient overall scores but had low section or item scores. This permitted the QI department to strategically shape provider behavior surrounding network opportunities for improvement and patient safety issues. Magellan also moved to a provider scheduling procedure that led to an increased number of reviews conducted per month 66.6% (n=12 in 2012-13; n=20 in 2013-14).

Another notable change to the TRR process was the inclusion of performance measure (PMs) monitoring for the 1915(i) State Plan Amendment and 1915(c) and 1915(b3) Waivers. Seventeen PMs are required to be monitored via onsite record reviews. Magellan implemented a policy and procedure to ensure quarterly auditing and reporting was standardized. Magellan adopted a tool to audit providers for waiver compliance. Providers are expected to adhere to PMs at 100% compliance. Magellan requires all providers who do not meet compliance standards to submit a Corrective Action Plan on how they intend to address deficiencies. More details of this new process are outlined in Section XVIII Behavioral Continuum (System Transformation) and detailed results are available in Appendix D.

Results

Because the old processes utilized a variety of tools, the data will be presented pre- and post-implementation of the review tools with the focus on post-implementation.

Pre-Implementation of Process Improvements

Cumulative Data by Level of Care (LOC) from June 2012 to August 2013

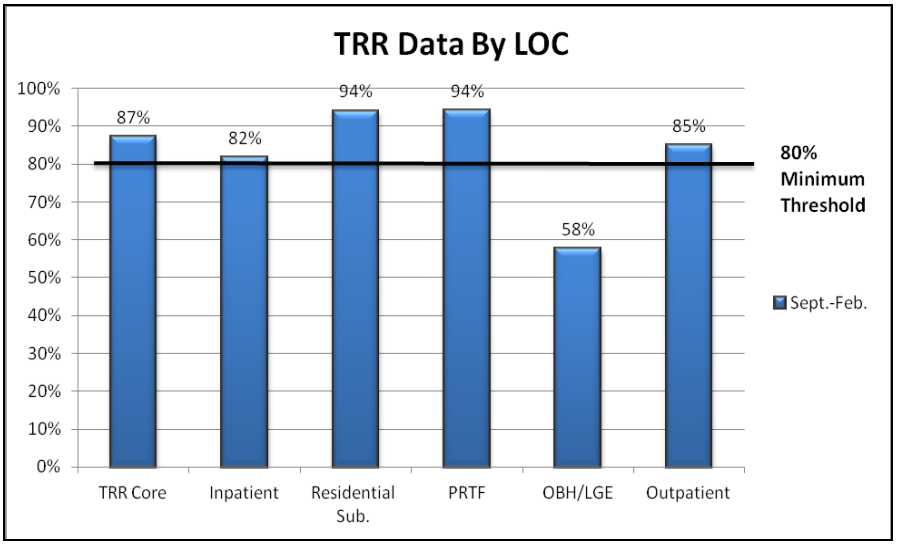
Level of Care	Total Facilities Reviewed	Total Charts Reviewed	Items in Compliance	Total Items Reviewed	Rate of Compliance (%)
Inpatient	50	689	29,534	32,331	91.3%
Residential Substance Abuse	15	207	7,938	8,975	88.4%
Outpatient	29	397	12,904	16,958	76.1%
WAAs	5	73	1,100	1,230	89.4%
Total Aggregate	99	1366	51,476	59,494	86.5%

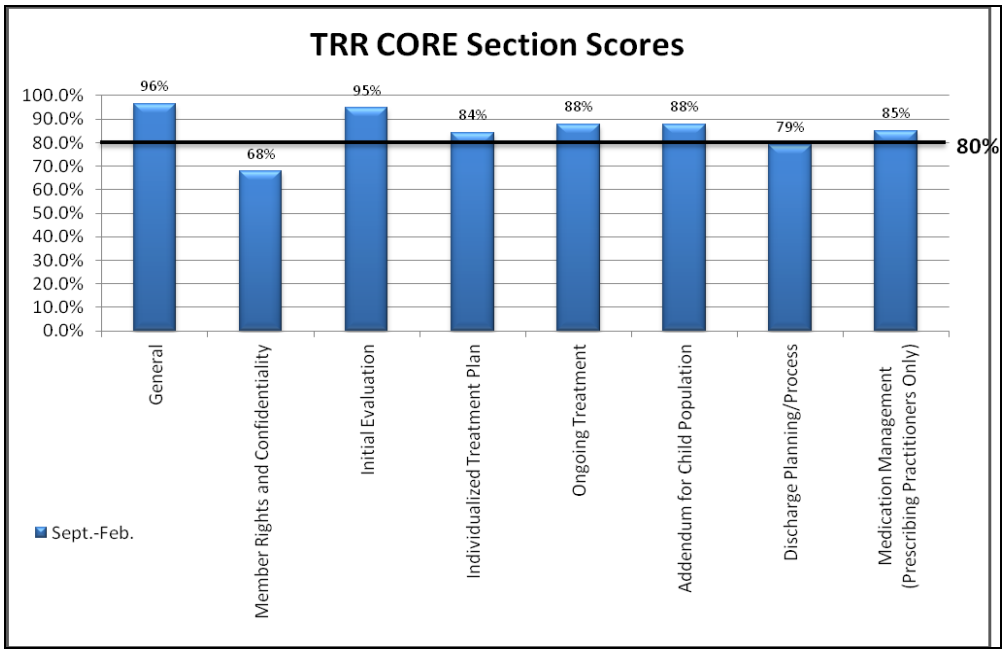
There were 99 providers reviewed from June 2012 to August 2013 with an overall compliance rate of 86.5%, which is 6.5 percentage points above the minimum threshold. The data was collected by separate tools for each level of care. These were replaced by a single tool implemented in September 2013.

Post-Implementation of Process Improvements

Seventy-five providers (n=784 charts) were reviewed for a TRR, Waiver and/or PIP Follow up review from September 1, 2013 to February 28, 2013 using the new audit tool. Sixteen inpatient hospitals, eight residential substance use treatment facilities, one psychiatric residential treatment facility, 13 Local Governing Entity (LGE) clinics, and 37 outpatient facilities were reviewed. Results for the network TRR data indicated that the macro-provider network was seven percentage points above the minimum performance threshold of 80% compliance rate. Since September 2013, five referrals were made to the Special Investigative Unit for investigation of potential fraud, waste or abuse.

Overall compliance for all level of care addendums was above the minimum performance threshold with the exception of LGE clinics. The LGE score was skewed due to low scores related to utilization of the Telesage Outcomes Measurement System (TOMS). Magellan began monitoring LGE clinics to monitor adherence to OBH protocol regarding TOMS utilization. This metric was added to support collection of data for federal block grant reporting and outcomes reporting. Magellan requires clinics that do not follow protocol to submit a PIP on how they will improve adherence. Magellan also sent training alerts to clinics to promote utilization of TOMS. As indicated in Section XII Clinical/Functional Outcomes Activities, there has been a significant increase in TOMS utilization when comparing Q1 of 2013 with 2014.





Opportunities for Improvement

Magellan addresses deficiencies at the individual provider level through results letters that identify strengths, opportunities for improvement, and any required corrective action plans. Data are analyzed at the network level to identify macro opportunities for improvement. The main opportunities for improvement and key drivers of non-compliance are lack of/need for:

- **Member Rights & Confidentiality**
  - Signed psychiatric advance directives
  - Signed informed consent for medications
  - Releases for communication with PCP and other relevant providers
- **Discharge Planning/Process**
  - Discharge planning occurs actively throughout treatment
  - Discharge actively coordinated with transitioning provider
  - Medication profile reviewed with member and transitioning provider at time of discharge
  - Discharge plan include appointment date and time with transitioning provider
  - Discharge summary reflects course of treatment.

A multi-departmental group conducted barrier analysis for compliance with these quality standards. Barriers identified included:

- Providers do not have a clear understanding of what is required of them regarding quality standards
- Providers often confuse Magellan authorization forms for assessments and treatment plans

An action plan was implemented in March 2014 to clarify and assist providers in understanding documentation requirements as well as to provide education and resources to providers. Action plan interventions included the creation of a provider training module that was uploaded to the provider web page. The training outlines the purpose of documentation monitoring, explains the monitoring process, and identifies specific quality requirements. Magellan also conducted a live TRR training during the February Provider all-call. Resources, including tip sheets on advance psychiatric directives, initial evaluations, writing treatment plans and writing progress notes as well as sample templates for crisis/safety plans, discharge plans, informed consent for medications, and member rights and responsibilities (English and Spanish versions) were uploaded to the web page. It is believed these interventions will lead to increased understanding of the process and improve provider compliance. Magellan will continue monitoring TRR data to determine if statistically significant improvement is achieved as a result of the action plan.

Performance Improvement Plans

Performance Improvement Plans (PIPs) are implemented to address opportunities for improvement that have been identified in the TRR, ACT Fidelity, and Waiver Performance Measure processes for individual providers. Clinical reviewers provide technical assistance at the request of providers and monitor PIPs until accepted. The following guidelines are used to determine if a PIP is required:

- Formal PIPs
    - TRRs with an overall aggregate score under 70%
    - ACT Fidelity scores in the Poor Range
    - Require that a written action plan is sent outlining the provider's intent to modify processes and procedures to address deficiencies AND a follow up to monitor progress
- Informal PIPs
    - TRRs with aggregate score between 79%-70%
    - TRRs with sections or items scoring under 80%
    - ACT Fidelity scores in the Fair Range
    - Require that a written action plan is sent outlining the provider's intent to modify processes and procedures to address deficiencies
- Waiver Corrective Action Plan
    - Waiver Performance Measures that do not meet the minimum performance threshold of 100% compliance
    - Require that a written action plan is sent outlining the provider's intent to modify processes and procedures to address deficiencies

The chart below depicts the number of PIPs and CAPs requested for each time period. The following chart represents provider specific data for September 2013 to February 2014.

PIPs for September 2013-February 2014

Total Facilities Reviewed	Formal PIP	Informal PIP	Waiver CAP	Total PIPs/CAPs
86*	7	50	15	72

*Includes 11 ACT providers as well. Details of ACT Fidelity Audits can be found in Section XVII Evidence-Based and Best Practice Initiatives.

TRR Automation

Beginning in March 2014, QI Clinical Reviewers began utilizing a corporately developed web-based TRR tool that automates the collection and scoring of records. It is believed that automation will improve the integrity and efficiency of data reporting. Minor changes were needed to align the Louisiana TRR Auditing Tool with the corporate tool. All TRR CORE elements remained the same; however, the LOC addendums were eliminated. Louisiana specific addendums were added to address areas of importance for the state of Louisiana. Addendum sections include: Access & Availability, Cultural Competency, Service Delivery, Discharge Planning, Medication Management, Restraints and Seclusions, Family Functional Therapy, Multisystemic Therapy, Homebuilders, and an OBH/LGE Addendum. A Suicide Risk Clinical Practice Guideline evaluation tool was also added.

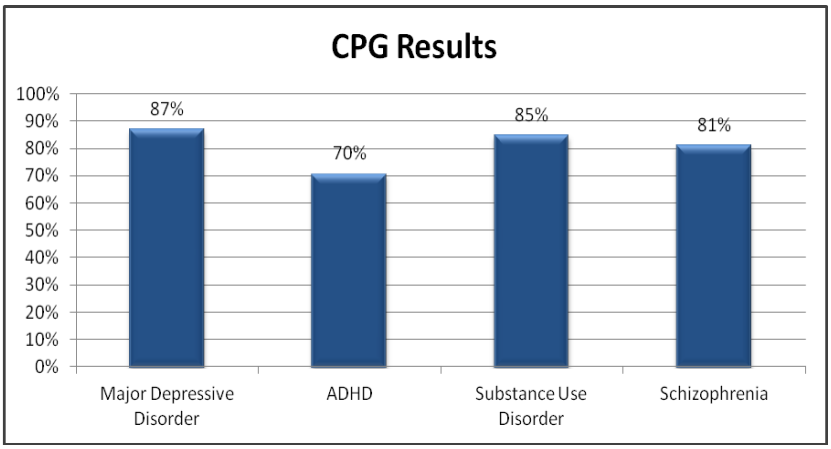
XV. CLINICAL PRACTICE GUIDELINES

Magellan develops or adopts clinical practice guidelines (CPGs) to assist providers in screening, assessing and treating common disorders. Prior to adopting each guideline, a multi-disciplinary panel—including board-certified psychiatrists and clinical staff—examines relevant scientific literature and seeks input from network providers as well as members and community agencies. Once implemented, Magellan reviews each guideline at least every two years for continued applicability and updates guidelines as necessary. Magellan's adopted guidelines are intended to augment, not replace, sound clinical judgment.

The LA CMC monitored CPGs for Major Depressive Disorder (n= 121 charts), Attention Deficit Hyperactivity Disorder (n=146 charts), Substance Use Disorders (n=135 charts), and Schizophrenia (n=90 charts) for 75 unique providers from September 2013 to February 2014. CPG data for ADHD were below the minimum performance threshold of 80% compliance rate. Magellan will conduct a provider training on best practices for treatment of ADHD in the third contract year. Magellan also requires

providers who do not meet the minimum performance threshold to submit Performance Improvement Plans on how they will improve compliance with CPGS. In the third contract year, Magellan will also monitor the CPG for Suicide Risk.

CPG Results for September 2013-February 2014



XVI. Inter-rater Reliability

Magellan policies provide for an annual measurement of the consistency of application of medical necessity criteria by clinical care management staff, physician advisor consultants and medical directors. Clinical staff members are asked to review an identical series of ten (10) vignettes and select the appropriate clinical determination for the level of care by applying the Service Authorization Criteria. The measurement process is designed to conform to customer, NCQA, URAC and licensing requirements. Answers are scored and reports generated for each individual who participates in the IRR measurement. All individual reports are reviewed by the clinician's direct supervisor and provided to the individual. The threshold for performance is 9 out of 10 correct answers, and those who respond with fewer than 9 correct answers are asked to participate in educational interventions and re-measurement. If an individual is unable to record 9 correct answers with re-measurement, the supervisor initiates additional interventions to address the clinician's application of criteria.

Magellan initiated procedures regarding monitoring of Physician Advisors beginning first quarter 2013. All physician advisors (PA) who conduct reviews completed the IRR process. The Chief Medical Officer has discussed the results of the testing with each physician advisor. Those who did not achieve at least 90% on the post-test re-took the IRR test in June. Monthly monitoring was implemented by the Medical Administrator of physician advisors' determinations to monitor application of medical necessity criteria. PA audits consistently shown 100% compliance with auditing standards since February 2014.

In addition, for those Clinical Reviewers conducting Treatment Records Reviews (TRR), inter-rater reliability is overseen and monitored by the QI Manager. Inter-rater reliability testing was conducted

with all Clinical Review staff that complete record reviews and all passed the test. All Clinical Reviewers scored two identical records to determine level of compliance with identified standards and the consistency of reviewer determinations. Findings showed 100% agreement among reviewers regarding whether the records fell into an acceptable or a non-acceptable range of compliance. Selected elements showed some variation and monitoring will be continued toward closing discrepancies in results to the extent possible. This remains a dynamic process and will continue to be monitored quarterly throughout the year.

XVII. Evidence-Based and Best Practice Initiatives

The Louisiana CMC authorizes a variety of evidence-based practices, including Assertive Community Treatment (ACT), Multi-systemic therapy (MST), Homebuilders, Functional Family Therapy (FFT), Child-Parent Psychotherapy (CPP), and Parent Management Training. This section describes each practice and discusses utilization trends.

A. Assertive Community Treatment (ACT)

ACT services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictive disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community. Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination. The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member. The majority of ACT services are provided in the community by multidisciplinary teams. The primary goals of the ACT program and treatment regimen are to:

- Lessen or eliminate the debilitating symptoms of mental illness each individual member experiences and to minimize or prevent recurrent acute episodes of the illness
- Meet basic needs and enhance quality of life
- Improve functioning in adult social and employment roles and activities
- Increase community tenure
- Reduce the family's burden of providing care

In the first year, there were 1140 authorizations for ACT services with 1382 unduplicated members receiving services. The mean number of days used in ACT was 163.5. Forty-five percent of the members in ACT were male, and the most common diagnoses were psychosis and mood disorders.

In the second contract year, 2304 unduplicated members were served in ACT. This was a 66.79% increase from contract year one. Initially 12 teams were actively serving members. By the end of contract year 2, three teams were added, two to the Florida Parishes area and one to the Northeast Delta area, to serve members in those regions.

ACT services were monitored by the QI department to insure minimum fidelity standards were met. ACT teams were scored using the Substance Abuse and Mental Health Services Administration (SAMHSA) tool kit to guide the fidelity reviews. This includes the Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI) auditing tools. Following the SAMHSA tool kit recommendations, the teams were scored on the DACTS and GOI, and the fidelity results were grouped as Good, Fair or Poor. From July to December 2013, Magellan completed site visits on all 12 ACT provider sites, with several sites having multiple teams reviewed. Using the DACTS, 10 of the 12 teams scored Good, 2 scored Fair and 0 scored Poor. Using the GOI, all teams scored Good. Each team received a report that summarized the results of the review. Also, each team was asked to submit a Performance Improvement Plan (PIP) to Magellan that specified the actions the provider intended to take to correct any identified deficiencies.

During year three of the contract, Magellan is planning to focus on continuous improvement in performance and outcomes of ACT teams. Magellan is implementing an ACT Scorecard that will provide feedback to ACT providers on performance indicators such as hospitalizations, readmission rates, and encounters. This scorecard will be used to enhance quality management practices for providers and as a rate setting tool, as Magellan shifts to a pay-for-performance model for these providers. Magellan will continue monitoring fidelity via site visits and require PIPs as needed to maintain and improve ACT fidelity.

B. Multi-systemic therapy (MST)

The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized interventions. MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Youth with substance use issues may be included if they meet the eligibility criteria and MST is deemed clinically more appropriate than focused drug and alcohol treatment. Services are primarily provided in the home, but therapists also intervene at school and in other community settings.

MST is designed to accomplish the following:

- Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care.
- Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.
- Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.
- Help caregivers develop effective parenting skills and skills to manage the member's mental health needs, improve caregiver decision-making and limit setting.
- Improve family relationships.
- Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardies and/or a decrease in job terminations.
- Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider).
- Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).
- Develop natural supports for the member and family.

Initiated during August 2013, a collaborative relationship was formed with the MST Institute, the agency that oversees provider fidelity to the model. A Memorandum of Understanding (MOU) was developed that established a collaborative protocol for quality monitoring and report sharing. MST Services Institute provided training to LA CMC clinical staff to improve understanding of the model for referral and monitoring purposes. Input was also gathered from MST Services to accurately develop monitoring questions for Treatment Record Reviews TRRs. Magellan anticipates the implementation of TRRs in the third contract year to monitor adherence to quality documentation and record keeping practices. In the second contract year, MST providers served 2,196 members. There were 15 agencies with a total of 35 teams providing MST during this time. All providers exceeded the minimum fidelity score of .61 with scores of .83 or greater.

C. Homebuilders

Homebuilders is an intensive, in-home Evidence-Based Program (EBP) utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement, or being reunified from placement demonstrating the following characteristics:

- Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
- Family members with substance use problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
- Babies that were born substance-exposed or considered failure to thrive
- Teenagers/adolescents that runaway from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol misuse, and/or experience parent-teen conflict(s);
- Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma

The primary intervention components of the Homebuilders model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems and developing outcome-based goals. Therapists provide a wide range of counseling and behavior change strategies using research-based motivation enhancement and cognitive behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. In addition, therapists help families enhance their social support network and access basic needs such as food, shelter, and clothing. Homebuilders programs have been successfully implemented in diverse and multi-ethnic/multicultural communities across the United States and other countries.

Starting August 2013, a collaborative relationship was formed with the Institute for Family Development (IFD), the agency that oversees fidelity to the model. An MOU was established to create a collaborative protocol for quality monitoring and report sharing. Input was gathered from IFD to inform the development of an audit tool to monitor providers as part of its TRR process. Magellan anticipates the implementation of TRRs in the third contract year to monitor adherence to quality documentation and record keeping practices. IFD also provided training to LA CMC clinical staff to improve understanding of the model for referral and monitoring purposes. Homebuilders agencies served 383 unduplicated members from March 1, 2012 through February 28, 2013. The number of agencies that provide Homebuilders declined (1 closed the program in February 2014 due to funding); despite this, there was not a decrease in service utilization, with 389 unduplicated members being served in the second contract year.

D. Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is an evidenced base family intervention targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health

conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment.

FFT is deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the client's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

Beginning August 2013, a collaborative relationship was formed with Functional Family Therapy, LLC (FFT, LLC), the agency that oversees fidelity to the model. An MOU was developed that established a collaborative protocol for quality monitoring and report sharing. Magellan gathered feedback from FFT, LLC to develop monitoring tools that will be implemented as part of the TRR process in the third contract year. FFT, LLC provided training to LA CMC clinical staff to improve understanding of the model for referral and monitoring purposes. FFT agencies served 260 unduplicated members in contract year 1. There was a decrease in utilization in contract year two, with 187 unduplicated members being served. Changes to the provider network that could have attributed to lower utilization (e.g., one program closing in March 2014). In February 2014, it was announced that FFT is an allowable service for families in the CSoC program. This is expected to have a positive impact on utilization in the third year of the contract. Magellan is also working with Medicaid and OBH regarding reimbursement rates. It is believed increased rates will facilitate sustaining more providers within the community.

E. Other EBP Initiatives

The LA CMC is actively working to improve the clinical program for 0- to 6-year-old members. During contract year two, Magellan worked closely with the LSU Health Sciences Center and Tulane Departments of Psychiatry to provide training in Child-Parent Psychotherapy (CPP-LSU) and Parent Management Training (PMT-Tulane), two evidence-based treatments for young children and their parents. These treatments have been shown to provide the most robust outcomes for individuals with major behavioral problems resulting from attachment issues, trauma and early discontinuous parenting. The training is comprehensive and includes two training periods for each therapy plus

supervision/consultation for 18 months following the initial training sessions. Providers completing the trainings and any providers previously trained (list supplied by the universities) will be considered preferred providers for members in this age group who may indicate need for this clinical practice. In order to be selected to participate, a provider must be a Louisiana Licensed Mental Health Practitioner (i.e., Psychologist, Clinical Social Worker, Practicing Counselor or Marriage and Family Therapist). Interested providers are required to submit an application to participate and must commit to participate in the entire training series (face-to-face sessions and monthly consultation calls). Selection is based on provider qualifications, geographical location, willingness to commit to all of the required trainings and consultation calls, etc. Currently, the LBHP allows twenty-four (24) pass-through outpatient therapy sessions to be provided to young children. It is our goal to build a network of providers who are trained/certified in evidence-based treatments for children birth through 6 years of age. As this occurs, Magellan will reduce the use of providers who do not have these skills for the young child population and, over time, the pass through sessions will be reduced significantly for non-trained/certified providers.

Child-Parent Psychotherapy (CPP)

CPP is an evidence-based intervention designed for working with youth in early childhood who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parents/guardians/caregivers as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. The LA CMC and the LSU Health Sciences Center are offering an opportunity for qualified providers to become a trained/certified CPP Therapist.

Training for CPP consists of an initial three-day training session in New Orleans at the LSU Health Sciences Center (November 20-22, 2013), two phone consultation calls per month for 18 months following the initial training session and two additional two-day follow up training sessions at 6 month intervals to be held in New Orleans at the LSU Health Sciences Center. In order to become a certified trained CPP Therapist, providers must participate in 18 months of training and phone consultations. The cost to the provider will be travel and expenses. Training costs, including training materials will be covered by Magellan and the LSU Health Sciences Center.

Parent Management Training

Disruptive behavior disorders (DBDs) are the most common reasons for referrals of preschool children to mental health clinics, and rates of disruptive behavior diagnoses continue to rise. These disorders

interfere with a child's functioning at home, with peers and in learning situations, and cause extraordinary parenting stress, and predict adverse mental health outcomes in childhood and adolescence. They also are associated with significant financial costs to family and society. Early intervention is effective in addressing these problems. A growing research base demonstrates the effectiveness and efficacy of parent management training (PMT) programs in reducing symptoms of DBDs in children and these interventions are the first line treatment for young children with DBDs. These interventions are based on fundamental behavioral principles. Magellan Health Services and Tulane University School of Medicine are offering an opportunity for qualified providers to train in the principles of parent management training, including innovative approaches from evidence based models.

Training for Parent Management Training consists of an initial four-day training session at Tulane Medical Center January 27-30, 2014, 24 consultation phone conferences (one every other week), and one day of advanced live training 6 months after the initial training. In order to become a certified trained PMT Therapist, providers must participate in all training sessions and consultation phone conferences. The cost to the provider will be travel and expenses. Training costs, including training materials will be covered by Magellan.

XVIII. Behavioral Continuum (System Transformation)

Magellan is dedicated to transforming and improving the landscape of how behavioral health services are provided to members of the LBHP. The LA CMC System Transformation Department conducts a multitude of programs and initiatives to continuously improve the services types and service delivery for our members. Three of the main programs evaluated in this section are the Coordinated System of Care (CSoC), Permanent Supportive Housing, and Recovery and Resiliency. Magellan also has dedicated full time equivalent liaisons that work directly with our DCFS, OJJ and DOE partners to ensure seamless delivery of care for members served by these organizations.

A. Coordinated System of Care (CSoC)

The Coordinated System of Care (CSoC) is a collaborative approach offered to children and youth in the LBHP who are in or at greatest risk of out-of-home placement. Services and supports are provided with the goal of assisting children and youth in remaining in their community and/or returning home. Specialized services, including CSoC services and wraparound facilitation, are provided through Wraparound Agencies (WAA), the Family Support Organization (FSO) as well as other network providers. Together with youth and families, the WAA and FSO work to develop and coordinate a plan of care which supports children and youth in returning to or remaining in the community. CSoC services are allowed through the 1915(c), (b3), and (b) federal waivers. Federally mandated performance measures are monitored to ensure compliance with these regulations.

From March 1, 2012 to February 28, 2014, the CSoC program served approximately 3,143 individuals. There as been an increase of 47.38% in current enrollment when comparing end of year data for each contract year.

Region	2/28/2013	2/28/2014	Increase
Region 1 – Orleans/Jefferson area	129	246	117
Region 2 -Baton Rouge area	148	221	73
Region 7 - Alexandria area	104	151	47
Region 8 –Shreveport area	171	211	40
Region 9 - Monroe area	173	238	65
Total	724	1067	343

During contract year two, 65.6% of enrolled children were male and 34.4% were female. Of those reporting, African-Americans represented 67.6% and Caucasians represented 30.1% of all enrollees. Breakdown of children/youth enrolled by age are as follows: ages 3-8 (14.7%), ages 9-14 (50.9%), ages 15-17 (29.5%), and ages 18-21 (5.0%). The target population of ages 12-16 represented the majority of those served (54.4%). CSoC Regions 1 and 9 represented 45.4% of the children currently enrolled. The four most frequent referral sources for the CSoC program were, in order, Licensed Mental Health Professionals, Hospitals, Other, and the Department of Children and Family Services. The other category can include individuals such as neighbors, friends, relatives, etc. that are not specified in a category. The Office of Juvenile Justice, school personnel and caregivers were three additional important admission drivers. The mean length of stay for the children/youth in the CSoC program that were discharged in the second year was 269.18 days. Reasons for discharge can be due completion of program, relocation, residential placement, child/family cannot be found, legal guardian choose to discontinue CSoC, child/family disengaged from services, and child choose to discontinue CSoC. The three most frequent psychiatric diagnoses among the CSoC children and youth were:

1. Attention-Deficit/Hyperactivity Disorder (27.8%);
2. Diagnosis or Condition Deferred (12.6%); and
3. Oppositional Defiant Disorder (8.6%).

These three diagnoses accounted for 49.0% of all diagnoses among CSoC members. Magellan reports on 17 Performance Measures that were identified and monitored by the CSoC Quality Assurance Committee. Please see Appendix E for the comparative analysis of results from contract year one and two. Some of the key performance indicators will be discussed in this section, including utilization data and network development.

Utilization

Over the course of the year, utilization of all CSoC services, except for Crisis Stabilization, increased each quarter. Crisis Intervention, Community Psychiatric Supportive Treatment (CPST) and Psychosocial Rehabilitative Services (PSR) showed strong and significant growth. Utilization of Parent and Youth Support Services continued to increase.

To assess the effectiveness of the CSoC program in reducing out-of-home placements, outcomes data showed a 13.1% decrease in the number of CSoC children and youth who had restrictive placements prior to enrollment in Wraparound services (31.4%) to the number of CSoC children and youth who had a restrictive placement setting after enrolling in Wraparound services (18.3%). Data indicated that 93.38% of CSoC children and youth utilized natural and informal supports during enrollment and 92.4% of them utilized natural and informal supports after discharge, as reported by the Wraparound agencies.

Educational outcomes data should be interpreted cautiously since report card periods are not standardized across school systems and consistent collection of performance and conduct data in all school districts remains an area of concern. School data collection provides an opportunity for growth and Magellan has partnered with the Youth IMT and DOE to identify process improvements. Over the past year, Magellan has provided a detailed outline of the challenges encountered when trying to accurately capture the school performance data from reliable and consistent sources.

The CSoC program continued the Performance Improvement Projects (PIP) for Year 2 and those outcome measures can be found in the Quality Improvement Activities and Performance Improvement project section. Outcome summary demonstrates 96.3% of CSoC children received some form of service authorization (CSoC + other) and 86.4% of authorized members received a claim for CSoC services. Please see **Section V Quality Improvement Activities and Performance Improvement Projects** for further details.

Other process improvements implemented in the second contract year include the implementation of a standardized CSoC Plan of Care, QI Data tracking spreadsheet and automated reports. These interventions presented significant opportunities to provide additional data drill down and therefore, improved outcomes reporting. Targeted trainings for the Wraparound agencies, FSO, community providers and members were held throughout the year that improved knowledge of 1915(c) and (b3) Home and Community-Based Services and Utilization. An in-depth training was conducted called "Quality Improvement/Quality Management" that focused on data integrity and accuracy for performance measures tracking using the QI Data Spreadsheet on March 13–14, 2014 with WAA Directors, QI Managers, Clinical Supervisors and the FSO Director. The QI Data Spreadsheet is undergoing revisions and technical improvements that will also aide the WAAs in data collection and

submission in the coming months. On future reports, it is recommended that the ALOS for members still currently enrolled no longer be included on this report since the program has matured, and this data element does not provide meaningful information to the performance measure.

A CSoC Scorecard is anticipated to be implemented in the third contract year. With this intervention, Wraparound agencies will receive quarterly data for their respective regions and for the overall CSoC program providing enhanced capabilities to monitor quality improvement and management efforts more closely.

Network Development

Network development is critical to the success of CSoC. Efforts continue to expand all five of the CSoC services through provider network development. The expansion of the CSoC program into the four remaining regions of the state during 2014 will present great opportunity for network growth and expansion of services. The LA CMC Network Department actively partners with the CSoC Department to identify and find solutions for unmet needs. Some of the challenges and successes made this year in network development are highlighted below.

CSoC Network Challenges

- Services with significantly higher overhead costs have not been feasible investments for private providers given small number of children served in this population (current maximum is 1,200 in the 4 implemented regions. 2,400 when implemented statewide).
- Need for improved accountability of WAAs to ensure youths are utilizing needed services, allowing providers to have sustainable occupancy rates.
- Crisis stabilization licensing rules (e.g. high cost, loan requirements) make it difficult for providers given small number of youth eligible in individual region and number needing service at any one time.

CSoC Network Highlights

- Significant support of the FSO has led to increases in staffing and penetration to ensure more CSoC youth and families are receiving peer services.
- Continued work to improve communications and relationship between WAAs and service providers and among service providers.

Network is actively working to recruit providers for implementing and non-implementing regions in preparation for CSoC expansion. Some interventions include:

- Partnering with OBH to pursue the opportunity to utilize TFC for Crisis Stabilization.

- Partnered with state agency (DCFS) to develop a list of qualified Short Term Respite providers to recruit.
- Increased ILSB providers to 94 total, 26 of which are in the non-implementing regions. Action plan is to train each provider on CSoC and facilitate the development of relationships with the WAAs to increase ability to quickly accept referrals when expansion is implemented
- Developed refresher trainings for current providers with the goal of motivating current providers to expand their services.

The following chart shows data up to May 2014 and shows the current number of providers for each region by type. It should be noted that Parent and Youth Support and Treatment is provided by one statewide agency that serves each of the implementing regions.

Number of CSoC Children	Crisis Stab.	ILSB	STR	PST	YST	Total
Jefferson Parish: 240	0	28	2	1	1	**32**
CSoC Region 2: 231	1	8	2	1	1	**13**
CSoC Region 7: 169	0	10	1	1	1	**13**
CSoC Region 8: 218	0	15	0	1	1	**17**
CSoC Region 9: 252	0	13	4	1	1	**19**
CSoC Region 3	0	4	0	0	0	**4**
CSoC Region 4	1	2	1	0	0	**4**
CSoC Region 5	0	10	1	0	0	**11**
CSoC Region 6	0	7	1	0	0	**8**
Grand Total:	**2**	**97**	**12**	**5**	**5**	**121**

B. Permanent Supportive Housing

Magellan began management of the Louisiana Permanent Supportive Housing (PSH) program in October 2013. PSH provides housing vouchers plus supportive services to PSH units in the GO-ZONE (Golf Opportunity Zone). The program services are only financed through a Community Development Block Grant (CDBG). This federal grant money was provided to the state as part of the hurricane relief efforts of Katrina and Rita and Gustav and Ike, and the vouchers are managed and funded through the Louisiana Housing Authority. However, in an effort to ensure the long-term viability of the PSH program, Louisiana implemented a shift in services funding to align the PSH services to the Louisiana Medicaid Home and Community Based Services (HCBS), and the services available under certain Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), and Ryan White waivers. This shift to sustainable funding focuses the remaining CDBG resources for those members who are not eligible for services under the Louisiana Behavioral Health Partnership or the designated waivers. Eligibility for the PSH program is based upon housing status (homeless or at-risk of homelessness) and financial criteria (very low income).

Magellan launched its involvement with the PSH program with nine staff members dedicated to serve this population. Since launch date and through February 28, 2014, Magellan's PSH team has received and processed 629 applications submitted by members. An additional 207 members were determined to be eligible for the PSH system from their Home and Community Based providers. The total PSH population, housed and awaiting housing has climbed to 2,878 under Magellan management with 996 (34.6%) having been moved from limited CDBG funding to sustainable funding sources. The PSH Team has processed more than 900 Independent Assessments and helped move a total of 250 members to Medicaid 1915i eligibility while actively managing the authorizations of all 2,878 members in PSH.

The utilization data for PSH from October 2013 to February 2014 was as follows:

- 2,878 Total members in PSH Services
- 2,760 Total members housed
- 34.6% Total members migrated to sustainable funding
- 19 Community and Provider trainings and outreach awareness events
- 2 Continuing Education (CEU) courses provided at state or national conferences

Within the PSH program, outcomes will be measured across multiple domains. The ability to quickly move a unit back to occupancy once it has been made available by the Louisiana Housing Authority (LHA) is a key indicator of Magellan efficacy as the PSH manager for the state. This will be measured as a percentage of units occupied of those available. Once a member is housed, the expectation of PSH is that it reduces the utilization of higher levels of care for participating members. A measure of this success will be a reduction in the hospitalization rate for PSH members after 6 months.

In May 2014, data were analyzed to evaluate clinical outcomes of the program and some promising trends were seen. Enrollment in PSH has continued to increase and totaled 2,897 as of May 2014. Forty-one percent of those achieved sustainable funding through 1915(i) SPA, EPSDT, OAAS, OCCD, or Ryan White waivers. Since October 2013, there has been an increase of 288 members (approximately 9%) who have been newly enrolled. Of these 288 members, 166 had a previous claims history with Magellan. Magellan did a comparative analysis of pre and post involvement of these 166 members and the following promising statistics were indentified:

- 279% increase in use of HCBS
- 73% decrease in ER cost
- 76% decrease in inpatient psychiatric cost
- 30% decrease in SA Residential costs
- 25.6% decrease in overall cost per month

Several opportunities for improvement and continued development are noted. Traditional PSH service providers were required to transition into billing for services under Medicaid programs and require continued support in order to sustain their viability and maximize member engagement and quality outcomes. Magellan PSH staff members will continue to work closely with PSH providers to assure cooperative engagement in the continued transition. Magellan staff members have quickly built a knowledge base related to PSH, and will continue to improve operationalization of the PSH model within the LBHP. With an eventual capacity of 3,300 units available for PSH, Magellan will be required to work with various stakeholders to develop the referral capacity to assure maximum utilization of the Permanent Supportive Housing program.

C. Recovery and Resiliency

In contract year 2013-14, the LA CMC Recovery and Resiliency team primarily focused its efforts on the development of an infrastructure in Louisiana which valued and supported services driven by and for peers (also referred to as individuals with a behavioral health diagnosis). As defined, a recovery-oriented service culture is based on the philosophy that recovery, which encompasses voice and choice in all aspects of care, is attainable for peers and as such is integral to quality behavioral healthcare. Therefore, recovery as a concept should be a driver in activities undertaken as a part of system transformation. In recognizing the need for the development of a recovery-oriented service culture in Louisiana, coupled with required RFP deliverables, the Recovery and Resiliency team drove and/or collaborated in the following activities for calendar year 2013.

Seed Grant Initiative

The purpose of the Seed Grant initiative is to award small grants to agencies to support the development of a person-centered service array. In 2012, 18 grant proposals were received of which 9 grants were awarded to 8 agencies. Grants supported activities such as Wellness Recovery Action Plan (WRAP) groups, stigma reduction education, drop-in center enhancement and community-based trainings. A summation webinar held on December 12, 2013 documented the importance of the grant program. For example, with an influx of $4,000, one agency was able to serve 1,431 individuals, primarily youth, young adults and family members, in stigma reduction and recovery education activities. One takeaway from the program was that agencies were invested in fostering recovery and recovery knowledge among populations served and in many instances exceeded grant amounts allotted to support these initiatives. In the second year of the Seed Grant Program, there was increased involvement with 19 agencies submitting 23 grant applications. Among applications received, 7 grants were awarded to fund a variety of programs including employment of a Peer Support Specialist to support transitional planning in cooperation with the East Baton Rouge parish prison and a disordered eating group for women who have been diagnosed with a co-occurring disorder. As evidenced by continued growth in year 2, the Seed Grant Program is helping to change the current system of care in

incremental approaches that support person-centered planning in combination with member voice and choice.

Peer Support Whole Health and Resiliency (PSWH and R)

The purpose of the Peer Support Whole Health and Resiliency program is to support peers in addressing co-morbidity issues through a person-centered approach that focuses on incremental goals that are accomplished during an 8 week support group. For example, if an individual wanted to quit smoking they would break the task into subunits such as smoking 2 fewer cigarettes a day to reach their goal. The process of implementing PSWH and R began in Louisiana in 2012, and has been undertaken at various Magellan CMC's, but gained traction and expanded in 2013 in part due to a collaborative relationship with Capital Area Human Service District (CAHSD). As part of a whole health grant awarded through HRSA, CAHSD was seeking a partner to provide whole health education and support to individuals served through the agency. As the identified partner, the LA CMC was able to host a number of PSWH and R groups at 3 separate CAHSD sites and was therefore able to expand the reach of the program. Since that time, a total of 10 groups have been started throughout the southern part of Louisiana. Additional PSWH and R trainings were held in September 2013 and April 2014 in Alexandria and Baton Rouge respectively as Magellan continues to expand the breadth and reach of the program.

As part of the 8 week Peer Support Whole Health and Resiliency classes a pre and post survey is given to each recipient to measure progress relative to whole health improvement. Because of their participation, support group members reported the following in the post survey:

- "It was a wonderful class, so positive and uplifting!"
- "He (the Peer Specialist) believed in me, that I could do it. Thank you and may God bless you."
- "I could discuss ideas and problems with the group. It was helpful to learn how to live with family members who have mental health issues."
- "The overpowering positive support, the reassuring attitude gives me confidence."

Facilitator Development Program (FDP)

Originally developed as part of the PSWH and R program, the purpose of the Facilitator Development Program is to compensate peers through a coordinated stipend program for time and expenses incurred while facilitating and/or participating in Magellan sponsored programs. Documents were developed which detailed services delivered and evaluation data, if available, of those services rendered. The first FDP funds to PSWH and R facilitators were distributed in December 2013 and since that time; compensation has been made to peers to participate in the Seed Grant Review Committee and supported peer travel to attend Magellan-sponsored trainings. In 2014, scholarships for attendance at local events will also be made available to peers throughout the state.

Peer Certification and Credentialing

In 2012, the Louisiana Association of Substance Abuse Counselors and Trainers (LASACT), the Louisiana Office of Behavioral Health (OBH)/Office of Member Affairs and Magellan of Louisiana formed a collaborative partnership to discuss opportunities to develop peer credentialing in Louisiana as an additional requirement in conjunction with the current Peer Specialist Training that began in 2008. The purpose of peer credentialing is to add a competency and testing component to the current training curriculum in addition to developing the foundation for future reimbursable peer services in Louisiana. Moreover, the credentialing process will support peers in gaining recognition as a viable position in Louisiana's workforce. In 2013, as part of this partnership, Peer Support Specialists were recognized as an unlicensed provider type, the credentialing manual was finalized and a Magellan representative participated in the test creation and cut score analysis for the peer credential. The manual will be fully released in August of 2014.

Peer Support/Member Services

As part of Recovery and Resiliency (R and R) efforts in Louisiana, an R and R team member performs direct member outreach and thus serves as an external face of Magellan in Louisiana. In her duties, she supports members in identifying and reaching long-term recovery and wellness goals and serves as an active listener to their individual needs. Moreover, she is actively involved in the coordination of resources to support members in meeting basic needs such as housing and reconnecting with local ACT teams. The number of people served, all of whom have been identified as those with the highest cost of care needs, has grown steadily in 2013 and services were tracked beginning in August 2013. A duration log was recently added to track time in association with desired outcomes. In 2014, Magellan will look at metrics associated with the members served by the peer specialist to evaluate outcomes and support continued expansion of the program.

Community Partnerships: Training and Education

- **Mental Health of America of Louisiana (MHAL):** Magellan's R and R team entered into a contract with MHAL for the purposes of increasing knowledge in regards to self-advocacy and legislative education in advance of Louisiana's annual Behavioral Health Awareness Day which is held at the State Capital. The goal of the educational forums was to increase attendance and participation in the event.
- **Survival and Resiliency:** Survival and Resiliency training was co-sponsored with LASACT, OBH/Office of Member Affairs and LAPS, whose purpose was twofold: To introduce Substance Abuse Counselors (SAC) to Recovery and Resiliency and to introduce Peer Support Specialists to

concepts in Substance Abuse Treatment. Magellan of Louisiana sponsored the event that featured approximately 60 attendees, split evenly amongst Peer Specialists and SAC.

- **Mental Health First Aid:** An R and R team representative conducted MH First Aid Trainings with CAHSD in both urban and rural environments. She also earned the Rural MH First Aid Certification and will obtain the Youth MH First Aid Certification in 2014 for a transitional-aged youth project.
- **National Alliance on Mental Illness (NAMI) In Our Own Voice (IOOV):** Magellan's R and R team entered into a contract with NAMI LA to host the first IOOV training in Louisiana since 2009. The purpose of the training is to help peers frame their recovery stories in a concise presentation for the purpose of stigma reduction and education.

Community Integration and Recovery Academy (CIRA)

In October 2013, the R and R team organized the first annual CIRA, a three day conference in Metairie, Louisiana. The purpose of CIRA was to introduce information primarily to the provider community about peer-centered services and how to create a recovery-oriented culture in Louisiana. The event featured national recognized speakers in the field of behavioral health including Dr. Judith Cook and Charles Curie. During the course of the event, 150 individuals attended from across the state, approximately 75% of whom were representatives of provider agencies. Attendee evaluations acknowledged that the conference provided ample networking opportunities and was an invigorating experience. A second conference is planned for 2014.

Louisiana Association of Peer Support (LAPS)

Currently, Louisiana does not have a recognized peer organization and in recognizing this void in Louisiana's peer movement, R and R team members have taken an active role in developing LAPS, not only as a voice for Louisiana's Peer Support Specialists but for peers and supporters in general. Sample activities undertaken in these efforts include developing bylaws, supporting LAPS in their efforts to host a LAPS 101 training, and partnering with the Café TA Center, who was assigned to work with LAPS to support efforts to grow and enhance the organization.

Community Engagement and Outreach

Below is a sample of activities and descriptions of events in which an R and R team member participated for the purpose of increasing Magellan's reach in the community.

- CAHSD Wellness Fair – The R and R team provided refreshments for the event which was sponsored by CAHSD to promote healthy lifestyles. Peers and providers were in attendance.
- Peer Scholarship Program-Scholarships, primarily for registration expenses, were sponsored by Magellan for peers to attend the following events: LASACT Annual Conference, Survival and

Resiliency Training, Community Integration and Recovery Academy and Alternatives in addition to supporting community-based programs for peers.

- Behavioral Health Awareness Day-R and R team members participated in and supported activities related to Behavioral Health Awareness Day.
- MHAL Policy Academy-As part of the MHAL Policy Academy, whose purpose was to discuss issues relative to peer
- Provider Newsletter Contributions– In efforts to promote programs developed by the R and R team newsletter articles on the Seed Grant, Warmline, CIRA and Peer Support Specialists as Providers were developed and distributed as part of the provider newsletter.
- Speaking Engagements-R and R team members presented and/or served as a Magellan representative at numerous events across Louisiana including the NAMI LA annual conference, the LASACT conference, the MHAL Policy Academy, Behavioral Health Awareness Day, Celebrating Families Conference, Louisiana Spirit Diversity Trainings and CIRA.

Warmline

Magellan proposed to implement a Warmline, or a non-crisis telephonic support line, by the end of the second contract year. In order to fulfill this, Magellan disseminated a Request for Proposal across the state with 10 companies submitting applications. Following a review process consisting of community members and Magellan employees, Start Corporation was chosen as the Warmline operating agency for 2013 and 2014. Warmline Operator Training was funded through OBH and was based on a model implemented in Oregon. Warmline officially started November 27, 2013.

D. Independent Assessment/Community Based Care Management (IA/CBCM)

The 1915(i) State Plan Amendment (SPA) is a Medicaid amendment that is designed to fund home and community based services for adults with serious and persistent mental illness. It requires each potentially eligible member be assessed and have a plan of care (POC) developed by a Licensed Mental Health Practitioner (LMHP) with no Conflict of Interest (COI). The SPA defines a LMHP with no "Conflict of Interest" as one whom:

- Has NO ties to a 1915(i) Services Provider;
- Not employed by or contracted;
- No other financial ties; and
- Not related by blood or marriage to anyone with financial ties to the member

When the contract was implemented, a sufficient number of providers that met the no COI requirements of the SPA did not exist. During the second contract year, Magellan developed and implemented an action plan to move the state into compliance with the SPA. A new provider type, or

Independent Assessor/Community Based Care Manager (IA/CBCM), was created. The Independent Assessor/ Community-Based Care Manager serves as the independent conflict-free LMHP who will:

- Assess member eligibility and needs;
- Develop a plan of care (POC) that addresses needs identified in the assessment; and
- Coordinate the overall delivery of HCBS services to the member.

A Request for Information (RFI) was disseminated across the state to select a provider or providers for IA/CBCM services. A cross-departmental work group was established to review responses and this group identified Pathways Community Health, a not-for-profit community mental health center that provides a full continuum of mental health and addiction recovery services. Pathways was chosen to serve as the preferred statewide provider and to be the primary partner in the IA/CBCM service delivery, however other providers who meet the COI requirements and choose to participate will be available around the state. Since Pathways was selected, Magellan has collaborated closely with the Pathways leadership team to develop a comprehensive implementation strategy to address compliance standards, geographical issues and anticipated member volume.

Although this new procedure changes who delivers the assessments, the basic process of 1915(i) eligibility process was not changed. The IA/CBCM provider completes the assessment packet and sends it to Magellan who verifies the functional eligibility and sends to Medicaid via electronic submission. This service can be conducted at a location convenient for the member. It may occur at an IA/CBCM provider's office, a hospital, a treating provider location or a community setting of the member's choice. In general, the process and time required for moving a member from assessment to 1915(i) SPA eligibility will not change. The IA/CBCM will be contacted by a provider, member or Magellan and make arrangements to complete the assessment at the earliest possible time appropriate for the member and the setting. It was agreed that priority will be given to those members in acute or specialized settings, as appropriate. Once the IA/CBCM has completed the assessment, the information is submitted to Magellan, processed and, where appropriate, a request is sent to Louisiana Medicaid for eligibility determination.

New components of the process include the POC development and case management. The POC addresses the needs that are identified in the assessment and is developed with the active engagement of the member, his/her supports and the treating providers. The POC is valid for up to one year or until the unique member needs change. If it is determined a member might need more or fewer services or a different type of service than what was originally authorized, the IA/CBCM will meet with the member and provider to develop an updated POC to be submitted to Magellan for reauthorization.

Implementation Schedule for IA/CBCM

Because of the complexities of implementing a new process across the state simultaneously, it was determined that a four-part, geographically phased approach should be taken to foster a seamless transition for providers and members. The chart below identifies the schedule and parishes involved in each phase. Only contracted IA/CBCMs will be able to provide independent assessments for eligibility once the implementation date is reached. Magellan has been actively conducting trainings for Pathways and independent practitioners to allow them to become contracted as an IA/CBCM. Magellan has also conducted a series of provider trainings and communications to inform the HCBS provider network of the new process and impacts to service delivery. Further, the Magellan of Louisiana website was updated with information and Frequently Asked Questions for providers. Magellan will continue to provide ongoing trainings and apply lessons learned when new phases are implemented.

Phase	**Phase 1**	**Phase 2**	**Phase 3**	**Phase 4**
Implementation Date	June 1, 2014	August 1, 2014	September 1, 2014	October 1, 2014
Parishes	• Ascension • Avoyelles • Bienville • Bossier • Caddo • Catahoula • Claiborne • Concordia • DeSoto • East Baton Rouge • East Feliciana • Grant • Iberville • LaSalle • Natchitoches • Orleans • Plaquemines • Pointe Coupee • Rapides • Red River • Sabine • Saint Bernard • Vernon • Webster • West Baton Rouge • West Feliciana • Winn	• Caldwell • East Carroll • Franklin • Jackson • Lincoln • Madison • Morehouse • Ouachita • Richland • Tensas • Union • West Carroll	• Acadia • Allen • Beauregard • Calcasieu • Cameron • Evangeline • Iberia • Jefferson Davis • Lafayette • Saint Landry • Saint Martin • Vermillion	• Assumption • Jefferson • Lafourche • Livingston • Saint Charles • Saint Helena • Saint James • Saint Mary • Saint Tammany • St John the Baptist • Tangipahoa • Terrebonne • Washington

XIX. Member, Family Member and Stakeholder Involvement

LA CMC actively involves members, family members, providers, customers and other stakeholders in its Quality Improvement and Utilization Management programs. Through this involvement, the LA CMC gains valuable input and distributes information related to furthering the principles of recovery, resiliency, stigma reduction and cultural competence to all stakeholders.

A. Communication with Members and Family Members

The LA CMC is dedicated to the exchange of information to our members and family members through the quality committee structure. The Member Services Committee (MSC) and the Family, Member, Advocate, and Stakeholder Committee (FMASC) provide a great avenue for member/family member involvement; however, retaining members on these committees has been difficult. In the second contract year, efforts were made to improve member/family member involvement in the committees. In January 2014, an action plan was implemented to recruit members for the Member Services Committee (MSC). Magellan was able to recruit a member for participation and in April 2014, the member representative actively attended and participated in the MSC. The Family, Member, Advocate, and Stakeholder Committee (FMASC) was also restructured to better facilitate the exchange of information to members and family members. The FMASC now has active involvement from three family members. Magellan also has active involvement of a member and family member representative on the Magellan Governance Board. The committees reviewed and provided feedback related to:

- Annual QI and UM Program Descriptions and Program Evaluations
- Results of studies of access and availability
- Member and family member satisfaction results and analyses
- Service Authorization Criteria
- Member and provider grievances and appeals
- Member satisfaction survey results
- Policies and standards
- Magellan's member rights and responsibilities statement

B. Communication with Providers and Stakeholders

Provider and stakeholder involvement is a key component of the quality committee structure and provides a mechanism to communicate important information regarding operational and quality

initiatives. Providers and stakeholders serve as standing members on quality subcommittees (e.g., Regional Network Credentialing Committee, MSC, FMASC, REC. etc.) and the Magellan Governance Board. Providers and stakeholders reviewed and provided feedback for the following:

- Annual QI and UM Program Descriptions, QI/UM Program Evaluations, and Work Plans
- Performance Improvement Plans
- Results of studies of access and availability
- Member and provider satisfaction results and analyses
- Service Authorization Criteria
- Clinical practice guidelines and new technology assessments
- Member and provider grievances and appeals
- Policies and standards
- Provider site visit results, including treatment record reviews
- Magellan's rights and responsibilities statement

  In addition, Magellan mails monthly newsletters to all practitioners and organizational providers in the network that serves the customer. These newsletters informed the network of most of the topics above.

C. Communication with Louisiana Behavioral Health Partnership (LBHP)

It is also vital to communicate actively with the organizations involved in the LBHP. The following is a sample of activities implemented to ensure information is exchanged:

- Senior management participates in bimonthly or monthly meetings
- Submission of monthly, quarterly, semiannual, and annual reports on RFP and IMT deliverables
- Participation and involvement in all Magellan quality committees
- Participation in CSoC Governance Board, CSoC Quality Assurance Committee, Youth Interdepartmental Monitoring Team (IMT), and Adult IMT.

XX. Satisfaction Surveys and Grievances

A. Member Experience of Care Survey

Member satisfaction surveys remain the most direct measure of assessing the member's perceptions of quality and outcome of care. The LA CMC utilizes the Magellan Member Experience of Care survey to measure satisfaction. The survey, based on the Mental Health Statistics Improvement Program (MHSIP)

Consumer survey, was modified for the public sector to promote consistency with surveys administered company-wide for the Medicaid population. There are minor and adult versions to better address the unique needs of the each subset. The survey responses are based on a balanced scale with a neutral middle for most questions.

Magellan utilized a mail-out and mail-back methodology. Surveys were distributed to a random selection of 2,500 adult and 2,500 minor members that received a service between July and September 2013 utilizes. Magellan did an initial mail-out on November 18, 2013 and did a second distribution on December 9, 2013 for non-responders. The survey was closed on January 17, 2014. Results were calculated and analyzed by the Magellan national survey department to ensure statistical validity and reliability of the results. The following chart outlines a sample of questions with comparison to national public sector scores.

Magellan Member Experience of Care (Combined Adult and Minor)

Question	Magellan National (Adult/Minor Combined) % POSITIVE		LA CMC % POSITIVE (Adult/Minor Combined)		
	2013 N=7,794	2012 N=6,314	Mar 2013-Feb 2014 N=556	Mar 2012-Feb 2013 N=592	Change (↑,↓, =)
If you contacted Magellan, how satisfied are you with the help you got to connect with the services you needed?	78.29%	79.08%	82.4%	80.2%	↑
If I had other choices, I would still get services from this agency.	81.17%	80.41%	82.0%	81.8%	↑
The location of services was convenient (parking, public transportation, distance, etc.)	81.37%	80.05%	81.7%	79.5%	↑
Staff members were willing to see me as often as I felt it was necessary.	82.52%	82.09%	85.8%	83.3%	↑
Staff members returned my call(s) in 24 hours.	79.26%	79.44%	83.5%	77.2%	↑
I was able to get all the services I thought I needed.	78.03%	77.52%	78.1%	80.3%	↓
I was able to see a psychiatrist when I wanted to.	75.59%	73.89%	76.2%	74.6%	↑
I felt free to complain.	79.45%	80.24%	81.0%	82.8%	↓
I, not a staff member, decided what my treatment goals should be.	90.38%	89.84%	77.9%	76.1%	↑
I was encouraged to use consumer-run programs (support groups, drop-in cases, crisis phone lines, etc.)	78.67%	78.73%	72.1%	73.2%	↓
I deal more effectively with daily problems.	70.65%	70.76%	67.1%	63.1%	↓
I am better able to deal with crisis.	65.5%	65.34%	59.5%	57.9%	↑
Overall, my satisfaction with the services and treatment I received was:	**58.07%**	**58.57%**	**84.5%**	**82.5%**	**↑**

Analysis of the results showed an improvement of 2 percentage points in overall satisfaction, increasing from 82.5% for contract year one to 84.5% in contract year two. There was a slight decline in the response rate as evidenced by a decrease of 0.7 percentage points from 13.3% in 2012 to 12.6% in 2013. Improvements were seen in 19 elements, declines in 8 elements, and 3 items did not change. Statistically significant improvement (p=.011) was seen in the following element: Staff members returned my call(s) in 24 hours (Q9). Statistical analysis identified the key drivers to overall satisfaction were outcome-oriented items (Q26, Q28, and Q29) and accessibility to prescribers (Q13). It should be noted that there is currently a national shortage of psychiatrists. Although there are still opportunities for improvement for network development, the Network Department has increased the number of contracted prescribers by 27% since implementation. Results were disseminated to the quality committees and Governance Board for review and input. An interdepartmental work group was formed to analyze member satisfaction data with a focus on elements that were under the 80% minimum performance threshold. An action plan was developed by the work group and approved by the Quality Improvement Committee in August 2014. In the third contract year, Magellan will implement satisfaction surveys that will be administered as part of the 1915(i) SPA and 1915(c) and (b3) waivers eligibility re-evaluation process. The surveys will be administered with the assistance of the Wraparound Agencies (WAA) and Independent Assessors/ Community-based Care Managers (IA/CBCM) and allow Magellan to monitor member satisfaction specific to individual treating providers (via MIS numbers) for these populations. It is believed that this will improve Magellan's scope to capture member's feedback

B. Provider Satisfaction

Provider satisfaction surveys remain the most direct measure of assessing the practitioner's satisfaction with features and services provided by Magellan Health Services. All participating providers who received at least one authorization or submitted a claim for service between January 1 and June 30, 2013 were selected to receive a questionnaire. Providers' contact information was drawn from Magellan's Integrated Provider Database (IPD). The questionnaires were distributed by e-mail or postal mail with an option to return them by mail, fax and instructions for completion online. The initial mailing was sent on September 9, 2013 and included a cover letter, a questionnaire and as appropriate a business reply mail envelope. To encourage participation a second mailing, by postal mail only, was sent to providers who had not returned a questionnaire on September 28, 2013. This mailing also included a follow-up cover letter, business reply mail envelope and information on how to fax or complete the questionnaire online. The survey period for inclusion of responses in this report was closed on October 30, 2013, approximately 30 days after the second mailing. The following chart outlines a sample of questions with comparison to national public sector scores.

Magellan Provider Satisfaction Survey

Question	National	LA CMC	

	Magellan %Positive		% POSITIVE		
	2012	2013	2012	2013	Change (↑,↓, =)
Overall satisfaction with the services provided by Magellan	**90.0%**	**92.1%**	80.2%	**87.6%**	↑
Timeliness of answering your call or contact	90.0%	91.1%	76.7%	82.3%	↑
Availability of clinical staff	93.4%	93.2%	78.8%	85.3%	↑
Consistency of decisions by clinical staff	91.4%	91.0%	69.1%	74.3%	↑
Ease of referring members to other providers in the network	90.0%	89.7%	78.3%	82.0%	↑
If you have called or written to file a formal complaint, satisfaction with the ease and timeliness of Magellan's complaint resolution process.	71.6%	73.7%	62.1%	53.9%	↓
Accuracy of the processing of your claims by Magellan	90.9%	92.9%	81.4%	86.1%	↑
Timeliness of the processing of your claims by Magellan	88.1%	89.3%	77.5%	86.2%	↑
Electronic claim submission to Magellan	87.6%	91.4%	85.8%	91.1%	↑
Claims appeals process	75.9%	78.0%	67.9%	68.4%	↑
Claims appeals timeliness	75.7%	78.4%	65.5%	71.8%	↑
Satisfaction with opportunities to give input to Magellan	87.8%	89.2%	81.0%	86.5%	↑
Do you have all of your new patients sign a consent form regarding contact with their primary care physician (PCP)?	64.2%	65.1%	53.7%	65.2%	↑

The results indicated that there was an increase of 7.4 percentage points in overall satisfaction, improving from 80.2% for contract year one to 87.6% in contract year two. As seen with the member survey, there was a slight decline in the response rate, decreasing 1.4 percentage points to 24.7%. Improvements were seen in 20 elements and declines in 8 elements. Statistically significant improvement ($p \geq 0.05$) was seen in the following elements: Timeliness of the processing of your claims by Magellan (Q15) and Do you have all of your new patients sign a consent form regarding contact with their primary care physician (PCP)? (Q26). Statistical analysis identified the key drivers to overall satisfaction related to the clinical and claims appeals processes and satisfaction with the complaint process. Results were disseminated to the quality committees and Governance Board for review and input. An interdepartmental work group was formed to analyze member satisfaction data focusing on elements that were under the 80% minimum performance threshold. Magellan will also submit surveys to providers to better determine what is driving satisfaction rates regarding the claims and clinical appeals processes. An action plan was developed by the work group and approved by the Quality Improvement Committee in August 2014.

C. Member and Provider Grievances

Magellan's priority is to ensure members have a "no wrong door" approach to filing a grievance and that the process is streamlined and as easy as possible for the Member to navigate. That starts with ensuring Members and providers and other LBHP stakeholders are informed of grievance and appeal

rights and processes. These processes are detailed in the Member and provider handbooks, are available online at www.MagellanofLouisiana.com, and are available in Spanish and Vietnamese (and can be made available in other languages upon request).

Staff across departments are trained in the rights of Members related to grievances and appeals, and are available to assist Members with filing grievances as needed. In addition, Magellan assigns a full-time Grievance Coordinator to ensure dedicated resources are available to work with members and providers to accept grievances, track and trend data, and ensure timely resolution. Magellan offers interpretation or TTD/TTY services when needed. Members can also file in writing or online. To ensure a timely response, Magellan has dedicated staff to monitor the processes, ensure responsiveness to Members, meet time frame requirements, and maintain fidelity to all the components. Magellan further ensures that individuals who make decisions on grievances and appeals were not involved in any previous level of review.

Magellan defines a grievance as an *expression of dissatisfaction about any matter other than an action*. Provider grievances are defined as any expression of dissatisfaction from any other entity other than a member (e.g., provider, stakeholder, customer, etc.). When a caller contacts Magellan with a grievance, we walk them through the grievance process, and if a referral is required, we provide the appropriate contact information and, where possible, warm transfer the individual to the correct entity for follow up.

All grievances are documented into Magellan's proprietary web-based Complaint and Resolution Tracking (CART) system for quality management purposes. We send an acknowledgement to the individual within three business days and member grievances are resolved within the contractual timeframe of 90 calendar days and provider grievances are resolved within Magellan's corporate standard of 30 calendar days. Because of the unique and vulnerable nature of the populations served by the 1915(c) and 1915(b)3 waivers, as well as the 1915(i) State Plan Amendment, grievances filed for those Members are resolved within 14 calendar days, as are quality of care concerns. Magellan uses the data generated by the grievance management system to identify and address any trends or patterns in use or misuse of services, as well as implement program enhancements to increase the individual's ability to obtain needed services and achieve optimal treatment outcomes. Grievances also routinely feed our FWA structure, so that patterns of grievances against a particular provider or provider type could result in referral to the compliance program and further investigation.

Successes for contract year two included a 248.7% increase in member grievances and a 15.6% decrease in provider grievances. Please see below for detailed analysis.

Member Grievances

The LA CMC received 136 member grievances during the contract year. This is an increase of 248.7% over the previous year's grievances of 39. This increase reflects the CMC's effort to address

underreporting and remove barriers to members reporting grievances. As written above, 100% of the 136 grievances were resolved within the contractual timeframe of 90 days. The average resolution time for member grievances was 23 days.

Grievances filed by members with the 1915(i) State Plan Amendment and 1915(c) waivers are required to be resolved within 14 days. Of the 136 member grievances, 38 of them were filed by the 1915(i) and 1915(c) membership. This represents 27.9% of the grievances captured. Those members with 1915(i) submitted 32 or 23.5% of the grievances and those with 1915(c) submitted 6, or 4.4% of the grievances captured. Although Magellan did not meet the goal of 100% compliance with the timeliness standard, the average resolution time for these grievances was 14 days. In the first quarter of the third contract year, Magellan Quality Management department implemented training with the Grievance Coordinator to ensure that these grievances are resolved timely in the future. Please see Appendix D Interdepartmental Team Monitoring Performance Measures for further details on action plan.

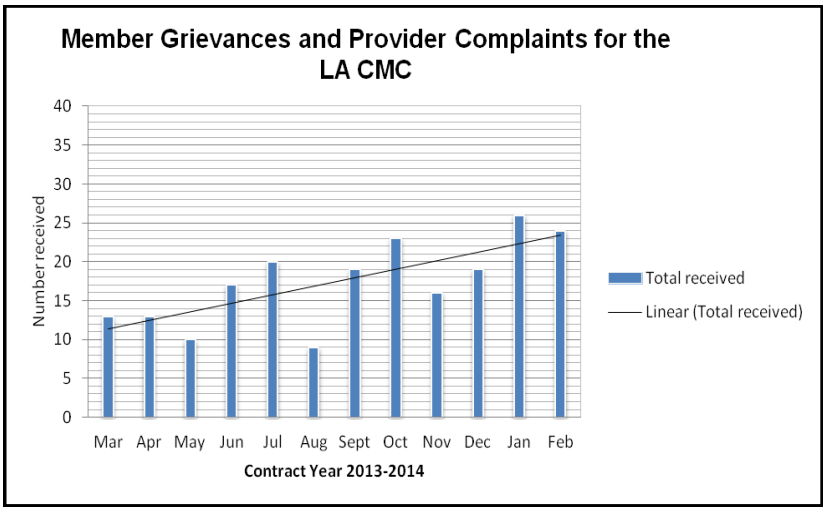
There can be more than one reason identified in a grievance. Magellan received a total of 176 comment reasons for the 136 grievances received. The top reasons for member grievances were Quality of Care and Quality of Service of the Provider, and Access to Service. Grievances citing Access to Service did show a significant increase in the second contract year (CY1: n=0; CY2: n=31), making this reason 22.8% of grievances. There is a formal PIP to address this issue (see section V Quality Improvement Activities and Performance Improvement Projects). Quality of Care and Quality of Service of the Provider continue to be addressed through the Quality Improvement and Network Development departments.

Provider Grievances

The LA CMC recorded and resolved 76 provider grievances, which represented a 15.6% decrease from the first contract year (n=90). This decrease reflects a decline in grievances related to Care/Utilization Management and Claims. Fifty-five of the 76 provider grievances (75%) were resolved within the CMC standard timeframe of 30 days; however the average resolution time for provider grievances was 22.6 days.

As with grievances, there can be more than one reason cited for each complaint. There were a total of 92 comment reasons for the 76 provider grievances received. The top 3 reasons for provider grievances were Care/Utilization Management, Quality of Care, and Provider Management/Access, which accounts for 51.3% of provider grievances. There was a 39% decrease in provider grievances regarding Care/Utilization Management and a 65% decrease in provider grievances regarding Claims issues when comparing the total comment reasons.

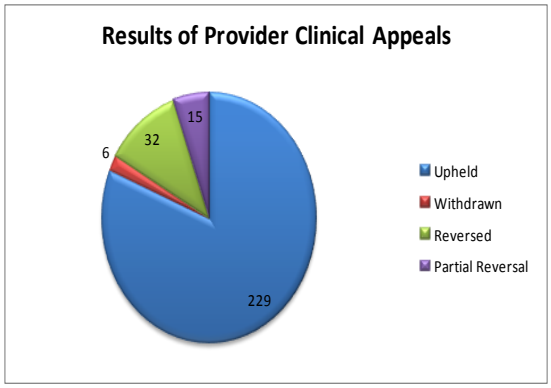
In contract year one, the LA CMC recognized that improving capabilities in the capturing of member grievances presented an opportunity for improvement. The graph below is a representation of all member grievances received at the LA CMC between March 1, 2013 and February 28, 2014. The trend line reflects the LA CMC's successful efforts to identify and capture member grievances. Magellan continues to support this initiative by requiring all LA CMC employees to complete annual trainings related to the identification and reporting of member concerns.

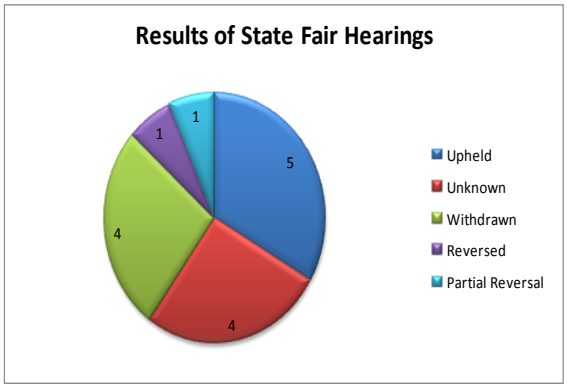


Member grievance and provider grievance data are collected and prepared for presentation and discussion on a monthly basis at the Quality Improvement Committee meeting and on a quarterly basis at the Member Services Committee meeting. By analyzing this information on a regular basis, the LA CMC is able to better identify developing trends and respond to issues to achieve continuous quality improvement.

XXI. Appeals Analysis

Member appeals may be filed by a member or by a member's authorized representative. From March 1, 2013 to February 28, 2014, a total of 282 appeals (195 standard appeals and 87 expedited appeals) were filed. Of the member appeals, 229 (81%) of the initial determinations were upheld, 15 (5%) were partially reversed, and 32 (11%) were reversed. In addition, 6 (2%) were withdrawn by the submitter. Appeals are considered withdrawn if the member's consent is not received within 30 days of sending the provider or member a Notice of Action letter indicating the consent is needed. Ninety-eight percent (98%) of standard member appeals were resolved within the 30-day resolution timeframe, with 99% of expedited member appeals resolved within three (3) business days of the request. Fifteen of these required a state fair hearing. Of those, 5 determinations were upheld, 1 was reversed, and 1 was partially reversed. A majority were either withdrawn (n=4) or the Department of Health and Hospitals has not released determination and are unknown (n=4).

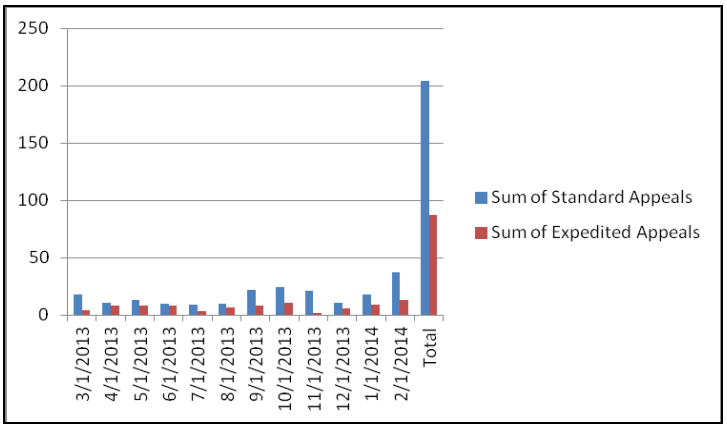




From March 1, 2013 to December 19, 2013, a total of 655 provider disputes were received. Of the provider disputes, 573 (87%) of the initial determinations were upheld, 21 (3%) were partially reversed, 23 (4%) were reversed and 38 (6%) were withdrawn by the submitter.

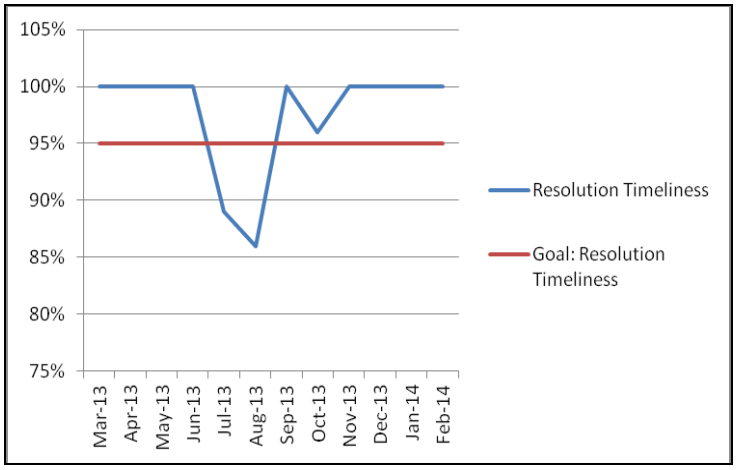
The LA CMC focused on improving the quality of services the Appeals Department provides throughout the year. Further, additional staff trainings have been taking place to ensure that staff has a clearer understanding of the procedures and internet applications going forward. Claims disputes are closely monitored to ensure that all timeframes are met for this process.

The following graph represents standard and expedited appeals figures from March 2013 to February 2014. The LA CMC has consistently noticed an increase in member appeals from March 1, 2013.

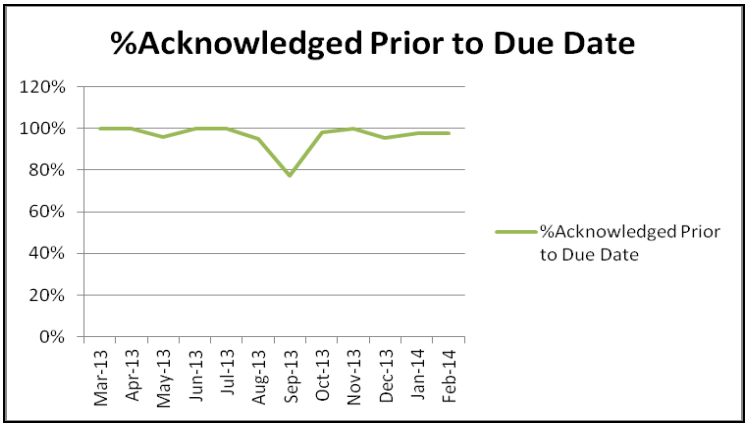


The graph below represents the timeliness of resolution of member appeals. While there is a good deal of variability in the timeliness of resolution, it should be noted that in 10 of the 12 months shown, the resolution timeliness goal was met. Results below goal can be directly attributed to staffing issues and turnover in the Appeals department. Hiring and training of staff was completed during August 2013,

which resulted in positive improvements and a return to compliance in September. The LA CMC will continue to look for and remove any barriers that may tend to preclude meeting the timeliness goal.



As shown in the chart below, Magellan consistently met the 95% compliance rate for acknowledgement until August, where a steep decline is noted. As stated above, this was due to staffing issues and turnover in the Appeals department. Thresholds have been consistently maintained since October.



XXII. Provider Site Visits

The LA CMC Network Department is responsible for assessing the quality, safety, and accessibility of office sites where care is delivered. The LA CMC conducts site visits with providers as part of routine monitoring and credentialing activities. During 2013, 56 providers were visited onsite for review as part of the credentialing process. All providers were found to be compliant with all review elements. Magellan anticipates that there will be an increase in provider site visits associated with credentialing in contract year three. Because credentialing is valid for three years, it expected that many of the providers originally credentialed in contract year one will require a credentialing site visit.

The LA CMC conducted 49 onsite Treatment Record Review, Waiver Performance Measure and ACT Fidelity Audits from August 2013 to February 2014. LA CMC QI staff reviewed record keeping and documentation standards to ensure it was complaint with quality standards. The QI Department also conducted 12 onsite reviews at 10 unique providers to investigate Quality of Care Concerns.

XXII. Accreditation and External Review

Magellan participated actively in both internal and external monitoring to ensure compliance with contract deliverables, federal regulations and corporate standards.

A. URAC

LA CMC was contractually required to obtain URAC Accreditation within two years of implementation. Magellan submitted its application for accreditation in August 2013. In November 2013, URAC conducted a site visit to evaluate the LA CMC's level of adherence with URAC Standards. In December 2013, the LA CMC was notified that it was granted full URAC Accreditation under Health Utilization Management Standards, Version 7.0. Effective date is through January 1, 2017.

URAC preparation at both the Corporate and CMC level is a continuous process. Following the 2013 review, an annual review initiative was developed to be implemented across all CMC sites pursuing URAC accreditation. The National Director of Quality and Accreditation will coordinate the development and implementation of review tools and assessments. Preparation will include a review of new URAC standards against existing Magellan policies, development of web-based review tools, training for divisional staff to conduct the reviews, and orientation of CMCs to the new initiative.

B. Customer Audits

Mercer and OBH conducted a comprehensive onsite review of the LA CMC in May 2013 to monitor compliance with contract requirements and deliverables. Mercer identified opportunities for improvements that were formulated into a formal action plan that is monitored by the OBH. Magellan has officially responded to each of these action items and has implemented process improvements to address deficiencies. Magellan implemented a standardized reporting process and now consistently submits monthly, quarterly, semiannual, and annual reports to the Inter-Departmental Monitoring Team (IMT) as required by contract. The LA CMC has also made significant progress in aligning the management of the Home and Community Based Services funded by 1915(c), 1915 (b3), and the 1915(i) SPA to ensure compliance with federal assurance and sub assurances.

C. External Quality Review Organization (EQRO)

OBH identified IPRO as the External Quality Review Organization (EQRO) for the LA CMC. IPRO was contracted to perform validation of the data collected during the customer audit. IPRO will perform the following tasks: data validation of Performance Improvement Projects, validation of Performance Measures (PMs), validation of compliance review, encounter data validation, validation of member and provider surveys of quality of care, and determination of Medical Loss Ratio (MLR) quality activities. IPRO will also evaluate Magellan's response to the Mercer Action Plan. IPRO began its EQR in January 2014 and the final report is expected in June 2014. The LA CMC cooperates with all requests by IPRO and OBH and incorporates recommendations as part of its continuous quality improvement activities.

XXIV. RESOURCES

The Magellan LA CMC Quality Program is well resourced, including centrally directed resources from Corporate that are administered locally. Corporate resources available to the LA CMC include but are not limited to the:

- Quality, Outcomes and Research Department which supports the LA CMC by providing direction on the identification, implementation, and documentation of Quality Improvement Activities and Performance Improvement Projects, QI document templates, and by implementing satisfaction surveys for members, providers, and customer organizations.
- Analytical Services Department which provides the LA CMC with data reports on several QI and UM indicators and provides consultation on report definitions and analysis.
- Network Services Department which supports the LA CMC by verifying the accuracy of credentials submitted by providers for inclusion in the network.
- National Clinical Management Department which supports the LA CMC through the development medical necessity criteria, clinical practice guidelines, and consultation on clinical, medical, and quality issues for all care and condition care management programs through meetings of the Corporate Committees that occur in the LA CMC.
- Corporate Compliance Department through the development of policy and standards, monitoring of HIPPA and related privacy and security practices and through operation of the Magellan Fraud and Abuse department.

The Magellan LA CMC quality structure is comprised of specialty care and care management center committees. CMC senior management, members, healthcare practitioners, and representatives from medical delivery systems participate in the QI and UM programs through participation in the local committee structure, which includes the Quality Improvement Committee, Regional Network Credentialing Committee, Utilization Management Committee, and related bodies such as member, family member and stakeholder committees.

The LA CMC QI program is supported locally through design, implementation, analysis, and reporting of QI data by healthcare data analysis, research methodology, Lean Six Sigma process, commercial statistical analysis programs, Access, Excel, GeoNetworks®, SAS, SPSS, Ambulatory Follow-up Report, Compliments, Appeals, Grievances, HEDIS®, Member Satisfaction Survey System, Monthly IUR Summary Report, Provider Satisfaction Survey System, Provider Profiling Report, RCM Report, and Readmission Report

XXV. DELEGATION

LA CMC does not delegate the authority to perform any functions on its behalf to any organizational provider, practitioner, or other enterprise.

XXVI. REGULATORY COMPLIANCE MONITORING

The LA CMC is committed to establishing a culture that promotes adherence to legal, contractual and policy requirements as well as promotes the prevention, detection and resolution of conduct that does not conform to those requirements. In order to ensure that business is conducted in a lawful and ethical manner, LA CMC has designated a Compliance Administrator as the resource for reviewing and distributing State specific Medicaid regulatory updates and requirements to appropriate departments and staff. The Compliance Administrator maintains current understanding of Medicaid regulatory requirements and updates through the following:

- Routine monitoring of the Centers for Medicare & Medicaid Services' website for regulatory updates, bulletins and any other relevant information impacting Medicaid
- State requests and distribution of information on necessary changes
- Information disseminated by local or corporate compliance

The Compliance Administrator works with senior management to ensure review of and familiarity with the state Medicaid contract through meetings with a representative from each department to support efficient implementation and ongoing monitoring of all requirements. The Compliance Administrator is actively involved with the Quality Improvement Committee and is the facilitator for the Compliance Committee.

The Magellan Compliance Handbook is distributed to all employees when they begin working at Magellan, and is reviewed annually, so that employees are familiar with the ethical and legal standards with which they are required to comply. The Compliance Administrator ensures all staff members are educated on policies and where to locate these policies. In addition, all Magellan staff is educated at the

time of orientation and annual URAC trainings on how to contact the Compliance Administrator. In addition, each staff member is required to complete an attestation insuring understanding of those procedures and guidelines. Annual trainings on State Medicaid requirements and changes affecting the Magellan of Louisiana CMC are underway. Links to applicable State Medicaid internet sites are also assessable through MagNet.

Providers are informed of the fraud and abuse program and practices, including the fact that allegations will be reported and investigated. This information is included in the Provider Handbook and reviewed through provider meetings, notices, or provider focus alerts.

The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls are investigated and remain confidential. Written confidentiality and non-retaliation policies have been developed to encourage open communication and the reporting of incidents of suspected fraud, waste, and abuse.

Magellan of Louisiana has implemented a fraud/waste/abuse notification plan to address all allegations of such under the Louisiana Behavioral Health Partnership (LBPH). Sources may be external or internal:

External Sources:

- Special Investigation Unit (SIU)
- Compliance Hotline
- Security Hotlines
- Dept. of Health & Hospitals (DHH) –Office of Behavioral Health (OBH)
- Medicaid Fraud Control Unit (MFCU)
- Attorney General's Office

Internal Sources:

- Employees
- Complaint Process
- QI review process
- Providers
- Other

All allegations are channeled to the Corporate Compliance Administrator. The Compliance Administrator is responsible for making SIU, DHH, MFCU and OBH aware of all allegations. Once an allegation has been submitted to the Corporate Compliance Administrator, a preliminary review ensues. If fraud or abuse is not suspected the allegation must be recorded, but no formal report is necessary. In the event fraud and abuse is suspected, SIU, DHH, MFCU and OBH must but notified of all updates.

Furthermore, Magellan's corporate Special Investigation Unit (SIU) is responsible for protecting the assets of Magellan and its clients by detecting, identifying, and deterring fraud and abuse through conducting audits of internal and external sources of information. Magellan's SIU has detailed procedures for detecting, identifying and deterring fraud and abuse as well as educating appropriate Magellan departments and external vendors/customers. The SIU routinely conducts trending analyses and data mining activities that identify billing outliers and irregular billing practices among Magellan-wide contracted providers who have submitted encounters/claims for behavioral health care services rendered. The SIU provides results from claims/billings trending analyses and data mining activities to the corporate compliance administrator. The SIU maintains a collaborative relationship with the Magellan of Louisiana compliance department.

During contract year one, the LA CMC submitted 12 reports to the Louisiana Attorney General (AG). This number was increased to 36 by contract year two for a 200 percent increase in reports submitted. The AG pursued 15 of these reports and actively prosecuted.

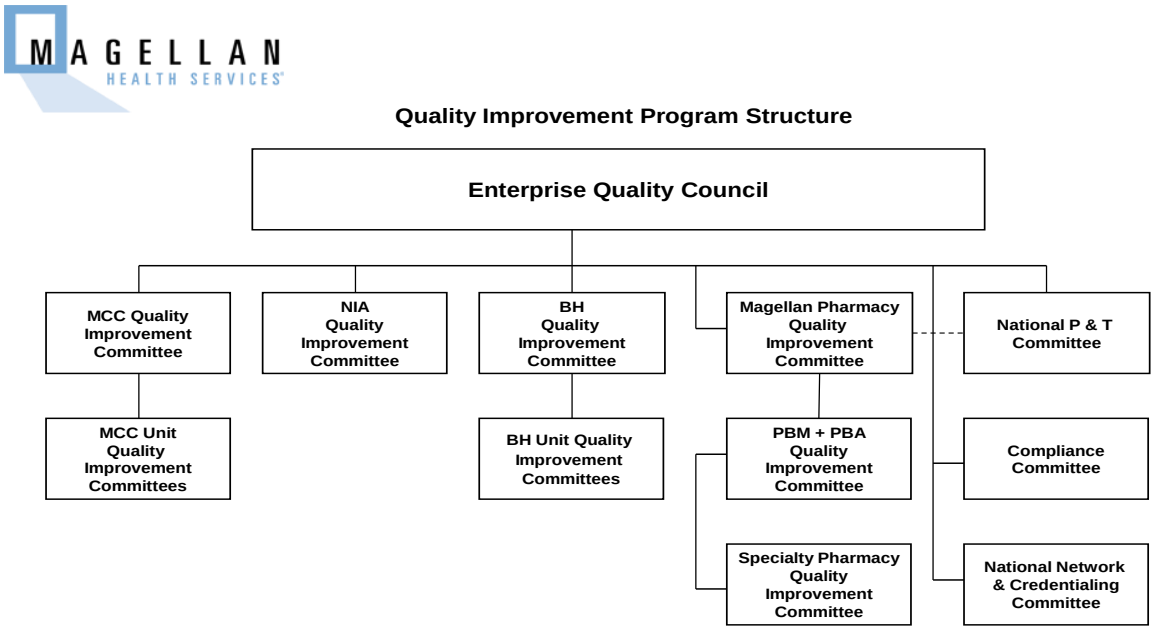
Magellan recognizes the increased complexity of protecting behavioral health recipient's privacy while managing access to, and the release of, protected health information (PHI) about behavioral health recipients in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security requirements. The Compliance Administrator also serves as the privacy officer and is responsible for the creation, implementation and maintenance of Magellan of Louisiana's privacy-compliance related activities. The HIPAA Desk Audits serve as another compliance monitoring method that is routinely employed by the Magellan compliance department to confirm Protected Heath Information (PHI) is controlled according to the HIPAA Privacy and Security requirements and Magellan's confidentiality policies and procedures, as well as to identify and assess areas of potential internal risk. In addition, Training Non-Compliance reports of annually mandated HIPAA/Privacy and Compliance trainings are routinely monitored and tracked by the Compliance Administrator, as these trainings are designed to help foster Magellan of Louisiana employees' awareness and ensure self-compliance with federal and state requirements. Compliance with these requirements is even more essential in light of the new breach notification provisions and associated financial penalties prescribed in the HITECH Act provisions of the American Recovery and Reinvestment Act of 2009. Employee's non-compliance with these training requirements is addressed, in collaboration with Magellan's Human Resources department, using a progressive discipline approach.

XXVII. SUMMARY

The LA CMC's contract year two achievements and opportunities for improvement, as well as prioritized areas for focus in contract year 3 are outlined in the Executive Report on page 3. The contents of this report and documentation provided in the Appendices summarize LA CMC's on-going QI activities, the

trending of measures to assess performance, an analysis of improvements and an overall evaluation of the effectiveness of the QI and UM programs. The LA CMC remains committed to on-going evaluation and improvement of care and services for members.

Appendix A. MH Enterprise Committee Structure



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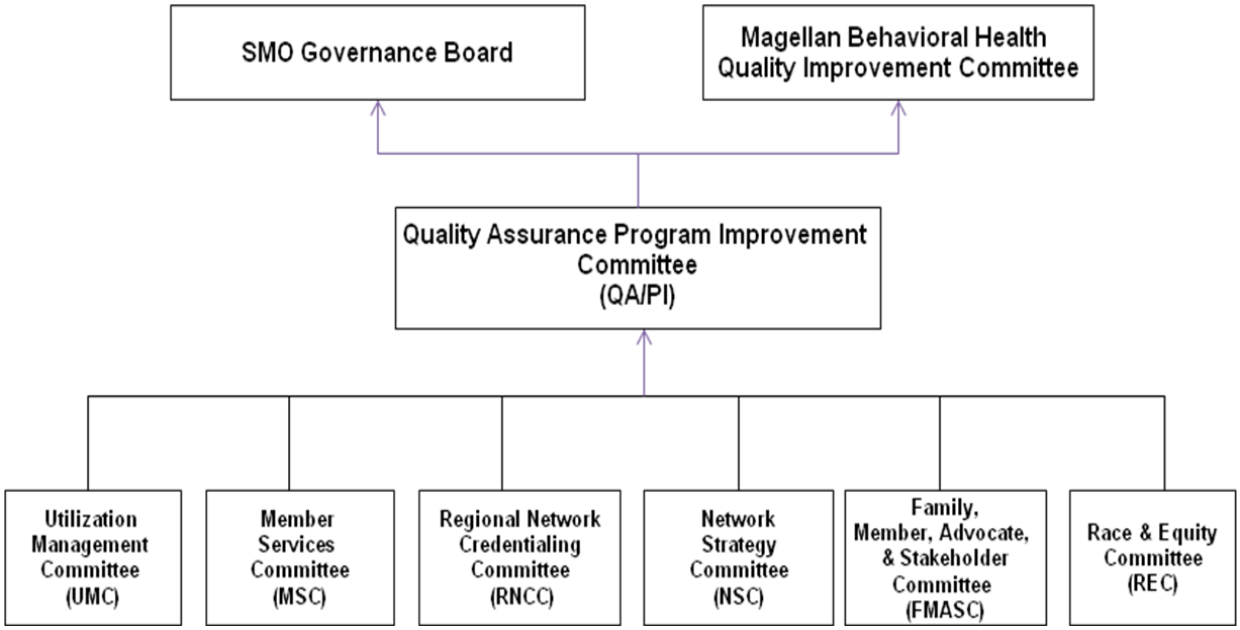
Louisiana CMC Quality Committee Structure



Appendix B. Staffing Grid Magellan Health:

Resources Allocated to
Louisiana CMC
Quality Improvement Program

Resource allocation is evaluated based on the calendar year. The LA CMC served a total of 150,791 unique members (unduplicated members with at least one claims received) during the period from March 1, 2013 to February 28, 2014. This is a 5.5% increase over the number of members served in the first contract year (n=142,923). The Louisiana CMC reorganized to obtain increased process efficiency in its staffing structure, resulting in an increase in staff allocation in the QI and Reporting departments. The workload was adjusted to support the QI functions throughout the year.

The following table outlines the staff resources going into 2014 based on FTEs allocated to meet the needs of the QI program.

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 & Analytics	100%
Sr. Data and Reporting Analyst	100%
Ambulatory Follow-up Supervisor	20%

Louisiana CMC Staff	Percent of FTE Allocated to QI
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 & Research	15%
Vice President Quality Improvement	25%
National Director, Quality Improvement	10%
National Director, Quality & Accreditation	10%
Vice President, Outcomes & Evaluations	20%
Vice President, QI Performance Measurement	10%
Chief Medical Officer – Behavioral Health	10%

Technical Resources
Clinical Information System
IP
Claims System
CAPS
Eligibility/Authorization System
IP
Other Technical Resources
Microsoft® Office Suite
Provider Stand Alone Search
Visio® Basic
Microsoft® Project
MagIC

Analytical Resources
Staff backgrounds in:

Computer programming
Healthcare data analysis
Research methodology
Lean Six Sigma process
Commercial Statistical Analysis Programs
Access
Excel
GeoNetworks®
SAS
SPSS
Customized Programs Available
Ambulatory Follow-up Report
Compliments, Appeals, Grievances
HEDIS®
Member Satisfaction Survey System
Monthly IUR Summary Report
Practitioner Satisfaction Survey System
Practitioner Profiling Report
Intensive Care Manager Reports
Readmission Report

Computer programming

Healthcare data analysis, research methodology, Lean Six Sigma process, commercial statistical analysis programs, Access, Excel, GeoNetworks®, SAS, SPSS, Ambulatory Follow-up Report, Compliments, Appeals, Grievances, HEDIS®, Member Satisfaction Survey System, Monthly IUR Summary Report, Provider Satisfaction Survey System, Provider Profiling Report, RCM Report, and Readmission Report

Appendix C

Interdepartmental Monitoring Team (IMT) Performance Measures

The Louisiana Office of Behavioral Health (OBH) has established an Interdepartmental Monitoring Team (IMT), comprised of separate Youth and Adult committees, which are tasked with ensuring compliance with the 1915(b) waiver, 1915(c) waiver, and 1915(i) State Plan Amendment requirements by collecting and analyzing data and information on all delineated performance measures. The IMT committees receive and review reports submitted by Magellan on the 119 performance measures. Many of the 119 measures are monitored to ensure upward trends and improvement. Fifty of the metrics have strict 100% compliance standards in order to meet federal regulations. Of those, 22 currently meet the 100% compliance standard. Twenty-nine of the PMs do not meet the compliance standard, with 23 of those related to the 1915(i) State Plan Amendment. Most performance measures reflect data from the date parameters March 1, 2013 to February 28, 2014. Exceptions include 1915(c) Performance Measures for Eligibility, Reporting, Enrollee Rights, and Treatment Planning Standards that have a methodology of onsite record review. These measures show the last quarter of the contract year (December 1, 2013 – February 28, 2014). This is because the same five WAA providers were audited each quarter and it represents the current status regarding compliance.

The below chart outlines the performance measures that are required to meet 100% compliance standards. Action plans for elements not in compliance are also included.

Report ID Number	Type of Requirement	PM / Report / Data Element	Methodology	Number and/or Percent of Compliance	Meeting Compliance Threshold	Action Plan Summary
Administrative Standards						
3	1915(c) Waiver Performance Measure	Number and/or percent of active providers (by provider type) meeting ongoing training requirements.	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed, qualified, and authorized to perform services for the LBHP.	97.4%	Not in Compliance	Quarter 3 analysis showed 6 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.
4	1915(i) QIS Performance Measure	Number and/or percent of active providers (by provider type) meeting ongoing training requirements.	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed	96.3%	Not in Compliance	Quarter 3 analysis showed 12 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.

9	1915(i) QIS Performance Measure	Number and/or percent of provider trainings operated by SMO.	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed	100.0%	In Compliance	
10	1915(c) Waiver Performance Measure	Number and/or percent of provider trainings operated by the SMO.	100% Review. Training verification records	100.0%	In Compliance	
11	1915(c) Waiver Performance Measure	Number and/or percent of providers providing waiver services that have an active agreement with the SMO.	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed, qualified, and authorized to perform services for the LBHP.	100.0%	In Compliance	
14	1915(i) QIS Performance Measure	Number and/or percent of waiver providers providing waiver services continuously meeting licensure and certificate requirements while furnishing waiver services	Record review, onsite, 100% sample	96.3%	Not in Compliance	Quarter 3 analysis showed 12 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.
15	1915(c) Waiver Performance Measure	Number and/or percent of Waiver providers providing waiver services continuously meeting licensure, training, and certification requirements while furnishing waiver services.	100% Review. SMO Credentialing	97.4%	Not in Compliance	Quarter 3 analysis showed 6 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.

16	1915(i) QIS Performance Measure	Number and/or percent of waiver providers providing waiver services initially meeting licensure and certification requirements prior to furnishing waiver services.	Record review, onsite, 100% sample	96.3%	Not in Compliance	Quarter 3 analysis showed 12 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.
17	1915(c) Waiver Performance Measure	Number and/or percent of Waiver providers providing waiver services initially meeting licensure, training, or certification requirements prior to furnishing waiver services.	100% Review. SMO Credentialing	97.4%	Not in Compliance	Quarter 3 analysis showed 6 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.
18	1915(i) QIS Performance Measure	Number and/or percent of waiver providers providing waiver services that have an active agreement with the SMO.	Record review, onsite, 100% sample Magellan: Claims review against par providers	96.3%	Not in Compliance	Quarter 3 analysis showed 12 providers missing an OBH Certification letter. All other quarters showed 100% compliance. Corrective Action – A Credentialing Checklist has been added to the contracting process. Verification of the OBH Certification letter is part of this new process.
Eligibility Standards						
23	1915(c) Waiver Performance Measure	Number and/or percent of child/youths that were determined to meet Level of Care requirements prior to receiving waiver services.	Member's CANS data, authorizations and claims were reviewed to demonstrate compliance with review element.100% Review of Prior Authorization Reports to OBH from SMO	100.0%	In Compliance	

24	1915(c) Waiver Performance Measure	Number and/or percent of child/youths who receive their annual Level of Care evaluation within twelve months of the previous Level of Care evaluation.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
25	1915(c) Waiver Performance Measure	Number and/or percent of child/youths' initial Level of Care determination forms/instruments that were completed as required in the approved waiver.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
26	1915(c) Waiver Performance Measure	Number and/or percent of Level of Care determinations made by a qualified evaluator.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	During Q1, 2 and 3, a 90+% compliance rate was met and In Compliance rate was met in Q4. Targeted efforts by the Network and CSoC departments in partnership with the Praed Foundation improved training and verification processes for CANS certified LMHPs (qualified evaluators).
27	1915(c) Waiver Performance Measure	Number and/or percent of child/youths' semi-annual level of care determinations where level of care criteria was applied correctly.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
28	1915(i) QIS Performance Measure	Number and/or percent of adults that were determined to meet LON requirements prior to receiving 1915(i) services.	Prior Authorization reports to OBH; 100% Review	Q1-100%; Q2-100%; Q3-99.99% Q4-99.56%	Not in Compliance	Continuing to educate providers about confirming the 1915i eligibility prior to conducting services.

29	1915(i) QIS Performance Measure	Number and/or percent of adults who receive their annual LON evaluation within 12 months of the previous LON evaluation.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	75.0%	Not in Compliance	10 out of 19 providers were required to submit CAPS to address deficiencies. 9 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
30	1915(i) QIS Performance Measure	Number and/or percent of adults initial LON determination forms/instruments that were completed, as required in the approved SPA.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	81.3%	Not in Compliance	11 out of 19 providers were required to submit CAPS to address deficiencies. 8 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
31	1915(i) QIS Performance Measure	Number and/or percent of LON determinations made by a qualified evaluator.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	76.4%	Not in Compliance	9 out of 19 providers were required to submit CAPS to address deficiencies. 10 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
32	1915(i) QIS Performance Measure	The number and/or percent of adults' annual determinations, where level of care criteria was applied correctly.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	90.9%	Not in Compliance	10 out of 19 providers were required to submit CAPS to address deficiencies. 9 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
Enrollee Rights Standards						
33	1915(c) Waiver Performance Measure	Number and/or Percent of child/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	

34	1915(c) Waiver Performance Measure	Number and/or Percent of child/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
35	1915(i) QIS Performance Measure	Number and/or percent of participant records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	0%	Not in Compliance	19 out of 19 providers were required to submit CAPS to address deficiencies. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
36	1915(i) QIS Performance Measure	Number and/or percent of participant records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	94.4%	Not in Compliance	9 out of 19 providers were required to submit CAPS to address deficiencies. 10 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
37	1915(c) Waiver Performance Measure	Proportion of children/youths reporting their wraparound facilitator helps them to know what waiver services are available	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	

38	1915(c) Waiver Performance Measure	Number and/or percent of child/youths who received information regarding their rights to a State Fair Hearing via the Notice of Action form.	Magellan staff reviewed 100% of member appeals filed during the review period of March 1, 2013 to February 28, 2014 to determine the number of appeals filed by 1915(c) participants and to verify that these members, at the conclusion of the internal appeal process, were informed of their State Fair Hearing rights via the Notice of Appeal Resolution letter.	100% (0)	In Compliance	A review of the appeals files revealed that only one (1) 1915c youth filed an appeal during the reporting period of March 1, 2013 to February 28, 2014. However, no State Fair Hearing rights were provided, because the initial denial was overturned completely on appeal.
39	1915(i) QIS Performance Measure	Proportion of participants reporting their care coordinator helps them to know what waiver services are available	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	38.2%	Not in Compliance	18 out of 19 providers were required to submit CAPS to address deficiencies. One provider was in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
40	1915(i) QIS Performance Measure	Number and/or percent of participants who received information regarding their rights to a State Fair Hearing via Notice of Action form.	Magellan staff reviewed 100% of member appeals filed during the review period of March 1, 2013 to February 28, 2014 to determine the number of appeals filed by 1915(i) participants and to verify that these members, at the conclusion of the internal appeal process, were informed of their State Fair Hearing rights via the Notice of Appeal Resolution letter.	100% (30/30)	In Compliance	Although 39 1915(i) members filed appeals during the second contract year, 9 of the non-authorizations were overturned. Of the 30 that were upheld, all received information on State Fair Hearing rights.
Grievance Standards						

41	1915(c) Waiver Performance Measure	Number and/or percent of grievances filed by child/youths that were resolved within 14 calendar days according to approved waiver guidelines.	Magellan's Grievance Coordinator verified the eligibility status of all individuals who submitted a grievance to determine if the member was a 1915(c) participant at the time the grievance was filed and whether that grievance must be resolved within 14 calendar days. Of those identified, the Grievance Coordinator also reviewed the length of time it took to resolve the matter. The numerator is the number compliant with this measure, the denominator is the total number reviewed.	66.7% (4/6)	Not in Compliance	Trainings have been completed with Grievance Coordinator to regarding timeframe requirements. Internal auditing has been implemented be ensure timeliness standards are met.
42	1915(i) QIS Performance Measure	Number and/or percent of grievances filed by participants that were resolved within 14 calendar days according to approved waiver guidelines.	Magellan's Grievance Coordinator verified the eligibility status of all individuals who submitted a grievance to determine if the member was a 1915(i) participant at the time the grievance was filed and whether that grievance must be resolved within 14 calendar days. Of those identified, the Grievance Coordinator also reviewed the length of time it took to resolve the matter. The numerator is the number compliant with this measure, the denominator is the total number reviewed.	65.6% (21/32)	Not in Compliance	Trainings have been completed with Grievance Coordinator to regarding timeframe requirements. Internal auditing has been implemented be ensure timeliness standards are met.
Network Standards						
44	RFP Deliverables	The Contractor shall subcontract with group home providers that are compliant with current licensing regulations available through the internet at: http://www.dss.louisiana.gov/	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed, qualified, and authorized to perform services for the LBHP.	100.0%	In Compliance	

45	RFP Deliverables	The Contractor shall subcontract with providers offering the following services: (a) Therapeutic Foster Care (TFC). (b) Non-Medical Group Homes. (c) Basic Group Home Level. (d) Group Home Diagnostic Centers /Step-down. (e) Mothers with Infant Level.	The Claims list was compared to the OBH certification list to verify that all providers were properly certified by OBH prior to performing services. Claims were also checked to verify that providers were properly credentialed, qualified, and authorized to perform services for the LBHP.	100.0%	In Compliance	
Reporting						
68	1915(c) Waiver Performance Measure	Number and/or percent of child/youths who received information on how to report the suspected abuse, neglect, or exploitation of children.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
71	1915(i) QIS Performance Measure	Number and/or percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	23.9%	Not in Compliance	17 out of 19 providers were required to submit CAPS to address deficiencies. 2 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Many providers indicated that members were being told how to report abuse as part of the assessment process, but there was not adequate documentation to support this. Magellan implemented new forms as well as a brochure to improve providers' ability to meet this Performance Measure. Improvement is anticipated in contract year 3. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.

Treatment Planning Standards						
78	1915(b)/QMS Performance Measures	Crisis plans developed and implemented as part of individual service plan	1915(c): Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region. 1915(i): QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	1915(c): CY2 Q4 (12/1/13-228/14): 100.0% 1915(i): CY2 (3/1/13-2/28/14): 70.1%	1915(c): In Compliance 1915(i): Not in Compliance	1915(i): IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information. New Plan of Care forms were created that include a crisis plan. If the crisis plan is not included at time of submission, Magellan will not accept the eligibility packet due to non-compliance.
80	1915(c) Waiver Performance Measure	Number and/or percent of child/youths reviewed who had plans of care that were adequate and appropriate to their needs and goals (including health care needs) as indicated in the assessment(s).	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
81	1915(c) Waiver Performance Measure	Number and/or percent of child/youths reviewed whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
82	1915(c) Waiver Performance Measure	Number and/or percent of plans of care that address child/youths' goals as indicated in the assessment(s)	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	

83	1915(c) Waiver Performance Measure	Number and/or percent of child/youths' plans of care that include the child/youth's and/or parent's/caregiver's signature as specified in the approved waiver.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
84	1915(c) Waiver Performance Measure	Number and/or percent of child/youths' plans of care that were developed by a Child and Family Team.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100%	In Compliance	
86	1915(c) Waiver Performance Measure	Number and/or percent of child/youths whose plans of care were updated within 90 days of the last update.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
87	1915(c) Waiver Performance Measure	Number and/or percent of child/youths whose plans of care were updated when warranted by changes in the child/youths' needs	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
88	1915(c) Waiver Performance Measure	Number and/or percent of child/youths who received services in the type, amount, duration, and frequency specified in the plan of care	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	77.5%	Not in Compliance	Magellan has implemented increased monitoring to better understand drivers to non-compliance. The audit tool was modified to determine if it was the WAA, HCBS providers, or the members who were not following the Plan of Care. This will allow Magellan to better target interventions to improve.

89	1915(c) Waiver Performance Measure	Proportion of new waiver child/youths who are receiving services according to their POC within 45 days of PCP approval.	Record Reviews, onsite; less than 100%; Representative Sample; Confidence Interval 95%; Randomly selected approximately 82 charts from 5 WAA providers each quarter. The sample was weighted based on the census of each region.	100.0%	In Compliance	
90	1915(i) QIS Performance Measure	Number and/or percent of participants reviewed who had plans of care that were adequate and appropriate to their needs and goals (including health care needs) as indicated in the assessment(s).	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	62.9%	Not in Compliance	18 out of 19 providers were required to submit CAPS to address deficiencies. One provider was in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
91	1915(i) QIS Performance Measure	Number and/or percent of participants whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	59.0%	Not in Compliance	18 out of 19 providers were required to submit CAPS to address deficiencies. One provider was in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
92	1915(i) QIS Performance Measure	Number and/or percent of plans of care that address participants' goals as indicated in the assessment(s).	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	83.9%	Not in Compliance	16 out of 19 providers were required to submit CAPS to address deficiencies. 3 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.

93	1915(i) QIS Performance Measure	Number and/or percent of participants' plans of care that include the participant's and/or caregiver's signature as specified in the approved waiver.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	71.9%	Not in Compliance	16 out of 19 providers were required to submit CAPS to address deficiencies. 3 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
94	1915(i) QIS Performance Measure	Number and/or percent of participants' plans of care that were developed by and interdisciplinary team.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	79.7%	Not in Compliance	13 out of 19 providers were required to submit CAPS to address deficiencies. 6 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
96	1915(i) QIS Performance Measure	Number and/or percent of participants whose plans of care were updated within 90 days of the last evaluation	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	20.2%	Not in Compliance	13 out of 19 providers were required to submit CAPS to address deficiencies regarding POCs. 6 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
97	1915(i) QIS Performance Measure	Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	12.5%	Not in Compliance	6 out of 19 providers were required to submit CAPS to address deficiencies regarding POCs. 13 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.

98	1915(i) QIS Performance Measure	Number and/or percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	93.5%	Not in Compliance	6 out of 19 providers were required to submit CAPS to address deficiencies regarding POCs. 13 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.
99	1915(i) QIS Performance Measure	Proportion of new participants who are receiving services according to their POC within 45 days of POC approval.	QI randomly selected 385 charts from random selection of high volume provider each year. QI will collect data quarterly (90-100 records). The annual sample size of 385 meets the required 95% confidence level with a +/- 5% error rate.	90.9%	Not in Compliance	6 out of 19 providers were required to submit CAPS to address deficiencies regarding POCs. 13 providers were in compliance. IA/CBCM Action Plan implemented for network improvement. Please see Section XVIII Behavioral Continuum (System Transformation) for more information.

Appendix D

Coordinated Systems of Care (CSoC) Quality Assurance Performance Measures

The CSoC Quality Assurance Committee (QAC) was established by the Office of Behavioral Health (OBH) to monitor the quality outcomes of the CSoC program. The QAC monitors seventeen performance metrics to monitor the quality and outcomes of the CSoC program. The QAC and Magellan have worked collaboratively on developing the methodologies for the metrics, but it is important to note that methodologies have not been consistent making aggregate reporting for contract year two difficult for some metrics.

The QAC received the first set of reports from Magellan in contract Year 2 quarter 1. These reports included data from March 1, 2012 – May 3, 2013. This reporting methodology was approved by the QAC. It should be noted that the reports contain data from the contract year 1 and some of the first quarter of contract year 2. The date parameters for contract year 1 are March 1, 2012 – February 28, 2013. Contract year 2 represents March 1, 2013 – February 28, 2014. When possible, aggregate comparisons between contract years will be provided. If not, Magellan will provide comparisons of March 1, 2012 – May 3, 2013 and December 1, 2014 – February 28, 2014. Time parameters for the data will be indicated for each metric.

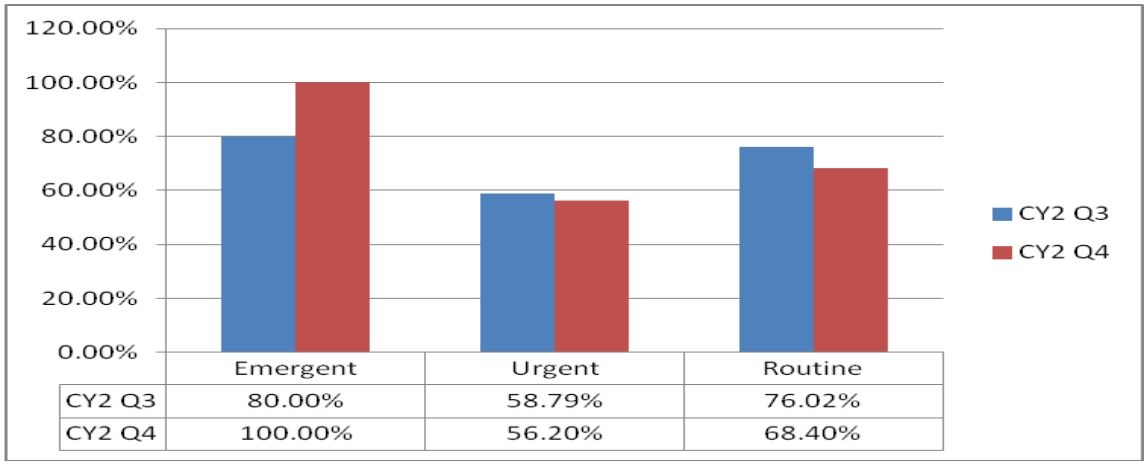
1. QA Report 1: Appointment Access/WAA Fidelity

A. Total # of days from initial date of authorization to date of first billable service. (Now Emergent, Urgent and Routine Appointment Access)

- **3/1/12-5/3/13:** 17.28 days on average between signing Freedom of Choice form and first paid claim.
- **12/1/13-2/28/14**: Due to enhancements in data collection methods, the CSoC QA Committee requested the format of this metric be changed to reflect emergent, urgent and routine access standards. This was first reported in Contract Year 2 Q3. Detailed report for CY Q4 as well as trending is provided below.

Service Risk Level	Number	Average Days to	Percent in

		Service	Range
Emergent	1	0	100.0%
Urgent	178	6.52	56.2%
Routine	500	13.35	68.4%



Corporate access standards for Emergent, Urgent, and Routine standards with goals respectively below:

- Emergent: 95%
- Urgent: 95%
- Routine: 70%

There are many barriers to appointment access that could be affecting compliance. Please see formal PIP Improve Member Access to Emergent, Urgent, and Routine Appointments in Section V of the Program Evaluation for interventions implement to improve access. It is important to data could show increased variability due to the low number of members involved in CSoC

B. Mean number of days between brief CANS and referral to WAA

- **3/1/12-5/3/13:** 13.54 days
- **12/1/13-2/28/14**: 7.57 days

There was improvement noted between the two contract years. The goal is reduce this number to ensure members are receiving services in a timely manner.

Action plan:

- Additional targeted trainings occurred for care managers to ensure that unknown delays are not occurring from the time the Brief CANS is completed to the referral being sent to the CSoC CM team internally
- In addition, during most of the 2012 implementation period, there was a "Re-referral" process in place that adversely affected this data because the brief CANS date would remain the same, but the "Re-referral" date would reflect a new date ultimately allowing more days from brief CANS to referral date to the WAA being recorded in the system. Once both systemic problems were identified, CSoC team held trainings with all clinical operations team that improved understanding of the CSoC referral process and operational workflow. Turnaround time from brief CANS to referral date to WAAs improved. The "Re-referral" guideline was changed to reflect a 30 day waiting period to occur from original referral date before a member could be "re-referred."

C. Means days between date of Referral to WAA and signing of FOC/ Number signing FOC

- **3/1/12-5/3/13:** 3.9 days.
- **12/1/13-2/28/14:** 6.0 days.

There was an increase in the mean number of days between date of referral and signing of the FOC between the two years. This can be attributed to four of the five Wraparound agencies being at full enrollment capacity at one point. Our Enrollment Management process for each region is outlined below providing additional drill down explanation of activities that can affect total # of days from the date a Brief CANS is conducted to the date of an initial referral to WAA. This Enrollment Management is a fluid process and has been successful and it requires an incredible amount of communication between Wraparound agencies, Magellan CSoC and RCM staff.

ENROLLMENT MANAGEMENT (Y2 Q4)		
REGION		
1	• Hit full capacity of 240. Increased staffing numbers and received an additional 10 slots giving them a total of 250. Currently, at full capacity for 250. An additional 62 referrals have been referred to Resiliency Care Management (RCM) until open CSoC slots become available.	
2	• At full capacity of 240. An additional list, fewer than 10 names, is ready for CSoC when slots become available and turnaround time is averaging 1-3 days.	
7	• Allotted 220 capacity and has open slots available	
8	• Hit full capacity of 240 during two months of this quarter, but currently has open slots available	
9	• At full capacity of 240. Increased staffing numbers and received an additional 10 slots giving them a total of 250. Currently, an additional list, fewer than 10 names, is ready for CSoC when slots become available and turnaround time is	

	averaging 1-3 days

2. QA Report 2: Emergency Department Utilization

The metric is calculated as the number of CSoC youth who have had one or more ED visits divided by the number of CSoC youth. The mean number of ED visits among CSoC children with at least one ED visits can also be reported. This measure does not capture enrollment into the CSoC program from ED's.

Time Period	ED PRESENTATIONS	UNIQUE CSoC MEMBERS	Total CSoC Population	% Of Members Utilizing	Average Presentations/ Member
3/1/12-5/3/14	157	87	1206	7.21%	1.8
12/1/14-2/28/14	43	33	1206	2.74%	1.3

There was a decrease in the percent of members utilizing the emergency room; however, Magellan continues to work towards improvements. The below intervention are in place to address:

- Network continues to explore expansion of lower levels of care
- Network development of "23 hour bed" option is being pursued
- Anecdotally, WAAs serving members with increasingly higher levels of acuity as program matures
- As more referral sources are developing, the referral comes in at a higher stage of acuity so that CSoC is more successful at preventing re-admissions to longer term levels of care.

3. QA Report 3: Utilization of Community Resources/Report 11: Utilization of claims paid services

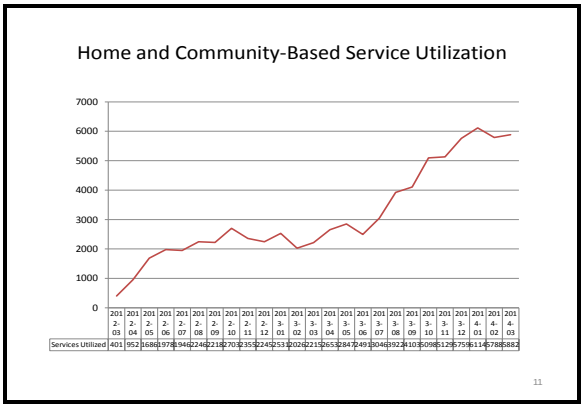
The mean is calculated as the total number of community-based services billed divided by the total number of CSoC youth and will be reported on a quarterly basis. Because the data in both reports are reported on paid claims the two metrics are the same.

- **3/1/12-5/3/13:** PSR – 62.7; CPST – 40.2; PST – 13.1; YST – 7.3; Respite – 0.03
- **12/1/13-2/28/14:**

Age/ Population Category	1915b3	1915c
CPST Members Served	325	340

CPST ANOU	32.59	31.19
PSR Members Served	276	328
PSR ANOU	57.86	54.04
CSoC PST Members Served	208	229
CSoC PST ANOU	59.87	63.42
CSoC YST Members Served	199	228
CSoC YST ANOU	65.93	65.39
CSoC ILSB Members Served	38	43
CSoC ILSB ANOU	142.13	91.77
CSoC STR Members Served	33	30
CSoC STR ANOU	237.45	173.6
CSoC CS Members Served	-	-
CSoC CS ANOU	-	-

As seen below, there has been a steady increase in home and community based services.



4. QA Report 4: Utilization of WAA facilitated services

A. Failure to enroll

- **3/1/12-5/3/13:** 15.3%
- **12/1/13-2/28/14**: 28.5%

During implementation year, there was an initial 30 day timeframe for members to sign an FOC and CANS comprehensive to be submitted before enrollment could occur. This early data negatively affects the overall timeframes in which FOCs were signed and members enrolled. The below interventions have been implemented to improve.

- Corrective plans started when the 10 day time period was set and enforced for an FOC to be signed and the Comprehensive CANS assessment to be submitted.
- Additional education and training to the WAAs and Certified Providers about new timeframes improved.
- As the program continues to mature and develop, the WAA staff and Certified Providers have gained experience in how to better engage with youth and families.

B. Refusal to sign FOC within 10 days

- **3/1/12-5/3/13:** Not reported
- **12/1/13-2/28/14**: 21%

C. ALOS

- **3/1/12-5/3/13:**157 days
- **12/1/13-2/28/14**: 269.18 days

WAA Region	Authorization Frequency	Average Length of Stay	Median of Length of Stay	Mode of Length of Stay
All Regions	132	269.18	248.50	285

This increase can be attributed to better ability to engage members in the CSoC program.

Interventions:

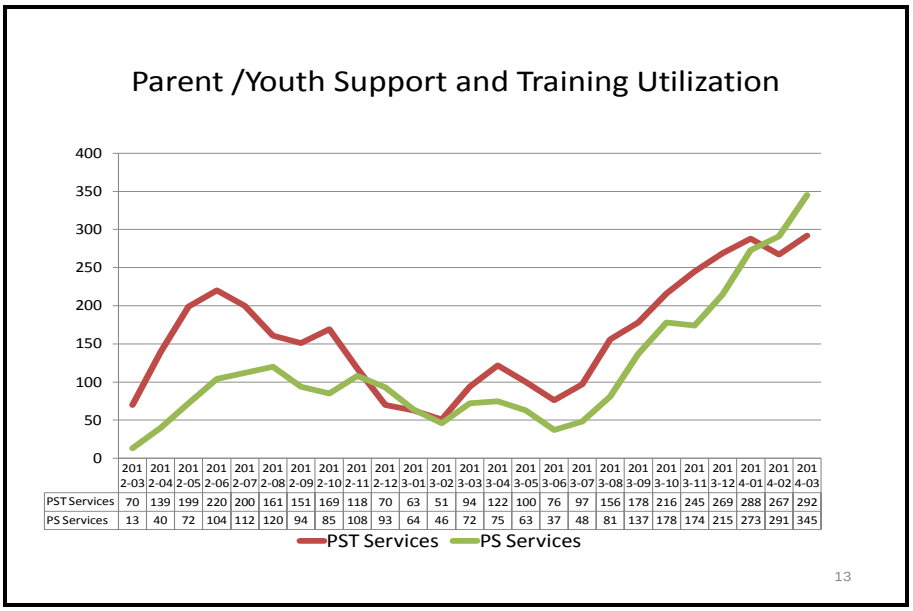
- Trainings: to increase community knowledge of eligibility requirements; how to call in a referral; state agency personnel improved referral submissions into Clinical Advisor.

5. QA Report 5: Utilization of Peer Support Services

The metric is defined as the mean number of Youth Support and Training services provided to CSoC youth divided by the number of CSoC youth enrolled. The mean number of Parent Support and Training services provided to parents is the total number of PST services provided divided by the number of CSoC enrolled.

- **3/1/12-5/3/13:** PST – 13.2; YST – 7.3
- **12/1/13-2/28/14:**

Procedure Description	Number of Services	Number of Members	Mean
PEER (YOUTH) SUPPORT SERVICES	2210	353	16%
PARENT SUPPORT SERVICES	2552	381	15%



While FSO administrative practices and number of staff have shown improvements, challenges have continued to affect their ability to provide Parent and/or Youth Support services in a timely fashion to CSoC members and on a consistent basis. State Family Support Organization staff turnover has presented its own challenges.

Interventions:

- The Executive Director of the SFSO has initiated additional staff trainings and a weekly call with the Wraparound agencies in an effort to improve collaboration on referrals and quality of services being provided.
- A joint OBH/Magellan/SFSO workgroup was formed this quarter to provide "hands-on" oversight, management, support and guidance to the SFSO to help improve services and stabilize staffing.
- During the 1915c HCBS Waiver Training, Session 2, for WAA Directors, Clinical Supervisors and SFSO Director on 12/17/13, this PM was also addressed.
- No true outcome measures from these interventions can be validated at this time, but are anticipated for future reports.

6. QA Report 6: Number of Peer Specialist Providing Services

Description	3/1/2013-5/3/2013	12/1/13 to 2/28/14

PEER (YOUTH) SUPPORT SERVICES	63	59
PARENT SUPPORT SERVICES	41	42
TOTAL	104	101

While the Family Support Organization (FSO) administrative practices and number of staff have shown improvements, challenges have continued to affect their ability to provide parent and/or Youth Support services in a timely fashion to CSoC members and on a consistent basis. SFSO staff turnover has presented its own challenges. The Executive Director of the SFSO has initiated additional staff trainings and a weekly call with the Wraparound agencies in an effort to improve collaboration on referrals and quality of services being provided. A joint OBH/Magellan/FSO workgroup was formed this quarter to provide "hands-on" oversight, management, support and guidance to the FSO to help improve services and stabilize staffing. During the 1915c HCBS Waiver Training, Session 2, for WAA Directors, Clinical Supervisors and SFSO Director on 12/17/13, this PM was also addressed. No true outcome measures from these interventions can be validated at this time, but are anticipated for future reports.

7. QA Report 7: Average Numbers of Wraparound Plans Developed per Youth Served

- **3/1/12-5/3/13:** 2.27 plans
- **12/1/13 to 2/28/14:** 2.94 plans

There was an increase of 0.67 plans on average per member in contract year 2. Although improvement was noted the following interventions have been implemented.

Interventions/Action Plan:

- Report automation during this quarter has allowed for additional drill down and closer monitoring of waiver requirements.
- Trainings – three targeted trainings on 1915c HCBS Waiver in-depth training on "Quality Improvement/Quality Management" performance measures required by the waiver conducted on March 13th and 14th, 2014 with WAA Directors, QI Managers, Clinical Supervisors and SFSO Director.
- Plans to provide each WAA with a monthly Scorecard that will include region specific outcomes data and PM results have been initiated
- Wraparound agencies will continue to be expected to conduct additional drill down at the individual staff member level for monitoring compliance.
- Magellan CSoC care managers will be receiving additional education on the Wraparound approach and philosophy.
- Wraparound high-fidelity monitoring will be conducted in contract year three quarter one.

8. QA Report 8: Youth Screened, Identified as At-Risk and referred to Wraparound Agency

Summary	3/1/12-5/3/13	3/1/13-2/28/14

Members who were screened for Eligibility	5,693	2,342
Members who were deemed initially eligible	3,384	2,186
Percent	59.4%	93.3%

Although the number of screenings declined, the percent that were deemed eligible increased. This is attributed to improved referral process and education about the criteria for the program. Factors affecting referral to WAA include: WAAs enrollment capacity; whether the child/youth lives in a CSoC implementing region or not; whether child is already receiving Multisystemic Therapy services (which cannot co-exist with CSoC); and if referring agency/caller declines CSoC. Interventions implemented by Magellan in contract year 2 are:

- Enrollment management process were implemented - to help manage the number of incoming referrals, meet the supply and demands unique to each CSoC region and WAA staff capacities while continuing to provide each member with the appropriate services and care coordination.
- The Resilience Care Management Team (RCM) became much more involved with CSoC eligible children and youth during this process and will continue.

9. QA Report 9: Crisis Plans developed and implemented as part of individualized service plan

- **3/1/12-5/3/13:** 153 = # of utilization claims for crisis services ; 1320 = total # of CSoC youth with crisis plans; 11% of crisis plans were utilized
- **12/1/13 to 2/28/14:** 100% of records sampled (n=82) had crisis plans developed
- Significant changes in reporting methodology make comparison of contract years meaningless.

Interventions that were implemented in contract year two to address include:

- Additional 1915 (c) HCBS Waiver Trainings occurred for WAA Directors, Clinical Supervisors and SFSO Director specifically addressing data collection and reporting on all waiver quality performance measures
- Care Managers provide feedback at the time of submission to ensure crisis plan development meets the needs of the member

Opportunities for Improvement/Action Plan:

- Magellan CSoC and clinical team members will continue to give feedback on daily calls and during weekly agency onsite visits to the Wraparound staff regarding crisis plan development and accurately collecting and documenting implementation.
- Crisis plan implementation remains a difficult element to capture in data since each CSoC enrolled member's crisis plan is very individualized. Magellan continues to speak with the QA committee on ways to improve collecting this data.
- Waiver audit tool has been updated to include "crisis implementation" as a line item

10. QA Report 10: Inpatient Hospitalization Readmission Rate

- **3/1/12-5/3/13: 48%**
- **12/1/13 to 2/28/14: 18.92%**

The metric is defined as the number of re-admitted divided by all CSoC youth with at least one in-patient admission. Early data varied quite a bit due to low enrollment numbers. Over time, the enrollment has significantly increased and program has served over 2,000 since contract year 1 and re-admissions have declined along with percentages of population. Magellan provides continuous and ongoing trainings with all involved providers (e.g., WAAs, FSO, HCBS providers) as well as increased monitoring. It should be noted that as more and more children and youth are served in CSoC and successfully complete the program, the acuity levels may be skewed higher due to new members enrolling in each region. Tracking and trending the data will continue to be reported.

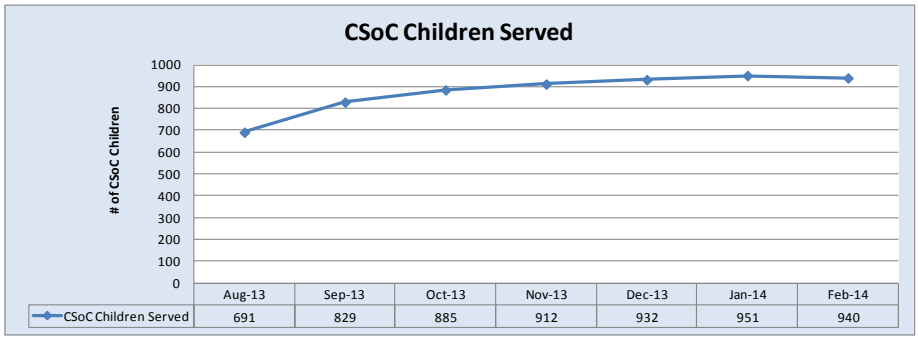
11. QA Report 11: Utilization of claims paid services

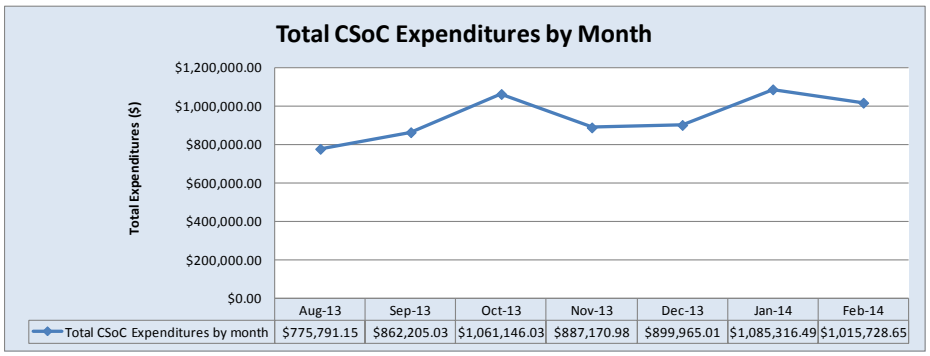
See report 3.

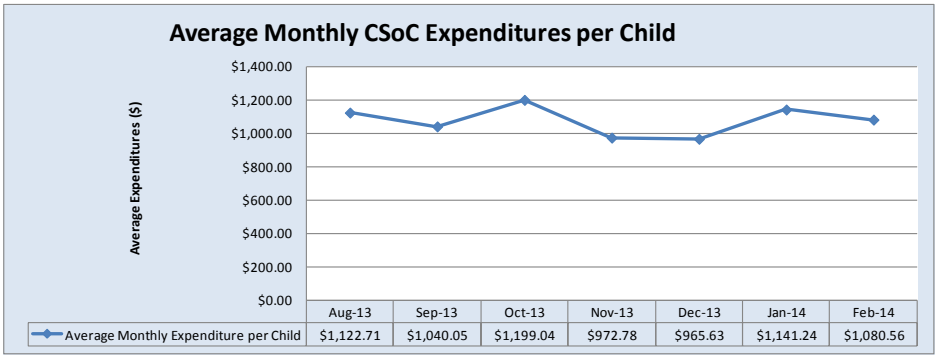
12. QA Report 12: Behavioral health cost per person served, per month

The below metric is defined as the mean expenditure per month for all CSoC children divided by the total number of CSoC children. The below charts and graphs outline the details of this metric and show slight declines in cost from August 2013 to February 2014.

Metric	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
CSoC Children Served	691	829	885	912	932	951	940
Total CSoC Expenditures by month	$775,791.15	$862,205.03	$1,061,146.03	$887,170.98	$899,965.01	$1,085,316.49	$1,015,728.65
Average Monthly Expenditure per Child	$1,122.71	$1,040.05	$1,199.04	$972.78	$965.63	$1,141.24	$1,080.56







CSoC Expenditure			
			Report ID : LCNS0004M
All CSoC			
Children		**Total Expenditure**	**Average Expenditure Per Child**
1,212		$3,078,109.81	$2,539.69
Non Medicaid			
Level of Care	**Children**	**Total Expenditure**	**Average Expenditure Per Child**
Other Outpatient	9	$1,191.18	$132.35
TOTAL	9	$1,191.18	$132.35
Medicaid			
Level of Care	**Children**	**Total Expenditure**	**Average Expenditure Per Child**
Inpatient	116	$488,457.33	$4,210.84
Intensive Outpatient (IOP)	6	$4,814.84	$802.47
Other	9	$55,932.67	$6,214.74
Other Outpatient	1,063	$1,234,108.05	$1,160.97
Parent Support	413	$271,786.00	$658.08
Peer Support	384	$255,420.00	$665.16
Residential Treatment	77	$618,467.54	$8,032.05

Center			
Short Term Respite	76	$68,827.20	$905.62
Skill Building	70	$79,105.00	$1,130.07
TOTAL	1203	$3,076,918.63	$2,557.70

There was a decline in the mean monthly expenditures from year 1 to 2. This report further details expenditures for all CSoC children both Medicaid and Non-Medicaid and by level of care. Expenditures are reported by total for each category including number of children, total expenditures, and average expenditures per child. Since August 2013 the number of CSoC children served increased by 249 with total expenditures increasing from $775,791.15 to $1,015,728.65 and average expenditure per child decreased from $1,122 to $1,081. See trending data below.

School Performance Measures (Reports 13, 14, 15)

Educational outcomes data should interpreted cautiously since report card periods are not standardized across school systems and consistent collection of performance and conduct data in all school districts remains an area of concern. School data collection provides an opportunity for growth and Magellan has partnered with the Youth IMT and DOE to identify process improvements.

13. QA Report 13: School Attendance

School Attendance/ Missed Days				
REPORTING PERIOD	**1**	**2**	**3**	**4**
3/1/12-5/3/13	3.53	2.55	2,20	1.42
12/1/13 to 2/28/14	2.12	2.24	1.47	1.34

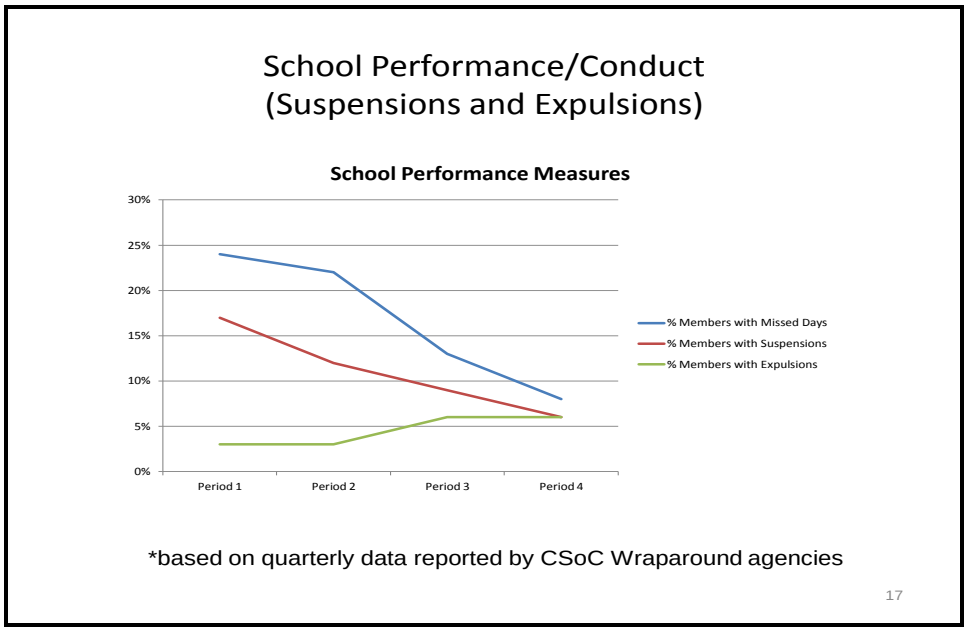
Discussion and action plan is found in Report 15.

14. QA Report 14: Conduct- Suspensions/Expulsions

This metric is defined as: the percentage of CSoC youth that has been suspended or expelled is defined as the number suspended + expelled (defined by DOE) divided by all current CSoC children. This will be reported on a semi-annually.

- **Contract Year 1:** Suspensions: R1 – 27.0; R2 – 24.0; R3 – 15.0; R4 – 6.0
  Expulsions: R1 – 5.0; R2 – 7.0; R3 – 7.0; R4 – 3.0
- **Contract Year 2:** The graph below provides data.

There was noticeable percentage decline in suspensions over reporting periods from 17% to 6% (or an 11% decline). Discussion and action plan is found in Report 15.



15. QA Report # 15 School Performance (GPA's)

- **Contract Year 1:** R1 – 2.30; R2 – 2.29; R3 – 2.14; R4 – 2.08
- **Contract Year 2 :** QAC currently working on methodology (see below)

Tremendous challenges are encountered when trying to accurately capture each CSoC member's school performance reported using grade point averages when GPAs are reported differently in each school district and with varying grading scales. Additional challenges have been encountered when trying to capture GPAs from alternative schools, private schools, homeschooled members and those in GED programs

Interventions for all 3 Related Performance Measures (#13, 14, and 15):

- Tremendous effort was allocated towards getting an agreement with JPAMS vendor to allow the appropriate sharing of school information with the Wraparound agencies as long as it was accompanied by a release of information form. The outcome of that agreement did improve the data reporting by the WAAs; however, for only a percentage of the overall CSoC enrollment.
- Magellan's DOE Liaison partnered with the Wraparound agency Directors and supervisors to outreach leadership in the surrounding school districts to also enhance data collection efforts.
- A workgroup with representatives from OBH/DOE and Magellan's Children's System that includes: CSoC and Quality Improvement team members convened. The workgroups primary focus is on identifying and evaluating other strategies and data sources to collect the most reliable information for all school performance measures for CSoC members. In

the initial meeting, it was clarified that the DOE collects data on student test scores rather than GPA due to varying grading scales across districts and types of schools

- Magellan moved to automated reports on school performance measures; thus, allowing for a more detailed presentation of the outcomes data submitted.

16. QA Report 16: Decreased # of CSoC youth in restrictive setting

- **3/1/12 – 5/31/13:** Percent of CSoC children who had restrictive placements prior to enrollment in WAA = 201/1259 = 15.9; Percent of CSoC youth in restrictive placement after enrolling in WAA = 83/1259 = 6.6%
- **12/1/13-2/28/14:** During Q4, 81 unique members (7.6%), out of 1064 enrolled members, who had 105 out of home placements in a restrictive setting. Over the past year, in Q3, there were 91 unique members (8.9%), out of 1037 enrolled members, who had 102 placements in a restrictive setting. In Q2, there were 69 unique members (7.4%), out of 928 enrolled members, who had 80 placements in a restrictive setting.

Changes to reporting methodologies make this metric difficult to compare directly. Restrictive settings include inpatient hospitalization, substance abuse inpatient settings, TGH, detention and secure care facilities. QI and CSoC departments will monitor providers to ensure that they are implementing plans of care that meet the needs of these children that should reduce total out-of-home placements.

17. QA Report 17: Utilization of Natural Supports

Natural and Informal Support Utilization		
	3/1/12 to 5/3/13	12/1/13 to 2/28/14
Total # of CSoC children/youth	1320	1034
# of children that have utilized natural supports	855	777
Percent of members utilizing natural and informal supports	65%	75%

There is an increase in the utilization of natural supports from contract year 1 and 2. The UM department monitors to ensure natural supports are included in the POC and the CSoC department monitors the POC to ensure the natural supports are utilized as needed.